

Beyond containment: Driving change in residential care: A Queensland, Australia model of therapeutic residential care

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Abstract:

Mercy Family Services is a Non-Government Organisation providing a range of out of home care services, including one 'therapeutic residential' and 12 traditional residential care programmes across South East Queensland, Australia. This paper will examine the implementation of a model of therapeutic residential care developed to address a gap in service delivery identified in the *Crime and Misconduct Commission: An Inquiry Into Abuse In Foster Care* in January 2004, which found there was a need for more therapeutic treatment programmes in order to assist children and young people with severe psychological and behavioural problems (Crime and Misconduct Commission, 2004).

Traditional residential care, with a focus on daily care provision and containment, had limited success in meeting this client group's complex needs and it was apparent that a trauma informed model that sought to provide a 'healing' therapeutic milieu was a sector priority.

The paper will provide an overview of the Mercy Family Services' therapeutic residential care model recently implemented in the final of four pilot programmes across Queensland, Australia. Further, the learning gained from the process of development of the model, informed by contemporary literature from within Australia and beyond, will be shared, along with the exciting developments emerging as practice is transformed and influences improvements across our entire network of residential programmes.

This paper will explore how the historical context of residential care in Queensland, Australia influenced the development of a model of therapeutic residential service delivery developed to meet the challenge of driving change in an environment where containment models and poor outcomes had resulted in a decline in popularity of residential care. The paper will also detail the Mercy Family Services Therapeutic Residential Care model, a community of care approach that is underpinned by a needs-based, trauma-sensitive, and relationship/attachment-focused framework developed by Dr Redshaw, in response to an opportunity to pilot therapeutic residential care commissioned by the Department of Child Safety after recommendations arising from an inquiry into

abuse in foster care conducted in Queensland in 2004. Finally, the paper will share learning experiences from the implementation of the model into practice and initial outcomes for the young people placed during the first year of operation.

Key words:Therapeutic Residential Care; Community of Care; Out of Home Care; Australia

Historical Context of Residential Care in Queensland, Australia

The use of residential care in Queensland, Australia as a placement option for children and young people in state care began approximately 150 years' ago when the first orphanages and children's homes were established in the 1860s. In the main, these were under the auspices of churches which remain the predominant providers of residential care in Queensland today. Although called orphanages, the reasons for children being placed in these residential facilities were primarily poverty, neglect and family breakdown (Schofield, 1999, p.31). The exceptions to this were indigenous children removed as part of the 'stolen generation' and a small number of British child migrants sent to Queensland after the Second World War (Forde, 1999, p.ii).

The first government orphanage, the Diamantina, was established in 1865, followed two years later by the Saint Vincent's orphanage at Nudgee established by the Roman Catholic Sisters of Mercy (Forde, 1999, p.32). In 1880, 77 per cent of the total number of children in state care were placed in institutions. By 1900, this had declined to 40 per cent and by 1930, only 10 per cent of children in state care were in institutions. By 1965 the figure had risen to 15 per cent, with a peak of 22 per cent in 1951 (Forde, 1999, pp.33-34). The decline in the early part of the century was predominantly due to the increase in the prevalence of foster care as the preferred placement of choice, with the rise in the second half of the century attributed to a lack of available foster families rather than a re-emergence of residential care as a deliberate policy choice (Forde, 1999. pp.33 - 263).

The state relied heavily on the charitable nature of churches to provide residential care and due to poor resourcing large conglomerate care facilities were the predominant model, although the late 20th Century also saw an emergence of some smaller group home models. With the professionalisation of child welfare in the 1960s and 1970s there was a deliberate move towards closing large residential facilities (Forde, 1999, pp.104-112). Across Australia between 1983 and 1996 there was a decrease in the number of children and young people placed in residential care, from 7,140 to 1,818 (Bath, 1998). This, however, placed more pressure and an over reliance on an already stretched foster care system, and failed to provide alternative models for those young people with particularly complex behaviours.

