An Examination of Individual Packages of Care for Young People under Ministerial Guardianship in South Australia

Ryan Scott Ogilvy

B.S.Sc (Justice Admin),B.S.W(Hons),M.C.M, M.S.W

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Flinders University of South Australia

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DECLARATION

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ABSTRACT

The research conducted in this thesis was initiated based upon on the need to evaluate and provide feedback about Individual Packages of Care (IPC) for adolescents in alternative care in South Australia. Despite maladaptive behaviour being prevalent in this population of looked after children, little is known about how stakeholder groups understand and manage behaviour within an IPC. Furthermore, whilst the complexity of young people's mental health and behavioural needs necessitates constant interaction between many agencies both private and government, research has sparsely explored how collaboration can be achieved within a professional foster care placement such as an IPC; particularly in relation to supporting young people and their carers. The enduring effects of mental health and behavioural problems that remain unaddressed are significant and include decreased placement stability and poor relationships with others into adulthood. This inspired the direction of this thesis.

This research had two major intentions. The first aim, to identify factors preventing effective practice in IPCs using the specific example of stakeholder experiences in supporting adolescents in out-of-home care to resolve the challenges faced with maladaptive behaviour and mental health problems. Second, to identify common accounts of behaviour between social workers and professional carers and to discuss what these accounts could imply in supporting adolescents in an IPC. The findings present a

thematic analysis of transcripts obtained during the interviews of 44 participants, representing three cohorts: professional foster carers, social workers and young people who have recently left care and were looked after in an IPC. Each cohort participated in an individual semi-structured interview in which their views and experiences were discussed. The focus of the interviews included experiences of each cohort with improvement in behaviour, improvement in stability of care and overall experiences with interactions between cohorts and with working in an IPC.

Thematic analysis of stakeholder experiences of interagency work confirms several barriers that have been reported in other research, indicating the ongoing difficulties experienced in service provision across a broad range of client groups and disciplines. Incidental data provided some interesting additional findings including: ‘manipulation’ by youth of social worker and carer relationships, presenting functioning problems within the IPC. This resulted in a reduced capacity for professional carers and others to implement behavioural strategies in a timely manner.

Participant views about behaviour were analysed to identify consistent views, experiences and points of discrepancies in understanding and responding to maladaptive behaviour and mental health needs. The analysis identified several ways in which behaviour was viewed and highlighted a dominance of poor understanding of young people’s behaviour in altnative care. Reports of behaviour occurring due to environmental influence, including abusive environments and placement disruption, appear to be few amongst participants in this research, despite accounts of incidents being

consistent with environmental and post-trauma behaviour. Disparities in participant views are discussed, together with common views which assist stakeholders to arrive at an agreed understanding of behaviour. Hutchinson (2003) stresses that individuals do not behave independently of their environment, rather, they exist *within* their environment. This concept is known as "Person-in-Environment". The concept of person-in-environment was found to be viewed by carers and social workers in ways that are not consistent from established theoretical understandings, and the potential negative outcomes for practice in IPC were highlighted. Purposeful behaviour was not readily considered in placements and appeared to be a source of frustration amongst carers trying to understand youth behaviour, where many suggested that behaviour was deliberate and served only to cause disruption in the placement.

Finally, the views and experiences of two cohorts (professional carers and former youth) were individually analysed due to the centrality of their involvement with the IPC. Professional carers, it would seem, are frequently required to manage stressful, dangerous and difficult situations with young people. These findings provide the opportunity for those involved in the IPC, and external to the actual placement, to understand the systems and relationship context in which efforts to implement effective care occurs, and the unique challenges faced in professional foster care and more specifically in an IPC. The range of individuals to which this information applies are numerous, including policy makers, supervisors, managers, front line social workers and those who work directly with young people in an IPC. The thesis concludes with a discussion of the practical implications of the findings.

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OVERVIEW

Introduction

This thesis aims to explore the use of Individual Packages of Care (IPCs) in the context of the current demand on placements, with specific reference to the behavioural and emotional challenges experienced by young people, carers, and social workers alike. Specifically the thesis aims to explore:

- Increasing demand upon alternative services in South Australia
- Higher levels of behavioural issues in care
- How IPCs fare as an alternative to managing behaviour and demand on placements
- How stakeholders in IPC placements understand what constitutes 'negative behaviour'
- Research claims that a misunderstanding of negative behaviour may be a key barrier to good communication, suggesting a need to identify how different stakeholders understand behaviour, especially within the context of an IPC.

For a variety of reasons including physical, sexual and emotional abuse by parents and other family members, parental drug addiction, and other factors that influence the

ability of parents to care for their children, approximately 35,895 Australian children are unable to live with their biological families (AIHW, 2011). This results in children being placed in alternative care, with 46% of children placed with kinship (relative) carers and 46% placed in non-biological foster care. The remaining 8% reside in residential placements across Australia, with that figure increasing to 10% in South Australia, (AIHW, 2011). Current Australian Institute of Health and Welfare reports (AIHW, 2011) report that the incidence of young people living in alternative care is increasing, reflecting both a combination of practice, policy and legislative changes (e.g., mandatory reporting and permanency planning for young people already in care), along with broader socio-economic stressors (e.g., government budget cuts and decreased use of government run residential facilities). Despite the growing number of Australian children removed from their birth parents and placed into care, there continues to be an ongoing shortage of suitable foster placements, and this problem has increased over the last two decades (Barbell, 1999; Barber & Gilbertson, 2001; Bromfield and Higgins, 2005). This shortage is exacerbated by the fact that fewer residential care facilities exist, meaning that children with greater levels of behavioural issues are now being placed with carers who are potentially unable to manage such behaviours (Bromfield and Higgins, 2005). The primary outcome of this is that placements are at greater risk of disruption (Barber & Delfabbro, 2004; Delfabbro et al. 2002), with research suggesting that this has a direct relationship to foster carer attrition (Fanshel et al., 1990; Farmer, 1993; Palmer, 1996; Oosterman et al. 2007).

By the time young people enter alternative care, they may have experienced severe physical, emotional abuse and in some cases neglect (Vigg, Chinitz & Schulman, 2005). Removal from a young persons biological parents and placement into alternative care can worsen problems of self-concept, negative behaviours, and mental health, due to the relationship between behaviour and placement stability (Delfabbro, Barber and Cooper, et al. 2002a). Amongst children in alternative care, diffcult to manage behaviours appear to be commonly experienced by those caring for young people. Previous research has reported that adolescents in alternative care have higher instances of mental health and conduct problems than chronologically comparable peers, or peers with similar similar maltreatment histories (Pilowsky, 1995). Penzerro and Lein (1995) suggest that disordered attachments are directly responsible for placement disruption. Furthermore, their research demonstrates that emotionally disturbed adolescents in care are most likely to have histories of placement disruption, especially those adolescents with externalising disorders which are uncharacteristic of peers who are not in care (Pardeck, 1983; Proch & Taber, 1987). Such externalising disorders include attention deficit hyperactivity disorder, oppositional-defiant disorder, and conduct disorder (American Psychiatric Association, 1994). Clinical qualifiers stated for conduct disorder appear to also be predictive of placement disruption (Barber, Delfabbro & Cooper, 2001).

Addressing the mental health needs of this population of adolescents may be difficult for psychiatrist, psychologists, social workers, nurses and key stakeholders because there is an crossover and interaction of mental health, social and behavioural problems for young people in care (Rosenfeld et al., 1997; Sullivan & Van Zyl, 2008; Vigg et al.,

2005). Adolescents in alternative care, due to their complex behavioral and mental health needs, are undoubtedly going to utilise multiple services, often simultaniously. In order for care to be effective, it is necessary for those providing aspects of care to young people, either through treatment, supervision or support that collaboration occur (Cottrell et al., 2000). Key components of a support team that are involved with adolescents in alternative care when they exhibit challenging behavior include mental health professionals, direct care workers, foster parents and social workers who manage the administrative and logistical needs of the young person. Preferrably, it would be helpful for these stakeholder groups to work collaboratively in order to execute commonly understood goals in relation to managing the young persons emotions and behavior.

While a collaborative approach would intuitively appear justified, there is little literature on collaboration between key stakeholders in foster care, and none specifically addressing IPCs (Hudson, 2002; Odegard, 2005). The small amount of previous research that exists in regards to interagency collaboration in alternative care identifies several general barriers to effective multiagency work. The first of these is communication, which is often affected by a lack of mutual understanding of how behaviors are interpreted or what causes them. The behaviours experienced by those working with young people in alternative care that have been the focus of intervention appear to be a common barrier in most previous research. Thus the understanding of behaviour adopted by professionals constitutes a second barrier. Beliefs about the causes of behaviour have been found to determine the importance of collaboration for those who care for adolescents in the development of policy and delivery of an intervention (Johnson et al.,

2000). Similarly, the beliefs that stakeholders and their subgroups have about behaviour and its causes could influence the way in which they approach it, the ability to tolerate, and their level of stress and willingness to remain in alternative care and specifically IPCs. Stakeholders may also have opposing explanations for behaviour, which could inform their recommendations for treatment and in many cases their own approach in managing the adolescents needs.

Research also suggests that group norms and beliefs held about behaviour, its causes and ways to resolve it may vary within each subgroup, discipline and professional membership (Worral-Davies, 2008; Worral-Davies & Cottrell, 2009; Dartington Social Research Unit, 2008). Alternatively, stakeholders across different groups surrounding adolescents in alternative care may also view negative behaviour and solutions for it with views that are compatible. It is therefore essential to improve understanding of other cohort's views to better manage and support children in professional foster placements who display negative behaviours. It is reasonable to argue that if one could establish and understand the multiagency structure in which a young person is cared for, they could target goals and the sharing of resources in a way that meets the needs of the young person cooperatively, thus contributing to improved collaboration and greater success in meeting the child's specific behavioural needs.

Accordingly, this research sought to examine and report the most common ways in which negative behaviour has been understood within subgroups involved with IPCs in South Australia. Within alternative care, barriers to multiagency, interprofessional

collaboration can be separated into systemic, agency and individual barriers (Darlington et al., 2005a & b). It is argued that views and understandings of negative behavior held by stakeholders about how it could promote barriers at organisational and subgroup levels. Such beliefs can influence approaches to managing and facilitating the care of a young person, and because of this exploration is warranted. A concern with how behaviour is understood necessitates questions such as: 'How do professional foster carers, along with social workers, psychologists and other professions in the different subgroups surrounding adolescents in an IPC, understand and therefore approach negative behaviours?', 'What common views and approaches to they share and how are they different with regard to understandings and meeting the needs of young people in care?', and 'What are the barriers to collaboration at systemic, individual and agency level?'. To date, It is apparent that these issues have not be explored across subgroups and agencies involved in supporting adolecents in professional alternative care.

Research aims

This thesis presents a view not previously available within the literature in this area in two major ways. First, this is the first time that the experiences of key stakeholders - including professional carers - in IPCs, along with social workers who have case-managed the children cared for have been considered. Other research has focused largely on interagency collaboration with children in voluntary foster care. The contribution of this research is unique as it focuses specifically on the experience and practice of professional care staff in managing young people placed in IPC placements.

The first aim of this thesis is to identify and examine problems within the collaborative framework in which an IPC occurs, using specific examples of professional carer and social worker experiences when supporting adolescents in an IPC to address challenges. It is argued that such an examination of these views and experiences can improve the overall understanding of how agencies and individuals can increase effectiveness of multiagency practice when managing young people with challenging needs and behaviors in the alternative care field.

The second broad aim is to understand how professional foster care, and specifically IPC, change the care experience of a young person, including meeting behavioural needs and what insight could indicate for adolescents in alternative care. It is argued that by reporting on common perceptions of behaviour, experiences, and collaboration amongst stakeholders will contribute to an understanding of how professional foster care is influencing the system, agencies, and children, and could contribute to more effective collaboration and better use of the IPC model. It is also argued that individual consideration of the experiences of each key cohort can promote a better understanding of collaboration by identifying the assumptions that are unique regarding behaviour and collaboration and found to be unique to each group of stakeholders, including professional carers, social workers and the youth served in an IPC.

Overview of thesis

To examine and analyse the issues presented, the thesis has been separated into four parts. In Part A, Chapter 1, a review of literature on alternative care, collaboration, and managing maladaptive behaviour disorders amongst youth in alternative care is conducted. Within Chapter 1, the first section (section, 1.1) overviews child protection and alternative care. The following sections (sections, 1.2, 1.3, 1.4, 1.5 & 1.6) outline how children enter and remain in care and previous trends on this. They are followed by sections (Sections, 1.7, 1.8, 1.9 & 1.10) discussing placement instability, child behaviour, impact of family relationships on placement, attachment, and the causes of placement disruption. Section 1.11 reports on the literature about children and youths' views of placement and the role of their view in alternative care. Following on from this section (1.12) discusses the importance of multiagency, mutually supported practice for young people in an IPC. Sections 1.13 and 1.14 report on established obstacles to effective interagency work amongst providers of services to young people, stressing the importance of the role of communication and common understanding of behaviors and young peoples needs.

Part B (Chapter 2) details the research methodology. Details about the recruitment of participants and summaries of participants' groups are addressed in this chapter. The process of thematic analysis which is utilised in this thesis is also discussed in this chapter.

Part C (Chapters 3, 4 and 5) explores the views and experiences of each stakeholder group regarding collaboration, understanding of behaviour, and the impact of IPCs on care. These chapters introduce more detailed literature about multiagency collaboration (Chapter 3) and understanding of behaviour (Chapter 4), and each chapter analyses the interviews within two cohorts about their experiences and views related to supporting adolescents in an IPC who have complex behavioral and mental health needs. The final part of each chapter comparesthese findings to previous research and suggests possible implications for collaborative practice in professional foster care in South Australia.

Chapter 6 details the experiences and views of youth who were previously placed in an IPC. This chapter uniquely considers the experiences of participants who have been cared for by professional carers in a specialized placement. The chapter analyses the interviews with participants about their experience and perceptions with respect to being supported in IPCs. The chapter is also summarised in terms of its contribution to understanding youth views.

Part C (Chapter 7) concludes by reviewing the findings of the entire analysis of professional foster care and stakeholders' discourse about managing challenging behaviour, along with the views of former young people in care, and considers the implications for specialized placements aimed at supporting adolescents in alternative care. The chapter also identifies deficiences to the understanding provided in this research of challenging behaviour and collaboration and makes recommendations for improving service delivery for adolescents with complex needs between cohorts that

make up care teams in South Australia when managing professional foster care. Finally, it identifies future areas of potential research that will further contribute to improved service delivery, collaboration and shared responsibility amongst stakeholders of professional foster care in alternative care in South Australia.

PART A

Chapter One: Literature Review

CHAPTER ONE

Literature Review

1.1 Introduction

Despite a stable economy in Australia, many families continue to experience significant social pressures. Broad ranging economic factors such as poverty, unemployment, and homelessness burden many communities, and there has also been a considerable increase of non-traditional family structures (sole parent families, teenage parents, or reconstituted families) which have made people increasingly vulnerable to broader social and economic pressures. Individually, more families are now affected by substance abuse, domestic violence, and poorer physical and mental health, all of which have greatly affected their capacity to provide sufficient care for children, resulting in an increased demand for alternative care placements (Barber & Delfabbro, 2004; Department of Human Services, 2004; Layton, 2003; Victorian Department of Human Services, June 2003).

This chapter is a review of the literature that relates to alternative care in Australia, and more specifically, South Australia. The reason for this focus is that IPCs have been identified as an alternative to conventional placements in South Australia, and it is essential to understand the context in which they are being implemented. The challenges faced by those who currently provide care as documented in previous

literature are examined to gain an understanding of the current barriers to effective care provision, with a specific focus on the impact of behavioural issues, mental health problems, and access with birth families. The chapter concludes by examining previous research that examines how issues such as these are managed through collaborative practice, and the barriers to this.

1.2 The Status of Alternative Care in Australia

The literature summarized in this first section explores the status of care in Australia. First 'alternative care' will be defined using common terms as used throughout Australia. Second, data which explore the number of young people in care throughout Australia and South Australia will be discussed together with trends and practices that have impacted the current figures. The section then moves more specifically into the issues that impact care provision including lack of placement options, behaviours affecting placements, mental health and the relationship that children have with their birth families.

1.3 Definitions

Throughout the literature the term 'alternative care' is commonly used to describe all forms of care where a child is raised by people other than their birth parents. The term may also be used in some instances to refer to one specific form of non-birth family based care (i.e., kinship care or foster care). Other terms used include alternative care and substitute care, which are used interchangeably to describe the system that provides care for children and youth at risk of harm or neglect as a consequence of living with their birth parents (Des Semple & Associates, 2002).

The principal forms of alternative care provided in Australia vary considerably both in terms of the nature of the arrangement as well as the duration. In Australia, the two main categories are “home-based” and “residential-based”. Of those in alternative care in 2009, 82% were in home-based care and 18% in residential care (AIHW, 2009). The Australian Institute of Health and Welfare (2011) provides this definition of alternative care: “placement with an individual or family who is reimbursed for expenses for the care of a child including:

> “*Foster care/community care – general authorised caregiver who is reimbursed by the state/territory when providing care for a young person and supported by an approved agency.
>
> *Relative/kinship care – family members other than parents or a person well known to the child and/or family (based on a pre-existing relationship) who are reimbursed for their care of the child” (p. 68).

In contrast to home-based placement, “residential-based care – includes care in a facility-based (residential) service whose purpose is to provide placements for children and where there are paid staff. Placements in ‘family group homes’ are considered facility-based care, even when the arrangement shares similarities with conventional family-based foster care” (AIHW, 2009, p. 68).

As implied by findings from the Australian Institute of Health and Welfare, the type of care arrangement favoured differs substantially across Australian States. For example, in South Australia the highest proportion of children are placed in foster care

(90%) and the lowest percentage of children placed in residential care (10%) (AIHW, 2009). Significant differences are also evidenced in relation to the age of the child. Nationally, children aged less than one year of age are most likely to be either in kinship (family) care (26%) or in home-based alternative care (64%). By contrast, relatively high proportions of children aged 15-17 years are in residential care (15%) (AIHW, 2009).

1.4 Statutory Child Protection

Many researchers agree that a substantial number of families will continue to require government support for the safety and well-being of their children (Ref; Ref; Ref). In Australia there is a tendency toward removal of children from their biological families and placement into government sponsored foster care. This is viewed by some researchers to be a reactionary approach to child protection that only partially resolves the issue of child abuse by providing a safe environment for children (Des Semple & Associates, 2002; Layton, 2003).

In Australia, State and Territory governments have legal authority for child protection, and alternative care is the responsibility of the Minister in each State (Barber and Delfabbro, 2004). This requires the Minister to ensure that all children have a satisfactory place to reside (Barber & Delfabbro, 2004). In most states, parents can agree voluntarily to have their children placed into care for a short period under a Voluntary Custody Agreement (VCA). Where this consent is not given, or a longer placement is required, a court order is sought by the state. For a child to be placed under an order of

care and protection, a court must be satisfied that the child is at risk and in need of care and/or protection. The legislation varies according to the definition of 'in need of care and/or protection' in each state and territory. Application to the court is generally the last option and is used only in circumstances where the family is opposed to state involvement and every avenue has been exhausted. Not all children are placed on a care and protection order and/or in alternative care due to issues relating to severe abuse. On some occassional familial conflict is the driving cause, or in other instances a child may present a danger to themselves. On rare occasions the parents may be ill and unable to provide care for the child (AIHW, 2011).

In South Australia – the state on which this thesis is focused – Families SA is the statutory agency responsible for the investigation of abuse and neglect, removal of children from unsafe environments and subsequent care of these children once removal has taken place. Families SA receives its authority to act from two main pieces of legislation. The first is the *Family and Community Services Act 1972* which provides governance for monitoring and licensing of alternative care services in South Australia, and the second is the *Children's Protection Act 1993* which establishes the Adelaide Youth Court jurisdiction to deal with applications relating to children in need of care and protection by Families SA (DFC, 2008). Once the Youth Court is satisfied with the basis of Families SA's application for care and protection of a child, it can grant wide ranging orders, usually in two main forms: care and protection orders for up to twelve months or guardianship orders for up to twelve months and long term orders until the child turns 18 years of age (Legal Services Commission of South Australia, 2010). Guardianship orders

(or Custody orders, as they are also known in Australia) are made by courts which grant child welfare agencies in each state the legal guardianship of a child for a specified period of time, (AIHW, 2011). When the parent(s) are in agreement to place the child into care, the courts may agree to a VCA.

1.5 Number of Children in Care in Australia

Research suggests that the number of young people in alternative care has continued to rise since the early 1990s in Australia (Barber & Gilbertson, 2001). As of June 2009 35,409 young people were placed in various forms of alternative care, and this compares with only 23,695 in 2005 (more than 45% increase) (AIHW, 2009). From 2004 to 2005, the growth rate was 9% (AIHW, 2006). Since 1996, there has been an alarming 70% increase ofyoung people in alternative care (AIHW, 2009).

Barbell and Freundlich (2001) suggest that a significant reason for why there has been such an exponential increase in the numbers of children in care is due to the phenomenon that a greater number of young people are entering care than are exiting, a greater proportion of children are returning to care once a reunification with their birth parents fails, and a greater rate of placement of children in care through other systems such as the mental health and juvenile justice systems which are not equipped to deal with the social and emotional needs of these children. Bromfield and Higgins (2005) suggest further that a policy shift towards permanency planning where young people are now staying in care longer has also contributed to the higher numbers of children in care in Australia. Barber and Delfabbro (2004) suggest that whilst permanency planning may

have benefits for those children who are placed in a stable long-term placement, for other children it may only exacerbate the effects of 'foster care drift', where children who are difficult to place are moved from placement to placement with no experience of stability or continuity. According to statistics from the Australian Institute of Health and Welfare (2009), an audit of care systems across Australia showed that approximately one third of all children (32%) had been in care for five years or longer. Another explanation offered as to why there has been such a significant increase in the number of young people in alternative care is that the definition and interpretations of abuse have changed and broadened over the last decade to include such forms as emotional abuse that were not previously included (Cashmore, 2001). Another explanation is that mandatory reporting requirements have led to many incidences of abuse being identified for the first time that might have previously gone unreported. Whatever the cause for the increase, the fact that national strategies and legislation are now in place to deal with abuse means that there is unlikely to be any immediate reduction in the number of children referred for alternative care placements because of abuse in the near future (Layton, 2003).

As of June 30 2010 there were more children on care and protection orders than the previous year, with an overall increase of 7% from 30 June 2009-30 June 2010. Since 2005 there has been an increase of more than 10,000 care and protection orders in Australia (AIHW, 2011). The increase in orders is attributed to flow on effect from greater awareness of child abuse and neglect, and the cumulative effect of children entering care at a young age and remaining until 18 years of age (AIHW, 2011). Other research indicates that the reason for this is that children are entering care for more

complex reasons such as parental substance abuse, mental health and family violence, (COAG 2009). This echoes findings from earlier studies by various researchers (Gilbertson et al., 2005; Delfabbro et al., 2005; and Scott, 2002a). Across Australia, 37,370 children were on a care and protection order at June 30 2010 (AIHW, 2011). This increase reflects the cumulative impact of children being admitted to, and remaining in, alternative care. Data also suggest that more children are being admitted to care each year than are being discharged. Increases in out alternative care statistics may also be related to the increasingly complex family situations of children associated with parental substance abuse, mental health and family violence (Dawe et al. 2008). Intergenerational cycles of abuse may also contribute to the growth in numbers of young people in alternative care (Pears & Capaldi 2001). These factors also affect the length of time children remain in care. In regards to those children currently in the alternative care systems in Australia, three quarters (73%) of them are on finalised guardianship orders as of June 2010 (AIHW, 2011). This finding is significant because it demonstrates the impact that permanency planning can have on the child protection system when nearly three quarters of the children in care are on permanent orders, through which the intention of the system is for them to remain in care through to becoming adults.

Nearly all children (94%) in alternative care through 30 June 2010 were in home-based care – 46% in foster care, 46% in relative/kinship care and 2% in other types of home-based care (AIHW, 2011). The high proportion of young people in alternative care reflects the trends in recent decades of increased use of placements with relatives or

foster parents, and decreased use of placements in residential care (Johnstone 2001). Tables 1 and 2 demonstrate the current distribution as reported by the AIHW in 2011.

Table 1. Number of Australian children in alternative care by placement. *Source: AIHW, 2011*

Type of placement	**NSW**	**Vic**	**Qld**	**WA[a]**	**SA[b]**	**Tas[c]**	**ACT**	**NT**	**Total**
Foster care[d]	6,720	2,234	4,393	1,267	1,013	454	219	251	16,551
Relatives/kin[d]	9,001	2,185	2,390	1,235	847	286	266	126	16,336
Other home-based care	0	572	. .	0	4	84	0	102	762
Total home-based care	*15,721*	*4,991*	*6,783*	*2,502*	*1,864*	*824*	*485*	*479*	*33,649*
Family group homes	. .	0	. .	64	0	19	. .	24	107
Residential care	378	454	567	144	216	20	47	6	1,832
Independent living	75	23	. .	26	28	0	0	4	156
Other/unknown	1	1	. .	1	80	30	0	38	151
Total	**16,175**	**5,469**	**7,350**	**2,737**	**2,188**	**893**	**532**	**551**	**35,895**

Table 2. Percentage of Australian children in alternative care by placement. *Source: AIHW, 2011*

Type of placement	**NSW**	**Vic**	**Qld**	**WA[a]**	**SA[b]**	**Tas[c]**	**ACT**	**NT**	**Total**
Foster care	41.5	40.8	59.8	46.3	46.3	50.8	41.2	45.6	46.1
Relatives/kin	55.6	40.0	32.5	45.1	38.7	32.0	50.0	22.9	45.5
Other home-based care	0.0	10.5	. .	0.0	0.2	9.4	0.0	18.5	2.1
Total home-based care	*97.2*	*91.3*	*92.3*	*91.4*	*85.2*	*92.3*	*91.2*	*86.9*	*93.7*
Family group homes	. .	0.0	. .	2.3	0.0	2.1	. .	4.4	0.3
Residential care	2.3	8.3	7.7	5.3	9.9	2.2	8.8	1.1	5.1
Independent living	0.5	0.4	. .	0.9	1.3	0.0	0.0	0.7	0.4
Other/unknown	—	—	. .	—	3.7	3.4	0.0	6.9	0.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Re-notifications and re-substantiations of abuse have also significantly increased in many jurisdictions (Layton, 2003; Mendes, 1996; Cashmore, Higgins & Bromfield, 2006). In South Australia (Layton, 2003; Mendes, 1996; Cashmore et. al., 2006), for example, the dramatic increase in re-notifications has reached the point where the percentage of notifications that relate to new children is only 33%, or alternatively viewed, 67% of

notifications related to children or young people are subsequent to previous notifications (Layton, 2003). The Victorian Department for Human Services (VDHS) had similar findings (VDHS, 2003). It attributed these changes to several crucial factors, including low socio-economic status, substance abuse, mental health issues and problems associated with sole parenting which contributed to some families coming into contact with the child protection system.

1.6 Lack of Placement Options

In addition to increased demand for placements through permanency planning and increased reporting of abuse (Cashmore et al., 2006; Layton, 2003; Mendes, 1996), there have also been several service factors that have made it more difficult to find placements for those children who are referred to alternative care. For example, a shortage of foster carers is evident throughout the Western world, including the UK, US and Australia (Barbell, 1999; Barber & Gilbertson, 2001; Victorian Department of Human Services, 2003; Bromfield and Higgins, 2005). In Australia, shortages have occurred as a result of a number of factors, including smaller numbers of carers entering the system, the high levels of attrition of existing carers, and the changing and complex needs of young people in alternative care leading to foster carers quitting or retiring (Barber & Gilbertson, 2001). Yet despite the relative lack of available foster placements, foster care continues to be the primary form of non-kin alternative placements. According to Barber and Delfabbro (2004), this trend has been a deliberate policy because "… not only is foster care cheaper but at its best models the kind of nuclear family to which the State aims to return the child" (Barber & Delfabbro, 2004, p. 46).

At 30 June 2010, there were 8,049 households across Australia with one or more alternative care placements (AIHW, 2011). This included all foster carer households that, as at 30 June 2010, had received authorisation (or provisional authorisation) from the relevant department or agency to enable a child (or children) to be placed in their care, and had at least one foster child placed in the household as at midnight on 30 June 2010. Among those jurisdictions with available data, there were more foster carer households with a placement over the 2009-10 financial year compared with the number of households counted at 30 June 2010. There is a significant disparity between the 37,000 children in care compared with just over 8000 foster care households. This is because many placements serve more than one child, while other children live in relative (kinship) care or residential care (AIHW, 2011).

As mentioned earlier, a small number of children within the alternative care system in Australia are placed in residential settings. Most often, residential settings are used only if a family-based placement is inappropriate and all other placement options have been exhausted. This is due to the fact that institutional-type placements are essentially diversionary programs for young offenders and because of this are normally perceived as the last resort for children who are deemed unsuitable for traditional alternative care (Barber & Delfabbro, 2004; Bath, 1998). In 1983, there were 7,410 children in residential care in Australia, but by 1993 the number had fallen to 2,455. Yet during that same period, the numbers of children in foster care remained relatively stable. In recent years, the numbers of children in residential care have fallen even more and, in

2000, there were only 1,222 children in residential care (Barber & Delfabbro, 2004). A significant reason for this shift in policy is economic rationalism, (Barber & Delfabbro, 2004). Mullighan (2008) also reports that another reason for the reduction of residential placements in South Australia relates to large amounts of physical and sexual abuse over several decades.

In recent years, governments have had to deal with the consequences of the decline in residential care options. Governments are now faced with the problem that they have fewer options for placement of children and young people who cannot reside in family-based settings due to emotional and behavioural problems. Consequently,

> "increasingly difficult children are being foisted on reluctant foster parents, resulting in an alarming rate of placement breakdowns as volunteer workers discover they have neither the skills nor the desire to deal with the children they are assigned" (Barber & Delfabbro, 2004, p. 48).

