

**The challenging behaviour of children in the  
South Australian out-of-home care sector:  
Stakeholders' experiences with collaborative  
practice and their frameworks for managing  
behaviour**

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Submitted for the award of

Doctor of Philosophy

in the School of Psychology

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December 2009



## DECLARATION

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## ABSTRACT

The research presented in this thesis was predicated on the need to improve service provision and care for children in out-of-home care. Although behavioural concerns are prevalent in this population, and frequently serve as the focus for interagency discussion, little is known about how the respective stakeholder groups in the out-of-home care sector understand and manage challenging behaviour. While the complexity of children's needs necessitates effective collaboration between multiple services, relatively little theoretical or practical guidance exists about how this can be achieved, particularly in relation to supporting children with challenging behaviour. The long term significance of unaddressed behavioural issues for placement stability and educational outcomes provided the compelling impetus for this research.

The research had two broad aims. First, to identify barriers to collaborative practice, using the specific example of stakeholders' experiences in supporting young people in out-of-home care to resolve challenging behaviours. Second, to identify what accounts of behaviour are dominant amongst key stakeholders and further, to understand what these accounts might mean for the practice of collaboration and for the support provided to children in out-of-home care. Accordingly, this thesis reports a thematic analysis of the interviews of 92 South Australian stakeholders, representing five key stakeholder groups: foster carers, teachers, residential care workers, child mental health workers and child welfare

caseworkers. Participants completed semi-structured interviews in which they were asked about their understanding of challenging behaviour and their experiences in working collaboratively with other stakeholders in order to support children.

Thematic analysis of stakeholders' experiences of collaboration confirmed several barriers previously suggested to be important, indicating the universal nature of these difficulties, irrespective of the population being serviced. Amongst the novel findings, however, was a pervasive 'triangulation' in children's relationships, originating in systemic issues, which resulted in markedly diminished ability for caregivers and others to implement behavioural contingencies and work through conflict in relationship with the child.

Stakeholder discourse about behaviour was then analysed in order to identify commonalities and points of divergence in understanding and approaches to behaviour. This analysis identified six ways in which behaviour was understood and confirmed the dominance of attachment conceptualisations in the out-of-home care sector. Accounts of behaviour as arising out of trauma appear to be under-represented amongst stakeholders. Discrepancies in stakeholders' accounts were discussed, and implicit attributions of control and responsibility inherent in accounts were argued to provide a 'way forward' for stakeholders seeking a common understanding of behaviour. The concept of 'attachment' was found to be employed in ways that deviate from accepted theory, and the potential consequences for policy and practice of these 'misrepresentations' of attachment was highlighted.

Finally, the discourse of one stakeholder group, residential care workers, was further analysed. These workers are frequently required to manage extremely challenging and difficult to control behaviour. Results provide the opportunity for those 'outside' the unit to understand the environmental and relationship context in which attempts to manage behaviour occur and the unique strains inherent in residential work. The policy and practice implications of the research are discussed.



## ACKNOWLEDGEMENTS

I would especially like to thank the people that took part in this research. I am extremely grateful to them for making the time to talk to me about supporting children in the out-of-home sector. Without their participation, this research would not have been possible.

I would also like to thank my supervisors, Associate Professor Paul Delfabbro, Dr. Lisa Kettler and Dr. Damien Riggs. I have been extremely fortunate to benefit from the unique combination of their skills and experiences. I am particularly grateful to Lisa for her support in dealing with the many obstacles that popped up along the way.

Finally, I am grateful to my partner Michael and my very understanding children: Ruth, Sam, Georgina and Alex. I know all this writing, reading and stressing has been hard for them to understand and I am sure that they are looking forward to Mum getting a real job again.



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## OVERVIEW

### Background to the research

#### *General introduction*

There will always be children who, for a variety of reasons, are unable to be cared for at home with their biological families. This ultimately results in the child being placed in a form of substitute, or ‘out-of-home’ care. Recent Australian Institute of Health and Welfare reports (Australian Institute of Health and Welfare: AIHW, 2007, 2009) indicate that the number of children living in out-of-home care is increasing. This is likely to reflect both a combination of policy and legislative changes and broader socio-economical and familial stressors, resulting from a combination of increased reporting of abuse and possible increasing levels of abuse and neglect. Importantly, this change has occurred in the context of the decreasing availability of suitable foster placements and a substantial reduction in the provision of residential care and group homes over the last two decades (Barber, 2001).

As a result of these factors, out-of-home care is increasingly likely to be used as a last resort, meaning that only those children with the most complex needs are likely to be placed in out-of-home care and, in these circumstances, the placements that do occur may be more at risk of breakdown (Barber & Delfabbro,

2004; Delfabbro, Barber & Cooper, 2000). Several studies have also identified that the challenging behaviours exhibited by children with complex needs feature strongly in placement breakdown (e.g., Oosterman, Scheungel, Wim Slot, Bullens, Doreleijers, 2007).

According to Emerson (1995) challenging behaviour may be defined as:

Culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to limit use of, or result in the person being denied access to ordinary community facilities (p. 4).

Amongst children in out-of-home care, such challenging behaviours appear to be extremely common. Children in out-of-home care have higher rates of emotional and behavioural problems than either their chronological age peers, or peers with similar maltreatment backgrounds (Pilowsky, 1995). Conduct disorder, in particular, features strongly (Sawyer, Carbone, Searle & Robinson, 2007) and clinical measures of conduct disorder appear predictive of placement breakdown (e.g., Barber, Delfabbro & Cooper, 2001).

Providing support to this population of children may be difficult for mental health professionals and other stakeholders attempting to address behaviour because of the complex interplay of developmental, behavioural, emotional, health and educational needs contributing to children's difficulties (Kortenkamp

& Macomber, 2002). However, the prognosis for children who do not receive effective intervention and support appears to be poor in terms of educational and mental health outcomes (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Kendall-Tackett, 2002; Landsverk, Davis, Ganger, Newton, & Johnson, 1996).

Children in out-of-home care, by virtue of their complex needs, are likely to come into contact with multiple systems and services. It can be argued that effective intervention in the case of challenging behaviours necessitates effective collaboration between these systems and services (Cottrell, Lucey, Porter & Walker, 2000; Morrison, 1996). Examples of the systems, services and stakeholder groups that are involved with children in out-of-home care exhibiting challenging behaviour include education staff, child mental health workers, residential care workers, foster carers and child welfare caseworkers. Ideally, these stakeholder groups should work together in order to execute commonly identified goals in relation to behaviour change.

Little is known about how such interagency collaboration between key stakeholders is affected in practice (Hudson, 2002; Ødegård, 2005). Accordingly, this research seeks to explore the reality of collaborative practice amongst stakeholders in out-of-home-care, using the specific example of addressing challenging behaviour. Given that several promising approaches to intervention with maltreated children and to children with conduct difficulties rely on collaborative approaches (e.g., Burns, Schoenwald, Burchard, Faw & Santos, 2000), it is important to understand the experiences of professionals and carers in attempting to address such challenging behaviour.

Although there has been some limited exploration of the experience of interagency collaboration in the case of children's services, the theoretical and empirical foundation for the delivery of effective collaboration in the case of children in out-of-home care exhibiting challenging behaviour remains extremely limited.

This research will represent a unique contribution to the literature in this area for two reasons. First, this appears to be the only attempt to take into account the experiences of key stakeholders; namely in teachers, residential care workers and foster carers. Second, in contrast to other research which has focused on general issues related to interagency collaboration, this research specifically explores the experience and practice of key stakeholders attempting to change the problematic behaviour exhibited by many children in alternative care.

In previous research, several broad barriers to effective interagency work have been described. It appears that a principal barrier to collaboration may be good communication which, in turn, may be influenced by the presence of a shared terminology and understanding of the behaviours serving the focus of intervention. However, the contribution of stakeholders' understanding of behaviour to collaboration has not been explicitly examined.

From a psychological perspective, it has been argued that causal beliefs about behaviour can determine the importance placed on collaboration when working with parents, and both policy and intervention practice (e.g., Johnson et al., 2000).

Beliefs that stakeholders have about behaviour may influence their approach to managing behaviour, their willingness to persist and their vulnerability to stress or burnout in relation to this behaviour. Additionally, stakeholders may have differing explanations for behaviour which may influence the recommendations they make for treatment or their preferred intervention approach.

There is some suggestion that the beliefs held about the causes of behaviour and the preferred approaches to managing that behaviour may vary as a function of professional discipline and stakeholder group membership. Through both professional socialisation and via organisational culture, workers in different systems may come to view the challenging behaviour of children in out-of-home care in a different ways. Alternatively, stakeholders across the different agencies surrounding children in care may view behaviour through a very similar lens. It is therefore important to understand how stakeholders in the different systems conceptualise, manage and intervene with behaviour disorders amongst children in alternative care. It could be argued that if one could identify and better understand the dominant conceptual frameworks through which behaviour is understood to arise, one could target interventions and information more aligned with those understandings and contribute to effective collaboration.

Accordingly, this research will identify and report the dominant ways in which challenging behaviour is understood by key stakeholder groups in the systems involved with out-of-home care in South Australia. In the case of child welfare, barriers to interagency collaboration can be delineated into agency level barriers and individual level barriers (Darlington, Feeney & Rixon, 2005 a,b). It

could be argued that the beliefs and accounts that stakeholders have for behaviour constitute such an individual level barrier. These beliefs can inform approaches to managing and facilitating change in behaviour and therefore warrant exploration. How do foster carers, along with professionals in the different agencies surrounding children in care, understand and address problem behaviours; what are the similarities and differences in their approaches? What impact will these beliefs and accounts of behaviour have on the potential for collaboration? To date, this issue does not appear to have been explored across the key agencies and stakeholders involved in supporting children in out-of-home care.

### **Scope of the thesis**

It is not the intention of this thesis to conduct a systematic review of the literature, or to conduct a comprehensive critical analysis of the literature on interagency collaboration or on approaches to managing behaviour. Instead, the purpose of the broad literature review presented in this thesis is to synthesise a broad body of diverse literature in order to provide a conceptual and theoretical context to the study. This body of work is not a social policy analysis or an analysis of social work theory or practice. Ultimately, the thesis is an examination of the ‘real world’ practice of behaviour management and collaboration, drawing on a diverse range of literature and psychological models to do so.

## ***Research aims***

The first broad aim of this research is to explore barriers to collaborative practice, using the specific example of stakeholders' experiences when attempting to support young people in out-of-home care to resolve challenging behaviour. It can be argued that such an exploration can add to our understanding of how to improve interagency practice in the case of children with complex and challenging behaviour in the out-of-home care sector.

This research presents a unique contribution to this broad area because, in contrast to previous research; 1) it involves the experiences of stakeholder groups that do not appear to have been previously included in research, despite playing an essential role in out-of-home care and 2), because it asks about collaboration in relation to a specific problem (i.e., reducing challenging behaviour).

The second broad aim of this research is to understand what accounts of behaviour are dominant amongst stakeholders and further to understand what these accounts might mean for the practice of collaboration and, in turn, for children in out-of-home care. It may be argued that identifying dominant accounts of behaviour amongst stakeholders can contribute to the formation of a common framework of understanding for stakeholders which, in turn, can contribute to more effective collaboration. This research attempts to address this question through an analysis of stakeholders' discourse about challenging behaviour to identify common themes and points of divergence between stakeholders' accounts.

It also reports the separate analysis of the discourse of one of the stakeholder groups: namely residential care workers. It may be argued that separate analysis of the experiences of an individual stakeholder group can further contribute to collaboration by making explicit some of the implicit assumptions about behaviour 'embedded' in any one group of stakeholders. The interviews of residential care workers were selected for further analysis because the experiences and approaches of residential care workers do not appear to have been subjected to empirical analysis, despite the fact that workers are frequently required to manage older children with extremely challenging and difficult to control behaviours (Ainsworth, 2001; Bath 2008a; Clough, 2000).

This research represents a unique contribution to the understanding of behaviour management in out-of-home care because 1), differences and commonalities of understanding do not appear to have been explored before across such a wide range of stakeholder groups and 2), there does not appear to have been any empirical analysis of individual stakeholder groups in relation to how they understand and address challenging behaviour.

### ***Overview of thesis***

In order to address these broad issues, this thesis is divided into five sections. The first section (Part A: Chapters 1 and 2) contains a broad overview of the South Australian out-of-home care context and a review of the literature on collaborative practice and on addressing behaviour disorders amongst children in

out-of-home care. Chapter 1 provides a very brief overview of out-of-home care in Australia and outlines the unique aspects of the historical and policy context in which out-of-home care operates in South Australia. Within Chapter 2, the first sections (2.1 & 2.2) detail the prevalence of emotional and behavioural disorders amongst children in out-of-home care and of conduct disorder in particular. The following section (2.3) outlines the importance of collaborative practice for this population of children. Sections 2.3.2 to 2.3.4 report what is known about barriers to effective collaboration amongst children's services and highlight the potential role of communication and shared language. Section 2.4 draws on the broad literature on what is known about stakeholder perceptions about behaviour and identifies gaps in the literature about key stakeholders' perceptions. Finally, section 2.5 summarises what is known about effective intervention in this population.

Part B (Chapter 3) provides details of the research methodology. It provides details of the process of participant recruitment and descriptive information about the participants. It provides details of the interview data that formed the basis of the research. It further describes the process of thematic analysis utilised in the research and provides examples of the coding process that was applied to the data.

Part C (Chapter 4) explores interagency collaboration amongst key South Australian stakeholder groups. This chapter provides a more detailed review of the literature in relation to effective interagency collaboration. It then reports on the analysis of 92 interviews with key stakeholders about their experience and practice with respect to supporting young people in out-of-home care who exhibit

challenging behaviour. The final sections of this chapter briefly discuss these findings in relation to previous research and in relation to the possible implications of these findings for interagency practice in South Australia.

Part D (Chapters 5, 6, and 7) explores stakeholders' understandings of behaviour, identifies dominant accounts of behaviour and discusses the implications of these findings for interagency practice. Chapter 5 presents an analysis of key stakeholder discourse about behaviour and identifies dominant themes as they appeared in the talk of participants interviewed for this research. Chapter 6 isolates one type of account given for challenging behaviour (i.e., behaviour as arising out of 'attachment disorder') and subjects this to further analysis. It identifies ways in which attachment disorder is variously constructed and analyses the implications for these constructions for practice. Chapter 7 presents an analysis of the discourse about behaviour provided by one stakeholder group; namely residential care workers. It further discusses the implications for collaborative work arising from the unique issues raised in residential care workers' talk about managing challenging behaviour.

Part E (Chapter 8) integrates the findings of the thematic analyses of collaborative practice and stakeholders' talk about managing challenging behaviour and considers the implications for services seeking to support children in out-of-home care. It further identifies apparent limitations to stakeholders' everyday understanding of challenging behaviour and makes recommendations for improving frameworks of understanding about challenging behaviour amongst stakeholders in South Australia. Finally, it identifies methodologies and future

potential areas of research that will contribute to better communication and understanding about challenging behaviour amongst stakeholders supporting children in out-of-home care.



## **PART A**

### **Chapter One:**

#### **Out-of-home care in South Australia**

### **Chapter Two:**

#### **Literature review**



# CHAPTER ONE

## Out-of home care in South Australia

### 1.1 Context for the current research

This chapter will outline the context for the current research by providing an overview of the nature of the South Australian out-of-home care sector at the time this research was conducted. Many aspects of the South Australian policy and practice environment mirror those of other Australian States and Territories; however a recent comparison of child protection practice in Australian States and Territories noted some variations in the procedures and policies between these jurisdictions (Bromfield & Higgins, 2005). Since the time this research was conducted, significant policy development has occurred with the Department for Families and Communities, Families SA Division; the Department responsible for the investigation of child protection concerns in this State. Most commonly, this department is referred to as Families SA. The recent policy developments alluded to here will be outlined in Chapter 8, in which the results of the research presented in this thesis and its implication for practice in this State will be discussed in more detail.

## **1.2 Out-of-home care in South Australia**

Australian families are increasingly affected by significant social and economic pressures (AIHW, 2009). Factors such as the growth in non traditional family structures, substance abuse, domestic violence and poor parental mental health have all been argued to reduce the capacity of families to provide adequate care for their children (Barber & Delfabbro, 2004; Layton, 2003). In addition to broad social and economic pressures, the demand for out-of-home care services also appears to be driven by increasing levels of reporting, investigation and re-notification of child abuse and neglect in Australia. It has been argued that the increasing rates of notification across Australia have been driven, in part, by a broadening of the definition of abuse and the widespread introduction of mandated reporting (Cashmore, 2001). At the same time, there has been a significant decline in the number of carers entering the system and continuing high levels of carer attrition (Barber & Gilbertson, 2001). In marked contrast to other western economies, the Australian out-of-home care sector has also been characterised by a significant decline in the use of residential care facilities (Ainsworth & Hansen, 2009). Where residential care is available, it is typically provided in small facilities without the supportive therapeutic or educational services provided in other countries (Ainsworth & Hansen, 2009). Taken altogether, the result has been in a decline in the availability of foster carers and other options for out-of-home care in a context of increasing demand, resulting in an ever increasing pressure on out-of-home care placements.

South Australia, in common with other Australian jurisdictions, has experienced a significant increase in demand for out-of-home placements (Delfabbro & Barber, 2002). South Australian out-of-home care places emphasis on foster care placements for the provision of the vast majority of out-of-home care, rather than using residential care models (Delfabbro & Barber, 2002). In order to support and maintain the placement of children with challenging behaviour or complex needs, the Government largely relies on providing foster carers with financial incentives, such as special leave loadings. This practice of using short term financial incentives to maintain what are essentially unsuitable placements has been questioned by some (Delfabbro & Barber, 2002). In addition there has been an increasing use of individual service contracts or ‘packages’ of care in which children are accommodated in rented houses, hotels and motels under the supervision of workers from a contracted agency (Ainsworth & Hansen, 2009).

In Australian out-of-home care, the primary forms of care are “home based care”, “family group homes”, and “residential care”, although less commonly, another arrangement such as independent private boarding does occur (AIHW, 2009, p. 53).

Home based care is defined as placement “in the home of a carer who is reimbursed for expenses incurred in caring for the child” (AIHW, 2009, p. 53). The principal forms of home based care are: 1) relative or kinship care (where the caregiver other than the parent has a pre-existing relationship with the child) 2), foster/community care (where an authorised caregiver, supported by an approved

agency, is reimbursed by the State or Territory for the care of the child) and 3), other home based care, for example private board arrangements (AIHW, 2009, p. 53). In South Australia home based care, either in the form of foster care or kinship care, is the predominant form of care that is offered. Vigorous attempts are made to place indigenous children, in particular, within their existing family or kinship networks.

In 'family group homes', placement occurs in residential buildings which are owned by the State or Territory jurisdiction and which typically aspire to run in a manner similar to family homes, have a limited number of children, and in which children are cared for around-the-clock by resident substitute parents (AIHW, 2009, p. 53). In South Australia this form of care is only used in one small group of cottage style residential houses.

The third main type of residential care facilities are purpose built facilities staffed by paid workers, typically rostered for on-site shifts (AIHW, 2009). In South Australia, this type of accommodation may be a unit that serves either a short term assessment function (assessment units or transitional units), or a longer term accommodation function. Families SA provides accommodation principally through 6 community residential care units (CRCs) and 20 smaller transitional accommodation (TA) units. The reality of placement pressures, though, means that most South Australian units, even those designed to provide temporary accommodation, serve as longer term 'placements of last resort' (Des Semples & Associates, 2002; Layton, 2003).

### **1.3 Australian and South Australian out-of-home care statistics**

The number of children in out-of-home care across Australia has risen consistently since the 1990s (Barber & Gilbertson, 2001). Nationally, the number of children in out-of-home care has risen each year from 1996 to 2008, the period for which national data have been collected. Indeed, the latest report from the Australian Institute of Health and Welfare (AIHW, 2009) indicate a rise of 115% over the past decade in the number of children in care from 14, 470 at 30<sup>th</sup> June 1998 to 31, 166 at 30<sup>th</sup> June 2008 (AIHW 2009, Table 4.3), reflecting the fact that more children are now entering care than leaving it. This represents a doubling in the rate of children in out-of-home care during this time from 3.1 to 6.2 per 1,000 (AIHW 2009, Table 4.7). Over this period, the rates of children in out-of-home care increased in all Australian jurisdictions. During the past year of reporting (June 30<sup>th</sup> 2007-June 30<sup>th</sup> 2008) the national numbers for children in out-of-home care rose by just under 10% (AIHW, 2009). The average rise across jurisdictions over the past decade has been just over 8% (AIHW, 2009, Table 4.3). These figures make it apparent that the need for out-of-home care is steadily increasing across Australia.

In South Australia at June 30<sup>th</sup> 2008 there were 1, 841 children in out-of-home care of some form (AIHW, 2009, Table 4.3). This represents 5.9% of the total Australian children in out-of-home care and places the South Australian out-of-home care population as the fifth largest of all the eight Australian jurisdictions. The figures for out-of-home care in South Australia mirror those obtained nationally which indicate a trend for placements with relatives and kin or

foster carers and a decrease in the use of residential care placements (Johnstone, 2001). For example, at 30<sup>th</sup> June 2008, 85.7% of South Australian children were reported as living in some form of home-based care (49.5% foster care and 36.0% kinship care) and only 9% were placed in residential care.

In all Australian jurisdictions there were higher rates of Aboriginal and Torres Strait Islander children in out-of-home care than other children (AIHW, 2009, Table 4.8). Across Australia, the rates of Aboriginal and Torres Strait Islander children in out-of-home care is almost 9 times the rate of other (non indigenous) children (AIHW, 2009). At 30 June 2008, there were 9,074 Aboriginal and Torres Strait Islander children in out-of-home care; an increase of 1,182 since 30 June 2007. The rate of Aboriginal and Torres Strait Islander children in out-of-home care at 30 June 2008 was 41.3 per 1,000 indigenous children aged 0–17 years (AIHW, 2009). This contrasts with a rate of 4.6 per 1,000 for non indigenous children of the same age range. In South Australia, the rate of Aboriginal and Torres Strait Islander children in out-of-home care was 39 per 1,000. This contrasts with a figure of 4.0 per 1,000 for non indigenous South Australian children (AIHW, 2009, Table 4.8).

The Aboriginal Child Placement Principle (Lock, 1997) guides South Australian child protection policy and endorses the placement of Aboriginal and Torres Strait Islander children with other people of Aboriginal and Torres Strait Islander descent when out-of-home care is deemed necessary. In South Australia, 77.6% of indigenous children were placed in accordance with the Aboriginal Child Placement Principle (with kinship care or an indigenous carer) and 22.4%

were placed with other foster care or residential care arrangements (AIHW,2009 Table 4.9).

#### ***1.4 Jurisdictional differences and South Australian out-of-home care***

Australia is a federation of States and Territories and each of these States and Territories has separate responsibility for their own health and welfare activity (Bromfield & Higgins, 2005). Accordingly, the child protection ‘system’ in Australia actually comprises eight different child protection systems (Bromfield & Higgins, 2005).

A recent national comparative study of Australian States’ and Territories’ child protection services, policies and procedures highlighted disparity between States and Territories that was most evident in the intake and case substantiation phase of child protection activity (Bromfield & Higgins, 2005). It found that, while the core activities engaged in by child protection practitioners were very similar between Australian jurisdictions, they were informed by procedural and legislative frameworks, definitions of abuse and harm, data collection intake procedures and training standards that varied greatly between jurisdictions. For example, while most States have some form of mandatory reporting, the mandate for reporting differs between jurisdictions. It ranges, for example, from a limited number of professionals in highly specific contexts (as in Western Australia) through to extensive lists of nominated occupations that are mandated to notify (as is the case in South Australia) (Bromfield & Higgins, 2005).

In Australia, each jurisdiction (State or Territory), and therefore the relevant Minister for each jurisdiction, has primary responsibility for child protection. If abuse is confirmed, and consent cannot be obtained from parents to place the child in temporary care, the relevant Department, on behalf of the Minister (in the case of South Australia, the Minister for Families and Communities), will apply for a court order to care for the child. In most jurisdictions, applications for such care and protection orders are made to the Children's Court. However, in South Australia, applications are made to the Youth Court, and in the Northern Territory to the Family Matters Court (AIHW, 2007). Legislation and definitions regarding what constitutes inadequate care and protection vary somewhat between jurisdictions. In South Australia, under the *Children's Protection Act 1993*, an application may be made to the Youth court when the Minister is of the opinion that the child in question is at risk and it is in the best interests of the child that an order be made to secure the child's care and protection. The *Children's Protection Act 1993* stipulates that family care meetings should normally be convened in respect of the child in question before any order for custody of the child can be granted. A new amendment to the *Children's Protection Act 1993*, (*Children's Protection (Miscellaneous) Amendment Act 2004*) encourages early decision making with respect to the child's custody and living arrangements and stipulates the preference for a long term guardianship order over a series of temporary orders. The Youth Court can ultimately grant a range of orders including custody orders for up to 12 months or guardianship orders for either 12 months or until the child turns 18 (Legal Services Commission of South Australia, 2009).

### ***1.5 Brief history of South Australian child protection policy and practice***

In South Australia, an integrated child protection model was introduced in the late 90's in response to an increase in child maltreatment reports, including a significant increase in re-notification rates; together with concerns that resources were used ineffectively as workers "cast the net too wide" by intervening in families where parental behaviour was problematic, rather than abusive (Hetherington, 1998, p.122). In order to target investigative and intervention resources more effectively, a new child protection model was introduced which relied on a centralised intake team (including an Aboriginal consultation and response team), a differential (tiered) response to reports (identifying levels of "assessed initial risk" and the introduction of a structured decision making system (Hetherington, 1998, p.128). South Australia continues to employ this structured actuarial decision making system to guide its assessment and intervention practice (Bromfield & Higgins, 2005).

The South Australian system appears to be unique in its use and placement of the Indigenous team (*Yaitya Tirramangkotti*- 'Prevention People') within the Families SA Central Intake Team (Bromfield & Higgins, 2005; Hetherington, 1998). The Aboriginal team act as consultants to advise on the appropriateness of assessments and ensures that "a person with sufficient knowledge of Aboriginal kinship and culture is involved in all investigations from the outset" (Hetherington, 1998, p.127).

The South Australian decision making framework dictates different child protection responses depending upon the scores obtained in the actuarial risk assessment tools used in this State (Bromfield & Higgins, 2005). Three assessment tools are employed at different points in the child protection response: 1) a safety assessment instrument 2), a risk assessment tool and 3), a family strengths and needs assessment.

The safety assessment instrument is used by the Central Intake Team to indicate the immediate need to protect the child, based on notifier information. Notifications are then assigned a priority level (Tier 1, 2, or 3). Tier 1 children require immediate response, usually in conjunction with police and health units. Tier 2 children are investigated by the department according to clear protocols and with clearly defined exit points and the provision of written outcomes for all families investigated (Hetherington, 1998). Tier 3 families are not visited by the Department but receive a letter inviting them to a meeting to discuss the situation. The emphasis is on problem solving, rather than having a forensic focus (Hetherington, 1998; Tomison, 2001). A risk assessment tool, completed within 7 days of confirmation of abuse, is then used to assess the likelihood of future abuse or neglect. Finally, an assessment of family needs and strengths is completed and used to guide case planning and case management response. The family assessment of needs and strengths is conducted by the allocated social worker on all cases where abuse or neglect is confirmed. Both the risk assessment tool and the family strengths/needs assessment are conducted at least every three months on all active cases. At the time of the national comparison of child protection practice conducted by Bromfield and Higgins (2005) South Australia was the only

State to have implemented such actuarial assessment procedures, although similar tools were under consideration in other jurisdictions. While the initial Departmental data suggested improvements in response times to Tier 1 and 2 cases as a result (Hetherington, 1998), rigorous evaluation of actuarial tools do not appear to have been conducted to date.

The restructuring of the South Australian alternative care system described above also meant that the provision of placement services was outsourced; resulting in a “separation of purchaser and provider roles” (Des Semples & Associates, 2002, p. 3). Put simply, a process of tendering occurred which resulted in a relatively small group of non-government agencies (alternative care service providers: ACSPs) providing all placement services for the State. These ACSPs were given responsibility for the provision of suitable placements, together with responsibility for the recruitment and support of foster carers in the State; roles that had previously been overseen directly by the Department. The metropolitan area is serviced by two agencies (indigenous and non indigenous clients are supported by separate ACSPs). Placement and support for rural South Australian clients and foster carers is provided by five agencies according to geographical region. A similar outsourcing process followed for services to families requiring a Family Preservation service. Family Preservation in South Australia refers to a continuum of services ranging from strengthening families to enable children to continue to live at home through to maintaining connections with birth families when children remain in out-of-home care (Des Semples & Associates, 2002).

Policy and practice in South Australia at the time of this research was influenced by several recent documents. The first is a major report on Child Protection in South Australia by Robin Layton QC: *Our Best Investment. A State Plan to Protect and Advance the Interests of Children* (Layton Review, 2003); usually referred to as the Layton Review. The Layton Review reported on a comprehensive review of child protection services and activities in this State. The review resulted in over 200 recommendations for structural, practice or policy change. Chapters of the review can be downloaded from <http://www.familiesandcommunities.sa.gov.au/>.

The South Australian government responded to this review in 2004 by launching their child protection reform program entitled *Keeping them Safe: The South Australian Government's Child Protection Reform Program* (Keeping Them Safe, 2004). This document represents the South Australian Government's vision for the future of children. It identified several priority areas for service reform. The areas that were identified as requiring significant reform were: the support provided for children and families, effective intervention, work practices and culture, collaboration and partnership and accountability. More detail on this reform program can be obtained at [www.dfc.sa.gov.au/pub/](http://www.dfc.sa.gov.au/pub/)

In response to the Keeping Them Safe reform agenda, the *Rapid Response* initiative was implemented across South Australia (Rapid Response, 2005). The Rapid response initiative is a whole of government service delivery system that aims, through affirmative action, to ensure that children in out-of-home care receive priority access to health, housing, and disability services in a seamless

manner and with minimal disruption to their lives. More details about the Rapid Response initiative can be obtained at

[www.familiesandcommunities.sa.gov.au/rapidresponse](http://www.familiesandcommunities.sa.gov.au/rapidresponse).

### **1.6 Key stakeholders in South Australian Child Protection activities**

Child protection activities in South Australia involve several key stakeholder groups. The roles and responsibilities of these stakeholders will be outlined in this section, in order that the reader can understand the context for the current research. This list is not intended to be exhaustive; rather it is designed to provide the reader with an overview of the general functions and nature of these stakeholder groups. Accordingly, the roles and functions of the main stakeholder groups that participated in this research are outlined below:

#### **1.6.1 Families SA:**

Families SA is a division of the Department for Families and Communities SA. The primary concern of Families SA is the protection of children. Families SA's key strategic objectives include the provision of support to children and families, and the provision of effective and appropriate intervention when concerns are held for the welfare of a child or young person (see Department for Families and Communities Strategic Plan, available from [www.dfc.sa.gov.au/pub/](http://www.dfc.sa.gov.au/pub/)). Throughout this thesis, the Department for Families and Communities, Families SA will be referred to as the 'Department' or 'Families

SA' unless specified otherwise. Caseworkers from Families SA will be referred to as Department workers.

#### *1.6.1 Department Education and Children's Services (DECS):*

The Department of Education and Children's Services (DECS) is responsible for the provision of children's services and public education throughout South Australia. DECS oversees the administration and standards of a range of children's services including the provision of preschool services, administration of Family Day Care, and sponsorship of Outside School Hours Care programs. DECS is also responsible for the delivery of primary and secondary education to school students across the State, across all areas of the curriculum. There are currently just over 500 schools (total of all primary and secondary schools) in South Australia for which DECS has administrative responsibility. More information about public education services in this State is available from [www.decs.sa.gov.au/portal/aboutdept.asp](http://www.decs.sa.gov.au/portal/aboutdept.asp). Throughout this thesis, this department will be referred to as 'DECS' or as the 'education sector', and staff as 'teachers' or 'education staff'.

#### *1.6.2 Child and Adolescent Mental Health Services (CAMHS):*

Child and Adolescent Mental Health Services in South Australia are provided by two separate agencies that each service different geographical areas. The Southern Adelaide Health Service Child and Adolescent Mental Health Service (SAHS-CAMHS) provides a range of mental health services to children and

young people in the southern metropolitan and rural areas of Adelaide. The Northern Division of Child and Adolescent Mental Health Service (Northern CAMHS) provides a similar range of services to the northern metropolitan and rural areas. While there are some differences in the specialised services provided by these two organisations, their aims, objectives and administration are largely identical. For the purpose of this research, both organisations are referred to by the generic term 'CAMHS' and their workers as 'CAMHS workers' or 'mental health workers'. For more information about these services see [www.flinders.sa.gov.au/mentalhealth/pages/camhs/](http://www.flinders.sa.gov.au/mentalhealth/pages/camhs/) or [www.wch.sa.gov.au/services/az/divisions/mentalhealth/index.html](http://www.wch.sa.gov.au/services/az/divisions/mentalhealth/index.html).

### *1.6.3 South Australian Alternative Care Service Providers:*

The recruitment, training and support of foster carers in South Australia are outsourced to non-government agencies. At the time this research took place, responsibility for alternative care services for the entire Adelaide metropolitan area was largely fulfilled by two non-government agencies. One of the agencies provided support and training specifically for indigenous carers and the other for all other foster carers (not identified as providing care for indigenous children). The rural areas of South Australia are supported by five other agencies along geographical boundaries. More information about alternative care service providers in South Australia is available from the Department for Families and Communities website: [www.dfc.sa.gov.au/pub/](http://www.dfc.sa.gov.au/pub/). For the purpose of this research, these alternative care service providers will be referred to as 'foster care support services' and their staff as 'foster care support workers'.

#### *1.6.4 Residential Care facilities in South Australia:*

The majority of child residential care facilities in South Australia are provided directly by Families SA, although such care may also be provided indirectly in South Australia through contracted non-government agencies. Community Residential Care (CRC), provided directly by Families SA, provides specialist accommodation to young people aged between 10 and 18 in a community congregate care setting. Most typically these are children who have had prior experience of out-of-home care, usually through foster placements. Transition Accommodation provides community based accommodation as a short term accommodation option for a core group of children for whom other forms of alternative care are not available. The aim of Transitional Accommodation, as the name suggests, is to assess what supports and programs are needed for a successful transition to an appropriate long term placement. For the purposes of this research, Families SA staff that worked at either Transitional Accommodation units or Community Residential Care (CRC) were included. Currently, there are 6 CRC units and 20 Transitional Accommodation Units in South Australia. It should be noted, however, that in response to demand, a range of non-government congregate care facilities, aimed at short term stabilisation and assessment have also been developed since this research was conducted. Similarly, private agencies are also increasingly contracted to provide emergency accommodation and supervision in private facilities for children for whom other forms of alternative care are not accessible. For the purpose of this research, staff from any of these

facilities that took part in this research will be referred to by the generic term ‘residential care workers’.

### **1.7 Summary**

This chapter was intended to provide a brief historical context and overview of the structural and policy context for the research presented in this thesis. It is important to note that there has been an increased focus in recent Australian literature and research on providing a national focus for Australian child protection activities (Bromfield & Higgins, 2005; Cashmore & Ainsworth, 2004; Higgins, Adams, Bromfield, Richardson & Aldana, 2005). Recent national research examining the profiles of children with high placement instability represents a good example of the Australia wide focus of out-of-home care research that has been called for (e.g., Osborn, Delfabbro, & Barber 2008). Thus, it is envisaged that activities and policies of the different Australian jurisdictions will become increasingly aligned. Currently, many elements of Australian child protection practices, policies and procedures are similar across jurisdictions; each jurisdiction faces common dilemmas in terms of the identification and prevention of abuse and in terms of provision of care for children no longer able to live with their immediate biological families. However, each Australian jurisdiction has also formed their own distinctive solutions to these challenges. Therefore, it was considered important to briefly outline how these issues have been resolved in the South Australian out-of-home care sector.



## CHAPTER TWO

### Literature review

#### ***2.1 Behavioural and emotional problems of children in out of home care***

The behavioural and emotional problems of children in out-of-home care have been well documented over the past two decades (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Glisson, 1996; Pilowsky, 1995; Trupin, Tarico, Benson, Jemelka, & McClellan, 1993; Webb & Harden, 2003).

In a major review conducted in 1995 of research focusing on children in out-of-home care, Pilowsky (1995) concluded that children in alternative care have higher rates of emotional and behavioural problems than either their chronological age peers, or peers with similar maltreatment backgrounds. This situation does not appear to have improved since that time.

Research continues to demonstrate that children in alternative care experience emotional and mental health problems that are much greater than expected in the general population (Bilaver, Jaudes, Koepke, & George, 1999; Blower, Ado, Hodgson, Lamington & Towlson, 2004; Clausen et al., 1998; Harman, Childs & Kelleher, 2000; Silver, DiLorenzo, Zukoski, Ross, Amster & Schlegel, 1999; Simms, Freundlich, Battistelli, & Kaufman, 1999; Stein, Evans, Mazumdar & Rae-Grant, 1996).

A recent review of the literature placed the prevalence of behavioural and emotional disorders as falling between 35-85% (Leslie, Landsverk, Ezzet-Loftstrom, Tschann, Sylmen & Garland, 2000). Some have argued that the rate of behavioural and emotional disorders has risen (Kerker & Dore, 2006) from an estimated prevalence of between 30-40% in earlier studies (e.g., Dubowitz, Fiegelman, Harrington, Starr, Zuravin & Sayer, 1994; Dubowitz, Zuravin, Starr, Fielgelman & Harrington, 1993; McIntrye & Keelser, 1986; Moffatt, Peddie, Stulginkas, Pless & Steinmetz, 1985; Schor, 1982) to current prevalence estimates of between 60-and up to 80% (e.g., Clausen et al., 1998; Simms, Dubowitz & Szilagyi, 2000). This contrasts with community prevalence rates that range from 16% to 22% reported in American and Australian samples (Kerker & Dore, 2006; Sawyer et al., 2007). Indeed, some have estimated that at least 50%, and up to 90% of children in foster care have mental health problems severe enough to warrant clinical intervention (Blatt & Simms, 1997; Burns et al., 2004; Harman et al., 2000; Leslie, Hurlburt, Landsverk, Barth & Sylmen, 2004).

However, considerable challenges may exist in accessing suitable treatment (Leslie et al., 2004; Schneiderman, Connors, Fribourg, Gries & Gonzales, 1998). For example, difficulties may not always be evident to carers or social workers, and when they are evident, waiting lists for appropriate services may be long (Halfon, Mendonca & Berkowitz, 1995). Children with certain behavioural characteristics, abuse or placement histories may be more likely than others to access mental health services (Leslie et al., 2000; Rubin et al., 2004). Furthermore, some have questioned the usefulness of existing mental health

services for this population. Child mental health services have been criticised for offering services largely in isolation from other services and systems (Hill-Tout, Pithouse and Lowe, 2003). Amongst children with behaviour disorders treated in a public mental health service, placement in alternative care (rather than being cared for at home) was amongst the factors predictive of poor outcome (Xue, Hodges & Wotring, 2004).

Supporting this population may be complicated by the complex overlap and interplay of their medical, mental health, behavioural and developmental problems (Rosenfeld et al., 1997; Sullivan & Van Zyl, 2008; Vigg, Chinitz, & Schulman, 2005). For example, a combination of developmental and emotional problems have been estimated to occur in between 72% and 92% of children under 60 months of age in foster care (Halfon et al., 1995). Similarly, Kortenkamp and Macomber (2002) found that 28% of children in the child welfare system had a combination of emotional, behavioural and physical conditions.

Children in out-of-home care are likely to have educational issues as well. A recent review of the academic achievement of children in out-of-home care highlighted the academic delays experienced by this population and concluded that children in out-of-home care were largely functioning below grade level and in the low to average range on most academic measures (Trout, Hagaman, Casey, Reid, & Epstein, 2008). Compared with children not in alternative care, children in out-of-home care have higher rates of absenteeism and disciplinary referrals and special education placements (Eckenrode, Laird & Doris, 1993; Goerge, Van

Vooris, Grant, Casey, & Robinson, 1992; Leiter & Johnson, 1997). Their behavioural problems appear to impact significantly on their educational experiences. They may display behaviour problems with greater frequency than other children (Eckenrode et al., 1993; Dubowitz & Sawyer, 1994) and may be more likely to be expelled or suspended for showing such behaviours (Zima et al., 2000). For example, in one recent US report, 20% of 6-10 year olds in care had committed a violent offence at school and furthermore, a significant proportion of children continued to show such problems even after attracting a special education classification and attendant supports (Smithgall, Gladden, Yang & Goerge, 2005). This has led to a call for better understanding of the educational needs of the child in alternative care (e.g., Trout et al., 2008; Vacca, 2008).

As the findings outlined above would indicate, behavioural and emotional problems of children in out-of-home care are probably multi-determined. By the time children enter out-of-home care they have typically been subject to physical or sexual abuse, exposure to violence, trauma or profound neglect (Vigg et al., 2005). The experience of removal from home and entering out-of-home care can exacerbate problems further due to systemic issues such as multiple placement changes which, it is argued, damage already fragile self concepts and interpersonal relations and attachments (Barber & Delfabbro, 2002). Many children have multiple caregivers, either as a result of coming into care or prior to being placed in care (Vigg et al., 2005). It is difficult however, using existing research, to disentangle the effects of developmental, behavioural and parental factors in the genesis of their emotional and behavioural problems (Holland & McGorey, 2004; Orme & Buehler, 2001).

Irrespective of the how they arise, behavioural and emotional issues appear likely to remain with young people as they become adults. Children who have been in out-of-home care are likely to continue to experience difficulties in adjustment into adulthood (Courtney et al., 2001). Behavioural problems may also persist into adulthood. For example, Kendall-Tackett (2002) found that behavioural problems such as engaging in self harm, substance abuse and high risk sexual behaviour were more likely to be found in adult survivors of childhood abuse than in adults in the general population. Mental and behavioural issues are also likely to have significant social impact as well (Dore, 1999; Landsverk et al., 1996), as children placed in out-of-home care face high rates of homelessness, incarceration, and institutionalisation as young adults (Blankertz, Cnaan & Freedman, 1993; Courtney et al., 2001; Kerker & Dore, 2006; Rosenhack & Fontana, 1994; Shlay & Rossi, 1992; Susser, Lin, Conover, & Struening, 1991).

## ***2.2 Conduct and externalising disorders in alternative care***

Amongst the behaviour problems that children in out-of-home care may experience, disorders of conduct and aggression appear to be extremely common. Disorders of conduct, aggression and oppositional behaviour have been reliably found amongst Australasian (Sawyer et al., 2007; Tarren-Sweeney, 2007; Tarren-Sweeney & Hazell, 2006; Tarren-Sweeney, Hazell & Carr, 2004), American (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Heflinger, Simpkins, & Combs-Orme, 2000; Horan et al., 1993; Pilowsky, 1995) and European alternative care populations (Lambert, Essen, & Head, 1977; Roy, Rutter, & Pickles, 2000;

Rushton, Quinton, Dance, & Mayes, 1998; St Claire & Osborne, 1987; Vorria, Rutter, Pickles, Wolkind, & Hobsbaum, 1998).

Using the Child Behavior Checklist (CBCL: Achenbach & Rescorla, 2001), for example, estimates of externalising difficulties amongst the out-of-home care population sit at around 30% (Armsden et al., 2000), but may be considerably higher in residential care populations (Armsden et al., 2000).

Amongst Australian out-of-home care populations, 60 % of adolescents were found to be experiencing conduct problems (Barber et al., 2001). Similarly, a survey of younger children in Australian foster care found that over half scored above the clinical cut off for conduct difficulties (Tarren-Sweeney & Hazell, 2006). In one recent Australian study, the proportion of children in home based alternative care with problems on the externalizing syndrome scales of the CBCL was 6 to 7 times that of a comparable community sample (Sawyer et al., 2007). Similar results were found in a UK study, in which children in out-of-home care were seven times more likely than children in the general population to have identified conduct disorders (Meltzer, Laden, Corben, Goodman & Ford, 2003).

Thus, disorders of conduct in particular appear to have attracted much attention in research on this population. This may be due to the overt nature of such difficulties and the distress they cause carers, however it may also reflect the manner in which problem behaviours are assessed. Typically, standard parent report checklist such as the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001) and Rutter Scales (Elander & Rutter, 1996) are used to assess

difficulties. Some have argued that the reliance of population and clinical studies on clinical checklists such as the CBCL may have served to highlight conduct and externalising disorders, and resulted in an under reporting and under researching of other pertinent issues for children in alternative care such as attachment related difficulties, anxiety, and dissociative responses to trauma (Tarren-Sweeney, 2007). Recently, attempts have been made to address this gap with the development of a checklist applicable to the out-of-home care population which attempts to address the need for more comprehensive clinical data in this population (Garwood & Close, 2001). The checklist includes indicators of relationship, sexual, and dissociative problems (Assessment Checklist for Children (ACC): see Tarren Sweeney, 2007 for initial Australian validation data for this tool).

### *2.2.1 Conduct disorder; prognosis and social cost*

Notwithstanding these issues, it remains clear that conduct disorder features strongly in this population. The high prevalence of conduct disorder amongst children in out-of-home care is particularly troubling. There is no doubt that conduct type difficulties pose problems for clinicians, carers and teachers alike. Disorders of conduct and aggression are particularly stressful for foster carers, and by definition impact on several areas of the child's life. Moreover, conduct problems are resistant to treatment. For about 60% of children seen with conduct disorder in routine outpatient clinics, there is poor prognosis (see Carr, 1999). Antisocial behaviour with onset before adolescence may be particularly likely to persist throughout life (Moffit, Caspi, Dickson, Silva & Stanton, 1996).

Furthermore, children with a diagnosis of conduct disorder have poor prognosis in terms of criminality, mental health issues including drug and alcohol abuse, poorer physical health, and lower educational and occupational attainment (Carr, 1999; Kazdin, 1995; Maughan & Rutter, 2001; Pajer, 1998).

### *2.2.2 Implications of challenging behaviour for placement turnover*

Behavioural disturbances have serious implications for children once they are placed in alternative care. Correlations between the severity of behaviour problems and placement history have been found repeatedly (Barber et al, 2001; Cooper, Petersen & Meier 1987; Horwitz, Owens, & Simms, 2000; Newton, Litrownik, & Landsverk, 2000; Stone & Stone, 1983; Teather, Davidson, & Pecora, 1994).

Additionally, behaviour problems are one of four characteristics of children that have been related to either positive or negative long term outcomes for children (Nissim & Simm, 1994). Disruptive behaviours in care have been linked to decreased likelihood of reunification (Landsverk et al., 1996), increased length of placement (Urquiza, Wirtz, Petersen & Singer, 1994), placement instability and turnover (Barber et al., 2001; Cooper et al., 1987; Newton et al., 2000; Pardeck, 1984; Pardeck, Murphy & Fitzwater, 1985) and with ultimate placement in residential care (Barber & Delfabbro, 2002).

Adolescents entering care with mental health or behaviour difficulties are least likely to achieve placement stability or display improved psychological

adjustment during their time in care (Barber et al., 2001). Disruptive behaviour and emotional symptoms, rather than placement history at time of allocation, appear to predict placement failure (Barber & Delfabbro, 2002). Behaviour problems were amongst key predictors for placement in restrictive or intensive settings (James et al., 2006) and foster parent reported behaviour problems were predictive of residential placement or incarceration five years later (Leathers 2006).

Externalising disorders such as conduct disorder, oppositional behaviour and larceny appear particularly implicated in placement turnover (Cooper et al., 1987; Fanshel, Finch, & Grundy, 1990; James, Landsverk, & Slymen, 2004; Newton et al., 2000; Palmer, 1996; Pardeck, 1983; Stone & Stone, 1983; Widom, 1991). Barth and his colleagues found that children with clinical level CBCL scores were 2.5 times as likely to experience a high number of placement turnovers (Barth et al., 2007).

There has been some question about the direction of causality in the relationship between behaviour problems, placement turnover and placement characteristics. Studies suggest that, although behaviour problems may be implicated in placement breakdown, they do not appear to be improved by reunification with biological families. Studies suggest that reunification may, at least initially, have little impact on observable behaviour problems *per se*, but may result in an increase in internalising difficulties for children (Bellamy, 2008; Lau, Litrownick, Newton & Landsverk, 2003), and perhaps poorer behavioural outcomes in the longer term (Taussig, Clymen & Landsverk 2001). However,

externalising problems may be exacerbated by foster placement changes (Newton et al., 2000) and may ultimately result in a reduced chance of reunification with biological family (Landsverk et al., 1996).

It seems that the relationship between behaviour problems and placement turnover is complex. A recent review and meta-analysis concluded that behaviour problems were a robust predictor of placement breakdown, especially when other factors were controlled for (Oosterman et al., 2007). Other studies suggest that it is placement instability itself that contributes to behaviour (Rubin et al., 2004; Rubin et al., 2007). Other factors such as parental substance abuse (Holland & McGorey, 2004; Newton et al., 2000), agency initiated changes (James, 2004), age of child (Barth et al., 2007; Oosterman et al., 2007), depression, and placement away from siblings (Barth et al., 2007; Leathers, 2006) also play a part. Notwithstanding this, behaviour problems remain a commonly cited reason for placement change (James, 2004; Leathers, 2006).

It has been argued that foster care in Australia is more selective than elsewhere (e.g., Barber et al., 2001) with the result that foster care and other out-of-home care placements are used as a last resort, and only children with more challenging behaviours who cannot be placed elsewhere end up in longer term care while others with less challenging behaviour are returned home.

### *2.2.3 Interventions for challenging behaviour require collaboration*

It is evident that behaviour problems in this population can be serious and their impact for the young person may be long lasting. It is important to acknowledge the difficulty of interventions for complex challenging behaviour. While results may be found in clinical research situations, the effect of 'real world' interventions for antisocial and challenging behaviour tends to be less impressive (Rose, Algate, Mc Intosh, & Hunter, 2009; Rutter et al., 1998). It appears that little is known about the real world delivery of effective interventions to children with identified mental health concerns that are particularly persistent or hard to manage, including those in out-of-home care. Much research is still needed to establish the optimal, evidence based interventions for the unique concerns of children in out-of-home care (Blower et al., 2004; Crawford, 2006).

Children in out-of-home care, by virtue of their complex developmental, emotional and educational needs, are likely to require the coordinated expertise of multiple services. For example, a large scale survey of the mental health needs of children in out-of-home care also identified high levels of physical or health issues, reading and academic difficulties and restricted peer relations (Meltzer et al., 2003). Evidence such as this strengthens the argument for interdepartmental and inter-disciplinary collaborative responses to this population (McAuley & Davis, 2009). It is likely that for any treatment strategies to be effective, they must be directed to all domains of the child's life. It therefore appears likely that interventions involving collaboration of all systems associated with the child are indicated. A recent review of effective intervention components in antisocial

behaviour emphasised the importance of multiagency approaches, with a focus on non-hierarchical, collaborative partnerships with parents and other stakeholders (Rose et al., 2009). For high risk children, 'wraparound services', which aim to 'wrap' services around children, schools and their communities, appear well supported (Burns et. al., 2000), although in many instances there may not be the community resources available to implement this approach effectively. This type of service delivery requires high levels of coordination over prolonged periods of time. Similarly, Multisystemic Therapy (MST: Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998), which integrates therapeutic input within an ecological view of the 'client', relies on the coordination of multiple services. As with wraparound services, it assumes collaboration with the child's family and other stakeholders. Although designed originally for 'at risk' youth, the approach has more recently been adapted for use with other populations with encouraging results.

While evidence based interventions may be lacking for children in out-of-home care in general, relatively more is known about interventions in the case of those children with disorders of conduct and aggression. These approaches are likely to be relevant for children in out-of-home care, given the prevalence of conduct disorder in this population. Many well supported approaches to conduct difficulties with children also involve collaborative treatments such as MST (Henggeler et al., 1998) which target specific and well defined problems (Henggeler, Schoenwald, Rowland & Cunningham, 2002).

Many other promising interventions in the treatment of children with high support needs such as those in out-of-home care involve collaborative and interagency approaches (see Saunders, Berliner & Hanson, 2004). However, this way of working may cause role ambiguity and stress for those required to take part in such collaborations (Coyle, Edwards, Hannigan, Fothergill, & Bernard, 2005). For this reason, it is important to understand better the experiences of workers and the demands placed on them when attempting to work in a coordinated fashion for the benefit of children in out-of-home care.

The following section will briefly summarise the issues involved with collaborative practice and review what is known to date about collaborative interagency practice in supporting children in out-of-home care. This literature will be further expanded on in Chapter 4.

### ***2.3 The importance of collaborative practice***

The importance of collaboration between welfare, developmental and mental health agencies has been highlighted by legislation in countries such as the U.S (Leslie et al., 2005) and also in Australia (see Absler, 2006). This has been reflected in policy imperatives and directives both in Australia and internationally that emphasise the need for interagency collaboration (Absler, 2006; Leslie et al., 2005; Salmon, 2004; Salmon & Rapport, 2005) and related phenomena such as the emergence of interagency training curricula (Gilbert, 2005), publications on interdisciplinary education, (e.g., Barnes, Carpenter & Dickson, 2000; Barker, Bosco, & Oandasan, 2005), measures of worker attitudes toward other disciplines

(Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005) and the establishment of the *Journal of Interprofessional care*, which is dedicated to expanding the empirical and theoretical knowledge base regarding interagency and interprofessional collaborative work.