Recommendations arising from the Forde Inquiry (1999) led to a significant increase of funding into the child protection system in Queensland; however a further decline in the number of residential placements was experienced. The number of residential care services in Queensland had reduced from 61 in the 1970s, to only 20 in 2003, the majority of which were staffed by house parents (Crime and Misconduct Commission, 2004, p.191). Despite the reliance on the foster care system in the post-Forde Inquiry era, the Crime and Misconduct Commission recognised that, 'there are significant numbers of children who do not benefit from placement in traditional foster care and require placements in residential facilities' (Crime and Misconduct Commission, 2004, p.192). The unintended consequence of the over reliance on the foster care system arising from the intentional decline in the number of funded residential placements was a trend towards expensive 'containment' based individualised placement packages for those young people who could not be managed in family based care (Department of Child Safety, 2008).

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

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

The re-emergence of residential care as a placement of choice after the Crime and Misconduct Commission has seen a rapid increase in the number of residential facilities across Queensland since 2005. However, some significant legacies from the past remain. These include a reduction in the residential care sector resulting in a loss of knowledge in the area; a lack of skilled and qualified residential care workers, and a lack of relevant Australian based research and literature around residential care, although this is improving. Most significantly, Queensland was left with a placement system that did not have the capacity to meet the increasing complexity of need of children and young people in the care of the state.

As a consequence of the implementation of the recommendations of the Crime and Misconduct Commission Inquiry outlined above, funding was granted in 2007/08 for four 'therapeutic residential' pilots to be established across Queensland (Department of Child Safety, 2008). In 2011, the final of these pilot 'therapeutic residential' services was established for six young people in Morayfield, to the north of Brisbane, in a purpose built facility; funding for the service was awarded to Mercy Family Services.

Mercy Family Services - Therapeutic Residential Care Model of Practice

Background

Mercy Family Services' Model of Practice was originally developed for our Residential Care Services and enhanced for our Therapeutic Residential Care submission in 2010. The model was developed by Dr Redshaw, Mercy Family Services' research and practice development manager, over the course of his 20 year journey within the organisation and his academic studies, including his PhD in social work, completed in 2010. This journey started in the 1990s during a program crisis resulting in a comprehensive search of the literature looking for answers to the existing program struggles. The review commenced with parenting literature, counselling and therapeutic intervention frameworks for working with children and young people with challenging behaviours, the out-of-home care and relationship sciences literature, and over this 20 year period has grown to the current collection of over 10,000 journal articles, practice papers and industry reports, in addition to an extensive book library. After a health crisis in early mid 2000s led Dr Redshaw to undertake a process of re-examining the model, the main underpinning foundations and components of the model were confirmed as valid by the current literature with some refinements, i.e. leaving out strategies like 'time out' where literature has since highlighted difficulties of these types of approaches. This journey has contributed to a shift from 'containment' or a punishment / consequences based approach to a therapeutic healing approach across the Mercy Family Services network of residential services, and not just the 'therapeutic' residential pilot (Redshaw, 2011; Redshaw, 2012).

Overview of MFS Therapeutic Residential Care Model of Practice

The intention of the model is to provide a body of knowledge and a practice framework to assist in the avoidance of the age old challenge to residential care practice which sees workers fall back on their own personal parenting practices and belief systems and instinctive reactions to young people which are often not helpful; the model seeks to support workers to view the young person from multiple perspectives to allow a holistic approach to intervention and healing (Redshaw, 2011; Redshaw, 2012).

The model is underpinned by a range of principles derived from the out of home care literature and informed by the Child Protection Act 1999 and relevant policies including the best interests of the child, and the Statement of Standards and Charter of Rights. In essence, the model argues that a quality residential care programme provides a 'community of care' that is needs-based, trauma-sensitive and relationship/attachment-focussed, responds to needs in a manner which is sensitive to the trauma children and young people have experienced, and emphasises the centrality of caring relationships and attachments in the healing process (Redshaw, 2011).

An underpinning principle of the our 'community of care' framework is that the young person is cared for within an environment that is founded on the principles of quality therapeutic communities, recognises and caters to individual needs (within the context of the group), creates a healing therapeutic milieu which recognises the centrality of the

relationship between carer and young person, and establishes safety to begin the healing process achieved through the implementation of the nine core intervention practices and advanced intervention strategies (Redshaw, 2011).

