



Submission to SA Royal Commission

Child Protection Systems

March 2015

The effectiveness and appropriateness of residential care for young children in Out of Home Care

*Based on a commissioned review of published literature by the
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1. Introduction

The Child and Family Welfare Association of South Australia [CAFWA-SA] is the South Australian peak body representing the not-for-profit non-government organisations [NGOs] providing child protection services for children, young people and families, especially in relation to various forms of Out of Home Care [including Foster Care and Residential Care], Family Support, Placement Prevention, Early Intervention and Family Reunification Services.

CAFWA-SA and its members have for many years been engaged as service providers and partners in the child protection sector, and we are acutely aware of sector complexities and challenges. Apart from being a difficult area of public policy, the impact of child protection incidents is challenging each one of us individually when we strive for what is best for children and young people.

This submission to the Royal Commission follows an earlier CAFWA-SA submission titled 'Ten Point Action Plan for Child Protection'. That submission set out the views of CAFWA-SA on a number of required changes to reform the child protection system in South Australia and highlights changes needed to improve outcomes for children in care.

CAFWA-SA members have been concerned about the extensive use of residential care in South Australia and in our earlier submission we recommended a full independent review of residential care. We suggested that this review should make recommendations on the design of an appropriate evidence based services response that is age appropriate and trauma focused.

In order to be better informed on the latest developments, CAFWA-SA commissioned¹ the Australian Centre for Child Protection at the University of South Australia, to undertake a literature review into the use and effectiveness of residential care, in particular the appropriateness of residential care for young children.

CAFWA-SA is very pleased to share the outcome of this literature review with the SA Child Protection Systems Royal Commission.

¹ *'The effectiveness and appropriateness of residential care for young children in out-of-home care' was prepared by Dr Sara McLean, according to the terms of a project agreement between the Australian Centre for Child Protection and Child and Family Welfare Association of SA Inc. dated 3/10/2014. This submission substantially reproduces the findings of this review. The views expressed in this submission are those of CAFWA-SA and do not represent the views of the Australian Centre for Child Protection.*

2. Aims and scope of the review

The Australian Centre for Child Protection in Adelaide was commissioned by the Child and Family Welfare Association South Australia [CAFWA-SA] to review the published literature related to the effectiveness and appropriateness of residential care for young children placed into Out of Home Care. In determining the scope of this review, the decision was made to focus on the available evidence about the extent to which residential care, as opposed to other potential placement options, is able to respond appropriately to children's developmental needs. The focus of this review is on the developmental needs of children under the age of 10 years who are placed in Out of Home Care.

Where applicable, recommendations and implications for optimising care of young children placed in residential care are included. This review addresses three main questions:

- What do we know about the use and effectiveness of residential care?
- What do we know about the needs of young children entering residential care?
- What characteristics of residential care best meet the needs of young children?

3. What is known about the use of residential care?

The Australian Institute of Health and Welfare report, *Child Protection Australia 2012-2013 (AIHW, 2014)*, identifies residential care as one of five main groups of living arrangements provided to children in Out of Home Care (see AIHW, 2014, p. 46).

Residential care is defined as “placement in a residential building whose purpose is to provide placements for children and where there are paid staff” (AIHW, 2014, p.46). These staff are typically rostered on rotating shifts and, as a result, children in residential care settings may have exposure to a range of adults during any one period of care. Residential care may be provided in small home like settings, housing between 2-6 children, or in larger facilities housing up to 12 children.

This is contrasted with home-based care, which the Australian Institute of Health and Welfare defines as “placement in the home of a carer who is reimbursed (or who has been offered but declined reimbursement) for expenses for the care of the child” (AIHW, 2014, p.46.). This is broken down into the three subcategories: relative/kinship care, foster care and other home-based out-of-home care (AIHW, 2014). The features that characterise home-based care and distinguish it from residential care generally include consistency of residents, including principal caregiver(s), and the provision of care in a home environment.

In Australia, the vast majority of Out of Home Care placements (93%) are provided in home-based care (AIHW, 2014). Of these, 43% are provided in foster care and 48% are provided in relative/kinship care (AIHW, 2014). Relatively fewer children are placed in residential care. Nationally, it is estimated that around 1 in 20 children in Out of Home Care are living in residential facilities (AIHW, 2014), although this rate varies slightly from jurisdiction to jurisdiction. In addition to the need to place children with complex care needs who have experienced multiple foster homes, an increasing driver of the use of residential care may be the need to place large sibling groups (AIHW, 2014), although there is no systematic data collected on this.

In South Australia, the proportion of children in residential care is currently higher than the national average. As of 30th June 2013, Australian Institute of Health and Welfare data indicated that there were 2,657 children placed in Out of Home Care. Of these children; 29.4% were aged between 10-14, 32.7% were aged between 5-9, and 20.7% were aged between 1-4 years. At that time, 12.4% of all South Australian placements were in residential care. Amongst South Australian children receiving residential care, 32.4% were aged between 1-9 years and 40.3% were aged between 10-14 years. Only 27.3% were aged between 15-17 years.

More recently, the Annual Report of the Office of the Guardian of Children and Young People in SA also indicate similar figures (Office of the Guardian of Children and Young People in SA, 2014). According to these figures, as at 30 June 2014, there were 2,577 children and young people under the guardianship of the Minister through care and protection court orders. They had the following characteristics: 32% were aged between 10-14, 32% were aged between 5-9, and 20% were aged between 0-4 years. 86.5% received home-based care (42% foster care and 37% relative/kinship care). Residential care was provided to 10% of all South Australian children in Out of Home Care, and emergency (commercial care) was provided to 3% of all children in care, making a combined total of 13% of children in non-family based care. Distributions of children by age group were not provided in this report (See www.gcyp.sa.gov.au)

There does not appear to be any published data on the number of sibling groups currently residing in South Australian residential group homes, but it is generally thought that being part of a sibling group is one of the significant reasons for use of residential placements for younger children.

South Australian research that asked residential care workers about the family contact experiences of children in residential care provides some insight into this issue (Iannos, McLean, McDougall & Arney,

2013). Workers in that study completed interviews for a total of 73 children and young people who were residing across a range of South Australian residential units, and had an average age of 13.3 years (range= 8-18 years, 38% ATSI). Workers reported that children desired to have more contact with their siblings. A significant finding was that for children who were in contact with siblings, 42% of those children's siblings were also in some form of care (another residential unit or foster home). While firm data does not appear to exist, anecdotal reports suggest that the placement of sibling groups is a significant issue for South Australian Out of Home Care services and that residential care is used as a means of keeping sibling groups together. One of the principle reasons for using residential care may be the need to place young children as part of a larger sibling group.