Interagency collaboration is increasingly viewed as the most efficient way to ensure delivery of effective high quality services (Miller & Ahmad, 2000; Salmon & Rapport, 2005). Indeed, some have suggested that the delivery of effective child protection may not be possible without such collaboration (Cottrell et al., 2000; Morrison, 1996; Scott, 1997, 2005). An effective multiagency approach for children with emotional and behavioural issues in alternative care means that “...professionals working in different services, with different experiences regarding children with mental health problems will have to collaborate” (Ødegård, 2005, p. 347).

Concomitant with changes in policy there has been growing rhetoric about collaborative practice, partnership and joined up services in relation to children’s welfare and particularly in relation to children with complex needs such as those in out of home care (Absler, 2006). The definition, nature and form of terms such as partnership, joined up practice, and collaboration have been subject to much discussion (e.g., Darlington et al., 2005 a,b; Hodges, Hernandez & Herman, 2003; Horwath & Morrison, 2007; Morrison, 1995; Scott, 2005).

There is a danger that the emergence of interagency policy and the imperative to work in a joined up fashion puts pressure on the pace of change in children’s

services (Absler, 2006; Walker, 2005). Some have noted with concern the risk that the evidence and research base for collaborative practice may be left behind in the rush to implement such policies (Leslie et al., 2005).

For example, Leslie et al. (2005), make the following points when they describe legislative changes in the USA which specifically address the importance of collaborations between child welfare and mental health agencies. They suggest that the legislative situation provides:

...a unique opportunity for physical and mental health clinicians and developmental professionals to work together with social welfare agencies in effecting positive outcomes for this high-risk population. Importantly, while new legislation provides a unique opportunity for agencies to work together, the reality is that substantial barriers exist to providing such collaborative care. In addition, there are numerous limitations in the conceptualization and evaluative research of collaborative service delivery models. (p.141).

Indeed, the reality of working collaboratively in the support of children may not be as easy as the simple and seductive rhetoric of integrated collaborative work might suggest. There appears to exist an assumption that workers will simply get on and do it, and that interagency practice will fall into place without conscious effort to facilitate the structures, training, guidance and resources to support it (Absler, 2006, Hudson, 2002; Richardson & Lelliott, 2003; Robinson & Cottrell, 2005; Salmon & Rapport, 2005; Walker, 2005). As Horwath & Morrison

(2007) state: “Too often the establishment of collaborative structure and systems are mistaken for the realization of collaborative activity” (p. 66). It is perhaps these issues that prompted Hallet and Birchall (1992), in their oft-cited review of interagency collaboration in child protection, to recommend that time needs to be invested in learning how to collaborate and in undertaking joint training endeavours.

Furthermore, although collaboration may well take place, there is no guarantee that what happens will produce change in the young person’s life. As Lee, Dillon, Dorries, Beech and McDermott (2004) note:

...although increased collaboration may deliver existing services more effectively, it is not a given that the resulting service mix is evidence based. All elements of service provision should still be evaluated and empirically substantiated. (p. 266).

The strength of the evidence base for intervention in this population is, however, unclear. In fact, there appears to be a paucity of research that explores components of effective interprofessional collaborative relationships (Hudson, 2002; Ødegård, 2005), effective program components (Cashmore & Ainsworth, 2004; Walker & Shutte, 2004), obstacles to effective interagency collaboration (Darlington, Feeney & Rixon, 2005a,b; Johnson, Zorn, Kai Yung Tam, La Montagne & Johnson, 2003; Ødegård, 2005; Robinson & Cottrell, 2005; Salmon & Rapport, 2005) and the demands placed on the workers compelled to work in this way (Absler, 2006; Smith & Bryan, 2005).

Theories and models of collaborative practice are still emerging and remain at the formative stage (Salmon & Rapport, 2005). Emerging models emphasise and reflect relatively static organisational structures. Theoretical models or descriptions of established multiagency services that exist in the literature (e.g., Cottrell et al., 2000) may be a far cry from the realities of the communication and collaboration between separate agencies that must in the main occur amongst children's services in South Australia.

Indeed, as Darlington, Feeney and Rixon (2005b) point out, interagency collaborative practice may take many forms, ranging from joint decision making and consultation over a single issue, to multifaceted integrated services. While fully integrated services may be the ideal (e.g., Cottrell, et al., 2000; Walter & Petr, 2000), in reality, less integrated levels of collaboration based on individual worker relationships may be more common (Johnson, Wistow, Schulz & Hardy, 2003). More flexible developmental descriptions of *levels* of collaboration, which range from individual action to true collaboration, may be of more utility because services can potentially use them to assess their current stage of collaboration (see Hodges et al., 2003).

Any attempt to integrate the research on collaboration thus far is hindered by the varying focus of the empirical literature. Studies vary according to whether they focus on individual or agency factors (objective structural aspects or individual subjective aspects) (Morrison, 1996), established multiagency services, or more *ad hoc* or less developed interagency consultations, frontline or

management workers (Hallett & Birchall, 1992; Huxham, 1996; Meyers, 1993; Roaf, 2002; Sandfort, 1999; Tomison, 2001) and whether there is an organisational or a service user perspective to the research (for more detail on some of these issues see Horwath & Morrison, 2007).

In summary, despite the apparent importance of collaborative practice in the case of young people with complex needs, the definition, parameters and limitations of collaborative practice largely remain to be explored. Our knowledge needs to be developed both theoretically and empirically in this area.

### *2.3.1 Advantages to collaboration*

Notwithstanding the theoretical and conceptual limitations outlined, it has been suggested that coordinated, collaborative service provision offers considerable advantages when it does occur. It is argued that this way of working is particularly relevant to clients whose health needs interact with their social needs or vice versa (Bullock & Little, 1999; Salmon & Rapport, 2005). This clearly has relevance for children's services: children in out-of-home care, young offenders, children with mental health issues and those repeatedly excluded from educational environments are thought to be examples of particularly suitable populations (Bullock, Little & Milham, 1998; Place, Wilson, Martin & Hulmsmeier, 2000; Salmon, 2004; Salmon & Rapport, 2005).

Amongst the potential benefits of effective collaboration is the ability to pool resources and knowledge to reach families with complex needs (Costongs & Springett, 1997; Darlington et al., 2005a), or as Darlington et al. (2005a) summarise:

...the bringing together of knowledge, skills and values of different professions and agencies to generate creative solutions for these families who would otherwise be beyond the scope of any one person or agency (p. 239).

Other benefits are thought to include improved cost effectiveness (Johnson et al., 2003), more holistic services (Williamson, 2001), and faster access to services for consumers (Cottrell et al., 2000). Thus, it is argued that collaboration amongst service providers is beneficial for children in out-of-home care. While this might be the ideal, it seems that obstacles may exist to the implementation and actualisation of collaborative practice. The following section will briefly summarise what is known about obstacles to interagency collaborative practice.

### *2.3.2 Barriers to collaboration*

To date, some studies have explicitly attempted to delineate barriers and obstacles to collaborative practice in the case of adult mental health and to a much lesser extent children's services and interagency case conferences (Salmon & Rapport, 2005).

In the case of child protection in general, the challenges of interagency collaboration appear numerous and include:

...different professional perspectives and frames of reference about the nature of child abuse and of intervention, different agency mandates and operational priorities or organizational tendencies towards autonomy, the time and other resource costs of collaborative work and interpersonal difficulties of trust and openness, gender and status differentials. (Hallet & Birchall, 1992, p.26).

Other issues may include competing funding arrangements and service mandates and a lack of procedures for resolving interagency conflict (Quinn & Cumbland, 1994).

Darlington et al. (2005b) have suggested that both agency level and professional level barriers exist in the case of collaboration between child protection and adult mental health services. Lack of supportive structures and policies (Darlington, Feeney & Rixon, 2004; Johnson et al., 2003a) differences in confidentiality policies (Pietsch & Short 1998), resource issues (Bryne, Hearle, Plant, Barkla, Jenner & McGrath, 2000; Darlington et al, 2005 a,b; Johnson, et al., 2003a,b; Hetherington, Baistow, Katz, Mesie & Trowell, 2002) and poor communication (Johnson et al., 2003b) are also thought to affect the level of collaboration.

Collaboration between child protection agencies and other child focused services, such as education services, child and adolescent mental health, child residential care or foster care systems has not been well examined. There appears to be very little research that focuses on the challenges of interprofessional collaboration and care in relation to children with mental health problems (Ødegård, 2005). In relation to children in out-of-home care, some have highlighted issues related to the tension between constraints of procedures and standardisation of services on the one hand, and the creativity and flexibility required to work effectively with this population on the other (Willumsen & Hallberg, 2003). Others have suggested that the collaboration and coordination of services may be particularly difficult for older adolescents with mental health issues (Richards & Vostanis, 2004).

In particular, while the behavioural and emotional issues of children often serve as a focus for interagency discussion (e.g., Salmon & Rapport, 2005), very little is known about how the various agency groups construct and understand these problematic behaviours and how that impacts on effective intervention. Supporting change in challenging behaviour necessitates high levels of interagency cooperation and collaboration and, amongst other things, a shared understanding of the behaviours that are the focus of intervention. It should be noted that no studies so far appear to have directly examined agency workers' experience of addressing behaviour concerns in children in out-of-home care.

### *2.3.3 Collaboration amongst children's services*

Empirical examinations of collaboration amongst children's services appears to be limited. This is especially the case when one considers collaboration amongst children's services supporting children in alternative care. There appear to be only a relatively few recent studies that have explored the barriers to collaborative practice amongst workers in children's services. Three of these examine collaboration between child protection workers and adult mental health workers (Darlington et al., 2005, a,b; Darlington & Feeney, 2008). One examines discourse between child focused agencies in case conferences (Salmon & Rapport, 2005). One analyses common experiences of workers from different agencies in supporting children with challenging behaviour, some of whom were in out-of-home care (Worrall-Davies, Kiernan, Anderton & Cottrell, 2004) and one examines barriers to interagency case management in high risk youth (Okamoto, 2001). These studies will be described in detail in Chapter 4, section 4.6. It is worth noting at this point, however, that the results of these studies emphasise the importance of communication, of clarity of terminology and roles and on better understanding of the conceptual frameworks of others. These factors may also be argued to be highly salient when engaging in problem solving about challenging behaviour.

### *2.3.4 Effective collaboration and understanding of behaviour*

The critical importance of communication has been highlighted in research examining interagency work in other populations too. Indeed, perhaps the most

common finding presented in the literature so far, irrespective of the type of interagency work involved, is that successful collaboration relies on effective communication between agencies (Akhavain, Amaral, Murphy & Uehlinger, 1999; Barker et al., 2005; Henneman, Lee & Cohen, 1995; Marino & Kahnoski, 1998; Salmon & Rapport, 2005). Further, it requires clarity and consensus regarding terminology (Barker et al., 2005; Salmon & Rapport, 2005) and in particular, it requires that all participants speak a ‘common language’ (Bruner et al., 1992; Miller & Ahmad, 2000; Ranade & Hudson, 2003; Salmon & Rapport, 2005). As Salmon and Rapport (2005) explain:

... professionals use the same words as each other, but apportion them with different meanings, in the belief that agreement has been reached in conversation, when in fact those conversing are at odds with one another... (p. 430).

Understandings about children’s behaviours are likely to be important in understanding interagency practice and effective intervention with this population. The ability to acknowledge differences in opinion or perspectives regarding behaviour is important in providing effective intervention and treatment programs for children (Culp, Howell, McDonald-Culp & Blankemeyer, 2001). However, different conceptual frameworks can inform practice in different agencies (e.g., Tye & Precey, 1999), providing the lens through which behaviour is viewed. Stakeholders in different agencies may have differing understandings of the needs of children in out of home care and of the role of other agencies in providing support for the behavioural and emotional issues of these children. The potential

impact on collaboration of negative attitudes held about the roles, competency, and motivations of workers in other agencies has previously been noted (Johnson et al., 2003; Sandfort, 1999).

#### ***2.4 Importance of stakeholders' perspectives in defining collaboration***

Hodges et al. (2003) offer the following definition of collaboration as:

...the process of bringing together those who have a stake in children's mental health for the purpose of interdependent problem solving which focuses on improving services to children and families...(p. 293).

The implications of this definition are numerous. It implies that problem solving occurs with a child focus, and is targeted towards a common goal (Quinn & Cumblad, 1994). Professionals coming together to collaborate is not an end result in and of itself and does not constitute effective collaboration (Bruner, 1991). Importantly, this definition also emphasises the involvement of foster carers as key contributors who "have a stake in children's mental health" (Hodges et al., 2003 p. 293), rather than just defining collaboration as a professional enterprise.

Indeed, in a recent article describing critical issues in the research on collaboration in children's services, the lack of key service users perspectives was highlighted (Horwath & Morrison, 2007). The importance of involving

stakeholders like family members in service delivery has been noted (Darlington et al, 2005b). However, there currently appears to be no research that has sought to include foster carers' perspectives on interagency relations and the process of addressing the behaviour and mental health issues of children in their care.

The key stakeholders involved in collaboration involving challenging behaviour in the out-of-home care environment are foster carers, child and adolescent mental health workers, education staff, child protection agency workers and residential care workers. In South Australia, these stakeholders are largely represented by different agencies.

The limited exploration of interprofessional and interagency perspectives amongst children's services suggests that differences may exist in their understanding and approach to problematic behaviour and mental health issues. Both organisational culture and professional (discipline specific) issues may contribute to any suggested differences in viewpoints (Ødegård, 2007; Willumsen & Hallberg, 2003). The following section will outline the broad literature base which speaks to what is known about the various stakeholder groups in relation to this issue.

#### *2.4.1 Stakeholder frameworks for understanding behaviour*

Hall (2005) has discussed the historical and sociological processes that come to influence the values, identities and practices of different professional group's cultures and how these can serve as barriers to collaborative practice. She

describes the development of 'cognitive maps' through training and professional induction. These cognitive maps can mean that "...quite literally, two opposing 'disciplinarians' can look at the same thing and not see the same thing ..." (Petrie, 1976, p 35.). Hall (2005) also highlights the different values that can develop as a result of the training and induction processes and argues that a major challenge in collaborative practice is to provide opportunities for workers of different professions to understand each others values and cognitive maps. As she states:

...since values are internalized and largely unspoken, they can create important obstacles that may actually be invisible to different team members struggling with a problem. For a solution to be reached, the professional values must be made apparent to all professionals involved....(p. 191).

This is clearly also relevant to the development of organisational and agency cultures (Ødegård, 2007). Both agency training and organisational culture could result in the existence of such cognitive maps for interagency collaboration or for understanding and addressing behavioural problems. There is some evidence that differences exist in the frameworks applied to understanding problem behaviour; both between professional groups and between agencies.

For example, social services and mental health services may disagree as to the cause of mental health and behavioural issues (Richards & Vostanis, 2004). It has been suggested that social workers may under refer children for mental health and behaviour difficulties, minimise the importance of educational issues (e.g.,

Phillips, 1997) or fail to fully realise the potential for engagement with educational systems (Gilligan, 1998). Amongst social workers, there may be a perception that teachers and schools disown students with behaviour problems (Altschuler, 2003). Conversely, different professional groups may have very similar views about identifying biological parents as the source of children's mental health problems (Johnson, Cournoyer & Fisher, 1994; Johnson, Renaud, Schmidt & Staneck, 1998; Ruffolo, Sugamele & Taylor-Brown, 1994).

Johnson et al. (2000) have suggested that different professional groups may hold a different set of cognitive constructs or beliefs about the origin of behavioural and emotional difficulties in children and, as a result, prefer differing treatment approaches. In their examination of mental health professionals' causal attributions, theoretical orientation and preferred treatment approach to clinic referred children they found differences in psychologists', social workers' and psychiatrists' beliefs about the cause of mental health problems; (i.e., whether caused by parent behaviour or biological determinants). Furthermore, the theoretical beliefs professionals held about the cause of behaviour influenced the treatment recommendations they made to parents.

In one study on how placement decisions were made, it was professional group membership that influenced information sought and used in making recommendations about reunification or placement, rather than factors such as chronicity of abuse and age of the child (Britnera & Mossler, 2002).

Clearly, the beliefs and approaches that professionals hold about the problematic behaviour of children in out-of-home care may also influence how they approach the management of behaviour problems in this population. To date, this does not appear to have been examined in relation to the behaviour of children in out-of-home care.

The following sections draw together a diverse range of studies outlining what is known about the attitude and approach of key stakeholder groups whose input is essential in the case of collaborative case work for children in out-of-home care services. It outlines studies that tie attitudes and beliefs about behaviour in each stakeholder group to relevant aspects of stakeholder practice, such as discipline, optimism about change and willingness to continue working with difficult populations. Taken all together, this body of literature suggests that the accounts stakeholders form about behaviour may be influential to their daily practice in relation to behaviour management.

#### *2.4.1 Residential carers' attributions for challenging behaviour*

Support for the importance of exploring perceptions of challenging behaviour amongst residential care workers comes mostly from studies based on an attributional model of help giving (Weiner, 1980, 1986), which holds that causal attributions made along the dimensions of internality, control and stability determine affect and helping behaviour. An attributional model predicts that if one regards challenging behaviour as under the control of the person exhibiting it, one is likely to experience negative affect towards that person and be reluctant to help

or persist with helping that person. This model has obvious implications for those in a variety of 'helping' roles, such as caseworkers, counsellors, teachers, residential care workers and foster carers.

Attribution models have been applied to professional carers of intellectually disabled adults and children in residential settings and have confirmed that attributions made by workers for clients' challenging behaviours are linked to their emotional reactions, optimism and behavioural intentions towards those clients (Jones & Hastings, 2003; Wanless & Jahoda, 2002). More specifically, attributions of control and internality are linked to unwillingness to help (Hill & Dagnan, 2002; Stanley & Standon, 2000) and optimism for change (Brian & Standon, 2000; Dagnan, Trower, & Smith, 1998; Hill & Dagnan, 2002; Stanley & Standon, 2000). Attributions of stability also negatively influenced residential care staffs' optimism about the possibility for change in behaviour (Stanley & Standon, 2000).

Thus, there is some support for the idea that how residential care workers understand the behaviour exhibited in a residential setting will impact on their practice and optimism for change, in the case of challenging behaviour amongst clients with intellectual disabilities. In relation to residential care staff working with troubled youth, it has been suggested that beliefs about control, consistency and reward in relation to (good) behaviour may be salient to workers, although this has not been subject to empirical study (Leaf, 1995).

There do not appear to be any studies that have explicitly examined the attitudes of residential care workers in the case of children in out-of-home care living in residential units. This is particularly troubling as residential care workers in Australia are likely to be exposed to very challenging behaviour including aggression and violence (Ainsworth & Hansen, 2008). Arguably, the understanding that workers in these units hold about behaviour is likely to be especially important, given that they are required to balance the difficult task of both caring for the child and imposing behavioural controls (Leaf, 1995). Previous studies on collaboration or behaviour have not involved this important group of stakeholders.

#### *2.4.2 Teachers' attitudes and actions towards child abuse and behaviour*

Webster, O'Toole, O'Toole & Lucal (2005), in an examination of teachers' perception and reporting of abuse, found that teachers' discretion was likely to lead to an underreporting of abuse. Additionally, they identified a belief amongst some teachers that the reporting of abuse would cause problems for the child or the teacher. Compared to other common problems, behaviour problems were seen by teachers to be more environmentally determined (Walker & Plomin, 2005). In reviewing recent research on teacher training in behaviour management, Giallo and Hayes (2007) suggest that teachers lack a preparedness and confidence to manage students with difficult behaviours and further, that students with disruptive behaviour received less encouragement, received more criticism and punishment than other children. Little appears to be known about how aware

teachers are of their students' mental health problems and how this affects their teaching practice (Gowers, Thomas & Deeley, 2004).

It appears that teachers may most commonly ascribe problem classroom behaviour amongst normal student populations to lack of student effort (Ho, 2004), and other student related (Bibou-Nakou, Kiosseoglou & Stogiannidou, 2000; Bibou-Nakou, Stogiannidou & Kiosseoglou, 1999; Mavropoulou & Padeliadu, 2002) and family related factors (Ho, 2004; Mavropoulou & Padeliadu, 2002), rather than to teacher, classroom or school related factors. However, the causal explanations made by teachers for the behaviour difficulties of children in out-of-home care do not appear to have been examined.

Furthermore, teacher cognitive processes have been linked to their teaching practice (Hollingsworth, 1989) and in particular to discipline practices (Bibou-Nakou et al., 2000; Bibou-Nakou et al., 1999; Brophy, 1996; Brophy & Rohrkemper, 1981; Davis & Sumara, 1997; Poulou & Norwich, 2000). In general, the literature suggests that teachers are more likely to use punitive discipline strategies when they perceive that the students have control over their behaviour (Brophy, 1996; Brophy & Rohrkemper, 1981; Tollefson, 2000).

How teachers account for and address the behaviour of children in out-of-home care is not known. However, interventions targeting aspects of teacher-child interactions and teacher confidence in working with at-risk children with challenging behaviours show some promise (Hamre & Pianta, 2005; Schiff & BarGil, 2004). The importance of understanding the experiences and perspectives

of teachers with respect to managing behaviours is indicated by the potential for the school environment to be a positive influence on the child in situations where there has been major upheaval in the child's life. One study found that out-of-home placement stability was enhanced when placement in the foster home did not coincide with a change of school (Berridge & Cleaver, 1987), suggesting the potential for schooling stability to influence the child's ability to recover from stressful events and trauma (Gilligan, 1998). Gilligan (1998) has argued that teachers may play many important roles for a child. They may contribute to the development of a child's identity beyond family (and foster family), and act as accessible confidants and valuable role models for the child. Therefore, the importance of mental health workers engaging with this group of professionals and understanding the "harsh realities" of managing behaviour "in high stress classrooms" has been emphasised (Gilligan, 1998, p.20).

#### *2.4.3 Social workers and child mental health professionals*

Social workers are typically trained in a humanistic (experiential, interdependent, inquiry based) paradigm as distinct from a scientific (individualistic, content driven) paradigm and may therefore be cautious of medical or pathological explanations for problems (Barnes et al., 2000). This may affect their collaborative work with other disciplines (and vice versa), particularly in the case of those disciplines that generally emphasise reductionistic, diagnostic models such as clinical psychologists and medically trained staff. Interprofessional stereotypes such as these can be further reinforced by immersion in a workplace culture dominated by one discipline to an extent that such

cognitive biases become perceived as an accurate representation of reality (Barnes et al., 2000). It could be argued that such conditions exist in many workplaces such as child protection, which is dominated by social workers. Similarly, psychologists may be more comfortable and feel more prepared for a diagnostic or practitioner role, rather than one of a facilitator or 'system change agent' (Pyle, 1977, p.197).

It has been suggested that social workers may not value, or may minimise any focus on the educational needs of children in care or not track educational issues systematically (Jackson, 1994; Zetlin, Weinberg & Kimm, 2005). This lack of focus may result in poor or tardy monitoring and handover of essential information relevant to educational attainment and issues (Altschuler, 1997; Ayasse, 1995; Emerson & Lovitt, 2003).

There is some indirect support for the notion that mental health workers, such as trauma counsellors, can have unhelpful cognitions, including about difficult clients and challenging behaviours and that unhelpful cognitions may impact on their emotional availability and vulnerability to burnout and stress (Forney, Wallace-Schutzman & Wiggers 1982; Mclean, Wade & Encel 2003). Trained child mental health professionals may be significantly underrepresented in systems such as child welfare, youth corrections and education (Glisson, 1996), possibly making detection of mental health issues and communication between child mental health workers and other agencies more difficult.

#### *2.4.4 Foster carer experiences and attitudes towards behaviour problems*

Foster carers are frequently required to manage challenging behaviour. Amongst the stressors foster carers face, dealing with challenging behaviour and emotional issues features strongly. The behaviour of foster children and difficulty related to discipline are factors impacting negatively on foster parents satisfaction and intention to continue fostering (McFadden, 1996; Rhodes, Orme & Beuhler, 2001) and foster carer 'burn-out' (Cooper et al., 1987; Kerker & Dore, 2006; Proch & Taber, 1987). Lack of realistic information, training and difficulty in dealing with challenging behaviour diminish foster carers' intention and willingness to continue fostering (Denby, Rindfleish & Bean, 1999). Approximately one quarter of placement failures appear to result from behaviours that foster carers report feeling incapable of dealing with (Cooper et al., 1987), feel unprepared for (Berridge & Cleaver, 1987; Rich, 1996), or lack the confidence to manage (Sinclair, Wilson & Gibbs, 2005). One third of foster carers list child behavioural problems as a reason for quitting foster care (Rhodes et al., 2001).

Foster carers frequently express the need for support in managing and controlling challenging behaviour (Quinton, Rushton, Dance & Mayes, 1998). Given this, it is clearly important for professionals to understand what foster carers understand to be the causes for the behaviour problems of these children and what approaches they take to managing behaviour.

Additionally, it is also important to explore and include the experiences that foster carers have of interagency collaboration and coordination of services in the case of children with challenging behaviour in their care. There is a suggestion that foster carers may find working with agencies in relation to their children's needs difficult and unrewarding (Brown & Calder, 1999). In one study, for example, 64% of foster carers gave reasons such as insensitivity towards them by agency workers and poor communication as the primary reason for giving up foster care (Barbell, 1999).

Other studies hint at salient cognitions for foster carers in relation to behaviour. Thematic analyses of foster placement disruption indicates that foster carers may struggle with the tension caused by beliefs about 'nature' versus 'nurture' in relation to how much influence they can have on children in their care (Butler & Charles, 1999). Others have suggested that foster carers may minimise underlying mental health issues (Halfon et al., 1995). Colton (1989) reported greater attitudes of control towards behaviour in special (treatment) foster carers compared with residential carers, although this did not appear to translate into less child centred practice. Somewhat relatedly, adoptive parents appear to make less internal (child focused) attributions for behaviour than other non-biological parents (e.g., step-parents) (Stratton, 2005).

To date, the exploration of foster carers' perception of challenging behaviour is sparse (see Bennett, 2000). Studies appear largely limited to the comparison of kinship and non kinship carers (e.g., Berrick, Bath & Needell, 1994; Dubowitz et al, 1993; Keller et al., 2001; Rosenthal & Curiel, 2006; Shore, Sim & Le Prohn,

2002), which report that kinship carers generally perceive behaviours as less problematic than non kinship carers. Those studies that do compare behavioural ratings of foster carers with other informants (e.g., using CBCL measures) have yielded inconsistent results. However, it appears that reports about behaviour from long term foster carers are as reliable as biological parent reports (see Tarren Sweeney et al., 2004). One recent study found no difference in foster carer and caseworkers ratings in predicting placement breakdown (Oosterman, et al., 2007). Others have found caseworkers' reports of behaviour problems, rather than foster carers' reports, to be predictive of placement breakdown (Leathers, 2006); although other factors such control over placement decisions may have influenced this finding. In this same study, however, foster carer reports of problem behaviour were more predictive of poor outcome over a five year period. On average, foster carers also reported more problems than caseworkers did (Leathers, 2006).

The literature exploring the link between cognitions and parenting behaviour in biological parents suggests that how parents account for problem behaviour is an important area of research. For example, a great deal of research has supported the relationship between biological parent cognitions regarding their children and parenting behaviour in the case of problem behaviour (e.g., Bugental & Johnston, 2000; Miller, 1995). When parents view their children as responsible for their misbehaviour, they are more likely to respond negatively to such behaviour (Johnston & Freeman, 1997; Johnston, Seipp, Hommersen, Hoza & Fine, 2005; Slep & O'Leary, 1998). They may also 'give up' trying to manage their children's behaviour because of beliefs that certain behaviours are beyond their control

(Chronis, Chacko, Fabiano, Wymbs & Pelham, 2004). These findings have implications for better understanding how foster carers account for challenging behaviour. It seems likely that foster parents may struggle with similar issues to biological parents in attempting to understand challenging behaviour. Currently, however, a gap exists in the literature about foster carers cognitions regarding challenging behaviour, how they understand and approach it and how it impacts on parenting practices.

It is therefore appears reasonable to conclude, given the body of literature reviewed above, that stakeholders' general frameworks for understanding and managing challenging behaviour may be important contributors to factors such as discipline approaches, willingness to persist with challenging behaviour, optimism for change, preference of intervention approach and willingness to collaborate. The way in which the behaviour problems that may be displayed by children in out-of-home care are understood and managed by the stakeholder groups discussed above does not appear to have been explored to date. The following section briefly reviews the evidence base for behavioural intervention in this population.

## ***2.5 Approaches to behaviour management in out-of-home care***

Clinicians seeking evidence based approaches to supporting young people in out-of-home care have relatively little to guide their practice. Indeed, intervention in this population has not been well examined. A recent systematic research synthesis found a lack of research on interventions specifically tailored for the

unique difficulties of children in out-of-home care (Craven & Lee, 2006). Of eighteen studies reviewed by Craven and Lee (2006), nine were preventative programs and only nine intervention programs were documented. Furthermore, of the nine intervention programs documented, only six were based on studies using children in out-of-home care. Most of the therapeutic interventions necessarily involved the collaboration of multiple systems of care and were multifaceted, making it difficult to identify critical effective components. Additionally, the authors commented that amongst these studies reviewed, acknowledgment of the specific behavioural and systemic issues unique to foster children appeared to be lacking. In particular, accommodation for the uniqueness of the foster family structure and dynamics such as separation and visitation with family was not integrated within any of the interventions reviewed (Craven & Lee, 2006). It should be noted that the conclusions reached by the authors about the efficacy of some interventions have been questioned (see Pignotti & Mercer, 2007). Nonetheless, many of the points raised by the authors in relation to the dearth of intervention studies specifically tailored for the unique needs of this population appear to be warranted.

International reviews, however, have highlighted a range of both child-focused and parent-focused interventions potentially suitable for children with high support needs (Delfabbro & Osborn, 2005) and other appropriate populations such as children who have been physically and sexually abused (Saunders, Berliner, & Hanson, 2004). However, reviews of treatments specifically for children in the out of home care environment are very limited (e.g., Craven & Lee, 2006). Further, implementation of any evidence based programs has been

extremely limited in Australia (Osborn, 2006) meaning that key stakeholders in South Australia might have very limited exposure to the conceptual and practical elements of effective interventions.

The situation is surprisingly similar in the case of parenting and behaviour management programs aimed at foster carers (Leslie et. al., 2005). There remains a lack of evidence based interventions supporting foster carers to address challenging behaviour (Craven & Lee, 2006; Hill-Tout et al., 2003), with the bulk of the published training programs evidencing disappointing levels of behaviour change or documented effectiveness, although foster carer confidence may improve as a result of completing training (Lee & Holland, 1991; Puddy & Jackson, 2003; Redding, Fried & Britner, 2000). Theoretical drivers for the program and program elements are often poorly articulated, making it difficult for stakeholders to identify effective components (Hill-Tout, Pithouse & Lowe, 2003). A notable exception to this is the Multidimensional Treatment Foster Care (MTFC) program, although it is not applied in any systematic way in the Australian context. MTFC utilises strict behavioural contingencies to reward prosocial behaviours and has proven to be an effective alternative to (correctional) residential treatment amongst juvenile offenders in the USA (e.g., Chamberlain & Reid, 1991).

In the absence of any clear guidelines for intervention practice, the need to understand dominant frameworks guiding clinicians and other stakeholders becomes even more important. It is only by making explicit what frameworks stakeholders are invested in that we can hope to find common ground or reconcile

differences. In this way, we may be able to make explicit, and provide clarity about, implicit assumptions that may guide stakeholder practice and may contribute to difficulties in working collaboratively to support change in complex and challenging behaviour. The broad research aims of this thesis will be outlined in the next section.

## **2.6 Research Aims**

This research is exploratory and iterative in nature. It interrogates three broad areas:

First, what is the experience of key stakeholders in working collaboratively to support children in alternative care with challenging behaviour? What does this collaboration look like in practice? What are the main perceived difficulties and obstacles commonly experienced by stakeholders when engaging in collaborative practice in order to support behaviour change amongst children in out-of-home care exhibiting challenging behaviour? What recommendations arise out of these findings that can help stakeholders to implement behaviour change?

An examination will be made of the experiences of key groups of South Australian stakeholders' with working collaboratively to support young people in out-of-home care to address their challenging behaviour. This will be achieved by:

- identifying barriers to interagency practice for stakeholders in relation to supporting behaviour change amongst children in out-of-home care.

This thesis will make a unique contribution to understanding in this area by:

1) including the views of stakeholders not previously involved in examinations of collaborative practice in mental health; namely residential care workers, teachers

and foster carers and 2), targeting issues specific to supporting change amongst children with challenging behaviour, rather than relating to collaboration more generally.

Second, how do key stakeholders understand and approach challenging behaviour amongst children in alternative care? What are the dominant accounts of behaviour amongst stakeholders? What are the likely implications of these accounts for the child in out-of-home care with challenging behaviour? This will be achieved by:

- identifying dominant discourses about behaviour amongst key stakeholder groups.
- analysing the possible implications of this discourse regarding the cause and treatment of challenging behaviour for engaging in interagency practice and changing behaviour.

Addressing these questions will make a unique contribution to understanding dominant accounts of behaviour amongst stakeholders and highlight potential areas to target when engaging with stakeholders in collaborative practice relating to children's challenging behaviour. In turn, it is hoped that this can enhance understanding of each stakeholder groups' perspective and experience, and lead to recommendations for the improvement of the practice of both collaboration and behavioural intervention with this population.

Finally, the unique experiences, tensions and approaches engaged in by one particular stakeholder group will be examined. It may be argued that, amongst the stakeholders in this research, residential care workers are most commonly called

on to manage extremely disruptive and challenging behaviour. For this reason, the experiences of residential care workers will be examined in more detail. What are the particular tensions and issues for residential care workers in managing behaviour. How does an analysis of their approach to managing challenging behaviour contribute to our understanding of collaborative practice more broadly. This third broad research question will be addressed by:

- examination of how challenging behaviour is addressed by providing a detailed analysis of the experiences of one stakeholder group; residential care workers.

Addressing this question will make a unique contribution to better understanding between stakeholder groups. This, in turn, will contribute to clearer communication and enhance collaborative practice with a group that has been perceived to be difficult to engage with

## **PART B**

### **Chapter Three:**

#### **Method**



## CHAPTER THREE

### Method

#### ***3.1 Participants***

Participants in this study were recruited from the Northern and Southern area Child and Adolescent Mental Health Services (CAMHS), from the Department of Education and Children's Services (DECS), from the Department of Families and Communities South Australia (Families SA case managers and community residential care workers) and from amongst current and former South Australian foster carers. A total of 92 respondents took part in the research. 36 were Department of Families and Communities SA employees: 19 were Families SA case managers and 17 were residential care workers. 12 were child and adolescent mental health (CAMHS) workers, 18 were teachers from the Department of Education and Children's services (DECS), and 26 were foster carers.

#### ***3.2 Ethics approval***

Ethics approval for the project was obtained from The University of Adelaide's Human Research Ethics Committee and The University of Adelaide's School of Human Ethics Subcommittee. Subsequent to this approval, additional research and ethics applications were required. These are outlined below within descriptions of the recruitment process for each stakeholder group.

### **3.3 Recruitment of participants**

#### *3.3.1 Recruitment of Child and Adolescent Mental Health workers:*

Participants from this stakeholder group were 12 child and adolescent mental health (CAMHS) workers recruited from both Northern and Southern area services. In addition to the ethics approval detailed above, ethics approval for the participation of CAMHS staff was also obtained from the Child, Youth and Women's Health Service (CYWHS) Human Research Ethics Subcommittee (HREC). Following approval from this subcommittee, an application was made to Northern Division of Mental Health CAMHS Divisional Operations Committee (DOC) members for approval of the research project and for the participation of Northern Division of Mental Health CAMHS staff. Following 'in principle' approval of the project, team managers from metropolitan and rural teams were approached via email in order to provide information about the aims of the project and to call for volunteers. Participants who indicated their interest in being interviewed were emailed a brief demographic survey to complete prior to interview.

The interviewing of staff took place over 12 months. The primary difficulty experienced in recruiting participants was the workers self-reported lack of experience in working with children in out-of-home care. Participants were 12 workers from a range of professional disciplines that considered themselves experienced in providing support for children in out-of-home care. The 12 participants included three workers from a therapeutic day program for

adolescents with serious and significant mental health issues, and two general caseworkers. Additionally, there were seven workers from programs designed to provide services to children who had been subject to notification or had been removed from home. There were two clinical psychologists, seven senior social workers, two mental health nurses and one speech therapist. All participants had bachelor or masters level qualifications. Most participants had between five and ten years experience in working with children in alternative care. Most participants were aged between 35 and 40 years, with an average age of 39.9 years. There were an equal number of male and female respondents. A summary of participants is provided in Table 1 below.

Table 1  
*Summary of Child & Adolescent Mental Health (CAMHS) interview participants*

Participant code	Profession	Gender	Age (yrs)	Duration of interview (mins)	Interview Number
CAMHS 1	Speech therapist	Female	31	51	1
CAMHS 2	Nurse	Male	37	51	2
CAMHS 3	Nurse	Male	53	56	3
CAMHS 4	Social worker	Male	54	62	4
CAMHS 5	Social worker	Female	47	61	5
CAMHS 6	Psychologist	Female	32	41	6
CAMHS 7	Social work	Male	47	45	7
CAMHS 8	Social work	Female	29	48	8
CAMHS 9	Social work	Female	26	66	16
CAMHS 10	Social work	Female	27	37	17
CAMHS011	Psychologist	Male	39	35	58
CAMHS012	Social work	Male	57	53	76

### *3.3.2 Recruitment of Department of Families and Communities workers:*

In order for Department of Families and Communities workers to be involved in this research, additional ethics approval for the project, and for the participation of Department of Families and Communities workers, was obtained from the Department of Families and Communities Research Ethics Committee. Families SA workers and community residential care workers were both recruited from the Department of Families and Communities, but the process of recruitment was different for residential care workers and Families SA caseworkers.

#### *3.3.2.1 Recruitment of Families SA caseworkers:*

Following Departmental ethics approval for this project a senior management representative from the Department was asked to circulate information about the project to team managers in order for them to distribute it to their team. As part of this information package, a request was made for volunteers to participate in interviews. Participants who indicated their interest in being interviewed were emailed a brief demographic survey to complete prior to interview.

Recruitment and data collection took part over 10 months. The primary difficulty experienced in recruiting participants was the frequent cancellation of interview appointments due to workload issues or crises involving the children in their caseload. More than half of scheduled interviews were cancelled due to unforeseen circumstances, other reasons, or no reason was given for cancellation. This recruitment process ultimately resulted in 19 participants, all of whom were

caseworkers from a variety of metropolitan and rural teams. 12 were guardianship team workers, whose role was the case management of children who are under guardianship of the minister till the age of eighteen. Two were from the intake team, whose role is the removal of children, initial forensic investigations and assessments and preparation of court documents where abuse is deemed substantiated. Five were from the reunification team whose role is to support reunification attempts and the assessment of potential for reunification of the child with their biological family. Three identified themselves at interview as final year social workers (social work trainees), 12 were social workers, three were senior practitioners (senior social workers in a supervisory role) and one was a support worker without tertiary training who undertook casework in a rural setting. Most participants were aged between 50 and 55 years, with an average age of 41 years. There were 12 females and seven males. Most were university graduates, who had completed a bachelor of social work, and all were social workers or final year trainee social workers, with the exception of one casework support officer. Most had had between two and five years experience in working with children in alternative care.

A summary of participants is provided in Table 2 below.

Table 2  
*Summary of Families SA interview participants*

Participant code	Profession	Gender	Age (yrs)	Duration of interview (mins)	Interview Number
FSA 001	Social work	Male	n/a	63	23
FSA 002	Social work	Female	54	41	24
FSA 003	Social work	Male	26	39	27
FSA 004	Social work	Female	54	60	30
FSA 005	Social work	Male	57	60	31
FSA 006	Social work	Male	42	47	46
FSA 007	Social work	Female	n/a	32	47
FSA 008	Social work	Female	48	55	50
FSA 009	Social work	Male	47	72	59
FSA 010	Case worker	Female	54	78	62
FSA 011	Social work	Female	25	39	63
FSA 012	Social work	Female	21	32	64
FSA 013	Social work	Male	31	36	65
FSA 014	Social work	Male	29	45	72
FSA 015	Social work	Female	34	45	73
FSA 016	Social work	Female	38	36	75
FSA 017	n/a	Female	44	55	83
FSA 018	n/a	Female	43	61	84
FSA 019	n/a	Female	50	54	85

Note: n/a indicates respondent did not provide this information on demographic survey

### 3.3.2.2 Recruitment of Residential care workers:

In order to recruit residential care workers, a presentation was made to the Community Residential Care management team which forms part of the Guardianship and Alternative Care Directorate within the Department for Families

and Communities. During this presentation, the opportunity was given for the researcher to address concerns and queries about the research and to negotiate the manner in which the research could be conducted with minimal disruption to the workers involved. 'In principle' approval for the project was obtained in this manner from the management team. Team leaders were then approached later by phone and asked to circulate information about the study and to call for volunteers amongst their team. Participants who indicated their interest in being interviewed were emailed a brief demographic survey to complete prior to interview.

Recruitment and data collection occurred over 10 months. This recruitment process resulted in 17 participants from community residential care units, including transitional accommodation units. Of these participants, four were unit supervisors and 11 were residential care shift workers. An additional two participants were recruited from residential correctional facilities via the same general recruitment process as the Families SA caseworkers outlined previously. The interviewees consisted predominantly of youth workers: five youth workers, six senior youth workers, two social workers and four unit managers that identified themselves as youth workers. Participants were from six residential care facilities including one from transitional accommodation and two from secure care. Four were from residential assessment units and ten from community residential care units. Most participants were aged between 35 and 40, with an average age of 38.8 years. There were 11 males and six females. Most participants held a certificate level qualification, three had university degrees and one had a masters degree in social work. Most had between five and ten years experience in

working with children in alternative care. A summary of participants and their stated profession is provided in Table 3 below.

Table 3  
*Summary of Residential Care worker interview participants*

Participant code	Profession	Gender	Age (yrs)	Duration of interview (mins)	Interview Number
RESI 001	n/a	Male	n/a	52	29
RESI 002	Youth worker	Male	41	46	32
RESI 003	Social worker	Male	53	33	43
RESI 004	Youth worker	Male	48	58	45
RESI 005	Social Worker	Female	37	51	48
RESI 006	Youth worker	Female	37	61	49
RESI 007	Youth worker	Male	25	34	51
RESI 008	Youth worker	Male	42	39	52
RESI 009	Youth worker	Female	24	31	53
RESI 010	Youth worker	Male	32	51	54
RESI 011	Youth worker	Female	49	46	55
RESI 012	Youth worker	Male	43	54	56
RESI 013	Youth worker	Female	27	27	60
RESI 014	Youth worker	Male	36	30	61
RESI 015	Youth worker	Male	50	66	69
RESI 016	Youth worker	Male	33	48	70
RESI 017	Youth worker	Female	43	45	71

Note: n/a indicates respondent did not provide this information on demographic survey

### 3.3.3 Recruitment of DECS staff:

In order to recruit teaching staff from the Department of Education, additional ethics approval was obtained following submission via the Department's process for research and ethics approvals. This process took in excess of four months of

email communication and written submissions. The manager for the Networked Learning Community provided final approval for the project. Subsequent to this approval, the Department's Behaviour Policy manager provided a list of schools that were identified based on data relating to proportion of children in out-of-home care attending those schools. Schools were then randomly selected from this list and approached via initial email and phone calls to principals. This ultimately resulted in 18 participants from both metropolitan (13) and rural (5) schools. Eight were 'mainstream' metropolitan schools, four were mainstream rural schools, and six were alternative schools (for Indigenous students, students with behavioural issues). Four participants were teachers in leadership positions, nine were classroom teachers, and five others were school counsellors and learning coordinators. The recruitment and interviews took nine months following the approval of the Department's research and ethics body. The participants ranged in age from 31 to 58 years with a mean age of 48.3 years. There were equal numbers of males and females. The majority had had over ten years experience in supporting children in alternative care. All had university or masters level qualifications in teaching.

A summary of participants is provided in Table 4 below.

Table 4  
*Summary of DECS interview participants*

Participant code	Profession	Gender	Age (yrs)	Duration of interview (mins)	Interview Number
DECS 001	Principal	Male	47	61	25
DECS 002	Principal	Male	50	51	34
DECS 003	Principal	Male	54	78	35
DECS 004	Counsellor/Teacher	Female	36	47	37
DECS 005	Teacher	Female	57	41	38
DECS 006	Teacher	Female	52	52	39
DECS 007	Counsellor	Female	50	60	40
DECS 008	Principal	Male	58	51	41
DECS 009	Teacher	Female	50	40	42
DECS 010	Teacher	Male	51	55	44
DECS 011	Teacher	Female	n/a	43	57
DECS 012	Teacher	Male	31	43	66
DECS 013	Teacher	Female	36	28	67
DECS 014	Counsellor	Female	39	61	68
DECS 015	Counsellor/Teacher	Male	58	44	74
DECS 016	Teacher	Female	54	37	80
DECS 017	Teacher	Male	49	34	81
DECS 018	Teacher	Male	n/a	63	89

Note: n/a indicates respondent did not provide this information on demographic survey

### 3.3.4 Recruitment of Foster carers:

In order to recruit foster carers for this study, agencies involved in providing support services to carers (alternative care service providers) were approached and an attempt was made to obtain 'in principle' agreement to circulate information to carers. However, this method of recruitment did not prove successful. Ultimately, foster carers were recruited via a combination of the use of an (independent) foster

care support network and advertisement in local community newspapers.

Although recruitment in this manner was necessary to ensure adequate participants, the possibility that this may have increased the participation of those who held strong negative opinions is acknowledged.

Participants indicated their willingness to take part by contacting the researcher. Details of the study, including the time commitments involved were discussed with carers at that time. Those that indicated their wish to take part were sent a background information sheet to complete prior to interview. Foster carers were paid \$25 for the completion of the survey and for taking part in interviews. Foster carers that contacted the researcher were initially screened in order to establish their experience with children in the age range in question; specifically about behavioural problems in school age children and older. The recruitment and interview process took part over 13 months. It was characterised by difficulties in completing interviews due to a variety of factors including crises involving children, or cancellations with no reason given or caution about participation in the research (12 interviews were not completed due to these factors).

The foster carers that took place were a combination of current foster carers and former foster carers. The recruitment of former foster carers formed part of another study which also explored foster carer motivation and reasons for ceasing to provide care. This data will be reported elsewhere and will not be presented in this thesis.

This recruitment process resulted in 26 interviews, 19 from current carers and seven former carers. For the purpose of this research current and former carers were not separated. The recruitment and completion of interviews took part over 12 months. The foster carers that took part in the study ranged in age from 34 to 64, with the average age being 49 years. The majority held technical or diploma level education and most (24) were female, however two males also took part. The majority of foster carers were interviewed independently, but two carer couples were interviewed together upon request. The majority (65%) of the sample had been providing foster care for over ten years. Six were carers from rural areas and the remainder were within the metropolitan environment. Two identified themselves as foster carers of Aboriginal children. A summary of participants is provided in Table 5 below.

Table 5  
*Summary of Foster Carer interview participants*

Participant code	Currently providing care?	Employed?	Gender	Age (years)	Duration of interviews (mins)	Interview Number
CARER 1	Yes	Part time	Female	51	90	9
CARER 2	No	No	Female	56	35	10
CARER 3	No	No	Female	64	77	11
CARER 4	Yes	Part time	Female	48	64	12
CARER 5	Yes	Part time	Female	49	79	13
CARER 6	No	No	Female	57	46	14
CARER 7	No	No	Female	64	45	15
CARER 8	Yes	No	Female	48	54	18
CARER 9	Yes	No	Female	48	55	19
CARER 10	No	Part time	Female	41	58	20
CARER 11	Yes	Full time	Female	41	87	21
CARER 12	Yes	Part time	Female	42	87	21
CARER 13	Yes	No	Female	44	66	22
CARER 14	No	Full time	Female	53	40	26
CARER 15	Yes	No	Female	39	52	28
CARER 16	Yes	Part time	Female	58	57	33
CARER 17	No	Full time	Male	50	67	36
CARER 18	Yes	No	Male	55	57	77
CARER 19	Yes	No	Female	50	57	77
CARER 20	Yes	n/a	Female	n/a	78	78
CARER 21	Yes	No	Female	62	72	79
CARER 22	Yes	Part time	Female	34	76	82
CARER 23	Yes	No	Female	n/a	74	86
CARER 24	Yes	No	Female	34	56	87
CARER 25	Yes	No	Female	42	45	88
CARER 26	Yes	No	Female	n/a	63	90

Note: n/a indicates respondent did not provide this information on demographic survey

### **3.4 Data collection**

#### *3.4.1 Demographic questionnaire*

All participants completed a background and demographic information questionnaire prior to participating in the interview (see Appendices A and B). This questionnaire was structured slightly differently for foster carers and other stakeholders in order to obtain information about qualifications or experiences providing foster care, depending on the group involved. It also asked for participants' perceptions about problematic behaviours in children. Much of this quantitative data forms part of another study and will not be presented in this thesis, but some of the descriptive information obtained is reported here. In addition, foster carers were asked to complete a survey about their motivation to foster and reasons for ceasing foster care (Appendix C), that also formed part of another study. In all cases, these additional questionnaires were completed by foster carers after completion of the interviews to ensure that the focus of the interview remained on their experiences of managing challenging behaviour.

#### *3.4.2 Directions to interview participants*

Participants took part in a semi-structured interview that asked about the following broad areas: 1) their experience of working collaboratively with other stakeholders in supporting children with challenging behaviour, and 2) their experience and understanding of challenging behaviour. Prompts were used to

encourage elaboration on these areas and to encourage the full description of specific examples of behavioural incidents or other incidents of interest (see Appendix D). Participants were not provided with a definition of ‘challenging behaviour’ because it was felt that this might restrict or guide participants in their responses. It was clear, however, that most respondents talked about violence and aggression, even though not directed to interpret the term ‘challenging behaviour’ in that way.

This interpretation of ‘challenging behaviour’ is also supported by the responses of participants to one question on the background questionnaire: “What are the main challenging behaviours shown by children in out-of-home care?” Participants were allowed up to three responses to this question. Participants’ first responses were tallied. When these responses were tallied, the importance of violence, anger, aggression and defiance to stakeholders was evident. Figure 1 reports the ‘number one’ challenging behaviour amongst all respondents who provided this information (n=83).

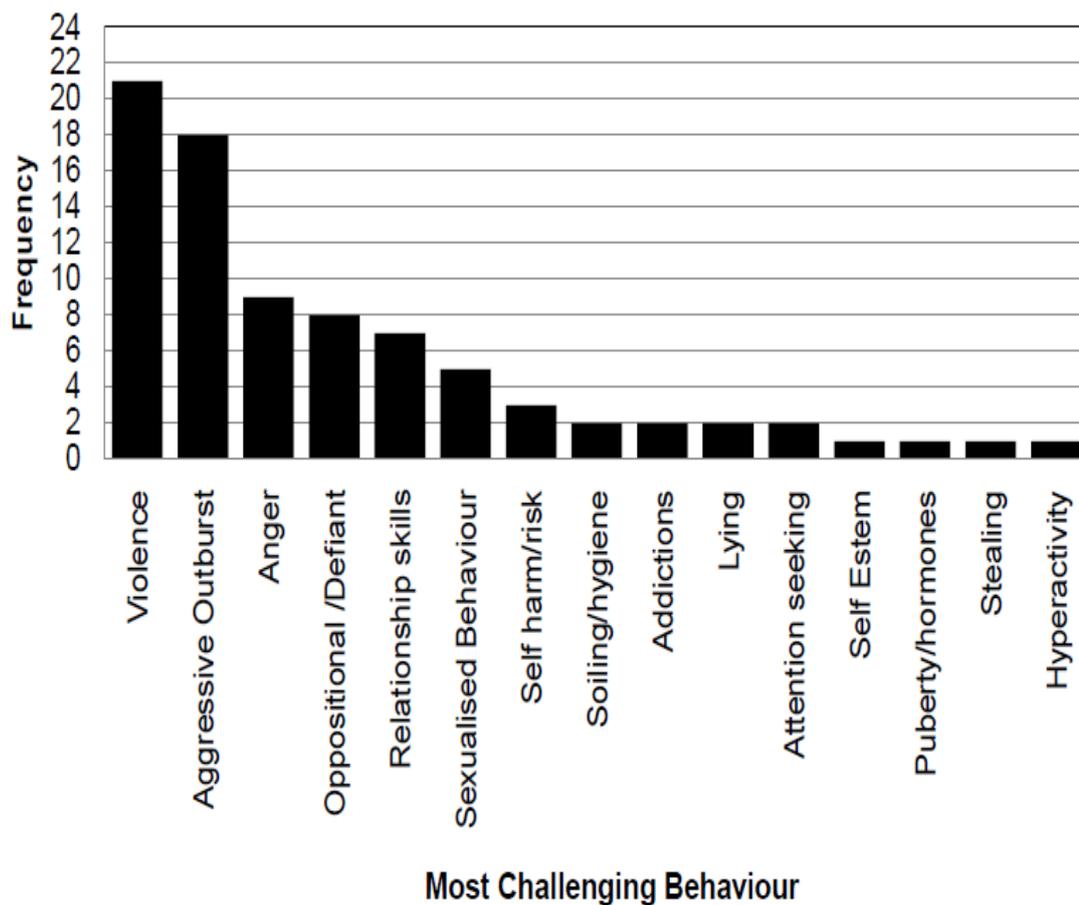


Figure 1 *Questionnaire responses (n=83) indicating main 'challenging behaviour' exhibited by children in out-of-home care.*

### 3.4.3 Completion of interviews

Families SA caseworkers, CAMHS workers and DECS staff were all interviewed at a time that suited them in their workplace. Residential care workers were interviewed at their unit in a private space apart from other staff. All interviews with residential care workers took place during school hours when most children were not present in order to avoid interruptions. Foster carers were offered the choice of being interviewed either at their home or at the University. The majority of carers chose to be interviewed in their home although one chose

to be interviewed at his workplace, two elected to be interviewed at the University and one chose to be interviewed at a 'neutral' location (a local park).