As stated above, the model is underpinned by years of research and practice development by Dr Redshaw and draws on a wide range of relationship sciences literature dating back to the 1920s which includes classic works by Aichorn (1925, 1965), Redl and Wineman in *Children Who Hate* (1951), and *Controls from Within* (1952), and Trieschman, Whittaker and Brendtro's *The other 23 hours* (1969); and then incorporating newer approaches such as neuro-biology, trauma and pain based behaviour including work by Perry (2003), Anglin (2002) and others; finally also incorporating works from the attachment literature including Hughes and Golding and others.

Model of Practice Components

The Therapeutic Residential Service practice framework is underpinned a 'Community-of-Care' that recognises four critical focuses: the centrality of needs; trauma-sensitive and relationship/attachment-focused care; the nine elements of Core Intervention Planning; and the series of Advanced Intervention Practices.

The essence of the organisation's 'Community-of-Care' framework is that the young person is cared for within an environment that is founded on the principles of quality therapeutic communities, recognises and caters for their individual needs, provides care with a sensitivity to the trauma that they have experienced and the impact this has had on their development and wellbeing, and emphasises the critical importance of building caring and lasting attachment relationships between a carer and young person. It is within this context that the nine core intervention practices and advanced intervention strategies are implemented. Each of the major components of the framework illustrated in Figure 1 are briefly described below.

Four Critical Focusses

Underpinning the Core Intervention Framework are the four critical focuses: General Wellbeing; Strengths and Interests; Identified Problems; and Day to Day Behaviour Management. These are utilised as a frame for assessment, therapeutic planning and for managing the day to day care of the young people. Ensuring that each of the four critical focus areas is attended to is critical to ensure a holistic approach to young people's wellbeing and the ultimate successful outcome of intervention. The process of initial assessment works through these quadrants in order to identify the opportunities for support of the young person and to determine their needs in each area. Day to day behaviour management also incorporates practice tools arising from the Therapeutic Crisis Intervention model, for example, life space interviews (Holden & Powers, 1993, pp.131-149).

Foundational Principles and Practices

The underlying knowledge frameworks (Needs-based, Trauma-sensitive, and Relationship/Attachment-focused care) provide the basis upon which all other aspects of service delivery and day-to-day practice are undertaken.

Residential care workers are encouraged to become very familiar with these basic frameworks and to further their knowledge and practice. Seeking to implement the nine components of the Intervention Framework and the Advanced Intervention Practices outlined below will be largely ineffective if the important principles and practices derived from these frameworks are not understood critically reflected on and implemented (Redshaw, 2011; Redshaw, 2012).

Core Intervention Framework

At the heart of the practice framework are 'Nine Core Components' (Figure 1), and these include 1) Assessment of needs, 2) Therapeutic milieu, 3) Residential carers as the mediators of change, 4) Positive-caring practices, 5) Positive development, 6) Focused support, 7) Prevention, 8) Emergency management, and 9) Corrective guidance and discipline.

These 'core components' are underpinned by a central logic that successful intervention in the lives of children and young people with complex and extreme support needs requires a multifaceted approach where the emphasis is on identifying and meeting needs, responding sensitively to trauma, providing safety and nurturing within a caring therapeutic milieu where there is a focus on strengths and where young people are able to be provided with focussed support in order to address serious emotional distress and challenging behaviours whilst their care and development is managed through clearly established strategies and procedures around conflict resolution (teaching approach) and, where necessary, effective emergency management and then appropriate corrective guidance and discipline (TCI framework and other planned interventions) (Redshaw, 2011; Redshaw, 2012; Holden & Powers, 1993, pp.49-52). For a somewhat different, but critically important perspective of these components, see Figure 2.

This diagram demonstrates the proportionality of the focus that should be placed into each component, for example, the larger sections at the base represent the increased time and focus that should be attributed to the component, i.e. the larger base components should be the main focus in order to build a foundation and avoid over focus on discipline or 'changing' behaviours that can lead to programme stress and environmental chaos (Redshaw, 2011; Redshaw, 2012).