In response to this problem, the Victorian review (Victorian Department of Human Services, 2003) noted that governments have begun to reappraise the role that residential care can play in the continuum of options to meet the needs of young people. This is an important consideration for IPC placements which are targeted to deal with more difficult children as it may increase the options for children who are difficult to manage in traditional placements.

Research has provided evidence that residential care may not be as 'bad' for the child as previously thought. For example, studies have revealed that the achievements of

foster care and residential care in terms of health and well-being outcomes for children and young people are broadly comparable (Barber & Gilbertson, 2001; Victorian Department of Human Services, 2003). More specifically, research indicates that younger children without clinically significant disorders fare better in home-based environments, whilst residential care is a realistic option for children and young people who exhibit major behavioural and emotional problems when such placements are serviced effectively (Bath, 1998). Studies in the UK and US (Fratter et al., 1991; Hudson et al., 1994; Whittaker et al., 1990) have revealed that group home settings staffed by family care workers may be the best alternative for this complex and behaviourally maladaptive group of children and young people as they provide the necessary support, structure and therapeutic intervention that is required.

Ultimately, these findings lead to the conclusion that one of the ways in which to address the current shortfall in available alternative care placements in Australia is to make better use of careful assessment of each individual child's suitability for placement, rather than placements being based on a prescriptive 'one-size-fits-all' model (Barber & Gilbertson, 2001; Victorian Department of Human Services, 2003). This is especially important for IPC placements as they are used to care for youth with difficult and challenging behaviours.

1.7 Challenges facing those who provide alterantive care

The ongoing attrition of volunteer foster carers from the Australian alternative care system has been attributed to both the poor relationship between carers and relevant

government agencies and the lack of support provided to foster carers (Victorian Department of Human Services, 2003 & Fisher & Chamberlain, 2000). Although there is research (Chamberlain, Moreland & Reid, 1992) to suggest that retention rates of traditional foster carers can be enhanced by increased payments, other research (Barber & Gilbertson, 2001; Fisher & Chamberlain, 2000; Scott, 2002; Rhodes et al., 2001; Victorian Department of Human Services, 2003; MacGregor et al. 2006) suggests that there is no simple solution for improving foster carer retention rates and that money alone is not a sufficient incentive. Whilst IPCs are typically attached to professional (i.e., non-volunteer) carers who are paid a salary for caring for a child, the issues raised in previous research on volunteer foster care, it could be argued, are equally applicable to professional carers. In the next section a basic overview of previous research on volunteer foster care is provided, with specific focus on the challenges to care provision.

1.8 Impact of challenging behaviours

The issue of child behaviour has been identified in a number of Australian studies (Bath, 1998; Delfabbro, Barber & Cooper, 2002a; Gilbertson & Barber, 2003), which draw attention to the increasing number of children with complex social, behavioural and mental health needs. As Barber and Delfabbro (2004) have identified, a very noticeable difference between foster care in Australia and elsewhere is that Australian foster care is more selective. In Australia, only a relatively small proportion of children are referred for foster placements (3 in every 1000 children aged 0-17 years), compared with a rate of 8 per 1000 in the United States (Barber, Delfabbro, & Cooper, 2001). One outcome of this difference is that Australian foster care systems tend to select only those children who

cannot be placed elsewhere and whose behaviour is expectedly worse than those who are not in care. Thus, foster care is used much more as a last resort than as an option of choice, so that children with more challenging behaviours tend to be placed into care, whereas those who have fewer problems tend to be returned home. Barber and Delfabbro et al. (2002) identified that between 15 and 20% of children placed into care in Australia could be described as extremely challenging, and these children do not appear to be suitable for family-based foster care. Such children cannot be maintained in stable family foster placements and tend to experience considerable placement instability, with the number of placement changes varying from between three and four placements a year up to twenty or more (Delfabbro et al., 2002b).

Attachment and behavioural and emotional problems are significant personal factors that impact the stability of a child or young person's placement (Fanshel et al., 1990). These problems are not only damaging to the children themselves, but they also increase the risk of setting into sequence a cycle of placement instability that may be perpetuated (Fanshel et al., 1989b; Farmer, 1993; Palmer, 1996). Proch and Taber (1987), for example, suggest that high-risk young people (defined by factors such as significant emotional and behavioural problems, running away, sexual acting out and multiple placements) tend to become locked into a spiral pattern of placements characterised by increasingly shorter terms and increasingly restrictive settings. As a result, Rosenfeld et al. (1997) note, "the foster care system has become an open air mental hospital serving many disturbed children" (p. 454).

One obvious impact of the complex behavioural and emotional needs of young people in alternative care is their effect upon placement stability and disruption (Gilbertson & Barber, 2002). Correlations between the severity of negative behavioursand placement disruption have been found, such that the greater the degree of behaviour problems experienced, the more likely that a child will have experienced a high number of placement breakdowns (Clausen et al., 1998; Glisson, 1996; Pilowsky, 1995; Webb & Harden, 2003; Oswald, Heil & Goldbeck, 2010; Barber, Delfabbro, & Cooper, 2001; Horwitz, Owens, & Simms, 2000; Newton, Litrownik, & Landsverk, 2000; Teather, Davidson, & Pecora, 1994). Negative behaviours in placements have also been reported to correlate with a decreased likelihood of successful return to the young persons birth family (Landsverk, et al., 1996), longer time in care (Urquiza et al., 1994; Gilbertson & Babrer, 2002; Barber, Delfabbro & Cooper 2001: Newton, Litrownik & Landsverk, 2000; Pardeck, Murphy &Fitzwater, 1985) and eventual placement in residential facilities due to the inability of other forms of care to meet the needs of the young person (Barber & Delfabbro, 2002). Adolescents who enter care with mental health complications are unlikely to adjust to alternative care regardless of the placement (Barber, Delfabbro & Cooper 2001). Emotional and behavioural complexitiesappear to be most predictive of placement failure (Barber & Delfabbro, 2002).

The causal relationship of maladaptive and delinquent behaviour on placement breakdown within alternative care is complex, however such negative behaviours remain a key indicator of likely placement success or failure. One research study concluded that negative behaviors were a reliable predictor of placements ending, especially when other

variables were accounted for (Oosterman et al., 2007). Other problems such as alcohol and drug abuse by birth parents (Holland & McGorey, 2004; Newton, Litrownick & Landvsverk, 2000), age of young person (Barth et al., 2007; Oosterman et al., 2007), mental illness and separation from biological siblings (Barth et al., 2007; Leathers, 2006) also impact placement stability. Despite this, it is noteworthy that behavioural problems remain a key focus in placement disruption (James, 2004; Leathers, 2006).

Foster carers frequently experience challenging behaviours and emotional problems with young people in care, (Gilbertson & Barber, 2005). These issues and the difficulty of foster carers to manage them feature prominently as reasons that individuals stop fostering (Triseliotis et al. 2000; Rhodes, Orme & Beuhler, 2007) as they lead to the mental and physical exhaustion of foster carers (Cooper, Petersen & Meier, 1987; Kerker & Dore, 2006; Ryan & Testa, 2005; Triseliotis et al. 2000). Approximately one third of placement breakdowns are the result of negative foster carer experiences, and feeling inadequately prepared (Herczog et al, 2001: Orme & Buehler, 2001).

1.9 Impact of Mental Health Issues

Mental health issues are an important consideration for child welfare stakeholders. The contexts that result in alternative placement for many children are associated with negative life experiences (Craven & Lee, 2006). Foster care and especially multiple placements are argued to contribute to the mental health challenges of a young person (Barber & Delfabbro, 2004; Rosenfeld et al, 1997). Many children in foster care are known to exhibit symptoms of post-traumatic stress (Perry, Pollard, Blakely & Vigilante,

1995), along with a wide range of other mental health problems (Clausen, Landsverk, Ganger, Chadwick. & Litrownik, 1998; Perry, Conrad, Dobson, Shick & Ryan, 2000), behavioural problems, (Rhodes, Orme & Beuhler, 2001; Barber & Delfabbro, 2004; Gilbertson & Barber, 2002), and developmental problems such as cognitive deficits (Rosenfeld et al, 1997). Because of all these problems, young people in alternative care can be expected to demonstrate, emotional, behavioural and developmental disorders at 2.5 times the rate of the general population (Garwood & Close, 2001). This highlights the need for effective treatment options for children, which may include IPC placements. This section highlights the complexity of the impact that mental health has on child welfare and alternative care.

Disorders in which maladaptive and delinquent behaviours are observed (e.g., larceny, assault, drug abuse, poor social choices, poor social skills, anger outbursts) such as those defined by conduct disorder and oppositional defiant disorder appear particularly relevant in placement changes due to the extreme nature of the behaviours (Cooper, Peterson, & Meier, 1987; Fanshel, Finch, & Grundy, 1990; James, Landsverk, & Slymen, 2004; Newton et al., 2000; Palmer, 1996; Pardeck, 1983; Proch & Taber, 1985; Stone & Stone, 1983; Widom, 1991). Maladaptive and delinquent problems may be further strained by changes to foster placements (Newton, Litrownick & Landsverk, 2000).

As noted above, mental health problems amongst young people in alternative care are a significant predictor of placement disruption. This is a significant issue given the high prevalence of mental disorder for those who are in alternative care, with upward of approximately 80% of individuals in care suffering from mental illness in various forms

(Leslie et al., 2000). Research indicates a sharpelevation in the rate of mental health disorders for young people in care, rising 30-40% in previous research (e.g., Dubowitz, Fiegelman, Harrington, Starr, Zuravin & Sayer, 1994; Dubowitz et al., 1993; McIntyre & Keelser, 1986; Moffatt et al., 1985; Schor, 1982) to revised estimates of between 60-80% (Clausen et al., 1998; Simms, Dubowitz & Szilagyi, 2000). There is a stark contrast between adolescents in care and those who are not in care, with only 16% to 22% of the latter detailed in United States and Australian population samples, respectively, as experiencing mental health issues (Kerker & Dore, 2006; Sawyer et al., 2007), suggesting a very real correlation between the alternative care experience and mental health and behavioural problems.

Australian research specifically indicates the prevalence of mental illness amongst youth living in alternative care. For example, Tarren-Sweeny's (2007) sample of 400 foster children reported more depressive symptoms on the CES-D than the comparison group of children not living in care. On the Australian Checklist for Children, approximately one-third of an Australian sample of 347 foster children (4- to 11-years old) were reported as engaging in at least some age-inappropriate sexual behaviour (Tarren-Sweeney & Hazell, 2006). Children showed considerable problems with social behaviour, most notably in the form of unprovoked behaviours. With the Youth Risk Behaviour Surveillance System Questionnaire, 10% of these foster children reported a suicide attempt during the previous year and 7% reported a suicide attempt that required medical treatment. On the Strengths and Difficulties Questionnaire, 64% of a sample of 182 foster children (5- to 16-years old) was evaluated by their foster parents as falling

into the abnormal or borderline categories (Minnis et al., 2006). On the hyperactivity subscale, the percentage of children falling into the categories abnormal or borderline was 54%, on the emotional problems subscale it was 45%, on the conduct problems subscale 66%, on the peer problems subscale 63%, and on the pro-social subscale 38%. These results therefore provide evidence of behavioural and mental health problems in excess of the rest of the general Australian population.

Despite the fact that children in the care system have long been identified as having significant mental health and behavioural problems, Simms et al. (2000) suggest that such children do not receive adequate or appropriate care while in placement. They conclude that given children spend a significant amount of their lives in foster care, the fact that they remain untreated, without therapy and access to other services, makes the alternative care system a very poor one. They argue that foster care should be viewed more as a context in which treatment occurs and not as a stand-alone system. One of the reasons why the issue of treatment remains important is that instability in placements can compound the potential for failure when an individual leaves care. Kendall-Tackett (2002) found that maladaptive behaviours, including engaging in self-mutilation, sexually maladaptive behavior and abuse of drugs were more prevalent in adult survivors of abuse than individuals who had never had those experiences, therefore including much of the population of those in alternative care. Previous literature reports that mental health and maladaptive behaviour will have a significant social impact on those leaving care, given that these issues have not been addressed or resolved during the care experience (Mendes, 1996), as young people placed in alternative care face higher rates of homelessness, and

corrective punishment, once they have left care (Courtney et al., 2001; Shlay & Rossi, 1992; Ackermann & Dozier, 2005).

1.10 Impact of Family Contact

The issue of family contact has continued to be contentious in foster care research. In South Australia, the Child Protection: Alternative Care Manual of Practice (Author, 2001) asserts that "family contact is a process of maintaining meaningful links between children in care and their families and networks of origin" (p.8). Family contact is considered to be a way in which children maintain an ongoing association with their families and is deemed to be a right of every child in foster care. The South Australian Children's Protection Act 1993 also expresses this view in Section 4 (2) (b) where it states that: "serious consideration must be given…to the desirability of…preserving and strengthening family relationships between the child, the child's parents and other members of the child's family, whether or not the child is to reside within his or her family".

Where children are not able to return home and end up in long term alternative care, Thomson and Thorpe (2003) recommend that birth families play a key role in all stages of the placement process. It is thought that by receiving birth family support through the long term care process, children will retain a clear sense of identity and continuity (Ainsworth, 1997; Cashmore & Paxman, 1996; Thomson & Thorpe, 2003). Family contact is also thought to keep children in touch with siblings and relatives and provide social workers with an opportunity to assess the viability of reunification (Scott, 2005).

Anderson (1999) postulates that for some children parental visiting may be the key to a successful foster placement, in that it demonstrates the parents' acceptance of the fostering arrangement and shows the child that both sides can accept each other. Indeed, Ainsworth reports findings on a study (Parmelee et al., 1995, cited by Ainsworth 2003) that found having family involvement during treatment was a factor that was predictive of a positive outcome for the young person. This is something that is often forgotten or ignored for many young people entering residential care. This finding was also reiterated in a review of residential care versus foster care that highlighted the success of family-centred residential care (see Barth, 2002).

However, as Stevens (1997) points out, children's continued contact with their birth parents can create confusion, uncertainty and be upsetting. Furthermore, he argues that "non-rehabilitative contact will only confuse, disrupt and undermine the new carers' roles" (p. 13). This suggests that if parental contact is going to occur while children are in care it should be purposeful and rehabilitative. Similarly, Henggeler and Santos (1997) point out that while most discussion points toward positive outcomes from regular family contact, there is some evidence to suggest that it is not always helpful. Parental contact has been reported to increase childhood depression and anxiety (Adcock, 1980, Millham et al. 1985; Schofield, Beek & Saregeant, 2000). As well as reminding children they are separated from their parents (Gean, Gillmore & Dowler, 1985), parental contact can result in behavioural problems for the client after the contact with the birth family (Biehal, 2007; Farmer, Moyers & Lipscombe, 2006). In traditional placements, Osborn

and Delfabbro (2009) point out, after a visit with the family the foster carer may find it difficult to maintain a happy placement for the child. They also suggest that these experiences may in the long term undermine the foster carer's attempts to socialize the child into the routines and attitudes prevailing within the household, especially when birth parents do not hold the same beliefs and values.

Several authors suggest that contact arrangements should be less prescriptive and more designed to meet the needs of individual children, their circumstances and those of birth families (Haight et al, 2003; Osborn & Delfabbro, 2009; Scott et al, 2005). IPC placements are intended to be individually tailored, suggesting that contact can be arranged individually, which is consistent with the views of the above authors. In order to tailor family contact with an individual placement, planning and collaboration between all parties is needed and social worker contact is seen as an important factor in the determination of how this should occur (McInnes, 2007; Cleaver, 2000; Hess & Proch, 1988, Macaskill, 2002). Despite this, Cleaver (2000) highlights that given the often strained relationship between social workers and parents and the adverse circumstances that characterise their contact, partnership principles do not necessarily translate into practice. Masson (1997) suggests that one of the difficulties in involving families in placements is that work to maintain links with parents is often displaced by other work, which is regarded as more pressing.

Osborn and Delfabbro (2009) indicate a paucity in research on this topic and encourage further examination of family contact in various circumstances, including

children in placements of varying lengths and situations where there is a greater prevalence of maladaptive behaviour and emotional adjustment problems. They also argue that it would be helpful to determine the extent to which the views expressed by carers and birth parents are shared by case workers and the children. This is consistent with the aims of the current research which seeks to take into consideration the state of family contact in the context of the views of carers, children and case workers who have worked with children in IPC placements. The current research therefore has the potential to bridge a gap in establishing the level of agreement among parties about parental involvement.

1.11 Young people and their views on alternative care

Research has stated the importance and value of including the views of children and young people in care on a range of issues including: their involvement in decision-making (Oneil, 2004; CREATE Foundation, 2004, CREATE Foundation, 2005; Gilbertson & Barber, 2003; Thomas 2002; Leeson 2007; Morgan 2007); care experiences (Voice for the Child in Care, 2004; Knight, 2006); health (Fleming *et al.* 2005; Mullan *et al.* 2007; Stanley 2007); education (Harker *et al.* 2003; Boyce 2004; Barnardos 2006; Rao & Simkiss 2007); placements (Thomas *et al.* 1999; Ward *et al.* 2005; Selwyn *et al.* 2008); relationships, social networks and identity (Ridge & Millar 2000; Munro 2002; Kelly & Sinclair 2005; McLeod 2007); experience of support services (Barnes 2007); and lastly, their experiences of leaving care (Barn *et al.* 2005; Dixon 2007). Children can form and express views, however partial, about their circumstances. Further research by Winter (2010) has confirmed that children want and need to talk. Another study also

found that some young children lived in an ‘emotional void’ because they did not have time or space to develop their self-awareness and to articulate their knowledge. The lack of opportunity to explore their memories, feelings and perspectives, in some cases, made their yearning for lost relationships with their birth family more intense and was accompanied by a range of unresolved feelings (Barnados, 2006).

In regards to decision-making specifically, Delfabbro, Barber and Bentham (2002) suggest that ensuring that decisions are made in line with children’s wishes results in children being more cooperative in placement and obtaining more preferable placement options. More importantly, children are likely to benefit psychologically and emotionally if their views are taken into account. For example, their self-esteem is likely to be enhanced as they are given more control over their own lives. The children and young people in a study by Mason and Gibson (2004) reported that having some power to be heard in their interactions with others was imperative to getting their needs met. It is therefore crucial that young people as the primary clients of alternative care services are given opportunities to voice their views and opinions on their experiences in foster care and how their needs can be better met (Delfabbro, Barber & Bentham 2002; Mason & Gibson, 2004; O’neil 2004; Osborn & Bromfield, 2007).

The New South Wales Community Services Commission (2000) conducted a study that aimed to identify children’s and young people’s (n = 66) perspectives on their needs in alternative care. The findings demonstrated that most young people in alternative care (aged 8 to 18 years) reported that they accepted their care arrangement

and thought they were better off as a result of being in foster care (Delfabbro, Barber, & Bentham, 2002; New South Wales [NSW] Community Services Commission, 2000). At the same time, however, the report noted that even small oversights can have a lasting and negative impact on the child or young person; for example, not being told why workers had moved on, or not being able to bring a pet to a new placement. Such occurrences can compound feelings of loss, grief, sadness and the feeling of being "different" from other children and young people.

The CREATE Foundation (2004) reports similarly and notes systemic factors that appeared to have contributed to a negative care experience for a group of children and young people in their study; for example: slow systemic procedures that prevented timely and adequate responses; lack of resources, support and training for carers and case workers; inadequate early intervention strategies to support families to stay together and prevent entry into care; inadequate entry into care support; inadequate support and preparation for young people preparing to leave care; and inadequate post-care support (findings echoed by similar research conducted by Gilbertson & Barber, 2003). This is valuable information for the current research as IPCs attempt to improve the care experience for young people.

Importantly, in terms of ICP's, other research suggests the importance of having a stable, trusting relationship with one person, and further that this relationship does not necessarily have to be with a primary caregiver. In a study by O'Neill (2004), for example, children reported that adults such as teachers who listened to and supported

them in the long-term were a highly valued resource. It was noted that when a positive relationship existed, it often had a marked positive impact on the young person's time in care (NSW Community Services Commission, 2000). Research by the CREATE Foundation (2004) similarly documents the importance of carers (foster, kinship or residential home) and case workers in the lives of children in care.

Despite recognition of the importance of listening to the views of adolescents placed in care, Delfabbro, Barber, and Bentham (2002) assert that few systematic attempts have been made to obtain information regarding children's satisfaction with care. Furthermore, and as documented above, although there is some evidence of children's voices appearing in the literature this is contradicted by their lack of inclusion in case planning and discussions of their own needs. Many young people are not clear about the reasons for their removal from their birth families (Festinger, 1983; Johnson, Cournoyer, Fisher, McQuillan, Moriaty & Richet, 2000; Wilson, 1996). Foster children are often excluded from case planning and case change decisions, which negatively influences their view of foster care as a whole (Festinger, 1983; Gil & Bogart, 1981; Johnson, Yoken, & Voss, 1990; Wilson, 1996). It is claimed that there are several reasons for failing to include children's wishes in placement decisions. These include difficulties in gaining access to children and young people, and the complexities of interviewing children with special needs. It has also been reported that children may be reluctant to express their true feelings about their foster homes, especially if they feel that it is likely to negatively impact on them or their placement (Gilbertson & Barber, 2002; CREATE, 2005; New South Wales Community Services Commission, 2000). Nonetheless, the

experience of being listened to and of someone valuing their perspectives may also help improve young children's general well-being within the context of their challenging circumstances and provide them with an accurate picture where there may be misunderstanding.

1.12 Collaborative Practice in Alternative Care

Given the impact of the care system upon all stakeholders, it is vital that all those involved work from a shared understanding of what constitutes the best outcomes for children. As a means of implementing such an ideology, the concept of wraparound services debuted in Australia in the 1980s with the Child and Adolescent Service System Program (CASSP), devised by the National Institute of Mental Health (later under the sponsorship of the Centre for Mental Health Services). CASSP was founded to develop an integrated system of care for children and adolescents with emotional disturbances, helping states improve collaboration among their child-serving agencies. In the approach developed by CASSP, the services are "wrapped around" children and families in their natural contexts, rather than being forced upon them in poorly accessible or restrictive settings (McGuiness, 2009). Unfortunately, fiscal limitations prematurely terminated CASSP's existence within approximately 10 years. Nevertheless, CASSP's legacy involved some enduring principles (Centrefor Mental Health Services, 1997; Stroul & Friedman, 1988), including, services driven by the needs of the child and families and delivered with a strengths-based perspective, community based services, and existing agencies collaborating with one another and delivering services in a culturally competent manner.

Many effective interventions in the care of young people with complex personal needs such as those found in alternative care are well documented and supported by research, with most reporting a collaborative approach as an essential component. Indeed, Absler (2006) suggests that there has been a legislative push for collaboration in Australia. It has often been policy in Australia and internationally through the emergence of interagency training programs and education (Gilbert, 2005, Barnes, Carpenter & Dickinson, 2000; Barker, Bosco, Oandasan, 2005), measures of one disciplines attitudes toward another (Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005) possibly the dedication of a journal that focuses on interagency care, whose primary aim is to expand knowledge regarding interagency and collaborative work.

There are considerable advantages in collaborative service provision when it can be arranged. The benefits of interagency cooperation are well documented (Darlington & Feeney, 2008; Friedman, Reynolds, Quan, Call, Crusto & Kaufman, 2007; Green, Rockhill & Burrus, 2008; Metcalfe, Riedlinger, McKenzie & Cook, 2007) and some of these include: faster access to services; increased quality of case monitoring and relapse support; ensuring agency demands on a family are not competing or overwhelming; consistency of messages from all involved; better decision-making; improved ability to provide needed and timely resources; more effective use of limited resources; development of new policy and practice; and reduction in duplication of services.

It is suggested that this collaborative engagement with the client is particularly relevant to those clients with complex needs and can improve the solution focus (Darlington, Feeney, & Rixon, 2004 & Fleck-Henderson, 2000). This clearly has particular relevance for young people in altnerative care who have severe mental health problems, who offend or display antisocial behaviour (Kurtz, Thornes & Bailer, 1997; Place, Wilson, Martin & Hulmsmeier, 2000; Salmon, 2004; Salmon & Rapport, 2005). As Green et al (2008) report:

"Collaboration can also improve the overall effectiveness of services, for example, by moving parents toward a greater state of "readiness to change" through provision of ample emotional, psychological, and tangible support" (p.58).

Possible benefits of effective interagency collaboration include the ability to collect resources and share knowledge to assist those families with the most complicated problems (Costongs & Springett, 1997; Darlington, Feeney & Rixon, 2005a; Mattessich & Monsey, 1992). As Lalayants, Epstein and Adamy (2010) summarise: "Treatment based on multidisciplinary contributions is intended to enhance the accuracy of decision-making" (p.2). Other positive implications are thought to include improved family focus and cultural sensitivity (Epstein & Adamy, 2010), more holistic services (Williamson 2001), and adequate treatment resources for consumers (Young & Gardner, 2003). Collaboration is therefore argued to be beneficial to those in all forms of foster care. Despite the obvious benefit of collaboration, it is important to recognize that individual professionals and their agencies do not operate under singular policy and practice structures. Such considerations can impact the ability to effectively collaborate.

Whilst there is agreement amongst mental health and child welfare workers that collaborative practice is the best way to address the needs of clients, there has been great difficulty in defining such practice, particularly in consideration of young people with complex biospychosocial needs, including those in alternative care (Darlington, Feeny & Rixon, 2004). One of the difficulties in defining practice is the multiple levels of agency connection, ranging from individual case collaboration between workers, through to program and resource collaboration (Gardiner, 2000; Walter a& Petr, 2000). There is also a danger that a push to work in a cooperative manner creates conflict between agencies whose theoretical underpinnings may be significantly different from each other (Hetherington, Baistow, Katz, Mesie & Trowell, 2002; Walker, 2005). Challenges to collaborative practice are now explored in closer detail, before turning to explore the myriad of ways in which collaborative practice can be achieved.

1.13 Challenges to Collaborative Practice in Alternative Care

As indicated above, collaborative work with clients in alternative care is not as simple as agreement to work on a client's needs together. Workers from different disciplines operate from different knowledge bases, discourses and conceptual frameworks (Hetherington et al 2002; Tye & Precey, 1999; Sheehan, Paed-Erbrederis & McLoughlin, 2000). There often appears to be an underlying assumption that interagency efforts will effortlessly occur with little conception of how such practices will be sustained (Salmon& Rapport, 2005; Walker, 2005). Darlington, Feeny and Rixon (2004) report that too often collaboration is achievedon the premise that one agency will fund the other's

efforts to be collaborative. Collaboration is more than an agreement to work together; it is a system of ensuring those involved have an awareness of other roles, actions and the needs of the client (Hetherington et al 2002; Pietsch & Short, 1998)

Theories of collaboration continue to evolve and change and remain underdeveloped (Salmon & Rapport, 2005). Some models presume static organizational structures and do not allow for the considerable variables that interagency practice presents with. Theoretical understandings of collaboration and accounts of well established multiagency services in the literature (Cottrell, Lucey, Porter & Walker, 2000) may be a significant departure from actual collaboration required between separate agencies within the constraints of any child welfare system.

Darlington, Feeney & Rixon (2005b) suggest that interagency practice can occur in many forms including macro, messo and micro, focusing on single problems or examining multidisciplinary integrated services. Arguably, fully integrated services are ideal (Cottrell, et al., 2000; Walter & Petr, 2000) however due to the nature of interagency relationships, lower levels of collaboration and experienced more (Johnson, Wistow, Schulz & Hardy, 2003). It is alo important to consider that, any attempt to implementresearch has typically been hindered by the variable focus of the literature. Studies themselves vary in focus according to individual or agency factors (Morrison, 1996; Reder & Duncan, 1999) such as established multiagency services or less formal arrangements between individuals who may have common clients (Hallett & Birchall, 1992; Hudson, Hardy, Henwood, & Wistow, 2003; Huxham, 1996; Roaf, 2002; Tomison

& Stanley, 2001). Yet despite these many challenges to collaborative practice, research still indicates a number of key factors that can best facilitate such practice.

Addressing barriers to effective interagency collaboration, or promoting collaboration is more complex than just implementing what is viewed as helpful to the client. Specific barriers may firstly need to be tackled directly (Head, 2008). Trust is a significant issue (Darlington & Feeney, 2008; Horwath & Morrison, 2007; Jones et al. 2007; Katz & Hetherington, 2006; Metcalfe et al. 2007) and deficits in communication, for example, have been found to contribute to worker mistrust (Darlington, Feeney & Rixon, 2005b; Head, 2008; Spath et al. 2008). This indicates that if communication has not been effective in the past collaboration is not only about establishing appropriate communication paths but is firstly about anticipating the potential lack of trust and creating readiness for change or addressing resultant conflict (Dunlop & Holosko, 2004). Metcalfe et al. (2007) caution that trust may need to be established slowly and in stages. Until barriers to communication are addressed, communication strategies can be ineffective.

Although considered highly desirable, multidisciplinary collaboration "remains elusive" and represents a methodology uncommon in most agencies (Darlington et al., 2004: 1176). Case managers in child welfare often face a number of service barriers such as: lack of training on substance abuse, domestic violence, and/or mental health issues; inadequate treatment resources as well as lack of awareness of referral sources to meet existing needs; conflicts in the time required for sufficiently thorough assessment,

documentation, and service provision; legislative requirements regarding child permanency; and the developmental needs of children (Young & Gardner, 2003; McAlpine, Marshall, & Doran, 2001 & Mills et al, 2004).

In terms of alterviate care and child welfare in general, barriers to collaboration are complex and numerous, including limitations in terms of the capacity of mental health services to incorporate the families of clients, especially those children who are looked after by the welfare system (Stanley & Penhale, 1999; Nicholson, Geller, Fisher & Dion, 1993 & Byrne et al, 2000). Competitive funding arrangements work against the desire for professionals to share resources, as does the inadequacy of resources which leaves little time for professionals to establish and maintain contact between one another (Hetherington et al, 2002; Pietsch & Short, 1998; Scott, 1997 & Hudson, 2002 & Johnson, Wistow et al, 2003).