#### *3.4.4 Duration of interviews*

The average duration of the interview varied slightly according to the stakeholder groups involved; carer interviews generally took longer to complete. Consent was obtained to audiotape the interviews (Appendices E and F). The interviews were subsequently transcribed verbatim.

The interviews with CAMHS workers ranged in length from 35 to 66 minutes, with an average duration of 50.5 minutes. This resulted in 342 pages of double spaced typed transcript for this stakeholder group. The interviews from Department workers ranged in length between 32 and 78 minutes, with the average duration 50 minutes. This resulted in 582 pages of double spaced typed transcript for this stakeholder group. Interviews with residential care workers ranged in length between 27 and 66 minutes, with an average duration of 45.4 minutes. This resulted in 474 pages of double spaced typed transcript for this group. The interviews with DECS workers ranged in length between 28 to 63 minutes, with the average duration being 49.4 minutes. This resulted in 534 pages of double spaced typed transcript for this stakeholder group. Foster carer interviews ranged in length between 35 and 90 minutes, with an average duration of 63 minutes. This resulted in 1071 pages of double spaced typed transcript for this stakeholder group.

### **3.5 Data analysis and reporting**

The data were subject to thematic analysis according to the general steps outlined by Braun and Clarke (2006). Thematic analysis is “a method for identifying, analysing and reporting patterns (themes) in the data” (Braun & Clarke, 2006, p.79). In this case, after reading through the transcripts numerous times, the data were subject to an inductive (bottom up) analysis in relation to the two main research questions separately. Codes emerged from the data, rather than the data being fitted into pre-existing coding or theoretical frameworks. This approach was considered more appropriate due to the exploratory and atheoretical nature of the research knowledge in these areas. Due to the large volume of data collected, the data was analysed in sections, which broadly corresponded to participant responses. Participant responses were examined for direct references to meaningful elements that could help accurately capture re-occurring patterns in the data.

This approach and level of qualitative analysis could be considered broadly aligned to a critical ‘realist’ epistemology; in which it is assumed that enquiry can tap “true representations of the world” (Madill, Jordan & Shirley, 2000, p. 3). This approach may be considered fallible, especially in relation to knowledge in the social realm, (Bunge, 1993, p. 231) as the researcher brings to their research their own perception based on their experiences and expectations. Accordingly, the identified themes should be considered to reflect the researcher’s unique perspective; that of a child and adolescent Clinical Psychologist, whose experience involves work with emotional and behavioural disorders at one

community and two tertiary public mental health day programs prior to undertaking this research. In this regard the researcher must ultimately be considered both a 'researcher' and a former 'stakeholder'. This "taken for granted" knowledge of the systems (Scott, 2002a, p. 928), while potentially problematic, also afforded an opportunity to engage with stakeholders that potentially enhanced the richness of the information obtained. In this way, an attempt was made to write the researcher into the research, rather than trying to "sanitize it by writing them out of the text" (Scott, 2002a, p.929). Accordingly, this research can only claim to represent the reality of collaborative casework from the perspective of a Clinical Psychologist. In order to partially address these issues, extracts that represented themes that were extracted from the data were reviewed by two other Clinical Psychologists, both experienced in qualitative analysis and any difference in interpretation were resolved, generally in favour of the more experienced researchers. Data analysis and subsequent determination of themes took six months to complete.

Thus, the entire data set was coded two separate times in relation to the two main research questions:

- 1) What common barriers exist for stakeholders in attempting to work collaboratively with other stakeholders to address challenging behaviour? The results of this analysis are presented in Chapter 4.
  
- 2) What are the dominant ways in which stakeholders account for challenging behaviour amongst children in out-of-home care? The results of this analysis are presented in Chapter 5.

The complete data set was subject to inductive thematic analysis in order to explore these questions. As a result of the analysis completed and reported in Chapter 5, a decision was made to subject one of the emergent themes - 'behaviour as attachment' - to further analysis. The wide variations that were noted in the meaning attributed to the term 'attachment' lead to a subsequent inductive thematic analysis of the complete data set in order to explore and report the range of meanings given by stakeholders to this term. The results of this analysis are presented in Chapter 6.

Finally a subset of the data, consisting solely of the interviews of residential care workers, was analysed. An inductive analysis was conducted in order to identify the tensions and difficulties experienced by this stakeholder group in managing challenging behaviour. The results of this analysis are presented in Chapter 7.

### 3.5.1 Presentation of the data

Illustrative or representative extracts are provided throughout the text of the thesis to demonstrate the theme being discussed. To assist the reader, the interview number for each extract is provided. Appendix G provides the participant details that correspond to the interview extract being discussed in the text. These are the same participant details that were presented in Tables 1 to 5, but listed according to interview number. To further assist the reader, for each extract the initials (**R**) and (**I**) identify the respondent and interviewer, respectively. Where there are two respondents in an interview, (**R1**) and (**R2**) will be used to distinguish them. The following extract, from a foster carer couple, provides an example of this:

**R1:** I think [the Department] is to blame as well because they give into them too easy. We had one sent home from school; [the Department worker] took him up to McDonalds. To me that is not right.

**R2:** It would have been better if his worker had spoken to him about why he had been sent home, but he rewarded him by taking him to McDonalds.

**I:** So to you -you saw it as a reward for bad behaviour?

**R1:** Yes-if he had [just] spoken to him about it. **Interview 77**

This extract is taken from Interview 77. Appendix G indicates that this was an interview of a foster carer couple, in which there were two participants interviewed concurrently. It also provides other relevant details of the participants. **R1** reports the text from the first participant, **R2** reports the text from the second participant. Text from the researcher is indicated by **I**.

### *3.5.2 Example coding of the data*

The following extract from a Department worker provides a simple illustration of some of the codes applied in relation to the two broad research questions:

**R:** I think it would be great if we did integrated training, if we were all on the same page and if we actually went to training sessions where it wasn't just the social workers, because that would also be networking. If it was the CAMHS workers as well, teachers as well. We are all working for the same end.

**I:** What kind of things would that training cover?

**R:** Definitely understanding of disordered attachment and understanding the behaviours arising from that and how best to work with children who have disordered attachment. If we were all working consistently, wow! That is one thing that guardianship children really need is consistency. But what they are getting is lots and lots of [nongovernment

services] and government departments, and they all have their own way of working. **Interview 85**

In relation to the first broad question “*What barriers exist to collaborative practice?*”, this quote was coded for:

- Collaboration-Desire better communication- joint training
- Collaboration-Desire better communication- common goal
- Collaboration-different frameworks

In relation to the second broad question; “*How is behaviour understood?*”, this same quote was coded for:

- Behaviour- attachment
- Behaviour-need for consistency

The following chapter reports the results of the analysis of participants’ experiences in working collaboratively to support children in out-of-home care that are exhibiting challenging behaviour.



## **PART C**

### **Chapter Four:**

### **Barriers to collaboration amongst South**

### **Australian stakeholders**



## CHAPTER FOUR

### **Barriers to collaboration amongst South Australian stakeholders**

#### ***4.1 Overview***

Chapter 2 provided a general overview of the theoretical and empirical status of research into interagency collaboration, with particular reference to those supporting children with challenging behaviours. It also highlighted the importance of examining how stakeholders understand and approach behaviour problems. It highlighted the lack of research in relation to the above issues in the out-of-home care sector. This chapter will briefly revisit and expand on this literature. It will then report the results of a thematic analysis in which the experiences of South Australian stakeholders supporting children in out-of-home care exhibiting challenging behaviour were examined.

#### ***4.2 Collaboration between stakeholders***

Multiagency collaboration is purported to be the most efficient way to ensure the delivery of effective high quality services (Miller & Ahmad, 2000; Salmon & Rapport, 2005), particularly to multi-problem, difficult populations (Okamoto 2001; Quinn & Cumblad, 1994). Children in out-of home-care, young offenders, children with mental health issues and those repeatedly excluded from educational environments are amongst those who are thought to benefit from this approach

(Bullock, Little & Milham, 1998; Okamoto, 2001; Place, Wilson, Martin & Hulsmeier, 2000; Salmon, 2004; Salmon & Rapport, 2005). These children may otherwise be at risk of falling “through the gaps” (Van Eyk & Baum, 2002, p.262). While effective child protection may not be possible without interagency collaboration (Cottrell, Lucey, Porter & Walker, 2000; Morrison, 1996; Scott, 2002b), establishing collaborative practice between agencies is likely to be challenging, complex and require a long term commitment (Van Eyk & Baum, 2002).

### ***4.3 Recommendations for collaborative practice***

Policy imperatives and directives both in Australia and internationally reflect a growing emphasis on the need for interagency collaboration (Absler, 2006; Leslie, et al., 2005; O’Flynn, 2008; Salmon & Rapport, 2005). Van Eyk and Baum (2002), provide an overview of the Australian policy context of the past 30 years which has repeatedly emphasised integration and coordination of health service delivery. In the UK, cooperation between agencies is now legislated (Richardson & Asthana, 2006). Similarly, service coordination is included as an essential process for meeting legal mandates in the U.S.A. (Okamoto, 2001).

Concordant with such policies and legislation has been a rise in the rhetoric of joined up collaborative practice (Absler, 2006) as the ‘future’ of service delivery in mental health care (Okamoto 2001; O’Flynn, 2008). This has led some to note the risk that the evidence and research base for collaborative practice may lag behind the pressure to implement interagency practice (Absler, 2006; Leslie et

al., 2005; Walker, 2005). O'Flynn (2008) provides a critical analysis of the "positive rhetoric" (p.183) regarding public sector collaboration in Australia. She highlights, for example, the call in recent Australian government publications for a culture of collaboration in public sector policy and contrasts this with the absence of a definition for 'collaboration' within such documents.

Indeed, the notion of multi-agency or inter-agency collaboration is conceptually and theoretically underdeveloped. Some have noted the ideological, rather than theoretical or empirical basis of much interagency practice (Absler, 2006). Conceptually, there appears to be some considerable variation in the meaning of the term 'interagency collaboration' (e.g., D'Amour, Ferrada-Videla, Rodriguez & Beaulieu, 2005; Hallet & Birchall, 1992). Collaboration may be viewed in terms of organisational theories or in terms of social psychological theories such as social identity theory (D'Amour et al., 2005). Collaboration has been variously described as a structural phenomenon, a process, an attitude or a relationship (Horwath & Morrison, 2007; Walker & Petr, 2000). Additionally, the literature varies in its relative emphasis on interdisciplinary or interagency collaboration (Scott, 1997; Scott, 2002b); organisational or individual factors, management or worker issues, or it may describe a "range of working together arrangements" (Horwath & Morrison, 2007, p.56). Many attempts have been made to formulate theoretical descriptions of collaboration, but a "common language" to describe collaboration remains to be developed (Horwath & Morrison, 2007, p.57). The present research does not intend to address these issues; rather it seeks to describe the reality of collaborative work by describing

attempts by South Australian stakeholders to work cooperatively to support children in out-of-home care.

#### ***4.4 Interagency collaboration in South Australia***

A South Australian review into child protection policies and practices, The Layton Review (2003), reported that the implementation of interagency coordination “has not fared well” in this state (section 7.2). The review describes interagency cooperation in South Australia as “...heavily reliant on workers within services and the services themselves networking effectively without any overarching system of guidance, direction, support, review or continuous quality improvement in place” (section 7.2). It recommended the formation of an overseeing body to address issues identified by the review, such as the need for better collaboration to enhance service provision, to address the needs and interests of the child, to provide service in a timely manner, and to address barriers to communication between existing agencies. In the time since that review was published, these recommendations have not been implemented.

#### ***4.5 Limitations to the literature about collaborative practice***

Much that is written about interagency collaboration reflects adult multiagency projects, usually within adult health services. While many of the issues related to collaborative practice are likely to be similar irrespective of the whether adult or child focused agencies are involved, there are nonetheless likely to be issues unique to collaborative practice in the case of children’s services. At

present, relatively little empirical data exist about collaboration amongst workers and stakeholders in the children's services sectors or about the obstacles to collaboration in children's services.

Many of the putative benefits of effective interagency or intersectorial collaboration are likely to be especially salient when considering the needs of children in out-of-home care. Amongst the potential benefits of collaborative service delivery are its relevance to clients whose health needs impact or interact with their social needs or vice versa (Bullock & Little, 1999; Salmon & Rapport, 2005) and those who require multiple services (Van Eyk & Baum, 2002). The ability to pool resources, knowledge and expertise to reach families with complex needs (Costongs & Springett, 1997; Darlington, Feeney & Rixon, 2005a,b; Mattessich & Monsey, 1992), less duplication of services (Van Eyk & Baum, 2002) and more efficient use of resources, and sharing of the responsibility for care are also suggested to result from good interagency collaboration (Van Eyk & Baum, 2002). It may be argued that this is particularly true in the case of children with complex needs, high risk or challenging behaviour, or those in settings such as residential care (Fletcher-Campbell, 1998; Francis, 2000).

While collaboration amongst service providers may be beneficial to children in out-of-home care, the potential challenges to interagency collaborative practice may be numerous (Hallet & Birchall, 1992; Quinn & Cumblad, 1994). Amongst the barriers previously suggested to occur in children's services include conflicting agency perspectives and understandings of child abuse, competing service mandates, lack of supportive structures and competition for funding and

resources (Byrne et al., 2000; Darlington, Feeney & Rixon, 2004; Darlington et al., 2005a,b; Hallet & Birchall, 1992; Hetherington et al., 2002; L.J. Johnson et al., 2003; P. Johnson et al., 2003; Quinn & Cumblad, 1994). Despite these potential difficulties, collaborative efforts probably do occur at many levels of children's services, with most taking the form of informal linkages or networks (Van Eyk & Baum, 2002) rather than occurring at a level supported by formal structures and processes.

Irrespective of whether adult focused or child focused services are involved in collaborative partnerships, successful collaboration is suggested to involve common factors. Effective communication and information flow between agencies is particularly important (Akhavain et al., 1999; Barker et al., 2005; Henneman et al., 1995; Marino & Kahnoski, 1998; Salmon & Rapport, 2005). To facilitate communication, participants benefit from the ability to share a common language (Darlington et. al., 2005b; Miller & Ahmad, 2000; Ranade & Hudson, 2003; Salmon & Rapport, 2005), and from clarity and consensus regarding terminology (Barker et al., 2005; Salmon & Rapport, 2005). The importance of a common language or lexicon has also been highlighted in other emerging fields. For example, inconsistent definitions and diverse terminology has been reported to hamper research on the implementation of evidence based practice in mental health (Proctor et al., 2008).

While difficulties in communication and lack of a shared language or understanding may be strongly implicated in effective collaboration, it may be argued that the potential for these difficulties to occur can be heightened under

certain conditions. There is some suggestion, for example, that difference in frameworks for intervention and understanding may be particularly highlighted where there is a lack of clear conceptual clarity about how best to intervene in clinical issues (Ladwa-Thomas & Sanders, 1999; Taylor & Daniel, 1999). For example, in a study on professionals' experiences of working with juvenile sexual offenders, the researchers noted that practitioners operated from a wide variety of theories on the cause of the behaviour. The authors speculated that this reflected the lack of a sound theoretical basis for practitioners in this area (Ladwa-Thomas & Sanders, 1999). Agencies have been noted to have disparate views on how to address issues of neglect such as non-organic failure to thrive (Taylor & Daniel, 1999). Complexity in the causation and multiple approaches to intervention may increase the likelihood of issues related to child protection falling through the gaps between professional groups and agencies (Taylor & Daniel, 1999). It may be argued that similar conditions exist when considering intervention for challenging behaviour amongst children in out-of-home care.

Scott (2005) has provided a conceptual framework for assessing the types of conflict and barriers inherent in interagency collaboration between human service agencies and sectors. She identifies five potential sources of organisational, professional and personal conflict and offers possible ways to effectively manage these tensions. She makes the important point that effective collaboration occurs, in the main, not because of an absence of conflicting views, frameworks or perspectives, but rather it occurs when sources of conflict are acknowledged and managed. She impresses the need to articulate and normalise the nature of these conflicts, not with the aim of eliminating them altogether, but with the hope that

they are made more overt. The next section will outline the relatively few recent empirical studies that focus on these barriers and facilitators to collaboration in the case of children's services.

#### ***4.6 Barriers to collaborative practice in children's services***

In a survey study, Darlington, Feeney & Rixon (2005a) explored barriers to collaboration between child protection and adult mental health workers in cases where there were parents with mental health issues which resulted in a child protection concern. Their survey of 232 practitioners found that 67% of practitioners felt that they did not have access to adequate information or guidelines for managing these types of cases. Factor analysis revealed five sources of difficulties in interagency work: 1) gaps in interagency processes (e.g., lack of information on services available, lack of knowledge about the role of workers in the other agency, and lack of culture of liaison), 2) inadequate resources (lack of time, high workloads, and lack of appropriate community resources), 3) professional knowledge domains and boundaries (differing theoretical bases, feelings of ownership of clients, conflicting aims and expectations), 4) unrealistic expectations (of workers in other agencies) and 5) confidentiality (different practices regarding confidentiality). Of these factors, respondents endorsed inadequate resources and confidentiality as most strongly affecting collaborative practice.

Darlington, Feeney and Rixon (2005b) subsequently conducted interviews with child protection workers, child mental health workers and adult mental health

workers to explore barriers to collaborative practice where a parent had a mental health issue and where there were child protection concerns for the child. They conducted interviews with 17 child protection workers and 15 adult mental health workers who indicated their interest in being interviewed as a result of participating in the earlier survey research. In relation to the collaborative process, four factors were found in thematic analysis: 1) communication, (regular, clear & timely communication maintained throughout the case), 2) knowledge (having knowledge of the framework, role, processes and criteria adopted by the other agency through education or previous employment), 3) role clarity (separate and agreed upon roles, separating the roles of the workers for clients) and 4) resources (crisis driven nature of service delivery, using 'dependency' as a rationale for not delivering services, withdrawing services even if the client did not want this to happen).

In the final paper in this series of studies, Darlington and Feeney (2008) conducted further thematic analysis of the survey responses of child protection workers and adult mental health professionals (N=232) to identify workers' suggestions for improving collaborative practice between these two sectors. Their analysis yielded three broad domains: 1) enhanced communication, 2) knowledge development and 3) the provision of adequate resources and adequate service models. Although they were not reporting on barriers *per se*, their findings are included in this section because they have clear relevance to collaboration in children's services.

Salmon and Rapport (2005) conducted a thematic analysis of child and adolescent mental health services (CAMHS) interagency case conferences. Their stated purpose was to identify the types of discourse that take place when workers from one agency (CAMHS) met with workers from other agencies to discuss cases. Data were collected over eight meetings between CAMHS and other agencies such as welfare and education services. Their analysis revealed nine discursive themes: single agency discourse, discourse about intervention, case complexity discourse, multi-agency discourse, discourse about the individual, social context discourse, interagency communication discourse and discourse about alternative viewpoints. According to the authors, two of these categories of discourse could be thought of as reflecting work-related stress. For example, when engaging in what would be considered discourse about the individual or discourse about the social context, workers tended to talk about their individual roles, needs for supervision and guidance, or about power issues in relation to management. The discourse of alternative viewpoints centred around differing views on appropriate intervention and responsibility for intervention. The discourse about communication centred around the need to pass on information and examples of where communication had broken down. The authors highlighted a lack of clarity about terminology in discourse. They concluded that agencies have different understandings of the terminology used in case conferences and that a consensus regarding terminology is not reached during these meetings. In their words:

There is a need for greater awareness amongst staff from different professional groups and agencies that meaning given by one group will

often need to be clarified by others and assumptions about common understandings should not be made (p. 440).

Worrall-Davies, Kiernan, Anderton and Cottrell (2004) explored the views and experiences of mental health workers, social workers and education staff about working with 91 young people identified by management as receiving service from more than one agency and having complex and challenging needs. Analysis of the 79 interviews yielded six main themes: 1) need for joined up working practices (identifying priorities, joining up from the assessment onward, and valuing others, 2) barriers to working together (identifying responsibility for multiagency practice and the need to follow procedures), 3) accessing resources (protecting budgets, lack of information and resources), 4) timely interventions, 5) communication (sharing between agencies, support of management and client practitioner relationships) and 6) placements (turnover, placement matching, and need for specialist placement resources).

Okamoto (2001) conducted semi-structured interviews of eight case managers working with high risk gang youth (young offenders either in detention or on parole) to identify factors involved in case-level collaboration between private and state agencies serving this population of children. They included practitioners from preventative services and residential treatment and detention services. Thematic analysis yielded five different patterns of negative interactions between agencies: 1) 'passing the buck' (e.g., refusal to take responsibility for difficult multi-problem youth), 2) blaming of other agencies for failure (e.g., accusing other agency of inappropriate practice leading to the child 'acting up'), 3)

withholding of information between agencies (e.g., in order to make referrals more appealing to other agencies), 4) covering up of mistakes (e.g., mistakes or omissions of assessment or treatment left out of transfer summaries), and 5) premature termination of collaborative arrangements (e.g., due to physical violence or disruption to the therapeutic milieu in residential settings). The author interpreted these “negative collaborative behaviours” (p. 12) as arising out of “agency fear” (p. 13). Agency fear was broadly defined by the authors as the fear that agency management have of committing resources for little perceived outcome and of exposing their staff to the demands and threatening behaviours of these high needs youth.

Taken together, these empirical explorations of interagency practice involving children with protection concerns or challenging and complex needs suggest that issues of communication, confidentiality issues, perceived gaps in knowledge domains and information and resource issues are likely to feature as sources of interagency tension. Issues of communication in particular have been highlighted as a potential barrier in interagency collaboration both amongst child services and adult services workers and between child services workers of different agencies (Salmon & Rapport, 2005; Worrall–Davies et al., 2004).

#### ***4.7 Limitations to the literature about barriers to collaboration***

Although the studies outlined above are relevant to the issues of child focused interagency or intersectorial collaboration in the case of complex cases, and in the case of high risk youth, none of these studies had a specific focus on challenging

behaviour amongst children in out-of-home care. Therefore, there does not appear to have been any empirical exploration of the experience of intersectorial collaboration in the case of supporting children with mental health problems or challenging behaviours who are living in an out-of-home care situation. This is despite indications of the suitability, and moreover, the pragmatic necessity of this approach, due to the salience of the multiple systems and services that surround in out-of-home care.

While the behavioural and emotional issues of children often stimulate interagency discussion and collaborative attempts (e.g., Salmon & Rapport, 2005), in reality, little is known about collaborative practice amongst those stakeholder groups attempting to address behavioural concerns. Williams and Salmon (2002) have argued that the tensions involved in interagency collaboration may be particularly highlighted in the case of children with challenging behaviour problems due to the variety of clinical issues driving behaviour and its variety of manifestations, which further complicates issues of problem definition and intervention focus. Information about successful collaborative interventions is often buried in 'grey literature', which is not widely circulated or formalised (Easen, Atkins & Dyson, 2000). It is perhaps these issues, among others, that have led some to conclude that "one of the most persistent and powerful messages is of recurrent failures and shortcomings in interagency co-ordination" (Hallett, 1995, p. 13).

Additionally, the exploration that has occurred to date has been limited by its failure to incorporate the perspective of key stakeholders from all sectors. The

literature outlined previously that does exist on intersectorial or interagency collaboration does not include participants such as education staff, foster carers or residential care workers. While the available literature on interagency collaboration is valuable, it does not fully capture the complexity of the collaborative endeavours that need to occur amongst stakeholders supporting young people in out-of-home care. Children in out-of-home care, by definition, are intimately involved with either foster care or residential care workers. For this reason, it seems essential to widen the scope of investigation to incorporate the views of people in these sectors when considering how stakeholders attempt to support young people with challenging behaviours in out-of-home care. The research reported here appears to be unique in that it has sought to include the experiences and the perspectives of the primary caregivers in the out-of-home care sectors; namely residential care workers and foster carers.

#### ***4.8 Analysis and themes***

Accordingly, the analysis presented in this chapter identifies the barriers that exist in practice, with a view to identifying what needs to be addressed in order to sustain collaborative practice in the case of children in out-of-home care with behaviour concerns. A thematic analysis was conducted as outlined in Chapter 3 and yielded six themes, reflecting commonalities in stakeholders' experiences in attempting to address the behaviour problems of children in out-of-home care. The following themes were identified:

- 1) Differences in frameworks

- 2) Triangulation in relationships
- 3) Information exchange
- 4) Power and control
- 5) Resources
- 6) Communication and understanding

#### *4.8.1 Differences in frameworks:*

The first theme related to differences in the frameworks through which participants understood and addressed challenging behaviour. The theme was comprised of two inter-related subthemes: i) negative view of other stakeholders' approaches and ii) the superiority of one's own understanding. These themes are discussed below.

##### *Negative view of others' approaches:*

Respondents frequently experienced their understanding of behaviour as different from, and incongruent with, the understanding and approach of other stakeholder groups. Where differences occurred, the approaches of 'other' stakeholder groups were perceived negatively and as unhelpful to young people. This is demonstrated in the description of one CAMHS worker of the way in which children in alternative care are managed by teachers:

**R:** I think they [DECS] have softened over the years; they have a bit more flare a bit more imagination around these particular cases. But at the

end of the day they run a very punitive behaviour management system.

### **Interview 58**

Further, these differences in frameworks and approaches were experienced as frustrating attempts to help young people, despite the good intentions of all stakeholders, as the following extract from a residential care worker describes:

**R:** I think it is a hard thing to do to try and make everyone understand. I think it is an ongoing culture within [the sector] and it is hard to try and stamp it out. People are different, different organisations run differently. Until everyone runs on the same ground then it will work. But at the moment, teachers have their own things to do, ways to deal with it; we have ways to deal with it and certain things to do. It is not all on the same level. Everyone is heading to the same place, but they are all taking different roads to get there. **Interview 61**

Respondents were particularly likely to express a negative view of the opinion and approaches of other participant groups when they perceived that those participants had limited experience of, or contact with, the young people in question, or had only a transient role in the young person's life. The following extract from a foster carer illustrates this viewpoint:

**R:** Social workers come and go and they all have different ideas. You have your [foster care support agency] worker telling you how to raise the

child, you have the social worker telling you this and that, but you are living with the child all the time. **Interview 33**

This perception of ‘difference’ related to other stakeholders frameworks in a range of ways: viewing other’s approaches to managing behaviour as being ineffective, as unaligned with the needs of the children, or viewing other stakeholders’ conceptualisation of the aetiology of behaviour problems as incorrect or inappropriate. Respondents frequently perceived others as having relatively fixed or inflexible views about how behaviour should be approached. In the worse cases, there was even disagreement between stakeholders as to whether or not a behaviour problem existed, or about the nature of the intervention required. The following extract from a foster carer illustrates this difference in viewpoints about what constitutes normal behaviour:

**R:** I have had 6 kids, and 3 from a blended family, so that is 9 kids - and I have never had one with sexualised behaviour! I had 7 brothers and sisters so I knew that sort of behaviour was not normal for a 4 year old child, but the social worker didn’t seem to think there was anything wrong with that sort of behaviour! **Interview 19**

Some stakeholders reported a tendency of other groups to minimise, overlook or fail to seek their opinion about behavioural problems, as the following extract from a foster carer illustrates:

**R:** I guess mental health and CAMHS I didn't have a lot to do with them, but had friends who did, we sometimes found that they didn't seem to take on any aspect of the fostering. They really didn't have an understanding of the issues of the child - there is what happened to them before hand - the fact that they have to relate to this family and another family, they have to fit into the family - they have workers involved in their life. We just often felt that the results they came up with were not correct because they didn't take into account all the other things of the foster child - the development delay etc. There were so many aspects that they didn't seem to take into account. Also quite often they didn't even interview the foster carer. They are the ones that know that child and nobody bothered to talk to them. They didn't pay attention to that sort of aspect at all. **Interview 14**

The perception of others views as different or unhelpful may, arguably, lead stakeholders to minimise the perspective of key participants in the child's life and therefore reduce the opportunity for collaborative problem solving.

*Perceived superiority of own view:*

The second subtheme related to respondents' belief that their understanding of the problem emotional or behavioural issue in question was somehow superior to the viewpoint or understanding of others. The implicit assumption following on from this was often that other stakeholders should develop a viewpoint or understanding more aligned with theirs. Respondents expressing this view

emphasised the need for their expertise about behaviour to be sought, as the following extract from a CAMHS worker illustrates:

**R:** I think there's a clash of theories sometimes and I suppose this kind of – I don't want to make it sound as though we've got it right and other people have got it wrong - but I think that it would be really important to acknowledge that there might be a need for places like residential units or [Department] social workers to understand things like that [the] Positive Behaviour Support [approach] is better for the population that we're working with. **Interview 1**

Claims such as these relating to 'clashes of theories' extended to issues of case planning, placement decisions, decisions about appropriateness of access to counselling and needs for additional supports. The implicit notion that the understandings of 'other' stakeholders were less developed or inferior can be seen in the following extract from a classroom teacher when describing the perspective of a foster carer:

**R:** The foster carer's perception can be quite - some foster carers do what they do with a passion, and they believe they have a bit of a mission around these kids. So they sometimes exaggerate or overplay the child's needs. **Interview 39**

This downplaying of the views and understandings of others was not limited to the descriptions of foster carers' understandings; however, stakeholders were

likely to express these views most explicitly when discussing foster carers, as the following extract from a CAMHS worker demonstrates:

**R:** These [foster carers] are good people, most of them are well meaning, but some of them are terribly difficult to work with. Because they do lack a bit of insight into who they are and why they behave [in response] to things. We pick up on our own parenting practice from their own parents how they were parented. We need to make a quantum shift to do something totally different because of the special needs of these kids, their abused backgrounds etc and how that plays out in terms of behaviour management.

#### **Interview 76**

Accounts of others' different understandings in terms of inferiority, or inaccuracy, can have implications for collaboration. Such accounts raise the probability that stakeholders work at cross purposes in attempting to understand and address the child's problem behaviour. Given the perception that others do not construct behaviour in the same way, stakeholders may be dissuaded from persevering in the implementation of behaviour management plans that are not perceived to be aligned with their views. This highlights the need to understand, or at least better articulate, which way the behaviour in question is actually being viewed by participants. Stakeholders may, arguably, be more likely to place clinical focus or invest resources in case planning, according to the perceived alignment of their accounts with others' accounts of the origin and solution for behaviour issues.

The perceived superiority of one's own understanding is potentially problematic. The importance of tolerance of different frameworks has previously been noted (Davies, 2000; Van Eyk & Baum, 2002). As Van Eyk and Baum (2002) point out, "The differences between stakeholder as well as their commonalities can strengthen collaborative work because of the range of personal and professional experiences, knowledge and expertise that can then be brought to the partnership" (p. 263). Indeed, good collaborative practice means "acknowledging that all participants bring *equally valid* knowledge and expertise from their professional and personal experience (Davies, 2000, p. 1021; italics added)

Interdisciplinary issues may also come into play here in addition to agency or stakeholder group membership. While there has been some exploration of the notion of perception or attitudes held by one professional group towards another in the context of interprofessional education (Hind et al., 2003; Lindquist et al., 2005; Mackay, 2004; Tunstall-Pedoe, Rink & Hilton; 2003), relatively less is known about attitudes towards interprofessional collaboration, particularly in a clinical context (see Ødegård, 2005). However, interprofessional differences do not occur in isolation from task and organisational constraints (Easen et al., 2000). The overlap of discipline membership with organisational culture or stakeholder group membership issues presents a confound that has previously been noted (Easen et. al., 2000). Amongst participants in the current study, organisational or stakeholder group membership is assumed to be the driving issue because the respondents from most organisational groups comprised a range of disciplines (i.e., psychologists, social workers, teachers, social work trainees and youth

workers). Furthermore, discussions of differences amongst stakeholders related to organisation or group membership, rather than being discipline specific commentary. Therefore, this theme appears to reflect stakeholder or workplace cultural 'received views' about problem behaviour in children placed in out-of-home care and about the appropriateness of 'other' stakeholders' understandings of behaviour.

#### *4.8.2 'Triangulation' of relationships:*

In this theme, the term 'triangulation' attempts to capture difficulties related to the involvement of external or third parties in the family and relational life of children in out-of-home care and, more specifically, how this externalising of the normal caregiver-child relationship interferes with supporting the child with challenging behaviour to learn more adaptive or prosocial behaviours.

Triangulation is seen in the cross-generational coalitions that can develop within families, a concept that many family therapists (see Bowen 1978; Kerr & Bowen 1988), have associated with the entrenchment of maladjustment in children. Such dysfunctional triangulation of relationships has been suggested to be involved in child maladjustment, including the development of conduct disorder, drug abuse and self harm in children (Stormshak, Speltz, Deklyen & Greenberg, 1997).

Importantly, in non-foster families, these coalitions are thought most likely to occur when there is a disruption in the level of intimacy and autonomy desired in

family dyadic relationships. In this situation, a third person may be drawn in either directly, or indirectly, in order to return the dyadic relationship to some sort of equilibrium or preferred 'distance'. Critically, these kinds of coalitions are thought to undermine a parent's ability to control behaviour because the child is constantly able to challenge consequences and avoid the resolution of conflict.

The term 'triangulation' has been used here to refer to this theme because in many aspects the examples and issues highlighted by respondents parallel the coalitions thought to occur in dysfunctional (non-foster) families, although here the term is not being used strictly as it was originally described. Nevertheless, it is a term that captures two important elements of this theme as it relates to addressing behaviour change in young people in out-of-home care in these interviews. It subsumes two subthemes: 1) interference with discipline, and 2) interference with family structure. The first subtheme reflects the impact of the involvement or 'drawing in' of stakeholder third parties into the caregiver-child relationship, particularly in times of conflict. This subtheme reflects how stakeholder dynamics interfere with how caregiver-child dyads are engaged in discipline related matters; by interfering with perceived parental authority or by eliminating the opportunity for the child to benefit from contingent learning. The second theme relates to the impact of stakeholder dynamics and relationships on the child's sense of belonging and family structure. Accordingly, this theme parallels the triangulation and formation of coalitions in family structure as it is applied in family therapy paradigm and as it is implicated in the maintenance of conduct disorder and other childhood problems.

*Interference with discipline:*

All stakeholders gave examples of (primarily) the Department intervening in the case of behaviour management, discipline and social learning opportunities. There were numerous examples given where ultimate power over decisions about the children by the Department workers was perceived to interfere with opportunities for children to grow and learn from discipline and logical consequences, to learn socially appropriate limits, problem solving and even living skills such as budgeting or cooking and self care. In the school environment, for example, it frequently meant that opportunities for learning and disciplinary issues (such as 'send homes' from school) could not be enforced or worked through quickly. In this extract, a school principal explains the impact of these systemic constraints on disciplinary practice:

**R:** Our procedure is the same for all kids, you leave school grounds—if you're in high school, you know, year eight upwards, you ring the carer to say they've left school grounds, they've been sent home—alright. But with the kids in care, I mean, they [Department workers] want us to keep them here, and if they're sitting outside waiting for a carer, that's always when it falls over [behaviour deteriorates]

**I:** Because they know they've blown it, and then they've...?

**R:** But they can't walk out—so, if they walk out, that causes another kerfuffle. Now, they're not big issues in the scheme of these kid's worlds,

but from an education point of view, they're the issues that usually push it over for us, and then, instead of getting on with it quickly, the next day, whatever happened in that moment escalates to something bigger

[increasingly challenging behaviour]. **Interview 34**

Systemic constraints such as these served to make discipline more difficult by removing the immediacy of consequences and by ensuring that children were treated in a manner differently from other children. In terms of providing therapeutic services, the triangulation of the child's relationships meant the potential involvement of the child with multiple stakeholders, making effective behavioural intervention increasingly difficult. This child mental health worker from a therapeutic day program provides an example of this:

**R:** I work in the family work team here so we arrange to support young people outside [the program] by meeting with their parents or carers on a fairly regular basis but when it comes to young people in out-of-home care then you're having to do that in a very disjointed and complicated way and deal with different individuals at different times – and how that filters back to the young person because it can become confusing - distorted.

### **Interview 2**

Many of the participants interviewed for this study reported that the triangulation of children's relationships appeared to increase as children got older which, in turn, increasingly meant that stakeholders who are involved with older children (such as residential care workers) were frustrated in their attempts to

discipline children. This appeared to result in a further reduction in the potential for the child to benefit from the imposition of consequences directly related to their behaviour. The following extract from a residential care worker captures the frustration caused by the effective removal of the workers ability to impose consequences or limits on the child's behaviour:

**R:** The courts need to tell these kids that what they are doing is totally inappropriate and you will be locked up. These kids get away with assaulting people, property damage after property damage and nothing ever happens to these kids. One kid here in particular - massive list of serious offences, goes to court-nothing happens. **Interview 52**

The involvement of more and more systems and services in the child's life was seen to further compound or entrench behavioural issues. Frequently, the tension produced by such triangulation was picked up on by the child and the child came to understand that he or she could invoke the Department when issues of conflict arose with the foster carer, teachers, or residential care workers. This was particularly the case amongst teenagers where children could seek the Department to override caregiver disciplinary decisions. These two extracts from foster carers provide an example of the type of interference in daily discipline that made it difficult to impose consequences or work through conflict within families:

**R:** [With one particular Families SA office], whatever [child's name] wanted, she got. I would say you are not going swimming this week and

[the Department] would say she can go swimming. They would let her go.

All the time they undermined the foster carers. **Interview 14**

Another foster carer described the problem caused by invocation of the Department as follows:

**R:** Now if you make the decision at home what you think is a good punishment, you should be supported by the workers, not [the child] thinking I can do what I like, the social worker will help me out and that is one big thing. **Interview 11**

The fragmentation and triangulation in a child's relationships with foster carers, teachers and residential carers impacted strongly on the ability of these stakeholders to manage behaviour by use of behavioural principles such as contingent reinforcement and logical consequences. Such triangulation in the caregiver-child dyad could also be argued to interfere with the resolution of unhelpful patterns of attachment-based behaviour by disrupting the normal cycle of caregiver-child conflict resolution (e.g., 'rupture and repair', see Cooper, Hoffman, Powell & Marvin, 2001). This kind of working through and reconciliation by the child of the caregiver's needs with the child's needs is thought to have profound implications for the reworking of 'internal working models' of attachment relationships and result in 'healthier', less rigid relational interactions.

*Interference with family structure:*

The broad theme of the triangulation in the child's immediate relationships also included extracts that described the fragmentation of the family structure in particular and the impact on behaviour management that followed from that. The fragmentation and outsourcing of foster carer support was identified as particularly problematic. Many stakeholders argued that it had made it more difficult to support children. For example, in South Australia, foster carers are expected to be supported by their agency worker and the practical and support needs of the child are expected to be met by the Department worker. This has resulted in a division of the essential components of the caregiving tasks (i.e., the separation of the practical, financial and legal aspects from the discipline, care and emotional nurturing aspect), resulting in further triangulation and distortion of normal (foster) family structure. This caused confusion and stress for carers because the practical and emotional aspects of parenting cannot easily be separated in the everyday care of the child. In reality, this division of foster carer and foster child supports has meant an increase in the workload of Department social workers and at the same time less actual contact with and understanding of the children under their guardianship. There were examples from all stakeholder systems where 'belonging' to the Department was experienced as interfering with belonging to family or being treated as a non-foster child would be, as this foster carer describes:

**R:** Every night we sat at the table and had dinner. We always talked about the day's events, what they did at school. When they brought their

reports home we always made it a special event and went to Hungry Jack's for dinner. [Child's name] wasn't allowed to bring her report home to me, she had to take it to the [Department] office and they would send it to me in the post a few weeks later. It spoilt the whole specialness, family time.

### **Interview 11**

Stakeholders such as residential care workers and foster carers expressed the desire to have more autonomy over discipline and everyday issues such as excursions or sleepovers, as this foster carer suggests:

**R:** I am not sure that it would ever be likely to happen, but I think [that] a lot more ability to make decisions on the child's behalf without having to go through the Department would probably work well. I make the decisions on behalf of my child probably rightly or wrongly, but I never allow her to do anything that I wouldn't allow my own children to do. If that was instilled from the beginning, you might end up with a better relationship between worker and carer, to allow them to make responsible decisions on behalf of the child. **Interview 12**

Taken as a whole, the implication of this theme for supporting children with challenging behaviours is a drastically reduced opportunity for the application of a contingent learning paradigm, where behaviours are followed by either positive or negative consequences. Involvement of third party stakeholders also reduced the opportunity for working through conflict, and therefore the potential for enhancing, attachment relationships. This interference with 'natural' discipline

was experienced across all stakeholder groups. Finally, this triangulation in the child's relationships, experienced primarily by foster carers, resulted in disrupted family structural boundaries; a factor which has previously been noted by family therapists as important in the maintenance of conduct disorder and other child maladjustment.

#### *4.8.3 Information exchange:*

Extracts in this theme broadly centred around two interrelated aspects of collaboration attempts: 1) insufficient exchange of information and 2) confidentiality and its impact on communication. Numerous examples were given by stakeholders in which important information about a child's behaviour was not sought, was not volunteered, was not communicated, or in the worst instances, was actively withheld. Confidentiality was often given as a reason for withholding or not exchanging information. Examples were given by participants where this had contributed to serious consequences for children, in the form of educational or placement disruption.

#### *Insufficient information exchange:*

According to respondents, there is a lack of clarity about what formalised pathways exist for the handover of information about behaviour. Many participants felt that such pathways were entirely absent. Where formal pathways were perceived to exist, they did not appear to be used appropriately, reliably, or promptly, as the following residential care worker describes:

**R:** We don't have access to files - well we do. But we can get a referral beforehand and have a 4 week notice and we say - yes - we are willing to accept this child on this date, please send us the current case notes, psychology reports etc. The stuff that turns up is so out of date. A child that is between eight and twelve [years old], they develop that quickly, so the file is really, really, old. I imagine information is a lot more readily available to myself than to a foster carer. But it always comes too late and you tend to make a lot of mistakes-

**I:** Learning?

**R:** Yes - you approach the behaviour in a certain way and you don't realise that that is a massive trigger - the kid will go and try and claw your eyes out! Then the report will turn up two weeks later, that you requested three weeks ago, and it says don't do this because this will happen and I am thinking that would have been handy to know! That happens here all the time. I pity foster carers I tell you! **Interview 32**

This lack of appropriate information exchange was perceived by some stakeholders to involve the active withholding of information, leading sometimes to further risk of harm to both the child and others. Other times, the withholding of information appeared to serve a 'gatekeeping' function (Scott, 1997), designed to minimise the chance of services and stakeholders refusing children with challenging behaviours, as this extract from a residential care worker illustrates:

**R:** I would imagine that quite a few foster carers are actually deceived by not being told certain issues about the child. They want to place them, so they take them. I have no doubt about that. They are a bit deceitful about placements at times. **Interview 29**

Conversely, some stakeholders did not actively seek potentially relevant information about the history of the child. This appeared to be based in an ideology that each child has the right to a fresh start, to be subject to the same behavioural expectations irrespective of their background, and not be 'labelled' as a guardianship child. However, the result was that an inadequate amount of information was conveyed in order to keep the child safe or address the child's needs.

The implication of this poor information exchange for effective behaviour change is that essential information about behavioural triggers was frequently not available to those required to care for children on a daily basis. In strictly behavioural terms, knowledge about antecedent triggers for violent behaviour allows for environmental manipulation in order to avoid negative behaviours. Lack of communication about these triggers frequently meant that episodes of undesirable or violent behaviour were experienced by caregivers or teachers that potentially might otherwise have been avoided. The following extract, taken from an interview with a foster carer and her partner, illustrates this theme:

**R1:** Even though [Department worker] is a lovely lady, she sees good in every child, and she will ring you and say such and such [a child] needs respite, lovely little child-absolutely perfect child...

**R2:** And you find out later that [the child] is not much short of an axe murderer!

**R1:** We had a child removed because she had an issue with a knife and tried to slit our dog's throat.

**R2:** On the very first day that we had her! We should have been told that this child had issues with knives.

**R1:** We had other kids in our care at the time, not only was our dog at risk, the other children, and us, may have been at risk. **Interview 21**

Events occurring during access visits with biological family or over a weekend break that were highly emotionally charged for the young person were frequently not communicated by one group to another stakeholder group. Accurate and timely communication of behaviour occurring during access, or during times of upheaval may have supported stakeholders to view challenging behaviour in terms of difficulty with emotional regulation and processing of emotionally charged events, rather than in strictly behavioural terms. Teaching staff or mental health workers, for example, were often unaware of significant issues in the child's life, as the following extract from a teacher exemplifies:

**R:** A good example that happened here was the person was going to go to foster care and she was really looking forward to moving out of group care and going to foster care and at the last minute something fell through and she didn't go to foster care at all, so her behaviour completely changed.

**I:** So no one told you the placement had fallen through?

**R:** No, but we noticed at the school, you can tell when the behaviours start to go backwards. **Interview 81**

At the very least, the prompt communication of such information can provide stakeholders with a context for any challenging behaviour and, therefore, possibly result in a different approach to the management of this behaviour. From an attachment theory perspective, poor communication about significant history or problem behaviours means that, for example, a child's carer lacks the background information to interpret behaviour, and help the child to label, regulate and order the emotions that frequently accompany outbursts of violent behaviour.

### *Confidentiality:*

Across this subtheme, the issue of confidentiality was frequently cited as a rationalisation for not providing a detailed background and history to other stakeholders. Stakeholders struggled with issues of confidentiality; respecting the child's right to confidentiality on the one hand, versus the need to communicate

information in the child's best interests. In effect, the child's right to be treated 'normally' often overrode the safety and therapeutic needs of both the child in out-of-home care, but also the needs of those children also residing with the child in question. Not being able to provide a historical context to the child's behaviour frequently led to poor practice and outcomes for children. This mental health worker describes the difficulty in providing service when not fully aware of important events in the child's life:

**R:** It is more the systems stuff that doesn't lessen [over time], so when you are working with [the Department] and the things around confidentiality, information sharing. Sometimes that is quite limited or you will get told two weeks after an event happens to a child, or the placement is breaking down, and you will find out about it when the child is moving. If you are providing therapy to this child, then you need to know when things are happening straight away, not a week later or when the child is actually in a taxi moving. **Interview 17**

Some stakeholders sought to counteract this implicit directive of confidentiality. As a result of the difficulties caused by poor information exchange, stakeholders came to their own rationalisations for breaches of confidentiality or found creative, flexible ways around issues of confidentiality while minimising their individual risk as workers. The same CAMHS worker describes this:

**R:** But I think if both [the Department and CAMHS] can work on the fact that this information will help the child, at the end of the day you give it over. So that is what you need to work on. If we don't get the information then it is to the detriment of the child. **Interview 17**

Notable amongst accounts of confidentiality in the context of information exchange was the lack of an overarching framework to guide less experienced workers, who were likely to err on the side of caution when decisions involving the child's right to confidentiality versus the best interest of the child arose. Experienced workers, at least those that took part in this research, were likely to be more comfortable with overcoming issues relating to the exchange of information and to have developed ways in which to circumvent issues of confidentiality, as the following extract from a Department worker describes:

**R:** Well, I like to think that we're all linking in. We all talk to each other. I believe that we've all got to be open and honest, and I probably don't worry too much about the confidentiality stuff, because at the end of the day it's the child's best interest. So, you know, you're covered [legally] by that aspect and, I mean, we all need to know what's going on in this child's life. I mean, how can a child function at school if things aren't right at home, and things like that, so, you all need to be working together for the child. **Interview 24**

This theme suggests that the appropriate and timely exchange of information is likely to be an issue at the centre of any collaborative attempts to help young

people in out-of-home care. This issue has also previously been highlighted by other researchers in relation to collaboration amongst children's services.

#### *4.8.4 Power and control:*

Respondents frequently spoke about issues of control and power in their relations and about its impact on their attempts to support children with challenging behaviours. Issues of power, manipulation, and control pervaded accounts of stakeholder and interagency relations, accounts of within agency politics, and in accounts of the child's interactions with caregivers and wider systems. All stakeholder groups spoke of feeling powerless at times and feeling forced into 'playing the system' to obtain outcomes for themselves and the child.

Critically, these dynamics were experienced by stakeholders as interfering with their emotional availability and effectiveness. One example of this was foster carers feeling compelled not to become too emotionally attached to the child because the child could be moved on at any time. However, this impact was not confined to interactions between stakeholder groups, suggesting that issues of power imbalance are pervasive both between and within stakeholder groups. This extract from a Department worker describes the concern about the impact of workplace bullying on the effectiveness of their practice with young people:

**R:** Like, there's no team morale, morale is very low and we pay lip service to a team spirit, but there's quite a lot of stress with individuals. Other individuals who are new to the office, say, don't know that - they

haven't got the historical context, and so, they accept whatever they're told. Especially if they're on contract, they won't open their mouths. And the contract system really allows managers to manipulate people, because they will not- in fact - one social worker told me this morning that her main concern is that her work with her clients does not suffer because of what's happening within the office structure. **Interview 23**

As a result of this kind of dynamic, in which respondents are unable to advocate for their own needs, respondents may be especially unable to advocate effectively for the child's needs.

Each stakeholder group was perceived by other stakeholder groups as powerful 'others', able to wield power within collaborative relationships in a range of ways. This wielding of power was perceived to be exhibited by such things as the ability to make statutory decisions on behalf of the child, withdraw access to services for the child, refuse placements, or by the ability to physically restrain children, depending on the stakeholder group in question. While some issues of power were experienced quite overtly, at other times power was perceived to be wielded more indirectly. It is perhaps not surprising that foster carers frequently felt that they had little control over how decisions were made, as the following two extracts from carers describe:

**R:** Too often the social worker moves them on because the social worker has a problem with the carer, not because of the relationship between the child and the carer. We have seen this with a lot of the carers

that we have known, as soon as the relationship with the social worker breaks down the placement is deemed to be broken and the social worker moves the child on. **Interview 21**

This foster carer expressed concern about the possible negative consequences of these power issues for the child:

**R:** The social worker at the time, and she has since changed, she has been promoted through her own level of incompetence, she said to us off the record, we are giving the mother enough rope to hang herself. Our comment was make sure you don't hang the baby, which nearly happened. **Interview 22**

Issues of power and control were also felt to impact on the implementation of disciplinary action or logical consequences for unacceptable behaviour. One example of this is the inability of foster carers to discipline the child in their care like a 'normal' non foster child because ultimate statutory responsibility lay with others or because of apparently arbitrarily imposed regulations. Any given stakeholder group frequently perceived 'others' as being more powerful and were fearful of incurring retribution from other stakeholder groups, as the following extract from a foster carer indicates:

**R:** I have often felt so outraged about the system [but] I can't talk publically about this because they might take him away. Maybe that is a large part of the problem with the system, you know what is going on, but

can't stand up and do that [because] - a) you have to defend your child's confidentiality which is an issue and b) you might have to take a risk by what might happen from the powers that be. **Interview 18**

Each stakeholder group described experiences in which they were subject to 'top down' decisions from 'powers that be,' that were arrived at without consultation, apparent justification or transparency of process. These decisions were perceived to be primarily resource driven, led to poor stakeholder morale, and interfered with their ability to work collaboratively in support of the best interests of the child or children in their care. Foster carers often experience these issues of power and control in terms of the timing and amount of information that was provided to their child or about their child. An example of this is provided in the following extract from a foster carer:

**R:** When she was about 12, the psychologist at [Department] said that it was time for [child's name] to know about her past, fill in the gaps for her. We said no - we think at 18 it is a more appropriate time, because she was very immature for her age. But she was given all the information by this psychologist and from then on it was all downhill, we could specifically note that that was the turning point [in her behaviour].

**I:** The information was just too distressing for her to cope with at that age?

**R:** She knew some of it and [child's name] had very stressful contacts with her mother and she didn't know who her father was. We weren't listened to on that issue either, we just had to cope with her behaviour when she got home, because she would be very upset [after seeing her mother]. When she was about 12 she said I don't want to do this anymore, I don't want to go and see her [biological mother], but she was forced to by the Department. **Interview 10**

However, these issues of control occurred not only between stakeholders from different agencies, but within the Department as well, as the following extract from a residential care worker indicates:

**R:** I got so hot with the director who dumped these kids with me, saying we have no placement [for them] - you have to have these kids, there is not much to know - the kids have been sexually assaulted they were seven years old at the time. He said we direct you to take the child - thank you very much!

**I:** So basically you are directed to take a child irrespective of the dynamics of the unit?

**R:** That is the worst [thing] that happens within the system, but it is something probably very important for your [research]. **Interview 45**

A significant implication of this theme is that the perception of many stakeholders was that issues of power and control frequently meant that the best interests of the child were secondary to the best interests of more powerful stakeholders. While some participants experienced themselves as powerless, others were able to find ways to gain control of their situation or to gain benefits on behalf of the child. This extract from a foster carer illustrates how some participants had learnt to ‘play the system’:

**R:** I had to threaten to quit with this child. I went to the [Families SA] office at [location] on a Tuesday and I said if you don't get CAMHS for this child by Friday I am quitting and I am not changing my mind and I would have. That night at 9 pm it was organised. **Interview 33**

It is important to acknowledge that children in out-of-home care are possibly the most powerless group of all and are frequently without advocacy and representation. As Davies (2000) notes: “Inequalities of power can make it near impossible for the less powerful members of a group to speak out” (p. 1022). Nonetheless, systemic issues were perceived by stakeholders to offer children opportunities to exert power and control. Opportunities to exert control frequently manifested themselves in response to issues of discipline and took the form of allegations of abuse made by children against stakeholders. Such allegations of mistreatment were perceived to contribute further to disequilibrium from a structural family therapy point of view, and often culminated in the breakdown of a placement. The following extract from a foster carer provides an example of this:

**R:** If you have little ones like this one here and the other young fellow I have got, you are pretty safe [from allegations of abuse]. But the moment you have a child over the age of 10 you leave yourself wide open, they know the system they have been in it for a long time, they know how it works, they know the moment they say 'abuse' they will get a new carer. The moment you set down guidelines on what they can and can't do, that is it-that is when you get problems. **Interview 19**

Other examples in which children were seen to assert control over their situation included the refusal to attend appointments or counselling. Issues of power and control, therefore, were widely reported across stakeholder groups and appeared to be one of the major obstacles to collaboration in the best interests of the child.