In order to move 'beyond containment' in a residential care environment, the nine core components of the model are utilised for the foundation for practice. Traditional generalist residential care models have focussed on containment with an over resilience on the top three components of the model, i.e. behaviour management, crisis

management, and conflict prevention. Whilst it is acknowledged that these are essential components of residential care, if they are the only focus it is difficult to move beyond these, to reach the goal of providing a 'healing' experience' (Redshaw, 2011; Redshaw, 2012).

Advanced Strategies

Following on from the original model of practice developed by Dr Redshaw in the early 1990s, a literature review and gap analysis of the model against contemporary literature was utilised to identify the 'advanced strategies' that forms the basis of the Mercy Family Services' Therapeutic Residential Care Model (Redshaw, 2011; Redshaw, 2012). This especially highlighted the family engagement strategy with the view to either reunify or at least build a safe relationship for post care connection. Further, elements of the Sanctuary model including 'safety plans', psycho-educational group work and community meetings have also been included (Bloom, 2005, pp.65-81).

In addition to these advanced strategies, the model includes a focus on the transition from the commencement of the placement, with the identification of a formulation or trajectory which informs the approach to intervention and goal development. Failure to achieve this, according to Menses and Durant (1990, pp.11-31), is where traditional models of residential care have failed young people, perpetuating a sense of failure from previous placement breakdowns. This approach includes seeking the young person's views about placement, incorporating these to the best of the service's ability, and early assessment including careful transition to increase feelings of positivity about the placement and building a collaborative care team involving all relevant stakeholders from the beginning.

A further advanced strategy is in the area of staff training including a specialised, intensive induction programme model of practice training which incorporates daily routines and programme guidelines. Other advanced training around trauma and attachment is undertaken to ensure staff are able to effectively respond to the needs of the young people accessing the service (Redshaw, 2011; Redshaw, 2012).

One of the most important advanced strategies is 'activity programming' as distinct from activity planning. The heart of this strategy is not to simply fill up young people's time but rather provide an activity programme which is purposeful and underpinned with a therapeutic intention aimed at increasing the young person's healing experience and achievement of improved life outcomes. Foundations for this include:

- building upon the successful characteristics and behaviours of the young person;
- defining success and progress within reasonable limits of their capacity;
- promoting a wide variety of activities, with opportunity for progressive skill development;
- drawing public attention to their achievements;
- promoting social relationships and skill development that leads to self-direction;

- assisting young people to complete tasks;
- celebrating participation.

Particular emphasis is also placed on ensuring that activities occur at a range of locations to avoid the potential of creating an insular institutional mindset (Redshaw, 2011; Redshaw, 2012). This strategy is informed by authors including: Redl & Brendtro (1950s); VanderVan (1985, 2003, 2005, 2006); Barnes (2009); and Beedell (2007).

The final advanced strategy is 'wildness/adventure-based therapy'. The central idea within such approaches is to spend time with the young person in an outdoor environment that is considerably different from the often intense atmosphere of the residential aimed at assisting to facilitate the building of one-on-one relationships with staff and peers, team work, self-confidence, and a sense of achievement. The intention of the model is to have such an wilderness / adventure-based therapy experience at least three times during the 18 months of placement: one towards the beginning of the placement, one during the young person's stay that may be able to involve a significant other, e.g. family member, and then one towards the end of the placement, i.e. a rite of passage (Anglin, Artz & Scott, 1998; Balzerman, 1998; Beames, 2004; Gavazzi and Blumenkrantz, 1993; Markstrom, Berman Sabino and Turner, 1998; & Sullwold, 1998).

Cleaning Your Glasses

The final underpinning component of the model is based around the concept of 'cleaning your glasses' (Redshaw, 2007, pp.28-34). Used widely throughout the various residential care programmes, Dr Redshaw incorporates the concept into the model. The phrase 'catch them being good' encapsulates much of current practice that has been shown to be effective in reducing instances of non-compliance in children with complex and challenging behaviours, namely praise, encouragement and positive reinforcement. For some residential care workers, however, 'catching the child/ young person being good' after long periods of challenging behaviour becomes almost an impossible task; metaphorically speaking, 'cleaning your glasses' is a necessary pre-requisite for effectively 'catching your child being good' reminding staff that the behaviour is most often a function of their trauma / a coping mechanism (Redshaw, 2007, pp.28-34). The therapeutic metaphor and associated six-phase intensive intervention has demonstrated to be a critically important strategy for helping staff to avoid and / or minimise the development of a damaging 'containment' mind set.