Darlington et al. (2005) identify two levels of connection between agencies, these being corporate and individual. The absence of collaborative policies and procedures (Bryne et al., 2000; Darlington, Feeney & Rixon, 2005; Johnson, Wistow, Schulz et al., 2003; Johnson., Zorn., 2003) and barriers caused by confidentiality policies and practices (Cleaver, et al, 2000 & Hetherington et al, 2002) are also thought to impact upon collaboration.

Examination of the topic of collaboration appears sporadic and without considerable depth (Odegard, 2005; Rubin & Babbie, 2001 & Nilsson 2001).

Specifically, there is minimal research that explores collaboration of services to meet the needs of children with mental illness (Odegard, 2005). Regarding young people in alternative care and interagency collaboration, many articles have focused on barriers, but very few on successes (Scott, 1997; Byrne et al, 2000; Hetherington et al, 2002; Pietsch & Short, 1998; Wistow et al, 2003; Sandfort, 1999; Paxton, Grund & Holt, 2003). It is noteworthy that no studies to date appear to have directly examined professional carers' experiences of maintaining placements in which young people with complex behavioural needs are present. In terms of child welfare, one of the greater collaboration needs is between those who maintain the children in care and those who understand their behaviour. There are a few studies focusing on the relationship between professionals in this area (Darlington et al., 2005, a, b; Worrel-Davies & Cottrell, 2009). One study examines practice attitudes and barriers between child focused agencies (Darlington et al, 2005a). The second study examines the practice challenges, specifically where a parent has mental health problems and there is a child protection concern. Worrel-Davies & Cottrell (2009) provide a research synthesis detailing how interagency work by CAMHS (Child & Adolescent Mental Health Services) should look. This paper defines evidence based practice as it applies to multiagency collaborative mental health work with children, some of which are in alternative care (Worrel-Davies & Cottrell, 2009).

While the needs of young people in alternative care serve as a focal point for interagency collaboration (Salmon & Rapport, 2005), there is limited information about how the focus is achieved, who decides on what the most important issues are and ultimately how intervention is carried out. Affecting change in adolescents in alternative

care requires a cooperative and complex level of collaboration including an agreement on the behaviours and needs with which young people present and the solution to these needs.

When considering problems in interagency collaboration, Hall (2005) identifies social, professional and theoretical barriers to interagency practice. In particular she describes some professions as "rivalling" (p. 190) and suggests that this fosters the exclusion of rivals by labeling them as frauds, amateurs or incompetents. "Boundary work blames scapegoats from outside when problems arise, exempting its own members from responsibility for consequences of their work (p. 189). Hall & Weaver (2001) suggest that cognitive learning skills and styles are common within a profession, but unique to the collaborative process. They further suggest that the uniqueness of a particular way of thinking can impact the culture of the profession as cognitive behaviours create a basis for understanding, expectations and norms. Petri (1976) suggests that, literally, two individuals from different professions can view the same problem with a completely different opinion. This creates a dilemma in multiagency teams, as others perceive the opinions of those not in their profession or role to be incorrect or invalid. To avoid this, there has been a policy push to reduce cultural inequalities and for agreement to be reached on how to deliver a culturally competent service (Poa, 2006; Davis et al, 2000; French & Reardon, 2003; McGory & Yung, 2003 & Richards & Vostanis, 2004). In an environment that is culturally competent, it is more likely that child protection and mental health could reach agreement as to the source of maladaptive behaviours and emotional disturbances because of the need to focus on the

client, rather than internal professional views and interpretations of what is wrong (Richards & Vostanis, 2004). Levy (2004) argues that for services to prevent duplication, poor exchange and conflict, formalized practices are essential.

1.14 Factors that Facilitate Effective Interagency Collaboration

Given that IPC placements rely heavily upon interagency collaboration, it is essential to consider research on facilitation of effective interagency collaboration. Factors that facilitate effective collaboration can be used to explore whether successful collaboration is being achieved in IPC placements and if not, what needs to be done to improve this.

Communication presents a key to effective collaboration (Darlington & Feeney, 2008; Drabble, 2007; Earles, Doyle, Lee, Malthouse & Selke, 2005; Feiock, Steinacker & Park, 2009; Garret, 2004; Green et al. 2008; Head, 2008; Spath, Werrbach & Pine, 2008) and is largely explored in the literature at three levels: client to worker; worker to worker; and agency to agency. One recurrence in the literature, regardless of the presenting problem, is that communication is essential to successful collaboration between stakeholders (Akhavain, Amaral, Murphy& Uehlinger, 1999; Barker et al., 2005; Henneman, Lee & Cohen, 1995; Salmon & Rapport, 2005, Malin and Morrow, 2007, Darlington & Feeny, 2008). Specifically, communication requires that all participants commonly define the presenting need or issue (Darlington et al., 2005; Laming, 2003 in Salmon & Rapport, 2005; Miller & Ahmad, 2000; Malin & Morrow, 2007; Salmon & Rapport, 2005).

It has been demonstrated that client and worker relationships are improved when all stakeholders working with a family are communicating effectively with each other and providing a seamless service to the family without the family having the responsibility to keep each worker up to date and repeat their stories (Friedman et al. 2007; Spath et al. 2008). Making clients aware of the differences in the roles of the staff working with them helps provide a meaningful rationale for decisions made (Darlington, Feeney & Rixon, 2005a). Maintaining knowledge of agency services which is up to date is also important for staff in larger organisations to ensure optimal responsiveness to client needs and questions (Ervin, 2004).

When addressing collaboration between workers in different agencies, communication which includes perceptions of who has the 'lead' has been argued to enhance the relationships between workers (Garrett, 2004), particularly when joint initiatives or projects are being implemented (Flemons, Liscio, Gordon, Hibel, Gutierrez-Hersh & Rebholz, 2010). Collaboration is also thought to be improved between individuals when explicit discussion of current practices, ideological /philosophical differences, and agency role occurs to determine common ground (Drabble, 2007; Garret, 2004; Head, 2008). The theme of mutual agreement or shared understandings emerges through much of the literature as the platform for building interagency relationships (Feiock et al. 2009; Horwath & Morrison, 2007; Krsevan, Dwyer & Young, 2004; Metcalfe et al. 2007; Spath et al. 2008; Willumsen, 2008; Witt & Wilburn, 2007).

Communication in practice is more than just efficient information sharing about the client or family. It should also include discussion about differences in practice and approaches so that these can be viewed as opportunities to develop shared understandings, such as for example, services can look how the community needs them to look (Fasoli & Moss, 2007), to inform changes to policy, guidelines and the like (Head, 2008) or to be more flexible in joint working arrangements in line with client need (Witt & Wilburn, 2007). It is also important for individual workers to know about the role of other service providers and their availability, alleviating the need for clients to seek information from multiple services (Friedman et al. 2007; Horwath & Morrison, 2007; Krsevan et al. 2004).

At an agency level, there are many factors that can contribute to effective communication. The adoption of clear rules, decision-making processes and realistic expectations of agency workers is crucial for sustaining effective multiagency interaction (Darlington, Feeney & Rixon, 2005b; Head, 2008). In addition, the importance of sharing ideas (Earles et al., 2005) and reviewing joint goals, plans or approaches is suggested in conjunction with the agency taking responsibility to ensure staff changes or turnover, policy reform or budgetary constraints are dealt with in a way that does not threaten the collaborative nature of the work being undertaken (Han, Carnochan & Austin, 2007; Head, 2008; Spath et al. 2008). In relation to an examination of the impact of staff turnover on youth in alternative care, Strolin-Glotzman, Kollar & Trinkle (2010) recommend a proactive approach involving identifying the views of the clients and

"collaborating with them on the development of interventions and innovations" that aim to address the issue (Strolin-Glotzman et al. 2010, p.52).

An agency needs to take responsibility for implementing effective case reviews to both support staff (Darlington & Feeney, 2008; Spath et al. 2008) and to identify cases that have been open longer than others in order to ascertain whether additional or other kinds of intervention are warranted, as this can impact directly on workers' perceptions of interagency effectiveness and case difficulty (Cross, Finkelhor & Ormrod, 2005; Han et al. 2007).

1.15 Summary of literature review

With an absence of any defined process for the delivery of IPC placements, the need to understand how these programs are currently progressing becomes increasingly important. By establishing which practices are essential and conversely which are damaging, that practice can be optimized to provide the best outcomes for the young person. This thesis examines the unique experiences, problems and solutions engaged in by any one stakeholder group. How does analyzing their approach to negative behaviour contribute overall to an understanding of collaborative practice? The answer to this question will contribute to a better understanding of multiple stakeholder groups from the unique perspective of each selected group. This will then contribute to improved communication and better collaborative practice. The research aims and method of this study will be discussed within the next section.

CHAPTER TWO

Method

2.1 Ethics approval

Ethics approval for data collection was sought from The Flinders University Human Behaviour Research Ethics Committee. Secondary to this approval, additional ethics apllications were needed to gain approval for the participation of professional carers from the agency involved with IPC placements. This process is detailed within the description of the selection process for the professional carer cohort.

2.2 Subjects

Participants who agreed to be interviewed were recruited from former Families SA case managers, professional foster carers with South Australia Baptist Community Services (SABCS) and from clients who were serviced by an IPC placement. A total of 44 stakeholders took part in the research. Twenty were current professional carers with SABCS. Fifteen were former social workers/case managers. Nine were former clients.

The subjects in this research were specifically chosen because they represent those stakeholders who have been directly involved with the delivery or use of an IPC placement. Families SA case managers represent the Department in making decisions for

the young person regarding their needs, case planning and advocating for the young person. The SABCS carers represent the care group that lives with the young person, delivers their care, and is at the front of the collaborative process. Finally, there is the young person who has been impacted by the implementation of the IPC, whose voice is invaluable to the evaluation of IPCs as they have experienced the care as a client.

2.3 Theoretical Framework

This research project has been influenced by two major theories, both of which contribute to wraparound services which are the basis of Individual Packages of Care (IPC). Particularly influential is social ecological theory (Bronfenbrenner, 1979). This theory sees behaviour as developing in the context of multiple reciprocal actions over time; the child, the family, the neighbourhood and the community interact to affect one another in a circular way. The theory suggests that these relationships are critical to the development of both adaptive and maladaptive behaviours within any given family and cultural setting. Burns and Hoagwood (2005) argue that the most important contribution of this theory to the development of wraparound services is the view that the developmental process of each child occurs within the unique ecological environment of each child and family. Burns and Hoagwood (2005) further argue that behaviour change or adjustment needs to take place within the normative roles, expecations and provisions of those settings and in interaction with those systems or contexts. In consideration of this theory the current research will explore the ecological interactions that occur in the process of caring for a child in an IPC, through interagency collaboration, teams of carers, and the interaction of the placement and culture with the young person themself.

The second theory considered in this research is Social Learning Theory (Bandura, 1977). Social learning theory argues that while each young person brings a unique set of biological characteristics into the environment, behaviour is still shaped by the impact of these biological characteristics and the many reciprocal relationships that occur within the child's environment over time. A key message from Bandura's (1977) theory is that maladaptive behaviour is learned according to the same principles as adaptive behaviour, and the challenge is to rearrange the environment so that the young person can learn to behave in adaptive ways. This theory argues that the needs of each young person are unique, which is consistent with the aims of the IPC, to provide a unique package of care that meets the individual needs of the young person. This theory underpins the exploration of placement success as measured against behaviour management.

2.3 Recruitment of stakeholders

2.3.1 Recruitment of SABCS Professional Carers

Participants from the professional carers cohort were twenty South Australian Baptist Community Services (SABCS) Professional Carers (PCs) recruited from the IPC Program. In addition to the Flinders University Human Behavioral Research Ethics Committee, approval to interview SABCS staff was granted by the Director of SABCS, Mr Curtis Richards. Following in principle approval from the director, the team supervisor was contacted by email to provide information about the project and coordinate volunteers who were interested in participating. Those who shower interest in

participating in an interview were provided a detailed handout on the study and a formal invitation to participate, together with a demographic survey once their suitability to participate was established.

The interviewing of PCs took place over three months. One of the main problems found when establishing professional carers to interview was finding those who met the criteria for having cared for a youth in an IPC for at least six months. Participants were from varied professional backgrounds and many considered themselves experienced in caring for youth in an IPC. An additional seven PCs met the criteria, however they either declined to participate or cancelled three or more interview appointments. The participants included three professional carers who had volunteered with children under the guardianship of the minister previously, and five participants stated that they had previously delivered programs to at risk youth which included a high number of children under the guardianship of the minister. Additionally, there were eight PCs who had previously provided mentoring services to children under the guardianship of the minister. Three participants had Bachelor level degrees. 18 professional carers had between 10-24 months' experience with adolescents in Individual Packages of Care. Twelve participants were male and eight were female. A summary of those interviewed is detailed in Table 2 .

Table 2: Summary of SABCS interview participants

Participants	**(n=20)**					

Interview no Participant ID	**Gender**	**Qualification**	**Length of Placement**	**Type of Placement**	**Age range of young person.***	**Duration of Interview (Minutes).**
PC1	M	Incomplete Bachelors degree	10 months	Long-term	15-18 years	54
PC2	M	None	10 months	Long-term	15-18 years	58
PC3	F	None	18 months	Long-term	15-18 years	56
PC4	F	Incomplete Bachelors degree	18 months	Long-term	15-18 years	51
PC5	M	Diploma	10 months	Long-term	15-18 years	52
PC6	M	None	12months	Long-term	15-18 years	54
PC7	F	None	12 months	Long-term	15-18 years	50
PC8	F	Diploma	18 months	Long-term	15-18 years	51
PC9	M	Bachelor degree	12 months	Long-term	15-18 years	53
PC10	M	1st Year Bachelor degree	12 months	Long-term	15-18 years	55
PC11	F	College Certificate	2 years	Long-term	15-18 years	52

PC12	M	Diploma	2 years	Long-term	12-15 years	51
PC13	M	None	12 months	Long-term	12-15 years	53
PC14	M	Bachelor degree	2 years	Long-term	12-15 years	52
PC15	M	None	2 years	Long-term	15-18 years	51
PC16	M	None	12 months	Long-term	15-18 years	53
PC17	F	None	2 years	Long-term	12-15 years	49
PC18	F	None	18 months	Long-term	15-18 years	60
PC19	F	None	2 years	Long-term	15-18 years	52
PC20	M	Bachelor degree	18 months	Long-term	15-18 years	63

*Range used to ensure young person served by PC is not identified.

2.3.2 Recruitment of Former Families SA Social Workers

Former Families SA (FSA) social workers were selected to increase the likelihood of unbiased responses, to prevent limitations being imposed by Department for Families and Communities' research approval processes and because the Department rejected the research proposals for this study with no valid explanation. Anecdotal evidence suggests that higher degree students have consistently been refused ethics approval and subsequent access to FSA clients and social workers. Thus former social workers' observations and experiences were considered in this thesis. The primary aim of their inclusion was to examine from a social work perspective whether previous collaboration problems and behaviour management issues are resolved with the implementation of IPCs, or

exacerbated by the placements. The role of the social worker and their opinion of alternative care were examined in this study. In order for former social workers to be including as a cohort in this study, interest was sought through initial discussion with one former departmental social worker who had been involved directly with managing an Individual Package of Care. A snowball sample was developed with each interview leading to the identification of other former social workers who also had experience with IPCs. Those social workers who were identified and met the criteria were invited by letter to attend an interview (see Appendix D). The letter outlined the purpose of the study and advised that the researcher would contact them again to arrange a time for participation. All participants who were approached and eligible to participate in the study agreed to do so. All participants gave comprehensive answers to all items in the interview schedule.

Following the provision of information about the study and the participants' involvement, the interviewer made a time to meet with the participant to conduct the interview. Prior to the interview commencing, further explanation of the study was given to the participant in writing and consent in writing was sought from them to participate in the study and for information to be utilised in a report of findings with the possibility of publication (see Appendix B).

Data were then collected through a 26-question semi-structured interview (see Appendix G), which was designed to elicit information about:

1. The social worker's experience prior to their involvement with IPCs
2. The social worker's views on collaboration

3. The impact of understanding client behaviour

4. How IPCs perform as an alternative to traditional alternative care

5. Changes in behaviour through implementation of IPCs

6. the impact of family on IPCs

The aim of the interview questions was to provide an instrument that could elicit responses that would allow conclusions to be made about the effectiveness of IPCs in terms of collaboration, behaviour management, client needs and overall effectiveness.

Data collection occurred over a six month period. A major complication experienced frequently in regard to this cohort was the ongoing cancellation of scheduled interviews due to unforseen work emergencies and other professional responsibilities. Half of the interviews were either cancelled or moved to another day due to conflicting responsibilities. These challenges to the recruitment process ultimately resulted in nineteen participants, all of whom were former social workers from a variety of metropolitan teams. All social workers interviewed had worked in teams in which their primary role was the care of young people who were under ministerial guardianship until the age of 18. All social workers identified themselves as having one or more Individual Packages of Care during their time with Families SA. Thirteen identified themselves as having a Bachelor of Social Work (BSW), thirteen had three or less years' experience, and two were former supervisors of guardianship teams. A summary of this cohort is displayed in Table 3 .

Table 3: Summary of Former FSA Social Workers

Participants	**(n=15)**					
Participant ID	Gender	Qualifica-tion	Years as CP Social Worker	No. of Clients	No. of IPC Clients	Age of Clients in IPCs
SW1	F	BSW	3 years	12	1	15-18 years
SW2	F	BSW	3 years	10	1	12-15 years
SW3	M	Dip Social Admin.	15 years	12	2	Both 15-18 years
SW4	M	BSW	2 years	11	1	12-15 years
SW5	M	BSW	18 months	12	2	Both 15-18 years
SW6	F	BSW	2 years	12	1	15-18 years
SW7	F	BSW	2.5 years	11	1	15-18 years
SW8	F	BSSc	1 year	11	1	15-18 years
SW9	F	BSW	2 years	10	1	15-18 years
SW10	M	BSW	2 years	11	1	15-18 years
SW11	F	BSW	3 years	10	2	15-18 years
SW12	F	BSW	2 years	11	1	15-18 years
SW13	F	BSW	1 year	12	1	15-18 years

SW14	M	BSW, MSW	4 years	11	1	15-18 years
SW15	F	BSW	2 years	12	2	15-18 years

Prior to commencing the interviews, the total social worker population of FSA was approximately 500 social workers. Of this, 150 were on temporary contracts at the completion of data collection. Walker (2008, personal communication) identified that there were 60 IPC packages in South Australia when data were collected, with 20 of these based on the professional carer model of care. A significant proportion of clients in the professional carer model of the IPC were from the Noarlunga and Elizabeth District Centres, both of which are considered to have some of the most complex young people in the state (Walker, 2008, personal communication). Table 2 demonstrates that most of the social workers were degree qualified, with one holding a Diploma in Social Administration, (formally the entry qualification for social workers to the profession throughout Australia) and two others holding a Masters level degree in Social Work (MSW) and a Bachelor of Social Science (BSSc) The study sample consisted of fifteen social workers, of which five were male and ten female. As this is a snowball sample, it is not considered representative of a particular gender, age or culture, however it does provide a critical insight into the experiences of social workers working in IPCs. Of the fifteen participants interviewed, all of them stated that they had significant experience in working with guardianship children prior to engaging with a young person in an IPC, with the most service being fifteen years and the least, one year (mean 3.06 and standard deviation 3.34). All but one of the participants advised that they had completed one

student placement with FSA prior to commencing their role as a qualified social worker; one participant advised that they completed their placement in an unrelated field, but felt that their child protection skills had been significantly developed over their fifteen years of service.

2.3.3 Recruitment of Former Youth from IPC Placements

In order to recruit and interview former clients in this study, agencies whose role it is to provide support after young people leave care were approached as they had regular access to this population of young people. Their agreement was given to circulate information to former clients. This method received several responses which form the basis for the third cohort. Those who responded were provided with details of the purpose and scope of the interview, including what would be expected from them in terms of time commitment and location of interviews. Those who then indicated an interest in participating were provided a prescreening form to gather data prior to interviews. Former clients who agreed to participate were screened for history of being in an IPC, those who indicated that they had not were not able to participate due to the nature of the research and its purpose to being to examine IPC placements. From initial recruitment of individuals in this cohort to completion of the interviews, this component of the research lasted six months. The research with this population was complicated with personal crisis for some people who eventually withdrew their participation and in some cases withdrawal from the study with no explanation at all. All participants who were eligible and agreed to participate in the research responded to each item in the interview schedule and offered detailed responses to each question.

Of those who took part all had left care within the past eighteen months. Nine interviews were undertaken, with seven males and two females. Gender was not considered in this study as it was not an aim to identify the impact of gender and it was thought that participant identities would be better protected if gender was not reported. The former clients that participated in an interview ranged in age from 18-19 years, with an average age of 18.5 years. All of the former clients were interviewed separately. A summary of this cohort is given in Table 4.

Table 4: Summary of Former Client Participants

Participants	**(n=9)**		
Participant Code	**Gender**	**Age of client when entering IPC**	**Duration of interview**
FY1	M	15	48
FY2	M	17	51
FY3	M	16	52
FY4	F	16	58
FY5	M	15	49
FY6	M	16	57
FY7	M	15	59
FY8	M	16	51
FY9	F	16	54

2.4 Data Collection

2.4.1 Demographic questions

All participants completed demographic questions as part of the overall interview. The data collected were different for each cohort as it is important to report qualifications for carers and social workers but not young people whose experiences in placement did not rely on qualifications. Questions were also asked in the social worker and professional foster carer cohorts about perception of problematic behaviours. The data received is reported in Chapter 4.

2.4.2 Directions to interview participants

A semi-structured interview design was adopted in which participants were asked a number of questions relating to their experiences and opinions (see Appendix F, G & H). A detailed discussion then followed each question. The subject of each interview was the IPC and the individual's experiences of the IPC in relation to three broad areas: 1) their experience of interacting together with other stakeholders in supporting young people with complex behaviours; 2) their experience and views of complex behavioural and mental health needs; and 3) their views about how helpful the IPC is as a placement alternative. Informal prompts inviting the participants to share more information were used to elicit a detailed account of their own experiences and examples of behavioural problems of other points of interest that they had direct experience with. Individuals in each cohort were given general definitions of mental health or complex behavioural

challenges as it was anticipated that this could have influced the breadth and depth of resposes given and unintentionally standardised answers. Despite this, however, most respondents gave accounts of experiences with violence, manipulation and acts of aggression, despite no definition for complex behavioural needs being provided.

Families SA social workers, SABCS professional foster carers and the former clients were were accommodated for interviews with a wide scope for choice of location and times to minimise discomfort and maximise the likelihood that they would participate. Professional foster care workers were interviewed at SABCS head office in an office that was private to allow for those participating to provide comprehensive responses. All interviews with them took place outside of days and times that were serving a shift with the young person to minimise disruption to the placement. Former clients were offered the choice of interviewed at any location that privacy could be accommodated and was safe for the researcher and young person. The majority of former invited the researcher to their homes or workplace, while two of them felt most comfortable conducting the interview is a meeting room at a local library.

2.4.3 Duration of interviews

Interview length varied from cohort to cohort; professional carer interviews were on average longer as they gave more detailed responses to the questions asked. Each interview was audiotaped after permission was given both verbally and in writing by each participant (Appendix B). Each audio file was then transcribed to allow detailed analysis and comparison.

Interviews conducted with participants in the former social worker cohort lasted from 47 to 61 minutes. The result was 151 comprehensive pages of data for this cohort.

The interviews with SABCS professional carers lasted between 49 to 63 minutes. Data resulting from these interviews included 203 pages of comprehensive information for this cohort.

The interviews with former foster children lasted from 48 to 57 minutes and were the only cohort where not all interviews were accomplished in one session. For some participants they felt the need to postpone their interview and complete it later in the day. This resulted in 89 pages of comprehensive data about the views and experiences of this cohort.

There was some identification of the young people served in an IPC placement as a result of questions answered during the interviewing process in each cohort. Information provided such as names and other unique details were omitted from the study without compromising the integrity of the data. In all cases, this involved the removal of names from data that is quoted. For reasons of confidentiality, all participants in this study were assigned a code, former youth (FY), former social workers (FSW) and professional carers (PC). Participants are referred to by a number in each cohort.

2.5 Data Analysis

There are several approaches to analysis in the practice of qualitative research. Many if not most such approaches develop a system for 'coding' or identifying categories or themes based upon patterns and ideas that emerge from the data in field notes, interviews, reflections, and other written artifacts. As a researcher reads the data she or he looks for patterns in the words, phrases, behaviours, thoughts, and events recorded and carefully notes/annotates those that repeat and stand out. After labelling observed patterns, and sorting, comparing and contrasting, a system for classification emerges (Patton, 1990). Sorting the codes themselves and finding patterns among them is itself a challenge. Once this has been undertaken, responses are then coded and categories appropriate to the responses are developed for each topic identified. The number of participants who responded to each topic is typically recorded to identify the significance of particular responses when compared with other data.

With the above points in mind, the data for this thesis were examined by thematic analysis as detailed by Braun and Clarke (2006). They conclude, thematic analysis is a method of analysis that systematically identifies, analyzes and reports patterns observed in data sets, in this case the interview data of three cohorts. After reading through the transcripts several times during the analysis period, themes were identified within the data, instead of subjecting the data to preconceived coding or frameworks based upon theoretical assumption. This method was favorable for examining the data given the evaluative nature of the research. Given the large substantial amount of interview data collected, the data were analysed for themes and then grouped according to

commonalities. Individual responses within each cohort were assessed for consistent information to identify recurring themes in each data set and overall.

This method can be considered flawed, particularly given the area of practice being researched (Rubin & Babbie, 2003), as the researcher potentially influences the research process through their own biases based on their experiences, knowledge and views of the research topic. Accordingly, it is reasonable to assume that the researcher's influence is reflected in the analysis. The themes can therefore be considered a unique perspective; that of a social worker, whose professional history involves responding to complex emotional problems and maladaptive behaviour in child welfare and work as a long-term care social worker and clinical therapist across two countries, Australia and the USA. In consideration of this, the researcher should be viewed as both a 'researcher' and a 'stakeholder'. This knowledge of practice created an opportunity for the researcher to engage more thoughtfully with participants and potentially improved the quality of the responses obtained. In order to address issues of partiality, extracts from interviews that represented themes that were taken from the data were examined by another social worker, who had expert knowledge in qualitative analysis. Changes in opinion between the research and research expert were resolved with preference given to the more experienced researcher.

Extracts that illustrate the current theme are provided throughout the analysis chapters of this thesis for the purpose of illustrating the theme being considered. Chapters 3 and 4 collectively document the views and experiences of each stakeholder group.

Chapters 5 and 6 provide an individual insight into how professional carer and former youth cohorts experienced their IPC. Data is coded according to common themes amongst participants.

PART C

Chapter Three:

Collaboration in Individual Packages of Care

Chapter Four:

Frameworks and approaches to challenging behaviour

Chapter Five:

Professional carer experiences of managing youth in an IPC

Chapter Six:

Former client experiences of being in an IPC

CHAPTER THREE

Collaboration in Individual Packages of Care

3.1 Overview

Literature reviewed in Chapter 2 provided an overview of the thesis and practice status of collaboration, with focus on those relationships that support children with complex mental health and behavioural problems. It also pointed out the relevance of examining how individuals understand and manage complex mental health and behavioural problems in the context of their professional and personal understandings of behaviour. The review of literature indicated a paucity of research on the topic of collaboration in alternative care. This chapter, after first expanding on the literature review on collaboration as presented in Chapter 2, then reports the results of an analysis which examines the experiences of and views on collaboration of stakeholders involved with Individual Packages of Care (IPC) were examined.

3.2 Defining Collaboration

The benefits of interagency cooperation are well documented and include: faster access to services (Friedman, Reynolds, Quan, Call, Crusto & Kaufman, 2007); reduced anxiety for workers through better understanding of their role (Metcalfe, Riedlinger, McKenzie &

Cook, 2007); and increased quality of case monitoring through interagency discussion and coordination of cases and relapse support (Green, Rockhill & Burrus, 2008), ensuring agency demands on a family are not competing or overwhelming (Darlington & Feeney, 2008).

Darlington and Feeney (2008) point out other important benefits of positive collaboration including: consistency of message from all involved; better decision-making; improved ability to provide needed and timely resources; more effective use of limited resources; development of new policy and practice; and reduction in duplication of services. Green et al. (2008) suggest an important benefit of collaboration for alternative care:

> Collaboration can also improve the overall effectiveness of services, for example, by moving parents toward a greater state of "readiness to change" through provision of ample emotional, psychological, and tangible support (p.58).

Young people in alternative care, and more specifically those with mental health issues, are thought to be most supported with cohesive and collaborative approach to care (Bullock, Little & Milham, 1998; Place, Wilson, Martin & Hulsmeier, 2000; Salmon, 2004; Salmon & Rapport, 2005). While efficient alternative care may not be possible without collaboration at various levels (Cottrell, Lucey, Porter & Walker, 2000; Scott, 2002b), establishing collaborative practice is thought to be challenging and requires a substantial commitment from all stakeholders to collaboration which is built slowly and in stages (Metcalf et al, 2007).

Professional, agency and government policy direction both in Australia and globally reflect an increasing shift toward collaborative efforts in alternative care (Bazley, 2000; Blanch, Nicholson, & Purcell, 1994; Darlington, Feeny & Rixon, 2005; Hetherington et al., 2002; Queensland Department of Families, 2002b; Department of UK Health, 1999; Salmon & Rapport, 2005). McLean (2011) provides an overview of collaboration in the context of meeting behavioural needs of children in care in South Australia, and emphasizes the need to integrate service delivery, given the number of complex roles that are involved in services to individuals with high needs. In the UK collaboration between agencies has been an increasing policy focus (Clarence & Painter, 1998; Balloch & Taylor, 2001; Hudson & Hardy, 2002; Clarke & Glendinning, 2003).