#### *4.8.5 Ineffective use of resources:*

All agencies cited resourcing, workload and staffing issues as interfering with their ability to support children with challenging behaviours. Examples of resourcing issues related to this theme were competition for resources, insufficient or inappropriately designed programs, and the inappropriate use of resources. This theme echoes previous findings which highlight resourcing issues as a barrier to collaborative practice (Darlington et al., 2005 a,b; Worrall-Davies et al., 2004).

*Insufficient resources:*

Insufficient resources were cited by all stakeholder groups as a factor interfering with collaborative practice and with effective behaviour change. Insufficient staff and pressure on services, together with relatively high administrative workload demands, resulted in less time available for stakeholders to spend in contact with an allocated child and stood in the way of the child forming meaningful long lasting relationships with stakeholders, as the following teacher suggests:

**R:** Generally I suppose one of the issues we find with Families SA is the change of case manager and people not being available when you want to speak to them - social workers never answering their phones - you will say to the kids you need to speak to your social worker about that and they say they never answer their phone. Now whether that is true or not, or whether they are saying that as a cop out because they want me to take over their problem and solve it for them which is a part of a common scenario...

**Interview 42**

The unrelenting resource and time pressures experienced by most stakeholder groups frequently meant children were not seen individually, that missed appointments were not actively pursued, or that children with challenging behaviours were moved on by caregivers. As suggested in the following extracts from Department workers, this can have negative implications for the development of a relationship between the worker and children in care:

**R:** Yeah, I think you can just be so engrossed in making sure that you've got the case planning, your case notes and that – you can be so engrossed in making sure that's done that you miss out on the engagement [with the child]. I mean, engagement with young people, and that, takes time, and I think that's important, that time. **Interview 24**

Such resourcing, workload and time restraints contributed to a sense of dissatisfaction on the part of workers due to their perceived lack of connection with the children in their care. In turn, this lack of connection meant that workers often felt that they lacked the understanding of the child's daily behaviour needed to help them effectively, as this Department worker describes:

**R:** And so much of our work to engage other services involves a huge amount of paperwork - and you have to do that - so you are into process stuff and you have to rely on the threads of everyone else's role in terms of the feeling of the human side - what that child has experienced and what that child needs. It is frustrating. **Interview 30**

In addition to a lack of time, a lack of financial resources meant that stakeholders could not provide children with activities that they felt would be beneficial, or involve them in clinical intervention programs or other activities as desired, as this Department worker explains:

**R:** The main frustration, and there would be several, and they would be on an equal platform. So, from the top of my head, I think the main frustration is sometimes that we would like to do things for our young people, but we're - because of lack of resources - we haven't got the finances - we have to almost beg for the money with our supervisors, because they have to – they're under instructions to limit the cost to the budget, because if the budget goes under the limit, then the office gets a tick from higher up, and higher up – our CEO's are eager to please the Minister, and Mr Foley [Treasurer], so that they don't overspend the budget, so [there is] considerable pressure to keep the budget within line.

**I:** From the top down?

**R:** Yes, from the top down – but the result is at the bottom. We have to beg and borrow – can I do this, or can I do that – and the theory is whatever the young child needs we'll provide. The reality is, you have to beg for that to occur. **Interview 23**

The demands on time and energy due to high caseloads and the demanding behaviours demonstrated by children meant that stakeholders were often drawn into short term crisis driven reactions rather than being proactive or engaging in long term planning. Others have noted how such time pressures discourage flexibility and reflexive practice and foster “task- oriented” or reactive style of working (Van Eyk & Baum, 2002, p. 264), as the following extract from a foster carer indicates:

**R:** We understood from the social workers that the main thing was they weren't allocated the time. They weren't social workers; all they were was care placers.

**I:** Administrators in a way?

**R:** Yes. For a lot of them that seemed to take an enormous amount of time to deal with the reactive stage, there was no time for proactive care.

### **Interview 36**

This time pressure often translated into a lack of clear direction for managing the child's behaviour and in terms of addressing the child's needs. The overall implications for these resourcing issues such as time pressures, delays in responding to requests or inquiries, and high workloads was a sense of a crisis driven sector, in which respondents often felt that it became difficult to have connection to young people or develop longer term plans for addressing the child's behavioural difficulties.

#### *Inappropriate or inconsistent resource allocation:*

Issues that related to this sub-theme include the inappropriate design of services for children with challenging behaviour and the inconsistent manner in which resources were allocated. When resources were available, they were not available in a way that best served the needs of young people. Decisions were

made based on the allocation of resources without consultation and with negative impact on the lives of children. This residential care worker describes how changes made to staffing and rostering, in order to reduce staffing costs at the unit had a negative impact on the continuity of care for children at the unit:

**R:** The only thing that really sort of stands out other than the nitty gritty and the bitching and back fighting, sometimes and probably more often than we would like to admit, decisions are made up here [management level] about down here. But up here doesn't know what the hell is going on down here and the rippling out effect is traumatic to us and the kids.

#### **Interview 69**

For example, therapeutic programs that are offered over a limited time frame or even on a school term basis were felt to be unsuitable for this population. Conversely, successful programs were perceived to be discontinued without adequate justification, as described by the following extract from a residential care worker:

**R:** We used to have a lot of programs like that. Camps like beach survey cleanups, go down to Elliston and spend a week down there cleaning up the beach and sand dunes, bag it, itemise it and use that information. Did a lot of work down the [animal welfare] shelter; the kids were able to give back the community whilst still serving their time. Again that all fell away, once the director decided no more day leave. **Interview 32**

Caregivers spoke about the difficulty in obtaining reimbursements for clothing or funding for excursions, camps, or activities. Resources, when available, tended to be available in small amounts, through specific funding arrangements that needed to be applied for on an individual basis. The application for such funding tended to rely on individual worker's or stakeholder's knowledge about the existence of such programs and resources.

One factor which may contribute to the perception of inappropriate use of resources may lie in differences in the way resources are allocated within agencies (Salmon, 2004; Williams & Salmon, 2002). For example, education services may operate on an assumption of equal access to resources for each child, whereas resource allocation is competitive and prioritised according to need in services such as health and child protection. Frequently, this produced tension between stakeholders as confusion arose as to the rationale for decisions about the allocation and prioritisation of (predominantly) financial resources and services.

Staffing issues and staff turnover also impacted on collaborative work. Infrequent mental health appointments, the use of staff rostering in residential care units, the use of short term contract workers and short term foster carers equated to inconsistently available connections for children and caregivers and contributed to difficulty in communication between stakeholders. The result of this was difficulty in establishing long term collaborative relationships that were demonstrably in the best interest of children. The combination of staffing issues together with high caseloads resulted in poor communication between stakeholders, despite the best intentions. This extract from a residential care

worker illustrates the frustration that is caused by issues such as rostering and staffing which results in poor communication about the child's needs:

**R:** Sometimes you don't get that phone call back from them [the Department] when you really need it. I understand that social workers have so many kids but that is the frustration at the moment, sometimes you try and get the social worker, but they are out somewhere, or at a meeting, they have a full caseload and it is not their fault. But that is what the frustration as a youth worker is, you try and get support of the social worker, you leave a message and they don't get back to you. Then when they do get back to you, you are off shift, so you leave a message with your co-worker to try and explain to the social worker. You send emails but sometimes you haven't got half an hour to explain the situation. **Interview 61**

Critically, the way in which staffing is configured with the use of contract staff, high workloads and rostering often translated for the young person into an absence of key people at times of behavioural crisis who possessed a sense of the historical context to the child's challenging behaviour, as both a DECS worker and a foster carer suggest in these extracts:

**R:** At this stage a lot of these kids have got different carers, they don't just have one person that you can actually relate to. Sometimes they have a relationship with one particular person, but that person is not always available. If they haven't someone they can actually turn to who is there all the time it is difficult for them to open up. **Interview 81**

This frustrating lack of accessibility to a person who has a strong historical understanding of the child's behaviour was also described in this extract from a carer:

**R:** They [Department workers] are supposed to do a home visit once a month, but you don't see them for months and months or until a placement breaks down. Then they are all over you, wanting to know what the hell went wrong! Why didn't you ring me? Yes -but after 30,000 messages you just give up! **Interview 19**

Staff and caregiver turnover also meant the duplication of meetings and administrative tasks. It also frequently meant the introduction of new ideas about what is driving behaviour and about appropriate intervention for the child's issues. This extract from a foster carer illustrates the difficulty caused by changing staff for the child:

**R:** So you've got one worker you might just start feeling, you know, comfortable with and trusting and then there's another caseworker. And they all have their own perspective on what they think should be happening for the child. So one of the huge problems is, you know, that you can be working very well with a particular worker over several years and with a particular child and then that worker leaves, another worker comes in and changes directions for whatever reason - and a whole load of conflicts come up and it can actually contribute to placement breakdown. So, it's about

recognising that the system itself is not stable in lots of ways because you've got this ever changing environment where workers come and go.

### **Interview 9**

It could be argued that staffing issues contribute to a lack of accountability and responsibility for addressing behavioural issues or the 'seeing through' of agreed upon behavioural programs. Investment in collaborative practice may come when interagency networks are seen by workers as supporting their "future collaborative efforts" (Van Eyk & Baum, 2002, p. 266). This contrasts with the situation of short term or contract workers (Van Eyk & Baum, 2002). Similarly, enlarging the "shadow of the future" by creating the anticipation of long term relationships between workers from different agencies and a stability of appointments of key staff has been argued to be important in enhancing collaborative practice (Williams & Salmon, 2002, p. 351).

#### *4.8.6 Communication and understanding:*

Extracts in this broad theme related to difficulties in linking and joining up the practices of different stakeholder groups. A central barrier to this process was a difficulty amongst participants in understanding the decision making processes and policies of other stakeholder groups. The desire was expressed by participants for more and better communication between stakeholders and a better understanding of the practices of other agencies and stakeholders. The following extract from a mental health worker expresses the frustration in communicating the child's mental health needs to workers from other agencies:

**R:** There's historically difficulty with linking with organisations - like [with the Department] it's big - and highlighting how much a young person might be at risk and I think that's a sort of a barrier. It's a barrier to - in my experience staff in CAMHS, for example, understanding why and whether or not [the Department] might make a decision to remove the child or not at a different time, those kinds of things. I think there's a lot of misunderstanding about the roles of the different organisations and if we could actually improve that, that might improve [things]. **Interview 3**

Although this theme of lack of understanding was expressed by all stakeholder groups, the frustration experienced by difficulties in understanding the policies and practices of the Department were more overtly expressed, as this extract from a CAMHS worker demonstrates:

**R:** I would really like to know more about Families SA policies and understanding of how they work with these young people and where it comes from - their end sort of goals in supporting these young people - and how they look at the long term needs of the young people. We have mutual goals but I think sometimes we come at it from different frameworks. So if we could understand their framework, I could then probably try and look at how we could support the young person in continuity as opposed to coming at it from a different pathway. **Interview 1**

Many participants expressed the desire to demystify, or make more transparent, the processes of the Department. This extract from a teacher conveys the frustration experienced by what appears, at times, to those outside the Department, to be arbitrary or unpredictable decisions about a child:

**R:** When we ring up and do the mandatory reporting because there are bruises on a kid and he said his Dad did it. I have done that 2-3 times and nothing happens - and then you have a kid who you thought was fine and he has been removed from his parents! I don't know what the line is. **Interview**

**66**

Issues of communication and joined up child-centred practice have been emphasised in previous studies exploring barriers to collaborative practice (e.g., Darlington et al., 2005 a,b; Worrall-Davies et al., 2004; Okamoto 2001). Better communication and understanding between agencies was seen as critical to establishing true collaboration in the best interests of the child. Examples were given in the interviews where poor communication between stakeholders equated to confusion for the both workers and the children alike.

Amongst all stakeholder groups, there was a strong desire for more child-centred and less agency-centred practice for the benefit of the child. Participants in this study expressed a desire for the mandates, policies and practices of other organisations and workers to be more aligned in order to better support children. This foster carer describes the need for child-centred practice:

**R:** I just feel that the departments should actually work a bit closer together and support each other. The departments are separated and it is like they don't mingle enough, they are not passing on information to each other. Instead of being separate departments they should all be together - have their separate things they do, but come together - because really it is about the child, it is not about what my department is doing and what your department is doing and how much money we get in our department. They are losing why they are there - they should all be working together in the interests of the child. **Interview 26**

The desire for better understanding between stakeholder groups was expressed especially overtly by participants who had worked for and 'belonged' in more than one agency or stakeholder group. This is articulated in the following extract from a current CAMHS worker that formerly worked for the Department when she describes the way in which she facilitates collaboration between agencies:

**R:** Part of it is my knowledge base having worked at [the Department], so I do know where it is coming from - and to a point I can understand [the] lack of resources, or you have new workers coming through, those sorts of things. So I use that quite a bit, I have a lot of friends left in [the Department], so I will ring and debrief with them, without giving out client details, and finding out what is new happening in the department to try and counteract that stuff - are we still battling the same things? -and

checking out what other avenues are out there, rather than just banging my head against the wall. **Interview 17**

Respondents that had worked for more than one child-focused agency were particularly likely to express the need for stakeholders to see things from another service's or from a caregiver's perspective. They were also likely to express the need to take active steps to circumvent or counteract communication barriers. They often appeared better placed to problem solve differences in perspectives and overcome communication barriers, typically through the development and maintenance of extensive personal networks. Moreover, these participants were able to take on the perspective of more than one agency, without identifying solely with one agency or another. The following extract is from a Department worker that was formerly employed with an alternative care service provider:

**R:** I think it would be good if we could have all services linked together, so that everything can be looked at and I don't think that happens. I can't talk from what happens in other offices, but I think from my experience at [Support Agency] - I just don't think it happens enough. I don't think that the other agencies are given enough credence. **Interview 47**

Some stakeholders made active decisions not to be drawn into 'agency bashing', as the following extract from a CAMHS worker describes:

**R:** You can get caught up in this sort of agency bashing; I don't get caught up in that. If they make a decision –okay. I do as much as I can to

have as much impact on the decision making according to the case and what I think. I might consult with colleagues as well. But at the end of the day, if things don't work out the way I want them to, I don't go saying well that is because of you or you [at another agency]. I prefer to work with people and try and have more influence that way. **Interview 76**

Participants expressed the desire for a coming together of agencies, primarily through the opportunity to do joint training that focuses on the needs of the child. This type of joint training was seen as affording the opportunity to step out of the shoes of their own agency and develop a better understanding of the frameworks and mandates of different agencies and stakeholder groups.

The desire for joint training as a way forward was an idea expressed by stakeholders from all groups. Joint training that aimed to understand things from a child's perspective or from the perspectives of the operational or policy mandates of other agencies was seen as especially useful, as this CAMHS worker suggests:

**R:** I think it would be really good if all the organisations sit in training together, I know that's a huge step but if there's an opportunity there with something like the IEP [individual education plans], that on the day that we did that [training], it did include staff from DECS, CAMHS and Families SA - all attending here - so that was an example of how it could work, and so I think it could be beneficial. It's important that we can understand the experience or the position of a residential unit or the position of a

[Department] worker or a school in their role so if we're aiming to improve that. **Interview 2**

As this extract indicates, this kind of joint training has occurred in a very limited sense over the implementation of new education documents, the Individual Education Plans, specifically designed to document the educational needs of children in out-of-home care. Somewhat surprisingly, no reports were given by participants of similar training in relation to the mental health needs of children in out-of-home care.

#### **4.9 Discussion**

The analysis presented in this chapter has highlighted several themes which feature in the tension surrounding providing intervention for behavioural concerns of children in alternative care in this sample of South Australian stakeholder groups.

Several of the themes identified in this analysis resonate with those touched on by previous research describing the general issues involved in interagency collaborative practice. Resourcing issues such as lack of time, high workloads and inappropriate models of resource delivery have been identified previously (Darlington et al., 2005 a,b; Darlington & Feeney, 2008; Worrall-Davies et al., 2004). Communication issues have also been identified (Darlington et al., 2005a,b; Darlington & Feeney, 2008) in relation to language and terminology (Salmon & Rapport, 2005) and role clarity (Darlington et al., 2005b). Similarly,

barriers relating to the flow of information between stakeholder groups have frequently been mentioned (e.g., Okamoto, 2001; Scott, 1997), including confidentiality practices (Darlington et al., 2005a) and a lack of knowledge about other agencies practices and mandates (Darlington et al., 2005a,b; Darlington & Feeney, 2008; Salmon & Rapport, 2005; Worrall-Davies, et. al., 2004).

Accordingly, some of the themes appear to parallel those experienced universally, irrespective of the client population in question and the focus of the collaborative venture. It can be argued, however, that these types of barriers are likely to be particularly salient in the case of attempts to address behavioural concerns.

For example, while poor information exchange may be generally problematic, its impact may be magnified when the information in question conveys essential details of a traumatic event or of the antecedent or maintaining conditions for the challenging behaviour. Information about antecedent events and behavioural contingencies is required to implement behaviour change measures. Information about past traumas is required to facilitate the working through and the accommodation of these events by the child.

Such information can, of course, be gleaned over time by any one stakeholder group as they get to know a child they are caring for. However, failure to convey important background information in a timely manner will, at a minimum, most likely mean unnecessary hardship for both carers and children alike. At worst, the withholding of important information can expose the child, stakeholders and caregivers to significant risk in the form of harm to others, school exclusion or placement breakdown.

Issues of power, control and manipulation have been alluded to in previous research. They may take a variety of forms, such as workplace bullying (Briggs, Broadhurst & Hawkins, 2004) or the active manipulation of referral information between stakeholder groups (e.g., Okamoto, 2001). Many stakeholders related the experience of being subject to 'top-down' decisions, both within their own agencies and between stakeholder groups, implemented without consultation. Amongst those working in caring roles, low perceived control over daily issues in the context of an emotionally exhausting role is implicated in burnout (Maslach & Jackson, 1984; Maslach, Jackson & Leiter, 1997). Arguably, stakeholders that have little perceived control over their daily lives due to such treatment could, in turn, treat those that they perceive as less powerful in a similar way. What this means for the most important stakeholders in the out-of home care system, the children themselves, with very little ability to make decisions about their daily lives is an important question.

There may also be competing imperatives for resource allocation when it comes to things like programs and services. It may be argued that resources are allocated according to divergent ideological imperatives such as equity and inclusiveness (in education services), versus priority of need (in health services) or in response to crisis (in the case of child protection welfare and placement dynamics) (Williamson & Salmon, 2002). Making explicit these differences may be important in order to facilitate better understanding between agencies, even if these ideological and pragmatic differences may not be easily reconciled. Resourcing issues such as staff turnover and the short term nature of funding

arrangements mean that a child does not have stable long term opportunity to work through issues relevant to behaviour change. Those resourcing issues arising out of budgetary constraints are unlikely to improve and accordingly this source of difficulty in interagency or intersectorial collaboration is unlikely to improve. Paradoxically, it has been suggested that the establishment of multiagency practice models leads to improved efficiency of resource use (e.g., Horwath & Morrison, 2007).

The significance of the barriers identified in this analysis that relate to difference in frameworks warrants further discussion. The negative view of the approaches of 'other' stakeholder groups as inferior is particularly troublesome. Blaming of other agencies for failures (e.g., accusing other agencies of inappropriate practice leading to the child behaviour problems) has been identified in one previous study (Okamoto, 2001). Differences, as well as commonalities, can strengthen collaborative work because they broaden the knowledge, expertise base and personal and professional experience brought to bear on the problem at hand (Van Eyk & Baum, 2002).

The answer to many, although not all, of these difficulties may lie in the suggestions of stakeholders themselves. In expressing the desire for both more joined up, child centred practice and for better understanding of the practices and mandates of other agencies and stakeholders, many participants nominated joint training as a way forward. This echoes the call of others for joint training between foster parents, social services staff and teachers (Hill-Tout et al, 2003).

Some of the themes identified in this analysis appear to represent newly identified barriers that are unique to the difficulties involved in addressing challenging behaviour. For example, the barrier formed by ‘triangulation’ of the child’s relationships and its impact on behaviour does not appear to have been reported before. This finding probably reflects the contribution of the inclusion of key stakeholders groups: namely foster carers, residential care workers and teachers, to understanding the dynamics surrounding challenging behaviour. Repeated triangulation in the child’s relationships limits the opportunity for those caring for the child, whether teachers, foster carers or residential care workers, to impose behavioural consequences for challenging behaviours. Similarly, the opportunity for the child, in response to conflict, to engage in power plays means that the child may be rewarded by avoiding conflict, but inadvertently miss the opportunity to learn to work through and resolve conflict. It may also mean that the child frequently becomes the object of such power-plays between other stakeholders and the child’s best interests may be overlooked. ‘Triangulation’, and its impact on discipline, may be reduced by better understanding of the unique environment within each service that behaviour management must take place (for example, residential care or the school environment). This in turn may be facilitated by joint training of the type suggested by the participants in this study.

The triangulation within the family structure represents a barrier to addressing behaviour that does not appear to have been reported before. This probably reflects the unique contribution of the inclusion of foster carers in this study to our understanding of intersectorial collaboration. The outsourcing of foster care supports has resulted in increasing fragmentation of the systems surrounding

children in South Australian out-of-home care, which contribute to the potential for the 'drawing in' of third parties. In relation to the triangulation of family structure, providing foster carers with an agreed upon 'parental authority' incorporating decision making powers about everyday events such as sleepovers, pocket money, hair cuts, excursions and routine medical treatment may be beneficial. An agreement that the foster carer is the first person called when discipline issues arise at school, rather than involving the caseworker could also improve this situation. This kind of triangulation and its impact on behaviour may be lessened in jurisdictions where carers are well supported by the department, or where foster carers are included as part of the therapeutic partnership/ treatment team. To that extent, the results of this analysis must be considered to reflect the unique circumstances that currently exist in South Australia.

#### **4.10 Summary**

Taken together, the results of this analysis indicate that multiple potential barriers exist to embarking on and sustaining collaborative work that addresses challenging behaviour. Although these are presented as separate themes, for the sake of clarity, they are somewhat interrelated. The broad issues presented in these themes interact and further complicate the picture, and may compound the difficulties for the child. For example, derogating others' understandings of frameworks for addressing behaviour may lead a worker to minimise the importance of communicating information about behaviour. Similarly issues of power and control between stakeholders may further entrench the triangulated distortions in the child's relationships.

Arguably, much of the literature on collaboration is seen primarily in terms of professional identity, and the values, power and knowledge that accompany that identity (Scott, 1997). This focus can be seen as minimising the importance of organisational or stakeholder group membership as a factor in collaboration (Scott, 1997). It is clearly difficult to disentangle the influence of stakeholder group membership from professional identity (Eason et al, 2000) and this study did not seek to do so. The talk reported in this chapter is assumed to reflect stakeholder 'received views' about 'own group' and 'other group'. This assumption was supported by the general lack of discipline specific commentary amongst participants discourse.

The perception of difference amongst stakeholder groups, where others were seen to have inferior approaches to managing behaviour, together with the lack of understanding of the approaches of others, makes a strong argument for a more focused exploration of the predominant frameworks through which challenging behaviour in the out-of-home care population is approached amongst stakeholder groups. Therefore, it is important to better document what dominant accounts of behaviour exist amongst stakeholders. In doing so, we create the possibility to make explicit the implicit assumptions behind beliefs about the origin and resolution of challenging behaviour. Making explicit underlying assumptions generates scope for finding possible common ground which may at best assist collaborative efforts, or at least provide a common language (Salmon, 2004) through which the further development of a mutual framework can take place.

Much has been written about the impact of a lack of agreed or common language in multi-agency practice (Bullock & Little, 1999; Miller & Ahmad, 2000; Salmon & Rapport, 2006). While holding different theoretical frameworks is thought to cause tension between agencies (Darlington et al., 2005a), it can be argued that any difference is particularly salient when it comes to interventions for challenging behaviour (Williams & Salmon, 2002). Different conceptual understandings about behaviour in particular are likely to be very significant, given the importance of consistency when dealing with behaviour change contingencies, or continuity when addressing attachment issues. This highlights the importance of more overt articulation of the kinds of accounts of behaviour that feature in stakeholders' understandings of challenging behaviour. It is perhaps for this reason it has been recommended that further work be undertaken on the use of language and definitions between agencies (Salmon, 2004). Better understanding of the conceptual frameworks that dominate amongst stakeholders in this area can contribute to a 'way forward'; through both better understanding of the perspectives of others and through the potential for the development of a shared framework for intervention. Accordingly, the next chapter will report the analysis of stakeholder accounts of challenging behaviour.



## **PART D**

### **Chapter Five:**

**Frameworks and approaches to challenging  
behaviour**

### **Chapter Six:**

**How 'attachment' is understood by South  
Australian stakeholders**

### **Chapter Seven:**

**Residential care workers' experiences of  
challenging behaviour**



## CHAPTER FIVE

### Frameworks and approaches to challenging behaviour

#### *5.1 Overview*

The previous chapter highlighted several issues that may diminish stakeholders' ability to effectively manage challenging behaviours. One of the issues identified was the perceived difference of 'others' frameworks for managing challenging behaviours. Furthermore, the approaches and knowledge base of 'others' were viewed negatively. Other stakeholder groups were seen to have different (and inferior) understanding about challenging behaviours. Differences in approach can be argued to be particularly problematic when considering their effects on collaborative attempts to manage challenging behaviour (Williams & Salmon, 2002). At the same time, respondents expressed the desire to understand the policies and practices of other agencies better, to facilitate more effective child centred practice. This chapter will identify the dominant accounts of challenging behaviours amongst this sample of South Australian stakeholders. It is hoped that clearer articulation of these accounts will contribute to better understanding between participants in the out-of-home care environment.

The literature reviewed in the previous chapter pointed to the lack of a common or shared language as an emerging concern in interagency practice

(Bruner et al., 1992; Darlington et al., 2005a,b; Miller & Ahmad, 2000; Ranade & Hudson, 2003; Salmon & Rapport, 2005). Lack of a common language for complex behavioural concerns may also be argued to have relevance for effective behaviour management. This chapter will identify the dominant accounts given by stakeholders for challenging behaviour because it can be argued that the explanations given for behaviour may influence the nature of a participants' engagement with challenging behaviour, their optimism that change in behaviour is possible and therefore they may ultimately influence the interventions taken to support young people. Beliefs about the necessity to work collaboratively, about responsibility for change in behaviour and about the importance of investing in co-operative approaches with caregivers (e.g., Johnson et al., 2000) could also be influenced by how a participant has come to understand challenging behaviours. Such beliefs about behaviour management practice may often be implicit and internalised rather than overtly articulated (Hall, 2005), making an explicit examination of these accounts relevant.

This chapter will also attempt to reconcile the dominant accounts that exist amongst stakeholders with published information about the theoretical and empirical basis for behavioural interventions with children. Although interventions specifically designed for the multiple and complex issues of children in out-of-home care remain underdeveloped, there is nonetheless a body of literature that offers some guidance to the clinician and other stakeholders about approaches that are beneficial (see Chapter 2, section 2.5).

## ***5.2 Differing frameworks amongst professionals and organisations***

A broad body of research suggests that factors such as professional identity and organisational induction, culture and training can result in differing frameworks for practice. These practice frameworks may also include formulations about the origin of challenging behaviours, about how challenging behaviours should be addressed, and about whose responsibility it is to address challenging behaviour.

Interprofessional differences have been widely explored within multidisciplinary health care settings (e.g., Pullon, 2008; Sheehan, Robinson, & Ormond, 2007). Such differences have been less well studied in the case of multidisciplinary or interagency mental health care or behaviour treatment initiatives, especially within children's services. Hall (2005) has argued that a major challenge in collaborative practice is to provide opportunities for workers of different professions to understand each other's values and cognitive maps in which the opportunity arises for the professional values of all members to become apparent to all professionals involved. However, agencies themselves, as distinct from professional groups, may also differ in their approach to challenging behaviours. Both agency training and organisational culture could result in the existence of implicit representations for understanding and addressing behavioural problems. The contribution of organisational group membership to attitudes and frameworks for practice has not been well studied.

There have been some empirical investigations that suggest that both agency membership and professional identity may be important contributors to how problem behaviour is understood. For example, Richards and Vostanis (2004) studied services for older adolescents presenting with challenging behaviours and relationship issues. They found social services and mental health services to have different views as to the source of the problem behaviours and as to who has primary responsibility for intervention; whether it is a primarily social problem or a health issue. Johnson et al., (2000) have suggested that different professional groups may hold a different sets of “mental models” (p. 329) about the origin of behavioural and emotional difficulties in children and, as a result, prefer differing treatment approaches. In their study, professional’s theoretical orientation and causal attributions not only differed according to their preferred way of working but also influenced the treatment recommendations they made to parents.

It may be unclear who is responsible for ensuring that children with challenging behaviour receive appropriate services. This may be particularly the case for children who no longer live with their biological families and for whom ‘duty of care’ issues are less clear cut. Addressing challenging behaviours is no doubt an extremely difficult task (Williams & Salmon, 2002), raising the possibility that stakeholders may engage in ‘passing the buck’ (Okamoto, 2001) when it comes to accepting responsibility for addressing challenging behaviours. Indeed, it is unclear how much communication occurs between agencies regarding children’s mental health and behavioural issues. It is conceivable that such communication occurs mostly in situations where the behavioural or mental health needs are expressed overtly by the child. Virtually all agency or stakeholder

groups have been suggested to overlook or minimise the importance of mental health and behavioural issues in this population. Social services (Phillips, 1997), foster carers (Halfon et al., 1995), residential care workers (Hillan, 2005) and teachers (Webster et al., 2005) have all been suggested to under refer or under-report children's mental health and behavioural issues. Issues of knowledge or training and a perceived lack of access to mental health services may all contribute to the minimising of mental health and behavioural issues that has been suggested to occur. There may also be an underrepresentation of trained child mental health professionals in child welfare (Glisson, 1996), possibly making the communication of mental health and behavioural issues between agencies more difficult. An explicit examination of *how* behaviour is understood amongst stakeholders may lead to a better understanding of the tensions that do occur for stakeholders when communicating about and managing behaviour.

There are some grounds for arguing that the beliefs or “implicit theories” (Dryer, Kiernan & Tyson, 2006, p. 177) that any participant holds about the causes of challenging behaviours can have important consequences for a participants' willingness to persist with helping to support change, their optimism that change is possible, and for the way that they engage with challenging behaviours. For example, workers' causal attributions for challenging behaviours have been linked to aspects of their emotional reactivity to challenging behaviours, their optimism that behaviour will change and to the manner in which they prefer to approach behavioural problems (Jones & Hastings, 2003; Wanless & Jahoda, 2002). Their attributions may influence their hope that behaviour is, in fact, changeable, (Brian & Standen, 2000; Dagnan et al., 1998; Hill & Dagnan,

2002; Stanley & Standon, 2000) and they may be less inclined to help when they perceive that a person has personal control over their behaviour (Hill & Dagnan, 2002; Stanley & Standon, 2000). Assumptions about the degree of control a child has over their behaviour have been linked to negative or punitive discipline reactions amongst both parents (Slep & O’Leary, 1998) and teachers (Brophy, 1996; Brophy & Rohrkemper, 1981; Tollefson, 2000). Beliefs that challenging behaviours are essentially uncontrollable may lead participants to “give up” on even trying to change behaviour (Chronis et. al., 2004, p.12), with poor outcomes for children likely to result.

Taken as a whole, it does not appear unreasonable to conclude that stakeholders may hold differing general frameworks for understanding and managing challenging behaviours and that these frameworks may be important contributors to their daily practice in relation to behaviour management, such as discipline approaches, willingness to persist with challenging behaviours, optimism for change, and preference of intervention approach. Such frameworks may arise out of professional training, organisational orientation or identification with a particular group (Hall, 2005; Sheehan et al., 2007) and may include implicit causal attributions about behaviour.

### ***5.3 Analysis and themes***

Accordingly, this chapter identifies the dominant accounts of behaviour presented by stakeholders, leading to a discussion of the similarities and differences in these accounts. Further, it considers what each account of behaviour

might mean for a child in out-of-home care in terms of who is held responsible for the behaviour and for changing the behaviour of that child. A thematic analysis was conducted as outlined in Chapter 3. The analysis was conducted using the whole data set, that is, the interviews from all participants. This analysis yielded six themes, reflecting the common ways in which stakeholders understood the behaviours of children in out-of-home care:

- 1) Behaviour has been learnt
- 2) Behaviour is purposeful
- 3) Behaviour is a conscious choice
- 4) Behaviour arises from constant change
- 5) Behaviour arises from strong emotions
- 6) Behaviour reflects attachment

Each of these themes will be discussed in turn and extracts will be presented that illustrate these themes.

### *5.3.1 Behaviour has been learnt:*

This theme reflects an account of the development and maintenance of challenging behaviours that can be argued to be most closely identified with the use of a traditional psychological behaviour modification paradigm to conceptualise child behaviour problems. Accordingly, accounts in this theme describe the origins of challenging behaviour largely in terms of reinforcement contingencies and in terms of the modelling of negative behaviours by significant

people in the young persons' life. In other words, the responses in this larger theme reflected the belief that challenging behaviour was learned; either by the inappropriate reinforcement of unacceptable behaviour or by the inappropriate role modelling of unacceptable behaviour to children. According to this account of the development of challenging behaviour, the combination of lax parenting and lack of consequences meant that the child had simply not learned socially appropriate rules and boundaries. The following extract from a foster carer describes this view:

**R:** I believe it is because I am not doing what he wants that he thinks I don't love him or something, he sees it as I am not caring for him because I am not getting him what he wants. He doesn't see it as good parenting because he has had 10-11 years where his father has given him everything that he wants. There has been no boundaries or anything. So it is totally ingrained in his learned behaviour. **Interview**

**28**

There was concern expressed amongst stakeholders about what this failure in social reinforcement and inability to conform to social conventions would mean for the child in later life. One imperative seemed to be the need for children to learn to 'rein in' behaviour and conform to the rules of society in order to have a productive life. Participants expressing this view felt a responsibility to teach children to control their behaviour. The following extract from a teacher expresses this imperative:

**R:** Particularly as they get older, there is also a sense of if they do have any behavioural issues, needing them to actually learn to conform to society norms and school norms. Because otherwise people aren't going to make accommodations for them when they are 18.

**I:** So that is part of your role?

**R:** Yes. Part of the role is to induct and integrate them into what a normal social setting would be. **Interview 39**

Respondents reported their belief that children had learned that challenging behaviour was acceptable because it went unpunished by parents. This was because the parents either lacked the skill to discipline effectively, or they exhibited considerable inconsistency in how they managed children's behaviours. Accordingly, the need for clear articulation of rules and expectations, together with the consistent reinforcement of appropriate behaviour was echoed by many respondents, such as this foster carer:

**R:** I am very big on discipline, I say to people it must seem like a Nazi camp. We have a naughty chair in the hallway and stuff like that. Kids respond well to structure and they do work well with discipline. With a lot of kids it is because they are not cared about, that they just go and do whatever, there are no boundaries for them. I find that kids work well with boundaries. I am a big one of using that. **Interview 88**

For some participants, poor behaviour was deemed to be learnt through a combination of exposure to inappropriate behaviour and the absence of appropriate (positive) role modelling. For example, participants explained that children learnt to use violent responses by being exposed to the modelling of violence in attempts to solve conflict; predominantly by fathers or other significant male figures, as the following teacher suggests:

**R:** If they have come from a societal setting where violence, aggression and screaming abuse at your neighbour over the fence and threatening to kill them is normal for them to see, and modelled to them from birth, then when you get in a cornered situation or you are extremely angry that is the only way that you know how to respond.

#### **Interview 40**

In essence, respondents viewed challenging behaviour as occurring because of the absence of a parent that provided consistent boundaries and control of behaviour and/or the presence of a parent that modelled inappropriate behaviour themselves. The child was consequently seen to have developed a different understanding of 'normal' behaviour which could only be corrected through the explanation of and exposure to 'normal' societal expectations in combination with the application of firm consequences. This correction was most typically envisaged to occur within a loving foster home. Implicit in this account of behaviour was the desire for the child to learn that society doesn't accept or endorse their kind of behaviour. Accordingly, the perceived inability of some stakeholders involved with the children to follow through with consequences and

teach socially appropriate behaviour was seen to further disadvantage the children.

Broad systemic issues were seen to further complicate and entrench this learned behaviour in a variety of ways. For example, Department caseworkers were frequently seen to undermine attempts by caregivers to impose behavioural consequences. This type of interference, tentatively termed ‘triangulation’ was identified as a barrier to collaborative interventions in the previous chapter of this thesis. Similarly, the exposure of children with behavioural concerns to other ‘like minded’ children, for example, through the removal or exclusion of children to ‘behaviour learning centres’ or by placement in residential care was also as problematic. It was seen to further entrench challenging behaviours, principally by increasing children’s exposure to inappropriate role models. One teacher described the negative impact of the practice of excluding children from school to special ‘behaviour learning centres’ or ‘school exclusion units’:

**R:** I don’t know whether it is professional for me to say this but...exclusion [from school]! One of the programmes run at exclusion is actually going to [school exclusion unit]. Now for me I don’t know whether [school exclusion unit] is a good option for these kids. They are mixing up with kids with very similar behaviours. I don’t see that as good.

**I:** So you see them come back with an expanded set of behaviours than when they went?

**R:** Yes. A lot of kids come back more street wise. I have learnt a few things from these people [at the exclusion unit] and some of them I am going to try. **Interview 80**

This account, implicating inconsistent or inappropriate application of rewards and punishments, is broadly consistent with a traditional behaviourist position that the cause of a given behaviour is best conceptualised in terms of the consequences maintaining it. Accordingly, this account resonates with operant paradigms of learning and behaviour management (Robinson, 1985). Social learning theories can, in turn, be thought of as emerging from a behavioural paradigm in which reinforcement contingencies can be extended to apply to elements of reciprocal (family) social relationships. The conceptualisation of challenging behaviour expressed in this theme are reminiscent of a social learning model of behaviours (Bandura, 1977). One example is the model proposed in Patterson's (1982) coercion theory of the development of aggressive behaviours that is derived from social learning principles. According to this model, both the child's behaviour and the parent's are thought to arise and persist through reinforcement for the termination of aversive behaviour. Although the principal mechanism for the development of a coercive cycle is negative reinforcement (Robinson, 1985), failure to provide consistent positive reinforcement for pro-social and compliant behaviours is also thought to be important. The parent and the child become

trapped in a coercive cycle in which the parent may ultimately withdraw from disciplinary interactions with the child due to their perceived inability to control the child; the child may then come to employ a variety of aggressive strategies without consequence (Patterson, 1995). Ultimately, the child's coercive behaviour is thought to generalise to other social settings such as the school environment (Patterson, Reid, & Dishion, 1992). Inconsistency in the application of consequences has also been implicated in the development and maintenance of aggressive behaviours. Inconsistent conflict management and parenting patterns, together with low degrees of parental monitoring, have all been linked to the development of disruptive behaviours (see Cappadocia, Desrocher, Pepler & Schroeder, 2009; Frick et al., 1992; Haapsalo & Trembley, 1994; Wasserman, Miller, Pinner & Jaramillo, 1996).

Participants who gave accounts consistent with this theme clearly saw behaviour arising as a result of the behavioural contingencies operating in the familial and social environment in which the child has been immersed. The possible implications of this account is the view that behaviour change arises out of the opportunity to learn new (improved) behaviour through their exposure to appropriate adults and through competency based programs which emphasise the positive reinforcement of appropriate behaviour. These respondents may, arguably, hold an optimistic view of the possibility of changing behaviour because, in principle, behaviour can be 'unlearnt' in the same way it was learnt. Respondents who favoured this type of account of 'behaviour as learnt' may be more likely to favour a more traditional behavioural approach, or to employ a

structured approach to addressing the contingencies surrounding challenging behaviour.

According to these respondents, the solution to behaviour problems may be best understood in terms of exposing the child in care to appropriate modelling and rewards. The applicability of using traditional operant and social learning approaches with children who have been neglected, maltreated, or traumatised in particular, has not been fully explored. However, this approach does assume that children are motivated to attain social reinforcement such as caregiver praise and attention (Levy & Orlans, 2000). It further assumes that the child is appropriately sensitive to rewards and punishment (but see Dadds & Salmon, 2003) and cognitively able to benefit from contingent reinforcement (Falhberg, 1991). These assumptions have been challenged in the case of children purported to have attachment difficulties (Hughes, 1997) or antisocial behaviours (Dadds, Fraser, Frost, & Hawes, 2005; Dadds & Salmon, 2003). Further, Levy and Orlans (2000) suggest that the use of programs based on operant paradigms of reinforcement and punishment may reinforce the view of adults as authoritarian. Reliance on behavioural strategies may also do little to build resilience, self control and self efficacy. Notwithstanding these concerns, such a paradigm, based on operant notions of reward for 'good' behaviour, probably has intuitive appeal to many stakeholders.

### 5.3.2 *Behaviour as purposeful:*

Accounts of behaviour coded under the previous theme, 'behaviour as learnt', emphasised the learning of inappropriate behaviour through the influence of external factors such as reinforcements and modelling of behaviour. In contrast, the extracts in this theme emphasis the meaning or purpose embedded in the behaviour. They have in common the perception that the behaviour in question is meaningful or purposeful in some way. The examples within this theme describe behaviour as functional or purposeful; either in terms of achieving a goal or in terms of attaining an outcome, in a way which the child otherwise could not (i.e., without using the challenging behaviour in question). This theme was considered distinct from the previous account of behaviour because of i) its relative emphasis on the underlying purpose of the behaviour and ii) because of its emphasis on resolving problem behaviour by finding an alternative way for the child to meet their needs. Within this theme, however, the descriptions of children's behaviour varied according to how much control that children were seen to have over their behaviour. The following extract from a residential care worker, when asked 'what works' in addressing challenging behaviour, exemplifies this understanding of 'purposeful' behaviour:

**R:** Ultimately it needs an attitude to change by themselves. If whatever they are doing meets their need they won't need to change.

**I:** So if you can find a way to meet that need?

**R: Yes. Interview 51**

In the above extract, the children being discussed are attributed a high degree of control over their behaviour. There is an implicit assumption that the child's attitude or approach is under conscious control, and therefore amenable to change. Put very simply, this description implies that if the child can get what they desire another way, then they will be willing to change their behaviour accordingly.

While still describing behaviour as serving a purpose, respondents drew some distinction between those behaviours that were used intentionally and those that were not. One example of this distinction between intentional and unintentional behaviour with 'purpose' arose in the discussion of 'attention seeking'. Attention seeking behaviour was described by some as intentional; in which case the behaviours served to attract the proximity of the caregiver or gain the approval of other children. The same category of behaviour was also seen by others to arise unintentionally because the child did not know a better way to gain attention (i.e., lacked the appropriate skills to ask for attention) or because the child had formed the belief that gaining negative attention was better than no attention at all. In both cases this type of behaviour was seen to serve an important function for the child. This distinction between intentional and unintentional 'purposeful' behaviour highlights respondents' assumptions of how much control the child is thought to have over his or her behaviour.

Importantly, these two accounts about behaviour (behaviour as intentional or behaviour as unintentional) often co-occurred within a narrative given by any

single stakeholder. This often resulted in inconsistent descriptions of behaviour and in inconsistent approaches to its management, despite an underlying belief that the behaviour served some purpose for the child. This can be seen in the following two extracts, both taken from an interview with a classroom teacher, who provided conflicting explanations for the ‘attention seeking’ behaviours of one child in her class:

**R:** The one [behaviour] I have in the classroom at the moment is very much attention seeking behaviour, like acting the fool to get everybody else’s attention even if it is to get them to laugh at him or whatever. So attention seeking but also a need to be accepted, so he is trying to get all the other kids [think] –yeah, he is pretty cool, because he is funny and makes us laugh. As it escalates, he gets more time outs and stuff and then it gets to a defiant behaviour, don’t want to follow what you are saying, don’t want to do it. I will do everything I can not to follow what you say. So there is a bit of the attention seeking. I want everybody’s attention but not knowing when to stop with that attention seeking, or taking it too far and becoming defiant in what they have been asked to do. **Interview 67, lines 66-75**

In this extract attention seeking is seen as an intentional attempt to gain acceptance from peers which escalates into defiance and therefore becomes problematic in the school environment. However, this same teacher uses a

different description later in the interview to account for the same behaviour from the same child.

**R:** Initially I thought it happened more around when we were told he was having access visits and it would happen more before he went to his access visit and then for a couple of days afterwards. Now I am not sure whether maybe the attention he got through that, he decided that well that has given him attention and so he is now making the choice more often to do it. But when he first started, that was the main time that you saw the behaviour.

**I:** You mean the staff were trying to support him with access and he has now seen that that is the way to get adult attention?

**R:** Yes. He might have been getting negative attention on those days, but it was still attention. To some of them any attention is what they want, so now it is more regular. **Interview 67, lines 106-119**

In these extracts the participant clearly understands the behaviour as meaningful and purposeful in some way. The respondent fluctuates, however, in how much 'intention' she attributes to the child's behaviour throughout the two extracts. Other accounts in this theme uniformly saw behaviour as purposeful, although they also tended to vary in terms of the amount of control that they attributed a child as having over their behaviour. Attributions about control may,

in turn, affect how willing the respondent is to persist in helping the child to change his or her behaviour (Weiner, 1980, 1986).

Frequently, children were seen as both having an awareness of the inappropriateness of their behaviour while at the same time, having limited ability to control its expression. This Department worker's description of clients' violence conveys this issue:

**R:** I do believe that they are in control of the violence side of things, but often they don't know how to communicate properly, because they have never learnt that, that is how they see to deal with issues, that is what they know. So in that sense they can't control it, they know what they are doing is wrong. **Interview 63**

This extract captures the frustration expressed by many participants in the paradox that the child 'knows better' but can't seem to 'do' better. Participants understood intellectually that there was a good reason for the child's challenging behaviour on the one hand; the behaviour served a purpose. They nonetheless experienced the behaviour as extremely stressful, particularly when considering the degree of conscious control the child had over their behaviour. Another feature of the extracts in this theme was the perception that challenging behaviour was the child's way to communicate something important; something that the child lacked the ability to convey in other ways. Accordingly, building communication skills was seen as a way to facilitate behaviour change, as this extract from a teacher articulates:

**R:** Once they [speech therapists] actually see the child and start to work with them they put in recommendations as to the kind of language strategies we should use, for example, because language and literacy is very important in the programme here [education unit]. It then enables the student, child, to express themselves. If the child can talk, write or draw their needs rather than act in a challenging way then [having] the language helps. **Interview 44**

Taken as a whole, the extracts in this theme have in common the belief that behaviour is purposeful (serves a function) and is meaningful (communicates meaning). Children are seen as attempting to meet a need through their behaviour, but as lacking the skills or abilities to communicate that need in any way other than through the use of forceful or challenging behaviour. The implicit assumption is that challenging behaviour can be reduced by teaching the child an alternative, acceptable behaviour that still meets or communicates the child's needs.

When considered as such, accounts in this theme strongly parallel explanations of behaviour derived from psychological interventions in the intellectual disability field. These are known broadly as Applied Behavioral Analysis (Schloss & Smith, 1998). Examples of these include Positive Behaviour Support (e.g., Carr et al., 2002) or the Functional Assessment of Behaviour, (e.g., Maag, 1999). These approaches place primary emphasis on the purpose or function that the behaviour serves to the child exhibiting it, but also on the context

in which a behaviour occurs. These theories are typically more widely employed in the disability and educational inclusion areas than in clinical domains. They are based on a philosophy that places foremost emphasis on providing strategies to enhance social inclusion and the quality of the child's life, including skills development, and puts only secondary emphasis on reducing problem behaviour (Carr, et al., 2002). Put very simply, this approach to behaviour management aims to 1) identify the purpose the behaviour serves and identify environmental contextual (antecedent) conditions that affect the behaviour 2), identify an acceptable replacement behaviour that is an appropriate way for the child to obtain the desired goal (and therefore serves the same function) and 3) identify any individual factors that prevent a child from performing the appropriate replacement behaviour (such as skills deficit, disability or communication difficulties) (Maag, 1999).

These psychological interventions theorise that challenging behaviours serve several 'intentions' or functions for the child (Emerson, 1995). These include the attainment of socially mediated rewards (e.g., attention), the escape from aversive events or people, the attainment of tangible rewards, or sensory stimulation (Emerson, 1995). Accordingly, the focus of psychological intervention is dual; analysis of the intention being communicated by the behaviour and on the provision of an acceptable alternative behaviour that communicates the child's need in a socially acceptable way and reliably attains the desired outcome for the child. The following extract, in which a residential care worker explains 'what works' in addressing challenging behaviour articulates this overall theme well:

**R:** More educational [approaches] to teach them other ways of dealing with the situation. You need to know what need that behaviour is meeting, if you can find that out, teaching them other ways to meet those needs, other more appropriate ways and developing rapport with the young person. **Interview 53**

The following extract from a teacher also captures this theme as she describes the way in which she addresses challenging behaviour:

**R:** We work on the premise that all children's behaviour is communication and so the critical thing is you have to work out what are they trying to communicate through their behaviour and then you deal with whatever that may be. **Interview 39**

The respondents endorsing this theme place emphasis on the development of communication skills and on instructing children on alternative ways to achieve their desired outcomes. The suitability of this approach and its application to children in out-of-home care does not appear to have been evaluated in any systematic way. One recognised difficulty in using a functional approach to analyse behaviour problems occurs when a behaviour serves more than one function or purpose for the child (Emerson, 1995). For example, an abusive outburst may allow the child to both avoid school work (escape aversive situation) and gain attention from his peers (socially mediated reward). Alternatively, several different behaviours can serve the same function. For example, an aggressive outburst and sexualised behaviour may both serve a sensory

stimulation function. Therefore, establishing the purpose of any given challenging behaviour may require thoughtful analysis.

In summary, the notion of purpose or meaning in behaviour appears to be one of the dominant ways in which challenging behaviour is understood. Such an account may be argued to engender an optimistic outlook regarding the possibility for behavioural change. This kind of account, arguably, appeals to our desire to provide meaning for, and make sense of, behaviour that may at times appear illogical. When considering a child's behaviour in terms of its possible purpose, implicit assumptions about control and intention should also be considered.

### *5.3.3 Behaviour is a conscious choice:*

The previous account of behaviour constructed behaviour as purposeful, although not necessarily as within the child's conscious control. In contrast, the accounts within this theme clearly conceive of behaviour as within the control of the child. According to this account, the child was seen as ultimately responsible for their behavioural choices, as the following teacher explains when asked about how to address challenging behaviour:

**R:** I suppose it comes down to whether the child wants to change their behaviour.

**I:** Can you give me an example of what you mean?

**R:** I guess a lot of what we teach them is that their behaviour is a choice. So if a child wants attention, then they actually have the choice which behaviour they choose to get that attention. So I guess what I am saying is does he always just choose the negative one because it is more fun maybe, or does he make the choice that the better solution leads to the correct choice. We can say to them this is the better way to get the attention, because you are not getting into trouble, people are not getting angry at you sort of thing. **Interview 68**

An account of behaviour as the responsibility of the child was seen by many as representative of the South Australian education sector, as the following respondent from the Department describes:

**R:** I have had a fair bit of contact with kids' schools and the kids here, a lot of tend to say that they see the child's behaviour as deliberate and they need to take responsibility. So their philosophy kind of differs a bit from ours and different agencies. **Interview 73**

Indeed, this account was primarily, but not exclusively, given by teachers: 15 out of 18 teachers provided accounts that were clearly consistent with this theme. There was a minimising of the child's mental health and behavioural history implicit in this viewpoint. The child was thought to benefit most from the choices he/she made in the present moment. One teacher articulated the assumptions that are often implicit in this focus on the present day choices of the child:

**R:** It is a good culture [at this school], the kids actually feel it. One of the things we do for the GOM kids [children in out-of-home care] is that I don't really want to know much about their history at all, we make it really clear to them as well, I understand that some of them are still seeing psychologists outside the school, but I would like to remove that from school.

**I:** What is that about for you, what advantage is there in that to you?

**R:** Because I say to the kids it is basically a fresh start for them here. I don't want to know what has happened in the past. I let them know that I am really not interested in that, I am really interested in them and what they want to do, so just being really up front with the kids. **Interview**

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This minimising of the child's behavioural and mental health history appeared to be driven by philosophical ideals of inclusion and normalisation. There was desire to avoid labelling a child as 'in care' or in terms of their past poor behavioural choices. In this way, all children were viewed as having equal potential to achieve good educational outcomes. Respondents that endorsed this theme expressed the view that, irrespective of what has happened in the past, children have the power to make better choices into the future.