Implementation Challenges and Initial Outcomes

The Mercy Family Services Therapeutic Residential Care pilot opened in October 2011 placing two young people at commencement, with a further young person accommodated in an annexe placement. Additional young people have transitioned in to the programme over the first year with a total of six young people accessing the service during its first year. The service has experienced many challenges during the first year of operation including:

- high cost resulting in high expectations for immediate change in the young people's behaviours;
- a lack of understanding of the model and differences to traditional 'containment' models of residential care;
- high turnover of staff;
- difficulty attracting appropriately skilled residential care workers;
- maintaining an effective orientation and induction training process for one off recruits;
- determining appropriate referrals utilising a 'shared need' versus a 'compatibility' matching framework; and
- resisting crisis management in favour of maintaining a programmatic approach.

Despite these challenges, the service has achieved promising anecdotal results such as one young person who has achieved observable improvements in regulation of emotions, a elimination of serious self-harm, regular attendance at school,; engagement in part-time employment, improved family relationships and a readiness for a transition to a step down model, i.e. a less intensive residential programme with a view towards supported independent living or a possible reunification with family.

Another young person entered into the program in an 'annexe' due to the recognition of issues of compatibility matching with the other young people. This young person has achieved improvements in sleep regulation, complete cessation of soiling and smearing behaviours, improved emotional regulations, reconnection with an estranged parent, continued engagement with his other parent, reconnection with schooling options, and planning towards an exit into the adult disability support sector.

One young person experienced difficulties with co-tenancing, emotional regulation and aggression, and served one period in detention. The young person was transitioned to a specialist foster care placement with intensive support. A further young person did not have a 'shared need' with the other young people placed in the service and was ill matched; this placement ended with a transition to an alternative placement option.

Most recently, two young people have transitioned into the service based on a 'shared need' around problematic sexualised behaviours. The model is being further enhanced with specialist knowledge in order to build the capacity to effectively respond to this need (Mercy Family Services, 2011-12).

These results are heartening given the current questioning of the place of residential care in the service system in Queensland, arguably as a result of containment models resulting in some poor outcomes. The results achieved in the first year of the pilot of the therapeutic residential service offered by Mercy Family Services in partnership with the Department of Communities, Child Safety and Disability Services, along with the results of 'therapeutic' residential care in other jurisdictions in Australia, appear to indicate that

there is indeed a place for such models in order to effectively respond to the complex needs of traumatised young people in the out of home care sector. The Mercy Family Services Therapeutic Residential Care model will be evaluated at the conclusion of the first year of operation to ensure its on going development and continued strive to get 'beyond containment' and drive change across the Mercy Family Services' network of residential care services; if not, the out of home care sector.

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Figure 1.