O'Flynn (2008), however, reports a stark contrast between practice and rhetoric in regard to collaboration, arguing that there has been a 'collaborative turn' in public policy circles in which governments are requiring their agencies to adopt collaborative policies and practices, It has also been argued that the shift towards collaboration is less about providing better services *per se*, and more about: pooling existing resources or leveraging new ones as a strategy to reduce risk or enter new markets; an attempt to reduce transaction costs; a reaction to complexity or turbulent environments; or a search for (re)integration in a fragmented domain (see, for example, Bryson, Crosby & Stone, 2006; Lawrence et al. 1999; Lowndes & Skelcher 1998). O'Flynn & Wanna (2008) Offer a commentary of the rhetoric observed within government agencies in Australia. They give the example of national and state government publications calling for public policy that

embraces interagency collaboration both private and public in Australia, and contrast this with the view that collaboration is not a panacea for all organizational problems.

Mattessich & Monsey (1997) further caution that collaboration must form part of a continuum for working together, and that it cannot be the exclusive method. They identify that collaboration is part of a continuum which includes cooperation, coordination and collaboration. Cooperation is described as an informal relationship without a common mission in which information is shared as needed, authority remains separated, there is little (or no) risk and resources and rewards are separated. Coordination is seen as more formal and occurs when there are compatible missions that require common planning and more formal communication. While each organisation retains authority, some risk is assumed. Collaboration is considered a more 'durable and pervasive relationship' (Mattessich & Monsey 1992,p39), which involves creating new structures within which to embed authority, developing a common mission, engaging in comprehensive and shared planning, and in which formal communication across multiple levels occurs. Collaboration includes pooling acquired resources, sharing rewards and risk. Clear distinctions are made here to demonstrate the complexities of working collaboratively. This thesis will not address the difficulty of defining collaboration; instead it will examine the unpreventable deficiencies and complexities of interagency collaboration by exploring qualitative data about stakeholders who work collaboratively to support youth in alternative care and more specifically in IPC placements.

3.3 Previous Research on Collaborative Practice in Children's Services

Worrall-Davies, Kiernan, Anderton & Cottrell (2004) contributed to the research on

collaboration in child welfare with a UK based study that examined the experiences of individuals working with children involved with child protective services. In total there were 91 participants with 79 interviews being transcribed for analysis and the remaining data being taken from interview notes. Thematic analysis of the 91 interviews produced six dominant themes, including first an identified need for collaborative working practices from assessment through to closure. The second theme identified was barriers to collaboration including two sub themes of confusion about responsibility and confusion about procedure. Thirdly, accessing resources had three sub categories of: refusal of agencies to provide funding for collaborative efforts; no central record of available resources; and an absence of resources altogether. Poorly timed interventions and poor communication were implicated as barriers to effective collaboration. Finally, placement problems were identified and comprised three sub categories of: multiple placements; poor placement matching; and lack of specialist placement resources. The interview responses suggested that better planning and collaboration about placements would improve placement stability. Several of those interviewed suggested that the cost of placing young people with complex needs could be reduced considerably, and the disadvantages avoided, if such children's needs were planned for in a long-term strategy by health, social services, education resources and facilities provided jointly and locally (p. 184).

Australian researchers Darlington, Feeney and Rixon (2005a) provide an analysis of data from a state-wide survey of statutory child protection workers, adult mental health workers, and child mental health workers. The study explored service collaboration

where a parent had mental health problems and there were serious child protection concerns. Questionnaires were mailed to 1105 participants with an overall response rate of 21%, with 232 returned questionnaires. The researchers considered their sample to be representative of the population: 43% of the sample from the city; and 45% from areas other than the capital city. Analysis of the data revealed common concerns about collaborative efforts including: the need for improved communication and role clarity; a competing primary focus among service providers; contested parental mental health needs; contested child protection needs; and resource deficits. Of these factors, respondents reported poor access to resources significantly and negatively impacting collaborative practice.

The results of Darlington et al (2005b) second study were presented through a thematic analysis which focused on worker perceptions of the nature of the service offered. Clear communication was nominated by 21 participants as essential to effective collaboration. Participants stressed that easily identifiable contact points (with the same person), regular contact with the client, regular communication about the client, and timely communication were all important. Despite this view poor communication was reported by 16 respondents as occurring concurrently with limited collaboration. As a result of poor communication, important information was not shared between agencies, including the extent of other services' involvement. Fourteen respondents associated unsuccessful collaboration with a lack of knowledge of processes regarding interagency information exchange, and a lack of knowledge of child protection or mental health assessment and treatment processes. Collaboration was reported to work well when

participants from different agencies took on separate and agreed upon roles which formed one holistic approach. Darlington, Feeney and Rixon (2005b) concluded that there is a pressing need for decision-makers to match current views about the need for collaboration with adequate resources, in the form of training about collaboration and time for staff to understand and perform their roles in a collaborative manner. They also suggest that attention needs to be directed to possibilities for more integrated models of service provision.

In 2008 Darlington and Feeney completed a qualitative analysis. The final sample of 232 respondents represented a response rate of 21%. Data were collected as part of a state-wide survey of professionals in both fields. Thematic analysis was used in this study and comprised three main themes including: the role of communication strategies; the importance of a sound skill and knowledge base; and adequate resources. These findings confirmed their previous research which found that collaboration is more successful or less successful based on the adequacy of each of the key areas mentioned above.

Given the focus of this thesis is on South Australian Packages of Care, two studies were explored that contribute to the picture on collaboration in South Australia. The first study reports on the evaluation of a mental health liaison project (Zuffery, Arney & Lang, 2006) between Families SA and Mental Health Services. This evaluation examined the views of workers, supervisors, managers and clients in relation to a collaborative project using action research.

The first stage of the evaluation in late December 2005 to January 2006 obtained the perspectives of 14 individuals through worker interviews and focus groups undertaken in Families SA and Mental Health Services (MHS). The first stage also obtained the perspectives of five clients (three of whom were involved with the MHLP and two of whom were clients of child protection before the project commenced). The second stage of the evaluation conducted in May 2006 obtained the perspectives of 11 workers through interviews and focus groups in Families SA and Mental Health Services and three clients involved with the project. The results from the interviews with workers and parents showed overwhelming support for collaboration, and recommended continuation of MHLP. The evaluation reported several positive aspects when collaborating between welfare and mental health workers including: improved communication between workers in each service; improved knowledge of roles by both services; and joint client assessments enabling improved client focused communication between the two cohorts. The evaluation also found that it was helpful for supervisors to be supportive of collaboration. An interesting point identified by this evaluation involved the project lead or liaison; the expertise, personality, experience, skills, knowledge and availability of the Project Officer in the project are of paramount importance in 'making the project work' (p.21).

McLean (2011) conducted research in South Australia on collaboration between key stakeholders. The study was conducted to capture the complexities of collaboration by considering the experiences of multiple stakeholders. A total of 92 respondents (35 males and 57 females) participated in an interview. They were asked about their collaborative

practice and their understanding and management of school-age children who are in a placement and exhibit challenging behaviour. Participants were 36 South Australian statutory child protection workers (19 social workers and 17 professional residential care staff), 12 mental health professionals, 18 teachers employed by the SA Education Department and 26 foster parents. The data were analyzed through a (bottom up) analysis examining the experience of collaboration. This approach was considered appropriate because of the exploratory and theoretical nature of the research. Due to the large amount of data collected, the data were analysed in sections that corresponded to participant responses. The analysis yielded six subthemes, reflecting commonalities in stakeholders' experiences with addressing the behaviour problems of young people in alternative care: (1) differences in frameworks for practice; (2) desire for better understanding and communication; (3) power and control; (4) triangulation in relationships; (5) inappropriate information exchange; and (6) inappropriate allocation of resources.

The findings strongly advocated for continued inclusion of key stakeholders in future research regarding collaborative efforts and the difficulties encountered. This supports the current research which takes into consideration the views of professional carers, social workers and the youth who are served by IPC placements (McLean, 2011).

When the literature on collaboration is considered, several key themes emerge. These consistencies are worth noting in the development of interagency practice involving young people in alternative care with challenging and complex needs and include: open and effective communication (Darlington & Feeney, 2008; Darlington, Feeney & Rixon,

2005a; Drabble, 2007; Ervin, 2004; Feiock, Steinacker & Park, 2009; Garret, 2004; Green et al. 2008; Head, 2008; Horwath & Morrison, 2007; Katz & Hetherington, 2006; Spath, Werrbach & Pine, 2008); finding resolutions to issues of confidentiality (McLean, 2011); reducing gaps in knowledge about interagency practices and individual roles (Darlington, Feeney & Rixon, (2005 a; and finally maintaining adequate resources that promote success in collaboration (Head, 2008). Such needs, when ineffectively met are likely to create interagency problems. Communication has been identified as one of the most significant needs to be addressed in interagency collaboration (Head, 2008; Spath et al. 2008; Metcalf et al, 2007, Darlington, Feeney & Rixon, 2005ab; McLeod, 2011). It has been shown that client and worker relationships are improved when all stakeholders working with a family are communicating effectively with one another, providing a seamless service to the family without the family having to keep workers up to date or repeat their stories (Friedman et al. 2007; Spath et al. 2008).

Barriers to collaboration documented as occurring in services to young people have included: conflicting agency views and understandings of the definition of abuse; multiple service obligations where one provider views their services as a greater priority than another; lack of formal structures in which to implement collaboration; and competing priorities for financial support and resources (Byrne et al., 2000; Darlington, Feeney & Rixon, 2004; Darlington et al., 2005a, b; Hallet & Birchall, 1992; Hetherington et al., 2002; Johnson, Wistow, Schulz & Hardy, 2003; Quinn & Cumblad, 1994).

3.4 Interagency Collaboration in South Australian Alternative Care

A review of child protection practices in South Australia, titled The Layton Review (2003), reported that collaboration was not established well in South Australia. The review described interagency collaboration in South Australia as lacking clear direction, including poorly defined roles of each party (section 7.2). It recommended an approach which establishes complementary statutorily mandated central and regional bodies which are able to communicate with each other to produce effective and efficient results. The prime focus of these bodies would be to improve outcomes for children, young people and their families with the aim of preventing abuse and neglect.

In 2009 a report on Families SA by a South Australian Parliamentary Select Committee noted the former's failure to implement greater partnership and collaboration between agencies as recommended in previous reviews including the Layton Review (2003). It reported that there was little evidence of any improvement in the culture within Families SA, and a comprehensive overhaul of management and structure was needed if the culture was to improve. Strong leadership was suggested as a requirement to improve collaboration, communication and cooperation between FSA and other parties. The report pointed out that Families SA has a written policy to serve children within a context of multidisciplinary teamwork, and co-operation and commitment to the protection and well-being of the child. It further suggested that Families SA should facilitate interagency collaboration and ensure clear communication between government, non-government and community services and networks to achieve best outcomes for children and families. The report found that the current policies of FSA are little more than idealistic rhetoric, as the Committee received evidence through interviews with stakeholders that this is not

what happens and that the Department's ethos is in complete contradiction to its actual practice. With regard to stakeholders' experiences in "partnership" with Families SA, the Committee received evidence demonstrating the Department's lack of accountability and openness, failure to share responsibility or work in a multidisciplinary team or communicate effectively (p. 26).

3.5 Limitations of Previous Research about Collaboration, its Effectiveness and Barriers

There appears to have been little empirical study in Australia that examines interagency work between agencies whose role is to support young people with complex behavioural and mental health needs and are in an alternative care placement. There is no research in South Australia that focuses exclusively on the relationship between professional carers and social workers when a child is placed in an individual placement. This paucity in research exists despite indications of the necessity for such research due to the presence of the multiple agencies, services and concurrent needs that surround a child in alternative care (Layton, 2003). While the behavioural issues of children often promote interagency discussion and collaborative efforts (e.g., Delfabbro, Barber & Cooper, 2004) little information is available about collaborative practice amongst the cohorts attempting to improve behavioural outcomes collaboratively. Several authors identify that tensions involved in interagency collaboration are particularly prominent when working with complex behavioural problems, because of the variables that cause the complex behaviour in all of its forms. In such circumstances collaboration has commonly been

reported as being difficult to achieve (for example, Dale, Davies, Morrison & Waters, 1986; Jones et al., 2007; Goddard & Hiller, 1992; Reder et al., 1993; Morrison, 1996).

Additionally, research that has occurred to date in South Australia has been limited in scope and included on a few key stake holder groups. One study outlined previously in relation to interagency collaboration included participants such as teachers, foster carers and residential care workers (see McLean, 2011). Despite previous research on South Australian alternative care being valuable, it does not fully consider the difficulties involved in interagency work that occurs between stakeholders supporting youth in alternative care. Adolescents in alternative care have, by definition, been traditionally involved with either foster care, family care or residential placements. Given the limited scope, it appears necessary to target the scope of exploration to include the views of people involved in innovative care practices such as IPCs when exploring how different cohorts support young people with complex behavioural and mental health needs in alternative care. The data analysed and reported on here is unique to Australian research it includes the perspectives of professional carers in individual packages of care as well as social workers who have worked with this form of placement in alternative care and has not been previously accomplished.

3.6 Analysis

The findings presented in this chapter identify the barriers to and benefits of collaborative practice in professional foster care, providing information about what works and what should occur to improve collaboration when managing specialized placements where the focus is children with complex behavioural and mental health needs. The analysis of

professional carers' and social workers' responses was performed as stated in Chapter 2 and identified six themes, reflecting commonalities among the two cohorts in their experiences of supporting adolescents in an IPC. The following themes emerged from the data:

1) Disagreement on views and methods

2) Problematic information exchange

3) Manipulation of relationships between the carer and social worker by the client

4) Confidentiality

5) Control of care and decisions

6) Resource limitations and turnover

3.6.1 Disagreements on views and methods

The first common theme identified reported on differences in the understanding through which participants managed and responded to complex behavioural needs. The theme identified two sub themes: 1) negative views of the other cohort's views and methods and 2) the perceived interference of social workers by professional carers. These issues are discussed below.

Participants in both cohorts frequently experienced their views, understanding and methods of care as inconsistent with the other cohort. Where differences in opinion and practice were found they were generally perceived negatively by social workers and professional carers. This is illustrated by one social workers response of the way that young people in alternative care are supported by professional carers:

> I have worked with many placement settings, but have never come across something as unstructured and unhelpful as the youth worker model of IPC. Some carers are very good, set appropriate boundaries, enforce them and respond to incidents as requested. Other carers contribute to the young person's issues, they support inappropriate activities, work against other carers by giving the young person what they want, and they don't manage the behaviour well at all. This type of inconsistent care has no place in the child protection system. While I believe the IPC concept has significant merit, their understanding of how to manage young people in care is poor at best (SW13).

Further, the differences in views and approaches were experienced as interfering with the efforts to support young people, regardless of the positive intentions of social workers, as the following interview response from a professional carer describes:

> We do not know about the goals and directions of the young person. There is inconsistency in the role of the worker. Some social workers will want to make all the decisions and others will have expectations, but will not communicate these to either the agency or the carer. The worker can also act with bias toward the young person as there are clashes with the social worker and young person (PC1).

Participants were highly likely to endorse negative views of opinions and abilities of each other when they perceived that other stakeholders had limited experience or interaction with the adolescents in the placement that they worked with. The following statement from a professional carer demonstrates this point:

> Many social workers are young graduates and there is a high turnover in and out of Families SA. We have a social worker who comes out once a month telling us how to mange the child, they aren't there all the time and don't know what we deal with (PC18).

This perception of interference related to each participant group's framework in a number of ways: viewing professional as being incompetent when managing complex maladaptive behaviours, or as unmatched to the challenges presented by the young people; or simply stating that conceptualisations of the behaviour problems of young people in other cohorts were simply not correct. Participants from the professional carer cohort frequently perceived social workers as having relatively rigid opinions about how maladaptive behaviour should be addressed, with some professional carers arguing that the methods suggested were on occasion unrealistic in the situation that they were being faced with. In some cases, both social workers and professional carers stated that there was disagreement between each other as to how severe a behaviour problem was, and subsequently whether an intervention was needed. The following extract from a social worker shows the difference in beliefs about what is considered complex behaviour:

> On many occasions a carer would call me and request to consequence a youth for something trivial. It was hard to agree with the way they thought, because I've seen severe behaviour and they just seemed to constantly overreact (SW 12).

Consequently participants from the professional carer cohort reported a tendency of social workers to minimise, dismiss or invalidate their opinion and observations of behavioural problems. The following statement by a professional carer argues this:

> I would call the Families SA worker and they would tell me that it wasn't really a big deal. Sometimes the young person would lock themselves in their room for hours and we were concerned about their safety. The social worker just wouldn't agree that something needed to be done. Some days I would call to tell them something and weeks later another incident with the same behaviour would come up and they would ignore the fact

that we had already told them about it (PC9).

This perception of the views of the other cohort as being different or unhelpful may potentially lead professional carers and social workers to minimise or ignore the perspective of the other and reduce their ability to work collaboratively.

The second sub theme to emerge regarding disagreements related to carers' perceptions that social workers interfered with placements and that their interaction was not helpful. The implied view accompanying this was that social workers should respond to placement needs more consistently with the views and understanding of the professional carers. Participants from the professional carer cohort overstated the need for their opinions to be sought regarding how social workers could respond to problems and needs in the context of the IPC.

> There is a band aid approach to how the social worker responds to the needs of the young person, they don't provide enough proactive intervention. They do a surface job of helping the young person, and we don't have enough direction because of it. You are fighting for the young person's soul and it's painful as a worker when you don't have the support to breakthrough, the social worker just isn't interested, we need specific help, not the help the social worker wants to give, we know what they need, the social worker must listen (PC 5).

Claims relating to 'not having support' extended to issues around placement decisions, case management, and provision of additional resources. The implied belief amongst professional carers that the understandings of social workers were less valid,

misinformed or out of touch with reality can be seen in a response from a professional carer detailing their perspective of a social worker:

> The social worker is so busy, and so removed from what we do that they just don't get it. Important things get missed because they aren't involved in meeting the needs of the kid daily, the only understanding they have is what they hear, that isn't always right (PC 13).

Dismissing the opinions and experiences of others was unique to descriptions of social workers' understandings; both cohorts expressed these views when discussing supervisors and program managers, as the following statement from a professional carer demonstrates:

> Our supervisors are clueless, most of them want the best for the client, but they are so unrealistic about how it can be achieved. Because they aren't there with the young person to see why they behave the way they do, they come with ideal solutions to complex problems that just won't work. We need to make a change to do something that works because of the messed up situations of these kids which impact our behaviour management (PC 9).

A primary problem with communication between cohorts was the difficulty in understanding how the other had arrived at a decision. Both cohorts stressed the need for more direct communication to assist with clarifying how the other arrived at a view or decision. The following statement from a social worker identifies the difficulty with communication between cohorts:

> During an incident with a young person there was always chaos from start to finish. Often I would commence work in the morning with a note from crisis care to say that the young person was in hospital. When I tried to contact the agency the placement coordinator

> never knew the details of the incident, often workers were not contactable and it would sometimes take several hours to find out that the young person was in serious trouble. As an example, a young person on my caseload was taken to hospital one night and it took two more days to establish the details of the event. Despite care standards being in place, the agency had no policies or procedures about managing events such as this and I was required to work intensively to piece together the information I needed to make decisions about the young person and their needs (SW4).

Participants in the social worker cohort reported that differences in agency practices were thought to contribute to most conflict between stakeholders, as these participants identify:

> When I realised that the carers did not know what they needed to report back to Families SA I spoke with my supervisor about the problem and we decided to implement a reporting form with a set of guidelines for reporting. Despite doing this, the private agency would often refuse to cooperate, workers would avoid completing the reports and often when they did report, many carers had poor writing skills and this caused the reports provided to have little information for me to assist in managing the client and assessing the situation (SW9).

Participants in both cohorts reported that communication problems between cohorts also contributed to their perception that social workers were interfering. Improved communication and understanding of the values and beliefs of other stakeholders was viewed as essential to developing effective collaboration that would most effectively meet the needs of the youth. Information was given during the interviews that indicated that neither cohort had a clear understanding of the desired

outcomes or values for the placement. Some participants in the professional carer cohort stated that their own role of professional carer was not explained in terms of the responsibilities and the ethos of the private agency during the initial induction process, as this carer argues:

> The surface nature of the role that we are provided in our interview, prepares us very little as long-term care workers with these young people. Instead we are expected to rely upon our life skills and personal abilities, which at times other carers lack. This is a dangerous and unreasonable practice considering the nature of the clients we work with. The agency must do more to prepare us, including development of written expectations (PC2).

Both cohorts expressed a strong desire for more autonomous practice in which they could make daily decisions to meet the needs of the young person without long processes of approval. Participants in both cohorts felt that there was such a divide in agency practices that it was difficult to know how to respond to some situations. One professional carer suggests a combined effort to establish placement practices:

> One day the supervisor would tell us we could go out to the park with the young person, the next day the social worker would call and say that wasn't ok. For my agency the placement is primarily about keeping the young person safe, I don't know what Families SA think it is for. I'm sure if our managers worked together things would make much more sense to everyone. Some days I don't think I even know who makes the decisions, other days I think it is everyone (PC 17).

In some cases, due to poor understanding of the rationale for decisions that social

workers made, professional carers would either ignore the decision or poorly implement what they were asked to do. All social workers reported that at some point at least one carer in a placement had failed to follow a direction. This is shown in a statement from this social worker:

> I had some really lazy carers who would refuse to cooperate with appointments I had set up to help with mental health and I would have to take the youth myself, this taking away valuable case management time and rendering the IPC a pointless placement in terms of achieving health goals. They didn't understand the importance of the appointments because they didn't know what the appointment meant for the young person and how much it would help them (SW9).

Participants who had been employed a year or more in their cohort were more likely to demand that other cohorts consider their view as valid. They were also more likely to show an increased desire for a more direct communication practice to prevent misunderstandings and to allow for clarification of reasoning behind decisions. Those professional carers with one or more years of service also reported being more comfortable with communication with the social worker. They stated that they felt that the social worker was more receptive to them and they were treated more equally once they had demonstrated a longer term commitment to the young person. Those who had served in IPC placements for lengthy (more than six months) periods reported that they were less stressed and frustrated once they accepted their own limitations and the limitations of the placement. The following statement by a professional carer summarizes this view:

> In the end, I have a choice to make and I can choose to do my best no matter what. Yes

> there are things that could be better, but after a year I know the social worker, I know I can call them whenever I need to, I also know the youth. Is the IPC ideal? Probably not, but it could be way worse than this (PC 1).

All participants in the professional carer cohort suggested that one solution to tension with social workers could be regular training on various care issues to promote a better understanding of the difficulties experienced in placements and ways to overcome these. McLeod (2011) made a similar finding in her study of key stakeholders working with young people in alternative care, which suggested a need to understand the roles, philosophies and rationale for decisions through joint training. Training was suggested by all participants in this study as a way to promote awareness of roles, improve carer ability and educate both groups about how to work together:

> Greater cohesion would have been achieved if my role was much more clearly explained and defined to the carer agency. Training is essential to promote an understanding of the carer and social worker role, which would also improve the carer's ability to do what the social worker expects. At least if they had an idea of what I am there for and what they are there for, they would arguably be more likely to come to me about the things I am employed to do (SW1).

For communication to be effective, the goals of the IPC should be clearly defined, workers adequately skilled and agencies prepared to provide training. This study indicated that participants in each cohort desired training but had not received it. Primarily, clarification of expectations of each role was reported in both cohorts as desirable to understand what is happening in an IPC. Sharing rationale for decisions was

thought to assist with gaining support between cohorts. These finding are consistent with previous research which has found that the relationship workers from different agencies have with one another can be enhanced when communication includes perceptions of roles and of who has the 'lead' (Garrett, 2004), particularly when joint projects are being implemented (Flemons, Liscio, Gordon, Hibel, Gutierrez-Hersh & Rebholz, 2010); and when explicit discussion of current practices, ideological /philosophical positions, and agency role occurs to promote support for decisions (Drabble, 2007; Garret, 2004; Head, 2008).

Despite the existence of care standards (DFC, 2008), there is no evidence that these standards are being communicated to agencies providing care. Where the IPC was reported to have stable care teams, communication was reported to be more effectively established. While this variable is difficult to control, it is certainly worth considering ways to promote commitment to long term care by professional carers.

Accounts of disagreement in terms of practice and views can negatively impact collaboration. These views increase the probability that social workers and professional carers have competing ideas when trying to understand complex mental health and behavioural needs of young people in an IPC. Given that the cohorts do not perceive behaviour in the same way, carers and social workers may be discouraged from implementing management plans for young people that are not consistent with their own views or practices. This stresses the importance of understanding the way in which behaviours are viewed by other participants in the care group. Professional carers and social workers may, be more willing to invest in collaborative measures when their own

views are respected and opposing views explained to arrive at an effective solution for behavioural issues.

3.6.2 Problematic information exchange

Data identified as falling within this theme focused on two aspects of collaboration attempts: 1) poor exchange of information; and 2) organizational influence on communication. Several examples were given by participants in both cohorts in which essential information about challenging behaviour was not provided, shared, available, or in some cases was withheld to prevent the care agency from refusing to accept the youth. Confidentiality was commonly used to limit the exchanging of information, but was not always the actual reason. Some social workers reported that supervisory staff instructed them to inform the agency that information would not be available because of confidentiality, when the actual reason was that the information was outdated or did not exist in the youth's official file. Several participants gave examples of how this had led to negative consequences for an IPC, in the form of behavioural problems and subsequent placement breakdown. It is also important to consider that social workers have a dual role in ensuring both the success of the placement and the young person as an individual. It is likely that social workers do not want to sabotage the placement by revealing too much about the young person to the private agency. The unintended consequence of this is that care teams and their agencies remain uninformed about the young person and are left to discover maladaptive behaviours and other concerns that can negatively impact the placement.

According to participants from both cohorts analysed in this chapter, there were no formal methods for information exchange (including providing history and placement

needs) at the start of a placement. Many of the participants were of the view that the information was completely unavailable. All participants from the professional carer cohort reported that they knew about the reason for the young person coming into care but not specific details. They reported that they never saw a copy of the case plan including the case history and many reported that they had never heard of a case plan at all. The following frustration was expressed by a professional carer:

> Knowing things about my young person, such as the fact that they have their own children who have been removed, better positions me to provide the ongoing support they need to address the tough experiences that they have. If I do not have knowledge of their issues I am not likely to be sympathetic to their immediate needs. This was not something I found out from the agency, we had to find it out from the young person (PC 6).

The poor exchange of information was viewed by some participants in the professional carer cohort to involve the purposeful withholding of information, increasing the risk of harm to carers and the youth. Many reported that they felt at times that the withholding of information was to prevent the refusal of accepting the placement, given the extreme behavioural histories, as this statement from a carer suggests:

> Our social worker told us that the young person had no serious behaviours. We later found out that he had sexually abused a young girl in his last placement and that he had set fire a few times to things. I would consider these serious behaviours and it feels like they are not being honest with us (PC 8).

Some professional carers interviewed admitted that they did not seek information that would have been helpful to the placement, including history, behaviours and client

needs. This appeared to be based on the assumption that the information would not help the placement and that the skills of the carer were viewed to be 'good enough' to handle anything regardless of the identified needs and complex behaviours the adolescent. The consequence of this was reported to have resulted in placement problems, including poor responses to behaviours as a result of an inadequate amount of information being shared to meet the child's needs, as one social worker reports:

> I remember going to a meeting with the other agency and asking what they needed to know about the youth. The manager laughed and said that he didn't need anything because everyone is treated the same and the staff can handle anything. It wasn't two weeks into the placement and they had to fire a carer because he left the placement without relief and the youth damaged the house in his absence (SW16).

Many participants expressed practical reasons for poor communication including: crisis driven placement; urgency of placing the youth; and unavailability of required information. This extract from a social worker shows how placement needs inhibit effective communication:

> On the Friday I had a phone call to say that placement services were going to fund a package and I had a week to move the young person into it. I spent all of that week finding out exactly who was going to be caring for them, the young person didn't want to move so soon as they had no relationship formed with the workers at the new placement. I couldn't prepare the carers for the young person's behaviour, because I didn't get to talk with them before the placement started (SW9).

The impact of each cohort's failure to share information with the other was that

placements were poorly prepared for the youth, for their needs and their behavior, resulting in reduced placement effectiveness or in some cases termination of the placement. Sharing of information to inform placement caregivers is essential to effective placement planning and responses to a youth in an IPC. Most concerning is that essential information about causes of behaviour could have improved the response to young people, better prepared professional carers, and led to the potential prevention of some serious incidents. From a behavioural perspective, knowledge about common triggers of behaviour can result in placement planning that ensures the absence of such triggers or at the very least the minimization of such triggers. Poor communication about potential triggers resulted in professional carers experiencing negative, violent and dangerous behaviours by the youth which could have been avoided with careful planning and practices that reduced or eliminated triggers. The following statement from a professional carer highlights this:

> There were so many things that the social worker didn't tell us when we went into this placement. When the person is behaving poorly, they place the placement at a risk of breakdown. The young person I work with at the moment has run away several times and can make it difficult to justify maintaining the placement. Their history was running away, we could have planned and avoided it (PC2).

Visits with biological family usually occurred outside of the placement and were reported by all professional carers to be problematic in nature, with frequent behavioural problems following visits. It was further reported by all professional carers that issues during visits were not communicated back to the placement at all, with the youth in placement often being dropped off and left without a handover. Effective handover of

emotional and family problems experienced during family contact would have benefited the professional carers by assisting them to understand the reason for problematic behaviour and adjusting their responses to the young person to be supportive of their experience. Many professional carers were often uninformed of significant issues involving the youth's family, as the following statement from a professional carer shows:

> The young person in our placement went out to see his mother one day. During the visit she told him he should have been a girl and that life wouldn't have turned out the way it had if he wasn't around. The social worker had ended the visit early and didn't tell us about any of it. It was over a week before we found out what was said and we had been critical of the young person for behaving badly. That is not fair to them (PC4).

Examples such as this highlight the need for effective handovers that enable carers to support young people after access visits.