Responses in this theme are closely aligned with theories of discipline that emphasise choice and the development of personal responsibility (Lewis, 2007)

such as Glasser's Choice theory (Glasser, 1999). Choice theory is one of the constructivist theories (Fields, 2007) that are amongst those that have been adopted by the Australian education sector and that continue to feature strongly in their discipline policy documents and behaviour management programs (Charles, 2002; Fields, 2004; Fields, 2007). Choice theory is argued to be epistemologically opposed to "external control psychology" or traditional behaviour modification (Carter, 2006, p. 36; Glasser, 1999). Choice theory emphasises personal responsibility, fostering (student) self control over behaviour, and helping students make "appropriate decisions about their actions" (Charles, 2002; Fields, 2004, p.5). It maintains that all behaviours are consciously chosen in order to satisfy one of five biologically driven needs: survival, love and belonging, power, freedom and fun. Conscious choices are made in the present moment in order to satisfy these basic needs (Glasser, 1999). This theory actively discourages emphasis on past events. All behaviour is said to be made up of four components: acting, thinking, feeling and physiology. The individual is always thought to have conscious control over the acting and thinking components of behaviour (Glasser, 1999). Elements of choice theory may be gleaned from South Australia's Department of Education and Children's Services (DECS) policy documents relating to discipline. For example, "Individuals choose their own behaviour to meet their needs, although some circumstances may limit the ability to make the best choices" (DECS School Discipline Policy Statement, 2007, p. 2) or "Individuals must accept responsibility for their own behaviour according to their developmental ability" (p. 2). An account that values personal responsibility also magnifies the degree of conscious control over behaviour on the part of the child.

Behaviour is viewed as a poor choice and the child can be assisted to make better decisions about their behaviour in the future.

It may be argued that stakeholders whose accounts emphasise responsibility and choice may have a preference for cognitive or rational strategies when addressing behaviour. This is suggested by the following extract from a teacher when discussing her approach to managing behaviour:

**R:** So I talk to students about behaviour coming from a thought. So what we have to do is put a gate between the thought and behaviour, words that come out of your mouth and actions of your hands and body. Stop, think and choose. Stop, take a breath, think ask yourself the question if I do [something], will it lead to trouble? If the answer is yes, choose something else. They are the things I tend to talk about.

#### **Interview 40**

Others gave accounts of challenging behaviour in terms of deliberate, conscious strategies, initiated by children and amenable to rational strategies, as this extract from a teacher seems to indicate:

**R:** One example is a kid who is changing schools because she has a friend who goes to that school, so she says if I get kicked out of this school, that is where I want to go. That is a behaviour that she does. We say to her the more you do this [behaviour], the less option you have for actually changing schools. You don't just change schools automatically.

So with more than one person talking to her about it, and with support from the home, [that message] has actually got through [to her]. Some of the behaviours are deliberately put on. **Interview 81**

Rationale, deliberate choices about behaviour may be argued to elicit rational responses. Such rational or cognitive approaches to the behaviour of children may, arguably, risk minimising the salience of previous traumatic events and relationships in the child's history and acknowledging their possible effect on present day behaviour.

This may be argued to occur in several ways. First, choice theory strongly opposes the notion that past events determine current behaviour. As Glasser (1999) states:

...perhaps we were abused as a child-what actually happened cannot be changed. If it were our fault or someone else's fault, it doesn't make any difference because, what went on can't be changed or erased. Since all we have control over is our own behaviour, all we can do is try to change our present behaviour so that we can get along with people we now need (p. 6).

Second, conceptualising all behaviour as within conscious control negates the emerging body of literature on the sequelae of trauma on the child's developing brain. Neuropsychological investigations of trauma suggest that memory, emotion and behaviour can become fragmented as a result of trauma (Cook et al., 2005).

This literature suggest that the cognitive processing of traumatic events may not be readily accessible to logical or conscious thought, especially during times of high arousal (Perry, 2006) or when aspects of the traumatic event are being re-experienced. Finally, if behaviour is seen as intentional or conscious, there may be a presumption that children could make better (good) behavioural choices if they really wanted to.

This type of account also has implications for the child that are more positive. For example, beliefs about personal control and choice can convey to the child a sense of personal efficacy and an optimism about the ability of children to improve their behaviour, as ultimately behaviour is viewed as within their control.

The belief that behaviour is chosen by children was commonly expressed amongst the teachers in this sample. This does not necessarily imply that this view is representative of formal education policy in this State. For example, South Australia's Department of Education and Children's Services discipline policy document (DECS, 2007) also acknowledges, in relation to a student's choice of behaviour, that:

The choice may not always be a conscious choice. Students behave in ways which are meaningful and purposeful, based on their perceptions of the best ways to meet their particular needs in a situation or context....Some circumstances may limit a student's ability to exercise choice, but do not diminish the student's responsibility (p.5).

Nonetheless, assumptions made about personal control, choice and responsibility for behaviour do seem to dominate many of the accounts given by the teachers in this sample. High expectations conveyed by teachers to students can be important in promoting resilience and self efficacy amongst children (Gilligan, 1998). While this is no doubt true, an implicit assumption of personal control over behaviour in all situations may represent a limited understanding of the traumatic origins of some challenging behaviours. The importance that educational systems and relationships with teachers can play for children experiencing adversity, such as those who have been traumatised or who are in out-of-home care, has previously been highlighted (Gilligan, 1998). Failure of other stakeholders to understand and reconcile the approaches of teachers may limit the opportunity to engage with this important source of support for children.

#### *5.3.4 Behaviour as arising from constant change in the child's life:*

In this theme, challenging behaviours were seen to arise out of a lack of continuity in the child's life. The child was seen to develop an expectation of impermanence and future instability in their life and in any given situation. These accounts emphasised routine and predictability, accountability for behaviour and the sense of life being 'normal' as pivotal features of the 'continuity' that was lacking. This extract from a foster carer articulates the implicit assumption in this theme, that providing continuity in the child's life will lead to improved behaviour:

**R:** I don't think we can change these children's behaviours. I think we can improve the environment and give them the opportunity to change their own behaviour. I think they [the behaviours] will normalise if there is anything normal in their lives that continues for a period of longer than 3 months.

**I:** So for you it is about...?

**R:** That is my biggest issue -permanency. Placement of children that involves knowing what the next year, 3 years holds for them.

### **Interview 86**

As this extract also indicates, continuity and stability appears to be equated with normality in the child's life. For some, the assumption appeared to be that placement continuity would (inevitably) result in improved behaviour. For others, the assumption was that continuity in placement provided the necessary environment in which behaviour problems could be more easily addressed, as this extract from a Department worker conveys:

**R:** Yes, a home life for these children [is important], if they have stability there, it helps with developing healthier relationships and these children already come in damaged, that has been researched. So if you can secure a safe place where they feel needed, loved and wanted, any other issues they might have in themselves can be dealt with and they don't have to worry.

**I:** So other things will resolve themselves?

**R:** You are more able to be successful to deal with other issues.

### **Interview 59**

Continuity of placement was seen to benefit the child because it meant that the child was consistently surrounded by people who have a historical sense of the child's behaviour. People such as teachers and caregivers could, over time, provide consistency and predictability in behavioural approach and expectations, could hold children accountable for their behaviours and follow through with consequences. Through the continuity of placement and school environments children could come to realise that their behaviour could affect their life into the future, as this extract from a foster carer describes:

**R:** It may be that they [children in care] have tried and tried and it hasn't worked and they feel that they are always in a different place. They do need to have a certainty that they will be going to the same

school and therefore some of their behaviour will affect them. They have to behave in a certain way because they will be here next year.

**Interview 90**

Continuity of placement and schooling was also seen to bring with it the possibility of long term relationships in the child's life, as this teacher describes:

**R:** More resources and more staff are not necessarily going to benefit the student. I think it is the consistency; you need people who are going to be there for them, be there for a long time, not just a few months or weeks. **Interview 68**

In discussing continuity and consistency in the child's life, the presence (or absence) of placement 'stability' featured strongly amongst explanations for deteriorating behaviour, as the following extract from a Department worker demonstrates:

**R:** There have been a few times where the kids have been set up with the carer [when the children are] around that 2-3 year old mark and 10 months down the track they are moved on to another carer. Then we always get the problems in the next placement. That happens quite a bit. So driving that is probably a mixture of the child's behaviour as a result of what has happened to them and also a mixture of the carer too easily saying I have had enough - [but] I am not really considering the impact that that is going to have [on the child]. **Interview 65**

Constant change was manifest in the child's life in many ways; by the turnover of significant people in the child's life, by the requirement to accommodate the often unreliable or inconsistent access with their biological families, and by frequent changes in their living arrangements (placement turnover). Of all the potential sources of instability in the child's life, however, the change brought about by placement turnover was viewed as the primary cause of behaviour problems. This Department worker describes the effects of placement instability on behaviour:

**R:** If you don't provide a child with a stable placement with a routine and the same habits, we are fucking with their heads big time. If they go to that house, [they think] what is the point in behaving and settling down because they are going to kick me out, they are not going to want me and [then] I am going to the next house. So what am I doing? I will play up there because they are going to get rid of me anyway, so I might as well let them know how bad I am to start with. **Interview 62**

Other factors, such as change of schools, access and change of workers were seen, in turn, to be influential through their negative effect on the stability of the placement. Participants that gave this account of challenging behaviours as arising out of lack of stability and constant change in the young person's life were frequently wary of the impact of access with biological parents on the young person. Infrequent or inconsistent access was viewed by many as particularly problematic, as the following foster carers suggest:

**R:** I think one of the other frustrations of foster parents was how many times the kids would go backwards and forwards [from access] and the things that happened in between. You would make progress with the child yourself and then it would all disappear by the next time they come back. **Interview 36**

The need to accommodate access into children's lives was equated by many respondents with further entrenching inconsistency in children's lives.

**R:** I know that [what I am saying] is not going to be well liked by people but I also see kids really struggling with lots of access with the whole routine of it, the whole disruption, the complete lack sometimes of any concern to what this means to a child. Normally, as a mother, you help to give a baby routine. Access breaks that up with absolutely no consideration of whether that kid should be having a sleep at that time or feeding or whatever. That teaches a child at a very young age that anxiety and disruption are normal. Lack of continuity of care is normal. **Interview 90**

Systemic issues and difficulties were seen to contribute to this lack of continuity and to the perception of constant change in the child's life. For example, caseworker turnover was frequently seen to bring new ideas for the management of behaviour and new directions in case management. Numerous changes of schools, with the associated loss of peer relationships, were also seen as contributing to a deterioration in behaviour, leading to increasingly intolerable behaviour and resulting ultimately in behaviour that could not be sustained in the home environment.

Somewhat unusually, given that placement instability was seen to be the *cause* of deteriorating behaviour, changing placement was also frequently seen to be the *solution* to challenging behaviour. This Department worker describes these assumptions:

**R:** To me I think they should jump on something as soon as you get a sign, act more quickly. They [other caseworkers] wait until the placement breaks down, the kids has broken the windows and smashed the lounge suite up. Oh well, that lady doesn't want him because he is a bit of hard work and he is wrecking the furniture. So we will move him over there [to another placement] and see [what happens]. **Interview 62**

This appears to reflect a circular logic inherent in assumptions about the notion of placement 'quality' which has implications for the continuity of a child's placement. For many respondents, good behaviour by the child is taken to reflect placement stability and challenging behaviour is equated with poor quality placement. This type of logic risks confusing behavioural compliance on the part of the child with the therapeutic quality of the placement or carer-child relationship. The assumption that behaviour problems equate with placement quality is potentially problematic for the child for many reasons. First, it can be argued that this assumption risks the child being moved on in response to behavioural issues, rather than these issues being worked through with the caregiver and child. The presence of challenging behaviour, or foster carer requests for support with challenging behaviour, may be construed as lack of continuity or 'stability'. Second, placement stability is frequently seen as a prerequisite by mental health services for access to therapeutic services (Jackson, Frederico, Tanti & Black, 2009). This means that, arguably, those children that are most in need may be denied mental health services based on the instability of their placement.

This raises questions about how decisions about the quality and ‘stability’ of placements are made. There is no doubt that both placement instability and behavioural problems are markers for poor outcome across a number of life domains. There is also no doubt that challenging behaviour is amongst the most common reasons given by foster carers for discontinuing care (James, 2004; Leathers, 2006). Foster carers’ ratings of poor behaviour were better than caseworkers’ ratings at predicting long term outcome for children (Leathers, 2006). However, how decisions are made about what constitutes an ‘unstable’ or unsuccessful placement and who initiates placement change has not been well explored.

Some attempts have been made to establish the nature of the relationship between behaviour problems and change in children’s lives, which is undoubtedly complex. Challenging behaviours are indeed amongst the most commonly implicated reasons for placement breakdown (Oosterman et al., 2007). For example, Australian studies indicate that behaviour problems at time of entry into care, along with age and placement characteristics, predict outcome two years later (e.g., Barber & Delfabbro, 2004). However, a recent longitudinal study indicated that placement instability itself did have a negative effect on behavioural adjustment, after the effects of baseline behavioural disturbance were controlled for (Rubin et al., 2007). While behaviour problems may be related to placement stability, it does not necessarily follow that the solution to behavioural problems lies in moving the child in the search for a more stable placement, rather than supporting the current carer-child relationship. Therefore, much research remains to be done to elaborate the dynamics and assessment of placement instability, the

resultant changes in a child's life, and its relationship with challenging behaviour. One implication of the account of behaviour as arising from (predominantly) unstable placements may be the equating of challenging behaviour with a placement being deemed 'unsuccessful' and with the relocation of the child in an attempt to find more 'stability' in the child's life, thus potentially further entrenching the child's maladaptive behaviour.

Clearly, 'stability', 'continuity' or 'change' in the child's life may be shorthand for other factors such as reliable routines, constant peer relationships, accountability for behaviour, ability to form attachment bonds with carers and the ability to access the school community over an extended period of time. It is interesting to note, however, that this account of behaviour problems as arising from constant change was common amongst the Department workers and the foster carers that participated in this study. Further exploration is needed of what meaning 'stability' and change has for these two key stakeholder groups and how the notion is applied in practice.

### *5.3.5 Behaviour arising from strong emotions:*

In this account, some behaviours were seen to be determined by the strong emotions that arose in the child, in response to apparently unrelated triggers. These accounts of behaviour as arising from the child's strong emotions were typically seen as beyond the control of the child. This account highlighted the sharp distinction made by respondents between behaviours that were seen to be within the child's control and those that were not; whereas many behaviours were

controllable, behaviours driven by strong emotions were not. This extract from a foster carer draws a distinction between these types of behaviour:

**R:** Sometimes I think his anger gets the better of him and it is almost like he is glazed over and it has all happened before he can control that. So I think some of those things are out of his control. The language, calling me a ‘fucking fat bitch’ is definitely in his control, he doesn’t need to say that. He is angry, yes-but the verbal stuff, quite often he is calm when he says that stuff. I think some behaviours, some things we have to take responsibility for some things, other things are out of our control. **Interview 88**

These accounts of uncontrollable behaviours that occur in a state of heightened emotions appear to fit most closely with those that describe a re-experiencing of a traumatic memory; where behaviour can occur in a manner that is disconnected from the normally integrated emotional, sensory and cognitive information that constitutes a ‘memory’. It has been argued that for children exposed to complex trauma (where repeated and cumulative trauma arises in the context of early interpersonal relationships) there is a risk of a range of behavioural and emotional expressions of pathology (Cook et al., 2005). Such children may experience an impaired ability to self regulate, emotional lability, extremely rapidly escalating behavioural or emotional responses to minor stressors, avoidance of emotionally laden situations and dissociative responses when faced with emotionally laden situations (Cook et al., 2005). It has been theorised that maltreated children make several dissociative adaptations to trauma

including the possible detachment from conscious awareness of thoughts, emotions, behaviours and bodily sensations that would normally be integrated (Cook et al., 2005, Putnam, 1997). Of particular interest to this discussion is the isolation of the strong affect associated with trauma. Although initially adaptive, these strategies can further compound difficulties with behaviour management, affect regulation and self identity (Cook et al., 2005). This is because of the ‘disconnect’ between a child’s actions and their awareness that occurs while the child re-experiences overwhelming fear or arousal and engages in behavioural attempts to avoid or escape it. Thus, as Cook et al., (2005) suggest:

Overcontrolled or undercontrolled behaviour may be due to the re-enactment of specific aspects of traumatic experiences (e.g., aggression, self-injurious behaviours, sexualised behaviours, controlling relationship dynamics) (p. 394).

Children may have very little conscious awareness of their behaviour in these circumstances. As a result, they may have diminished ability to benefit from behavioural contingencies and learn from any consequences that may be linked to their behaviour. The following extract from a CAMHS therapist describes the difficulty in applying behavioural contingencies to some challenging behaviours:

**R:** The greatest problem is the violence as well, they smash the whole house up without any sense of they have done something wrong. These kids go into rages and when they come out of a rage quite often they can’t remember anything. That is another problem in itself, because

they have done something but don't remember what! It is very hard  
[for them] to reflect on ...well, I did this. **Interview 16**

Other recent literature has drawn links between emotional dysregulation, neurobiology, and disruptive disorders such as conduct disorder (e.g., Cappadocia et al., 2009). Emotional dysregulation theory suggests that difficulties in emotional regulation can initiate or maintain symptoms of psychopathology (see Cappadocia et al., 2009; Cole, Michel & Teti, 1994). Emotional dysregulation theory suggests that disorders of disruptive behaviour such as conduct disorder arise when abnormalities in the central neurobiological circuits result in deficits in the ability to voluntarily control negative emotions and process the environmental cues and feelings of fear that normally facilitate emotional restraint (Cappadocia et al., 2009; Davidson, Putnam & Larson, 2000; Frick et al., 2003). Lack of emotional regulation ability has been linked empirically to both proactive and reactive type aggression (see Cappadocia et al., 2009; Card & Little, 2006; Frick et al., 2003). Others have detailed neurological and neuroanatomical correlates of conduct disorder such as reduced P300 wave amplitude (see Cappadocia et al., 2009, for review), atypical functioning in the frontal and temporal regions (Cappadocia et al., 2009) and reduced right temporal lobe volume which may be related to a lack of empathy (Kruesi, Casanover, Manhem & John, 2004; Perry et al., 2001) although much of this research is based on adult samples.

As indicated earlier, there was an implicit assumption amongst respondents that behaviour arising in the context of strong emotions was not within the control of the young person. This belief may arguably lead stakeholders to believe that the

behaviour cannot easily be changed, as the following extract from a Department worker appears to illustrate:

**R:** I actually do not think of their behaviours as being in their control. I think they have trouble controlling their behaviours, so I am not likely to say that they are able to. You might get some caregivers, not just foster carers but workers [that] will say –oh-what she was doing was quite deliberate and she was in control, but I tend to disagree. But then it is a bit hard to say that, because it then infers that the young person can't get a grip on that behaviour, or can't change, or can't take responsibility. Overall I would tend towards saying they have problems controlling their behaviour, they have problems controlling their emotions and how they respond. They really can't help it.

**I:** If you have trouble controlling your emotions, then you have trouble controlling your behaviour? Because behaviour follows?

**R:** Yes. **Interview 72**

The previous extract describes the implications of a belief that the child is unable to control his or her behaviour; namely that holding this belief conveys a sense of pessimism to workers (and presumably the child) about the possibility of change.

One possible counter to this pessimism lies in reframing the nature of these apparently uncontrollable behavioural outbursts. Accounts of behaviour as arising from strong emotions such as anger and fear are clearly consistent with an explanation of the impact of trauma on a child's developing neurobiology. It is interesting to note that accounts of behaviour based in trauma did not, however, feature strongly or overtly amongst respondents as an explanation for behaviour. This suggests that while respondents may understand that children have been traumatised, this did not translate into well elaborated accounts of behaviour as 'arising from trauma'. Indeed, notions of anxiety and trauma were not generally well elaborated in stakeholders' accounts of behaviour. The following extract from a foster carer is a notable exception, as it one of very few that explicitly includes anxiety and hyperarousal as one of the causes of challenging behaviour:

**R:** Attachment is [the] number one [reason for behaviour problems], that whole self control...where do I fit?...where do I belong?.. It is all kind of linked, but having that unstable start and where do I fit in the world, how does this all work? They don't have a lot of that stuff. Then there are high anxiety levels and that comes out in behaviour, which will look different dependent on their personality. Attachment and anxiety I would say... [are the main reasons for behaviour problems]. **Interview 22**

It may be argued that a strengthening of stakeholders' understanding of the impact of anxiety and trauma on children's development may be beneficial. This is because highlighting the traumatic backgrounds of many children in out-of-

home care may enhance stakeholders' optimism that this behaviour can, in fact, be addressed. Awareness of the impact of trauma is a necessary precursor to stakeholders even seeking help to address behavioural concerns through trauma-based counselling. Empirical studies suggest the usefulness of such approaches for maltreated children (e.g., Cohen, Deblinger, Mannarino & Steer 2004).

### *5.3.6 Behaviour reflects attachment:*

This account of challenging behaviour described such behaviours as arising out of an attachment disturbance or difficulty. This was the most common account of behaviour that was provided by respondents. It is important to note, however, that the extracts within this theme were also the most variable. Although ostensibly about attachment, many of these extracts reflected representations of attachment that deviated from accepted attachment theory and therapy. This appeared to be despite the fact that participants clearly intended their accounts to represent explanations derived from attachment theory.

Accordingly, all the extracts that gave accounts of behaviour in terms of attachment theory were further divided into two groups. Only those extracts that were considered to be aligned with well accepted constructs from attachment theory and literature were retained to form this theme; 'behaviour as attachment'. The remaining accounts, while ostensibly about attachment and behaviour, were considered misrepresentative of attachment in some way and therefore isolated for further analysis. The analysis of these 'misrepresentative' accounts is presented in the following chapter.

It is worth noting at this point that a recent review into the application of attachment theory (Chaffin et al., 2006) emphasized the lack of clarity around the concept of attachment disorder. As they state “The terms *attachment disorder*, *attachment problems* and *attachment therapy*, although increasingly used, have no clear, specific, or consensus definitions.” (Chaffin et al., 2006, p. 77). For the purposes of this analysis, extracts that talk about aspects of attachment difficulties that are widely accepted in the literature and based soundly in attachment theory (Chaffin et al., 2006) have been included in this theme. Extracts that did not appear to address these core elements form the subject of the following chapter which will elaborate on attachment theory and its elements in more detail.

Accordingly, extracts were coded as relating to an attachment account if they referred to an enduring bond, to caregiver empathy and affective attunement in order to facilitate emotional regulation, to attachment/exploration balance, to internal working models of relationships, or to difficult relationships and coping styles thought to reflect these internal working models such as rejecting, avoidant, ambivalent or controlling patterns of coping with attachment needs. For example, accounts of behaviour patterns as attempts to control interpersonal relationships or as coping patterns in relationship arising from fear of intimacy or autonomy were included. Similarly, accounts of attachment in terms of an enduring bond which was characterised by the use (or misuse) of an attachment figure as a source of comfort, consistency and emotional regulation were coded under this theme (see Cassidy & Shaver, 2008).

This extract from a Department worker describes the potentially devastating effects on relationships and placement stability that can be attributed to attachment difficulties:

**R:** In my opinion most of the kids here, or all of them, would struggle with behaviours that come out of having disrupted attachment experiences. They act to sort of reject their carers; they act like they don't like their carers. They struggle to form intimate relationships with their carers. So some of that rejecting can be in the form of assaulting carers, being very abusive, verbally abusive. Putting the carers through so much stress that it jeopardizes their placements. In general they are terrified of being rejected, deep down they are terrified of their carer getting rid of them and it is all just too hard for them. They don't want to feel that rejection, they want to be in control so if the placement breaks down they want to be able to look at that and say I did that, not [that] the carer didn't want me.

**I:** Anything but that?

**R:** Yes. **Interview 73**

Several stakeholders spoke about the importance of providing an emotional literacy or language for the children in order to support emotional development. Much challenging behaviour was seen to arise out of the inability for children to recognise what they are feeling, especially feelings other than anger or fear.

Labelling and normalising children's emotional experiences, and supporting children to regulate them, were considered essential to managing children's behaviour. This is consistent with the notion that difficulties arise out of a lack of early affective attunement. The following extract from a foster carer provides an example of this emotional labelling and attunement in her description of how she managed oppositional behaviour:

**R:** He will say I don't want to go, and I say come on, it will be fun- and we get there and he loves it. Doing stuff like...I will say to him- well I really don't want to go either-when he says he doesn't want to go. But it will be fun when we get there; I am tired too. Just acknowledging that what he is feeling is normal. **Interview 87**

The importance of providing an environment in which strong emotions are able to be contained without threatening the caregiving relationship was also expressed by many. This extract from a CAMHS worker describes the importance of providing an opportunity for the safe expression of emotions:

**R:** Like with anger management, you have to contain it, you have to be able to stand alongside it without getting upset or distressed yourself, to give that person a sense of -hey -this person can manage it. Whereas they [the children] were coming from environments where they [parents] couldn't [manage it]. **Interview 58**

Several participants spoke about the importance of having an enduring attachment relationship that can ‘weather the storm’ of behavioural outbursts. In other words, having an attachment figure who could be relied on for comfort and security irrespective of how badly behaved the young person was towards them, as the following extract from a Department worker articulates:

**R:** I have had a couple of boys and a girl over the years that have had those kinds of [challenging] behaviours. One boy in particular went to a placement of a really old lady who lived in a very small country town and somehow or other, his behaviours didn’t change - in fact they probably got worse - but she stuck by him and she would advocate on his behalf to [the Department]. They were kind of like a team I suppose, even though she at times did get really, really upset with his behaviour - even to the point where she was thinking about not being able to have him anymore. But when push came to shove, she always held him there and I think that was really, really helpful for that boy. Even when [the Department] weren’t happy with this particular carer, so they arranged for him to go to into residential care...but she still kept in contact with that boy and he eventually has done really well, has made some really good choices. He has gone on to [trade school] and those kinds of things. She has always kept in contact with him. I think that made a big difference to him. **Interview 84**

The critical importance of having at least one significant relationship in the child’s life that endured despite ongoing behavioural issues was repeatedly

emphasised. This important and sometimes difficult role was most often filled by the child's foster carer, as this Department worker acknowledges, when talking about the role of the foster carer:

**R:** I don't think their role is valued or respected and a lot of them do embrace these children as their own, even though they are told not to. The number of carers who stick by those kids when they themselves are abused. Some of those kids treat their carers dreadfully. That needs to be more acknowledged. **Interview 47**

These accounts highlighted the importance of having a caregiver who was able to repeatedly reconnect with the young person following conflict. These adults took the stance that, no matter what the young person did, they would always be there for them. This parallels what attachment theory refers to as the 'rupture and repair' in difficult attachment relationships (Marvin, Cooper, Hoffman & Powell, 2002). The following extracts from foster carers illustrate the nature of this 'rupture and repair' in attachment relationships:

**R:** It is almost as if she burns her bridges because she believes that this year will be the last [year in foster care] and she will go home to mum and it will all be wonderful - rose coloured glasses stuff.

**I:** So the [challenging] behaviour is related to getting home?

**R:** I think so. The burning bridges-if I make a bad enough enemy they won't want me here anyway-so I will move out and it will all be wonderful.

**I:** But you refuse to have your bridges burnt?

**R:** Yes. I keep throwing the kindling over the edge - and rebuilding.

### **Interview 12**

Another foster carer captures 'rupture and repair' in a different way in this extract in which she describes the way that everyday conflicts could provide the opportunities to strengthen the carer-child relationship:

**R:** After I have told them off I say give [foster carer name] a hug. That hug meant more to those kids than giving them \$5.00 - and to know it was okay to get stressed, but let's sort it out in a proper way. I used to say to my kids, I get angry, kids get angry, so you can get angry, but let's manage it.

**I:** And seal it with a hug at the end?

**R:** Yes. **Interview 11**

Other participants described behaviour in terms of the child's apparent disregard for relationships that was frequently expressed in rejection or

controlling interactions with significant adults. This foster carer describes the extremely violent behaviour of the child in her care in terms of his need to have control in his relationships:

**R:** It has really blown my mind, because at school they have this cement cell thing they put him [the child] in- they call it the 'chill room', because he is too dangerous to be in the school until I get there. But that really works! Whenever he has been like that, or in one of the cells at the police station, or in handcuffs, then he is able to stop. When he realizes there is nothing he can do, that he is totally not in control, that other people have got that control, he is able to calm down and calm down quickly. But when he is free to move about, he will try and keep controlling the situation. If he is in this room he will pick up whatever is around and throw it, or bash the walls, do whatever to keep people in his control. That is another indicator too- when he is not in control of a situation he goes off. **Interview 82**

Another feature of descriptions in this theme was the perception of the child's behaviour as rejecting the caregiver and their efforts to help the child. Children were seen to place little value on the relationship with the caregiver and behave poorly as a result. Caregivers perceived that they were required to expend enormous effort in maintaining relationship with children. This effort was perceived to be met with little result in terms of behaviour change, as this CAMHS worker describes:

**R:** With a normal child, if you raise your voice, the child knows the relationship has been cracked a little and behaves. It is not like that with foster kids.

**I:** There is no drive to reconnect?

**R:** No because the primary relationships haven't been formed earlier in their lives. So you really have an uphill battle to affect change.

### **Interview 58**

The frustrating nature of a relationship characterised by rejection and apparent disregard for carers, teachers or others was acknowledged by many. The challenging behaviour exhibited by the child was seen to undermine the enormous energy and effort expended by adults in their life, or as one foster carer summarised:

**R:** You give them the best building blocks but they still knock them down. **Interview 86**

Taken as a whole, the accounts in this theme conceptualise controlling and rejecting behaviour as the child's attempt to protect themselves from harm and defend themselves against overwhelming attachment needs. Following on from this, behaviour change was seen to occur only once an enduring (and ideally, secure) attachment relationship was able to be established. This foster carer

captures this emphasis on the child feeling secure, rather than needing the child to conform to behavioural expectations, in the following extract:

**R:** Really in terms of, all I mean is that if you make that child feel secure, secure enough to feel that they don't need the antisocial behaviour to make themselves feel protected or to keep the world at bay, then you have a chance of fixing the cognitive aspects of it, rather than just a band aid approach to it. A lot of carers have been brought up in the old school, which was do what I say and be obedient. We open up a can or worms when we say –okay- we want to hear why you are behaving that way. **Interview 86**

The extracts provided above capture a variety of elements that are consistent with explanations in terms of attachment theory; disrupted or disordered attachment and its impact on the nature and form of relationships and emotional lability. There appeared to be several implicit assumptions inherent in this account of behaviour. One implicit assumption may be argued to be the notion that the child is the source of behaviour difficulties. The child's need to defend themselves against close relationships or control relationships, for example, is seen to result from the child's deficit in emotional regulation and the child's internal working models of relationship. Thus, responsibility for the problematic behaviour is largely placed with the child. However, emphasis was placed on the caregiver to provide the emotional and relational environment in which the child could relinquish the need for these behaviours. Therefore, the responsibility for intervention, at least according to these accounts, lay primarily with the foster (or

residential) carer. It is interesting to note that none of the extracts in this theme expressed the need for the child to receive individual therapy.

#### **5.4 Discussion**

This analysis indicated that South Australian stakeholders appear to conceptualise challenging behaviour in several different ways. The stakeholder that seeks to work collaboratively, therefore, appears to be faced with diverse opinions about the origins and nature of challenging behaviours. Based on this analysis at least, it appears likely that a stakeholder may encounter beliefs about behaviour that are diametrically opposed to their own in terms of assumptions about control, causality and optimism for change. Under conditions in which implicit assumptions conflict, stakeholders may favour explanations that feel more familiar to them. As collaborative problem solving about behaviour may be said to require a shared understanding of behaviour, the importance of making explicit the assumptions underlying these various approaches is highlighted.

It was suggested from previous research that stakeholders groups may form differing views about behaviour, based on professional identity, organisational or stakeholder group membership. This analysis did not clearly demarcate accounts of behaviour in terms of either stakeholder group membership or professional identity. The exception to this was the accounts about behaviour as the responsibility or 'choice' of the child which occurred predominantly amongst education staff. Thus, it may be suggested that in collaborative case management with education staff, participants may encounter beliefs about a child's behaviour

as within the child's control, whether or not these beliefs are explicitly expressed in relation to the child. When the total set of interviews was analysed, the account of behaviour as arising from attachment difficulties was the most prevalent one. Accounts of attachment were also the most varied, however, suggesting that the term 'attachment' has many meanings to stakeholders. This suggests that in case discussion or collaborative work, stakeholders may well attribute differing implicit meanings to even common or well accepted terminology (Salmon & Rapport, 2004).

The descriptions of challenging behaviour presented in this analysis may also be considered in light of attribution theory (Weiner, 1980, 1986). The varying descriptions of behaviour outlined in this chapter incorporate several implicit judgements about behaviour that can be argued to distinguish between the various accounts of behaviour. These judgements include whether challenging behaviour arises due to internal factors or external causes, about the child's control over their behaviour, about where the responsibility for behaviour change lies, and about how amenable the behaviour is to improvement (optimism for change).

For example, some of the dominant themes about behaviour that were identified in this analysis appear to place emphasis on an 'internal' locus for the child's challenging behaviour. The extracts of respondents that viewed behaviour as the result of a conscious choice ('behaviour as conscious choice'), those that viewed behaviour as the result of overwhelming emotion ('behaviour as strong emotion'), those that viewed behaviour meaningful to the child ('behaviour as purposeful') and those that viewed behaviour as arising primarily out of early

attachment experiences ('behaviour as attachment') suggest that the core of what needs to change is 'located' within the child. Alternative accounts of behaviour that place the locus for the challenging behaviour as originating 'outside' of the child include those that account for behaviour as being taught to the child ('behaviour as learnt') and behaviour problems arising from instability in the child's life ('behaviour as constant change').

Some accounts of behaviour attribute the child with a high level of personal control over their behaviour. These include accounts of behaviour as choice ('behaviour as choice'), and some accounts in which behaviour is described as purposeful or meaningful ('behaviour as purposeful'). Those accounts that do not consider behaviour as capable of being controlled by the child include behaviour problems arising out of constant change ('behaviour as constant change'), behaviour arising from overwhelming emotions ('behaviour as poor emotional control') and behaviour as arising from early attachment experiences ('behaviour as attachment disorder').

At their most extreme, frameworks that judge behaviour as both 'caused by' or 'located within' the child and, at the same time, able to be controlled by the child, may result in a danger of blaming the child for their current behaviour. Extracts in the theme 'behaviour as a choice' may be considered to be examples in which, potentially, judgements made about children may result in stakeholders blaming children for their behaviour. In contrast, some accounts attributed the child's behaviour to largely external causes, over which the child is considered to have less personal control. Extracts in the themes 'behaviour as learnt' and

behaviour arising from 'constant change' may be considered examples of those. At their most extreme, frameworks that judge behaviour as caused by outside influences may run the risk of a relative overemphasis on environment (e.g., placement change or reinforcement contingencies) in 'fixing' the child.

The inferences about causation and control that are contained within the identified themes may hold particular importance when considering the interventions that might compliment them. For example, participants that place emphasis on external environmental factors in the genesis of behaviour problems may favour a focus on stability and consistent and predictable reinforcement contingencies as the solution for behaviour problems. In these instances, the involvement of caregivers or teachers in interventions in the manipulation of environmental contingencies may be welcomed, or even seen as essential. Stakeholders that place emphasis on internal causation and personal control over behaviour may favour rational or cognitive strategies that focus on the individual rather than (or in addition to) interventions that enlist the manipulation of behavioural or environmental contingencies.

Another assumption embedded in respondents' descriptions of behaviour relates to beliefs about who is responsible for changing these unacceptable behaviours. In most instances the responsibility for changing behaviour is placed with the child, although this may be facilitated or instigated by significant adults in the child's life. A notable exception to this appears to be stakeholders that viewed behaviour as arising out of an 'attachment disorder'. In this instance stakeholders appeared to view the 'disorder' as an 'internal' attribute of the child,

but viewed placement with an emotionally attuned and responsive caregiver as the way to resolve this problem.

This analysis may constitute a relatively simplistic summary of the main understandings of the participants in this study. Social work practice in this area, for example, may be informed by a wide variety of approaches (Gilligan, 2000). Nonetheless, an analysis of the implicit assumptions inherent in these accounts offers a simple framework through which an understanding of the experiences of 'others' can be facilitated. For this reason, it also provides one possible way in which the various accounts can be reconciled. The need to integrate conceptual frameworks has been identified by others in the case of social work intervention in the out-of-home care sector (Gilligan, 2000).

It is, perhaps, surprising that stakeholders' accounts of the origin and treatment of challenging behaviour amongst maltreated children did not feature descriptions of trauma or anxiety related problems more prominently. The account that most closely corresponded to a description of trauma or 'pain based behaviour' (Anglin, 2002) was one of behaviour arising from overwhelming emotions, in which children were typically characterised as having little control over their explosive behaviour. One possible consequence of viewing this behaviour as uncontrollable may be a pessimistic outlook regarding the possibility of change amongst children who experience such violent or explosive outbursts. Belief that behaviour is both caused by internal factors and uncontrollable may cause stakeholders to 'give up' on even attempting to address behaviour concerns (Chronis et al., 2004) with poor outcomes for the child as a result.

Reconceptualising this type of behaviour as trauma-driven behaviour may support all stakeholders to develop a more optimistic view of the possibility of resolving behavioural issues and therefore be more willing to persist in supporting the young person as a result.

It is difficult to explain the apparent lack of emphasis on trauma in the genesis of behaviour difficulties amongst this population. There may be several possible reasons for this. It is possible that stakeholders are simply not aware, or minimise, the impact of trauma on the children in this population, and therefore on any possible link between traumatic experiences and behaviour in either its origin or treatment. It may also be possible that stakeholders are aware of the impact of trauma on children but assume that others would understand it 'as a given'; therefore they do not feel the need to explain it more fully. Alternatively, it may be that stakeholders have different understanding of trauma and therefore explain trauma in different ways. Cameron, Elkins and Guterman (2006), for example, have suggested that both workers and laypeople may ascribe the words 'trauma' and 'traumatised' with a variety of meanings: as a non pathological reaction to extreme stress, as an overwhelming experience, or as a psychological outcome of an identifiable event. Adding to this are further definitional distinctions in relation to trauma; for example between type I (single incident) and type II traumas (numerous frightening events over time) (Terr, 1991); or similar distinctions between simple and complex trauma (Cook et al., 2005; Van der Kolk, 2005). Further exploration of the limited nature of stakeholders discourse about trauma is warranted in the future.

This analysis does not intend to establish which, if any, of the accounts given here are the more appropriate conceptualisations of behaviour and behaviour change. Indeed, most accounts are linked to a body of literature in support of the paradigms they most closely resemble. More importantly, each account makes implicit assumptions about the causality (internal/external) and the controllability of a child's behaviour which may have important implications for practice: specifically for willingness to persist, optimism for change, and blame (Brian & Standon, 2002; Chronis et al., 2004; Jones & Hastings, 2003). These factors are potentially highly relevant to stakeholders attempting to support children with challenging behaviour in alternative care. Therefore, collaborative casework or partnerships may benefit from attempting to identify the assumptions implicit in 'other' participants' beliefs about the behaviour in question.

Identifying possible 'common ground' for these diverse accounts provides stakeholders with a 'way forward' in terms of a common conception of behaviour. One source of common ground has been identified above; namely the attributions implicit in differing stakeholders' accounts and the implicit assumptions made about what best facilitates change. For example, accounts of behaviour arising from constant change, social learning accounts and attachment accounts, although apparently disparate, all implicate predictability, routine and the provision of empathic yet firm and consistent caregiving as a means of improving behaviour.

In addition, the literature suggests that these diverse accounts of behaviour may be reconciled to some extent. Meta-analytic reviews of early childhood attachment interventions have identified the common elements of successful

interventions with children. Those interventions that were short term and goal focused, included a behavioural approach targeted at parental sensitivity and engaged both parents, were reported to be most successful (see Bakermans-Kranberg et al., 2003). As Chaffin et al., (2006) point out, therefore, "...many characteristics of effective attachment interventions are the same characteristics found among many effective child interventions in general (e.g., including parent skills training, goal-directed behaviour focus, etc)" (p.78). In other words, effective interventions, nominally based in both attachment theory and behaviour therapy, may be mediated by common factors. For example, one home-based behavioural intervention program, based on Multidimensional Treatment Foster Care demonstrated concurrent improvements in attachment security amongst the preschoolers involved (Fisher, Burraston & Pears, 2005). In practice, therefore, empirically supported attachment therapies and traditional behaviourist approaches may not differ as markedly in outcome or execution as might be assumed.

Attempts have indeed been made to reconcile behavioural and attachment constructs and approaches (e.g., Scott, 2003; Spetz, 1990; Sutton, 2001) or behavioural and child parent relational therapies (e.g., Clavell, 2000) in the case of aggressive and oppositional children. For example, Spetz (1990) has attempted to reframe the child's need to control the proximity of the caregiver (an attachment idea) using operant principles of reward and reinforcement. Others have suggested the two paradigms can be reconciled by redefining attachment constructs in terms of 'attachment behaviours', which allows for this concept to be translated into observable, operationalised indicators of secure behaviour

(Sutton, 2001), positive relationships (Sutton, 2001) and responsive parenting (e.g., DeKlyen & Spetz, 2001). It has been suggested that attachment and behavioural ideas can compliment each other, provided that the use of cognitive behavioural strategies, for example, does not precede the establishment of secure attachment (Hughes, 2003). Another possible way in which behavioural and attachment notions might be reconciled is through reframing attachment difficulties, particularly disorganised attachment, in terms of the classical conditioning of fear, in which the attachment behaviour becomes paired with a frightening stimulus (the caregiver). The implications of this reframing would be an emphasis on the need to extinguish this pairing over time, through association with pleasant (non-aversive) stimulus. Finally, there is clearly scope to draw out and reconcile ‘core assumptions’ (a cognitive behavioural notion) and the ‘internal working models’ of children, therefore possibly making at least some of these schema amenable to cognitive-behavioural interventions.

### **5.5 Summary**

This chapter has detailed the accounts given by stakeholders for challenging behaviour. These accounts were varied and were not, in the main, aligned with any one stakeholder group. The exception to this was the accounts of education staff which were predominantly, but not exclusively, aligned with a position of high personal responsibility and control over behaviour. Other accounts, although disparate, allow for some common ground through their common implicit assumptions about change. The dominance of attachment accounts in this group of South Australian stakeholders confirms the suggestion of others (Bath et al., 2005;

Newman & Mares, 2007) that such accounts may prevail amongst the out-of-home care sector. The wide variety of ways in which attachment and its relationship with challenging behaviour was described is concerning. It probably reflects, however, the lack of consensus even within the attachment literature as to what the essential features of attachment and attachment disorder actually are (Chaffin et al., 2006). Given that attachment accounts of behaviour were indeed prevalent, further analysis of these accounts was deemed warranted. Accordingly, these accounts will be examined in more detail in the next chapter.

## CHAPTER SIX

### How 'attachment' is understood by South Australian stakeholders

#### *6.1 Overview*

The previous chapter indicated that accounts given for behaviour predominantly featured an attachment explanation. While talk about attachment was common, occurring in most stakeholder accounts of the needs and behaviours of children in alternative care, these accounts were also the most variable. Accordingly, this chapter will further explore participants' talk about attachment in which attachment appears to be understood in ways that appear inconsistent with attachment theory. These accounts of attachment are first considered in relation to attachment theory to speculate about the possible origins of participants' interpretation of the term 'attachment'. Additionally, each theme is discussed in terms of what this might mean for children whose attachment needs are conceptualised in these ways.

Although a comprehensive exploration of attachment theory is beyond the scope of this thesis, an overview of the key concepts of attachment theory is warranted in order to understand the theoretical landscape from which stakeholder ideas about attachment and its implications for challenging behaviour could potentially be derived. An overview and clarification of some basic concepts

provides a reference against which stakeholders' accounts can be considered. Critically, attachment theory has developed many variants since its initial formulation by Bowlby (Bowlby, 1969-1980; Crittenden, 2006), and it is these variations and the accompanying literature which influence current policy, clinical practice, and popular accounts of attachment. For more detailed accounts of the history and contemporary state of attachment theory, the reader is particularly referred to:

- **Karen (1994)** for a historical overview of the origins of attachment theory.
- **Cassidy & Shaver (2008)** for a comprehensive overview of the current state of attachment theory.
- **Kerns & Richardson (2005)** for a review of attachment literature related to middle childhood.
- **Zilberstein (2006)** for a discussion of the construct and predictive validity of Reactive Attachment Disorder (Diagnostic and Statistical Manual of Mental Disorders: DSM-IV; American Psychiatric Association (APA), 1994) in particular.

## ***6.2 Brief overview of attachment theory***

Bowlby stated that, as part of evolution, human beings have developed a predisposition to initiate and form attachments (Bowlby, 1969-1980). While this universal, life long drive to form attachments is initially focused by children on

their primary caregivers, it can later be directed toward a range of individuals throughout a person's lifespan.

Attachment is defined as a strong disposition to seek proximity to and contact with a preferred caregiver (in western societies this is typically the mother) (Bowlby, 1969). Bowlby's concept of attachment offered an alternative to behavioural notions of preference for the mother arising out of secondary reinforcement (feeding of the infant) that were prevalent at the time (Rutter, 2008). Bowlby elaborated on the concept of attachment by also introducing the notion of the responsiveness and emotional availability of the caregiver. By doing so, he began to account for individual differences in the quality of parent-child interaction. Ainsworth further highlighted the cognitive aspect of the infant's world by introducing the notion of appraisals and expectations of caretaker availability to account for individual differences in infants' responses to a standard operationalised stressful situation (the 'Strange Situation': Ainsworth, Blehar, Waters & Wall, 1978).

In the literature the term 'attachment' appears to have been used to refer to the attachment (bond), to refer to attachment behaviour, and to refer to the organisation of the attachment behavioural system. The following section will attempt to draw a relatively simplistic distinction between these terms as they were originally intended to be used. It will also examine their clinical utility, particularly in relation to accounting for the challenging behaviours amongst children in out-of-home care.

### **6.3 Attachment; behaviour and the attachment behavioural system**

The first clarification that is warranted is the distinction made by Bowlby between *attachment* and *attachment behaviour* (Bowlby 1969). Attachment is seen as an innate drive, the desired goal of which is the formation of an attachment bond. Attachment behaviour refers to behaviour that is engaged in to get or maintain proximity to a preferred individual. Attachment behaviour is thought to be activated by certain stressful conditions such as hunger, fatigue, distress, fear or the unavailability or unresponsiveness of the preferred attachment figure (Bowlby, 1980) and deactivated when the goal of proximity to the preferred caregiver is attained. Attachment theory maintains that attachment behaviour is primarily determined by caregiver responses in early life, although it acknowledges that a range of other factors are also influential (Bowlby, 1969-1980; Cassidy, 2008).

According to Bowlby (1969/1982), these attachment behaviours are thought to be organised into an *attachment behavioural system* (or attachment system). The organisation of a child's repertoire of attachment behaviours is thought to occur within any one child in response to their particular developmental history and their unique set of experiences with their caregiver (Cassidy, 2008). The organisation of the attachment behavioural system also involves the incorporation of cognitive elements- 'representational models' or 'internal working models', and these are based on the child's actual experiences and allow the child to anticipate, predict and make decisions about the necessity and salience of attachment behaviour in various situations (Bowlby, 1969/1982; Cassidy, 2008).

The way that this attachment system is conceptualised has changed over time. In original descriptions Bowlby conceived of the attachment system as being similar to a thermostat, which regulated the child's proximity to the primary caregiver. In original formulations, then, the attachment system was considered either activated or not (i.e., all or nothing) and the goal was to achieve proximity to the attachment object. However, in later writings, he described a system that acts more like a physiological homeostatic system; one which is never deactivated, and where the goal is the attainment of a desired state, rather than an object *per se* (Bowlby, 1969/1982). This ultimately gave rise to the notion of 'felt security' as the desired state or goal of the child (Sroufe & Waters, 1977), rather than physical proximity to the caregiver *per se*.

Therefore, an attachment (behavioural) system is suggested to exist which incorporates the organisation of attachment behaviours and cognitive representations regarding attachment and attachment behaviour. This attachment system is conceived of as more or less activated at any one time.

Further, the degree to which the attachment behavioural system is activated is influenced by other systems that are suggested to exist. Specifically, activation of the attachment behavioural system can be understood as relative to two other important biologically-based behavioural systems in particular: the *exploratory* behavioural system and the *fear* behavioural system; both of which provide advantages to the infant in terms of survival. These are just two of several well organised behavioural systems that are suggested to exist in even the very young

child. Other behavioural systems include the sociable system and the caregiving system, although these generally feature less prominently in attachment formulations (Cassidy, 2008). The relationship between the exploratory system and the attachment system is “particularly intricate” being both “complementary and mutually inhibiting” (Cassidy, 2008, p. 8). To elaborate further, activation of the attachment behaviour system is thought to suppress activation of the infant exploratory behaviour system. Conversely, infant exploration is thought to be greater in situations in which the child has proximity to an attachment figure (and therefore the attachment system is not activated). In contrast, activation of the fear system is thought to heighten activation of the attachment behaviour system. Accordingly, the availability of an attachment figure makes the infant less vulnerable to fear.

This interplay of the attachment, exploratory and fear behavioural systems, or ‘attachment-exploration balance’ is a central notion in attachment theory (Cassidy, 2008) in which the infant uses the attachment figure as a ‘secure base’ or ‘safe haven’ from which to explore the world (Ainsworth et al., 1978). The inhibitory role of anxiety on play and its heightening of attachment behaviour has been broadly supported by subsequent empirical data (see Rutter, 2008). This notion of an attachment-exploration balance remains prominent in attachment theory and forms the basis of attachment interventions for infants and preschool children (e.g., Circle of Security Project: Cooper et al., 2005; Marvin et al., 2002) although the significance, and the presentation, of ‘attachment-exploration’ balance in older children remains largely unexplored.

#### **6.4 Attachment and behaviour**

The distinction between attachment behaviour, the attachment behaviour system and an attachment bond is a conceptually and theoretically important distinction. Clear articulation of the difference between these theoretical constructs becomes important when ascribing any behaviour that is exhibited to ‘attachment’ or probable ‘attachment disorder’.

Cassidy (2008) describes the distinction between “attachment behaviour” and an “attachment behavioural system” (p. 5) which is relevant to considerations of the link between attachment disorders and challenging behaviours. Attachment behaviour refers to behaviour that reflects the seeking of proximity to a preferred attachment figure. The exact nature or form of the behaviour will vary according to the child’s age and other contextual factors. The most well known descriptions of attachment behaviour can be found in accounts of the ‘Strange Situation’ assessment protocol (Ainsworth et al., 1978). An ‘attachment behavioural system’ refers to the schematic organisation of this attachment behaviour and its cognitive and affective representative schema, which guides the expectations about availability of the caregiver and ultimately other relationships. This organisation develops in the child based on their actual experiences of caregiving, but informs their future expectancies regarding the possibility for the attainment of attachment needs. Little is known about the organisation of such attachment representations and behaviours beyond toddlerhood and how this organisation interplays with other behavioural systems.

Cassidy (2008) draws a further important distinction that is germane to the discussion of children in out-of-home care; namely the distinction between attachment bonds and affectional bonds. An attachment bond is one type of the larger class of bonds that Bowlby and Ainsworth referred to as “affectional bonds” (Cassidy, 2008, p.12). Importantly, a child may have an affectional bond with someone that does not constitute an attachment bond. According to Ainsworth (1989), an attachment bond does not reflect a dyadic or relational construct. Rather, it is described as a characteristic, reflecting internal representations within the individual. An attachment bond shares many of the characteristics of an affectional bond. That is, both attachment and affectional bonds are persistent, emotionally significant and are directed towards a specific person with whom one desires proximity and from whom involuntary separation causes distress. The two types of bonds can be distinguished by one factor. That is, for an attachment bond to exist, the child/individual must seek out security and comfort in a relationship with that person - it is the *seeking of security* that is the defining feature of the bond, irrespective of whether or not that security is ultimately attained (Cassidy, 2008). Thus, a child may form close enduring relationships with many people, but an attachment bond may not be assumed to exist unless that child seeks to experience that person as a source of felt security in times of distress. Similarly, a parent (or carer) may have an affectional or parental bond with a child, but a child will have an attachment bond with a parent (that is, ideally, the child will seek security and comfort from the parent and not *vice versa*).

Therefore, the attachment (behavioural) system, attachment behaviour and attachment bonds are separate constructs, despite the fact that they appear to be used interchangeably in much attachment literature. The presence of one cannot necessarily be taken to infer the presence of another, for several reasons. First, attachment behaviour and attachment bonds may be distinguished; the existence of an attachment bond cannot be inferred by the presence of an attachment behaviour (Cassidy, 2008). One example is the case where an infant will accept comfort or food from a complete stranger, yet an attachment bond cannot be inferred (Cassidy, 2008). Similarly, when a child is not directing attachment behaviour to a parent, the child is still assumed to have an attachment bond to that parent. Therefore, attachment behaviour is best conceptualised as context dependent and the ‘strength’ of its expression should not be equated with ‘strength’ in the attachment bond. Unfortunately, the ‘strength’ of attachment behaviour does appear to be sometimes (erroneously) assumed to reflect the strength of the attachment bond. As Cassidy (2008) notes, it is a mistake to assume that the fearful clinging behaviour on the part of a small child means that the child is “very attached” to the mother (p.13). The clinging behaviour could reflect insecure attachment or secure use of the mother as a ‘safe haven’, depending on the context. Second, behaviour may or may not reflect attachment needs. Any one behaviour could in fact serve more than one organised behavioural system at any time, even if directed towards the same individual (Bretherton & Ainsworth, 1974). For example, any given behaviour could reflect the attachment, the exploration, or the sociable (behavioural) systems (Cassidy, 2008). One example of this may be a small child smiling and holding their arms up to a stranger. Therefore any behaviour, even those that ostensibly look like

attachment behaviour, may in fact be serving another function for the child. Thus, making inferences about behaviour as reflecting attachment, without consideration of its context and function, becomes problematic.