4. What is known about the effectiveness of residential care?

Internationally, residential care is a form of care that is most typically used for the care of children with complex needs including offending behaviour, substance use and complex mental health needs, although these children may not necessarily be under the care of statutory child welfare services (James, 2011; McLean, Price-Robertson, & Robinson, 2011; Stuart & Sanders, 2008). Residential treatment of youth in facilities is well accepted in mental health, forensic and, to a lesser degree, statutory services internationally.

The majority of international peer-reviewed evidence generally concludes that the majority of children receiving tailored residential services do improve following a period receiving residential treatment (Curry, 1991; Knorth et al., 2008). The nature of these residential treatment facilities differs significantly, however, from what currently exists in Australian statutory residential care because it is typically 1) delivered in much larger facilities, 2) is staffed or supported by multidisciplinary teams, 3) is short term and time limited by design and 4) is generally designed and delivered with a clear mental health or forensic focus and outcome in mind. These residential care models also tend to serve older children and adolescents with multiple or complex needs. *In Australia, however, residential care is used almost exclusively as an alternative care arrangement for children for whom there is active involvement of statutory agencies.*

Although reviews do indicate the potential of well-designed residential care services to contribute to psychosocial development, they have also highlighted the lack of monitoring of long term outcomes, the lack of detail about the nature of support offered to children and the process of change involved in residential care (James, 2011; Knorth, Harder, Zanberg & Hendrick, 2008; McLean et al., 2011). *We still know little about the long term outcomes for children who have exited from a period in residential care,*

but it seems likely that long term improvements may be limited without the ongoing connection and involvement of family in treatment plans (Knorth et al., 2008).

Comparing models of residential care is made difficult by the fact that, outside of Australia, such services can be provided by mental health services, juvenile justice or statutory child welfare (James, 2011). This means that it is difficult to draw conclusions about what makes residential care effective for children because the services that are being compared do not necessarily have the same aims, may not be delivered to similar populations, or employ similar outcome measures. It is further complicated by the variety of forms that residential care can take.

Any service that is classified as “residential care”, for example, can vary immensely in regard to important dimensions of the care environment. These include, but are not limited to:

- 1) how staffing is configured (is specialist support on site or ‘wrap around’; do staff have a therapeutic or a containment role?; are staff consistent e.g., teaching parents or rotational/casual; what are the qualifications if any?)
- 2) aspects of the physical setting (is it a community or institutional setting, is there a single unit or multiple unit dwellings, what is the size of the unit or home) and
- 3) what is the management of the care environment? (are behavioural sanctions used; what is the ideological orientation to care?) (Delfabbro, Osborn, & Barber, 2005).

As already noted, much of the evidence in support of residential care for children is drawn from research outside of Australia. Much of this work is focussed on models of care that are not available in Australia, such as residential treatment care models, together with some promising smaller group care models (James, 2011). The published evaluations typically focus on mental health outcomes, rather than issues like experience of psychological safety or placement stability (Curry, 1991; James, 2011).

Arguably, issues such as stability and psychological safety are critically important for children in statutory residential care services. Finally, the lack of detail involving how support is offered to children within residential care services means it is difficult to identify effective treatment components (James, 2011; Knorth, Harder, Zanberg & Hendrick, 2008; McLean et al., 2011).

5. Broad principles of effective residential care

Notwithstanding the limitations set out above, some broad conclusions can be drawn from the available literature about what the characteristics of effective residential care services might be and about the

principles of care that might contribute to effective residential services. Many of these principles are applicable to children in statutory services.

a. The service is guided by a clear conceptual model

Promising models of residential care are characterised by a clear conceptual and treatment model. Many models are able to articulate the key features of the development of supportive residential culture including aspects of group dynamics that are unique to the residential group care setting. These include organisational congruence, being aware of the impact of trauma on children's development and interpersonal relations, staff – child relationships, attachment and addressing a supportive and healing culture (e.g., see Sanctuary; Abramowitz & Bloom, 2003; CARE; Holden, Izzo, Nunno, Smith, Endres, Holden, & Kuhn, 2010; Positive peer culture models; Vorrath, & Bendtro, 1985).

b. The residential service takes an approach to care that is tailored to suit the needs of the child

Residential treatment care appears to be most effective for children with externalised behavioural problems, e.g. antisocial behaviours, hyperactivity (Knorth et al., 2008) and includes behavioural modification and specific skills training (e.g., empathy and problem solving). Family focussed components appear important in residential treatment programs for juvenile offending (Knorth et al., 2008). This is likely to reflect a treatment approach in which the support offered to children is *directly related* to the nature of their needs (Curry, 1991). One of the key considerations is *tailoring* the approach and expectations of the residential care staff to the child's developmental needs (Barth, Greeson, Zlotnik, & Cintapalli, 2009; Holden, et al., 2010). The impact of many staff interactions will be influenced by a child's cognitive development, language ability and reflective capacity (Stevens, 2004). For younger children, for example, behavioural approaches that focus on building alternative ways to express behaviours and to communicate needs are more effective than traditional therapy approaches.

c. The service targets developmentally appropriate skill development

Reviews of promising residential models indicate that many include a specific focus on building children's competencies in relevant areas such as social skills, executive functions and building resilience skills such as self-efficacy and coping skills (Holden et al., 2010; McDonald & Millen, 2012). There may be an explicit focus on tailoring expectations and emerging skill development at a level appropriate to the child's current level of functioning (e.g., CARE model; Holden et al., 2010).

d. The service engages with family and wide social and cultural connections

Research suggests that the longer-term effectiveness of placement in residential care may be related to engaging more widely with the child's supports. The inclusion of family-focused interventions has clear support as an adjunct to residential placement for young people with severe behavioural problems (Knorth et al., 2008; Leichtman, Leichtman, Barber & Neese, 2001). Research also points to the need for including wider networks such as family and community/cultural supports both during the stay in residential care and in the post-care support phases (Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005). Although evidence for the positive effect of involving family of origin hasn't been explored in the case of children in statutory residential care, ongoing relationship with significant family members could contribute over time to a child's sense of identity and cultural heritage (Connolly, 2009). Children in residential care frequently report the desire to have more contact with family members (Commission for Children and Young People and Child Guardian, 2013). Workers may need support to develop the skills and confidence in supporting family and community connections, rather than viewing this work as part of the role of the case worker (Hillan, 2006). In addition, research suggests that a residential program should employ active strategies for engaging with or developing the young person's educational, training and/or work experience. Engagement with academic support and academic achievement are related to positive outcomes (Curtis et al., 2001; Hair, 2005). Post-care support appears critical and involvement of family and/or wider community connections is likely to be central in this.

e. The service engages staff in building children's competencies and modelling social skills

Emerging and evidence informed approaches invest in the fostering of a range of staff competencies and behaviours, including non-confrontational approaches to problem solving, modelling of strategies and skills, engagement with family and broader community, training in key concepts and principles of the service model and commitment to creation of a nurturing culture and participation in regular team meetings (McDonald & Millen, 2012).