3.6.3 Manipulation of relationships between social workers, professional carers by their clients

The third theme to emerge identifies difficulties experiencedwith involvement of social workers in placement practice and the everyday life of children in Individual Packages of Care and, more specifically, how external (social worker) decisions about care and placement limits can interfere with supporting the youth with challenging behaviour to develop more adaptive or socially appropriate responses to various situations. Manipulation is the term used here and shares commonalities between a child in care who has several external supports, and a traditional family with several extended familial supports, a parallel identified in previous research (McLeod, 2011). McLeod (2011)

identified triangulation that occurs between stakeholders through relationship manipulation by the youth. Relationship manipulation is a concept that some family therapists (see Jongsma, 2007; Lehman 2010), have associated with the prevalence of maladaptive behaviour in children. This manipulative triangulation between relationships has been reported to result in the development of conduct disorder, and violence in young people (Stormshak, Speltz, Deklyen & Greenberg, 1997). Critically, the kinds of coalitions formed through manipulation are thought to undermine or limit the caregivers' ability to respond to behaviour because the youth may baulk consequences and increase maladaptive behaviour. Similar to McLeod (2011), this research suggests that in consideration of behaviour management, the externalizing of the caregiver–child relationship, because of systemic issues, reduces the effectiveness of appropriate discipline and conflict resolution when the child effectively goes to another person such as a social worker or therapist when unhappy with decisions made by the carer.

This section reports on two key subthemes that arose from the data in relation to improving the behaviour of young people in alternative care. The two subthemes comprise: 1) interference with accountability; and 2) interference with the placement process. The first subtheme shows the impact that social workers have on the professional carer–youth relationship, especially in situations that are difficult. This theme reportssocial worker dynamics and how they interfere with professional carer and youth interactions which occur when attempting to maintain the youth's accountability; this occurs by undermining professional carer authority or by eliminating boundaries and structure imposed by the carer. The second theme reports on the impact of interactions between stakeholderson the young persons sense of belonging and placement structure.

These two sub-themes show how issues of manipulation play out between young people in IPCs, their professional carers, and their social workers.

All professional carers gave examples of social workers intervening in the case of placement decisions, placement structure and behaviour management of the youth. It is not typical for a social worker to make decisions about placement structure and policies within another agency or placement as the care agency is typically tasked with the responsibility of creating their own policies and procedures as part of their IPC contract. The primary role of the social worker in a long-term care team is to ensure that the needs of the youth are being met in each life domain, including health, family connection, education, placement and identity and that further abuse or harm is prevented while a youth is in care. The role of the carer and care agency is to facilitate care through the development of practices and policies consistent with the standards that are set by Families SA (DFC, 2008). It is a delicate balance to determine where the social worker should be involved in decision-making and where the agency should be allowed to make decisions independently within the given guidelines. However many professional carers suggest that basic decisions about what a youth will wear, food, house rules and general expectations should be decided either independently of the social worker or in collaboration, not by the social worker alone. Numerous statements were made that indicated that social worker authority over decisions about the children was perceived to negatively impact upon spontaneous opportunities for children to learn from boundaries and structure through imposed consequences and decisions, to assist with their personal development, problem solving and even independent living skills such as house

maintenance or hygiene and budgeting. In this extract, a professional carer reports on the impact of involvement by social workers on accountability practices:

> The procedure in the home is to consequence the youth when they don't follow a direction. The youth constantly complains to the social worker and gives them half a story. If the social worker is not well informed about the situation it is hard to provide direction around the situation and offer effective solutions they think we have blown, when the reality is, the kid is just playing us against them. Instead of a quick response, we usually have to wait until the next day; whatever happened becomes something much bigger and much more serious (PC2).

Placement constraints such as these reduce the effectiveness of carers by removing the decision-making ability of carers during crisis and by ensuring that youth in an IPC experience care that is not consistent with youth who are in other placements. When providing placement support, the triangulation of the youth's relationships with others creates the potential for frequent involvement of the child with Families SA social workers, making spontaneous interventions increasingly difficult due to the limited time they have to respond. This former social worker from Families SA provides an example of this:

> I worked in a long-term team and had an IPC with a young person who had several conduct and behavioural problems. Despite having twelve cases this one young person consumed at least 20 % of my working time. Most of the time I would receive a call from the placement coordinator at the agency who would try to explain the behaviour and then ask me to make a decision about it. By the time that gets back to the carers the behaviour is either worse or the child feels they got away with whatever they were calling about

(SW 7).

Many participants interviewed reported that manipulation of stakeholder relationships appeared to increase the longer a young person was in an IPC, which in turn meant that professional carers were increasingly frustrated in their attempts to maintain accountability of young people in IPC placements. This frustration was thought to negatively impact and reduce the potential for the the young person to benefit from limit setting and consequences corresponding to their maladaptive behaviour, as the frustration of carers decreased their effectiveness in interacting with young people.

The following extract from a professional carer evidences the distress caused by their inability to make daily decisions about boundaries and accountability of the young person:

> There are days where I really don't see a point in holding the kid accountable. He has set fire to the house twice, carers were in it once, and nothing happened. It is irritating to say the least. I guess in the end we keep trying because that's our job, some days I wonder why (PC 13).

Frequency of involvement of Families SA in the youth's life was viewed as consistent with frequency of behavioural issues. This could be considered a cyclic phenomenon where one aspect promotes the other. Frequently, the frustration produced by external decision-making was identified by the youth and they knew that they could contact social workers when they were dissatisfied with the carer. This was evident amongst youth who were extremely oppositional and who would seek for the social

worker to change decisions made by carers or would call them to offer an alternative view of a situation. The following two statements from professional carers detail the way in which youth triangulate between social workers and carers in an attempt to manipulate the placement to their advantage. Triangulation defined here as an attempt to manipulate one care team member into conflict with another with the aim of avoiding responsibility and accountability:

> In one situation, [youth's name] was told not to come back to class due to disrupting the learning environment. We decided to keep him home for a few days. He wanted to go and visit friends and we would say can't go out and Families SA said he had to because it wasn't reasonable to leave him in the home all week. The kid knew they would let it happen and we look like the bad guys for it (PC 4).

Another carer shared their view of the problem created by a young person's contact with their social worker as follows:

> We should be able to make the decisions in the home. If the young person thinks they can make a call and change their situation, what is the point of having us in the home? The social worker isn't there to see what is happening, or the impact of their decisions (PC12).

Despite the view that children in care are amongst the most marginalized and disadvantaged (Pecora, White, Jackson & Higgins, 2009), power and balance of power issues were viewed by professional carers to increase negative opportunities for young people to manipulate and control placement outcomes and practices in an IPC. Opportunities to manipulate placement decisions frequently occurred in the form of

complaints to social workers in response to attempts by care staff to discipline the young person. Allegations ranged from carers supplying drugs and alcohol to sexual abuse and were viewed to contribute to the difficulty of the care task and lead to termination, resignation and in a couple of cases placement breakdown. A professional carer discusses how youth manipulation affected them while working in an IPC:

> Our young person had pretty significant mental health problems and frequently looked for attention any way they could get it. One carer I was working with used to smoke and the kid asked to have one during a shift, and he handed one over. Later the same night they demanded money to go out and the worker said they couldn't do that. The next day I was being interviewed by the Department about misconduct by the other carer, I knew straight away what had happened. Combine this with general negative behaviour, it can be really stressful (PC 7).

The social worker cohort described other examples of manipulation in which young people were viewed as having control over professional carers, including the refusal to attend appointments that were essential to their ongoing care. This suggests that control can be experienced in a variety of ways, resulting in placement disruption and poor collaboration. One social worker described how ineffective the IPC becomes when the youth uses manipulation:

> One of my primary frustrations with IPCs is that the carer would sometimes listen to the young person and cancel appointments or change things they weren't supposed to. In one case the result of this was that the young person did not have their medication for a mental illness and they damaged their accommodation. In the more extreme circumstances the young person would require hospitalisation (SW2).

The professional boundaries in a child's relationships with professional carers prevented effective responses to maladaptive behaviour which would have usually been achieved with behavioural management strategies such as implementation of rules and consequences that were consistent with the behaviours exhibited. The external impact on the professional carer and young persons relationship was also viewed as negatively impacting attempts to resolve relationship difficulties caused by poor attachment to the carer. Barth et al. (2005) argue that one main concern with poorly guided placement support is a painful sense of loss from not feeling closer to the youth and a fear that they will grow up to have distant and dysfunctional relationships throughout life. Barth et al. (2005) conclude that understanding children's working models of attachment security can be useful to those supporting placements but that cognisance of a broader set of influences on children's social relationships is also critical, as there is a need to recognise that there is a broader range of ways to help promote relationships which should be explored for the young people and those who care for them.

Accountability was also reported to be difficult to maintain the longer that a youth was in an IPC, as they became more aware of how to manipulate their relationships with stakeholders to achieve their own end, reducing the effectiveness of the care group as a whole. This suggests that social workers involved in IPCs should consider the impact of their involvement and work with professional carers rather than over them to improve their responses and consequently improve the relationship between carers and the youth.

The broad theme of triangulated conflict between carers and social workers and the youth also included data that described the disjointedness of the placement structure and coordination that was a consequence of this. The disjointedness and outside decision-making by social workers was identified as problematic and unsustainable. Many carers argued this made it difficult to support young people in an IPC. As an example, in IPCs in South Australia, professional carers should be supported by their agency supervior, employed by the placement agency. Despite this the practical needs of and decisions about the young person are to be reviewed and accomplished by the FSA social worker whose views and opinions could vary to those of the placement supervisor. This has resulted in the separation of placement management (i.e., the separation of hiring carers and rostering, legal aspects of care, decisions about rules for workers and the youth), resulting in further breakdown and a shift away from the typical family structure. This was reported to have caused confusion and at times stress for professional carers and youth because of the difficulty in understanding who was responsible for decision-making about various aspects of the placement.

In reality, this separation of professional carer and youth supports has increased the administration and coordination expectations of social workers while simultaneously decreased actual contact with the youth and therefore decreased social workers' understanding of the situations of children they are case managing.

> There were times that I felt all I did was make arrangements for the IPC. I had twelve other cases and at least half of my time would be phone calls to approve things, reading reports and messing with calling the agency to get things done that were not being done (SW 11).

There were examples from professional carer and social worker cohorts where guardianship held by the Department was experienced as disruptive to the placement and as preventing a sense of normality in daily life, as this professional carer describes:

> We try to make things as normal as possible for the youth. They would ask about when they would get to go to a certain place expecting us to be able to make that decision. But because this involved consent to travel somewhere outside of the placement we were not allowed to make a decision for them, we took it to the social worker and they would get approval a few weeks later. By then the youth was either disinterested or it just didn't seem to matter (PC 9).

> Every time the team wanted to do something for the youth I had to get approval from the state. Sometimes it even involved ministerial approval and this just creates a lot of red tape. The hard work is worth it in the end, but I just don't think it needs to be this hard (SW 9).

Professional carers expressed the desire to be more autonomous when it came to daily decisions such as having friends over and letting the adolescent in the IPC stay with friends. Many felt that the placement was socially limiting to the young person as this professional carer states:

> Because each IPC is considered a working environment, it is difficult to normalise the experience for a young person. We are not obliged or allowed to supervise other young people and because of this, the young person in our care misses out (PC 4).

Many participants in the professional carer cohort argued that their agency structure was undermined when the statutory agency imposed their own policies and practices on the placement. In some cases carers reported that this imposition was contrary to their own agency's policy:

> It was not a requirement for our agency to have two carers on during the day because the young person was not home. Despite this the social worker advised that this is what their Department wanted and if it did not happen the placement would be terminated (PC7).

> I have a supervisor at the agency but often felt like I had another one with the social worker. My agency tried several ways to get the social workers to back off, including only allowing contact between the social worker and supervisor, but they still called us and told us to change things, including the plans for the youth on a daily basis (PC3).

Overall, the implication of this issue when supporting young people with maladaptive behaviours presents a drastically reduced ability for carers to provide the experience of a natural living environment, where behaviours are followed by logical rules and consequences. Involvement of social workers in a disruptive and authoritative way also limit the ability of carers to work through the conflict inside the placement, and also the ability for carers to enhance their working relationships with young people. The outside influence over decision-making about the young person was experienced across the entire professional carer cohort. Finally, separation of decision-making between carer and youth responsibilities added subsequent conflict, was negatively experienced by professional carers and resulted in disjointed placement structure and reduced accountability of the youth; thus creating an issue that many carers viewed as requiring

further attention. It was also abundantly reported that IPCs increased the workload of social workers as they attempted to coordinate the many needs of professional carers and the youth being served.

3.6.4 Confidentiality

This theme points out that the rhetoric of 'confidentiality' may at times be wielded by social workers as a justification for failing to provide a history and case plan to professional carers. Social workers and professional carers were conflicted with issues of confidentiality; conflict between communication of essential information where needed to resolve incidents, versus maintaining the client's privacy and the privacy of their biological family. In many cases the Department was thought by professional carers to treat confidentiality as a greater priority than safety and placement needs of the youth. As previously noted, not being able to establish the historical or emotional context of behaviour frequently leads to behavioural incidents and occasional placement breakdown. A professional carer describes the difficulty in supporting a placement when not aware of key problems for a young person:

> Key issues arise in the placement that we should have some idea of. We later find out that the Department is fully aware and yet we are left to work through it under a blanket of confidentiality. I understand that the kid needs to be able to start again, but we aren't there to judge them, we get paid to do this, this isn't foster care. (PC15).

Some participants from the social worker cohort sought to rationalize the use of confidentiality as a reason for poor information exchange with more alarming explanations than a simple desire for confidentiality. All participants from the social

worker cohort stated that they had used confidentiality as a reason for not providing information when case plans were out of date, or were simply not sufficiently prepared for distribution. One social worker describes this Departmental shortfall:

> It came to my attention earlier on in my career as a Families SA social worker that there is an extremely poor standard of record keeping, caused by poor supervision and limited accountability. Whilst the standards stated that case plans must be updated yearly at a minimum, I had several on my caseload who had plans dating back four or more years, and even during the time that I had them, I was not able to find the time to adequately trawl through history and make them a useful document for other agencies to use as a basis of practice. Instead I was told to tell the agency that the information could not be shared for reasons of confidentiality (SW9).

During interviewing of both social worker and professional carer cohorts, all participants reported that there was an absence of a formal process for providing or accessing information. This was reported to result in interpretation of confidentiality according to social workers' personal wishes and views of what the placement needed, and how much information they actually had. Many carers reported not receiving information after being informed that no Departmental information is shared with private agencies. In some cases, professional carers reported that after persistent requests some social workers agreed to meet to discuss the history of young people and would refer to records, but would not provide copies, as this professional carer reports:

> Despite pushing for information on various things about the young person, we always got told the same things: it's not information we can share, because the law says we can't. Our social worker eventually agreed that something needed to be shared and met with our team but they still never left us anything, we had to make our own records of history

based on what we were told (PC 12).

This information suggests that practices involving the sharing of history and other information require further clarification and greater structure including defined time frames, how much information is needed and with whom the information is shared. As practice currently stands, IPC placements are significantly disadvantaged with poor information about the youth and limited ways to obtain such information. Darlington et al. (2005 a & b) have reported this to be a problem in collaborative efforts in their research. McLean (2011) also reports that failure to communicate important information effectively can in some circumstances lead to placement breakdown.

3.6.5 Control of care and decisions

Participants in the professional carer cohort frequently reported feeling controlled in relation to placement problems and decisions regarding their efforts to support young people with complex social and behavioural needs. The reported manipulation and negative interference were thought to undermine relationships between each cohort and in some cases create conflict between social workers and private agency management. Both cohorts reported feeling helpless in some situations and feeling forced into accepting things they were not comfortable with due to a lack of alternatives. These concerns were reported to impact negatively on the motivation of both cohorts as they reported that things were even more stressful to address when conflict occurred between agencies. Such conflict obviously detrimentally influences the capacity of all stakeholders to work collaboratively.

An example of the impact of such conflict and control experiences was that professional carers felt compelled to hide information from the social worker about the young person to prevent the interference of the social worker in the placement. This further exacerbated issues of control when social workers eventually discovered that information had not been reported and would then place restrictions on the young person and placement as a whole. A professional carer provides an example of the negative impact of social worker control on placements:

> There is a really bad connection with the social worker, they often make us feel like crap, because they are so critical of what we do. They call the day after an incident and want reports and all sorts of things to be provided, they don't ask if we are ok, they just tell us we should have done it better. I just want to do the right thing by the young person, they need to let us do our job (PC9).

Due to this low morale in placements, in which professional carers are limited in their decision-making, the benefit to youth of the IPC may be reduced.

Social workers were perceived by professional carers as having greater authority in placement decisions, and as being dominant in the collaborative relationship. This power imbalance was seen as affecting the placement structure and was seen in such matters as social workers' ability to make staffing decisions about the placement, deny implementation of strategies, terminate placements, and investigate carers who had been accused of misconduct. Some power imbalances were more obvious than others, ranging from subtle calls to stop a particular event from taking place, to more severe sanctions on placements restricting the movement of the youth for lengthy periods of time. It was most

alarming that social workers appeared to be able to make decisions based on how they felt about the youth, as this carer states:

> If I call the social worker about the young person, they often appear disinterested and will sometimes refuse to respond to a request simply because it is a particular client. This doesn't help the young person foster positive traits because they are treated poorly by the very people who are supposed to support them (PC3).

Another professional carer expressed concern about the impact of this power imbalance on the youth being served in the IPC:

> The kids aren't dumb, they know that we answer to Families SA and they know that anything we do can be overturned by the social worker. This just isn't helpful when you are trying to care for someone (PC1).

Power and control were primarily felt when carers attempted to impose logical structure and limits for a child and were overruled by social workers who opposed decisions or had other ideas of what was appropriate. One example of this was the refusal of the social worker to approve the carers taking a young person's game machine away due to property damage. The social worker viewed this as excessive and unnecessary, threatening to place the child elsewhere if the carers did not comply with the direction to leave the youth alone. All members of the professional carer cohort viewed social workers as being more influential than they were and were fearful of losing employment due to their contract status as a professional carer, as the following example from a professional carer demonstrates:

> The constant turnover of professional carers is not surprising, given the way in which we are treated by social workers and our own. If we say no to a shift, we are overlooked for

> the next week; if we won't stay past our designated shift we are accused of not being team players. Because the agency is under pressure to provide a service, we are also placed under pressure, which comes from the social worker and ends up on us. We work irregular hours, we don't see our friends on weekends and yet our loyalty to the young person is met with uncertainty. The pressure is emotionally draining; social workers don't realize how much control they have (PC9).

All members in the professional carer cohort gave examples of experiences where decisions were made about their youth without contacting the home of the youth, the youth or the care agency. In some cases the professional carers reported that the social worker called to say that they had discussed things with the supervisor and had made a decision about certain matters. These decisions were viewed by the professional carers to be negative for the placement, poorly planned, and interfering with the carers' ability to work collaboratively and prepare the youth for any changes in their life. Professional carers reported experiencing changes to placement with no notification in terms of the timing, information about the change or any information on how this would affect the placement. All professional carers also suggested that including them in the decision-making process would allow them to offer views and opinions consistent with their observations of the young person in their placement. An example of this problem was reported by one professional carer:

> Apparently the social worker met with his boss one day and they thought it would be a good idea to let [youth name] go and see his parents. This came completely out of nowhere and we knew that he hated them. They never asked what we thought, never asked if we knew what the youth thought, talk about disaster waiting to happen! After the

> visit he came back and said his mother had called him all sorts of names, the social worker just left him at the house for five hours and came back. Talk about protecting the kid! (PC12)

However, these issues of control were not exclusive to relationships between carers and social workers. Exacerbated by pressures from Departmental management on social workers to maintain tight fiscal restraints and where possible limit placement spending, social workers too felt controlled in some circumstances, as the following example points out:

> In the end, I gave up. After months of advocating that the young person needed more than FSA were prepared to allow finances for, I resigned myself to the fact that this was no longer about doing something, but rather being seen to be doing something. At a time when everything was about kids in motels, the best FSA could do was move them somewhere out of the spotlight. It didn't matter how good my information to the agency was, the real needs of the young person weren't going to be met, on a more for less budget. I just had to force the carers to do the best they could with the little they had (SW5).

One implication of challenges of power and control experienced by stakeholders was that the needs of the youth often became secondary to political and fiscal priorities of being seen to be doing something while saving the state money.

While most participants in the professional carer cohort viewed themselves as

limited in their control of placement decisions, others simply found alternative methods to make decisions within the placement, including not sharing information with the social worker. One professional carer felt that social worker and Departmental control could be limited by sharing only the information that would place the youth at risk if not shared, as follows:

> I knew my place as a carer, but I also had the common sense to figure out what the social worker and others needed to know. If I take away a kid's cell phone for the day, do I really need to tell everyone I did that? I don't think so, in fact, the kid respected me more for keeping it to myself, and they knew I would not get into the games and other crap (PC14).

Problems of power imbalance have been identified in previous research particularly in relation to a lack of consultation when giving directives, case management decisions, and in the form of manipulation or ommitance of referral details to improve the appeal of referrals takes place (e.g. Okamoto 2001; Scott 2005).

Collaboration requires an effort where all parties are valued by each other. When decisions are made, they should be in the interests of the common goal. In the case of IPC placements the goal is to provide ongoing care for young people. Sharing information amongst cohorts is essential to the collaborative process, ensuring that the needs of the youth are central to any action taken within the care team.

3.6.6 Resource Limitations and Turnover

Both social worker and professional carer cohorts made statements about resourcing, staff

turnover and poor staff quality as limiting the effectiveness of IPCs. Resource issues included poorly trained and unqualified carers, limited access to physical resources including furniture and other materials for the placement, and inappropriate use of time. This information is consistent with previous research which has found that poor access to resources is a barrier to effective collaboration (Darlington et al., 2005 a & b; Darlington & Feeny, 2008; Mclean, 2011).

Poor availability of adequately qualified carers was viewed by both cohorts as negatively affecting collaborative practice and placement stability. Prohibitively large social worker case loads and pressure on both professional carers and social workers, together with lengthy administrative processes, resulted in inadequate allocation of time to meet the needs of the young person for both carers and social workers. For many participants in both cohorts, responding to incidents with reports, and writing policies in reaction to incidents and investigations following incidents, consumed a large amount of time. One social worker reports:

> When I came to Families SA, I was under the impression that I would be planning change for young people, setting goals and helping them to achieve them. Every month a new form was introduced for something, another signature was needed to get something approved, and in the end I was doing more administrative exercises for the young person than helping them where I was needed. Given that, I had twelve kids on my caseload. In the context of the additional pressure of constantly keeping up with the paperwork associated with each case, it was impossible to support the young person in a social work capacity, because I was always busy doing something else (SW5).

The administrative pressures and time constraints experienced by social workers usually meant that: they only responded to crises and requests rather than assisting with ongoing planning; case planning became a distant concern; and client contact was limited due to the overwhelming caseloads of social workers. The impact of this on placements and professional carers is significant, as limited availability of social workers can increase the time it takes to respond to an incident and decrease their effectiveness as placement coordinators and carer supports, as noted previously in this chapter. This can undermine the overall effectiveness of IPC placements as a professional carer states:

> On a daily basis we are faced with challenges from our clients. I have lost count of the number of times that the social worker has simply not been available to assist with these challenges. We have team meetings about problems, but we end up talking in circles, because the social worker isn't there to suggest a way forward (PC 11).

Staffing, time and caseload pressure contributed to professional carers feeling disconnected from social workers due to the lack of consistent and proactive support of the placement. This lack of connection was also felt by social workers who reported that they felt they only had an understanding of the negative behaviours of young people in an IPC and not of their progress, as one social worker argues:

> If my caseload was half of what it was when I worked at Families SA, I could easily have achieved far more. Even when the IPC was implemented, it was a struggle to keep up with the daily needs of the youth. Most of all, if I had a smaller caseload I could have planned for each young person's future. Unfortunately this was not possible as I was constantly meeting the immediate needs of many, instead of the long-term goals of a few (SW7).

Little time, high caseloads, and frequent responses to crises, fiscal restraints on IPC placements meant that professional carers could not engage youth in typical activities without social worker approval, or seek any form of mental health or physical treatment without consent, increasing the bureaucracy of the placement and decreasing the sense of normality for the youth, as these professional carers explain:

> When I turn up to work and there is nothing to do but sit around with the young person looking at me whilst I look at them because we have to get approval for everything else, it suggests that something is wrong with the way things are being done. While I don't know what the goals of the placement are, I do know that they should be living normally where possible. It isn't normal for a young person to sit in a house and do nothing every day (PC19).

> While I try my best to be positive about the IPC, there are some things that just don't make sense. Take for instance the need to call the social worker before taking the kid to a medical appointment. I mean seriously, they are sick, what are they going to do, say no? Often they would say they didn't want to pay for the carer to stay during the day when the young person was supposed to be at school, so they would tell us to send him anyway. Money or needs of the kid, that's what that was about (PC 13).

Fiscal, time, and caseload constraints were reported to create a demanding work environment in which social workers were unable to be flexible in their response to placements, and instead were responding to constant crisis. Gilbertson and Barber (2003) report in their study that children now enter care with far more complex needs than ever before and such needs require more time and resources to be resolved. The following

statement from a social worker confirms the complexity in providing services to young people in an IPC and the difficulty in providing more than a crisis response:

> Regardless of the placement type, the young person in the IPC was always time consuming. The very reason for the IPC was because of the young person's difficult to manage behaviour. The Department needs to realise that this has flow on effects to case managing the client, which I think was overlooked when we were given a numerically equal number of cases to everyone else in our office, despite the placements being more difficult to manage. Numerically one IPC can be worth several typical placements (SW13).

Resource constraints create a significant challenge in managing IPCs. Planning becomes a secondary priority to frequent immediate crises due to the conflicting demands that each presents on the time of social workers and professional carers. The implications of poorly resourced collaboration include: substantial delays in social workers responding to non-emergency requests; confusion about future direction; and a constant state of placement crisis in which relationships between all parties are strained and difficult to maintain.

Issues of staff turnover reported by the participants included the recruitment of professional carers who had little background in live-in care of children and in some cases very poor communication and social skills. This often meant that even when IPC placements were available, they were not staffed in a way that best met the needs of young people. This social worker describes how difficult it was to establish a placement with suitable staff:

> It was a huge concern to me to be told that I needed to shift this volatile young person into a placement that I had no idea about. Central office managed the whole tendering process, and with it, the case management function of transition. This was done by people without social work skills, or those who had been out of direct practice for some years. In the end what was happening was quite political, we were asking for services, the agency would price them, they would be told by FSA executive to do it for less, and in the end a standard no frills Service Agreement would be drawn up for most of our kids. Carers were hard to recruit and in the end agencies will take anyone to keep a contract. With this smoke and mirrors method of placement acquisition, I feel strongly that the best carers were not always a priority (SW3).

In another example, the care agency was sometimes required to push their care staff to do extra shifts while they acquired extra staff due to the short notice of new placements. The limited time frame impacted professional carer morale and ability as they were severely overworked and under immense pressure to keep placements functioning. This social worker describes the problem:

> The immediacy of the placement implementation often meant that the care agency did not have the staff to manage it, and were forced to over utilise the staff that were available. This was a cost issue for the care agency because they paid employees with funds provided in the package of care and unless they had a package to employ into, they didn't have funds to recruit carers. This perpetual cycle of need created substantial problems as we couldn't take packages without staff, but couldn't employ staff without funding for packages (SW11).

Professional carers spoke about the difficulty in frequently addressing negative

behaviours with the youth in the IPCs. Behaviours ranging from threatening behaviour, property damage and self-injurious behaviours were reported to have a heavy impact on their desire to care, and many reported that placements experienced frequent turnover of staff as a result of their lack of ability to cope with the severity of behaviours. Many carers felt that the behaviours experienced were beyond the scope of any carer's ability, yet despite this carers reported having to cope with such behaviours and 'survive' the placement. The perception of unrealistic expectations of professional carers was discussed by one professional carer:

> I get spat on, sworn at and argued with on a daily basis. In return for this I am offered a week by week roster and have no guarantee that I am going to remain employed. If the young person does the wrong thing, an entire team of people are out of work (PC 12).

Participants in the social worker cohort confirmed that professional carers turned over frequently due to an inadequate level of skill in addressing placement needs and more specifically, severely maladaptive behaviours by the youth. As one social worker explains:

> Two things are happening here, the kids in these placements are tough to deal with, real tough, and many of the carers being recruited are unskilled, simple as that (SW 2).

Staffing issues in IPCs were reported to hinder successful collaborative work. Frequent absences and the unreliability of some professional carers, the use of rotational rostering, and the use of casually contracted professional carers and short term carers led to poor connections between youth and carers and increased the difficulty of establishing and maintaining communication amongst professional carer and social worker cohorts.

The problems resulting from employment of short term, casually employed carers included difficulty in establishing long term relationships that were collaborative in nature and intended to meet the best interests of the young people in ICPs. A combination of these staffing problems and constant crises in placements resulted in poor communication between Families SA and the agencies. This statement from a professional carer illustrates the distress that is created by issues such as inconsistent rostering practices and difficulty experienced by carers in contacting social workers between shift changes:

> It can be really hard sometimes between shifts to get in touch with the social worker. It can be weeks before I get to communicate what I need to. We have shift logs, but our agency just fills them up and puts the next one down. I would like to see this change, otherwise, what's the point in the job? It makes me feel frustrated and unmotivated (PC 19).

One social worker identified how collaboratively resolving incidents was difficult which contributed to frustrations that could lead to turnover of social workers:

> It was always difficult to resolve incidents, carers would tell me they couldn't do certain things and so I would have to try to find alternative ways to deal with problems. In the end I felt like I was doing more work than the carers and I can say it was a factor in why I left (SW4).

Issues such as that cited above were compounded by high staff turnover, as the following social worker indicates:

> I felt at times like I had to get a clear picture of the carer's knowledge and ability before

> deciding how to respond. At least monthly a new worker was coming into the placement. Despite the placement being the same physically, it felt at times like a new placement with the amount of changes in carers (SW 11).