Therefore, attachment behaviour is variable and may be situationally or contextually determined and an attachment bond is enduring and consistent: one may not be taken to reliably reflect the other (Cassidy, 2008). Further, attachment behaviours look different for each child, depending upon their age, physical and cognitive development and "...no evidence exists that these variations in themselves map onto variations in child-mother attachment in any meaningful way" (Cassidy, 2008, p.13). Thus, drawing inferences about the nature of an attachment bond based on observations of behaviour alone is fraught with potential error. This may be true even in very young children where there is a well operationalised behavioural observation base (e.g., 'Strange Situation', Ainsworth et al., 1978), let alone in older children where less is known about how underlying attachment bonds may be reflected behaviourally. This is a particularly relevant point when attempting to draw conclusions about attachment from observing challenging behaviours, such as, for example, demands for attention, defiance, and aggression towards the caregiver. Following on from this, articulating attachment bonds in terms of 'strength' of attachment (e.g., saying a child is/is not strongly attached to a caregiver) is also problematic, particularly if one adds the assumption that characteristics of behaviour in some way reflect the strength of the underlying attachment bond (Cassidy, 2008).

## **6.5 Security and attachment classifications**

Bowlby originally identified attachment bonds as either secure or insecure (Bowlby, 1969). Mary Ainsworth subsequently identified three distinct organised attachment (behavioural) patterns; one described as *secure* (B), and two *insecure* - insecure avoidant (A) and insecure- ambivalent (C) (Ainsworth et al., 1969; Ainsworth et al., 1978). These three classifications of attachment organisation were characterised by different attachment behaviour in a structured situation and were hypothesised to reflect different cognitive expectancies regarding the availability of the caregiver under conditions of stress. Subsequently, Main identified and added a fourth attachment pattern insecure-disorganized (D) which was thought to reflect a lack of coherent organisation of attachment behaviour and representations, resulting in inconsistent attachment behaviour in the same stressful assessment situation (Main & Solomon, 1990).

Children who are securely attached are thought to have experienced their caregivers as physically and emotionally available to them. Secure attachment is thought to foster a belief in the availability of the caregiver as a 'secure base' that allows for safe exploration and learning on the part of the infant or toddler. According to attachment theory, securely attached children are thought to have better developmental outcomes and less psychopathology than children with other attachment patterns (Zilberstein, 2006).

Insecure patterns of attachment are thought to represent organised strategies that attempt to maintain proximity to a caregiver that is inconsistently responsive

or available, but in different and relatively predictable ways. Thus, at least in an assessment situation such as the Strange Situation, the child whose attachment is deemed 'avoidant' in its organisation is thought to have developed an expectation of conflict or rejection in response to the expression of their attachment needs, and therefore avoids expressing these needs to the caregiver. The 'ambivalently' attached child, uncertain of their mother's response to their needs, demonstrates angry resistant or passive behaviour towards her. Both these patterns of attachment behaviour are thought to represent organised ways to maintain proximity to the caregiver.

Finally, in children who present as disorganised in their attachment behaviour, the caregiver is thought to have been simultaneously a source of comfort and fear, leaving the child in an impossible bind. Children with a disorganised attachment are thought to both seek proximity to the caregiver and also fear the caregiver. Accordingly, disorganised children exhibit apparently contradictory behaviour such as freezing, spinning or fearful apprehension towards their attachment figures in a structured assessment situation (Main & Solomon, 1990; Zilberstein, 2006). Children with disorganized attachment are thought to be at the highest risk for behavioural and emotional disorders (Zilberstein, 2006) possibly due to their lack of integration and organisation of behavioural, cognitive and affective attachment representations.

Attachment theory makes other links between early attachment organisation and the quality of further emotional and social relationships. As a result of the child's internalisation of the early affective attachment relationship, the child

comes to form an ‘internal working model’ incorporating beliefs, attitudes and behaviours in relation to themselves and others (Bowlby, 1979). This internal working model becomes increasingly differentiated and elaborated into patterns of affect regulation, self organisation, attitudes and expectations about self and self in relation to others in the world (Sroufe, Carlson, Levy & Egeland, 1999). Accordingly, organisation of the attachment system is thought to ultimately influence emotional regulation, self identity and to pervade experiences of social relationship.

Broadly speaking, attachment theory proposes that the organisation of a child’s attachment behavioural system is thought to be reflected in the child’s ability to regulate and express affect (where the child may be emotionally over- or under-regulated), representations of self and others (where the child may fear punishment for autonomy or for dependence in relation to the caregiver) and attachment behaviour (where the child may be, amongst other things, compulsively self reliant, or overly demanding) depending on the ultimate organisation of the attachment behaviour system. Thus, the array of elements and behaviours potentially subsumed under the notion of ‘attachment’ is huge.

## ***6.6 Developments in attachment theory***

The previous sections presented a simplified summary of some of the key early attachment ideas. In addition to the development and identification of attachment patterns, there have been subsequent changes in the relative emphasis placed on aspects of attachment and how attachment is conceptualised. When

these further developments are considered the literature on attachment becomes expansive. The following list illustrates some (not all) of the principal developments in the attachment literature. Varying emphasis has been placed on the term attachment and accordingly, it has been characterized in terms of:

- **The child's early caregiving experience:** e.g., Bowlby, (1969/1982) and the importance of caregiver accessibility and responsiveness: caregiver availability as the set goal of the attachment system.
- **Cognitive and representational models:** e.g., incorporation of cognitive aspects and appraisal/evaluation; the development of the internal working model (Ainsworth, et al., 1978; Bowlby, 1969/1982); reflected in attachment patterns classifications in response to the Strange Situation (Ainsworth et al., 1978).
- **Maternal or caregiver attachment representations:** e.g., Attachment as a maternal 'state of mind' (Main, 1995) and the role of states of mind in development of coherent versus incoherent narratives (Main 1995; Main & Hesse, 1990) and the capacity for the reflective self (Fonagy, 1996; Fonagy et al., 1991).
- **Coping styles:** e.g., Psychological defenses or secondary attachment strategies against the emotional pain associated with caregiver unavailability which feature non optimal emotional regulation strategies and interfere with development. In these coping styles

emotions may come to be viewed as congruent or incongruent to attachment goals and hence become deactivated or hyperactivated (Mikulincer, 1997; Mikulincer & Shaver, 2003).

- **Emotional regulation:** e.g., theoretical links between insecure avoidant attachment and minimisation of expressions of distress (emotional overregulation) and between insecure resistant infants and maximisation of expressions of distress (emotional under regulation) (Cassidy, 1994; Isabella, 1993). The critical role of affective attunement (Stern, 1985). The developmental effects of contingent emotional sharing between the child and parent (Trevarthen, 2001).
- **Parent child interaction and synchronicity:** e.g., The role of well synchronised parent child interactions (Isabella & Belsky, 1991) and applications of parent-child interaction therapy with young children (Dozier, 2000, Lieberman, 1992; Erickson, Korfmacher & Egeland, 1992).
- **Neurobiology and brain development:** e.g., theorizations about the lasting impact of attachment on development (Stroufe, 1977), on the developing brain (Schore, 2001) and mind (Siegel, 1999).
- **The quality of adult romantic relationships:** e.g., Attachment as a relational and personality construct in which formulations of

attachment theory have been extended to adult romantic relationships (e.g., Hazan & Shaver, 1987; Pietromonaco & Barrett, 1997).

This range of variations in the application of attachment theory means that the potential literature relating to attachment is expansive and covers a variety of concepts and theorisations.

The historical roots of attachment theory are equally diverse. Historically, attachment theory has roots in a diverse range of epistemologies: psychodynamic, sociological and evolutionary theories. The measurement of attachment has been approached from the perspective of interviews with children and adults, from a personality and social psychology perspective, from observations of infant and child behaviour, and even from observation of animal behaviours. Early animal studies were interpreted as providing support for an attachment drive. One example is Harlow's (1958) observation that infant rhesus monkeys, in times of stress, preferred a cloth covered 'mother' that provided contact comfort, but not food, to a wire-mesh 'mother' that did provide food. Further, recent developments in neurobiological findings relating to trauma and brain development have also added to the body of information which has now been subsumed under attachment theory (e.g., see Coan, 2008; Perry, 2006). Perhaps for all of the above reasons, there is lack of conceptual clarity about what attachment theory actually describes and *prescribes* as treatment beyond toddlerhood.

### **6.7 Attachment theory, 'attachment disorder' and clinical intervention**

This section attempts to summarise the difficulties faced by stakeholders attempting to employ an attachment framework to understand and to formulate an intervention for challenging behaviours such as violence and aggression. The lack of current conceptual clarity around the term 'attachment disorder' has been noted previously. In particular, the relationship between attachment disorder and issues of aggression and violence, and other challenging behaviours has been the subject of discussion. Some have highlighted the possible overemphasis of the link or relationship between attachment disorder, Reactive Attachment Disorder (RAD: APA, 1994) in particular, and aggression (Zilberstein, 2006).

Reconciling the available literature on attachment and drawing conclusions for treatment arising out of that is complicated because of the very different clinical and theoretical emphases placed on attachment literature (Zilberstein, 2006). Most of the literature is theoretical or conceptual in basis, and rarely refers to interventions. As a result, there is a considerable body of literature which the mental health clinician and other stakeholders supporting children in out-of-home care must attempt to reconcile when understanding what attachment means and how it influences behaviour. For this reason, some have argued that conceptualisations of attachment have become blurred in the same way as concepts such as self-esteem (Werner-Wilson & Davenport, 2003).

The advantage of attachment theory over other theories is that it is a developmental theory that has evolved out of empirical studies of infants and

developed 'forward' into attempts to understand attachment in older children, rather than starting with the study of adult disorders and working backwards (Crittenden, 2006). This ultimately affords the opportunity for prospective longitudinal research which has great potential to enrich our understanding of the relationship between variations in early attachment behaviours and psychological functioning and behaviour throughout the lifespan.

However, the ability to make clinical or treatment recommendations that are derived from attachment literature is hindered by several fundamental problems. The nature of attachment theory presents an essential problem for those who wish to draw from it in order to support children in out-of-home care because it presents clinicians or stakeholders with the necessity to reconcile a *developmental* theory with clinical interventions. Further, as attachment theory is fundamentally a theory of development, rather than one of clinical disorder, there is no clear distinction between the range of so called normal variations in attachment and clinically *disordered* attachment (Zeanah, 1996; Zilberstein, 2006). Historically, categorisations of attachment derived from research settings and normative (non clinical) populations may have limited relevance for clinical presentations (Minde, 1999; Zilberstein, 2006). Relatedly, attachment theory is not a theory of treatment (Crittenden, 2006) and does not, *per se*, provide clinical guidelines for when and how intervention is required. As stated by O'Connor and Zeanah, (2003), in summarising the state of knowledge about disorders of attachment: "...there is still no consensual definition or assessment strategy; nor are there established guidelines for treatment or management" (p. 241). Finally, even theoretical categorisations of attachment *disorders* that do exist do not marry well with the

clinical diagnostic classifications that are currently available (APA, 1994). Indeed the construct validity of the diagnostic criteria Reactive Attachment Disorder of the DSM-IV (APA, 1994) has been questioned (Boris, Zeanah, Larrieu, Scheeringa, & Heller, 1998; Zilberstein, 2006). While the DSM-IV categories ('inhibited' and 'disinhibited' Reactive Attachment Disorder) do specify pathogenic caregiving, their validity has been criticised by many (e.g., Deklyen & Greenberg, 2008), and their predictive and clinical utility for children with behavioural disturbance remains unclear (Zilberstein, 2006). For a comprehensive discussion of the limitations of the current diagnostic classifications see Zilberstein (2006).

One alternative conceptualisation and taxonomy of attachment disorders has been proposed which offers more clinical utility and is based both on attachment theory and clinical experience (Zeanah & Boris, 2000). Zeanah and Boris (2000) distinguish between 'non attachment' (where a child has not formed any discriminant attachment), 'disordered attachment' (where a selective attachment exists but is disturbed) and 'disruption of attachment' (where a child's attachment to a caregiver has been disrupted). This nosology may be more aligned with the clinical presentation of children in out-of-home care and other situations of extreme caregiving maltreatment although more work needs to be done to validate this diagnostic system and relate it to problematic behaviour, especially amongst school age children (Deklyen & Greenberg, 2008).

Thus, the clarity and utility of current conceptualisations of attachment has been questioned. Before moving on to the analysis of stakeholder discourse about

attachment that is the focus of this chapter, it is worth briefly reviewing the theoretical and empirical basis for the association between attachment constructs and challenging behaviour.

### **6.8 Attachment, aggressive behaviour and psychopathology**

The association between challenging aggressive behaviour and attachment disorder is particularly prominent in the literature, and therefore the relationship between these constructs warrants some consideration. First, there are a plethora of popular books and websites which describe a ‘laundry list’ of behavioural disturbances attributed to attachment disorder (Zilberstein, 2006). These have been criticised for lack of empirical or theoretical justification (e.g., Barth et al., 2005; Zilberstein, 2006). In particular, ‘holding therapy,’ ostensibly an attachment intervention that targets aggressive non-compliant, attachment disordered children, has been singled out as “antithetical to attachment theory” (Dozier & Rutter, 2008, p. 713) and as lacking empirical justification (Zilberstein, 2006). In recent reviews of psychological interventions for children at risk, holding therapy has been described as potentially harmful and lacking efficacy (Lillienfield, 2007; Saunders, Berliner & Hanson, 2004).

Additionally, although attachment disorder and aggression often coexists, the nature and direction of the relationship remains unclear (Zilberstein 2006). As very little is known about how attachment disorder may present at various developmental stages across the life span (Volkmar, 2002; Zilberstein; 2006), the appearance of attachment disorder “...in older children and adolescents is not well

recognized or understood” and can be confused with other disorders or co-morbid presentations (Zilberstein, 2006, p.57).

In short, the criteria by which aggression can be assumed to be wholly or partially due to attachment issues appear unclear, especially in the case of school age or older children. Caution has been recommended by some when considering the theoretical and conceptual basis for attachment disorder and, in particular, for the use of attachment disorder as a justification for treatment intervention. As Maldonado-Duran et al. (2003) state:

In some facilities, clinicians have become very interested in attachment disturbances. As a result, they may view any behavioural disturbance in a child as caused by disruptions in attachment and therefore diagnose the behaviour as an attachment disorder (p. 295).

A relative emphasis on the attachment or ‘felt security’ of the child may diminish or minimise the importance of targeting aggressive behaviour specifically (Zilberstein, 2006). As many have noted, there are reasonably well supported interventions for conduct disorder, ADHD, and trauma in clinical populations, elements of which are likely to be applicable to ‘at risk’ populations (Deklyen & Greenberg, 2008; Zilberstein, 2006). These interventions, however, may be overlooked in favour of a relative emphasis on attachment and the ‘felt security’ of the child. While securely attached children might show less aggression, it does not necessarily follow that making an aggressive child ‘securely attached’ will mean that aggression will be diminished. Nevertheless,

this seems to be the implicit assumption behind a literature placing an emphasis on the child's attachment or 'felt security'. Insecure attachment may not always be of aetiological significance in aggression, as indicated by case studies of children with externalising problems in which parent-child attachment appeared to be concurrently secure (Deklyen & Greenberg, 2008; Greenberg, Speltz, Deklyen & Endriga, 1991). As Zilberstein (2006) states, in relation to the treatment of children: "Considering attachment to be comorbid with other condition rather than encompassing them deepens our formulation and broadens our repertoire of available treatments" (p. 62).

Much attachment literature appears to contain potentially erroneous logic in relation to behaviour problems. In the words of Barth et al. (2005) "Indeed, the discussion of attachment is often circular- the child has difficulties in social relationships (attachment), and therefore s/he has attachment disorder" (p.263). This kind of reasoning risks overlooking the many other reasons why a child may have difficulties with social relationships. Comorbid conditions frequently presenting in conjunction with attachment disorders may come to be viewed as part of the disordered attachment. In reality, co-morbid issues such as conduct disorder, aggression and learning difficulties can be discrete disorders that require separate interventions (Zilberstein, 2006). Problem behaviour may be determined by multiple risk factors (Deklyen & Greenberg, 2008) and multifaceted interventions will often be required (Hanson & Spratt, 2000; Ziberstein, 2006). Many other factors, other than attachment, or in addition to attachment, are likely to influence development (Zilberstein, 2006) and contribute to behaviour difficulties (DeKlyen & Greenberg, 2008).

The issues involved in addressing behaviour problems amongst clinical and at risk populations are undoubtedly complex. While attachment issues may indeed contribute to behaviour problems, there appears to be little evidence that they determine behaviour problems in isolation. Thus, as DeKlyen and Greenberg (2008) suggest: “The enthusiasm to utilize attachment theory has at times led to over interpretation of findings and a fruitless search for a “Holy Grail” of psychopathology....”(p. 638).

In other words, there may be a danger that all children displaying problematic behaviour are assumed to be attachment disordered, where specific targeted interventions might (also) be required. This may be a particular risk for children in alternative care with significant maltreatment histories where such explanations make good sense, and given the arguable dominance of attachment ideas amongst stakeholders and policy in this area (see Bath et al., 2005; Newman & Mares, 2007). In the words of Maslow (1966) “I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail” (p. 15). Therefore, caution is warranted when considering the link between attachment disorder and all challenging behaviour, where an overemphasis on such a connection between the two issues may be “perilous” (Bath et al., 2005, p. 259). Thus, as Deklyen and Greenberg (2008) suggest in relation to children in out-of-home care and other maltreated children:

Much more research is needed, particularly with respect to children in the child protective system, to clarify the forms that attachment

disorders are likely to take and to inform the design of more effective interventions (p. 654).

In particular, measures of attachment that can provide assessment benchmarks in clinical decisions regarding removal of children and the effects of foster care are needed (Deklyen & Greenberg, 2008; Rutter, 2008). It is particularly notable that there has been very little study of psychological and behavioural disorders in school age children that are believed to be related to attachment (Deklyen & Greenberg, 2008).

In summary, it is conceivable that stakeholders in the out-of-home care environment may be exposed to poorly delineated descriptions of attachment that may be more applicable to younger children. These accounts may also over-represent the role of attachment in the development of challenging behaviour and may not clearly articulate what aspects of challenging behaviour might reasonably be taken to reflect attachment difficulties and therefore what aspects are amenable to attachment interventions.

### ***6.9 Attachment in middle childhood and adolescence***

In addition to the difficulties in identifying the therapeutic elements of attachment interventions in general, there is also very little known about how any effective interventions might differ according to the developmental stage of the child in question. Relatively little is known about the nature and measurement of attachment in school age children and in early adolescence (Thompson & Raikes,

2003). This is particularly concerning as this is arguably a time when children are more likely to come to the attention of mental health and educational professionals.

More work remains to be done on the validation of assessment measures (Dwyer, 2005; Laidle, 2005) and the development of a gold standard for measurement of attachment in middle childhood similar to the ‘Strange Situation’ of toddlerhood (Laidle, 2005). Relatively little has been written on the cognitive and communicative processes involved in the development of attachment representations and internal working models post infancy (Bretherton & Mulholland, 1999) or how the communication of attachment needs may change/differ (Cicchetti, Cummings, Greenberg & Marvin, 1990) and indeed whether attachment can be conceptualised in terms of the same organised patterns that it can in infancy (Crittenden, 2000; Laible, 2005; Solomon & George, 1999). Indeed, it seems likely that the attachment relationships of a child in middle childhood might take a different form as they are typically a subsequent attachment, (i.e., not the child’s only or first attachment relationship), although they may develop in a similar way (Howes, 1999). It is unclear as to whether different measures of attachment, used at different developmental stages (e.g., toddlerhood to school age), are actually measuring the same construct and in any event such measures are generally based on normative, low risk samples, rather than clinic, or ‘at risk’ samples such as children in out-of-home care (Deklyen & Greenberg, 2008). As Rutter (2008) states: “...the issue of how to conceptualise and measure attachment security in the post infancy years remains essentially unresolved” (p. 959).

### **6.10 The meaning of attachment to stakeholders**

This thesis is largely concerned with the experiences of stakeholders supporting children in out-of-home care whose ages range from early school age to adolescence. The literature in relation to attachment in this age range appears particularly under-developed. This raises the possibility that clinicians and other stakeholders could develop an understanding of attachment theory based largely on inappropriate and underdeveloped literature. Further, theoretical literature on attachment in this age range is not readily accessible. Popular and accessible literature such as books aimed at foster parents and websites dealing with attachment disorder have been criticised for their lack of empirical basis (Zilberstein, 2006). Therefore, the further exploration of stakeholders' accounts of attachment in this age group appears warranted, particularly as it represented the main account given by stakeholders for behaviour problems.

It has been suggested that inaccuracies in the understanding of attachment contribute to damaging interventions and practices (McIntosh, 2003). McIntosh (2003) has highlighted the danger of over-simplifying or corrupting the meaning of 'attachment' in case practice and in legal situations. She suggests that children's experience of care is sometimes lengthened or complicated by professionals' misunderstanding of the nature and importance of children's attachment needs. Others have noted that attachment theory has developed many variants since its initial inception (Crittenden, 2006; Zilberstein, 2006). It is therefore important to further explore what meaning stakeholders might give

attachment disorder or difficulties in attachment, what that might mean for how the relationship between attachment and behaviour is viewed, and further to consider what it might mean for how they intervene or support that young person.

### **6.11 Analysis and themes**

An analysis of attachment talk was conducted to identify dominant accounts of attachment and meanings and assumptions underlying this. This analysis was conducted as outlined in Chapter 3, using the entire set of interviews. It should be noted that there was considerable overlap in these themes. Many participants expressed attachment in terms of one or more of these themes. Accordingly, many of the extracts presented here may illustrate more than one theme. The possible implications of these themes will be discussed later in the chapter. The analysis identified the following four key themes:

- 1) Attachment is not desired by some
- 2) Attachment is a close trusting relationship
- 3) Attachment capacity is limited
- 4) Attachment is transferable

#### **6.11.1 Attachment is not desired by some children:**

Some children were seen by stakeholders as having severely limited desire or ability to form attachment bonds. Further, in these accounts, many children were perceived of as incapable of forming attachments. This extract from a teacher

provides an example of this in relation to a child that he describes as attachment disordered:

**R:** I have had a couple of kids, one kid in particular, who was so badly abused that he is just-everyone recognises that he will never ever-he is just so badly damaged-he is just going to be a problem forever, the abuse was just so horrendous. **Interview 89**

This description of attachment was common when participants were discussing children that have had multiple placements, who are adolescent, and who were seen as ‘damaged’ and incapable of forming new attachments. This extract from a residential care worker illustrates this view, in which the child’s behaviour is seen as unlikely to change due to their ‘inability’ to form attachment with a significant adult:

**R:** I tried to always be about the attachment and it is flawed and at times you will never get it to work because the kids are so damaged, but you will never have the relationship that you can use. Because I think that is the best behaviour management tool. But sometimes these kids are so damaged that you can be with them for three years and still not have a relationship that is going to change their behaviour. So you have to have all that other [behaviour management] stuff. **Interview 48**

These children were frequently seen as better off in a residential care unit, where they are not required to form an attachment to a significant carer, as this extract from a CAMHS worker demonstrates:

**R:** A young person who came into care, he could never have gone into a foster placement, so as hard as it was for him to be in a unit, he was going to be more successful there than in a foster placement and you know that they have attachment, even if its just to a place, and if they fuck up a relationship with one worker, they've got like 15 others.

### **Interview 16**

The above extract exemplifies the view expressed by some participants that some children are incapable of forming attachments. It also conveys little hope that the child will form attachment to *any* significant person (and, conceivably, denies the existence of any attachment that they may have formed in the past). Some descriptions, like the one above, appeared to portray some children's ability to attach as so diminished, that they express the desire for these children to become 'attached' to *a place*, rather than a person. This extract, taken from an interview with a residential care worker, provides another example of this:

**R:** It is obvious which kids have attached to this place and which kids haven't, which kids are going to stay and which kids think they are not going to stay, just by looking at their rooms and what is in there. If you go to the girl's rooms for instance, the girls that are here plan to stay here, they have pictures and things around the wall. Some of the boys

have no intention of staying here, there is nothing, it is just a bed, and everything is boxed up, hidden away for a quick exit. **Interview 71**

An inherent assumption within the talk in this theme was that responsibility for the inability or lack of desire to form attachments rested with the child. For these children, residential care was seen as an appropriate choice because of implicit assumptions that, on the surface, appear to be in the child's best interests. Examples include the assumption that children would feel more *comfortable* with less intimacy, that they *prefer* to spread out their 'attachment' amongst more workers thereby requiring only a superficial or shallow attachment to any one person, and that, ultimately, it is *harmful* to children to expect them to attempt to form attachments as their inability to attach meant that they would only 'fail' at yet another relationship. This extract from a Department worker articulates some of these assumptions:

**R:** But he can't be placed in another foster home, because that will break down and he will go to another one, and another one. So, the only option, I think we'll have, in order to prevent further attachment disorders from taking place, is to share the care, so that in some sense he doesn't become attached to any one person. **Interview 23**

This type of statement appears aligned with notions that attachment is an 'all or nothing' phenomenon; either one can form attachment bonds or one can not. If one cannot, then one should not be expected to form anything other than superficial or shallow relationships. This interpretation of attachment may be

seen, arguably, to arise out of the historical context of the early categorical approaches to attachment research, which have been left behind in recent times in favour of dimensional approaches to measurement and coping styles (e.g., Yunger, Corber & Perry, 2005).

Early classic studies of adoptive infants, suggesting a critical age (6-8 months) after which adopted children had considerable difficulty forming attachments to adoptive parents, may also be influential (Tizard & Rees, 1975). The notion of a critical period for attachment formation has since been challenged (Howes & Spieker, 2008; Marcovitch et al., 1997; Singer, Brodzinsky, Ramsay, Steir & Waters, 1985). Studies of Romanian orphans adopted (after the critical period) *do* suggest the ability to form secure attachments in the right environment (Zilberstein, 2006). However, the notion that early events, particularly profound neglect, can render the child unable to form attachments may persist. Additionally, children in out-of-home care are likely to have been exposed to multiple family stressors, including traumatic interpersonal relationships and may or may not have been subject to profound neglect. Therefore, the nature of the early history of children in out-of-home care is qualitatively different than those in the orphanage studies, making comparisons between orphanage studies and the out-of-home care population problematic. As Rutter (2008), concludes "...the evidence is not available to substantiate claims on either the presence or limits of a sensitive period, and certainly not to draw conclusions about implications for therapeutic practice" (p. 964).

There is also a danger here of a confusion between the ‘inability’ to attach and compulsive self reliance. According to attachment theory, compulsive self reliance reflects an organised (albeit insecure) attachment strategy, not a sign of being ‘unattached’. As Rutter (2008) states “... there has been a recognition from the outset that attachment insecurity should not be considered as synonymous with any form of disorder” (Rutter, 2008, p. 963). Similarly, according to Howes (1999):

It is reasonable to look closely at the organisation of the attachment relationship between a child and an alternative attachment figure and to consider extreme insecurity as one mode of organisation. When children are extremely insecure, particularly if they are avoidant of an attachment figure, they may appear not to be attached. When the attachment figure is an alternative attachment figure, it becomes difficult at times to distinguish between nonattachment and extremely insecure attachment (p. 680).

Even in the case of disorganised attachment, some have argued that there is little evidence to consider it an attachment ‘disorder’ in its own right (Rutter, 2008). Crittenden and Clausen (2000) have argued that a disorganised style of attachment might best be viewed as an adaptive response to particularly difficult circumstances. Indeed, Bowlby himself maintained that “it is a mistake to suppose that a young child diffuses his attachment over many figures in such a way that he gets along with no strong attachment to anyone, and consequently without missing any particular person when that person is away” (Bowlby, 1969/1982, p. 308).

Another important question here is the implicit assumption that ‘bad’ attachments in the past necessarily translate to bad attachments in the here and now (and in future relationships). In relation to this implicit assumption, two bodies of literature are relevant. The first relates to concordance rates of multiple attachments; in other words the extent to which a child’s attachments to different caregivers is similar or different. There is by no means conclusive evidence of a relationship between attachment to mother and other (subsequent) attachments. While many studies have shown independence of attachment across caregivers, others have shown significant but weak correlations in attachment quality, at least between attachment to mother and attachment to father (see Berlin, Cassidy & Appleyard, 2008; Cassidy, 2008 for discussion).

The second body of literature relates to the research on children raised in orphanages in which they have been subject to early deprivation (see Rutter, 2008). While a failure to develop specific attachments (particularly disinhibited attachments) has been demonstrated amongst some children institutionalised for longer than six months in the first two years of life (e.g., Zeanah & Smyke, 2005), the majority of evidence suggests that children who were in foster care (rather than orphanages) do not show high rates of indiscriminant sociability (reflecting disinhibited attachment) (Dozier & Rutter, 2008). Indeed the available evidence suggests that even early failure to develop a specific attachment itself may not be necessarily a significant clinical issue (Dozier & Rutter, 2008) as a substantial proportion of institutionally deprived children did not show this pattern (Dozier & Rutter, 2008). Amongst those institutionalised children subsequently placed in

foster care, inhibited attachment was *not* disproportionately represented (Zeanah & Rutter, 2008). Only *disinhibited* style attachment disorder did not appear to remit over time (Rutter et al., 2007; Zeanah & Rutter, 2008). This attachment disorder is reflected in socially inappropriate physical contact, lack of social reserve, and verbal and social violation of conventional boundaries (Dozier & Rutter, 2008). However, this disorder is associated with prolonged early institutional deprivation (> 6 months) and the influence of biological determinants and temperamental disposition in its development has recently been emphasised (Deklyen & Greenberg, 2008; Dozier & Rutter, 2008). For this reason, the applicability of these findings to the majority of children placed in foster care is unknown. Finally, even where children have been maltreated by their parents, they nonetheless appear to develop specific attachment relationships with them (e.g., Crittenden, 1985; Egeland & Stroufe, 1981, Dozier & Rutter, 2008).

Conceivably, holding the view that attachment is not possible or desired by some children could impact on stakeholders' willingness to attempt to form relationships with young people. Barth et al. (2005), for example, have suggested that an emphasis on attachment explanations may encourage amongst carers (and professionals) a pessimistic outlook with respect to the possible social and developmental outcomes for the child.

#### *6.11.2 Attachment as a close, trusting relationship:*

In this second theme, attachment was seen as reflecting the formation of a close, dependent and trusting relationship. Therefore, this understanding of

attachment may be suggested to reflect an idealised notion of (secure) attachment, in which the child is comfortable to rely or depend on adults, and able to form close, intimate relationships. Consequently, 'attachment disorder' was equated with the notion of a lack of trust in, or ability to depend on, adults. Accordingly, in this type of account, behaviour change was seen to arise out of the formation of a good (healed) relationship (i.e., one characterised by intimacy, dependency and trust), as can be seen in the following extract from a residential care worker.

**R:** The best thing that works good is relationship building and attachment stuff. So if the young people think that you care about them and you form a close relationship with them, then they are more likely to take the risk of caring back, so that is when you get that mutual sort of [changed] behaviour. **Interview 71**

The first element of this account equates attachment disorder with a lack of trust in the adults in their life, as the following account from a Department worker describes:

**R:** At the very root of it is the attachment disorders, the lack of trust that is a huge issue for 18 months – 2 years at least with most of our kids [going] into the placements. **Interview 83**

In this account the development of trust was seen as integral to the child relinquishing the need for challenging behaviours, as this Department worker explains:

**R:** When things are well in their world they start to begin to trust again, that is when the behaviours, the negative ones, tend to stop and the positive ones start. **Interview 84**

In this account, trust may be appropriately interpreted in terms of a child's cognitive expectations regarding the availability of the caregiver. However, in this account another essential element was the additional assumption that the child would form a close (emotionally intimate) relationship with the significant adult/carer and that this would mediate healing. The following extract from a residential care worker illustrates this:

**R:** That is exactly what it boils down to. You are not going to help young kids unless they have that level of trust and relationship with you. Our management has been very proactive in recognising that, they are doing that trial on attachment theory down at [unit named] where they are providing things which will allow them to really latch onto that attachment theory, allow workers to spend one on one time with the kids, and really create that close relationship with your care worker.

**Interview 70**

Such an understanding of attachment is potentially problematic when one considers its possible impact in terms of support for the child. First, such an account fails to accommodate other attachment patterns that, although insecurely organised, do not constitute attachment 'disorder'. Thus, an attachment to a carer

may be present, despite the absence of a close trusting relationship or the behaviours that we normally equate with it. Accounts that equate attachment with a close trusting relationship negate the validity of the past experience of the child, where for example a child may have formed an avoidant (although *organised*) attachment bond with a caregiver. This extract from a Department worker describes the attachment related behaviours of the children she works with:

**I:** What are the main behaviour issues that you would see?

**R:** It is all attachment related behaviour, aggressive, the inability to form close relationships, they are hard to get to know, they don't trust, that inability to trust. Just challenging behaviour. **Interview 75**

Having this understanding of attachment as a close and trusting relationship style necessarily conflicts with other acceptable, organised attachment styles which are within normal limits (non clinical), and not disorganised or requiring intervention. This is true even if they do not conform to idealised or desired notions of a loving social relationship. Accordingly, there is a danger of such a child's avoidant attachment style being misconstrued as being aloof or 'unattached', or of an ambivalent attachment style, characterised by poor emotional regulation, being misconstrued as dislike.

Second, such thin descriptions and understandings of attachment have the potential to influence clinical goals and approaches. Theoretically, preoccupied and avoidant coping styles are underpinned by two different insecurities in the

child, fear of autonomy (in the case of the preoccupied, emotionally under-regulated style) and fear of intimacy (in the case of the avoidant, emotionally over-regulated style) (Mikulincer & Shaver, 2008). Perception of attachment as achieved through the development of a close trusting, *dependant* relationship works against an intervention focus that would ultimately seek to address the underlying fear of independence and exploration. Furthermore, in the case of the adolescent, how this perception of attachment as a close *dependent* relationship interplays with the normal adolescent developmental tasks of autonomy, *independence*, and identity formation appears unknown.

Additionally, such formulations do not acknowledge the need to match parenting (caregiving) style to encourage the underdeveloped representations in the child. That is, to encourage emotional expression and release in a child whose emotional expression is ‘over-controlled’, and the development of emotional self regulation in child whose emotional expression is ‘under-regulated’. Similarly, the potential for conflict and confusion arises when considering approaches that might be recommended, such as a ‘strengths-based’ approach to parenting, as the following extract from this Department worker articulates:

**R:** We work with families and we go in and see [that] the family [is] really caring for the child, not smothering, but that beautiful caring. And we might say –yes -that is fantastic - but they are not given the opportunity to be exploring! The same with families who give the child the opportunity to do that exploring and are not nurturing that child. So

because we are working from a strength based perspective- how do you know?

**I:** So when you say strength based focus, highlighting things people are doing well?

**R:** Yes- and that is not just what we should be focusing on. That was an eye opener for me because I very much work from a strength based mindset. I say oh you are doing that great, I love the way when he is upset you do this or that. But that might not be right [for the child]. So a proper assessment is so important when looking at attachment.

Attachment can be everything. **Interview 47**

Inherent in accounts of attachment as the formation of a close trusting relationship is an assumption that attachment can be 'healed' through relationships: that placement with a loving, safe foster carer will result in a relationship in which there is appropriate close attachment. Here the implicit assumption is that healing is mediated by supporting the foster carer to form a close relationship with the child, without the need for further clinical intervention. This understanding of healing, which places responsibility with the carers, can be seen in the following extract from a CAMHS worker:

**R:** Primarily the work is done with the carers, 80% of the work is with carers and 20% with the kids. That 20% would be explaining why they are in care, what has happened to them and getting them to have a story

about their life and why they are where they are. But 80% of the work is with the carers getting them to understand the children that they are now caring for, what they need to do to care for these children so they can thrive. **Interview 5**

Paradoxically, if the placement fails, it is the child that appears to be seen as being at fault for not being able to cope with close relationships. This type of account runs the risk that the child is not offered any intervention targeted at issues such as emotional regulation or cognitive restructuring of attachment representations. As a result, there may be an implicit reliance on enhancing maternal/parental sensitivity and responsiveness as a cure for attachment disorders. Yet the clear, theoretically-driven evidence that improving maternal sensitivity and responsiveness alone improves attachment quality is based on studies of low risk *infants* or toddlers referred to clinics for a variety of problems (see Rutter, 2008). Other interventions that are clearly guided by attachment theory seek to facilitate reworking of the child's internal working models and provide concurrent corrective emotional experiences. This is mediated by the child therapist initially, or via co-therapy with foster or adoptive parents, rather than relying on parenting interventions alone (Rutter, 2008).

Similarly, Crittenden (2006) draws a distinction between a treatment goal of achieving *balance* (in attachment representations and behavioural strategies) and achieving *felt security*, which is situational, temporary, not within the child's control, and ultimately not therapeutic. The clinical intervention goal of working through and readjusting/ realigning attachment representations and strategies

through (emotional) exposure and cognitive behavioural strategies contrasts often with the (temporary) situational goal of having the child feel secure or safe *in any one particular* situation or placement, without the ability to generalise it to future relationships.

### 6.11.3 Attachment capacity is limited:

This theme reflected respondents' concern that young people might become *too attached* to a person. Implicit in this theme is the anxiety that young people should not become too attached to any one person and that their '*primary*' attachment be suitable in order for behaviour issues to resolve. Underlying this talk appears to be an assumption that the child's capacity for attachment is somehow limited and that therefore logically the 'strength' of the child's attachment to one person automatically diminishes or takes away from their capacity for attachment to another person. This type of account, in which the child's attachment capacity was seen as limited, was common in discussions about foster placements. This example from a respite foster carer describes concern that the child's developing attachment to her would interfere with his attachment to his 'full time' carer:

**R:** What happened around Christmas time, he became so attached to us, he wanted to come and live with us. So at that point, after Christmas, I had to say to everybody we have to review this, because he's getting too confused. So then, I put it to them, look I think we need to have a transition now where we have him come every four weeks,

and then every six weeks cause his primary attachment should be with his long term family and so that's what we did. **Interview 9**

In this extract, the foster carer describes how she manipulated the frequency with which the foster child had contact with her in order to control the 'strength' of his attachment to her, relative to his full time carer. This notion of managing the strength of a child's attachment generates a level of anxiety amongst stakeholders and appears to drive the idea that it is important to prevent children from becoming 'too attached' to any one person. This seems to generate a need amongst some stakeholders to regulate or manage the child's attachments if they become too 'strong'. For example, foster parents may be discouraged from or indeed believe themselves that it is important not to become too attached to children.

The idea of a limited capacity for attachment leads stakeholders to evaluate the 'appropriateness' of the primary attachment. This, in turn, may result in the desire to regulate access via the manipulation of the frequency of access, or even by placement change, rather than facilitating and managing a child's potential multiple relationships. For caregivers and professionals alike, this may also result in a belief in the need to remove themselves from the young persons' life so as not to interfere with the formation of new (more appropriate) attachments. This residential care worker describes how he removed himself from the child's life in order that the child could be free to form new attachments:

**R:** Another thing we had to do because I had him since he was 5 and he is now 14, so I spent about 8 years with him, so there was too much attachment - where it was good attachment but he was starting to become too reliant on me. I spoke to social workers and I left, I came over to CRC [community residential care unit] and I still keep in contact with him once a month. I am teaching him that people do leave you, but they are always in your memory and in your life, people do move away, do other things. **Interview 61**

It is difficult to account for this kind of approach to a child's attachment need. However, it has been argued that professionals may adopt an "emotionally detached" style in order to minimise the distress of separation (Rutter, 2008, p. 960). This type of stance with respect to attachment may, arguably, be traced to early writings of Bowlby (1951) which emphasised risk as arising from separation (from an attachment figure); a position he later moved from (Bowlby, Ainsworth, Boston & Rosenbluth, 1956) in favour of risk arising from lack of ongoing attachment relationship or neglect (Rutter, 2008). Another implicit element in this account of attachment, in addition to the capacity of the child to attach being limited in some way, was an apparent confusion of attachment with over-dependency when talking about children becoming too attached to any one person. The previous extract provides an example of this. Bowlby distinguished attachment behaviour from the psychological notion of dependency which has pejorative connotations and serves no biological function (Kadison Golden, 1990). Despite this distinction, some stakeholders appeared wedded to an understanding of attachment that confused it with being overly dependent.

There is, indeed, some evidence for a hierarchical structure to attachment representations in the early years, with not all attachment figures being equivalent or interchangeable (Cassidy, 2008). Bowlby described the preferred caregiver of the infant as the principal or primary caregiver and other caregivers as subsidiary, or tertiary, thus introducing the construct of a hierarchical organisation of attachment relationships (Cassidy, 2008). Intimately tied to the hierarchical construct is the notion of monotropy, which holds that when a child's attachment needs are activated, then "having a consistent set of preferences for a primary figure will lead to better adaptation" (Kobak, Rosenthal and Serwik, 2005, p. 84). Thus, in the context of multiple potential caregiving relationships, being securely attached to a 'primary' attachment figure is thought to lead to better outcomes than having secure attachment with a secondary carer when the attachment with the primary figure is insecure. Nonetheless, empirical studies suggest that even infants can become attached to more than one (sufficiently responsive) person in the first year of their life (see Cassidy, 2008). Further, the literature on multiple caregivers (Howes, 1999; Howes & Spieker, 2008) and theorisations about attachment relationships in middle childhood and beyond (Kobak et al., 2005; Kobak, Rosenthal, Zajac and Madsen, 2007; Laidle, 2005) call into question the necessarily hierarchical nature of attachment relationships and (therefore) the notion of a primary attachment and primary attachment needs for this age group. Thus, while appropriate in clinical formulations of younger children, the relevance of the notion of primary attachment figure in this developmental stage is by no means clear.

Indeed, it is not yet clear how attachment representations are organised in school age children. It has been theorised that the organisation of a child's internal working model of attachment relationships may be 'hierarchical' (Bretherton, 1985); 'integrative' (van Ijzendoorn, Sagi & Lambermon, 1992) or 'independent' (Howes, 1999). In a hierarchical organisation of attachment working models, the representation that is most influential is that of the primary caregiver (usually the mother). In the case of an integrative model of attachment representations, the child integrates all of his or her attachment relationships into a single representation of relationships. Finally, in an independent organisation of attachment representations, the child holds different attachment representations that are independent both in quality and in their impact on development (Howes, 1999; Howes & Spieker, 2008). At this stage it appears that there is insufficient research to distinguish which model best accounts for the development and organisation of attachment representations in middle childhood and beyond. Irrespective of what the outcome of this debate will be, it appears that the notion of a primary attachment may be largely a hangover from infant attachment research that offers no clear utility for clinicians and other stakeholders in supporting older children.

#### *6.11.4 Attachment is transferable:*

Finally, for some participants, attachment appeared to be described as a capacity that could, once developed, be transferred from relationship to relationship. In many accounts it appeared that attachment was viewed in terms more aligned with it being conceptualised as a skill set that could be learnt,

practised or acquired through relationship. Further, there appeared to be an assumption that this 'ability', once developed, could then be transferred or carried over to other placements or subsequent relationships. In this account of attachment, therefore, attachment is seen as a transferable ability that once mastered, can be re-applied to another placement. In this kind of account of attachment, there appears to be a disavowal of the child's enduring need for an ongoing attachment relationship in which the caregiver comes to be viewed as a 'secure base' or 'safe haven' from which the child can venture forth to (explore and) form subsequent relationships. The following extract from a residential care worker, when asked about her preferred way of working with children with challenging behaviour, illustrates this thinking:

**R:** [The] Attachment model is probably the closest [to an acceptable way of working], that is based around the idea that we are therapeutic parents, so they can form attachment with us so that they can then go on to form a relationship within foster care. **Interview 55**

An assumption that appears to be underlying this talk about attachment is that attachment is a dormant ability or skill that a child can learn or that can be 'activated' within the child. However, once this ability has been 'activated' within the child, then they are able to retain this ability into the future, and apply it in order to maintain fulfilling relationships in the future. Arising from this assumption is belief in the need to ensure that foster parents 'give them a few good years', and 'prepare them' for later relationships. Some exposure to good

attachment or relationship is seen as better than none, as the following extract from a foster carer seems to indicate:

**R:** The first two [children], they had run out of placements for them and I said yes I would do it. The second one they also had run out of placements for, they advertised and everything but nobody put their hand up. They said even if you could give him a couple of good years, it is better than nothing. **Interview 28**

The responses in this theme talk about attachment and the child's attachment needs in a way that minimizes the affective and subjective nature of the tie that a child may form with their caregiver. The attachment bond is conceived of in the literature as *enduring* and not able to be 'substituted' with another relationship, or transferred to another relationship, although it may form a cognitive and affective template from which subsequent attachment relationships are built or modified (Howes, 1999). Thus, it might be suggested that respondents who used this kind of talk about attachment may be more accurately held to describe affectional bonds, or relationship skills, rather than as an attachment *per se*. Affectional bonds are distinguished from attachment bonds by the fact that only attachment bonds involve the significant adult as a potential source of comfort and security, irrespective of whether that security is attained or appropriately used. In these accounts then, stakeholders are representing an attachment bond, incorrectly, in a way more aligned with the broader class of bonds. In the case of a true attachment, the child cannot readily interchange one caregiver with another.

One possible implication of this understanding is that there may be insufficient consideration given to the impact of a reliance on temporary or short term relationships, such as carers, in the child's life. This understanding of attachment may have the effect that the child's needs become subordinate to the structure of the care system. The following quote is taken from an article about the use of 'relationship' as a therapeutic tool in residential care:

We are providing these kids with a safe experience of relationship. At some point they may be able to transfer these skills to other relationships, especially within their own families. We are role models; we provide an example of how to promote and maintain a relationship in the face of conflict....We make the first stitches in their torn attachment robes. But there is a cost, both to the child and to the counsellor. Children will experience separation anxiety and will often protest that they were set up, that is, led and guided into a close relationship only to have it terminated (Leaf, 1995, p. 20-21).

A perception that the child's attachment can be disrupted and 're-attached' to a subsequent carer or relationship may serve to rationalise many potentially damaging practices in which systems, programs or access to significant people may be short term or time limited. This above quote from an article about the use of 'relationship' as a therapeutic tool in care provides an example of this kind of rationalisation about the services and relationships offered to young people.

## **6.12 Discussion**

As explicated above, contemporary attachment theory describes attachment as an affectional bond, potentially enduring a life time, which becomes elaborated into emotional, affective, behavioural and cognitive schema or representations and expectancies regarding the availability of initially the caregiver, but subsequently the other significant relationships in a child's life. Further, internal working models or representations are thought to ultimately influence affect regulation, self organization, emotional regulation and expression and coping strategies such as being overly self reliant, controlling or overly demanding. Although early primary attachments may become less pervasive in the child's life as they enter middle childhood or adolescence, they may form an affective template on which other relationship expectancies are built.

Attachment appears to be many things to many people. It has been tied variously to relational constructs, to parenting sensitivities, to biological determinants and to cognitive/affective representations amongst other things. It is not surprising, then, that stakeholders hold a range of understandings about attachment. The arguable appeal and prevalence of interventions claiming to be based in attachment theory, and the prevalence of 'attachment talk' in readily available popular literature, only adds to this confusion.

The analysis provided in this chapter identified four largely separate ways in which stakeholders appeared to understand and express disorder or problems in attachment amongst children in out-of-home care. It should be said that many

aspects of attachment theory are not fully developed for children school age children and beyond. Accordingly, the perceptions held by stakeholders cannot reasonably be held to be either accurate or inaccurate; rather that they appear inappropriate from the perspective of this researcher.

Notwithstanding this, it is possible to speculate as to the origins of these accounts and about the likely impact of these accounts on the practice of intervention. Arguably, some of these accounts may be traced to infant research, or research primarily with normal, non clinical, not at risk samples. Some accounts may be argued to have their roots in very early attachment theory and research. As Rutter (2008) notes: “Often it takes some years for new ideas to catch on, but frequently it takes even longer for them to be put aside when they are not supported by empirical research” (p. 960).

The first account, in which attachment is not desired or able to be achieved by some children may, arguably, be traced to early research which highlighted the profound impact of early (institutional) deprivation. Longitudinal research has since questioned the validity of a critical period for the formation of attachment relationships. In any event, the early life challenges for children ultimately placed in out-of-home care are qualitatively different from those raised in institutions. The implications of this type of account of attachment as not possible for some children may conceivably result in stakeholder pessimism about the possibility for change, and cause some stakeholders to keep emotionally distant from the child, possibly further reinforcing relationship difficulties.

The second account of attachment, in which attachment is reflected in a close dependant relationship with a significant other, has potential implications for those supporting the child with challenging behaviours. Amongst the most concerning is the possibility of negating or overlooking an insecure but organised attachment category (e.g., avoidant). The (insecure) attachment behavioural system that is characterised by an overcontrolled emotional regulation, and avoidance of strong affect, a miscueing of attachment needs and self reliance may be misinterpreted as a 'disorder' of attachment or 'non-attachment'. In other words, the child may be seen as not having an attachment bond to a caregiver whereas in fact it is simply extremely insecure. Stakeholders may conceivably be assisted to decouple the expression of emotion or affection from the quality of the underlying attachment bond and in that way be able to conceive that even the most emotionally unexpressive child may still be attached to the caregiver, despite his/her apparent lack of trust and intimacy.

The third account of attachment- one in which the child's capacity for attachment is seen as limited- is also potentially problematic. The organisation of the attachment behavioural system in school age children is unclear, but is likely to accommodate several important relationships. It may also be argued that the child in out-of-home care is extremely likely to have multiple important relationships and the child can form attachment bonds with more than one caregiver. The notion of monotropy, while appropriate for infants, may not be appropriate in the case of either school age children, or for children in out-of-home care. As such, this account of attachment may, arguably, reflect the misapplication of this theoretical construct. One unfortunate apparent

consequence of this account of attachment is the manipulation by stakeholders of important relationships, ostensibly for the good of the child and to facilitate the formation of an 'appropriate' primary attachment. Examples of such manipulations might include changes in the frequency of access and putting distance between themselves and child so the child can form new more appropriate attachments.

The final account of attachment- as a 'transferable' ability that once mastered, can be applied to subsequent relationships- does not appear to be linked to any theoretical ideas from attachment theory. However, its implications for the child could be a minimising of the child's need for enduring attachment bonds and conceivably lead stakeholders to deny the potentially devastating impact of placement breakdowns and placement drift on the child.

The brief summary of the literature presented in this chapter has not been intended to argue that attachment difficulties and attachment history are not important contributors to the behavioural presentation of the child in out-of-home care. Instead, the purpose of presenting this literature was to highlight the lack of conceptual clarity of much attachment literature, particularly in older children, and to stress the possible over-emphasis on attachment history in judgements about the aetiology of behavioural disturbance. In turn, it might be speculated that this over-emphasis, together with lack of clarity about the clinical implications of attachment history may contribute to the term 'attachment' being used in a generalised manner, similar to concepts such as self-esteem (Werner-Wilson & Davenport, 2003).

Attachment issues may well be a risk factor for later psychopathology including behavioural issues. However, it is also likely that risk factors have a different developmental impact in different developmental periods of the child's life. Therefore,

...secure attachment may be especially important in early development, whereas cognitive ability and motivation may be more critical in middle childhood, and peer relationships and parental norms regarding behaviour may be especially influential during adolescence. (Deklyn & Greenberg, 2008, p. 639).

Accordingly, Deklyen and Greenberg (2008) have articulated a model in which insecure attachment interacts with ineffective parenting, atypical child characteristics (including temperament) and high family adversity to contribute to psychopathology. Similarly, Rutter (2008) has argued that the success of attachment theory has led uncritical enthusiasts to neglect the role of social interactions and relationships more broadly (see also Dunn, 1993 & Stroufe, 1988), which has had ongoing ramifications for child protection and child care policy (Rutter, 2008).

The data presented in the previous chapter suggest that attachment conceptualisations feature strongly amongst South Australian stakeholders. The analysis presented in this chapter suggests, at least from this researcher's perspective, that some of the ways in which attachment is understood appear to be

misrepresentations of attachment theory and its implications for practice. It is particularly troubling that these accounts of attachment appear to describe attachment difficulties in terms of a problem or skill deficit lying 'within' the child. It could be argued that making causal attributions for difficulties that lay blame with the child is problematic, especially in the case where behaviour difficulties do not resolve. It may be argued that, under such circumstances, stakeholders' optimism that the child can be helped and their willingness to persevere with problem behaviour may be challenged. Moreover, childhood difficulties or disorders cannot readily be eliminated by treating only causes purported to lie within the child (Rutter, 1982; Deklyen & Greenberg, 2008), even if that were the case.

### **6.13 Summary**

The preceding chapters have indicated that attachment disorder is one of the major ways that behaviour is understood, across all stakeholder groups. The analysis presented in this chapter reported several ways in which the term attachment can be used that appear inconsistent with the current theoretical attachment literature. This suggests the importance of clarifying the meaning to stakeholders of commonly used terms, such as attachment, in collaborative problem solving regarding challenging behaviour.

The following chapter details the analysis of the experiences of one stakeholder group; residential care workers, when attempting to address challenging behaviour. This particular stakeholder group was chosen for further

analysis because it can be argued that residential care workers must deal with some of the most challenging behaviours that occur amongst children in out-of-home care. Despite this, little is known about how they account for and manage challenging behaviour. While residential care workers may, arguably, be perceived by others to be punitive and reactive, rather than proactive and reflective in their management, there does not appear to have been much empirical exploration of their practice to date. Improving stakeholders' understandings of others' practices and mandates may be considered important for improving collaborative practice. Accordingly, an analysis of residential care workers' experiences of managing challenging behaviour is warranted and is reported in the next chapter.