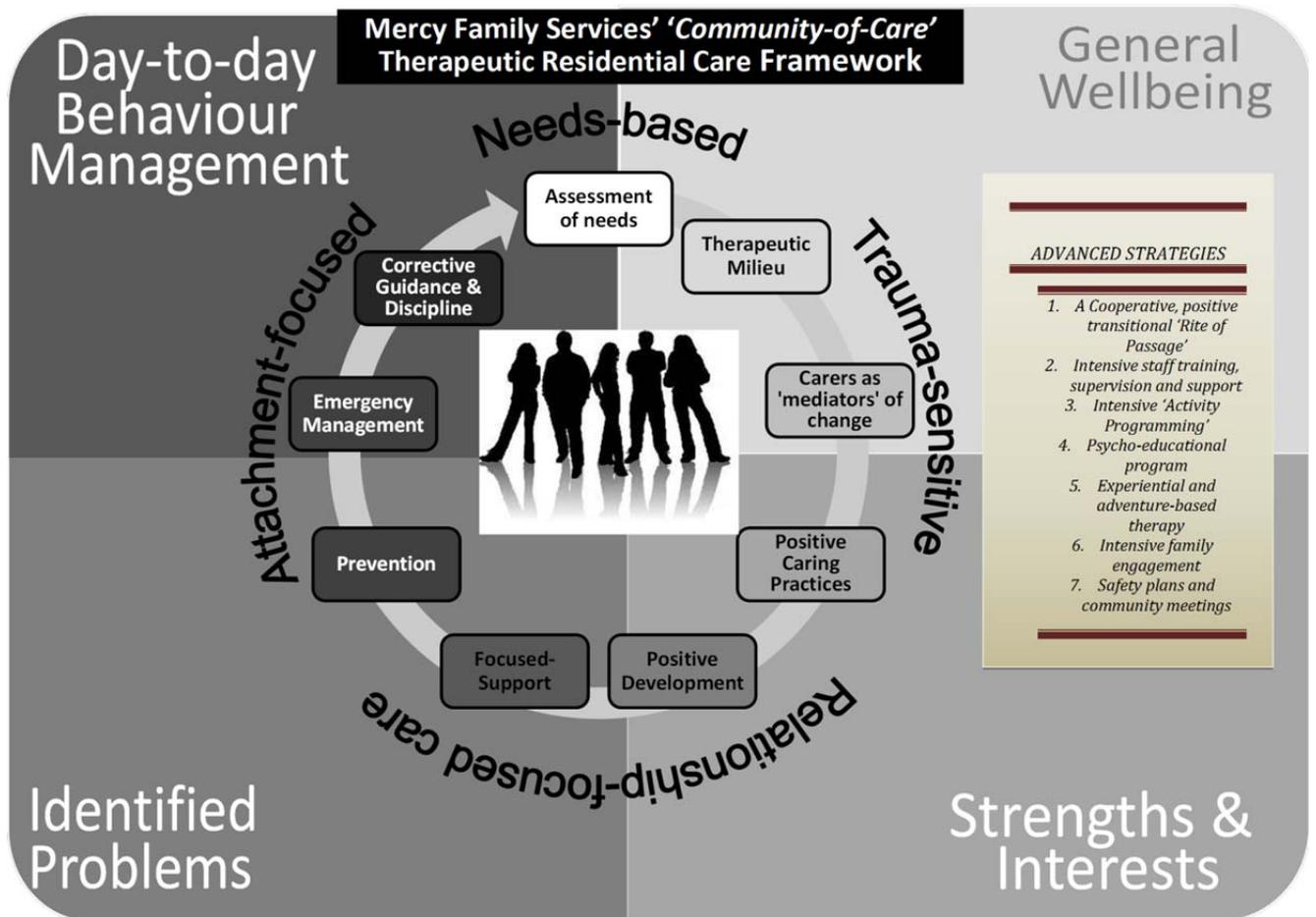
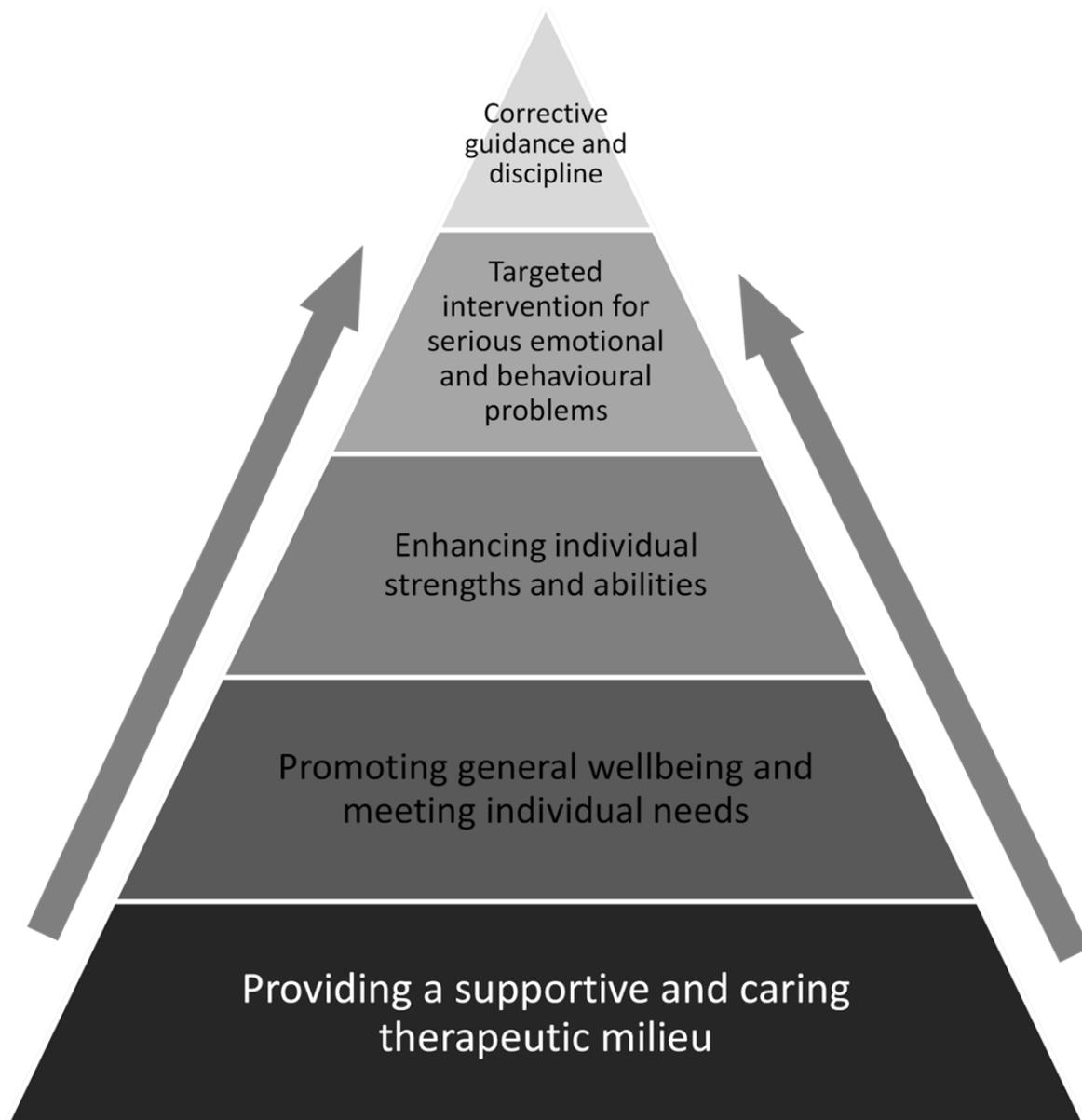