Social workers reported that monthly meetings appeared to duplicate each other for the benefit of new professional carers and appeared to be focused on informing them about the youth. Both social worker and carer cohorts reported that meetings rarely involved planning due to frequent crises and the need to debrief and move forward. One carer who had served a placement for several months makes this observation:

> Our monthly meetings were usually an introduction of new workers and a discussion about what the kid is like and how much he's going to put them through. We would always talk about how to handle the bad stuff. We couldn't plan because the meetings usually got sidetracked with these new people (PC9).

It is argued that turnover of staff contributes to poor cohesion of the care team, reduces the ability to plan, and decreases the effectiveness of IPC placements. It could also be argued that when care teams have ongoing turnover of staff it is difficult to achieve placement stability for the youth. McLean (2011) suggests that collaborative efforts are difficult to maintain when staff are on contracts because they are not part of the long-term plan, this creates uncertainty for the young person, and does not support a commitment from professional carers or social workers. It is argued that if job stability was promoted through longer terms of employment, staff in both cohorts could be encouraged to invest more effort into their jobs on a daily basis. Encouraging staff in both cohorts to stay promotes familiarity with behavioural problems and the ability to be

forward focused. As McLean (2011) suggests, improving outlooks for young people by creating long-term relationships between professionals is essential to developing effective collaboration.

3.7 Summary

The findings presented in this chapter suggest many of the difficulties faced by both social workers and professional carers in maintaining collaborative working relationships in regard to Intensive Packages of Care for youth in South Australia. These difficulties include several key themes of which the most significant appear to be: 1. Manipulation of the care team by the youth in the placement; 2. Separation of decision-making and care caused by poor placement structure; and 3. Poor information sharing throughout the placement preventing efficient and positive service delivery in many situations.

Both professional carer and social worker cohorts reported that manipulation of care staff by the youth is a significant problem in an IPC. Repeated 'playing off' of stakeholders against each other in the practice of packages of care limits the ability of the IPC to effectively address behavioural deficits through consequences and support of the young person. The ability of the youth to directly report to the social worker in response to negative events in a placement provides an opportunity for the youth to gain significant control over aspects of the placement that are not helpful to the development or safety of the youth. It was reported that youth in IPC placements may avoid consequences in some cases when their version of events is either believed or accepted by the social worker, decreasing the effectiveness of the professional carer/youth relationship, but increasing

the amount of maladaptive behaviour exhibited by the youth. Participants from the professional carer cohort were in agreement that the longer a placement had been established the more frequently manipulation occurred. Many carers reported giving up on disciplining and consequencing negative behaviour which subsequently reduced the effectiveness of the placement.

Through an increase in interference in placements by social workers, the ability of professional carers to assert any positive control over the placement was limited by the need to seek approval for most decisions from the social worker. This was reported to result in significant delays in meeting the social, personal and physical needs of young people and further impacted the effectiveness of the placement. It is essential to understanding the care dynamic to know that when Families SA has guardianship of a child, they have primary responsibility for the care and any harm to the youth. It is therefore vital for carers to accept that issues of safety, health care and anything that could result in care concerns still require decisions by the social worker who represents the government.

Finally, poor exchange of information was considered to be a significant barrier to collaboration. Information about previous incidents and behaviour management strategies arising out of these events are essential to the success of IPC placements. Information about past history is essential for professional carers in order to assist them in structuring services in a way that is sensitive to the young person's past and in a way that accommodates the behaviours that may arise as a result of past abuse or negative

experiences. Failure to make information available or failure to communicate it when it is most needed has led to placement breakdown and significant behavioural problems, influencing the effectiveness of the IPC by increasing the tension between professional carers and the youth they serve. The withholding of substantial information about behavioural histories creates risk of harm through a lack of preparedness of the care team.

Problematic human resources arrangements, including short term contracts and temporary employment, resulted in instability of the care team which in turn affected the consistency of care as youth attempted to work with people on personal change including behavioural improvement. IPCs operate in a climate of job uncertainty, which adds to the overall stress of working in a potentially hazardous and stressful environment. The detriment caused by theidentified barriers in this study that result from differences in philosophical, practice and organizational frameworks demands further analysis. Negative views and experiences of the other cohorts involved are concerning in terms of this leading to inability to trust and accept the role of other groups, and could be considered significantly detrimental to the collaborative process. Blaming professional carers for placement failure or problems is counterproductive to the purpose of the placement. Differences can be considered as beneficial as commonalities as they improve the dynamic function of a collaborative group through unique contributions. For example, a carer may bring one skill to the placement that a social worker does not have and the social worker can engage in thinking outside of the scope of care to provide unique input.

The results of this study are reflective of the unique challenges that are faced in

the implementation of IPC placements. Findings from the study suggest that collaboration remains essential to effective interagency work, but suggest that there are many challenges that need to be addressed to improve the collaborative response to youth in an IPC. Different conceptual understandings about behaviour are likely to exist in different stakeholder groups. Given the importance of responding to behaviour consistently and with unity between cohorts it is important to have a shared understanding of each other's conceptual framework to enable discussion of behaviour in an IPC without bias towards one's own view. This demonstrates the need to examine behavioural understanding between cohorts in terms of the experience of challenging behaviours in IPC placements. In response to this need, the next chapter will provide an analysis of professional carers' and social workers' experiences with and understanding of difficult behaviours.

CHAPTER FOUR

Views and Approaches to Challenging Behaviour

4.1 Overview

The last chapter documented several examples of limitations and problems that can negatively impact the ability of various stakeholders to collectively and individually manage maladaptive behaviours. Critical to understanding the complexities of IPC placements was the emergence of differences in understanding of behaviours and subsequent frameworks for addressing the behaviours and needs of children in an IPC. Specifically, the knowledge of caring for young people and approaches to care of professional carers were viewed negatively by those in the social worker cohort. The professional carer group was seen to have a different (and poorly formed) understanding of the management of behavioural problems of youth in care. Such differences create tensions between stakeholders and become problematic when they harm attempts to be collaborative in caring for young people (McLean, 2011). Both cohorts expressed a strong desire to improve collaboration by being assisted to understand each others organizational policies and practices, and by enabling a more cooperative and functional relationship which takes into consideration both similarities and differences and ultimately leads to a better response to the young person in care. This chapter will identify the commonly experienced challenging behaviours in the social worker and professional carer cohorts. It is anticipated that the presentation of these accounts will

promote better understanding of the differences between participants involved in IPC placements.

The literature identified in Chapter 3 indicated a lack of common language and understanding as an ongoing concern in interagency practice (Darlington et al., 2005a,b; McLean, 2011; Salmon, 2004; Salmon & Rapport, 2005). Poorly structured and opposing reasoning for maladaptive behaviours can also be implicated as a cause for ineffective management of young people and their needs. This chapter analyses the accounts given by participants of challenging behaviour because it is argued that an individual's understanding of behaviour may influence the way in which they address it, their motivation to support change in behaviour, and the interventions used to support a youth in an IPC. Views related to working collaboratively, including individual responsibility for behaviour management and the importance of working collaboratively (e.g., Darlington, Feeney and Rixon, 2005, a,b; McLean, 2011), may be impacted by the understanding an individual or cohort has of challenging behaviours. Stakeholder beliefs which are heavily influenced by their individual profession can be shared with other cohorts to achieve a common language about behaviour management practice (Hall, 2005). This chapter alsocomapres and contrasts the most common accounts of participants with previous research that considered theoretical and practical understandings for behaviour management strategies with youth in care.

4.2 Previous Literature on Collaboration in Behaviour Management

Behaviour management requires a collective approach if it is to be successful (Darlington

Feeney & Rixon, 2005 a). The literature reviewed indicates that there are many considerations to be taken into account when working with others to improve behavioural outcomes for youth. Differing standpoints, evaluations and professional opinions all have an impact upon the effectiveness of behaviour management.

4.2.1 Impact of Differing Professional Standpoints

Each professional views behaviour differently to another and this can impact approaches to behaviour both collectively and individually. A substantial amount of research indicates that factors including identity and culture can result in differing practice frameworks (Worral-Davies & Cottrell, 2009, Van Eyk & Baum, 2002, Darlington Feeney & Rixon, 2005 a, b). Such practice frameworks may also include underlying assumptions about the cause of challenging behaviours, how they are most effectively addressed, how well outcomes are achieved, and which key stakeholders should address the behaviour or make decisions about it. Stakeholder differences, for example, have been examined within interagency placement settings (e.g., Barber, Delfabbro & Cooper, 2004; McLean, 2011).

Hall (2005) argues that a significant barrier to stakeholders collaboratively supporting behaviour change is that different professions have different "cognitive maps", and two disciplines can look at the same issue and see two completely different things, including behavioural needs and level of success. When examining the responses of both professional carer and social worker cohorts in the present research, this point about cognitive maps is an important factor to consider as each cohort arguably

approaches behaviour with a different cognitive map. Darlington, Feeney & Rixon (2005) argue that another difference which contributes to varying views about behaviour and its management is the organisational culture. The impact of group membership to attitudes and approaches to practice has not been adequately studied in the alternative care sector; however, one South Australian study (McLean, 2011) suggests that it can be a significant barrier to successful collaboration when there is significant disagreement about what constitutes negative behaviour and how it should be addressed.

A qualitative investigation by Richards and Vostanis (2004) suggests that identity and membership are influential in a service provider's view of a problem and how behaviour is understood. Their study comprised 39 participants who were a combination of managers and practitioners and reviewed service for adolescents with complex behavioural problems. Their findings suggested that communication between services was variable and often inconsistent agreement about the cause and nature of behaviour contributed to this. Worrall-Davies and Cottrell (2009) similarly suggest that different professional groups view mental health and behaviour through completely different models, attributing the cause of behaviour and emotional difficulties in children to different causes and, as a result, approach the treatment of such behaviour differently. Roach-Anleu (1999) suggests, for example, that social workers tend to gravitate towards social and external factors as contributors to behaviour, while psychologists focus on the cognitive functioning of the individual when exploring behaviours and how to address them.

4.2.2 Impact of Differing Evaluations of Problem Behaviours

There are substantial differences in opinion about what constitutes problem behaviours as issues such as tolerance, personal views and professional understanding of behaviour all impact the assessments that various stakeholders make. In most instanced all stakeholder groups, overlook the severity of mental health and behaviour problems in adolescents in care. foster parents(Halfon et al., 1995) Residential workers (Hillan, 2005) to name but a few, have all been documented as under-acknowledging the behavioural issues of young people in care (McLean, 2011). Poor knowledge and training of stakeholders and a severe shortage of mental health services have been suggested to contribute to the under-reporting of behavioural problems and mental health needs (Gilbertson & Barber, 2001). There is also an under-representation of trained professionals in the welfare system in South Australia (Layton, 2004), potentially increasing the difficulty of communicating mental health and behavioural needs between stakeholders. A contextual examination of behavioural understanding for each cohort involved could improve the overall understanding of the challenges that occur for the care team when identifying, experiencing and addressing negative and complex behaviour as a collective.

In addition to the potential impact of low levels of training on mental health issues, the willingness of any professional to engage with challenging behaviours can also be impacted by the theories that underpin their profession (Hutchinson, 2003). For example, person-environment is one of the theories that underpins social work practice. This theory offers an explanation of challenging behaviour by suggesting that the environment is dynamic and has an influence on an individual's ongoing behaviour

(Altman & Rogoff, 1987). Attributions such as these may influence the professional's view of whether an individual is changeable or not (Dagnan et al., 1998; Rose, Horn & Hastings, 2004), they may de disinclined to assist the client when they perceive that the young person has greater personal control over their behaviour and negative affect (Stanley & Standon, 2000).

When considering organisational, professional and individual understandings of behaviour and its management, it is reasonable to postulate that stakeholders may hold differing views and beliefs about what is occurring and what is needed when managing challenging behaviours. It is also reasonable to conclude that differing views and beliefs influence daily practice in relation to running an IPC – such as methods of behaviour management, willingness to continue with caring for a young person in an IPC, belief about the ability of the young person to change, and the individual's understanding of what is causing or contributing to the behaviour. As outlined above when discussing previous research, these factors may be influenced by professional training, organisational policies or professional theories that underpin each profession (McLean, 2011; Sheehan et al., 2007) including imposed views and implicit assumptions about behaviour, its cause and how to address it. The findings presented below show how the South Australian cohort of professional carers and social workers in this study accounted for challenging behaviour, and report on six distinct understandings and explanations of behaviour.

4.3 Analysis and Themes

The analysis presented below identifies common accounts of behaviour presented by both

social worker and professional carer cohorts, including the similarities and differences in each cohort's account. This chapter considers how an account of behaviour might indicate different things for a youth in an IPC, including responsibility for maladaptive behaviour and who is responsible for assisting the youth to change their behaviour. A thematic analysis occured as detailed in Chapter 2. Data were collected from the interviews with all participants in the social worker and professional carer cohorts. It is noteworthy that while the social workers and professional carers were not in agreement on all aspects, some of the time they shared consistent views, demonstrating that despite differences in professional roles, not all views were exclusive to a particular cohort, rather they were often completely independent. The analysis produced six themes, reflecting the common views held by participants in the social worker and professional carer cohorts regarding the behaviours of adolescents in alternative care. These were:

1) Behaviour is influenced by the environment
2) Behaviour is used to control others
3) Placement experiences impact behavioural choices
4) Behaviour is influenced by change
5) Behaviour is influenced by emotion
6) Behaviour reflects the client/caregiver relationship

Each theme is addressed individually and interview responses will be used to illustrate each finding.

4.3.1 Behaviour is Influenced by the Environment

This first theme reflects stakeholder views of how challenging behaviours develop and are maintained, and includes influences ranging from placement breakdowns, treatment by significant figures in a child's life, responses to behaviour and other environmental influences. Accounts in this theme identify origins of maladaptive behaviour in terms of environmental phenomena and modeling of behaviours by significant people present in the life of the youth. It was concluded here that the responses reflected a belief that maladaptive behaviour is influenced; either by the encouragement of unacceptable behaviour or poor modeling of acceptable behaviour to the youth. In some participants' accounts, this learning of inappropriate behaviours occurred in placements, in addition to birth families. According to these accounts of how maladaptive behaviour develops, the combination of frequent placement changes and lack of support meant that the youth had simply used negative behaviour to have some form of control. The following extract from a social worker's interview describes this view:

> I believe it is because he has been through so much rejection with nine placements, he thinks there is no point in trying. It's not that he doesn't want it to work out, but he thinks it won't because nine placements have told him that it won't, so he tries to prove that the carers in the IPC will let him down by behaving in way that proves they are not committed (SW 4).

Similar to those in the social worker cohort, those in the professional carer cohort considered the young people's behaviour a result of poor social boundaries and lack of structure in past placements (i.e., environmental impact), as this carer argues:

> The social worker constantly refers to the kid having a poor placement history and other

> crap. Bottom line in the other places just didn't know how to handle him and now he is messed up. There is nothing to understand, he behaves badly because he chooses to, this placement is not going to allow him to behave poorly, end of story (PC9).

There was mutual concern expressed amongst stakeholders about the impact of instability of placements on a young person. Despite different reasons for the concern, both cohorts agreed that placement instability negatively influences the behavioural development of the youth. One specific concern related to the lack of consistency that the youth had already experienced in behaviour management and how this may impact the youth's desire to make positive choices. Participants expressing this view felt that behaviour was extremely difficult to manage and control after prolonged placement disruption and constant changes to the youth's care environment. The lack of consistency in approach, created an environment in which the youth felt confused and in some cases confrontational. The following extract from a professional carer points out the impact of this problem:

> After nine placements our young person would constantly say, I don't have to do that, none of the other families made me do that, or, you can't make me do that noone else did. It can be very draining trying to get them to conform to a consistent set of rules especially when their lives have been so inconsistent. I think the staff in the IPC do a pretty good job of being persistent in getting them to follow rules (PC5).

Participants in both cohorts reported that their belief was that young people had experienced such frequent environmental change that they chose to not conform to future environments. This was because past placements either lacked the skills to respond to the

young person effectively, or there was inconsistency in how stakeholders managed the youth's feelings and subsequent behaviour. Accordingly, the need for clear structure and expectations, together with a strong commitment to the care of the youth, was viewed by participants in each cohort as an appropriate means to encourage positive change, as illustrated by this professional carer:

> Our team is committed to the young person, the rules are in place, we have expectations of them but we don't give up because they don't meet them. The advantage of being part of a team of carers is that we get to collectively respond to the youth and when we have a hard week we still get a break. We keep our end no matter what; I think that is a key difference with the IPC (PC 11).

Participants in both cohorts viewed negative behaviour as learned through exposure to negative behaviour and lack of modeling of positive behaviours. Some participants explained that their youth learnt to use negative behaviour by being exposed to the modeling of such behaviours in daily interactions in previous placements, predominantly with previous caregivers (including their birth parents), as this professional carer explains:

> Our youth came from very abusive homes, aggression, yelling, hitting and threats were frequent and expected by the youth. It became so normal for them that it was the way they responded to everything, by the time we got them in care; it became an expected response to everything in the first few months (PC15).

Participants viewed challenging behaviour as occurring in equal but opposite proportion to the boundaries and structure of past and present homes and the absence of the presence of positive role models in the youth's life. Young people were viewed as

having a maladaptive or inappropriate view of acceptable behaviour that would only changed through a structured placement and corrective behavioural strategies. Those in the professional carer cohort expressed that they felt that this is best achieved through a supportive and positive care experience. In other words, problems in behaviour resulting from *negative* environments could only improve through the modeling of appropriate behaviours in *positive* environments.

Another form of environmental influence reported by stakeholders occurred in the interaction of youth in ICPs with behavioural concerns with other 'maladaptive' youth. All professional carers expressed that this interaction exacerbated negative behaviours, by increasing youth engagement with mutually negative examples of behaviour. One social worker described the concern of bringing youth together from other placements to interact within the care agency:

> I'd often hear about activity days where the young people in an IPC would get together. I understand the need for care to be normal, but these kids just get together and behave badly. I agree socialization is essential for young people, but this is not it. The end result is collaborative antisocial behaviour, one youth was arrested doing something with another youth. The message that gets sent is that we want you to know you have a place here no matter how badly you behave. That's positive in one way, but the message also needs to convey that positive behaviour is more desirable than negative (PC4).

This extract supports the view that inconsistent or inappropriate relationships and environments are negatively influential on a young person. This is also broadly consistent with a psycho-social perspective in which consideration is given to person-in-

environment as an ongoing process that facilitates or blocks one's ability to experience satisfactory social functioning. Accordingly, this account resonates with psycho-social paradigms of behaviour arising from environmental experience (Hepworth et al, 1997). According to this theory social learning is not thought to occur individually, rather, it is thought of as emerging from interaction with the individual's environment which includes those around the individual.

Participants who shared views and experiences consistent with this theme suggested that some behaviour is the result of the failed behavioural management method operating in past and current care environments in which the youth have been for varied periods of time. An implication of this is the understanding that behaviour change arises when the environment that a youth interacts with is free of relational conflict and stressful transitions and includes exposure to appropriate adults who emphasise and encourage appropriate behaviour. This is also consistent with social learning theory (Bandura, 1986) which suggests that a combination of environment and cognitive processes can lead one to learn behaviours both positive and negative, suggesting that if the environment and interactions are negative, then the behaviour has greater potential to be negative. The participants who held the view that environment influences of behaviour present an optimistic explanation of ways to change behaviour, given the enormity of the task of teaching an individual to unlearn one behaviour while replacing it with another. Participants who favoured this theory of behaviour as environmentally influenced may be more likely to utilise a structured and consistent behavioural approach to addressing the difficulties surrounding challenging behaviour.

The participants who responded to this theme suggested solutions to maladaptive behaviours are best understood in terms of the way they assist the youth to interact with their environment in a manner that promotes pro-social behaviour. The applicability of using person-in-environment approaches with young people who have been abused or neglected in particular, to date has not been comprehensively examined. However, this theory does assume that individuals are influenced by the relationship that they share with their environment or other people (Hepworth, Rooney & Larsen, 1997), and does not restrain change to the client themselves (Hutchinson, 2003). It also does not rely on the client's behaviour being seen as normal or abnormal (Germain & Gitterman, 2008). Rather, it relies on behavioural strategies which consider the improvement of the relationship between the client and those around them or their environment. Despite agreement amongst stakeholders that person-in-environment is an important consideration for the care of a youth in an IPC, there was some notable disparity in views about how the environment can engage in relational conflict. Participants from the social worker cohort viewed the interaction of other youth in an IPC as problematic and negative, while carers encouraged the interaction for socialization. The theory supports socialization with 'positive' influences, suggesting that the dilemma is in defining whether or not mutual support and interaction provided by other youth in an IPC can be considered positive.

4.3.2 Behaviour is used to Control Others

Accounts of behaviour discussed under the theme, 'behaviour is influenced by environment', suggested that maladaptive behaviour is influenced by the relationship that

young people in care share with their environment including others around them. In contrast, the findings in this theme demonstrate the individual purpose of negative behaviour. Participants in both cohorts suggested that negative behaviour is purposeful on the part of the youth. The examples presented in relation to this theme identify behaviour as functional for the youth; essentially the findings suggest that behaviour is used as a means of control that the youth does not have without such behaviour. This theme is considered different from the previous theme because of its focus upon behaviour as purposive rather than responsive. The following extract from a professional carer exemplifies how maladaptive behaviour can be purposeful:

> So many times the kid has called the social worker because they want to get someone into trouble. They do it because it gets them what they want. The social worker will call and ask why we aren't doing something; this sends the message that the behaviour is going to get them what they want. (PC8)

In the above example, the youth's behaviour is attributed to conscious choices leading to the behaviour. Essentially, this implies that if a youth can be shown or taught other means to achieve their end then they will be less inclined to engage in maladaptive behaviour.

While all participants described behaviour as purposeful in some cases, some participants emphasized a difference between behaviours that were deemed conscious and those that were deemed unconscious. One example of this distinction was found in the discussion of self-harm. Self-harming behaviour was viewed by some to be a conscious decision to manipulate the placement; in which case the behaviour's purpose

was to gain the attention of professional carers or to seek emotional support from others, such as is reported in the following extract:

> It was pretty obvious that the young guy was deliberately hurting himself to get attention, running out to the main road and tying a belt around his neck so the public would call the police. One time he cut himself and ran around the street yelling that he was going to die. The message to us was that he didn't want to be in the house and that he would harm himself until he was allowed to go somewhere else (PC2).

In the above example, self-harming is seen as a conscious attempt to gain control of the care team, which escalates into more dangerous and injurious behaviour and therefore becomes disruptive to the placement. However, this same professional carer offers a different understanding later within their interview to explain the same behaviour of the same adolescent in a different scenario:

> My experience was that he (youth) would normally self-harm following an incident at the house or when he would be told he couldn't do something. It was almost like he made this his automatic response to everything. I mean it still didn't give him what he wanted, but it did control the placement (PC2).

In this second extract, self-harm is viewed as habitually and ritualistically engaging in injurious behaviour. Therefore, there is a degree to which it is unconscious (or at least less consciously intended as a form of control) when compared to the previous extract. Yet in both examples the behaviour of the young person functions to exert control over what is happening around the youth and/or those who engage daily with the youth, and whether conscious or unconscious, the issue of control is still at stake here.

Other participants also agreed that some behaviour is aimed to control others but they struggled to categorise whether this was conscious or unconscious. This point about whether participants viewed behaviours as consciously or unconsciously aimed at control is important, as the attributions that people make about why particular behaviours occur may impact their willingness to continue their helping role when they feel that behaviour is intentionally aimed at control (i.e., they may believe that controlling behaviours should be ignored, rather than responded to).

Despite claiming that the youth in their care knew the difference between positive and negative behaviours, all participants reported that there were times when the youth were unwilling to respond differently. This intentional refusal to engage other skills was thought by many participants in both cohorts to contribute to deliberate negative behaviour in situations, as this social worker suggests:

> They know it's wrong, they often tell us after that it is. The problem is they still make the choice to hit, punch, kick, spit, because they know it will control things for them or at least give them a sense of control. Since the kid has come into placement though, we have worked on replacing that behaviour with statements of feelings, giving them alternatives, even sometimes just walking away. It's easy to see that they behave the way they do by choice, because they don't have a bag of skills like many other people do (SW 9).

This view points out the complexity of caring for a young person with challenging behaviours, particularly with regard to the cause of their behaviour as expressed in conflicting accounts about purpose, control and ability of the youth regarding the

maladaptive behaviour. In relation to this theme, participants emphasised that they understood that the behaviour was aimed to control those involved in their care. Given the extreme nature of some of the behaviour, including self-harming, fire lighting and running away, participants from both cohorts found the behaviour to be both frustrating and stressful, given its frequency and the lack of change. Some participants viewed the behaviour as more frustrating when it was assumed that the decision to engage in the behaviour was conscious or planned. The perception that maladaptive behaviour was the youth's way of controlling their circumstances and communicate dissatisfaction with conditions in the home or with staff was also evidenced by the views presented. The IPC responded to this, behaviour, according to participants, with structured behavioural strategies that encouraged positive change, as this professional carer indicates:

> Any change that we try to encourage in the young person is usually met with hostility and sarcasm by the youth. With the ability to rotate carers consistently through a roster, work as a team, and professionally train to change behaviour, we can respond constructively to the resistance. In one case our team taught the young person to stop running away and use safer options like going to their room journaling and coming back when they were ready to discuss things. It isn't consistently experienced that they behave that way all the time, but it is better than it was and I think this is success in an IPC (PC11).

4.3.3 Functional Behaviour Perspective

Psychological interventions in which the function or purpose of a maladaptive behaviour is considered suggest that challenging behaviours serve a purpose for an individual (Brown & Brown, 1994). These include the achievement of influencing outcomes (e.g., control), avoidance of required tasks, or sensory stimulation (Emerson, 1995). The functional behaviour perspective, as it is known, focuses on intervention with

two priorities: 1) an understanding of the youth's purpose for behaviour and 2) the provision of a direction for the professional carer to respond to the behaviour. The following view of a professional carer suggests what works in IPC placements when a youth uses negative behaviour to control a situation:

> The kid is street smart and doesn't want to change. If change is going to happen, we have to understand what the behaviour is helping to achieve now, we get that, we can trigger the change by giving them something, anything else that is positive to meet that need (PC5).

The following view of a social worker also provides insight into this theme as they describe the way in which they address challenging behaviour:

> They have been through so much in their lives, they are tired, lonely, distressed and angry, many negative actions are attempts to control their situation. I keep that in mind when trying to help them, because the better I understand them and the fact that they are behaving a particular way to gain control of their life and situation, the better I can meet them where they are at to champion positive change (SW6).

All participants who contributed to this theme placed high importance on the need to assist youth in an IPC to find alternative ways to communicate their feelings of helplessness and desire for control. This has not been explored in the evaluation of professional foster care previously. One complication in using functional approaches in managing maladaptive behaviour arises when the behaviour is aimed at achieving multiple outcomes, including removal from placement, attention, and control over the situation (Brown & Brown, 1994). For example, self-harming may allow the youth to

both leave the placement and gain attention from those around them. Multiple negative behaviours, hitting, breaking things, running away could be linked to the young person's attempt to gain control over their placement. Careful consideration of the motivation for behaviour as well as the extent of the behaviour should occur before making any attempts to address it.

In summary, the notion of using behaviour to control others is a dominant perspective in which behaviour is viewed and experienced. Purposeful attempts to control through maladaptive behaviour creates a hopeful outlook for the possibility of behavioural change. The above account or attribution of behaviour could appeal to stakeholders' ongoing desire to validate and explain behaviour that may otherwise seem irrational and inexplicable. Yet, as noted above, when issues of *intentional* enactments of control are emphasized, this can be to the detriment of understanding the multiple causes of particular challenging behaviours amongst young people.

4.3.4 Placement experiences impact behaviour

The previous theme viewed maladaptive behaviour as a purposeful attempt to control the environment and those around the youth, by both consciously and unconsciously engaging in negative behaviour. Alternatively, participants within both cohorts offered other explanations for negative behaviour. The explanation or view of some behaviour within this theme suggests that behaviour is influenced by the dynamic of the placement itself and the consistency or lack of consistency of the care team. All participants suggested that some of the time the youth were permitted to engage in negative behaviour by other carers while at other times some carers were so restrictive that the youth

engaged in negative behaviour to push back. As the following professional carer explains:

> Some weeks I would work with a carer who sat around and did nothing. I'd step out for groceries or other things and come back and the youth would be outside smoking with the other carer. Other times, another carer would chase the kid around the house and yell at them. The response was always yelling back and that just doesn't help (PC 8).

Baumrind (1971) describes three parenting styles: authoritarian; authoritative; and permissive. The authoritative parenting style is considered the most desirable approach to discipline because it balances authority with reinforcement and nurturing. When those in care are cared for with a permissive parenting style they are viewed as cheerful, but have little impulse control, are unreliable and have low levels of self-reliance as they demand things from caregivers. Children under an authoritarian parenting style become hostile and moody and have difficulty managing stress (Carey & McDevitt, 1995).

The conflict between permissive and authoritative care styles was also observed by social workers and professional carers as the following social worker and professional carer report:

> It wasn't that the team wasn't working well together, but the kids knew when we said no, the social worker would want to restrict them so we would be faced with the problem of trying to reward behaviour with limited ability to find a flexible balance (PC6).

> What the carers didn't get was that I couldn't just say yes to everything. They wanted the kid to be able to hang out with adults that I had no idea about. We are responsible for the

> welfare and safety of these kids, I would rather be cautious than have them end up in trouble or even hurt (SW12).

Social workers being authoritarian was seen by many in the professional carer cohort as representative of the Department, as the following professional carer suggests:

> I work in a couple of places and the social worker would often interfere with the placement by telling us that we couldn't do something, or demand extremely restrictive consequences for the youth. This was not compatible with effectively addressing the behaviour of the youth because it would often just get worse (PC 9).