6. How can the current literature inform residential care for younger children in Australia?

One of the major limitations in evaluating the suitability of residential care for younger children is the lack of evaluation research that includes younger children. In a recent review of treatment efficacy of

published interventions on residential care, James (2011) explicitly noted two “promising” interventions that could be extended to younger children. Both the Stop GAP program (McCurdy & McIntrye, 2004) (ages 6-17) and the Teaching Family Model (TFM: Daly and Dowd, 1992; Fixsen & Blasé, 2002; Phillips, Phillips, Fixsen & Wolf, 1974) (ages 0-17) are designed to accommodate younger children in ‘residential’ settings, although both of these programs are typically delivered to older children. The two programs differ in key ways.

The Stop Gap program is delivered in a larger residential treatment facility by professional staff, employing intensive ecological and behavioural interventions, over a relatively brief time period (McCurdy & McIntrye, 2004). The Teaching Family model uses ‘teaching parents’ to offer a family-like environment and to teach living skills and positive interpersonal skills. They also liaise and support children’s parents, teachers and others in the child’s support networks to help children with their progress. Key features of the Teaching Family model includes use of a social learning paradigm, skill based training and support of teaching parents as professional carers, 24 hour professional consultation and support to carers and an emphasis on family style living in a normalised home like environment (homes or clusters of residential homes).

Although the Teaching Family Model is classified as a residential care program, in many respects it is more similar to a specialised home based placement, because of the presence of consistent caregivers. This consistency is one aspect that might make this model of residential care particularly suitable for the use of younger children. The model uses Teaching parents, that live with about 6-8 young people in small therapeutic group home units. James (2011) highlights the fact that specially trained ‘parents’ living in small therapeutic group home units makes it in many ways more similar in nature to a specialised foster care model such as multidimensional treatment foster care (Chamberlain, 2002) by virtue of the stability of relationships and by virtue of the level of training and multidisciplinary support available to the primary caregivers.

For these reasons, although this promising approach is delivered in a ‘residential’ setting, it has more in common with treatment foster homes than residential group homes that rely on rotating shift staff. Given the empirical support for treatment foster care (Chamberlain, 2002), an approach based on Teaching Parent Model can afford the opportunity to provide consistency of care for younger children and sibling groups.

7. What can we learn from comparing the outcomes of residential care and foster care?

As noted above, the main alternative to residential treatment is multidimensional treatment foster care (Chamberlain, 2002) in which specially trained foster parents are supported by weekly meetings with a multidisciplinary team to provide a planned behavioural support program to youth in foster care displaying disordered conduct and offending behaviour. A recent literature review concluded that, generally, comparisons between residential care and professional foster care tend to favour professionalised foster care, after controlling for adverse factors at the time of entry to care (Luke et al., 2014). They do note, however, that more difficult children tend to be placed in residential care rather than foster care to begin with.

A recent controlled evaluation study concluded that there appears to be no real difference over time between 'usual care' (principally residential placement) and Multi-dimensional Treatment Foster Care (MTFC) (Green et al., 2014). The exception may be in the case of 'anti-social' children, for whom MTFC was originally developed; these children may fair better with MTFC than *standard* residential care (Green et al 2014). Once again, such comparative studies don't appear to exist for younger populations of children.

There is some relevant information for younger children in foster care. Although there do not appear to be any studies in which foster care training interventions are compared to training for residential carers of similar age children, interventions with foster carers of younger children provide some insight into what might help support young children in care.

Multidimensional Treatment foster care, originally devised for older conduct disordered children, has been adapted for use with children aged 3-7. This approach uses social learning and behaviour management approaches, together with wraparound multidisciplinary support for carers and children, close supervision of children and reinforcement for prosocial behaviours. In younger children this intervention shows some promise in terms of 'improved' attachment behaviour and reduced placement disruption, although improvements in behaviour are not as great as when this type of foster care is used with older children (Bruce et al, 2009; Fisher & Kim, 2007, Fisher et al, 2011; Jonkman et al, 2012; Lynch et al, 2014).

Parent-Child Interaction Therapy (PCIT) has also been used with carers of children aged 2-8 to help carers shape positive behaviour in children through reinforcement of positive behaviour, attention and training in giving instructions. Although less rigorously evaluated, this training has been linked to

reduction in carer reported problem behaviour in foster children, and at one month follow up (Fricker-Elhai et al, 2005; Timmer et al, 2006a; Timmer et al, 2006b; McNeil et al, 2005).

Attachment and Bio-behavioural Catch up (ABC) is a foster carer training program for very young children, (usually between 1-2 years old) based on attachment theory, which aims to support carers to develop children's self-regulation and cognitive development. The attachment based intervention has been linked to reductions in infant markers for stress (Dozier et al, 2008); 'improved' attachment behaviour (Dozier et al, 2009), reduced problem behaviours (Sprang, 2009), and cognitive skills (Lewis-Morrarty et al, 2012).

Although none of these interventions were designed for residential facilities, they have been designed and evaluated with a view to the needs of young children in care. These studies all highlight the significance of consistency in responding to children's emotions and behaviour, whether this is conceptualised in terms of reinforcement, social learning, or in terms of attachment and co-regulation of behaviour. Consistency of interaction may be more difficult to achieve in a residential facility as staff numbers increase, or as children interact with staff that are unfamiliar with their developmental, behavioural and emotional needs.

8. What do we know about Residential Care services in Australia?

In Australia, the residential care provided to children falls into one of two main categories—'standard' and 'therapeutic' (VAGO report, 2014). Both models aim to provide temporary, short-term or long-term accommodation and support to children who have been removed from the family home. A range of government and non-government organisations may provide both standard and therapeutic care models across Australia. Some organisations that provide residential care are quite small and may only provide services to four children in one property. Others are large and provide residential care in houses across multiple locations and may manage many residential care placement services. Residential care can be distinguished from treatment foster care because the aim is to provide a therapeutic service in a staffed, residential group home or cluster of homes, rather than to support therapeutic foster parents to carry out a program of intervention.