Figure 2



Shelley Wall, Residential and Transition Services Manager, Mercy Family Services

Shelley Wall (BSocSc, MSW Prof Qual) - has over 19 years of experience working in the out of home care sector across both frontline and leadership roles specialising in residential care. Her achievements are recognised in areas such as program development, governance and a commitment to best practice. Shelley is currently employed as the Residential Care & Transition Services Manager for Mercy Family Services. In this role, she has overall responsibility for innovative services which support over 50 children and young people placed in the out of home care sector; employing over 150 staff.

Dr Stewart Redshaw, Research and Practice Development Manager, Mercy Family Services

Dr Stewart Redshaw has over 25 years' experience working in community services with children and young people at risk and in out-of-home care, and, at times, as a counsellor and trainer in private practice. He works with Mercy Family Services, Queensland, as the Research and Practice Development Manager. He has presented papers at state, national and international conferences, and conducted workshops across Australia. He has also published in counselling, child protection, and child and family welfare practice journals.

Kym Edwards, Former Placement Services Director, Department of Communities, Child Safety and Disability Services

Kym Edwards (BA Psych) - has over 25 years of experience working in the area of child protection as both a practitioner and across various leadership and management positions. Her particular passion is out of home care, ensuring that children and young people have the best possible placement experience. She is the former Director of the Placement Services Unit for the North Coast Region, Department of Communities, Child Safety and Disability Services, Queensland, which is responsible for managing placement options for approximately 1000 children and young people in statutory out of home care.