## CHAPTER SEVEN

### **Residential care workers' experiences of challenging behaviour**

#### ***7.1 Introduction***

Much debate exists about the place of residential care in the spectrum of alternative care options for children who have been maltreated. This debate is driven by the desire to maximise the likelihood of positive psychosocial outcomes for maltreated children who frequently have poorer developmental, educational and vocational outcomes than other children. Much of this debate centres on the characteristics of the children for whom residential care is best suited, what constitutes best practice in residential care and what factors maximise positive psychosocial outcomes for children placed in residential care (for example see Ainsworth & Hansen, 2008; Bath, 2008a,b; Hillan, 2008; Knorth, Harder, Zanberg, & Kendrick, 2008). While the debate continues, the pressure on the alternative care system continues to grow.

In most western countries, the numbers of young people in residential care has increased significantly (Hawkins-Rogers, 2007; Hooper, Murphy, Devany, & Hultman, 2000; Spencer, Shelton, & Frank, 1997). In Australia, however, the use of residential care has been decreasing and is currently comparatively low, with only a small proportion (approx 4%) of children in out-of-home care living in

residential care (AIHW, 2007; Flynn, Ludowici, Scott & Spence, 2005). In South Australia, for example, less than 10% of children in out-of-home care are placed in residential care (AIHW, 2009). Australian residential care is typically provided in small facilities without the supportive therapeutic or educational services provided in other countries (Ainsworth & Hansen, 2009; Bath, 2008a).

In Australia, the decreasing use of residential care as an option appears to have been driven, amongst other things, by ideological pressures for de-institutionalisation and normalisation (Bath, 2008a) which have favoured foster care and kinship care alternatives (Bath, 2008a,b; Clark, 1998; Johnstone, 2001). The combination of the increasing number of children coming into care (AIHW, 2009), the complexity of their behavioural presentations, together with economic factors, has contributed to an increasing difficulty in attracting foster carers (Hillan, 2006a). Accordingly, there has been a renewed interest in the possible contribution, role and function of residential care in Australia.

## ***7.2 Residential care in South Australia***

Recent reports into alternative care and child protection in South Australia highlighted several important points about the utilisation of community residential care in this state (Des Semples & Associates, 2002; Layton, 2003; Tomlison & Stanley, 2001). According to these reports, community residential care in South Australia is viewed as a placement of 'last resort' for difficult to serve young people following multiple placement failures. This frequently results in children staying in a community residential care unit for prolonged periods of time because

of difficulties in finding an alternative placement for the child. In addition, the reports found that residential care was not typically viewed as integral to the alternative care system or part of a continuum of services for children. These reports recommended both the inclusion of residential care as an important component of the system and its more effective use in treatment planning.

### ***7.3 Behaviour problems in residential care***

In Australia, residential care is typically utilised following multiple foster placement failures (Bath, 2008a; Foltz, 2004; Hillan, 2006a,b), rather than a proactive choice based on the child's mental health and behavioural needs (Bath, 2008a; Hillan, 2006a,b). Perhaps as a result of this, the 'typical' child placed in residential care in recent times is likely to be referred due to challenging behaviours including high levels of aggression and placement breakdown. Indeed, the main reason for choosing residential care may often be the need to control or improve challenging behaviour (Bath, 2008a; Clough, 2000; Clough, Bullock & Ward, 2006).

Children in Australian residential care are likely to have extremely high needs (AIHW, 2007, Ainsworth, 1999). Several overseas studies have shown high levels of psychiatric and mental health issues amongst young people in out-of-home care (Dimigen, DelPriore, Butler, Evans & Ferguson, 1999) and particularly amongst those in residential care (McCann et al., 1996). For example, Arcelus, Bellerby and Vostanis (1999) found depressive conduct disorder in 21% of a group of 70 looked after children referred from U.K. residential children's homes, with an

alarming 35% of this group requiring referral for clinical intervention. Amongst the most common diagnoses applied to children in residential care are conduct disorder, oppositional defiant disorder and attention deficit disorder (Bath 2008a; McCann, James, Wilson et al., 1996). In one recent national survey, conduct disorder was the most prevalent of all the emotional and behavioural problems recorded for children in residential care, with 60% of the children in residential care classified as exhibiting conduct disorder (Meltzer et al., 2003). Conduct disorder appears to be more prevalent in residential care than in similar aged children in foster care (McCann et al., 1996; Meltzer et al., 2003). The level of clinically significant emotional and behavioural problems appears to be increasing relative to previous years (Burns et al., 2004). While it has been suggested that up to 96% of adolescents in residential care may demonstrate some form of psychiatric disorder (e.g., McCann, 1996), there is a possibility that selection effects may come into play in studies surveying youth in treatment residential programs. However, children in Australian residential care facilities are have also been described as engaging in high levels of violence and aggression and substance abuse (Ainsworth, 1999, 2001; Ainsworth & Hansen, 2009; Bath, 2008a).

It has been suggested that children in residential care may demonstrate a strikingly different style of interpersonal relations and emotional regulation to children that have not been subjected to interpersonal trauma (Abramowitz & Bloom, 2003). This emotional lability in interpersonal relations has been described as "...vulnerability to affective flooding under even minimal levels of stress, high levels of aggression towards others as well as themselves and significant cognitive deficits" (Morris, Muehlbauer, Francis, & Naylor 2005, p. 4,

as cited in Hillan, 2006b). Amongst children who have been exposed to trauma there may be persistent changes in arousal, muscle tone, affect regulation, impulsivity and sleep cycles (Dozier & Rutter, 2008; Hillan, 2006b; Perry, 2006; Van der Kolk, 2005). At the very least, these children will have experienced significant changes and loss in family, surroundings and friends.

Considering these issues, there is good reason to suppose that the residential care worker will be routinely confronted with the cognitive, behavioural and emotional sequelae of significant neglect, abuse and trauma. Moreover, these issues are likely to manifest themselves behaviourally, within the constraints of a confined environment, in the context of a group of children with similar issues and typically without the support of multidisciplinary teams.

#### ***7.4 Debate about residential care***

Views about the place of residential care tend to be highly polarised (see Knorth et al., 2008). According to some, residential care should be seen as a 'last resort' or temporary response due to its probable negative impact on children, whereas others argue for the positive influence of well planned, appropriately timed residential care (see Knorth et al., 2008). Compounding this, there exists relatively little evaluation data for residential care in all its forms (Knorth et al., 2008).

Amongst the criticisms levelled at residential care include its lack of clearly articulated goals (Hillan, 2006b), treatment elements (Knorth et al, 2008),

evidence based practice (Hillan, 2006b) and explicit theoretical underpinnings (Bath, 1998a; Morton et al., 1999). Others have argued that while existing models of residential care may suffice for less vulnerable children, new models need to be created for traumatised children (Abramowitz & Bloom, 2003; Connor & Melloni, 2002; Wells, 1991; Wells & Whittington, 1990).

Still others have argued that residential care plays an essential role in alternative care options and should be used as a positive choice, not just as a last resort (Ainsworth 2007; Wagner 1988). Amongst suggested improvements and frameworks for change are careful case planning, plans for managing difficult behaviours, therapeutic supports for children and careful attention to staffing and agency management (Tomison & Stanley, 2001). Additionally, residential programs should be highly selective in terms of who is placed, and have a clearly defined function (Ainsworth & Hansen, 2008). Irrespective of the model of care in question, it has been argued that effective residential care needs to incorporate: 1) the inclusion of a clearly thought out philosophy of treatment (Clough, 2008; Hillan, 2006b), 2) child centred practice, in which the service is matched to the child's need rather than child's need being subordinate to the service model (Clough, 2008; Hillan, 2006b) and 3), a service wide commitment to training, continuous learning and evaluation (Hillan, 2006b).

'At risk' or high risk youth have served as the focus for reviews and attempts to rethink residential care practice. Ainsworth (2001) has recommended that the Australian residential care system needs to set aside ideological notions of care and consider a growing evidence base for carefully planned, professional

residential services. Indeed, there has been much debate about what residential care for these children should look like. While some appear to favour small homes with a 'family-like' feel, others argue that the level of services required, particularly for children with conduct disorder or offending behaviour, can be better supplied in larger residential facilities (Ainsworth, 2003).

In Australia, although residential care is deemed an important and essential part of the options available to children (Bath, 2008a; Hillan, 2006b, 2008), and a critical component of any mature child welfare system (Ainsworth & Hansen 2005; Bullard & Johnston 2005), it has been neglected in terms of both the alternative care literature and in the research (Bath, 2008a; Bromfield, Higgins, Osborn, Panozzo & Richardson, 2005). Furthermore, although residential care is used and researched more extensively overseas, there still exist considerable difficulties in identifying and extracting the effective elements of residential care in order to apply them to an Australian setting.

### ***7.5 Evaluation of residential care***

At the present time, it is difficult to determine the effectiveness of residential care in improving psychosocial outcomes for children. This is due in large part to the wide variations in the residential care models in question, making comparison of like with like difficult (Delfabbro, Osborn & Barber, 2005). Residential care models and services vary widely across the world (Hillan, 2006b), in response to the broad social, ideological, economic and political contexts in which they operate and are funded (Yelton, 1993).

For example, residential units may vary in size, and in the age and clinical issues of children in the unit. There are also differences in the goals of the units across different countries; whether the stated goal is reunification with the biological family, subsequent placement with a foster family, offender rehabilitation, custodial care until independence; short term or permanent care. Additionally, residential models vary according to their philosophical, ideological and theoretical approach. Similarly, the professional backgrounds of residential staff and the composition of the staff team can vary enormously. A comparison of models and ideologies is beyond the scope of this thesis. For an interesting description and comparison of international service models and philosophies, the reader is referred to Courtney and Iwaniec (2009).

It may often be unclear what the aims of residential care are (Clough, Bullock & Ward, 2006; Leichtman, 2006), making outcome measurement difficult. Outcome measures are not routinely reported, vary from study to study and rarely include measures of stability over time (Parker, 1988). When outcome measures are reported, there are frequently factors inherent in the research design which result in difficulties in accounting for, or explaining, outcome (Parker, 1988) such as selection effects and the inability to conduct randomised trials (Butler, Little & Grimard, 2009). Due to the often significant financial and ideological investment of service providers, the use of external bodies to evaluate effectiveness has been suggested; however, for the most part funding bodies continue to monitor outcomes themselves (Hillan, 2006b).

There are numerous difficulties in determining the contribution of residential care to the mental health and wellbeing of the children involved. More specifically, it is difficult to tease out the relative contribution to behavioural issues of removal from biological home, trauma, the impact of institutionalisation, other mental health issues and the numerous placement breakdowns. To state this more cynically:

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 (Yelton, 1993, p. 185).

Conversely, there may be a tendency to blame residential care for poor outcomes (Bath, 2008a; Hillan, 2006) when the contribution of other issues occurring earlier in the child's life can also be great.

Notwithstanding these issues, the potential for residential care to benefit children appears great. In a recent review of outcome studies in European models of residential care Knorth et al. (2008) concluded that, on average, children improve in psychosocial functioning following a period in residential care. According to Knorth et al., (2008), young people with externalising behavioural problems appeared to benefit more, and residential programs appeared more effective than similar programs delivered in the home environment. While others have also found that children with more severe emotional disturbance respond better to residential (treatment) care than those with less disturbance (Hoagwood

& Cunningham, 1992), this suggestion has also been contested by other findings (Joshi & Rosenberg, 1997). Indeed, the deleterious effect of placing children with externalising disorders together in groups has been well recognised for some time (Dishion, MCord & Poulin, 1999; Kazdin 1997). Dishion and his colleagues, for example, have suggested that systemic interventions aimed at reducing deviant behaviour in youth might actually result in adverse, iatrogenic effects. They highlighted the concern that any positive effects of the content of a therapeutic intervention might be offset by processes of peer influence that occur when 'deviant' youth are allowed to interact together, although what factors mediate and moderate this is not yet fully understood (Dishion & Dodge, 2005).

Some attempts have been made to determine the effective treatment components of residential care. A recent review concluded that there appears to be some evidence for the effectiveness of a range of cognitive-behavioural interventions (including social skills and assertiveness training, self control and self instruction training), especially in combination with parental, school and peer support (Stevens, 2004). However, consideration should be taken for the child's developmental and intellectual level, since such approaches are generally more effective when children have reached Piaget's formal operational cognitive level (Stevens, 2004). Similarly, the recent review by Knorth and colleagues (2008) concluded that behaviour modification and family interventions showed promise, and that the addition of specific social skills training also enhanced treatment outcomes. It is questionable, however, to what extent family interventions are included amongst treatment components in residential care in Australia.

Other approaches that continue to be supported are based on the positive peer culture model (Vorrath & Bendtro, 1985), which emphasises the development of a caring norm and responsibility for self and for the group, and appears to lead to positive behavioural, academic and emotional outcomes. In its original form it assumed a small same gender environment, although programs arising from the original that seek to promote positive value of helping others (Quigley, 2004), correction of cognitive distortions (Gibbs, Potter and Goldstein, 1995), anger management (Goldstein, 1998), and notions of restorative justice (Steiner & Johnson, 2003) have also been successfully employed (Ainsworth & Hanson, 2008; Handwerk, Field & Friman, 2000). Programs that assume and encourage the child's need for mastery, belonging, independence and to express prosocial behaviour; focusing on opportunities for these developmentally vital tasks, also show promise (Bendtro & Brokenleg, 2001). Although diverse, these programs may all be characterised as emphasising strengths, developmentally appropriate skill development, and encouraging belonging to community, in contrast with a problem focus or deficit model.

At this stage, relatively little is known about presenting problems or clinical issues as predictors of outcome, or how these factors interact with type of residential setting (Knorth et al., 2008). Similarly, very little information is available even in the published outcome studies reviewed by Knorth et al. (2008) about the components of the actual interventions programs being reviewed. As a general comment, too much of what occurs in residential care constitutes a 'black box' (Axford, Little, Morpeth & Weyts, 2005; Hoagwood & Cunningham, 1992;

Knorth et al., 2008; Lewis, Lewis, Shanock, Klatskin & Osborne, 1980; Moses, 2000b), providing little guidance for therapeutic intervention.

Additionally, there remains very limited ability to speak confidently about the long term outcomes even for well articulated programs because the findings that do exist regarding long term outcome appear equivocal (see Butler et al., 2009; Corbillon, Assailly, & Duyme, 1991; Frensch & Cameron, 2002; Lyman & Campbell, 1996; Parker, 1988; cf Valle & Casas, 2002). For this reason, the applicability of these models to the Australian system still remains unclear.

The lack of clearly articulated treatment approaches to guide residential care workers is troubling given the repeatedly documented high levels of mental health and behavioural issues amongst children in out-of-home care (Dimigen et al., 1999) and particularly amongst those in residential care (McCann et al., 1996). The following sections will outline what is known about residential care workers' attitudes towards, and engagement with, behavioural and mental health issues.

### ***7.6 Workers engagement with mental health and behavioural issues***

Ideally, residential care staff should be familiar with the impact of trauma, loss and mental health and learning issues on the life of the children in their care. However, it has been suggested that mental health issues may be denied or downplayed by residential care workers (Hillan, 2006b) or even go undetected by workers (e.g., McCann et al., 1996). Concerns have been expressed about the access that children in residential care have to mental health services (Nicholas,

Roberts & Wurr, 2003). A recent Churchill Fellowship Report (Hillan, 2006b) highlighted the fact that all the residential facilities visited had young people who exhibited significant distress, or where concerns were held for their mental health. In addition, residential care workers frequently felt that mental health professionals or other stakeholders did not sufficiently consult with them regarding mental health issues of the children in their care. Mental health workers and other stakeholders, in turn, may not adequately understand the issues facing residential care workers and have different objectives to residential care workers when it comes to behaviour management (Piersma, 1985).

Anglin (1999) has described the ideal characteristics of the effective residential care worker: the ability to develop therapeutic relationship with the young person and their family; a focus on the optimal development of the child using a holistic approach; an ability to focus on strengths and social competence, rather than focus on problems, and the ability to work in direct day to day encounters with the child rather than in a sessional or interview arrangement. Such descriptions of the ideal worker and have been influential in residential care training, at least in the UK. However, the extent to which these ideals of engagement with mental health and behavioural issues are actualised in practice are unclear, particularly in the Australian models of 'residential care' which do not tend to emphasis therapeutic or treatment elements (Bath 2008b; Delfabbro, Osborn & Barber, 2005). Some of these ways of working, while possibly second nature to many residential care workers, may be unfamiliar to mental health professionals and other stakeholders, raising the possibility of contrasting ideas about addressing behavioural concerns.

With respect to residential care workers, relatively little is known about how they understand, approach and manage challenging behaviours. Despite the fact that the residential care environment is likely to be populated by children that could attract a diagnosis of conduct disorder, oppositional behaviours or other psychiatric difficulties, there has been very limited exploration of worker attitudes, characteristics or other “microprocesses” related to behaviour management (Moses, 2000b, p.114).

Understandings, values and beliefs or “theories of the resident world” are thought inform residential care workers frameworks for approaching behaviour issues (Clough, 2000, p. 74). Professional training and workers understanding of behaviour can impact on judgements about how to respond to situations involving young people in care (Cameron, 2004). Theoretical frameworks for residential care can vary widely between, and within continents, and depend on factors such as unit size and treatment focus (Hillan, 2006b), so explicitly examining worker understandings and values becomes increasingly important. Although several well received books describe the general characteristics of well functioning residential units (e.g., Anglin, 2002; Clough, 2000), relatively little is generally said about the attitudes of workers; what essential tensions exist for the workers in managing extremely challenging behaviour and how these are resolved.

### 7.6.1 *The experience of the residential care worker*

Much of what is written about residential care workers appears to be negative or to provide contradictory advice to the worker. For example, Whittaker (2009) has suggested that residential care may be subject to “reflexive negative attitudes” (p.175). Residential care workers are frequently subject to indirect criticism from others in frequent calls for more qualified, reflective practitioners. For example “Investment is required in the development of a skilled, knowledgeable, sensitive and creative workforce able to express and encourage high aspirations for all children in terms of their potential (Clough, 2008, p.40); or “There is a pressing need to develop a cadre of leaders in residential child care, able to communicate the vision to their staff, young people, councilors and trustees, and the public” (Clough, 2008 p. 40). Additionally, there is often an implication that workers are reactive, rather than proactive, in their approach to behaviour. They are seen to take a short term view about behaviour and to focus on procedural issues such as the recording of any behavioural incidence without reflecting on its long term meaning for the child (Lane, Barton-Arwood, Nelson & Wehby, 2008). It has been suggested that staff emphasise independence skills or self reliance (rather than dependence and care), and may use staff attention or time as a reward and something that is earned by good behaviour (rather than given unconditionally) (Leaf, 1995).

Furthermore, much of the rhetoric about residential care workers appears contradictory and given without consideration of the model of care provided. Workers are both invited *into* and advised *against* emotional involvement with the

child. For example, many writers exhort the importance and therapeutic nature of the relationship between a child in residential care and the residential care worker in which their role is to “create a corrective environment for the child, allowing the re-experiencing of proper adult-child relating” (Chop, 2003, p. 301). The importance of staff-staff and staff-child relationships as a “consciously used” route to intervention is advocated (Ainsworth & Hansen, 2008, p. 44). Accordingly, residential care staff are “...responsible for reaching into the past and evoking relational responses that are unpleasant and uncomfortable for both the child and staff” (Chop, 2003, p. 301). On the other hand workers are advised not to take the behaviour and reactions of children personally (Chop, 2003; Fitzgerald, 1994).

Adding to the pressures described above, there may also be perception of time pressure about achieving change in the young person’s behaviour and preparing them for independent living in the outside world. For example:

Adolescents have a small window of time to garner the necessary skills to manage independent lives as adults....The expectation is that the adolescent will have 2-4 years, in some cases, to experience a new model of consistent care and to build resilient response to threatening and anxious-provoking situation within a family-like milieu.”

(Hawkins-Rogers, 2007, p. 1136).

### *7.6.2 Residential care worker attitudes and behaviour management*

Little empirical research has been conducted on the unique stresses and tensions inherent in residential care work and, in particular, about their experiences in attempting to understand, manage and address significant challenging and aggressive behaviour. In many aspects of this work they may experience demands which cause tension for them, and may in fact impact negatively on their ability to support change in young people.

Critical reviews of residential care practices frequently emphasise the need for trained staff and consistent support and consultation (e.g., Lindsay & Foley, 1999; Milligan, 2003). Low level of staff training is frequently cited in discussions on what is wrong with residential care (e.g., Ainsworth & Hansen, 2008). However, this call for more training does not seem to be based on any empirical analysis of the needs, stresses or tensions experienced by these workers in managing challenging behaviour. Further, advocates of training rarely provide details what training is needed. Self care and the ability to work through competing imperatives in the workplace is not routinely mentioned (e.g., see Bath, 2008b). Better understanding of the dynamics and tensions that exist for workers in managing behaviour will help to train and support workers in this 'front line' position. To date, this does not appear to have been explicitly examined.

Therefore, on the whole, relatively little is reported about the subjective experience of residential care workers and in particular about their experiences and concerns when attempting to understand, manage and address the challenging

behaviour they face. However, some related literature does provide clues to the attitudes and unique tensions that may exist for unit workers.

Fitzgerald (1994) and Morrisette and Bodard (1991) have outlined some of the reactions that can arise in residential care workers as a result of perceived resistance on the part of young people in residential care. Amongst others, these include a mixture of negative reactions which impede the workers ability to understand behaviour and respond in a supportive, positive manner (Fitzgerald, 1994). Additionally, workers who are unable to work effectively with resistance and opposition on the part of the young person may feel drawn into to a retaliatory, punitive stance (Morrisette & Bodard, 1991) or inadvertently convey feelings of disappointment and frustration to the young person (Morrisette & Bodard, 1991) which can further contribute to resistance and opposition.

In response to organisational culture, there may be pressure to place emphasis on safety and management, fairness and consistency, independence skills and staff attention as a reward that is earned for good behaviour (Leaf, 1995). Further, workers may feel obliged to maintain professional distance (Leaf, 1995).

Insights into the tensions involved in residential work may be also be found in one attempt to identify the issues faced by trainee psychiatric staff in treatment residential unit teams (Evans, 1987). Trainee psychiatric staff members were reported to experience tension between competing and co-existing treatment philosophies (e.g. token economies and therapeutic community; encouraging independence and maintaining control of the unit functioning). In addition, they

experienced a tension between the convergent (i.e., diagnostic, logical) and divergent (creative, wholistic) thinking required in the role. Clearly, many of the tensions highlighted amongst psychiatrists undertaking training in residential care are applicable to other residential unit staff. However, workers may feel inhibited in implementing creative responses due to the “fear factor and blame culture” and risk aversive work environment that inhibits creative practice (Clough, 2008, p. 40).

There has been a limited exploration of attitudes of residential care workers towards their clients and their behaviour. Colton (1989), in a UK study, compared worker attitudes towards behaviour amongst specialised foster care and residential group home workers. He found differences in attitudes towards behavioural control in the two forms of residential care, but this did not translate into difference in practice. In studies of attributions made by residential care workers working with intellectually disabled clients, however, causal attributions made about challenging behaviour did appear to be related to optimism for change and willingness to persist in helping the client (e.g., Jones & Hastings, 2003; Stanley & Standon, 2000; Wanless & Jahoda, 2002). Further, observations of staff–child interactions has shown that children in inpatient residential care do modify their behaviour, including aggressive behaviour, in response to staff parenting style, attitudes and expectations about behaviour (Amini, Burke & Edgerton, 1978; Joy, 1981; Moses 2000a,b).

Anglin (2004) has also described the interactional dynamics in a residential unit which best serves young peoples needs. Amongst these are several factors

related to worker approach, attitude and understanding of behaviour such as sharing a framework for understanding events, respect for personal space, listening and responding with respect, offering emotional support, and challenging thinking and action.

Thus, although residential care workers are likely to experience significant exposure to aggressive and challenging behaviour, relatively little is known about how they understand, approach and support change in such behaviour. However, the available literature suggests that, in many aspects of their work, they may experience demands which cause tension for them in attempting to manage behaviour and which may in fact impact on their ability to support change in young people. It is important to understand some of the dynamics and tensions that exist for workers in managing behaviour in order to better train and support workers in this 'front line' position. It is conceivable that their understanding of mental health and behavioural issues is likely to influence the perceived importance of counselling and seeking out mental health support for these young people. This in turn is important, because of the likely long term impact of unaddressed mental health issues on young people and poor long term prognosis for young people with conduct difficulties and other behavioural and mental health issues (Courtney et al., 2001).

The previous chapters have noted variations in the approaches and understandings of challenging behaviour amongst stakeholders in out-of-home care. Residential care workers are uniquely positioned amongst stakeholders in the out-of-home sector in that they are placed in both the role of parent and of

professional. It is therefore interesting to explore how residential care workers are influenced in the decisions they make about addressing challenging behaviour, and the factors which are taken into consideration by workers when supporting this most challenging group of children.

## **7.7 Analysis and themes**

Accordingly, the remainder of this chapter reports an analysis of 17 interviews with residential care workers in which they describe their understanding and experiences in managing challenging behaviour in a residential care unit. A thematic analysis was conducted as outlined in Chapter 3. The following themes were identified, and reflect the tensions experienced by residential care workers when attempting to support young people to address their challenging behaviours:

- 1) A different kind of parenting
- 2) Congruence in approach
- 3) Control and connection
- 4) Desire for normality
- 5) Inconsistency in relationships

### **7.7.1 A different kind of parenting:**

Some participants' accounts of attempts to manage challenging behaviour were organised around the tension between adopting a professional approach to

managing behaviour and one more aligned with 'normal' parenting. A constant tension existed between professionalism, and its implicit culture of distance, and a felt pull towards caring for the child as though the child were their own, as can be seen in the following extract:

**R:** What I say to people who aren't real familiar with the alternative care system is that my job as a youth worker is pretty much a parental role. It is to play a parent if you like, not that I adopt the same philosophies as a parent in my own time as I do here at the worksite. My relationship with my own child is far different and the way I conduct myself is far different. So therefore I certainly don't treat the kids as I do my own. A lot of people will say that you treat these kids as you do your own. I understand where they are coming from, but it is not the same - not from where I stand. **Interview 54**

Conflicting feelings emerged as residential care workers attempted to manage feelings of closeness towards particular children and reconcile this with the constraints of the professional role. Workers vacillated between seeing themselves in a parenting role and adopting a stance of parenting at a distance; a dual identity they found difficult to assimilate. Workers frequently expressed disappointment about their inability to spend time with the children and guilt about how much of themselves they were able to give to each child:

**R:** Once you have finished your day, run kids around and answering phones, doing all the paperwork you need to do, there are some days

when you haven't even spoken to them, there really are. There are days when you haven't given them yourself at all. You have just kept the shit rolling and done what has to be done. There are other days when it is great; you have heaps of time up your sleeve. We don't often have that time to do that extra that they need. We keep them well, alive, safe.

### **Interview 70**

This tension was felt more acutely in relationship to children that a worker felt that they had a special connection with. Several workers spoke of the sense of guilt or wrongness about feeling closer to, or having a special relationship with, one child over another and of an awareness of ensuring a sense of equality and fairness in their dealings with all children. Others had resolved to challenge this implicit culture of adopting a 'professional' stance, as this participant describes:

**R:** It used to be the old school of belief that you couldn't be emotionally involved and that it would be really bad for you to be emotionally involved. I would challenge that, challenge anyone who could work in a place like this and not become emotionally involved at some level. **Interview 51**

Systemic issues further contributed to this implicit pressure for distance in workers' relationships with children. For example, workers' ultimate lack of legal authority over the child meant that they were frequently unable to negotiate and to impose consequences on children. Frequently, Department case-managers, who did have legal authority, were perceived as failing to back up workers and

reinforce suggested consequences. Similarly, legal consequences for offending behaviour on the part of the young person were not administered in an appropriate and timely manner. This ultimately meant that, from the perspective of the worker, the child was not able to benefit from the opportunity to experience negative consequences for socially inappropriate behaviour. This kind of interference ultimately resulted in a “non normative” kind of parenting (Eastman, 1982, p. 95), in which the opportunity to work through conflict and ‘repair’ relationship, or to impose logical consequences was often interfered with by third party (systemic) issues. Therefore, workers ability to parent effectively was disrupted in a similar way to that experienced by foster carers.

Additional ‘distance’ in relationships arose because of a culture of active discouragement of ongoing long term relationships with the children in residential care. This was something that caused frustration and sadness for some and minimised their ability to have a long term impact on the children’s lives. Organisational issues such as staff turnover also contributed to a minimisation of the importance of an ongoing relationship with the worker. In this extract, one worker talks about an event that helped him realise the importance of ongoing connections with between workers and children:

**R:** What I have noticed is we get kids who are just turning 18, so they would have left here a year ago and gone into independent living and they phone up here, looking for anyone that they remembered. It happens a fair bit. There was one girl in particular, she [phoned and]

said I am turning 18 and she just wanted to tell somebody-I am almost 18.

**I:** A milestone?

**R:** Yes, she phoned up here and she said who is on shift? -and I basically said sorry, but there is no one that you know, we are all different now. So who else are they going to turn to? It does show that a lot of times they do care about the relationships here that were really important to them.

**I:** They carry those [relationships] with them?

**R:** Yes, a few of them actually tell us, they look at us as their family, this is their home, they don't want to leave, and it is rare considering they tell us what fuckheads we are. **Interview 52**

Hillan (2008) has spoken about this implicit imperative to workers not to get emotionally involved with the children for whom they are responsible on a daily basis, and its consequences for children. She draws a sharp contrast between the regard in which we hold our own personal relationships (as workers and mental health professionals) and the regard we have as workers for the relationships of young people:

We value the importance of relationships in our own lives, marvelling at friendships that last over 20 years and family connections that go on for generations, but we ‘professionalise’ young people’s lives to the point that long-term connections to organisations or staff are demonized (p. 49).

The literature on residential care exhorts the importance and therapeutic nature of the “consciously used” relationship between a child and the worker (Ainsworth & Hansen, 2008, p. 44). Through relationship with the worker, the child is exposed to “corrective emotional experience” (Moses, 2000a, p. 113), in which they are able to experience “proper adult-child relating” (Chop, 2003, p. 301). However, the results of this analysis suggest that workers also feel the need to remain professional in their interactions with children and that these competing imperatives (connection versus professional distance) form an important dynamic in workers’ daily interactions with children.

Reports from young people suggest that the best experiences of residential care may be those in which young people are involved in caring relationships (Hillan, 2006b, 2008). Systemic factors have also been given by workers overseas as reasons for not continuing relationships with young people (Hillan, 2006b), so this particular aspect of this theme is unlikely to be unique to the participants in this study. This finding suggests the need to think creatively about the importance of relationships not only for the child, but also for the workers, in the hope of validating the workers’ relationships with children in care. As one participant put it:

**R:** Ideas have changed enough so that now you have all sorts of blended families, why can't that be extended to families and not necessarily blood [families]. You can have multiple parenting options really, and that to me seems to be what is needed. A less rigid idea of-it is like trying to achieve a norm that just isn't there. So why try to achieve the norm? Why not think outside the square and come up with something completely different? **Interview 61**

This theme suggests that for some workers the pressure to maintain a professional approach to the management of the children in their care suggests that they may, at times, minimise the importance of investing in ongoing relationship with the child. They may be discouraged from a more usual parenting relationship with children by systemic issues such as their ultimate lack of legal authority over children, despite having the responsibility of the daily care of the children.

#### *7.7.2 Congruence in approach:*

In describing challenging behaviour, much of participants' talk centred around the primacy of the needs of the majority of children in residential care over the needs of the individual child, and the importance of a consistent and congruent approach in facilitating that. In addressing challenging behaviour, participants felt constrained by the necessity to attend to the needs of the group environment for consistency and equity. This resulted in a tension between the desire for fairness

and congruence on the one hand, and the desire for flexibility in responding uniquely to each behavioural incident on the other hand. In the following brief extract, a participant describes the difficulty in finding behaviour management strategies that both staff and children find satisfactory:

**R:** Because it is like that [with behaviour management]-sometimes that causes some conflict amongst ourselves and it confuses the kids. [The children think] How come I can do it with them but I can't do it with you? **Interview 71**

Protests from the children about lack of fairness and consistency in behaviour management approaches were a source of stress for workers. On the whole, these difficulties were accepted as an insoluble problem and part and parcel of the job. This participant describes his attempts to make children understand decisions about behaviour management that frequently appear to lack equity and to make little sense to children:

**R:** Well [I tell the child] that is because this is how they [other children] react to stuff and because of their experiences and age –and it will be different for you. This is the way we treat you and respond to your individualness. That is hard for kids to understand. It is hard for workers to understand sometimes. **Interview 49**

The culture of presenting a unified front (or united parenting) often conflicted with an individual workers understanding or preferred approach to the problem

behaviour or crisis situation. While workers frequently disagreed with unit rules, the need for conformity with an implicit culture of consistency with respect to behavioural consequences outweighed both the individual workers preferred (more creative) practice towards behavioural incidences and the needs of the individual child, as the following worker suggested:

**R:** Rewards work, absolutely. Particularly with the group we are working with in [community residential care]. They are very reward focused, and they want something for everything they do, just to get paid to behave well with the program. I certainly comply with the team structure around that, because that is a team decision and I have a responsibility to fulfil that, but I hate going around putting in extra rewards. I have known this group for quite a while and what they have come to expect in terms of rewards and such. **Interview 54**

This tension was echoed in workers' stress when considering the impact of a child's behaviour on the wider group (neighbourhood, community, or society). Anxiety about the potential consequences of a child's behaviour frequently manifest itself in the desire to use stronger sanctions in order to protect other children in the residential unit or members of the community. In addition, challenging behaviour exhibited by any individual child aroused a level of anxiety about the risk of the 'contamination' of other clients. This further added to the tension between the needs of the child to express emotions (often in the form of challenging behaviour), and the perceived needs of the other children in the group

environment for safety, consistency and routine; as the following participant describes:

**R:** Another issue that the kids face whilst living in CRC [community residential care] is living in large groups, we are talking 8-12 kids. The issues around the negative influences that a number of kids can bring into the household, and how it can rub off on all the kids. In many incidences it becomes a really poor culture amongst these kids.

### **Interview 69**

For some, this dilemma was reconciled by placing an emphasis on the greater need of the group for consistency and clear boundaries at the expense of flexibility. Conversely, the difficulty in simultaneously addressing the needs of the majority and the individual children resulted in some workers consciously choosing to focus more on the underlying needs of the child that they had personal responsibility for, as one residential care worker suggested:

**R:** So I am focusing on my care child [participant is key allocated worker for that child] and the 3-4 years that I will probably get with him. I am quite optimistic, in fact I made a pact with him, that I will get him ready for high school, and that is a huge motivating factor to me. [I'm] just focusing on [the] one individual that I have responsibility for. Rather than thinking too much about the 8 kids in here, or the 60 kids in CRC, or the 120 kids under alternative guardianship care. You can't take their stories too personally, you do what you can. **Interview 56**

The essential difficulty in both caring for all and caring for the individual has been alluded to by others. Leaf (1995) has argued that amongst residential care workers the implicit assumption that there is "one rule for all" may preclude workers employing a flexible, individual approach (Leaf, 1995, p.18). The data from this study would support this notion.

Heterogeneity of client group mix appeared to magnify this tension. Many units provided examples in which they had little input into which clients were allocated to their program, as this extract illustrates:

**R:** We used to get a fair bit of say in what kids we had as to what suited the kids we already had here. But I think that has been pretty well over taken just by the crisis that is [the need for] placement, which means beds for kids. So we get less and less say about what sort of kids we have. We can't pick and choose to see what suits us - as opposed to

this kid is breaking down their placement pretty badly, [the child's behaviour] is high profile, we have a bed, so we get them regardless.

**I:** That is just the way it is?

**R:** Yes. That is the problem. We have 8 kids, ranging from 10-17 and having 8 kids in care from various ages with various mental health issues, behavioural issues, is quite a juggle.

**I:** What has been the impact of that change in culture?

**R:** I suppose we run into problems of kids who have certain needs and issues, either as a victim or perpetrator of abuse, sexual abuse, all that sort of thing. Whereas we try not to have that mix in here, we do. So it makes us more vigilant around the kids in knowing where they are and what they are doing. That is hard with 2 workers and 8 kids sometimes. Especially when things happen, it is just hard because of those ratios.

### **Interview 70**

The mixing of young people with a variety of needs and problem behaviours (Ainsworth & Hansen, 2008), presents management problems for staff and makes it increasingly difficult to manage the tension between the needs of the group and the needs of the individuals. In this study, workers in residential care units with clients with a mixture of genders and ages were especially likely to talk about 'contamination' effects. Anglin (2002) has argued that in this kind of situation,

problematic behaviours are taken up by other children in the unit and the staff are therefore required to impose more and more rules in an attempt to regain control of the environment. In this scenario, a negative and stressful environment can be created for the residential care worker and children alike.

Much has been written about the use of group norms and group processes as a principal means for creating behaviour change in the residential care environment (e.g., Vorrath & Brendtro, 1985). Positive peer culture has been used successfully by workers to create an environment of peer (internalised) self correction, rather than placing responsibility for behavioural control (externally) with workers. The distinction between universal rules (not negotiable, whole of community behavioural contingencies) and individual triggering events for problematic behaviour is also relevant here (e.g., O'Neill et al., 1997). Such elements are supported by functional behavioural analysis and positive programming approaches that lend themselves well to group environments such as classrooms or residential units (O'Neill, et al., 1997).

Therefore, one of the main difficulties faced by the residential care workers in managing challenging behaviour was the tension produced by the need to attend simultaneously to the needs of 'all' and to the needs of the individual child. That is, for workers to provide an equitable and egalitarian approach to all children that is consistent with organisational needs and staff desires, while at the same accommodating the need that each child's behaviour receives individual consideration.

### 7.7.3 Control and connection:

This theme relates to the tension workers experience between two different, simultaneous, and competing needs. That is, the need for behavioural control, and the threat to relationship and connection with the young person posed by such a need. In contrast to the previous theme, extracts in this theme relate to the management of an individual child's behaviour and the effect of that management on the worker's relationship with that child. Staff struggled with the dilemma of attempting to form relationships with young people and the frequent need to impose behavioural control, particularly when such control occurred in its most extreme manifestation (i.e., physical restraint), as can be seen in the following extract:

**R:** The first time I came here it actually took me a couple of weeks- it set me back a bit about restraining. Emotionally, it just blew me away, it was like- wow! Having this kid, and having so much control and force just to try and keep them in a safe area. The young person just breaks down. It is very traumatic and hard to get [used to]. I don't think anyone gets used to it, and if you do there is something wrong with you I think.

**I:** Do you think that is something that is unavoidable?

**R:** I think it is unavoidable because you try to remove that person from a danger situation to themselves. That is the pros of it, but

sometimes I find when you are in full restraint with a young person, and no one likes their wrists up behind their heads, in a 'figure 8' and that. You tell the young person to calm down. How can they calm down? I find it difficult to manage that. **Interview 61**

Although distressing, physical restraints were on the whole viewed as a 'necessary evil'. In discussing restraint in particular, participants drew parallels between themselves and a biological parent that is abusive: participants experienced themselves simultaneously as the 'good guy' (in forming relationship) and the 'bad guy' (in imposing physical restraint). Staff frequently felt they were put in a 'double bind' situation, perpetuating abuse in a way that was stressful and potentially damaging to their relationship with the child, as the following participant illustrates when describing the aftermath of physical restraint:

**R:** And that is where you debrief with them [the child subject to restraint] and [there are] certain questions you are meant to ask them. It is also very hard to maintain a relationship when you have just restrained someone physically for half an hour and then go in and say how are you feeling?...A bit sore! **Interview 51**

Participants attempted to reconcile their desire to care for children and the need to control behaviour by the rationalisation that imposing limits, boundaries and control on the young person was showing them that they were cared for, as the following extract suggests, in her description of physical restraint:

**R:** I don't think it is great for the kids, I don't think they appreciate it, but I started from a position when I started doing this sort of work that I would be anti restraint. I didn't think that children should ever be restrained, and that was where I started and I stayed there for a long time. Over time really, and with experience, I thought –No. There are times - it really is there to just stop them rampaging, and that kind of fits with the attachment stuff. **Interview 45**

The need to impose control on behaviour was seen to result from the young person either never having been subject to appropriate boundaries and behavioural controls, or from the young person not understanding that 'normal' caring parenting means saying no to things that are unsafe to themselves or others. Extreme behavioural control (especially restraint) was rationalised as leading to higher levels of connection and learning opportunities for both the worker and the child, and as such it became easier for workers to reconcile this tension within themselves over time, and with experience:

**R:** The way I rationalise it is, I know at the other end of that [physical restraint]-9 out of 10 times there are just the most awesome conversations that happen afterwards. I also managed little children as well as the older boys. With the little children, they will sit on your lap and you can have that [nice] stuff. It is not like being in a home situation, where someone has smacked you and then said- no, I am sorry-I love you. It is about –“What happened? This [behaviour] is not

okay. I won't let you hit me. I won't let you hit somebody else. I won't let you get out of control. And we will help you. You will learn how to help yourself over time". I think that stuff is really important, and that is how I let them know [about why we restrain them]. Is it the nicest thing in the world to say -No! **Interview 49**

There is no doubt that the workers that took part in this study found the need to impose physical restraint difficult. Nonetheless, those workers, especially those with multiple experiences of having been involved in restraints, felt that restraints could be (and predominantly were) used as therapeutic tools, affording the opportunity for greater depth of connection with the child. Workers frequently felt that 'outsiders' would find this tension between the need to control behaviour and the benefits of doing so difficult to understand. This participant explains how he equates the willingness to impose restraint with care:

**R:** But the thing is, it is not that 3 seconds, or 10 minutes, or 15-20 minutes [the time that the child is being restrained for]. It is the hours, days and weeks afterwards - going back and connecting. What it comes down to is- Yes! I do care about you! Yes. I care enough to sit you on the carpet if that is what it takes to keep you safe. That is what I mean [about] the boundaries. **Interview 69**

The tension experienced by workers between control and connection may be argued to parallel the difference between behavioural and attachment frameworks, which are informed by different epistemologies and make very different

assumptions about the process necessary for behavioural change. The recent application of attachment ideas into some residential units introduced anxiety that using a 'soft' approach and minimising consequences would mean a surrender of control over young people, as the following participant suggests:

**R:** We got rid of a whole lot of behaviour management systems that we had. We had a level system that we had had here for years and it was behaviour management, a bit like rats in a cage and you got rewards and stuff, and consequences when you didn't. It really has made no difference letting go of that. There was lots of trepidation about not having that. How are we going to control the kids? What is going to happen? But it has made no difference whatsoever. **Interview**

**48**

The place of behavioural control in residential care has been subject to some debate. Some have criticised the use of restraint, claiming it only serves to reinforce negative feelings towards authority figures and does little to assist young people to internalise control (Morgan, 2004) and avoid involvement with the criminal justice system (Hillan 2006b). On the other hand, reluctance to use restraint has been seen as a failure of the system, and to parallel the neglect that young people had experienced in their families of origin (Hillan, 2006b). According to Hillan (2006b), guidelines, policy directions and regulations around the use and monitoring of restraint practices are largely "lacking" in Australia (Hillan, 2006b, p.43). The lack of such guidance is likely to add to the stress of residential care workers. The data from this study would suggest that the trade-off

between relationship and behavioural control is a pivotal concern for workers. Support for workers in maintaining positive relationship (fostering ‘attachment’) while enforcing limitations (behavioural ‘control’) in the context of emotionally charged situations is essential.

#### *7.7.4 Desire for normality:*

Workers interviewed for this study clearly desired to give children as ‘normal a life’ as possible. Implicit in some participants’ accounts of managing behaviour was an ideal of treating children ‘normally’. Participants expressed acute awareness of the many ways in which young people in residential care constantly stood out, were not treated like other children (particularly in a school environment), and there was a desire amongst workers not to further single children out or draw further attention to children. A tension arose between the imperative to treat children normally and the implicit culture of normalising everyday interactions and behaviours on the one hand, and seeing behaviour as extreme, deviant or different, on the other hand.

One inherent tension within this was the consideration of what constituted ‘normal teenage behaviour’ and what behaviour was considered abnormal and therefore required intervention or support, needed to be challenged, or was deemed ‘out of control’. Anxiety was frequently expressed amongst workers about the potential for situations to go wrong, rather than the children’s actual behaviour being challenging or dangerous. The following extract illustrates the tension inherent in worker’s assessment of children’s behaviour:

**R:** A lot of us have done this job for a long time, so you catch yourself looking at the world from the gutter. Like, thinking everything that is said is some plot [against staff]. Just out of touch of what the reality of teenage-hood is, because we have a skewed view of what teenage-hood is. So sometimes the kids might be behaving in a normal teenage manner with a bit of an attitude, because they don't quite get it [how to act] - then we find ourselves going wow! - What is going on? - and really it is just some teenage behaviour, but maybe a little bit more extreme - or with less resources, boundaries or insight. But it is still teenage behaviour. So [we get] a bit isolated around that sort of stuff.

### **Interview 51**

However, many participants also appeared to discount or minimise apparently significant behaviours amongst children. In many instances concerning behaviours were described as 'normal' teenage behaviour, and there appeared to be a culture in which only very extreme behaviour came to be considered abnormal. In this extract, the worker demonstrates the relative way in which 'normal' unit behaviour is defined:

**R:** Our girls at the moment are reasonably settled. When I say reasonably settled, it is opposed to other girls we have had in care. We don't have very much substance abuse here. A lot of the kids smoke tobacco, which isn't good, but we were dealing with glue, speed, heavy prostitution, self harm. A few of our girls have got issues around self

esteem, which manifests in them having risky behaviours at the moment. I wouldn't say any more than a normal 16 year old girl. My kids are young so I have that to come, but I know there is that adolescent stage where they want to rip away anyway, and be a bit more risky, and have a bit of fun in the sun. **Interview 70**

Problems such as this were resolved amongst workers by developing an understanding of what was 'normal for these kinds of kids'; a range of behaviours that would not necessarily be understood by others 'outside' of residential care. Examples of 'normal' behaviour of this type included things like making allegations against workers, refusal to do school work or attend school, engaging in behaviour that the child knows will result in physical restraint, or non compliance with curfews or other rules.

At the same time, workers were also frequently confronted with experiences in which their understanding of normal behaviour conflicted with or opposed the child's experiences of normal. What was considered normal daily routine for staff was often considered unusual by children. This led to conflict with children due to staff's attempts to get children to behave normally, according to normal family style ideals (e.g., washing hands before dinner, not going outside without shoes on), as the following extract suggests:

**R:** A lot of it is the surroundings they actually come from, so they actually think of it as normal. Mum and Dad do this around us all the time so it must be normal. It must mean that we can do it. I find that is

sometimes - 50 to 60% of the cases, it is just a normal thing for them.

When you say it is not normal-the face on them then! Then they say-

what do you mean? It is normal! Mum and Dad do it all the time! It

blows them away! **Interview 60**

Ward (2004) has argued that the pressure amongst residential care workers and their managers for “ordinary everyday living” (p. 214) may result in a drive amongst workers to treat children as normally as possible, and to downplay their special needs. He argued that this dismissal of children’s needs may derive from workers’ denial of the distress and trauma that the children have experienced, and a desire to avoid explicitly dealing with these issues as they may be too threatening and distressing for workers themselves. Additionally, it has been suggested that many staff that work in residential care may have their own histories of abuse that may not have been addressed, making “pain based behaviour” difficult to acknowledge (Hillan, 2005b, p. 49). Indeed, 32% of American residential care workers in one study cited the opportunity to make sense of negative childhood experiences as a motivation for becoming a residential worker (Moses, 2000b), although the extent to which this applies generally is unclear.

Implicit in this drive for normality was the apparent omission or minimisation of the need for mental health intervention and of the potential benefits of mental health intervention to young people in residential care. The utility of counselling was questioned by some:

**R:** My personal view is, I like the physical therapy, and I like the relationship building type model [of intervention]. I think it is very hard for our kids to walk into an office for 30 minutes and get anything out of it, especially when that happens once a month. I have found in the past what has been more beneficial is that the CAMHS workers have advised us what we can do in situations. To be honest, with our kids, a lot of them just switch off [in counselling]. **Interview 70**

Mental health professionals were not seen to understand the children and their needs and the 'normal' things children in residential care do, like making allegations against workers. This extract provides an example of the wariness that the workers in this study had about the involvement of mental health services, and what consequences that might have for the unit workers:

**R:** I don't really believe that one appointment a fortnight or a month makes any difference. What we come up against with them [CAMHS] is that the kids will go there, and all our kids have agendas obviously, and they are not happy here - Nobody wants to live here, this is not where they want to live. They want to live at home. One of the things that kids do in order to get out of where they want to be is [to] be really bad. So, they will go to these appointments and say horror stories about us. They make up stories, or not even make up, they misinterpret. They leave out the fact of why they got restrained. They forget that they smashed the house, assaulted two kids and one of us. That often makes

us really wary, because we are not sure whether they [CAMHS] are going to have the right conversation with us after or not. **Interview 71**

Dealing with mental health issues was also seen as stigmatising to children and ultimately disruptive to the unit; or at least led to more behaviour problems than carrying on as normal. In essence, counselling or mental health professionals were frequently seen as ‘outsiders’ who further removed the child from the experience of normal everyday routine. Mental health services were also seen to convey a sense of expertise and ownership of the child’s mental health problems, and were often seen as working in a way that was counter to the philosophy or approach of the unit. This extract illustrates one worker’s perception about mental health services:

**R:** I think that perhaps a lot of people are working from different frameworks. Perhaps [they need to be] working maybe a little bit more collaboratively. What I have observed is, people are very quick to take ownership over a child-well I have made that assessment -and that is how it is going to be. I think sometimes we need to work by taking other people’s perspectives on board. **Interview 60**

At best, external mental health workers were seen as not understanding behaviour in the context of the unit environment. In extreme cases, the advice of the mental health workers was seen as counterproductive to the aims of the unit, as this extract illustrates:

**R:** I was involved as a 'key worker' with a kid who was doing therapy through CAMHS, and I really didn't think she [CAMHS worker] was very good at what she did. In fact, I must admit I ended up getting really angry one day and telling her what I thought, because she seemed, to me, to be working against the unit. She was basically telling the child that we were causing his problems. He was getting angry because of what we were doing. It didn't matter how much I said "this kid has anger issues". He got really angry because we made him go and have a shower, but the odds are if we left him in bed and he wasn't ready for school, he could get really angry about that as well. This kid gets angry. He could fire up instantly. So once he then gets that idea, there is no way you can do anything. He is then fed that idea that he is not responsible for his behaviour, we are. So I was saying to her- listen, I know you are saying this to him, but we have 7 other kids, that has to be considered in this situation as well. If we don't make him do 'so and so', what about when the other 7 [children in the unit] go -Well, why do we have to do it if he doesn't? Then you end up [in a situation] where nobody is doing anything! **Interview 55**

Although this extract represents an extreme example, it nonetheless illustrates the implicit assumption that those 'outside' the unit are not able to understand the unique context in which behaviour is expressed and needs to be addressed.

Ward (2004) argues that the implicit assumption that the best interests of the child are served in residential care by creating an environment in which business

is conducted in a calm, ordinary and even family like atmosphere are based on a false ideology, and often on poor assessment of the developmental, cognitive, and therapeutic needs of the child, and indeed, on the assumption of a shared understanding of what 'ordinary' or normal is. At the very least, one might argue that this implicit desire to carry on as normal and not single out children to be treated differently may discourage a culture of isolating children for special attention to their behavioural or emotional needs (e.g., by referral to a mental health professional).

#### *7.7.5 Inconsistency in relationships:*

This theme relates to the nature of relationships that workers formed with children. Generally speaking, relationships with young people were characterised as inconsistent and unpredictable. Workers spoke about the incredible difficulty they often had in maintaining relationships with the young people in their care. At the same time, 'relationship' was seen as the primary tool through which young people could learn new behaviours from workers, and through which young people could be motivated and rewarded for learning improved behaviour, as the following residential care worker suggests:

**R:** Sometimes they [children] have to push it until you drop them [restrain them], or someone else takes charge. But otherwise, a lot of it is about the relationship you have already established with the kid. So when you say that is it - I have had enough - You go to your room...[then] they go. They might scream abuse at you as they go, but

they will go. Then later on, you go down and talk to them about it, or not, depending on what reception you get when you get there. So it is all about the relationship. **Interview 54**

However, relationships with young people were experienced as frustrating, stressful, effortful, and often unrewarding. Workers often felt 'singled out' as the target for the kind of aggressive behaviour and verbal abuse that would not be directed at other people:

**R:** Just their behaviour, the way they interact with people especially us. It is different. They can get along quite well in the community- some kids- and yet they will come back here and just abuse us! So a big issue for people working with the young people in care is that they seem to blame us for where they are situated now. **Interview 51**

Workers were frequently the target of abusive behaviour which impacted negatively on how rewarding they experienced their relationship with the children to be:

**R:** I see aggressive behaviour quite frequently targeted at the adults, the workers. That is mainly verbal, not so much physical. That might be a child who maybe frustrated with their own personal life and [is] trying to take it out on the nearest adult- almost trying to visualize the worker as a parent in their own mindset and unleashing frustration [on the worker]. **Interview 54**

The effort expended by workers in relationships was frequently experienced as disproportionate to the reward they received in return, either in terms of affection or in terms of improved (better) behaviour. Workers felt they were invited into negative and unrewarding interactions with the children. While this occurred mostly through low level annoying behaviours, it also occurred in the form of extremely challenging behaviours requiring physical interventions. Participants reported situations in which they put in extraordinary effort with some children who they never felt they 'got through' to. Conversely, some workers felt that they had good relationships with children who, despite this, would seem to unleash their feelings on workers without apparent justification.