Historically, residential care in all forms has been provided as a point of 'last resort', rather than a 'first placement' option. Children often end up in residential care following multiple placement failures, and it is said that children can 'fail' their way into residential care. Historically, standard residential care has been the main form of residential care for children who cannot be successfully placed in home base

care. Recently, there has been increasing interest in the targeted use of 'therapeutic' residential placements to address children's complex needs.

Nationally, there has been increasing recognition of the need for therapeutic residential care in response to the need to provide out-of-home care service solutions for children with complex needs, that are applicable to the unique cultural and care need of children in an Australian context (McLean et al., 2011). Therapeutic residential care can be distinguished from standard residential care by its ideology of care and by practical aspects of the daily care of children (e.g., increased staffing ratios). The National Therapeutic Residential Care Working Group offered this definition of Therapeutic residential care:

Therapeutic Residential Care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs. (National Therapeutic Residential Care, in McLean, Price- Robertson & Robinson, 2011)

While therapeutic residential care is similar to mainstream or standard residential care in many ways, its aspirations are unique. The aim of a therapeutic residential facility may be to facilitate healing of interpersonal trauma. There is not necessarily the intensive input of a multidisciplinary professional team such as exists in residential treatment models overseas. A key feature of therapeutic care is providing young people with a safe experience of adult relationships with residential staff, rather than relying on external professionals. A central assumption is that the provision of high quality, safe and healing relationships with 'trauma-informed' workers will enable young people to form internal models of relationships and self that are more adaptive and realistic than those that arise in the context of chronic abuse and neglect (Anglin, 2002; Bloom, 2005; Perry, 2006).

A therapeutic residential service can also be distinguished from therapeutic foster care because the aim is to provide therapeutic and healing relationship in the context of *professionally staffed residential homes* rather than in *home based care by foster carers*. Therefore therapeutic residential care seeks to take the best of relationship-based healing, but apply it to the professionally staffed, group care setting. It is a time-limited and intensive support model in which the ultimate goal is to strengthen young peoples' positive relationships and to support the young person to transition to a preferred care environment, such as a family-based foster care placement, or to independent living. Increasing interest in therapeutic residential care corresponds with a change in ideology/orientation towards residential care in which there is increased acceptance that residential care may be an acceptable and suitable

form of care for specific groups of children (e.g., specific cultural groups, sibling groups, children whose behaviour threatens their own safety or the safety of others).

Therapeutic residential care is still not widespread as a form of care for children in Australia. Where its use has been subject to evaluation, however, it has been judged a viable and cost effective alternative to standard residential care for troubled children (Victorian Auditor General's Report, 2014).

Therapeutic residential care is not offered across all jurisdictions, nor has it been routinely adopted in South Australian residential care (McLean, Price-Robertson & Robinson, 2011).

The majority of residential care in South Australia and in other jurisdictions, is still 'standard' in nature, that is, it is delivered without additional or specialist support or exceptional staffing configurations.

According to a recent Victorian Auditor General's Report into residential care (VAGO: 2013), the average annual cost of a standard residential placement is \$162,880 - \$233,448 per year depending on the complexity of the placement. Each therapeutic placement attracts an additional loading of \$74, 580 per year to accommodate the need to provide therapeutic supports (principally in additional staffing and/or therapeutic specialist support).

Staff in therapeutic placements are also required to adopt an intentional and purposeful approach towards their practice. A recent review documented some of the key features of therapeutic residential work (McLean et al., 2011):

- All staff are able to clearly articulate their approach to the framework that guides the provision of care
- There is a prioritisation of children and young people with complex needs who are able to benefit from a trauma-informed therapeutic approach
- There is a child-focused program structure and orientation to care
- Staff ensure that the program addresses the therapeutic needs of young people
- Staff ensure that the program is highly attuned and responsive to the particular characteristics and needs of young people so that they can heal, develop and grow.
- The service has the capacity to engage specialist therapeutic input in response to young peoples' specific needs.
- Staff members provide a sense of safety, structure, acceptance and security at all times.
- Staff place value on strong, positive relationships between staff members and young people, and emphasise these relationships as being integral to therapeutic healing.
- Staff ensure that young people are listened to, and mechanisms (e.g., advocacy) are in place that allow participation in decision-making processes.

- Staff provide care that is sensitive and respectful and actively explores and seeks to understand each child's unique circumstances and experiences.

9. What can we conclude about the effectiveness of residential care?

In summary, our current knowledge about residential care services for children is under-developed for a number of reasons. There has not been a great deal of research conducted in this area and the information that is available also includes groups of children other than child welfare populations. Where statutory child welfare populations are described, these are generally adolescent children who have had multiple previous placements, rather than younger children with little prior history in care. Frequently, it is unclear what the effective elements of residential services are, as staffing configurations and qualifications, ages and gender of young people being cared for, and characteristics of the physical environment such as size of group home vary between settings and are often not reported. Recent calls for standardisation in the description and reporting of residential services should improve our ability to draw conclusions about what works in residential care of children (Bath & Lee 2011).

International reviews of residential care models have highlighted the lack of evidence on long term outcomes for residential care and lack of detail involving the nature of support offered to children (James, 2011; Knorth, Harder, Zanberg & Hendrick, 2008; McLean et al., 2011). Notwithstanding this, some general conclusions can be drawn.

Residential care may be most effective for youth with externalising behavioural problems, and including behavioural modification and family focussed components appear to be an important consideration in residential treatment programs. Another important component of effective care appears to be the inclusion of specific training, aimed at the appropriate developmental level, and targeting children's emerging social-cognitive and social-emotional skills (Knorth et al., 2008).

Well known models of residential care all have in common a focus on creation of a nurturing culture, building supportive attachment relationships, building competencies in areas such as social skills, executive functions and building resilience skills such as self-efficacy and coping skills (McDonald & Millen, 2012). Emerging programs also articulate the importance of staff-child relationships; of fostering a range of staff competencies and behaviours, including non-confrontational approaches to problem solving, modelling of strategies and skills, family involvement, training in key concepts and principles and regular team meetings. *It should be noted that many of the emerging models of residential care have yet to be subject to any form of evaluation.*

The vast majority of the programs that form the subject of these international reviews relate to residential services provided to children *over the age of 10* and there appears to be very little information indeed about residential service provision for children under 10.

There appears to be some evidence for a model characterised by multidisciplinary 'wraparound' specialist input and the presence of professionalised teaching parents (i.e., Teaching Family Model; Fixsen & Blasé, 2002), which more closely parallels multidisciplinary treatment foster care than conventional (standard) residential care (James, 2011).