This view was shared by all carers, but some also reported that on occasion the social worker would make placement decisions which were permissive of negative behaviours. All participants agreed however, that placement experiences influence behaviour, particularly with regard to the approach taken when addressing maladaptive behaviour. In both cohorts there minimising was observed when considered the impact of the youth's mental health problems on their behaviour. Adolescents were thought to experience greatest benefit from a care style that was authoritative, warm and nurturing and that set reasonable limits. One professional carer states the benefit of a style that is supportive, consistent and nurturing:

> The aim of the placement is to provide a kind of care that gives the youth an experience that is different from the abusive life they come from. Too much authority and we are being just as abusive, too little and we are neglecting them. The balance is found when we do everything with the purpose of encouraging positive and lasting change (PC 6).

The minimising of the mental health problems seemed to be influenced by the view that a focus on the here and now was the best way to advocate for positive change. There was a desire to avoid defeating thoughts about the placement by suggesting that change is not necessarily unattainable due to the mental health status of the youth. In this way, every youth in an IPC is thought to have equal potential for change, both mentally and behaviourally. Participants that shared information in which suggested that, despite poor placement histories and disruptions, an IPC has the potential to impact the life of a youth positively:

> It is clear these kids have had a shit life. The one thing that we do well as a team is stick with them and try our best to give them a home that is there no matter what (PC9).

Responses given in this theme are aligned with models of discipline that improve behaviour and promote positive choices (Hutchinson, 2003). When considering the approach taken to behaviour change in an IPC, Hutchinson (2003) suggests that punishment of behaviour implies an attempt to get even with the youth, whereas discipline involves helping the youth to change a behaviour or overcome a problem. Care providers and those responsible for the youth reported that they often struggle with how forceful to be in response to undesired behaviour. Because carers in the IPC are not formally trained in the care of youth, specifically with regard to managing complex behaviour, they reported that the type of discipline they use and the way they use it is often modeled by cultural norms and the way in which they were parented.

Epstein, Bishop, Ruan, Miller & Keitner (1993) suggest that care givers usually respond with discipline to three types of situations: 1) physical danger; 2) expression of psycho-biological drives such as aggression; and 3) socializing of the youth inside and outside of the placement. They suggest that logically dangerous situations require a more rigid response than minor infractions within the home which may elicit responses that are less restrictive. Some accounts about behaviour management by carers and social workers reported significant success when addressing behaviour in proportion to its seriousness and level of danger. However, some participants in the carer cohort reported that the frequency of negative behaviour by the youth resulted in frequent restrictive responses by the care staff, ensuring a cyclic pattern of restriction and negative behaviour as demonstrated in the following extract:

> In the beginning I was confident that we could help the youth change their behaviour by being supportive. The problem was that their behaviour was so extreme that the response to that behaviour had to be equally extreme. In the end we just seem to go in circles, they behave badly and then we keep them restricted to the home. We do persist in the hope of positive change, that is one good thing about the IPC (PC2).

Others made statements about complex behaviour decreasing over time, when restriction was balanced with encouragement to change in a non-confrontational way:

> It's hard work caring for these kids, I mean, sometimes seemingly impossible. Over the year I have worked with this kid change in behaviour has been slow. There have been some really concerning events from house fires to running away, but we have persisted, told him we care and every time he makes a negative choice we respond with a consequence and make ourselves available when the youth is ready. It's a really tough

> balance between being kind while enforcing the rules. They need to know that negative behaviour won't be tolerated, but we need to be patient for change (PC5).

There was a consensus amongst all participants in this study that the behaviour of a youth is impacted by the response of care staff and youth in the current placement. Conflicting styles of discipline were reported to be a significant problem in the placement and were viewed as problematic both within the carer and social worker cohorts. Extreme restrictions imposed by carers can be extremely detrimental to the effectiveness of an IPC (Carey & McDevitt, 1995) while a balanced authoritative and supportive placement has been reported to improve behaviour over time. The importance of the IPC for youth engaging in poor behaviour is significant as it can disrupt negative behaviour and foster more adaptive responses. Refusal of individuals in other stakeholder groups to accept and integrate the approach of carers and social workers to an authoritative approach that is supportive but structured could decrease the overall effectiveness of the IPC and lead to ongoing cycles of conflict between carers and youth.

4.3.5 Problem behaviour arises from placement instability

In relation to this theme, maladaptive behaviour was attributed by carer and social worker cohorts to poor consistency in the care experience. The youth were seen to anticipate placement failure and future instability in their lives. These views suggested routine and structure, personal accountability, and a feeling of permanence as critical features of the placement which were absent. The following view of a professional carer summarises the importance of this theme, suggesting that providing long-term, stable care and persisting with the improvement of maladaptive behaviour will lead to a decrease in maladaptive

behaviour and an increase in positive behavioural choices:

> When we started the placement, the young person was always testing us, telling us we didn't care and that this was going to be another place to let him down. Over a year later, that has changed, they still mess up, but they also tell us frequently that it's nice to have someone who cares, no matter what (PC7).

The above extract also indicates that continuity and stability appear to be interdependent variables; for a placement to last it must be stable and for the experience to be stable it needs to last long-term. Many participants in the professional carer cohort were unanimous in declaring that continuity of the IPC would improve behaviour. Previous research (McLean, 2011) places a high value on the continuity of placement, suggesting that the more stable a placement is the greater the likelihood of positive behavioural change. Participants in the social worker cohort, on the other hand, shared the assumption that continuity in placement provided a positive environment in which behaviour could be consistently addressed, as this social worker suggests:

> When a youth enters an IPC they have often already gone through many placements that have been unsupportive, short term or ended abruptly. The preconceived notion of the youth is that this placement will be like others and that it won't last. The advantage of paid carers in an IPC is that they are motivated to provide ongoing care in multiple ways, they work as a team to provide the care and they engage objectively as a guest in the home of the youth. The IPC provides a secure, safe place where they are valued, cared about and wanted. Simply guaranteeing an ongoing placement for the youth puts the IPC at an advantage over other placements where people give up, lose hope or reject the youth (SW14).

This view of placement instability as a primary cause of challenging behaviours is notable, given the fact, as the above participant suggests, that addressing behaviour issues is thus a matter of promoting placement stability. Yet as the following extract suggests, the issue of stability and maladaptive behaviour is somewhat circular, in that once challenging behaviours are already in place, it can be hard to generate a stable placement within which behaviours can be addressed:

> There is a deep systemic failure when placements continue to be sought for the same client. In the end it becomes abuse of system proportions. In the end they take control of their life because we don't. Every placement is assumed to be another stop on the placement train so they try to jump off early by destroying it with bad behaviour. By behaving badly they gain a small sense of control by being able to predict or force the failure of the next placement (SW11).

In addition to placement changes, other changes in mental health professionals and changes of social workers were viewed as influential on the negative behaviour that the youth exhibited as demonstrated in the following extract:

> Changes in social worker were no less unsettling than the dozens of placements for the kid sometimes. In the year we had worked with them there were three changes in social worker. They would get upset and trash the house or in some cases use the change as an opportunity to try to manipulate the new social worker into making changes to the placement (PC9).

Participants that shared the view of challenging behaviours arising out of a lack of stability also felt that contact with biological parents was unhelpful for the young

person. Inconsistent family contact was viewed by many in the professional carer cohort as devastating to the placement and youth, as this professional carer reports:

> Every other week the kid's parents would cancel, this was so disruptive to the placement. In the end, I don't understand the need to keep them connected when it just results in constant disappointment. The emotions that the kid displayed were relevant after being screwed around by mom, but the behaviour coming out of those emotions was just tough to deal with (PC7).

The requirement to ensure that family contact occurred for young people in care was viewed by many participants in the carer cohort as unreasonable:

> Personally I don't see how they can expect us to continue to facilitate family contact when it only ends up in arguments, tears and disruption to the placement. Those running the IPC should have a choice about whether they think it's a good idea or not. We are the ones who work with the youth on a daily basis (PC5).

In direct contrast to this, social workers felt that family contact was essential to the placement from an evidence based and historical perspective, as this social worker explains:

> While it isn't always possible to get the parents to a visit, it is helpful to have contact with them because that is what the child wants. When we take away the option for family contact it becomes something else that they do not have control over. In one case the family were allowed to visit the placement, it was unprecedented and it was very successful, boundaries were clearly defined, the youth understood where his home was and the family understood that contact was structured. It was closer to a natural interaction than a local office (SW2).

Systemic issues were also viewed as a contributor to change. For example, social worker and placement supervisor turnover was frequently seen to influence the placement negatively as individual ideas about behaviour and its management were imposed upon the placement, resulting in increasingly difficult to manage behaviour and ultimately an inability to contain it even in the constraints of an IPC. For some participants in the professional carer cohort, this was their reason for wanting to quit. One carer spoke about the reality of the strain that imposed ideologies and assumptions have upon the behaviour of the youth:

> It is difficult enough to be consistent with behaviour as a care team. When a social worker changes roles and a new one comes in, they have their own agenda, methods for involving themselves and they don't pay attention to what is working or not. They simply don't care about what we think is needed, they impose their views and tell us that this is the way we are going to change the behaviour of the young people in our care. It results in conflict in the home and dangerous interactions with the youth (PC11).

This appears to reflect a common complaint amongst participants in the carer cohort. Many participants in the social worker cohort saw adaptive and positive behaviours as indicators of placement stability and maladaptive behaviour as an indicator of poor placement performance. The fiscal implications of this assumption is that an expensive placement option such as an IPC could be terminated due to the view that success is measured by behaviour outcomes only. Frequent negative behaviour, or requests for support by care staff to help manage challenging behaviour, could be interpreted as lack of placement viability. Delfabbro, Barber & Cooper (2003) advocate for a supportive relationship between carers and support services and report that those

who care for children should anticipate difficult behaviours as part of the care experience. With this in mind, placement success should instead be measured by the level to which the placement can be maintained, despite maladaptive behaviour.

Placement stability appears to improve for youth who enter an IPC. Despite the challenge of engaging with youth who have experienced multiple placement breakdowns, professional carers appear to respond in a way that accepts the youth and their problem behaviours along with the challenges in caring for them.

4.3.6 Behaviour arising from emotion

This theme documents the ways in which, for some participants, behaviours were depicted as occurring as a result of an emotional response to an event or person. Importantly, such elicited behaviour was not necessarily related to the event or person, but rather these served as emotional triggers. Maladaptive behaviours due to negative emotions were often thought to be a physical reaction to irrational thoughts. This theme therefore suggests that there is a relationship between poor emotional regulation and loss of control over behaviour. Whilst other causes of behaviour were viewed as controllable by the adolescent (as indicated in theme 2), emotionally-based behaviour was viewed by participants as outside the control of the youth. The following view of a professional carer argues that there is a difference between emotionally-based behaviour and other behaviour:

> There are times when I think behaviour is well within the kid's control, but it is hard to blame him sometimes for how he behaves given the circumstances and negative experiences he has had and will have in the future. Behaviour such as refusing to

> complete a task is often associated with deliberate actions, but there are times he doesn't seem to be in control. After a visit, if it goes bad he will come back and kick walls, punch furniture and staff. It is then that I believe that he is reacting to an event due to extreme negative emotions (PC1).

The accounts of maladaptive behaviours that occur due to a response to severe negative emotions appear to be consistent with irrational thought tendencies due to a lack of ability to engage in rational thought processes (Baron, Granato, Spranca & Teubal, 1993; Klaczynski, 2000), where problem behaviours arise from cognitive distortions. Arguable, when adolescents are exposed to complex trauma risk of maladaptive behavioural trajectory increases (Cook, Spinazzola, Lanktree, Blaustine & Cloitre, 2005). These youth are known to experience an impaired ability to regulate their own behaviours, and thus there is a rapid escalation of maladaptive behavioural or disproportional emotional responses to minor stressors (Cook et al., 2005). During adolescence most individuals are thought to have the ability to develop rational thought processes that are beyond those held in childhood (Damon & Hart, 1998). Included in these are: 1) contemplation of the future; 2) comprehension of the nature of human relationships; 3) consolidation of specific knowledge into a coherent system; 4) ability to envision possible consequences from a hypothetical list of actions; 5) abstract thought; 6) empathy; and 7) internal control. Hutchinson (2003) suggests, however, that adolescent thought processes are influenced by experience, culture, personality, intelligence, family values and identity and while most individuals develop the attributes listed, some are influenced by negative life experiences and subsequently develop distorted patterns of thinking.

The youth in an IPC may have very little awareness of their maladaptive behaviour when distressed or angry. As a result of their diminished cognitive functioning, typical behavioural strategies may have no immediate impact due to the inability of the youth to think rationally. The following extract from a social worker describes the difficulty in encouraging adaptive behaviours in some situations:

> There is definitely a difference between times that the youth is teachable and times that they are not. When behaviour arises out of a strong emotional circumstance, it is unhelpful for a carer to respond with severe consequences or restrictive responses. The child is seeking a way to communicate their distress; we can clearly add to it by the way we respond (SW3).

Despite agreement in the social worker cohort that behaviour can be a reaction to a severe negative emotion, those in the professional carer cohort did not share the view that the resulting maladaptive behaviour should be objectively considered before consequences or challenges to the behaviour are issued. All professional carers felt that behaviour - regardless of its cause - is disruptive to the placement and needs to be addressed with an immediate response (where possible) in order to prevent an escalation of the behaviour, as the following extract suggests:

> Regardless of the reason, we can't have the kid smashing the place up because they are upset. Consequences show that the behaviour is not ok. If we let them get away with it because they are sad, mad or have a bad experience, it sends the message we think that behaviour is ok (PC8).

As previously indicated, there was an underlying assumption amongst participants in both cohorts that maladaptive behaviour arising from emotional events or experiences was engaged in with little cognitive processing by the youth. This belief can promote a sense of helplessness amongst carers and social workers who feel that the behaviour is unchangeable due to its unconscious nature, as indicated by this social worker:

> I don't know that any placement is suitable for the young person due to their constant negative emotional state. The IPC has been a major benefit because the staff continue to support them despite their behaviour, however they don't quite understand that yelling, punishing and pushing the kid isn't helpful. Not all behaviour is the same and some of the time he does make a choice to behave badly, really badly. But it is during the times that he is just plain mad or extremely angry that I feel the most sensitivity. In situations where negative behaviour is a response to the experience of a negative emotion I would hate to be a carer trying to solve that problem, balancing preventative with reactionary, punishment with compassion is not an easy task (SW14).

The previous view suggests that there are implications of the belief that behaviour is outside of the control of the youth; it implies that the behaviour is unchangeable or that some external event needs to happen that is neither within the carer's nor the youth's control. Holding this view suggests a sense of defeat by social workers and professional carers about the possibility of improved behaviour and cognitive processing skills.

One positive experience reported by many participants in both cohorts related to behaviour change across time. Where it was thought by some participants that behaviour arose out of strong negative emotions, it was also reported by some participants that the

emotions observed by them decreased the longer that the IPC was in place. It was also suggested that the length of some behaviours also decreased over time as the staff learned to respond more individually to the young person's needs. This suggests that while emotional development may be delayed due to traumatic events, abusive environments and placement drift, young people can be supported to develop the skills, abilities and knowledge they need to regulate their emotions and utilize adaptive behaviours. The following view shared by a professional carer addresses the relationship between placement stability and emotional regulation with minimal intervention:

> When the kid moved in it wasn't great. I mean every night was a critical incident, in the end I just planned on walking into chaos. Over time things became less problematic, they responded to the relationship we had built with them and we were able to encourage a more appropriate response to their emotional experiences. Their anger lasted as long as it took to talk through things, instead of waiting for him to get tired and fall asleep because he was exhausted. The consistent compassion and encouragement to change was something I felt we provided well (PC11).

It is important that stakeholders in both cohorts acknowledge the impact of past experiences on the cognitive development of the youth and therefore their ability to respond adaptively to situations that elicit negative emotions. This knowledge can provide insight for those who participate in the care of a youth in an IPC and encourage persistence with behaviours that may be viewed as difficult to change due to their link to poor cognitive processing skills. Awareness of the impact of emotional and physical abuse is necessary in planning that effectively addresses behaviour, especially given the limitation of carers to address cognitive limitations which may need to be addressed

through individual therapy with a counselor.

4.3.7 Behaviour reflects the relationship between youth and caregiver

This theme involved the attribution of maladaptive behaviour to relationship difficulties with the current carer and historical problems with relationships caused by poor attachment in early childhood. Most participants in the professional carer cohort reported that difficulties with establishing a healthy relationship were common in an IPC. When exploring the concept of positive relationships between youth and carers, Goldenberg and Goldenberg (2004) offer an insight into how individuals should interact, including the youth. Adolescents are suggested to be living in relationship with others and rely on concrete needs such as money, food and shelter and also love, affection and mutual commitment, companionship, socialization and the expectation of long lasting relationships. To function successfully members of a placement need to adapt to the changing needs of each other (Rice, 1993). A well functioning care relationship needs to allow room for self-discovery along with protection and installation of security (Constantine, 1986).

All interviews that shared views of behaviour in terms of relationship with the caregiver were separated into one of two subthemes: 1) where the relationship with caregivers in an IPC positively influenced the youth, and 2) where the negative impact of the relationship was explored. Some participants did also report on poor attachment in earlier years as a factor for the youth's refusal to build new relationships.

It is worth noting that attachment is considered one of the most essential aspects of human development (Hutchinson, 2003), emphasized by the need for a secure relationship in which the child can develop skills needed for everyday living including the ability to discern appropriate behaviour. For this study, interviews that discuss attachment difficulties are examined soundly from the perspective of attachment theory (Bowlby, 1982; Ainsworth, Bleher, Waters & Wall, 1978). The absence of secure attachment has been previously reported to result in maladaptive behaviour (Main & Hesse, 1990). Main and Hesse (1990) suggest that disorganized attachment can have symptoms such as contradictory behaviour, attempts at closeness and then rejection, and fear of the unknown. Most children come into foster care without secure attachments (Hutchinson, 2003). Frequent changes in foster placements are considered to contribute to ongoing insecure attachment and are also thought to contribute to negative relationships and subsequent placement breakdown. Barber and Delfabbro (2004) state that it is difficult to know which variable is dependent on the other, or whether individual circumstances can lead to one variable becoming dependent on the other.

Accounts shared in this theme were also consistent with the view that youth who enter care are more likely to have experienced broken relationships (McCauley & Davis, 2009). All participants in McCauley and Davis' (2009) study reported that the youth they were serving had experienced frequent disruption to the relationship they had with their biological family. They further stated that the children had problems with forming and maintaining relationships and in addition, due to the rejection they had experienced in earlier life, found it difficult to trust other adults and therefore follow direction

(McCauley & Davis, 2009). This is again consistent with the current study as all participants reported that improving the aspect of trust in the relationship with the youth was mutually difficult to achieve both because of the behaviour of the youth and because of their historical experiences with those who had cared for them. However, research evidence also demonstrates that many looked after children do form significant secure attachments with long-term foster carers or adopters even when placed later in childhood (Schofield et al. 2000; Rushton et al. 2000). This theme explores the impact of relationships in an IPC on stability of placement and behaviour. Findings in this theme confirm previous studies (Delfabbro, Barber & Cooper, 2004; McCauley & Davis, 2009; Rushton et al, 2000). This extract from a social worker describes the impact of positive care relationships on stability of the placement:

> The change after five placements was hard going, he would struggle with knowing how to behave a lot of the time, but our consistent support showed we weren't going anywhere and so over time he started to trust us. Rejection often came in the form of behaviour that showed they wanted to be difficult on purpose. Over time he would ask why we weren't getting rid of him. Not all carers had an easy time with the kid, because some couldn't get past how he behaved, for the most part though he became settled, likeable and showed he wanted to do well. Helping them feel accepted, valued and simply to know they weren't going anywhere was a key to a positive relationship with them. I would say this kind of placement provides something this kid has never had (PC1).

Replacement behaviours were reported by many in the social worker cohort to improve relationships between carers and youth and one of the ways many felt that this could be achieved was through replacement of physical behaviour with affirmative

statements. Through the development of a ‘feelings vocabulary’ the youth had an alternative means through which to communicate their many emotions. This required the unlearning of maladaptive coping measures and the implementation of purposeful dialogue.

Supporting a youth in IPC through their emotional experiences, and supporting them to regulate their emotions, were considered essential to managing some maladaptive behaviour. Lazarus (1980) proposes a three part psychological theory in which emotion is based upon appraisals of situations. He suggests that emotion develops when we assess a situation as relevant to a personal value or life concern. First there is the unconscious assessment of threat, then conscious or unconscious coping responses followed by reappraisal and labeling of our emotion. The data appears to support the experience that youth entering an IPC would often negatively appraise situations, but later, depending on the quality of the relationship between the youth and members of the care team, the youth’s appraisal of situations became positive, resulting in positive emotions:

> When they started in the IPC, I was worried they were never going to stop being negative, explosive and troubled by their past. Over time it was like a light bulb went on that the world was not bad and he seemed to see the world through a different lens. I mean let’s be real, he had bad days, but not like he used to. I can’t say it enough, relationship matters. You can’t come into these places treating people like shit, kids don’t function well like that (PC5).

Length of placement was viewed to favour the youth as it suggested that the professional carers could establish a history of understanding the youth, their thoughts

and subsequent maladaptive behaviour. Professional carers could, over time, provide a consistent response to behaviour and establish reasonable expectations, which could hold the youth accountable for their maladaptive behaviour through the relationship with the carer. Continuity of care and ongoing commitment to support the youth, suggested the young person could be influenced to make changes to their behaviour in order to maintain these valuable relationships, as this carer explains:

> By providing the assurance that they are not going anywhere, we give them a chance to find out that people are not all bad, that some do care and that relationships are important. Placements should be free of judgment, the kid knows when he has done the wrong thing, kicking him out won't improve that. It's our job and our role to end the placement cycle. That may mean allowing the youth to be angry and sometimes take it out on us. Eventually we will be valuable to them, they will want the placement enough because we cared enough to want them (PC9).

Length of placement was also viewed as contributing to a reduction in the frequency of maladaptive behaviour, as this professional carer explains:

> When a relationship has been developed, a mutual respect exists. Relationships that cannot develop this respect tend to end, hence the previous placements that have not worked out. When they respect us, they tend to stop behaving badly because they achieve better outcomes by maintaining a positive relationship (PC13).

> There were two IPC I worked with. One of them, the youth had 9 placements in 6 years. The other was a youth whose IPC was only the second placement. The obvious difference between the two was the desire for relationship. The youth who had been in nine

> placements did not care about what happened in the IPC, while the youth in the second placement still had problematic behaviour, but was more amenable to change through the encouragement of placement staff (SW12).

Providing a placement in which negative emotions are able to be exhibited without threatening the stability of the placement was also expressed as essential to caring for youth in IPC by both cohorts. This extract from a social worker stresses the necessity of providing a placement that is conducive to outbursts from a young person without threat of placement breakdown:

> Behaviour isn't always acceptable, but it's also not a reason to give up on someone. After five or six placement breakdowns it is essential that we find a way to give them the stability that they need. It is easy for a care team to give up on a young person, but the reality is it just tells them they are bad kids who are not wanted. The new message needs to be that no matter what, they are valuable (SW14).

Every participant in both cohorts stressed that unique to the IPC was the unwavering support that was provided to the youth despite maladaptive behaviours. Positive relationships that encouraged change consistently, despite waves of maladaptive behaviour toward care staff, were viewed as critical to change and maintenance of positive behaviour. This professional carer explains the value of positive relationships in an IPC:

> I have supervised and worked in more than one IPC. In one, the environment was so negative because the carers treated the kid like crap, they discouraged bad behaviour but there was never support for the positive. In the other placement they were very balanced and worked hard to maintain the placement with a lot of encouragement, praise, rewards,

> and just positive interaction. There were times that they got really upset with the way he acted out but they stuck it out and told him every day he was wanted. It was rewarding and motivating to work with a group of people who cared so much. We did what ten years in foster care didn't do, gave him a stable home. On the other hand the poor relationships in the other placement, fighting with the youth, between the carers and conflict with the Department led to a huge breakdown that resulted in the youth going to detention. IPCs can replicate the problems that exist in foster care or it can be the better option. It requires positive relationships and requires hard work (PC12).

The important and sometimes difficult role of support was most often filled by one or two professional carers who developed a close relationship with the youth, this social worker illustrates, in their discussion of professional carers in an IPC:

> Some but not all of the professional carers go all out for the kids they look after and treat the kids as their own despite being encouraged to keep a professional barrier with the youth. They take all the crap that is dished out by the kid, and continue to care anyway. That is a big deal in care and protection (SW8).

These accounts suggest the importance of having professional carers who are prepared to engage in a positive and supportive relationship with a young person. Brown, Bednar and Sigvaldason (2007) report that carer burnout is one of the most significant factors that leads to poor relationships and an eventual unwillingness to care. Several carers in this study suggested that being able to leave the placement and rotate through various shifts allowed enough time away to rejuvenate and come back motivated and willing to challenge the young person in the IPC in a supportive way. Another factor

related to relationships was largely outside of the control of any carer or social worker and involved the inability of the youth to adapt to an IPC or one of the carers in the placement, as this social worker suggests:

> It was strange, because the youth frequently said he wanted to be in the placement, but he just couldn't seem to settle in. He even said it was hard for him when people showed they cared because he couldn't handle people being nice. In the end he didn't adjust and was locked up, it was really sad (SW3).

Another professional carer described how a consistent relationship was achieved despite unpredictable behaviour of the youth. One carer pointed out that behavioural incidents were an opportunity to challenge the thinking of the youth and demonstrate that their negative behaviour was not going to change the relationship with the carer:

> He used to pull shit all the time. My motto was to not let him see I was upset and show him that it wasn't going to make me go anywhere. The whole team worked together to show that his behaviour wasn't going to get him what he wanted and it also wasn't going to get him kicked out. He used to ask me why I didn't hate him for some of the stuff he had done to me. The simple answer is that I care about the kid and what happens to him (PC7).

Some participants in both cohorts described young people's lack of respect for members of the care team, both social workers and professional carers alike, which impacted negatively on the relationship between them and the professional carer. It was thought that this manifested itself as refusal to cooperate, aggressive behaviour, threats toward staff and other maladaptive behaviour. This professional carer describes how a

young person used maladaptive behaviour to communicate their dislike of some carers:

> There were a couple of carers in the placement that the young person didn't like at all. It became obvious when I would come on shift and they would be refusing to do something for them, but agree when I came on. When he realizes that he is in control and upsetting those carers, he tries harder to upset them. It was the same with social workers. We have had two in the placement and one of them really upset the young person. He would go outside and let the tyres down on her car, yell at her and refuse to engage in programs. In contrast, we ended up with a new social worker who the youth loved and he chose not to engage in maladaptive behaviour (PC2).

The findings of this study suggest the importance of a sense of belonging and relationship. While the placement experiences combined with past abuse and neglect can create barriers to promoting the well-being of youth, the positive development of young people can be achieved through supports, stabilized care and services that support the relationships within the placement (Berson, Vargo, Roggenbaum & Baker, 2002). Many carers, in relation to this theme, indicated that fundamental to the relationship with the youth is the preparedness to advocate for their needs including seeking appointments for therapy to address the reasons for placement in care, their behaviour and other needs. One professional carer summarized the importance of advocacy in establishing and maintaining a positive relationship with the youth:

> Every day they would call the social worker and ask when they would be able to start seeing someone about their anger. This went on for months. The kid got angry about it, sometimes telling people that they want him to stop his behaviour but won't give him a chance to talk to someone. In the end I pushed for it through a local agency, they agreed

> to meet with him and it was very successful. He saw that I cared too and the time with the young person became very easy because the behaviour was within appropriate limits (PC14).

Professional carers felt that family relationships were not helpful to relationships within the placement due to inconsistency and the youth's ongoing desire to return home. When it was perceived that professional carers were required to invest significant effort in promoting relationships with birth families, many professional carers stated that they did not like this because of the damage it did to the relationship that the youth had with staff in the placement. Many carers felt that the social worker was not realistic about family contact and thought that it was more detrimental than helpful as this carer suggests:

> Every visit brought with it the guarantee we were going to have problems for the rest of the day. I mean, I understand that family is important, but when the parents don't turn up five visits in a row and then when they do they yell at the kid, who is benefitting from that? In our IPC we came to expect bad behaviour after a visit (PC8).

Participants in the social worker cohort did share a conflicting view on this issue, stating that they felt that family contact remained important for identity, relationships with family and to support the placement. Social workers reported that incidents in the IPC following a visit with family were not always related to the visit and were consistent with the behaviour typically displayed by the youth. One social worker suggested that relationships with family could be preventing placement breakdown:

> The visits didn't always help to keep the placement settled, but they certainly didn't make

> them worse. Many times I supervised the visits myself and the parents would speak very positively about the placement and the fact that they did not feel as threatened about their role as parents, because the people caring for their child were professional. They even encouraged the youth to maintain positive behaviour. I know realistically, just missing their parents could trigger negative behaviour after a visit, but children need to know their parents, it's healthy when the relationship is positive (SW12).

When viewed collectively, the statements in relation to this theme suggest maladaptive behaviour arises out of a desire to control and disrupt relationships, as the youth attempts to prove that this care relationship is unstable just as others have been. Behaviour change was viewed as possible where consistent relationships were provided for the youth to change over time and in which the youth could err without disruption to the placement or the care of the child. This professional carer summarizes the nature of the relationship required to support, sustain and move a youth forward:

> The aim of being a carer isn't to tell them off about everything and then punish every move. I believe my role is to show them that I care in a way that says that they are valuable and wanted. Sure I need to set a limit here and there, but every day they should know they are loved. When I model good interaction, it is then that I can expect change from the youth (PC9).

4.7 Summary

The extracts provided throughout this chapter suggest how complex behaviour management of young people in an Individual Package of Care can be. The challenges include several key themes of which the most significant appear to be: 1) that if environments are viewed as primary causes of behaviour then the focus will be on changing behaviour through provision of a positive environment; and 2) behaviour in many cases is experienced as purposive rather than responsive. Responses to behaviour in an IPC should therefore aim to replace maladaptive behaviours and provide youth with alternative mechanisms for resolving emotions and problems. It is important for carers to differentiate between responsive and purposive behaviour, because engagement in maladaptive behaviour in situations where behaviour is purposive is functional for the youth and requires considered understanding by the carer and others to assist the youth to change.