Positive changes in the young person's behaviour were seen to occur incredibly slowly, and where change did occur, such improvement was seen as tenuous, short term and easily subject to set backs:

**R:** It can be very disappointing and you invest a lot of time and energy into trying to assist the young person to get their lives back on track and set them up with educational or vocational opportunities, or

opportunities to continue to address rehabilitation like drug and alcohol, anger management- then the young person doesn't fulfil their part of the bargain if you like. That can be a source of frustration in some way. But I try and console myself that it is not because I haven't done my best, I have fulfilled my role and given 100%, and possibly the young person is just not ready at that point in time to see the benefit, so that can be a source of frustration at times. **Interview 43**

In addition to the frustration caused by the unrewarding and emotionally draining nature of relationships, some participants also experienced frustration due to their inability to predict or shape children's behaviour. Behaviour was often inconsistent and unpredictable, and it was frequently difficult for workers to understand what had caused problem behaviour at any one time. Any one consistent way of managing behaviour appeared to be inadequate, at least for any prolonged period of time. This often meant that workers experienced little ability to predict 'what works' in terms of managing behaviour, as the following extract illustrates:

**R:** Everyday as a youth worker, you try different things. Sometimes you might do it for a week and it works, and then another time it doesn't work. Last week we had issues where kids were struggling to get up in the morning to go to school. So this week we have tried different things. Last week we stood at the door and barked at them. This week we have tried something different. Simple things, like if they have done their rooms, showered, brushed their teeth - [then] they can

choose who will pick a channel on TV - a bit of healthy competition. Also, I tried just getting their clothes ready for them. Like you do as a Mum and Dad with your own kids, put their towel behind the door, or run the shower for them. That has worked really well this week. We haven't had any problems getting things done. They have all been sitting waiting to go to school. That has been a bonus for us this week. It might not work next week, but we tried it and it worked this week, [so] it will be something we can perhaps try later on. **Interview 61**

This type of environment appeared to lead workers to develop multiple strategies and approaches that they might try at any one time, a 'tool kit' of strategies, as the previous extract illustrates. Additionally, there appeared to be an expectation that there *was* no approach that could work consistently, as this worker suggests:

**R:** I guess in some ways we do [implement] consequences, so it is quite soundly behaviouralist based. I think that works sometimes, but I don't think you can use that all the time. I think if you use one approach or one method exclusively that you are putting yourself in a box and not giving yourself the full tool kit to work from with the young person.

**Interview 69**

Frustration arose when workers felt they had understood the circumstances that contributed to a behaviour and were relating well to the young person, and then 'went backwards' when it became evident that their strategy no longer

worked. Staff then felt obliged to change tack, change their thinking, and come up with new accounts, explanations, and consequences for behaviour. This meant that workers (and children) were constantly experiencing inconsistency in the interplay between themselves and the young person, and in terms of behavioural contingencies.

Some workers rationalised that this dynamic occurred because the young person is too 'damaged' to get through to, and would never be able to achieve satisfactory relationships. In this way, the children were seen to be incapable of 'attachment' and therefore incapable of benefiting from relationships. This thinking is similar to the theme described in the previous chapter; namely that some children had no capacity or desire to 'attach' to workers. However, others interpreted the negative interaction style towards a staff member to mean precisely the opposite; that is that the staff member was an important person in the child's life that the child was attempting to connect with through challenging behaviour. In essence, these workers saw challenging behaviour as the young person's way of showing how important the worker was to them. In this way, the child's behaviour was viewed in a way more aligned with that suggested to occur in ambivalent attachment patterns. The potential impact of these two different interpretations of challenging behaviour on workers' willingness to persist in helping a young person warrants further exploration.

Experienced workers talked in terms of an optimistic perseverance, and a belief in ultimate change; albeit not necessarily during the time they were involved in the young persons' life.

**R:** You want to say the right thing that will have an affect on them, but you might say something today and two years down the track it will have an affect. Because I am relatively young myself, I can see like when I was 15, things were said to me and it didn't really take affect until recently. So I guess that is good, but frustrating at the same time, because you want to help them right here and now. Like you want to do the best, so they can be the best they can be. **Interview 53**

The seeming ineffectiveness of relationship and contingent reinforcement is likely to be experienced as stressful by the workers attempting to manage behaviour. Effort, perceived control over the work environment and perceived reward are acknowledged factors in workplace burnout and worker turnover that appear relevant to this discussion (Savicki, 1993).

Others have discussed the resistance and opposition frequently displayed by children in their care and the range of negative reactions that workers may experience. These negative reactions may impede their ability to work effectively, understand behaviour and respond in a supportive, positive, and non-punitive manner (Fitzgerald, 1994; Morisette & Bodard, 1991) that does not further contribute to resistance and opposition. The results in this study suggest that strategies designed to assist the residential care worker to manage their expectations and cognitive appraisals regarding the meaning of behaviour; regarding reward and effort in relationship; together with the temporal sequencing of behaviour management plans may be beneficial.

## **7.8 Discussion**

Some reviews into residential care call for better training of residential care workers in issues related to the mental health of the children in their care. While this is necessary, the analysis presented in this chapter suggests that there are also unique pressures inherent in this work that need to be accommodated and understood before other issues can be successfully addressed. Many of the stresses and tensions identified in this analysis may not be easily resolved. Tensions between the needs of the group and the needs of the individual; between professionalism and natural care in parenting; and between the need to connect and the need to control, are all dynamics that are likely to be heavily influenced by organisational culture and a focus on risk management. These issues are resonant with Maier's (2006) discussion of the impact of secondary systems on the primary relationships between workers and the children. In the words of Maier (2006):

The ever present struggle of reconciling primary care requirements of children and young people living in group care facilities with the program's secondary organizational demands finds its expression and potential balance in the daily work of the child and youth care staff.

Actually workers seem to be serving two masters (p. 92).

It therefore appears essential that stakeholders understand these tensions when seeking to engage with residential care workers in order to support children

with behavioural concerns. Youth workers may feel that other professionals do not appreciate the stresses they face (Savicki, 1993). The results of this analysis suggest that this may be particularly true of mental health professionals. An open relationship characterised by a mutual understanding of behaviour between the mental health professional or other stakeholders and the residential care worker is likely to be of critical importance in negotiating the optimal support for the young person (Piersma, 1985).

Piersma (1985) has drawn parallels between the often competing objectives and viewpoints of a mental health professional and residential care staff and that found in traditional (somewhat dated) parenting tensions found between the viewpoints of the birth parents of any child. In the traditional two-parent arrangement, there can be large discrepancies in the experiences of a child's behaviour between the person who is with the child all day, and that of the parent whose experience of the behaviour occurs within a more limited context. So too, the experiences and understanding of challenging behaviour can differ between the consulting mental health professional and the residential care worker, whose experience of the young person's challenging behaviour may be much richer. Issues of responsibility, authority or ownership over the child and perceived misunderstanding may lead to residential care workers mistrusting the mental health professional (Piersma, 1985).

The results of this analysis lend support to the need for 'outsiders' to understand and accommodate several unique pressures inherent in residential care work. This is likely to be particularly relevant to advise given about managing

behaviour and addressing mental health issues amongst children in residential care. Mental health professionals and other stakeholder groups need to be aware of the tension workers experience when attempting to manage the needs of the individual child and the group needs for rules and an approach that is perceived as egalitarian. Individual behaviour management plans are unlikely to be taken up when prescribed without full understanding of the contextual environment of the unit.

The inability of workers to use relationships in the manner to which one might be accustomed to, together with the perceived inability to apply any contingent reinforcement successfully for any length of time, is something mental health professionals and other stakeholders should be aware of. Problems arise when behaviour is multi-determined or when the function 'behind' the behaviour finds outlet in another behaviour, making conventional behaviour management techniques unlikely to be successful. Additionally, Hughes (2003) argues that the success of contingent behaviour management techniques is predicated on factors such as emotional regulation, interpersonal motivation and attunement. An over-reliance on behavioural programs may run the risk of minimising the use of individualised strategies more appropriate for trauma-based behaviour. Unassimilated trauma-related events and memories are not readily (or appropriately) subject to the application of behavioural contingencies. Therefore, residential workers may need to possess a 'dual' awareness when addressing behaviours. That is, they may need awareness of both contingent and non-contingent, trauma based, approaches. They may also be required to simultaneously consider 'non negotiable, whole of unit' rules and the

circumstances of an individual child. This kind of approach to behaviour management parallels the simultaneous ‘convergent’ and ‘divergent’ thinking identified by Evans (1987) and applying these dual thinking styles is undoubtedly a demanding task.

In addressing both the requirements of the individual and the unit environment, approaches like functional assessment and positive programming which incorporate both universal (whole group) and individual contingency management may be relevant (e.g., O’Neill et al., 1997). Dunlap et al. (2000) outline the core competencies inherent in this approach which may be applied to the training environment. A distinction between ‘barrier’ behaviours, such as aggression and property damage, which prevent the child from meaningful integration, and other behaviours may also be relevant (Isett, Roszkowski, & Spreat, 1980).

A resolution of workers’ obligation towards providing conformity and normality when addressing behavioural issues may be likely to influence the perceived importance to the worker of seeking out mental health support or counselling for these young people. Removing children from the unit environment for a weekly or fortnightly appointment is not likely to be perceived as useful at best, and at worst may be seen as damaging the child’s self esteem. A mental health professional is not likely to understand behaviours that workers consider ‘normal’ for residential care environment; possibly raising anxiety amongst workers, and exposing workers to unnecessary behavioural disturbance at best, and false allegations at worst. A possible reluctance to disturb the normal routine

of the unit by the involvement of mental health professional is important because of the likely long term impact of unaddressed mental health issues for young (Courtney et al., 2001).

Leaf (1995) notes that strong countertransference reactions can occur amongst workers in residential care area:

Countertransference is not an evil to be avoided; rather, it is an inevitability that we must be aware of and work through. This is when colleagues, supervision, clinical direction and effective self/ stress-management become vitally important (p. 18).

Mental health professionals or other stakeholders working with residential care units may encounter descriptions of the young persons behaviours that arise from the emotionally exhausting process of caring for young people in emotionally charged and sometimes volatile environment. Supporting the workers in reframing their appraisals of difficult behaviour and in self reflection may, arguably, be ultimately as productive as any behaviour management plan. This is particularly likely to be true of management plans devised without consideration of the broader residential unit dynamics.

Finally, it appears likely that a caring nurturing relationship with at least one consistent person is an important factor in long term outcomes for children in care (Hillan, 2008). The mental health professional is unlikely to be able to provide such a relationship for the young person. This analysis indicates that residential

care workers may be discouraged from such long term involvement, despite the reality that many children in residential care stay until they are able to attain independent living. Therefore, children in residential care may benefit more from strengthening relationships with residential care workers. Mental health professionals can facilitate this by adopting an inclusive attitude with respect to involving workers in mental health interventions. Some have called for the need for residential care workers' opinions regarding behaviour to be given equal weight in decision making (Barnes & Kelman, 1974; Larsan, 1973). Ongoing relationship with the worker is likely to be beneficial for the child in the context of organisational processes that can accommodate ongoing relationship once children are living independently. As Savicki (1993) has suggested, worker stress and burnout may be reduced by allowing workers the capacity for long term follow up with children, otherwise the worker is "denied the rewards of his or her work" (p. 443).

## **PART E**

### **Chapter Eight:**

### **Discussion**



## CHAPTER EIGHT

### Discussion

#### **8.1 Overview**

As indicated in the first section of this thesis, this research was based on the importance of providing support for an ever increasing population of Australian children that are unable to be cared for in their biological families and that are consequently placed in substitute or out-of-home care (AIHW, 2009).

It was pointed out that one of the principal concerns is the very high rates of behavioural disturbance present amongst children in out-of-home care (e.g., Pilowski, 1995). Australian data on behavioural problems in out-of-home care echoes that of overseas research, which indicates that disorders of conduct and other externalising behaviours are prevalent in this population of children and are particularly concerning for stakeholders (e.g., Denby et al., 1999; Quinton et al., 1998). Only those children with extremely complex needs are likely to be placed in out-of-home care and in these circumstances the placements that do occur are at high risk of breakdown (Barber & Delfabbro, 2004; Delfabbro et al., 2000).

Attempts by mental health clinicians and other stakeholders to support children with complex needs are frustrated by the complex interplay of the child's behavioural presentation and their socio-emotional and developmental issues

(Kortenkamp & Macomber, 2002). Effective intervention for challenging behaviours therefore necessitates the coordination of multiple systems and services to execute commonly identified goals in relation to behaviour change (Cottrel et al., 2000; Morrison, 1996). This research was predicated on the increasing emphasis placed in policy, legislature and research both in Australia and elsewhere on developing sound interagency collaborative practice amongst children's services. Further, this research has been driven by the salience of collaborative multi-agency approaches for children with complex needs, such as those in the out-of-home sector. It was suggested, however, that the imperative for collaborative practice occurs within a context of relatively little conceptual, theoretical or empirical guidance, particularly in relation collaboration between children's services.

It was further suggested that little was known about how stakeholders account for the challenging behaviour of children in out-of-home care and that a broad body of literature raised the possibility that differences in conceptual frameworks and attributions may contribute to difficulties in interagency practice. For clinicians and other stakeholders seeking to support children with challenging behaviour, there exists very little literature relating to empirically supported interventions specifically targeting children in out-of-home care. Implementation of any evidence based interventions is extremely limited in Australia (Osborn, 2006), meaning that South Australian stakeholders may have very limited exposure to the conceptual and practical elements of effective interventions. This broad literature on the importance of addressing challenging and complex behaviour amongst children in out-of-home care, in the context of increasing

pressure for effective interagency collaboration in this sector, provided the compelling impetus for the research presented in this thesis.

Accordingly, this thesis had two broad aims. First, the thesis aimed to identify the barriers to interagency collaboration amongst services for children in out-of-home care in South Australia, using the specific example of addressing challenging behaviour. In doing so it sought to widen the scope of research into collaboration by including the perspectives of key stakeholders in this sector whose views had not previously been included. Second, this thesis aimed to explore the dominant ways in which behaviour was understood by key stakeholder groups in South Australia. In doing so, it sought to identify the dominant conceptual frameworks and causal attributions implicit in accounts of behaviour in order to better understand the environment in which attempts to address challenging behaviour occurred.

While behaviour frequently serves as the focus of interagency discussion (Salmon, 2004), stakeholder frameworks for understanding behaviour do not appear to have been explicitly examined before. Similarly, little is known about the factors surrounding interagency involvement when addressing behaviour problems. It has not been the intention of this research to align itself with any particular theoretical orientation or make recommendations about the superiority of any particular psychological intervention. Instead, the goal has been an empirical exploration of the reality of interagency practice. From this, emergent themes may be used to generate further research questions.

## **8.2 Discussion of results**

The examination of stakeholders' experiences of collaboration confirmed several issues that had been reported in relation to collaboration amongst other sectors such as health, adult mental health, and child clinical services (Horwath & Morrison, 2007). This suggests that these issues may be experienced universally, irrespective of the population being serviced or the focus of the intervention. Examples of this include resourcing issues such as high work loads, time pressures, worker turnover and the inappropriate use and delivery of services. Such issues are only likely to be resolved, if at all, with greater commitment of financial resources.

The issues related to the effective communication identified in this study such as use of terminology, confidentiality practices and poor information exchange have also previously been suggested to affect interagency collaboration. Issues of communication and information exchange are likely to have particular salience, however, when the focus of discussion is the treatment of challenging behaviour. Irrespective of the treatment philosophy or approach in question, information about the antecedent context for behaviour, including details of traumatic events and about strategies that have been successfully employed in the past constitute essential information that will help support behaviour change. Failure to convey important background information in a timely manner will mean unnecessary hardship for carers and children alike and, at worst, may expose the child and caregivers to significant risk in the form of harm to others, school exclusion or placement breakdown.

Issues of power and manipulation have also been alluded to previously, particularly in relation to lack of consultation in case management decisions, workplace bullying and the manipulation of referral information to make referrals more appealing (e.g., Briggs et al., 2004; Okamoto, 2001; Scott, 2005). Arguably, stakeholders that are subject to such ‘top-down’ control could, in turn, treat those that they perceive as less powerful in a similar way. Children in out-of-home care may be viewed as being at the bottom of this ‘chain of power’.

Some of the themes identified in this analysis of interagency practice represented new insights into the dynamics of interagency collaboration that warrant further attention. The negative view of the behavioural approaches of ‘other’ stakeholder groups as inferior, for example, is concerning. It is promising to note that many stakeholders, at the same time, expressed the desire to understand better the frameworks, practices and mandates of other agencies. The pervasive ‘triangulation’ of a child’s relationships and its negative effect on attempts at discipline also represents a novel finding. It may be argued that the inclusion of the key stakeholder groups; teachers, residential care workers and foster carers, along with the other stakeholder groups, allowed these barriers to be identified.

Although many barriers to collaboration were identified, it is promising to note that many of these barriers are amenable to improvement. For example, issues of information exchange and confidentiality may be addressed at the level of organisational procedure and policies. Such policies may articulate what

constitutes essential information about behavioural incidents that needs to be conveyed, and in what circumstances it may be conveyed to other stakeholders. Similarly, many of the answers to enhancing interagency collaboration may be found in the suggestions of the respondents themselves. Joint (child-focused) training was emphasised as a way in which all stakeholder groups could gain better understanding of the approaches and imperatives driving other stakeholder groups. Conceivably, such training could focus on issues that require high levels of collaboration. One example might be documents that are required to articulate behavioural goals, such as the Department of Education and Children's Services' IEPs (individual education plans). The involvement of foster carers in professional training would also assist professionals to understand the needs of this group of stakeholders. Similar aims could be achieved by providing participants with opportunities to experience working in other agencies. For example, new recruits to agencies could complete a rotation or exchange, in which they experience a period of time or a visitation program in each relevant agency, in order to familiarise themselves with the terminology, processes and mandates of other agencies.

Following the analysis of stakeholders' experiences of interagency collaboration, this thesis examined the range of accounts that stakeholders provided for challenging behaviour. This was achieved initially by an analysis of stakeholders' accounts about the nature of challenging behaviour, its cause and amelioration. The results of this analysis indicated several different accounts of how behaviour arose and could be managed. These accounts reflected implicit beliefs that could be delineated along the dimensions of causality, responsibility

for change, and locus of control for the challenging behaviour. These accounts did not generally reflect membership with any one stakeholder group. A notable exception was teaching staff, where it was possible to identify a dominant and consistent theme in their descriptions of behaviour, in which personal responsibility and choice featured strongly.

Despite the disparity of these accounts, commonality could be identified amongst some account in terms of their beliefs about the importance of routine, predictable and consistent reinforcement contingencies as a solution for problematic behaviour. Paradoxically, accounts that placed emphasis on internal factors within the child (internal locus of control) did not necessarily view individual therapy as a preferred solution to behaviour difficulties. The implicit culture of placement with foster carers as a form of 'intervention', together with an apparent minimisation of the need for individual counselling, is concerning. The notion of placement stability and continuity as a means of improving behaviour was similarly concerning. Further exploration of the concept of behaviour change through stability, the potential circularity in this assumption, and what that might mean for the child warrants further investigation.

This analysis of stakeholders' accounts represents a unique contribution to the literature in that it overtly articulates the conceptual frameworks that dominate amongst South Australian stakeholders. More specifically, it identified the dominance of attachment conceptualisations for behaviour amongst those supporting children. A particularly concerning finding was the apparent underrepresentation of accounts of trauma amongst stakeholders' descriptions of

the origins of behaviour. Highlighting the probable influence of trauma and anxiety on cognitive and emotional development could support stakeholders to take a more optimistic view of the possibility of the child gaining control over their behaviour. An analysis of the implicit causal attributions, together with an identification of common elements in apparently disparate interventions contributed to a 'way forward' in developing a shared understanding of behaviour. In future research, more definitive articulation of stakeholder accounts could be extracted through examination of the accounts given for one identified behaviour (e.g., hoarding), rather than asking about challenging behaviour more broadly.

As a result of the analysis of stakeholders' accounts for behaviour, representations of 'attachment' were further analysed. The results of this study confirmed the commonly advanced belief that attachment conceptualisations dominate philosophical and clinical theorisations about behaviour in out-of-home care (Barth et al., 2005; Newman & Mares, 2007). One important contribution of this thesis to the literature has been the identification that the concept of 'attachment' is employed in at least four separate ways that deviate significantly from the accepted theoretical and conceptual foundation of attachment theory. These apparent misinterpretation of a child's 'attachment' needs in terms of dependence, as capacity limited, as diminished in some children, or as an ability that can easily be transferred from one placement to the other, held potentially negative consequences for the child whose attachment needs were misrepresented in these ways. Further, the potential for adverse consequences in terms of placement decisions was emphasised. It is perhaps not surprising that such confusion exists over the construct of attachment, given the wide variety of

literature that is subsumed under the category of attachment theory. The results of this study, therefore, add weight to the call of many others for clearer articulation of the theoretical and clinical parameters of attachment theory (e.g., Chaffin et al., 2006; Ziberstein, 2006). Above all, the results of this study encourage stakeholders to employ caution when making assumptions about elements of a child's 'attachment' and to place emphasis on making overt these assumptions when considering placement and program characteristics. This analysis therefore supports the suggested lack of commonly defined "operational language" used, at least in relations to the term 'attachment' (Salmon, 2004, p. 157).

Finally, the experiences of one stakeholder group, residential care workers, were analysed. Workers accounts indicated that they may be discouraged from forming long term relationships or assuming a parenting role with children, despite the fact that they are responsible for their daily care. Workers frequently needed to prioritise the needs of the group and for consistency of approach over the needs of any individual child, even when they would prefer to do otherwise. The frequent need to forcibly control children exhibiting violent behaviour represented a special kind of stress for workers as they felt invited into a role that paralleled that of an abusive parent. 'Relationship' was seen as the primary force for change in a child's behaviour, but such relationships were perceived as inconsistent, effortful, and emotionally unrewarding. Pervading the residential care environment and ideology was the desire to 'normalise' children and their behaviour, resulting in a redefining of normal behaviour into behaviour that is 'normal for residential care'. Implicit in this desire for normality was a minimising of children's need for mental health intervention, and a perception that

'outsiders' could not understand the behaviour issues of these children. The data suggests the need to fully understand the environmental context in which attempts to manage behaviour occur and the unique strains inherent in residential work. This may be particularly important for the mental health clinician making recommendations for behavioural interventions. This data emphasised the importance of the researcher immersing themselves in the world of any one stakeholder group and indicates the potential value of continuing this analysis with other stakeholder groups.

When considering the results from the four sets of analyses, three common issues emerged that have practice and policy implications. Principal amongst these was a minimising and mistrust of the accounts of 'other' stakeholder groups and a poor tolerance for incongruence between stakeholder accounts of behaviour, in which 'own' accounts and understandings of behaviour were seen as superior to that of 'others'. This lack of understanding of the perspectives of others was found in stakeholders' accounts of the frameworks applied by other agencies to the understanding and management of behaviour. It was also found in the views expressed by residential care workers, who expressed a mistrust of others 'outside' the unit that were perceived as unable to understand the unique difficulties and perspectives of the worker. This wariness has important implications for the consultant mental health clinician seeking to implement behavioural strategies in the unit environment.

Another recurring theme was the implicit pressure amongst some stakeholders to provide a sense of 'normality' in children's lives. This appeared to

arise out of a culture of inclusion, and from a desire to not further stigmatise a child who is already considered ‘different’ in the eyes of society. However, it manifested itself in many ways that could be potentially damaging for the child. For example, teachers frequently did not want to know about a child’s behavioural or placement history. Many stakeholders did not want to further stigmatise children by the involvement of mental health services which were perceived as inaccessible or inappropriate. Confidentiality practices, driven by the child’s right to be treated normally, often overrode the safety and therapeutic needs of the child and others residing with the child, leading to poor practice and outcomes for the child. One possible policy imperative arising from this culture of normalisation is the desirability of making mental health services more accessible and integrated with, for example, residential care units or school environments. In combination with heightening awareness of trauma-based behaviour, this could facilitate the ‘normalisation’ of help seeking for children.

Another major theme that pervaded across all analyses was that of the powerful effect of systemic issues on all aspects of the child’s relationships and behaviour management contingencies. ‘Triangulation’ of relationships and family structure, or the potential ‘drawing in’ of third parties into issues of conflict and discipline afforded by systemic issues was evident in many respondents’ talk, especially those that had daily care of the children. This frequently resulted in the compounding, or exacerbation, of behaviour problems due to interference with the caregivers’ or teachers’ ability to impose consequences and resolve conflict with the child. This issue could potentially be ameliorated by giving caregivers greater control over daily events and decision making. Many stakeholders claimed that

the outsourcing of South Australian alternative care service providers contributed greatly to this difficulty.

### ***8.3 Limitations of the research***

There are several general methodological and design issues that should be considered when reflecting on the findings presented in this thesis. Foremost amongst these from a research design point of view is the obvious omission of one important stakeholder group; namely the children themselves. While this research represents a significant contribution because it appears to be the only study to include foster carers, residential carers and teachers in the analysis, it is nevertheless glaring in its omission of the views of children themselves. There are clearly ethical issues associated with the inclusion of this vulnerable group, especially when discussing often distressing behavioural incidents. Use of a story board involving a hypothetical scenario about a child in care might be one obvious structured and non-threatening way to explore the beliefs children have about behaviour and interagency relations in the future.

Second, causal inferences about behaviour were not able to be made due to the qualitative and exploratory nature of the research. This research has provided an empirical basis upon which structured quantitative surveys or questionnaires could be designed. For example, obtaining stakeholder attributions for scenarios depicting a range of challenging behaviour would be one way to further research in this area.

Finally, participants were asked to give accounts of their experiences with ‘challenging behaviour’ and a definition of challenging behaviour was not provided. Interview participants predominantly talked about challenging behaviour in terms of violence and aggression, although specific incidents involving other behaviours were mentioned by many (e.g., sexualised behaviour). However, participants also provided quantitative data (reported in Chapter 3) that also confirmed that respondents predominantly defined challenging behaviour in terms of violence and aggression. Therefore, there was a high degree of consistency between their written and verbal accounts of challenging behaviour. Interview questions were deliberately open-ended, which had advantages due to the exploratory nature of the research. Future research, using quantitative measurement of specified behaviours, or giving definitions of the behaviour to be considered, would overcome this limitation. For example, participants could rate causal attributions for a specified challenging behaviour (e.g., stealing). Alternatively, respondents could endorse attributions for a challenging behaviour, in which the description provided for the vignettes about challenging behaviour is manipulated (e.g., see Dryer et al., 2006).

There was no attempt in this study to disentangle stakeholder group identity from professional identity. There was no theoretically driven reason to expect that stakeholder group identity might be more important than professional group identity. Scott (1997) has identified that much research on collaboration focuses on interprofessional, rather than interagency differences, making some exploration of interagency differences salient. Given that professional group identity appeared to influence accounts of behaviour, at least amongst teachers, some attempt

should be made to disentangle this confound in future investigations into beliefs about behaviour. This will not be an easy task in South Australia, as some agencies (e.g., Families SA ) are predominantly staffed by social workers, and others are multidisciplinary (e.g., CAMHS).

From a methodological viewpoint, the self selection of participants warrants discussion. The recruitment of participants was prolonged and characterised by numerous difficulties, raising the possibility that only those that felt strongly about the issues involved volunteered to participate. The climate of time and resource pressure in which the research took place makes this highly likely.

Ultimately, the results of this series of studies reflect the unique situation in South Australia at the present time. Factors such as training, the structure of foster carer support services, and residential care service models all impact on the out-of-home care environment and may produce differences between Australian jurisdictions.

It is worth noting that since this research was conducted, related policy development and activities have occurred within Families SA (Department of Families and Communities, 2009: Annual Report, 2007-2008). For example, there has been an increased emphasis on partnership between agencies, and the Department has developed an across Government information sharing protocol. Information exchange has also been facilitated through the distribution of a carer identity card, in order to allow carers access to health services and health related information. In addition, collaborative partnerships have since been undertaken

with other government agencies. For example, Children's Centres have been established in collaboration with the Department of Education and Children's Services, which provide intensive counselling, parenting programs, and service coordination for vulnerable children and their families.

Finally, this research is open to the criticism that can be levelled at any qualitative analysis. The over reliance on "small-scale, qualitative studies" has previously been noted (Cashmore, Higgins, Bromfield & Scott, 2006, p. 4) in relation to research in out-of-home care. As indicated, the results of this study suggest the need for further quantitative analysis. However, it may be argued that a qualitative approach is particularly relevant in under developed areas of knowledge and practice. Similarly, Scott (2002a) has stressed the context-bound nature of qualitative research, particularly in human services. She also cautions that qualitative research is "inextricably intertwined with subjectivity" as it requires the researchers "use of self" (Scott, 2002a, p. 929). Therefore, ultimately, consideration should be taken for the background of the researcher, who is both researcher and former 'stakeholder'. Similarly, the reader should consider the unique configuration of agencies and stakeholders in South Australia at the time the research was conducted.

#### ***8.4 Implications for improving collaboration and service provision***

The research reported here leads to several possible recommendations for improving interagency practice and better understanding of the behavioural practices of other stakeholders. First, stakeholders indicated that joint training

opportunities with a possible focus on the perspectives, mandates and imperatives of each relevant agency would serve to improve understanding between agencies and stakeholder groups. This type of training could also occur at the university level or as part of agency intake or orientation. Others have recommended joint training as a 'way forward' to overcoming barriers to information sharing, child abuse reporting and interagency collaboration (Bunting, Lazenbatt & Wallace, 2009). Early social psychology work suggested that exposure to 'other' groups is helpful, provided it is sustained, participants are of relatively equal status and the outcome is perceived to be successful (Brown, 1988). This suggests that training should be ongoing with a focus, ideally, on tasks that are relatively specific, and with achievable outcomes. Training or development on a relatively specific issue of mutual benefit to all stakeholders would be an example of such a task.

Similarly, the involvement of carers, alternative care support workers, and Department workers in formal or informal training and support sessions may help to minimise the perceived division between these stakeholder groups, and possibly make some contribution towards reducing the 'triangulation' in relationships discussed by participants. As mentioned, awareness of the models of practice of 'others' can also be increased through partnership agreements between agencies; such agreements could stipulate the use of brief visitations, or mutual exchanges of staff, between agencies.

In a climate of resource pressure, the pooling of resources and structures in a manner negotiated by agencies and key stakeholders may afford the opportunity for 'purpose built' programs, specifically catering for young people in out-of-home care. One less resource intensive way to support children is the formation of

an overseeing panel, comprising representatives from key stakeholder groups, to supervise collaborative endeavours involving high needs children in alternative care. This recommendation echoes that put forward by the Layton Review (2003), which made a similar suggestion about the need for at least one independent body to monitor interagency collaboration with respect to vulnerable children (see Chapter 2; Recommendations 28, 29, 40, 68).

The findings presented in this thesis also suggest the need for protocols to be developed that specify obligations regarding information exchange between stakeholders, including foster carers. Such protocols should articulate what considerations and circumstances dictate the ability to exchange or withhold information, in this case about historical events and relevant behavioural contingencies. Mechanisms of accountability should be developed for non exchange of information. Agreements, assigning responsibility for daily care and minor disciplinary decisions to carers, could contribute to more clearly delineated roles and may go some way towards reducing the ‘triangulation’ identified in this research.

In addition to policy implications, this research suggests several implications for practice, especially for the mental health clinician. The disparate accounts of behaviour amongst stakeholders presents an interesting problem for clinicians seeking to engage with other stakeholders about challenging behaviour. Although apparently discrepant, points of convergence can be identified when underlying assumptions are considered. Assumptions of control and responsibility are especially likely to have negative implications for stakeholder optimism and

persistence. Increasing awareness of the role of trauma is likely to support a more optimistic view of the possibility of change. The results of this study suggest that many stakeholders may lack awareness of the role of trauma in children's lives and may have developed understandings of attachment that are at odds with the theoretical and empirical literature. It is suggested that reframing children's behaviour in terms of anxiety affords one way in which stakeholders can find a common language for much challenging behaviour. The clinician that seeks to implement behavioural programs in the residential environment should be aware of the unique features and strains of the residential environment. In formulating behaviour management plans, these results suggest the clinician must be mindful of whole group environment and the primacy of relationship. Staff are unlikely to support intervention from an 'outsider' that is not seen to have significant relationship with the child and does not understand unit dynamics.

Above all, the results of the research presented here strongly support the inclusion of those stakeholders that are intimately involved in the daily lives of children in out-of-home care. It is suggested that the inclusion, and comparison, of foster carers, residential carers, and teachers' perspectives allowed important dynamics to be identified that have significant implications for the support of young people. The findings reported here advocate for the continued inclusion of these important stakeholders in future research.



## APPENDICES



## APPENDIX A

### Demographic and Background information from professional groups

<b>Background Information</b>
-------------------------------

Age \_\_\_\_\_ years

Gender Male   
Female

Occupation \_\_\_\_\_

Years experience in that occupation \_\_\_\_\_ years

Years working with children in out of home care? \_\_\_\_\_ years

Are you currently working full time or part time? Full time   
Part time

Highest education level attained (tick one)

- Primary
- Secondary, completed yr 10
- Secondary, completed yr 11
- Secondary, completed yr 12
- Technical qualification/diploma
- University graduate
- Postgraduate degree

Qualifications (if applicable) \_\_\_\_\_

Have you completed training in behaviour management since starting to work with children in out of home care?

- Yes
- No

Please estimate your total exposure to formal behaviour management training since starting work with children in out of home care.

- < 1 day
- 1 day
- 1-3 days
- 3-7 days
- 1-3 weeks
- 3-5 weeks
- 5+ weeks (describe \_\_\_\_\_)

Please describe the type of training you received (what framework/model)

\_\_\_\_\_

List any additional training in the issues related to children in care:

Type of training? \_\_\_\_\_

Amount ? \_\_\_\_\_ hours/days/weeks

Please answer the following questions by circling a number below:

Overall, how **stressful** do you find working with children in out of home care?

1	2	3	4	5	6	7
not at all stressful			somewhat stressful			extremely stressful

Overall, how **optimistic** are you that your work with children in out of home care makes a difference?

1	2	3	4	5	6	7
not at all optimistic			somewhat optimistic			extremely optimistic

Overall, how **willing** would you say you were to persist in working with children in out of home care?

1	2	3	4	5	6	7
not at all willing			somewhat willing			extremely willing

Overall, how **effective** do you feel in working with children in out of home care?

1	2	3	4	5	6	7
not at all effective			somewhat effective			extremely effective

Overall, how much **control** do you feel you have over your work with children in out of home care?

1	2	3	4	5	6	7
no control at all			some control			absolute control

Overall, how often do you think about **stopping** your work with children in care?

1	2	3	4	5	6	7
never think about it			think about it some of the time			think about it all the time

Overall, how **satisfied** are you in your work with children in care?

1	2	3	4	5	6	7
Not satisfied at all			Somewhat satisfied			extremely satisfied

Overall, how **satisfied** are you in the quality of information provided by the Department about children you work with?

1	2	3	4	5	6	7
Not satisfied at all			Somewhat satisfied			extremely satisfied

In your experience, what is the **most common problem** behaviour shown by children in out of home care?

1.-----

2.-----

3.-----

In your experience, what behaviour is **most likely** to cause a foster placement to be **unsuccessful**?

1.-----

2.-----

3.-----

What, in your opinion, is the single most important thing that needs to change in order to better support the needs of children in care?



## APPENDIX B

### Demographic and Background information from Foster Carers

<b>HANDOUT 1: BACKGROUND INFORMATION</b>
--

Age \_\_\_\_\_ years

Gender Male  Female

Occupation (if applicable) \_\_\_\_\_

Years experience in that occupation \_\_\_\_\_ years

Years working with children in out of home care? \_\_\_\_\_ years

Are you currently working full time or part time outside of foster care?  
 Full time   
 Part time

Highest education level attained (tick one)

- Primary
- Secondary, completed yr 10
- Secondary, completed yr 11
- Secondary, completed yr 12
- Technical qualification/diploma
- University graduate
- Postgraduate degree

Other Qualifications (if applicable) \_\_\_\_\_

Combined household income :

- < 20,000
- 20,000-39,999
- 40,000-59,999
- 60,000-79,999
- 80,000-99,999
- 100,000+

Please complete by ticking boxes that best describe the employment status of each parent in the household:

Parent # 1 (parent completing questionnaire)	Currently in paid employment?  <input type="checkbox"/> YES   <input type="checkbox"/> NO	<input type="checkbox"/> Full time <input type="checkbox"/> Part time   <input type="checkbox"/> Not currently looking for work <input type="checkbox"/> Looking for work
--	--	--

- Retired on a pension
- On other government pension
- Student
- Other (please describe)....

Parent #2  
(If applicable)

Currently in paid employment?

- YES
  - Full time
  - Part time
- NO
  - Not currently looking for work
  - Looking for work
  - Retired on a pension
  - On other government pension
  - Student
  - Other (please describe)....

Who is primary carer for foster child/children in home?

- Mother
- Father
- Other (describe)

---

Please describe family structure

- Two parent, defacto
- Single parent, mother
- Single parent, father
- Other (describe)

---

Two parent, married

Have you completed training in behaviour management since starting to work with children in out of home care?

- Yes
- No

Please estimate your total exposure to formal behaviour management training since starting work with children in out of home care.

- < 1 day
- 1 day
- 1-3 days
- 3-7 days
- 1-3 weeks
- 3-5 weeks
- 5+ weeks (describe \_\_\_\_\_)

Please describe the type of training you received (e.g., workshops, & what theory/model if known)

---

List any additional training in the issues related to children in care:

Type of training? \_\_\_\_\_

Amount ? \_\_\_\_\_ hours/days/weeks

Please complete following information about the foster children you are currently caring for:

	Child's Age	Child's Gender	How long have you known this child ?	Does this child stay with you full time or for respite care?
Child #1		M / F		Full time/ Respite
Child #2		M / F		Full time/ Respite
Child #3		M / F		Full time/ Respite
Child #4		M / F		Full time/ Respite

Are any of these children related to you? (indicate how many and your relationship to child e.g., mother, grandmother)

\_\_\_\_\_

Please complete following information about other/ biological children living in your home:

	Child's Age	Child's Gender	Child's relationship to you? (e.g., biological child; step child)
Child #1		M / F	
Child #2		M / F	
Child #3		M / F	
Child #4		M / F	

Please indicate the number of foster children you have provided care for

- 1-2  
 3-5  
 6-10  
 11-15  
 16-20  
 21-25  
 25+

Please tick box that best describes the type of care you have provided for these children:

- long term care only  
 mostly long term, some respite care  
 respite care only  
 mostly respite, some long term care  
 mostly respite, some short term care  
 short term care only  
 mostly short term, some respite care  
 combination of short and long term care  
 other \_\_\_\_\_

**Please answer the following questions by circling a number below:**

Overall, how **stressful** do you find caring for children in out of home care?

1	2	3	4	5	6	7
not at all stressful			somewhat stressful			extremely stressful

Overall, how **optimistic** are you that your support for children in out of home care makes a difference?

1	2	3	4	5	6	7
not at all optimistic			somewhat optimistic			extremely optimistic

Overall, how **willing** would you say you were to persist in supporting children in out of home care?

1	2	3	4	5	6	7
not at all willing			somewhat willing			extremely willing

Overall, how **effective** do you feel in supporting children in out of home care?

1	2	3	4	5	6	7
not at all effective			somewhat effective			extremely effective

Overall, how much **control** do you feel you have over your caring for children in out of home care?

1	2	3	4	5	6	7
no control at all			some control			absolute control

Overall, how often do you think about **stopping** your support for children in care?

1	2	3	4	5	6	7
never think about it			think about it some of the time			think about it all the time

Overall, how **satisfied** are you in your role supporting children in care?

1	2	3	4	5	6	7
Not satisfied at all			Somewhat satisfied			extremely satisfied

Overall, how **satisfied** are you in the quality of information provided by the Department about children you support?

1	2	3	4	5	6	7
Not satisfied at all			Somewhat satisfied			extremely satisfied

In your experience, what is the **most common** problem behaviours shown by children in out of home care?

- 1.-----
- 2.-----
- 3.-----

In your experience, what behaviour is most likely to cause the placement to be unsuccessful?

- 1.-----
- 2.-----
- 3.-----

What, in your opinion, is the single most important thing that needs to change in order to better support the needs of children in care?

\_\_\_\_\_

Have you ever requested that a child be removed from placement with you? YES/NO

If YES, on how many occasions?\_\_\_\_\_

If so, please state main reason (s)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What was outcome of request (s)

? \_\_\_\_\_



## APPENDIX C

### Foster Carers: Motivation to foster and reasons for leaving

Reason given for becoming a foster carer
--

Listed below are some reasons that people have given for becoming foster parents. Please think back to when you became a foster parent and with this in mind...

Indicate how important this reason was for you in becoming a foster parent

Reasons to foster	How important to you?				
	1=	2	3	4	5=
Wanted companionship for myself	1	2	3	4	5
Wanted a certain kind of child ( e.g., a girl or a five year old)	1	2	3	4	5
My own children were grown and I wanted children in the house	1	2	3	4	5
Wanted companionship for my own child/children	1	2	3	4	5
Fill the gap created by my own child's death	1	2	3	4	5
Wanted to have something to fill my time	1	2	3	4	5
Wanted a larger family	1	2	3	4	5
Wanted to care for a child but did not want permanent responsibility	1	2	3	4	5
Wanted a child but did not want to care for a baby.	1	2	3	4	5
Desire to help someone else/ interested in child's well being	1	2	3	4	5
Desire to share what I have (resources)	1	2	3	4	5
Religious beliefs/ spiritual reasons	1	2	3	4	5
Community service/ repay society	1	2	3	4	5
Wanted to do something for the community	1	2	3	4	5
Wanted a sense of purpose in life	1	2	3	4	5
Love of children	1	2	3	4	5
Family oriented reasons	1	2	3	4	5
Wanted to provide a child with love	1	2	3	4	5
Wanted to be loved by a child	1	2	3	4	5
Thought a child might help my marriage/relationship	1	2	3	4	5
Fulfillment as role as a mother/father	1	2	3	4	5
Wanted to provide a good home for a child	1	2	3	4	5
Compensation for inability to have own child	1	2	3	4	5
Could not have any, or any more children of my own	1	2	3	4	5
Thought about adopting and thought foster parenting would be a good way to start	1	2	3	4	5
Wanted to adopt but wasn't able to	1	2	3	4	5
Was single and wanted a child	1	2	3	4	5
Thought fostering would lead to ability to adopt child	1	2	3	4	5
Wanted a child to help with chores or work in family business	1	2	3	4	5
Wanted to increase my family income	1	2	3	4	5
Wanted to work from home	1	2	3	4	5
Thought child would be grateful	1	2	3	4	5
Desire to rescue a child from a miserable life	1	2	3	4	5
Desire to provide a child a happy childhood like mine was	1	2	3	4	5

Knew other foster parents	1	2	3	4	5
Unemployed and filling time	1	2	3	4	5
Supplement family income	1	2	3	4	5
Knew the child	1	2	3	4	5
I knew the foster child or the child's family and wanted to help	1	2	3	4	5
I was related to the child	1	2	3	4	5
I was a foster child myself	1	2	3	4	5
I was abused or neglected myself	1	2	3	4	5
Wanted to provide a home for children who would otherwise be in an institution	1	2	3	4	5
Undoing parental deprivation	1	2	3	4	5
Suffered trauma & loss myself as child	1	2	3	4	5
Wanted to help a child with special problems	1	2	3	4	5
Other reason/ s (specify below and rate in column B)	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

<b>Reason given for stopping foster care</b>
--

Listed below are some reasons that people give for stopping foster caring.

Please read each item and indicate in column A how common these problems are, based on your personal experience.

Next, read each item and indicate in column B how much these factors have contributed to your decision to stop providing foster care (for former foster carers) or would contribute to you deciding to stop providing foster care in the future (for current carers).

	Column A	Column B
	How common? 0= never occurs 5= occurs about half the time (50%) 10=occurs all the time (100%)	How important? 1=not very important factor 5= extremely important factor
Reason		
No say in child's future	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Disagreed with agency goals for child (e.g., reunification)	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
No understanding or support from agency	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child's bad behaviour	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child's emotional problems	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Problems with effective discipline for child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Change in personal/ family circumstances	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate payment/ reimbursement	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate recognition/ acknowledgement	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Had to work	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of respite from child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Problems with biological parents	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Difficult social worker/ communication with social workers	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Unrequested type of child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Poor health/ sickness	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Age	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5

Unrealistic expectations	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate space	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Difficulty seeing child leave	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Conflict within family	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Poor timing	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
It took too much hard work	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Not given realistic information about role	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of clarity about my role	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of clarity about nature of placement e.g.,(temporary/ long term)	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Change in nature of placement (e.g., took child on short term basis but turned into long term placement)	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate training prior to starting as carer	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate ongoing training	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Inadequate time for self care- too stressful	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Foster child's behaviour caused embarrassment	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Foster child's behaviour unmanageable following visitations	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Unable to bond with child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child too old to be helped	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child ungrateful in spite of my help	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Could not afford cost of child's care	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Family member objected to the child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Disagree with planned visitations with biological parents- does more harm than good	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child hurt/ threatened own biological child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Burnt out from caring	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
My expertise not recognized	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Too many children to care for in available time	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child with special needs I did not feel that I had enough expertise to manage without help	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Unable to access specialist help needed (psychologist/ speech therapist etc)	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Unaware of extent of child's difficulties until placed	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Feel extent of child's difficulties were kept hidden from me	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child had special needs I was unequipped to deal with	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Child made allegations against me/my family	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Complaints made by child's biological family against me/my family	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Unhappy with how complaints were managed	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of respect from community	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of respect from professionals	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Lack of respect from child	0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5
Other reason(s) ( please specify below and rate in column B)	0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5



## APPENDIX D

### **Semi structured interview questions: Guidelines for interview**

- Can you tell me about your experiences collaborating with others to help children with challenging behaviours?
- What have you found works well?
- What could be done differently?
- Can you talk about the challenging behaviour that you have experienced?
- How have you come to understand this challenging behaviour?
- What have you found works well; what helps children to change their behaviour?
- What is important about this approach for you?



## APPENDIX E

### Information for participants and consent form:

#### Professionals

**I hereby consent to my involvement in the research project entitled:**

**Perceptions of issues involved with supporting children in out of home care**

1. The nature and purpose of the research project described on the attached Information Sheet has been explained to me. I understand it, and agree to taking part.
2. I understand that I may not directly benefit by taking part in this study.
3. I acknowledge that the possible risks and/or side effects, discomforts and inconveniences, as outlined in the Information Sheet, have been explained to me.
4. I understand that while my responses will be tape recorded & information gained in the study may be published, I will not be identified and information I provide will remain confidential.
5. I give consent on the understanding that I am free to withdraw my consent from any aspect of the study at any stage and therefore any information provided by me will not be included and recorded information provided by me for the purpose of this study will be destroyed. Opportunity for written withdrawal of consent is provided below.
6. I understand that there will be no payment to me for taking part in this study.
7. I am aware that I should retain a copy of the Consent Form, when completed, and the Information Sheet.

Signed: .....Witnessed

.....Dated:.....

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: ..... Dated: .....

I hereby withdraw my consent to participate in the research project entitled Perceptions of issues involved with supporting children in out of home care

Signed: ..... Dated: .....



## APPENDIX F

### Information for participants and consent form: Foster Carers

**I hereby consent to my involvement in the research project entitled:**

**Perceptions of issues involved with supporting children in out of home care**

1. The nature and purpose of the research project described on the attached Information Sheet has been explained to me. I understand it, and agree to taking part.
2. I understand that I may not directly benefit by taking part in this study.
3. I acknowledge that the possible risks and/or side effects, discomforts and inconveniences, as outlined in the Information Sheet, have been explained to me.
4. I understand that while my responses will be tape recorded & information gained in the study may be published, I will not be identified and information I provide will remain confidential.
5. I give consent on the understanding that I am free to withdraw my consent from any aspect of the study at any stage and therefore any information provided by me will not be included and recorded information provided by me for the purpose of this study will be destroyed.  
Opportunity for written withdrawal of consent is provided below.
6. I understand that there will be a payment of \$25 to me for taking part in this study.
7. I am aware that I should retain a copy of the Consent Form, when completed, and the Information Sheet.

Signed: .....Witnessed

.....Dated:.....

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: ..... Dated: .....

I hereby withdraw my consent to participate in the research project entitled Perceptions of issues involved with supporting children in out of home care

Signed: ..... Dated: .....



## APPENDIX G

### Summary of interview participants

Interview number	Participant code	Duration of interview (mins)	Gender	Age (years)	Occupation
1	CAMHS 1	51	Female	31	Speech therapist
2	CAMHS 2	51	Male	37	Nurse
3	CAMHS 3	56	Male	53	Nurse
4	CAMHS 4	62	Male	54	Social worker
5	CAMHS 5	62	Female	47	Social worker
6	CAMHS 6	41	Female	32	Psychologist
7	CAMHS 7	45	Male	47	Social work
8	CAMHS 8	48	Female	29	Social work
9	CARER 1	90	Female	51	
10	CARER 2	35	Female	56	
11	CARER 3	77	Female	64	
12	CARER 4	64	Female	48	
13	CARER 5	79	Female	49	
14	CARER 6	46	Female	57	
15	CARER 7	45	Female	64	
16	CAMHS 9	66	Female	26	Social work
17	CAMHS 10	37	Female	27	Social work
18	CARER 8	54	Female	48	
19	CARER 9	55	Female	48	
20	CARER 10	58	Female	41	
21	CARER 11	87	Female	41	
21	CARER 12	87	Female	42	
22	CARER 13	66	Female	44	
23	FSA001	63	Male	n/a	Social worker
24	FSA002	41	Female	54	Social worker

Interview number	Participant code	Duration of interview (mins)	Gender	Age (years)	Occupation
25	DECS001	61	Male	47	Principal
26	CARER 14	40	Female	53	
27	FSA003	39	Male	26	Social worker
28	CARER 15	52	Female	39	
29	RESI01	52	Male	n/a	n/a
30	FSA004	60	Female	54	Social worker
31	FSA005	60	Male	57	Social worker
32	RESI02	46	Male	41	Youth worker
33	CARER 16	57	Female	58	
34	DECS02	51	Male	50	Principal
35	DECS03	78	Male	54	Princippal
36	CARER 17	67	Male	50	
37	DECS04	47	Female	36	Counsellor/teacher
38	DECS05	41	Female	57	Teacher
39	DECS06	52	Female	52	Principal/teacher
40	DECS007	60	Female	50	Counsellor
41	DECS008	51	Male	58	Principal
42	DECS009	40	Female	50	Teacher
43	RESI 003	33	Male	53	Social worker
44	DECS010	55	Male	51	Teacher
45	RESI004	58	Male	48	Youth worker
46	FSA006	47	Male	42	Social worker
47	FSA007	32	Female	n/a	Social worker
48	RESI005	51	Female	37	Social worker
49	RESI006	61	Female	37	Youth worker
50	FSA 008	55	Female	48	Social worker
51	RESI007	34	Male	25	Youth worker
52	RESI008	39	Male	42	Youth worker
53	RESI009	31	Female	24	Youth worker

Interview number	Participant code	Duration of interview (mins)	Gender	Age (years)	Occupation
54	RESI010	51	Male	32	Youth worker
55	RESI011	46	Female	49	Youth worker
56	RESI012	54	Male	43	Youth worker
57	DECS011	43	Female	n/a	Teacher
58	CAMHS011	35	Male	39	Psychologist
59	FSA 009	72	Male	47	Social worker
60	RESI 13	27	Female	27	Youth worker
61	RESI 14	30	Male	36	Youth worker
62	FSA 010	78	Female	54	Caseworker
63	FSA 011	39	Female	25	Social work
64	FSA012	32	Female	21	Social work
65	FSA013	36	Male	31	Social worker
66	DECS 012	43	Male	31	Teacher
67	DECS013	28	Female	36	Teacher
68	DECS014	61	Female	39	Counsellor
69	RESI 015	66	Male	50	Youthworker
70	RESI 016	48	Male	33	Youthworker
71	RESI 017	45	Female	43	Youthworker
72	FSA 014	45	Male	29	Social worker
73	FSA015	45	Female	34	Social worker
74	DECS015	44	Male	58	Counsellor/teacher
75	FSA 016	36	Female	38	Social work
76	CAMHS 012	53	Male	57	Social work
77	CARER 18	57	Male	55	
77	CARER 19	57	Female	50	
78	CARER 20	78	Female	n/a	
79	CARER 21	72	Female	62	

Interview number	Participant code	Duration of interview (mins)	Gender	Age (years)	Occupation
80	DECS 016	37	Female	54	Teacher
81	DECS017	34	Male	49	Teacher
82	CARER 22	76	Female	34	
83	FSA 017	55	Female	44	n/a
84	FSA 018	61	Female	43	n/a
85	FSA 019	54	Female	50	n/a
86	CARER 23	74	Female	n/a	
87	CARER 24	56	Female	34	
88	CARER 25	45	Female	42	
89	DECS 018	37	Male	n/a	Teacher
90	CARER 26	63	Female	48	

Note: n/a indicates respondent did not provide this information on demographic survey

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