10. What do we know about the needs of young children entering residential care?

Children placed into care are likely to have had their physical, cognitive and psychosocial development disrupted in significant ways due to a range of factors including abuse, physical and emotional neglect (Miller & Bromfield, 2012). There may also be cognitive and developmental delays due to other factors such as poor nutrition and exposure to prenatal toxins.

In addition, they may already be experiencing significant mental health and emotional issues. International survey research indicates high levels of mental health issues amongst even very young children in care. More than 3 in 10 (36.5%) of the 5-10 year old children in care were reported to have conduct disorder, a serious behavioural disturbance (Meltzer et al., 2003). Just over one in 10 (11%) of 5-10 year olds were reported to be experiencing a clinical anxiety disorder (Meltzer et al., 2003).

Once placed in care, the stability of a placement appears a critically important factor in whether or not behavioural and mental health issues improve or become worse over time. There is good evidence that placement instability is directly related to the worsening of mental health of young people in care over time, irrespective of what level of mental health difficulties they had upon entry to care (Rubin et al 2007). Multiple moves in care cause further stress and can be deleterious to the young child's brain growth, mental development and psychological adjustment (Miller et al., 2000). *Stability of place and relationship is a critical developmental need for young children.*

Furthermore, placement into residential care can itself constitute a major stressor for children (Little et al., 2005). A recent discussion paper on the use of residential care for children highlighted the potential of residential placement to both *enhance* development (for example, when damaging family relationships are replaced with consistent adult care) or *increase risk* for young children (for example when exposed to bullying or other misconduct by peers) (Little et al., 2005). This paper also highlighted the lack of research that has attempted to evaluate the impact of residential care on children's

attachment or behaviour from a developmental perspective. They argue that the stressful impact of placement in residential care may be greater early on in children's lives, but is likely to reduce over time and does not *in itself* necessarily contribute to further difficulties in young children (Little et al., 2005). Overall, the paper concludes that there is no systematic evidence base either for or against the use of residential treatment of young children (Little et al., 2005).

In determining how residential care might be best enlisted to support young children, some of the considerations include:

- What the literature suggests about how early adversities, trauma and the early caretaking environment affects the developing brain and subsequent social and emotional development, and what the literature suggests could be done to support the development of children who have experienced such adversity
- What the literature tells us about the significance of key relationships including early caregiving relationships and sibling bonds to young children

a. Disrupted brain development

There is increasing evidence that children who come into care are likely to have experienced a range of adverse early life experiences that affects brain growth during critical periods of development. This affects children's neuro-cognitive, social and behavioural functioning to varying degrees. Both neuropsychological and developmental literature has documented the changes in the developing brain that occur as a result of exposure to multiple early life adversities during critical periods of development. It appears likely that this results in structural and functional changes in the developing brain that translates to chronic hyper-arousal, difficulties in social and emotional regulation, language development and behavioural and executive control.

These changes result in a what is sometimes described as a cohesive developmental disorder (Cook et al., 2005; De Jong 2010; Van der Kolk et al., 2005), characterised by a broad spectrum of language, cognitive and social difficulties, due to the effect of chronic stress and traumatic experiences on the developing brain (e.g., DeJong, 2010; McCrory et al 2010; Oswald et al., 2010; Perry, 2006; Van der Kolk et al 2009). It is thought that chronic interpersonal trauma leads to a chronic hyper-arousal of the structures in the brain that detect and respond to threat, leading to a relative under development of other brain structures such as those involved in the processing of socio-emotional information and language over time (Perry, 2006).

The significance of pre-natal alcohol exposure in this population of children has also recently been recognised. Prenatal alcohol exposure can lead to a spectrum of neurocognitive difficulties and

behavioural and social consequences, termed Fetal Alcohol Spectrum Disorder (FASD) that have life-long implications for the developing child (McLean & McDougall, 2014). One of the main effects of prenatal alcohol exposure on children is compromised development of adaptive skills such as planning, flexible thinking and problem solving ability – collectively called the executive functions or executive functioning. A recent meta-analysis of the prevalence of FASD amongst children placed in care indicated that between 11- 24% (on average 17% of children) were affected by prenatal alcohol exposure (Lange, Rehm & Popova, 2014).

The neuro cognitive and social difficulties that children who are placed in residential care may present with are likely to reflect a complex interplay of the effects of physical and emotional neglect, early interpersonal trauma and possible prenatal events. While their needs will be highly individualised, the research suggests that early adversity leads to common developmental challenges including:

- Poor language competence and difficulties in understanding language, even when they present as extremely talkative (Coggins et al., 2007; Spratt et al., 2012; Poletti, 2011).
- Diminished cognitive flexibility (difficulty in thinking in abstract terms, generalising learning from one situation to another and adapting to changing conditions, difficulty in learning new behaviours) (Cook et al., 2005; Lansdown et al., 2007; Lee & Hoaken 2007; Morgan & Lilifield, 2000; Ogilvie et al., 2011).
- Memory and learning problems that are unrelated to overall intelligence (Crozier et al., 2011; McCrory et al., 2010).
- Sensory and emotional regulation problems that underlie rapidly fluctuating attention and arousal (Atkinson, 2007; Capadoccia et al., 2009; Cook et al., 2005; Committee on Early Childhood, 2000; Ochsner & Cross, 2008; Spinazzola et al., 2005)

Taken together, it seems likely that changes in the developing brain can impact a child's capacity for sensory and emotional regulation, and affects the way that verbal information is attended to and processed by the child. These underlying deficits make it difficult for children to respond to conventional approaches to caregiving and discipline that rely heavily on language skills and cognitive flexibility. *It means that children with a history of multiple adversities and risk will need extra support to assist in organising themselves, learning new social skills, managing and adapting to change.*

At this stage it is unclear to what extent the impact of early life adversity can be reversed. There is some evidence that quality caregiving and characteristics of the care environment can contribute to improved psychosocial functioning in the shorter term. Dozier and colleagues, for example,

demonstrated that high quality caregiving led to changes in infant cortisol levels, considered a marker for stress-related hyper-arousal (Dozier et al., 2008; Dozier et al., 2009).

A highly structured and simplified environment characterised by routine may also be helpful. Children may need supervision and monitoring to assist them in learning and remembering the skills of emotional expression, self-regulation, and behavioural control until such time that these skills can be attained independently. It is important to recognise that expressive language skills may be further delayed relative to peers (Trout et al., 2008). This may place these young children at increased risk of harm due to their decreased ability to seek help or report harm. *This highlights the potential benefit of independent monitoring and advocacy for young children in residential care.*

There is little information available in the literature about effective interventions for addressing neurocognitive compromise amongst children in care. Promising interventions include the involvement of a consistent and emotionally attuned caregiver, engagement of caregivers in the teaching and modelling of executive, self-regulation, problem-solving and social skills, high density learning environments, high levels of case coordination and communication, and structured expectations and environments (Dawson & Guare, 2004; Dozier et al., 2008; Dozier et al., 2009; O'Connor et al., 2012; Pears et al., 2013; Wells et al., 2012).

Taken altogether, this argues for the importance for young children affected by trauma and other early life adversities to have access to a continuous relationship with at least one caregiver who can nurture emerging skills in self-regulation and provide structure and routine in an individualised way that works effectively for each child.

The provision of a structured environment might include modifying the physical and social environment to remove distractions, reduce the number of children they need to interact with and remove other sensory triggers (bright lights, noise) and modifying interactions with children to make them easier to understand (repeating instructions and keeping language simple) (Dawson & Guare, 2004). Children may need high levels of monitoring and supervision to ensure that they can complete tasks due to difficulties with memory and organisation that result from trauma, at least in the short term.

Although important, providing consistency and structure in the caregiving environment may become more difficult to achieve in the context of multiple staff, especially in the absence of procedures and processes in place that guarantee clear communication.

b. Disruption in significant relationships

The presence of a responsive and nurturing caregiver is thought to predict good social emotional outcomes in children. This is because it provides a child with the opportunity to form a secure and organised attachment relationship. This is how children begin to develop an internal working model of self and others; they learn social reciprocity, and to trust and rely on others when needed. Through experiencing responsive and sensitive caregiving a child develops empathy, learns how to relate to other people and understands what to expect from them.

Many young children do not experience this optimal care, yet they will still form a specific attachment to their caregiver. For example, children reared by caregivers who are inconsistent or demonstrate inadequate parenting practices are much more likely to form an insecure or disordered attachment, reflecting a more negative internalised model of self and other (Cassidy & Berlin, 1994; Zeanah, Boris & Leiberman, 2001). In this case, while the child may not have formed a secure attachment to their caregiver, and may not have formed a healthy internal working model of self and other, they have still formed an important and specific emotional attachment to their caregiver. At minimum, a child placed in care is likely to have at least one significant attachment relationship disrupted.

The ongoing presence of a nurturing and responsive caregiver will continue to be important for young children. We know very little about attachment relationships in the context of children placed from home into alternative care (Rutter, 2008). The capacity of even very young children to form multiple attachments should not be interpreted to mean that young children can get by with being cared for by multiple caregivers who each have a superficial or professional relationship to the child, or as a substitute for at least one consistent caregiver (Rutter, 2008).

We know that children raised in the absence of *any* specific attachment figure, for example in institutional orphanages, generally have poor outcomes unless adopted into foster homes. Therefore ongoing periods of time in which children are cared for by multiple professional caregivers, and therefore do not have the opportunity to form a specific attachment to a consistent, nurturing and responsive caregiver, is likely to be detrimental to children's subsequent cognitive, social and emotional development (Rutter, 2008). We also know that once these institutionalised children are adopted into stable foster homes, the majority of children *are* able to form a specific attachment to a sensitive and responsive caregiver, despite a history of early care in which there was an apparent absence of a specific attachment figure. Based on the available evidence, it "does not ever appear to be too late "for a child to form a specific attachment relationship (Zeanah & Smyke, 2009, p.431)

irrespective of the quality of the early caregiving environment, although the behavioural issues that accompany the child may not easily resolve (Rutter, 2008; Zeanah & Smyke, 2005).

There does not appear to be any research that can guide decision-making regarding a young child's capacity to tolerate placement in residential care. While children placed in care are already likely to have formed a specific attachment to their caregiver, if they are unable to remain in the care of their biological parents, then *they are likely to be able to tolerate formation of other relationships, providing there is consistency and predictability in these relationships.*

It is ideal, however, that children are placed in an environment in which there is at least one caregiver who knows the child well, and is able to predict the child's needs, provide stability, routine and physical and psychological safety and regulate their emotional, sensory and social world. This will be most readily achieved in an environment in which there are a small number of caregivers who are well supported in terms of emotional and practical supports.

Therefore, on the whole, there is good reason to suppose that the provision of stable placement, characterised by continuous relationships should be priority concern for the welfare of children placed in Out of Home Care. This is true for all children but particularly so for younger children.

c. The child's relationship with their sibling(s)

Another significant early relationship that may be disrupted by placement into care is a child's relationship with their sibling (s). Anecdotally, one of the common reasons for placing young children in residential care is to avoid the separation of a sibling group.

In most instances the sibling bond forms part of a child's network of affection bonds that can act to protect and contribute to children's psychosocial development (Kothari, McBeath, Lamson-Siu, Webb, Sorenson, Bowen et al., 2014). Residential placements may be used to accommodate larger sibling groups due to the need for physical space. However this often comes at the cost of the requirement for young children to interact with larger staff groups and the need for more complex supervision requirements. The placement can become complex when there are siblings of multiple ages, or who have different therapeutic needs.

According to Kosonen (1996) "most children in care have siblings" (p.809). Placing siblings together is often cited as good practice, but nonetheless siblings can be separated when placed into out-of-home care placements. While Australian data is lacking, North American research estimates that roughly 70% of children in foster care have at least one sibling who is also in care (Shlonksy, Bellamy,

Elkins, & Ashare, 2005). The United Nations (2010, B.17) states that siblings should not be separated unless there is a “clear risk of abuse or other justification in the best interests of the child” (United Nations 2010, B.17) and that contact should be “facilitated and encouraged in keeping with the child’s protection and best interests” (United Nations, 2010, VII.2.81).

The potential for sibling relationships to enhance young children’s subsequent mental health, academic, and other outcomes has been emphasised (Kothari et al., 2014). At present, there is no rigorous evidence base for how to best support siblings within existing service models or interventions (Kothari et al 2014) and it is not yet clear what factors contribute to good outcomes for siblings placed together or separately (e.g., Hegar & Rosenthal, 2011). While some support the placement of siblings together in residential facilities (Davidson Arad-Klein, 2011; Leichtentritt, 2013), it is not always appropriate or safe to do so, particularly if there has been abuse perpetrated by one sibling to another (James, Monn, Plinkas & Leslie, 2008).

In Australia, policy and practice regarding the placement of young children who form part of larger sibling groups in care is not well developed. The overarching legislation guiding practice within Families SA is the South Australian Children’s Protection Act of 1993. The Act highlights the need for serious consideration to be given to the desirability of maintaining family connections where possible but does not make specific reference to siblings *per se*. The Act also provides for the Youth Court to grant orders, which specify contact arrangements. *Specific sibling contact is rarely mentioned in orders granted to GOM children* (Office of the Guardian for Children and Young People South Australia 2011).

European collective quality regarding working with children in out of home care, recommend that siblings are cared for together. Standard four states that “Siblings are only placed separately if it serves their well-being. In this case, contact between them is ensured, unless this affects them negatively” (Quality for Children Standards for Out of Home Care; Jointly produced by SOS – Kinderdorf, International Foster Care Organisation (IFCO) and Federation Internationale des Communautés Educatives (FICE), p. 14). The SA Guardian for Children and Young People (2011) also recommends that caseworkers record children’s views and opinions regarding their relationships and contact with their siblings and that this information be included in children’s Annual Reviews.

There are thought to be many advantages in co-location and/or frequent contact between siblings placed in care. These include the opportunity to support and maintain positive sibling relationships and connections, which are likely to be enduring throughout a child’s life. These connections can help maintain a child’s feelings of safety and family and cultural identity - in care and throughout life

(CWIG, 2006). Maintaining positive sibling relationships through co-location may contribute to placement stability (NSW Department of Community Services, 2007). The co-placement of siblings may provide an opportunity for siblings to be supported to form more positive and constructive relationships and to develop alternative ways of relating to each other. Co-placement may also allow cultural expectations of caregiving towards younger siblings to be fulfilled (Argent, 2008; Dudgeon, Garvey & Pickett, 2000). Strong sibling relationships may also be important in facilitating reunifications amongst children of all ages (Argent, 2008; Kosonen 1996).

Finally, siblings themselves repeatedly report the desire for more frequent contact once placed in Out of Home Care. In many ways residential care units may provide a pragmatic means to provide such contact.

However, the location of siblings together in residential care can also offer challenges when children in sibling groups span differing age ranges and have differing developmental and psychosocial needs. In particular, aggressive or sexualised behaviour requires clear management strategies within a residential environment to ensure the safety of co-located siblings. Once placement has occurred, and where reunification is not possible, longer term alternatives to residential care need to be sought. This may require the coordinated case planning between several case managers who may have different plans for children.

There may be complex family arrangements, and ties with a number of different families, which can make the definition of siblings and key attachment relationships difficult to establish (J.Bacon, personal communication). In particular, children of different developmental stages may have different case planning needs, for example, independent living versus foster care, meaning that large sibling groups may become physically separated following placement in residential care. Large sibling groups can also be difficult to place within one foster home. Multiple homes, with foster carers willing to take several siblings may be required in order to transition children out of residential placements.

There is a need to explore innovative models of foster care practice for maintaining optimal sibling contact and placement stability for children in care (J.Bacon, personal communication). While co-location in residential care may afford the most contact, optimal contact could also occur through foster placements that are connected through hub and spoke respite arrangements or through placement in foster homes within the same agency, with contact facilitated by the foster carer agency as part of their service agreement.

While we do not have research to indicate the relative merits of co-location (to guarantee ongoing sibling contact) versus placement in smaller homes with consistent caregivers (and the potential to

bond to adult caregivers), this is a factor that will need to be carefully considered in the case of young children remaining in residential care.

For young children, the need for a consistent caregiver to mediate the emotional and physical needs may be paramount; and where this need is met, the need to maintain sibling bonds nevertheless remains undiminished. However, there does not appear to be any evidence that the co-location of siblings can act as a substitute for consistent, predictable adult care by at least one caregiver who is emotionally available and responsive to a young child's needs.

While residential placements may allow siblings to be physically co-located, in practical terms this can sometimes occur at the expense of continuity of adult caregiver because of the necessity to involve multiple rotating staff. One compromise that might be explored is the co-placement of sibling groups within the same foster care agency, thereby enhancing the agency's capacity to maintain communication and connection between carers and children.

d. Summary

For developmental reasons, young children are best cared for in a stable and nurturing environment in which there is the opportunity to form a stable and continuous relationship with at least one caregiver who is reliable and responsive to the child's physical, developmental and emotional needs. The absence of a key attachment figure and significant enduring attachment relationships early in children's lives is linked to poor long term mental health outcomes (Committee on Early Childhood, 2000; Rutter, 2008).

Once re-unification has been determined to be not feasible, providing stability of placement and continuity of caregivers becomes a critical consideration.

Young children placed in Out of Home Care will develop optimally in a caregiving environment that is characterised by stable and continuous relationships and where they have the best possible connection with community and culture, including family when appropriate. Research suggests that the presence of a stable, nurturing and responsive caregiver constitutes the minimum necessary condition for recovery from trauma, neglect and family violence (Perry, 2006).

In a residential care context, this may be best achieved through attention to the provision of a therapeutic model of care, through a culture of awareness and training in child development and the impact of trauma. Key staffing issues include the retention of staff to maximise young children's experience of continuous and consistent care and provision of staff training in trauma, brain

development, child development, and in the modelling of social problem solving and self-regulation skills (Holden et al., 2010; Knorth et al., 2008; McDonald & Millen, 2012; Perry, 2006).

11. Implications for residential care service provision

There will always be a proportion of children who will be placed in residential care for reasons that range from the need to address their complex needs, to systems pressures, to the need for children to be placed together with siblings. There is very little research literature that explicitly examines the use and effectiveness of residential care for young children. There is a clear need for practitioners to develop and articulate a model of practice for young children that is based on and responsive to the child's developmental needs (Clough, 2008; Hillan, 2006). Such a model should consider the evidence relating to the impact of consistency of caregiving environment and prosocial modelling and skill development, and a commitment to attracting, supporting and retaining staff who are trained in child development, and can provide high quality relationships and care (Hillan, 2006).

The literature reviewed in this paper does provide some guidance as to the **principles** that might shape the use of residential care for young children, that can be summarised as follows:

a. Provide a consistent, integrated and team oriented model of care

The significance of having a consistent and integrated organisational culture in residential care has been emphasised by Anglin (2002), and in several well-known models including the Sanctuary model (Bloom, 2005) and the CARE model (Holden et al 2010). These models advocate intensive training of all personnel at all levels of the organisation (Anglin 2004; Bloom, 2005; Holden et al., 2010;) about a set of research informed practice principles regarding child development, attachment, trauma and family involvement (Holden et al., 2010). This mirrors evidence-based programs outside of residential care, such as Multidimensional Foster Care, in which the importance of having a well coordinated, or congruent approach has also been clearly demonstrated. Highly effective programs for children placed in foster care emphasise integrated care and coordinated case management between schools, carers, justice and health services (Chamberlain, 2002).

Therefore having a clear model of care, delivered in a consistent manner by all staff who support children appears strongly linked to effective outcomes for children in both residential and foster care. This enables the child to experience consistent care and consistent responses to their behaviour. While this is always important for children who have experienced inconsistent caregiving and/or trauma, it is especially important for younger children who do not have the cognitive capacity

to rationalise inconsistent responses by staff or the language to express their frustration and concerns.

b. Provide care that is developmentally informed

Research shows that the effectiveness of residential care is related to its fit with a child's developmental needs (Curry, 1991; Knorth et al., 2008), including their developmental stage (Barth, Greeson, Zlotnik & Cintapalli, 2009) and their cognitive level (Stevens, 2004). The CARE model (Holden et al., 2010) places particular emphasis on the importance of remaining developmentally focussed in terms of the expectations we place on children and the importance of setting expectations within the child's zone of proximal development (Vygotsky, 1978). Within the CARE therapeutic care model, setting goals that are just beyond a child's current developmental stage, but that can be done with assistance, is viewed as a key therapeutic task that encourages the child's development and mastery of life skills.

The CARE model also emphasises a social competence orientation by building on children's social skills and problem-solving skills in a purposeful and goal directed way (Holden et al., 2010). While these principles are important for all children, the rapid developmental trajectory of children under the age of 10 emphasises the critical need for workers to be trained in normative developmental expectations and stages of development in order to maximise the social, cognitive and language development of young children who may be experiencing significant delays. Where multi-disciplinary or specialist input cannot be provided, staff should receive training in basic approaches to support cognitive and language development in young children. This approach has been trialled successfully in residential settings to identify and develop language skills amongst children in care (Manso, Sanchez, Alonso, & Romero, 2012).

c. Staff have the skills to respond to interpersonal trauma, neurocognitive compromise and neglect

Children who are placed into out of home care are likely to have been exposed to a range of adverse early life experiences, including early interpersonal trauma, neglect, exposure to parental conflict and violence and possible prenatal exposure to alcohol or other substances. While the developmental outcomes of these issues are diverse, there are several common implications for service provision that have been highlighted in the literature.

It is critical to ensure that the residential environment is as safe and predictable (routine) as is possible. Perry (e.g., Perry, 2006) has theorised that children raised in the context of exposure to interpersonal violence can become hyper-aroused and hyper-vigilant towards threat cues in the

environment. Exposure to violence can re-traumatise children and will further hinder the child's development.

All activities, routines and expectations should be designed to take into account the effect of trauma on a child's development (Abramovitz & Bloom, 2003; Holden et al., 2010; McLean et al., 2011). In the case of very young children, who will not be able to actively engage in trauma therapy, allowing children a sense of control over their environment through routine and structure can assist them to experience feelings of safety. At a minimum, the service should strive to provide a safe, predictable environment in which young people are protected from re-traumatising experiences.

The provision of a safe environment is central to the capacity for the effects of trauma to be explicitly addressed (Rivard, Bloom, McCorkle & Abramowitz, 2005). The positive peer culture model (Vorrath & Brendtro, 1985) specifically targets and fosters non-violent problem solving and rewards prosocial behaviour. Although developed for use with older children, principles from this model such as involving children and explaining the code of conduct within the home that assures a safe environment and promotes pro-social behaviour and supporting children to participate in group problem solving can help to foster a sense of belonging.

d. Staff are adequately trained, supported and monitored

Research suggests the importance of positive, adult-led interactions between staff and children in residential care (Knorth et al., 2008; Marsh, Evans & Williams, 2010). Staff can play an important role in modelling appropriate social problem solving and communication skills, self-regulation skills, and dispute resolution skills (Armeliuss & Andreassen, 2007; McDonald & Millen, 2012; Stevens, 2004). The Department of Human Services, Victoria (DHS, 2014) has outlined interim Program requirements for Residential Care Services that explicitly acknowledge and outline staff approaches and interactions that can optimise and support children's psychosocial development and healing.

Providing continuity in caregiving relationships is also important for young children. There are several issues that support the retention of residential staff, which translates to more consistent relationships for children in care. It is important for workers to feel that they have some control and autonomy over their work (Connor et al., 2003; Decker, Bailey & Westergaard, 2002; Heron & Chakrabarti, 2002; Leon, Visscher, Sugimura & Lakin, 2008). Setting out well-defined goals and objectives, tasks and processes during supervision can help maintain motivation and foster workers' sense of achievement (Del Valle, Lopez & Bravo, 2007). Staying goal focussed and being clear about the steps needed in setting small goals for children helps workers to maintain this sense of control over their work environment despite doing complex work. Workers report the importance of feeling

as though their work has rewards and that children are making progress under their care (Whittaker et al., 1998; Sinclair & Gibbs, 1998).

Providing high quality supervision is also important in retaining and supporting residential staff (Colton & Roberts, 2007; Curry, McCarragher & Dellman-Jenkins, 2005). Several models of care incorporate a commitment to on-going staff training and supervision to help direct-care staff internalise practice principles (Holden et al., 2010). Research suggests that worker resilience is enhanced by the provision of a clear practice framework and quality supervision (Byrne & Sias, 2010). The emotional aspects of the work, such as reactions to managing challenging behaviour, should be discussed separately to administrative aspects of the work (Byrne & Sias, 2010; McLean, 2012 a). The relatively underdeveloped language and cognitive skills of younger children can make them more vulnerable to psychological and physical harm at the hands of workers who may be particularly stressed. *Supervision and oversight is particularly important in the case of work with younger children.*

Workers may also need additional training to develop the skills supported by the research. Skills such as modelling self-regulation and problem solving family conflict may not form part of current training. The rapid development of young children points to the need for staff to develop skills in promoting developmental milestones by identifying appropriate developmental tasks and setting appropriate expectations. For some services, this may represent a change from the skills in youth work that might traditionally form part of the skill set of the residential worker.

Training in engaging with families and community activities is also important, given the evidence indicating the significance for children in residential facilities of such engagement on children's long term outcomes (Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005). Therefore, workers should be supported to develop the skills and confidence to connect children with community activities, positive social networks and siblings and families where it is safe to do so. Family and sibling contact could vary from phone contact, visits or may be as intensive as family therapy that focusses on problem solving, communication and safety strategies. Family involvement is central to positive child outcomes in the longer term and to the development of a child's cultural identity (Holden et al., 2010), therefore staff could be encouraged to develop the skills to engage and work effectively with family, community and culture.

Please contact Albert Barelds, Executive Director of CAFWA-SA, if we can be of further assistance in either clarifying or expanding on the comments made in this submission.

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