Both cohorts reported that when a relationship with a carer is not valued by the youth, they will undermine the relationship with excessive maladaptive behaviour. Participants in the professional carer and social worker cohorts both agreed that relationships that had been established for several months had greater potential to lead to positive relationships between carers and the youth being served.

Three types of environmental interaction are thought to be most likely to produce problems in social functioning and include stressful life transitions, relationship

difficulties, and environmental unresponsiveness (Germain & Gitterman, 1996). According to environmental theory, both the youth's and carers' behaviour is thought to occur and be maintained following stressful life transitions and relationship difficulties. Given the complex problems presented by youth behaviour and professional carers' and youth's conflict, this theory has significant implications for the management of a youth in an IPC including: 1) it is relational in nature and offers solutions that are deliverable by the client; 2) it helps clients to assess the effectiveness of particular coping strategies for specific situations; 3) where appropriate the theory advocates for the use of case management which improves social supports through linkages to supportive others in a variety of clusters; 4) it recognizes carers are sources of stress as well as support; and 5) it helps clients to connect current stress with patterns of past functioning, with the aim of improving coping methods (Hutchinson, 2003). Ultimately, when left, the adolescents negative behaviour within the placement then transfers to other environments such as school (Patterson, Reid, & Dishion, 1992), suggesting the need for positive relationships and environment within the IPC.

Inconsistency of consequences was also implicated in the development and persistence of maladaptive behaviours in an IPC. It is therefore essential that care of youth in an IPC is consistent and disruptive behaviours are minimised.

As already discussed in this chapter, behaviour is influenced by the environment, relationships with others, past experience, mental health and personal experience. There appeared to be several assumptions amongst both professional carer and social worker

cohorts in this analysis of behaviour. It is reasonable to offer one conclusion that at times behaviour is within the choice of the youth. Past relationship experiences including previous foster placements promote suspicion and low levels of trust amongst youth in an IPC which requires patience and ongoing support by the care team. Responsibility for change rests with the youth, social workers and care staff. Therefore, the need for intervention in maladaptive behaviour rests with the front line placement workers who are with the young person on a daily basis. It is important to understand that causes of behaviour are interchangeable and not necessarily exclusive. Events can cause emotion which triggers behaviour and challenges the strength of relationships. Behaviour can be cyclic in nature and at other times unpredictable. This chapter demonstrates that IPC placements are not immune to problems that arise out of behavioural challenges. Failure to maintain an awareness of the potential for behaviour to be purposeful can significantly decrease the potential benefit of a placement. When the function of behaviour can be established, it is then that the carer can understand and support the youth in finding alternatives.

CHAPTER 5

Professional Carer Views and Experiences of Working in an IPC

5.1 Introduction

The literature provides substantial evidence that placement breakdown is persistent and problematic within alternative care. In 2005 a special youth carer program was introduced in South Australia to provide therapeutic care services with wraparound features to at risk adolescents. It had two intentions, the first to provide placement stability and the second to promote behaviour change (Gilbertson, Richardson and Barber, 2005). Its foundations were based upon the therapeutic foster care model and it was found by Gilberston et al. (2005) to be successful in its aims. Following Anglicare South Australia's success with the special youth care placement, Families SA provided opportunities for other agencies to provide similar services under a wraparound professional care placement, which became known as Individual Packages of Care (IPC).

Competing views exist about the use of professional care within the range of placement options for youth who for varied reasons cannot live with their biological family (Osborn & Delfabbro, 2009). Some argue that less restrictive options including relative based placements and traditional foster care are more desirable than professional options because of their tendency to provide a less restrictive and normal environment for the child to exist in (Barber, Delfabbro & Cooper, 2004). Others suggest that residential

options including professional foster placements with rotating workers should be considered equally, according to the likely success of the placement (Osborn & Delfabbro, 2009). The focus of this debate is on the adolescents for whom residential or professional options are better intended, what is required to achieve efficient practise in professional placements and how positive outcomes can be maximised for youth placed in a professional setting (Ainsworth & Hansen, 2008; Delfabbro, Barber & Cooper, 2004; Osborn and Delfabbro, 2009; Hillan, 2008). While systems continue to use professional placements including Individual Packages of Care as a last resort, strain upon alternative care as a system continues to expand.

As with many Western countries it is accepted policy in South Australia that children experience as little disruption as possible when placed into substitute care Delfabbro, Barber & Cooper, 2000). In Australia this has equated to a reduction in the residential care options in favour of kinship and foster care. Residential care is currently low, represented by a small proportion (less that 5%) of young people in alternative care being cared for in this way (AIHW, 2011; Flynn, Ludowici, Scott & Spence, 2005). South Australia, has equal to or less than 10% of young people in alternative care are in a professional placement run by youth workers in a group or individual setting (AIHW, 2009).

In Australia, trends of decreased reliance on professional care appears to be prompted by increased social pressures to provide a normal care experience to those in care and decrease institutional options (Bath, 2008a). A combination of more young

people coming needing other placements (AIHW, 2011) with behavioural problems, complex histories including parental drug abuse, severe violence and socioeconomic problems, are all considerations to increased challenges in recruiting foster carers (Hillan, 2006). There is also a general decline in the pool of carers due to age, cultural changes and the fact that fewer families are making themselves available to foster (Scott, 2001). Increasingly, there has been a need to examine the possibility of alternative options to traditional placements due to these needs. Such alternative options are seen to be more specialized and better equipped to address these increases in demand both mentally and numerically (Create, 2003; Gilbertson, Richardson & Barber, 2005).

5.2 Professional Care in South Australia

Several reports spanning the last decade in South Australia suggest several important systemic improvements (Des Semple & Associates, 2002; Layton, 2003; Mullighan, 2008). These reports document an ongoing trend that foster care options fail to meet the needs of some children with complex behavioural problems and should be remedied with placement options where carers are sufficiently trained and supported to meet these complex needs. Absences of such placements were found by Mullighan (2008) to result in youth staying in temporary residential placements for unreasonably long timeframes due in part to difficulties in finding suitable long-term, stable placements for them. The reports reported that residential residential placementswere not favoured within alternative care especially on the end of a long list of placement alternatives. These reports recommended inclusion of residential care as a primary option together with a middle ground placement option in which paid carers are trained to work one on one with

youth.

In response to the need for a broader range of services and to avert a crisis where many adolescents whose traditional placements had broken down had resulted in placement in motels and hotels, the IPC was conceived to provide a tailored intensively supported service to youth. Features that the program has in common with Therapeutic Foster Care (TFC) include a focus on youth with complex behaviours and needs, carers who are recruited and trained for the role of professional carer, remunerated positions and scheduled services for the young person (Farmer, Burns, Dubs & Thompson, 2002). Similarities of the IPC to the lead tenant model include placement in a home not owned by the carer or care agency, only one child in the placement and no requirement for the young person to fit into a family. Defining features of the IPC are:

- Placements are limited to one adolescent and at least four carers per home;
- The home is rented either privately or from the housing authority;
- Breakdown in relationships between carer and child results in the carer leaving home not the child;
- The program is annually funded;
- On reaching the age of 18 the young person may transfer the contract of the home to themself to maintain tenancy.

By offering independently sourced accommodation the IPC seeks to limit placement instability, one of the main problems experienced in care. It allows service providers to be interchangeable, and carers to be removed if unsuitable without changing

the physical placement of the youth. Young people are referred to the program if they have a history of placement breakdown, problem behaviour and high risk behaviour, substance abuse and if other placement options have been exhausted. Due to the limited number of placements, a psychologist from the Department, a placement specialist, a current social worker, a current foster carer and others in the care team convene a case conference to discuss the need for the IPC before referring to the provider agency. If the case conference identifies that the IPC is in the best interest of the young person funding is discussed, case plans are submitted and a budget analysis conducted to fund the placement according to identified needs.

5.3 Maladaptive Behaviour in Residential Care

For South Australia, professional care is an option of last resort following multiple foster placement breakdowns (Bath, 2008a; Gilbertson et al, 2005), rather than an integrated placement option based on the care needs of the child (Bath, 2001; Hillan, 2006, Gilbertson & Barber, 2005). As a result of this practice youth placed in an IPC are typically older, have complex behaviours, are oppositional and negative (Triseliotis, Sellick & Short, 1995). Indeed, the primary reason for placing a youth in residential or professional care is often due to the extreme nature of their behaviour and subsequent lack of an alternative (Gilbertson et al, 2005; Clough, Bullock & Ward, 2006). Young people in residential care in Australia, whether individual or congregate care, have predictably complex needs (AIHW, 2011, Ainsworth, 1999). Overseas studies have shown higher levels of mental illness with adolescents in alternative care compared with youth who are the same age and not in alternative care (Pecora, White, Jackson, & Wiggins, 2009). What is especially concerning is that those in professional or paid

placements appear further disturbed than the general care population, both mentally and behaviourally (McLean, 2011).

The most common mental health diagnoses assigned to youth in residential placements involve conduct, hyperactivity, and attention deficits (ADHD) (Bath 2008). Conduct problems are more prevalent in community congregate care when compared with young people in traditional placements (McCann et al., 1996; Meltzer, Gatwood & Goodman, 2003). Children in residential care facilities have also been described as more likely than other young people to engage in high risk behaviours such as self-harm, running away and violence (Ainsworth & Hansen, 2009; Gilbertson et al, 2005).

Considering these issues, and those mentioned in the previous chapter, it is reasonable to assume that the professional carer will be frequently confronted with cognitive distortions (eg Beck, 1991), emotional deficits and maladaptive behaviour due to neglect, abuse and trauma. Previous research (Delfabbro et al, 2004, Gilbertson et al, 2005, Bath, 2008) suggests that these issues are likely to present within the placement as maladaptive behaviour, within the constraints of a restrictive placement.

5.4 Locating Residential Care on the Continuum of Care

Debate about the use of residential care tends to locate this option at the end of placement options rather than amongst them (Knorth et al., 2008). Some suggest (Gilberston et al, 2005) that residential care should always receive consideration as a final resort due to its negative impact on attachment relationships and its deviation from normal experiences for youth of the same age. Some however, argue that residential placements supported by

professional care staff provide structured and positive care experiences for those who do not need or want to live in family based settings (Knorth et al., 2008). Still others have shared opion that new care models should be developed for troubled children (Abramowitz & Bloom, 2003), thus supporting innovative residential options such as the IPC.

Other researchers have argued that residential care maintains a vital place in alternative care and should be considered as an equal choice, not just an option of last resort (Ainsworth, Pollock & Ramjan, 2007). Suggested improvements of residential options include thorough case planning, strategies for managing difficult behaviours, integrated mental health support for youth who are served and more deliberate recruitment of care staff (Tomison & Stanley, 2001). Regardless of the model of care being implemented, it is argued that any model of residential care should include: 1) a clear purpose; 2) a child focused service, in which the placement matching regardless of cost is achieved (Clough, 2008); and 3) a commitment to training and supportive supervision of staff within the placement (Hicks, Gibbs, Weatherly & Byford 2009).

Youth with high risk behaviour have been the focus of several reviews in South Australia (Des Semple et al, 2001; Layton, 2004; Mullighan, 2008) and attempts to rethink care practice. Ainsworth (2001) has suggested that the residential care system needs to replace global models of care with more personalised residential care, a sentiment supported by the Mullighan Inquiry (2008). Debate has occurred about how residential care for adolescents with complex behaviours should be presented. Some

commentators (Colton & Hellinck, 1994) appear to favour more intimate settings with a more individual focus, despite this others argue in favor of a congregate model in which, multiple young people with major behavioural and mental health problems, can be collectively serviced (Ainsworth, 2003).

In Australia, residential care is deemed an essential care option (Bath, 2008a; Delfabbro, Barber & Cooper, 2004). Despite this it has been under-represented in terms of evaluation and research supporting it (Bath, 2008a). Despite residential care being utilized and researched overseas, the uniqueness of its use in Australia is not widely documented and this research gap raises concerns about the effectiveness of its use in Australian child protection systems.

5.5 Effectiveness of Residential Care

The effectiveness of residential care options as tools to improve outcomes for young people is difficult to determine due to wide variations in models of care, from congregate care which is state run, to state funded placements with teams of carers in individual homes (Delfabbro, Osborn & Barber, 2005). Studies conducted in the United States (Fanshel, Finch & Grundy, 1990; Teather, Davidson & Pecora, 1994), in Europe (Kalland & Sinkonnen, 2001; Strijker, Zandberg & Van Der Meulen, 2002), in the United Kingdom (Rowe, Hundleby & Garnett, 1989; Thoburn, 2010), and in Australia (Barber, Delfabbro & Cooper, 2001; Fernandez, 1999), all confirm the vulnerability to placement disruption of a sub-group of young people in alternative care populations across the Western world. The severity and frequency of poor outcomes for youth in care points out

the urgent need for alternative and effective approaches to caring for youth who are frequently displaced within the foster care system. Specialist programs and packages of wraparound services are an increasingly common approach to meeting the needs of youth in care which have been previously unmet (Gilbertson, Richardson & Barber, 2005).

Delfabbro, Barber and Cooper (2005) indicate that residential placements have different placement goals across different countries including: reunification with the biological family; placement with a foster family once stable in behaviour; rehabilitation from delinquent behaviour; or permanent care until reaching an age when they are able to live independently. Residential placements differ according to ideological and theoretical approaches, influenced by the organisational and social structures in which they exist. In the same way, backgrounds of staff and composition of teams can vary enormously (Gilbertson, Richardson & Barber, 2005). Detailed discussion of individual workers' views from previous research is beyond the intent of this current study and therefore outside of the scope. For an interesting study which explored staff perceptions see Heron and Chakrabarti (2003).

The aims of residential care placements are often unknown, given their variety and structure (Leichtman, 2006), making measurement of specific outcomes difficult to obtain and even more difficult to generalize. From study to study outcome measures vary and rarely include placement continuity over time (Parker, 1998). In a lot of studies there are frequently research limitations that prevent a generalization of the outcomes (Parker, 1998), such as small sample sizes and non-random samples (Butler, Little & Grimard, 2009).

It is difficult to determine whether the contribution of residential placement options to behavioural and mental health of young people involved are positive or negative given the range of events, experiences and problems that have occurred prior to the young person entering a residential placement (Gilbertson & 2005). There are many variables that contribute to exaccerbation of symptoms including removal from the birth home, abuse, placement instability, and placement disruption (Delfabbro & Cooper, 2004). Gilbertson & Barber (2005) critically suggest that with the consideration of the above issues it becomes difficult to determine whether the original reason for removal is the reason for maladaptive behaviours or whether complex placement issues create further problems over time. There is a tendency to suggest a failure by residential care for adverse mental health outcomes when such placements are implemented after consecutive unsuccessful foster, relative and other placements that have had poor structure, routines and poor support for mental health (Bath, 2008a).

In a recent review of outcomes Knorth et al. (2008) concluded generally that youth who enter and remain in residential care, show an improvement in psycho-social funtioning. Knorth et al. (2008) also suggest that young people with maladaptive behaviours experienced greater benefit, and for some, residential programs were better suitedfor the young person than a foster home environment. Other studies assert that youth with complex emotional needs respond more successfully to professional care than those with less problematic behaviour (Delfabbro & Cooper, 2004), suggesting that professional care should be reserved for those youth who are behaviourally and emotionally challenging.

Attempts have been made to identify the key factors of a successful professional placement. One study concluded that there is evidence suggesting cognitive behavioural strategies improve the likelihood of success (this includespositive self-talk, coping skills, and challenging of irrational beliefs), especially when accomplished with informal support (Osborn & Delfabbro, 2009). It is difficult to establish how involved birth families are in the lives of children throughout residential placements in South Australia. Programs that encourage belonging, autonomy and express pro-social behaviour are also thought to have merit (Bendtro & Brokenleg, 2001; Elgas, 2001). Although diverse, these programs are strengths based and promote developmentally appropriate skill development in comparison to traditional problem focused placements which do not teach the youth behaviour change.

The lack of clearly defined treatment approaches to guide professional carers is concerning given consistently reported high levels of maladaptive behaviour and emotional disturbance problems amongst youth in alternative care (Layton, 2003; Mullighan, 2008) particularly with youth in a residential placement (McCann et al., 1996). Sub-sections below will discuss and document views about professional carer attitudes towards behavioural and mental health problems.

5.6 Mental Health and Maladaptive Behaviour

Professional care seeks to provide an environment in which professional carers are sensitive to loss and responsive to any trauma suffered (Mclean, Robertson and Robinson 2011). After experiencing a negative impact from abuse, loss of relationships, separation

from family members including siblings, mental health and learning delays, professional carers aim to provide an environment that promotes emotional, social and academic development for adolescent. For some residential workers concern has been expressed that mental health problems may be overlooked or not properly understood by them (Hillan, 2006; McCann et al., 1996). Previous studies have expressed concern about the availability of mental health services to youth in care (Nicholas, Roberts & Wurr, 2003). Research by Perry (2006) and Bloom (2005) argues that despite advancements in knowledge about what is needed for youth in care, there is a sparseness of research that provides solutions to problems suggested by this new knowledge. Hair (2005) suggests that efficacy in the provision of mental health services to the young person could be achieved by providing professional carers with a coherent strategy and conceptual framework for understanding and addressing challenging behaviour, as well as a strategy to manage risk and de-escalate behaviour during critical incidents, while also maintaining their relationships with the youth.

Findings from a UK national survey of mental health for young people in care indicated that 72% of young people in residential or professional forms of care had a mental health issue: 60% were classified as conduct disordered, while 18% had an emotional disorder (Meltzer, Lader, Corbin, Goodman, & Ford, 2004). Increasing levels of aggression shown by young people in residential care have been argued to lead to high levels of stress in staff (Colton & Roberts, 2007), indicating that training and support in the management of children's emotion-based behaviour (Anglin 2002) while maintaining relationships would be highly advantageous. The extent to which the above ideals for care of young people regarding their emotional and behavioural complexities are

achieved is not certain, specifically in Australia where models of professional care are so varied in terms of methods and structures (Delfabbro, Osborn & Barber, 2005). The abovementioned methods of working, while possibly beneficial in most placements, may be unknown to professional carers and this lack of knowledge limits the effectiveness of the placement.

Moses (2000) argues that there is little known about the understanding of professional carers or residential workers employed within a professional placement. Also, despite residential placements being occupied by adolescents with, maladaptive behaviours mood and personality disorders, limited examination of workers' attitudes, experiences and knowledge in relation to behaviour management has occurred.

Formal training that provides an understanding of behaviour can positively impact on decisions and actions of professional carers who respond daily to difficult situations with young people in professional placements (Cameron, 2004). The underlying placement frameworks for professional care can vary widely between organizations, jurisdictions, and from one country to another, and depend on variables such as purpose and placement capacity (Hillan, 2006). Purposefully examining carer understandings and experiences is vital in order to comprehensively understand issues that are unique to various placement types as well as common issues experienced across a range of placements. Despite the emergence of some research about carer attitudes to professional placements in Australia (Mclean, 2011), little knowledge is available about the attitudes of carers in professional placements. This includes research about difficulties they experience in managing complex behaviour and ways to address these barriers and

difficulties.

5.6.1 Carer Experiences

Professional carers are likely to make a lasting impression on young people. Caring worker-client relationships can help a worker to build feelings of safety and positively influence a young person's behaviours and attitudes (Connolly, 2009). Whittaker (2009), alternatively suggests reports residential placements could be subjected to negative attitudes which can be counterproductive to the therapeutic relationship. Residential care workers are frequently subjected to critical reviews from others including researchers who call for more qualified and better trained staff (Layton, 2004; Mullighan, 2008).

A range of skills and experience level are important across the care team, as it is an unrealistic expectation for one worker to fill all roles. Young people will benefit from team competence, rather than the general competence of every team member. Perry (2010) describes one aspect of this as the young person being able to go from worker to worker for different needs. One worker may engage in the most positive discussion of family problems, while another organizes the best games and yet another participates in activities outside of the home.

In problematic placements it is often implied that carers are reactive and punitive in their approach to maladaptive behaviour. It is also viewed that they take a 'crisis' view regarding behaviour and focus on responsibilities external to the placement such as notifying the supervisor of an incident and following proper procedures (Lane, Barton-

Arwood, Nelson & Wehby, 2008). Other arguments suggested that some professional carers emphasise self-development rather than a supportive and caring environment, and may use engagement with the youth to reward positive behaviour and demand that it is earned by positive choices and behaviour instead of unconditionally as part of the care experience (Leaf, 1995).

Some authors state that in any model of professional care consideration should be given to ongoing provision of staff support, given the high levels of turnover amongst care staff in the various residential settings (Colton & Roberts, 2007; Curry, McCarragher, & Dellman-Jenkins, 2005). It is further suggested that retention rates may be improved by the inclusion of clear practice structures and supervision that supports the worker and reduces stress and anxiety related to the role of carer (Byrne & Sias, 2010). Access to co-worker and supervisory support including personal emotional support, skill development, developing coping strategies, and reasonable control over some placement decisions may enable workers to experience feelings of self worth and job satisfaction, despite the intensity and emotional strain of caring for a young person with severe emotional and behavioural disturbance (Stalker, Mandell, Frensch, Harvey, & Wright, 2007, Colton & Roberts, 2007), and in the management of behaviour in particular.

5.6.2 Professional Carer Attitudes

Very little qualitative research is available that details the unique challenges the unique experiences and problems experienced in the professional care of young people and, in

particular, about the carers'knowledge in relation to attempting to understand, support and address significant maladaptive behaviour in a professional placement. In many aspects of professional care the carers may experience stressors which are overwhelming, and could negatively impact the delivery of services that support the advancement of youth in care.

Critical examination of professional placement practices consistently suggests a need for better trained staff and improved supervision (see, Colton & Roberts, 2007; Curry, McCarragher, & Dellman-Jenkins, 2005; McLean, Price-Robertson & Robinson, 2011). A lack of any formal training is frequently suggested to be a substantial problem in professional care (e.g., Ainsworth & Hansen, 2009). Advocates of formal training do not however provide details of what training is needed. Better understanding of placement dynamics and stressors that exist for professional carers in managing maladaptive behaviour will help to educate and support workers in this 'primary' care role. To date, there is a paucity of evidence that this has been comprehensively researched.

Colton (1989) found differences in viewsof behaviour management in two care settings, but found no differences in practice or approach to managing maladaptive behaviour.

The previous chapters have noted differences in understanding and responding to maladaptive behaviour amongst participant cohorts in Individual Packages of Care. Professional carers are uniquely placed as they maintain a dual role of 'parent' and

‘professional’. It is therefore imperative to explore how professional carers are influenced in the practices they engage in to address maladaptive behaviour, and the considerations made by professional carers when supporting youth with complex behavioural and mental health needs.

5.7 Analysis and Themes

This section documents findings of a thematic analysis of 17 interviews with professional carers who describe their own understanding and experiences in responding to complex behaviour while working in an Individual Package of Care. A thematic analysis occurred as detailed in Chapter 2. Several themes emerged, and are reflective of the difficulties experienced by professional carers when attempting to support youth who are living in an IPC to address emotional and behavioural needs:

1) Negotiating personal versus professional relationships with young people

2) Challenges to a consistent approach

3) Support and accountability

4) Normality in the IPC

5) Professional carer and youth relationships.

5.7.1 Negotiating Personal Versus Professional Relationships With Young People

Some participants in the professional carer cohort reported that there was a role conflict when managing the young person in their IPC. On the one hand, there was a clear expectation to maintain a professional boundary with the young person, while on the

other hand, there was the requirement to provide a supportive and nurturing environment for them. Some professional carers expressed feelings of frustration about policy limitations that prevented them from spending time with the youth on days off.. The constant challenge of balancing support versus professional boundaries, and the impact upon the professional carer/youth relationship, was experienced by all carers, and is highlighted by this extract:

> When asked what I do, the answer seems pretty simple. I'm a professional carer for youth in alternative care. The challenge comes when I internally look at what I do. I mean on the one hand I am all the kid has for a parent with the rest of the team, so it is personal to them, yet on the other hand my employer says it can't be personal because I am paid to provide care and employed as a professional. I guess the best way to explain it is that my role is to care for them and be as friendly as I can, fair and consistent. My role is not to be a friend (PC3).

While all professional carers acknowledged the challenge of the dual role of parenting a youth in an IPC whilst being professional, some carers reported that they were able to manage it well while others felt that some individuals in their IPC team were unable to separate their emotions from their role as carer. This was reported to result in conflicting feelings as some professional carers attempted to reconcile feelings of closeness and empathy towards particular children with the expectations established within the professional role. It was interesting to note that some professional carers had no difficulty with establishing a professional boundary because they did not desire a close relationship with the young person. Instead their difficulty was found in a lack of desire to be supportive of the young person as this carer reports:

> It isn't that I don't care, I just didn't think of the young person as someone I needed to worry about when I went home. I did have a hard time wanting to be around them sometimes though because I didn't see them as someone important in my personal life, so when they did annoying or unacceptable things I had little tolerance for it (PC7).

The role conflict was reportedly more problematic when the professional carer felt that they were closely bonded with the youth. Several participants in the professional carer cohort spoke of the need to be cautious about how they interacted with the young person due to the criticism that was drawn from inferences made about not being professional. Some professional carers even reported not fitting in with the care team because they felt closer to, or had a stronger relationship with, the young person than other professional carers in the placement. Others had committed to challenging the use of professional distance, as this carer reported:

> It is not reasonable to suggest that when you go into the home of a child on a daily basis and live their life with them that you do not form a personal connection. For those making these decisions they have obviously never done a day of our work. It is not fair to keep a distance on a young person who often has no one else. Sure there needs to be a boundary set, they would never come home with me, but I don't think professional means impersonal (PC2).

Organisational and systemic policy also contributed to this pressure for personal distance between the youth and professional carers. In one example professional carers were continually reminded of the lack of decision-making power they had and the need to constantly defer to the Departmental social worker to make decisions about the

placement, including consequences for behaviour and events that the youth could attend. Frequently, social workers were perceived by participants in the professional carer cohort as neglecting to support them and to collaborate on decision-making about needs and consequences. Similarly, consequences for disruptive behaviour were often delayed because of the length of time it took to make contact with team supervisors and social workers. Many in this cohort viewed as a barrier to growth in the young person as they did not experience negative consequences for their behaviour. This placement structure ultimately resulted in a "triangulated" kind of parenting (McLean, 2011), where working through problems and providing consequences for behaviour, was impacted by interference by social workers whose roles are external to the placement. Therefore, the professional carer's parental autonomy was negatively interfered with in similar ways to that foster carers have (see Delfabbro, Barber & Cooper, 2004).

Given the intended brevity of the IPC (1-2years), further distance between young people and their carers occurred because of the active discouragement of forming bonds and lasting relationships with the youth being cared for. Some participants in the professional carer cohort reported feelings of frustration and suggested that the limited time with the young person created a barrier to how much of an impact they could have on their lives long-term. Organisational issues such as high staff turnover also contributed to the limitation of forming long-term care relationships with youth in an IPC. In the following extract, one professional carer discusses their own view of the importance of maintaining long-term relationships with young people in alternative care:

> Kids we get here are older teenagers from 16 through 17 and they are almost aged out of care. When we are all they have, who do you think they are going to call for help when

> they are struggling with something after they turn 18? There was one young guy who called and said he had been kicked out of his place and needed help. If the expectation is that we just ignore their call for help and dismiss the connection we had with them we are setting them up to fail. They obviously value the relationship they had with us, or feel comfortable with us, with some saying we are the only people who have ever cared about them (PC9).

Hillan (2008) critically analyzes the view that carers should not get emotionally involved with the youth they are caring for on a daily basis, and the consequences of this thinking. She examines the contrast between the value professional hold of their own personal relationships, and the regard the same individuals have for their relationships with young people in their care:

> It is here that I think that residential care could play a significant role, especially for adolescents. For some reason our society has moved to separate children from their families or significant relationships, and work in exclusive ways that are creating fragmented individuals and fragmented communities. This is not consistent with evidence available to us in alternative care (p. 49).

Residential care literature stresses the therapeutic benefit of the care group and the need for a relationship between the youth and carer (Ainsworth & Hansen, 2008). Through a relationship with the carer, the youth is influenced by appropriate behaviours and responses to various situations (Moses, 2000). Despite this information being available in previous research, the current analysis indicates that professional carers also feel the need to maintain a professional boundary in their interactions with youth and that

these competing obligations (personal relationship v professional relationship) create a challenging dynamic in professional carers' daily interactions with youth in an IPC.

Organisational and practice based policies have been identified overseas as factors that contribute to carers not maintaining relationships with young people beyond their role as professional residential workers (Hillan, 2006), so the finding of this theme confirms a widespread limitation of care as professional carers seek to balance caring for youth while maintaining the organisational role as carer. It is helpful to individually consider the value placed on relationships not only for the youth being served by an IPC, but also for the professional carers, in the hope of strengthening the positive impact that the professional carers have on the youth they serve. One extract recognises this:

> I came into this role to make a difference. There are days where that is harder than others. I believe what is needed is a critical look at how we have a positive relationship with a young person while still maintaining an appropriate level of professional boundaries. For me this is about the young person knowing they can count on me for support no matter what, while still understanding my life is private and they will never have a personal involvement in that. This is about me caring for them, that is personal, but professionally I can maintain a distance by not inviting them into my life (PC8).

This theme identifies that for some professional carers the requirement to maintain a professional distance from the youth that they are caring for could reduce their level of investment in the IPC because of the organisational and systemic barriers in place. They could become frustrated by the lack of autonomy in their care role caused by systemic issues such as a lack of decision-making authority over the youth, despite being

responsible for their well-being.

5.7.2 Challenges to a Consistent Approach

In describing maladaptive behaviour, almost all of the participants stated that ideally there should be a consistency of approach amongst care staff in an IPC. Yet for many there was a tension inherent to enacting such an approach, due to differences between professional carers who were less structured and more empathic, and those who were structured and policy driven. Many carers reported also a struggle to reconcile the desire for fairness and consistency, with the desire for more individualized responses to each behavioural incident and within different IPCs. In the following extract, a participant from the professional carer cohort details the challenge of establishing approaches to managing behaviour that encourage unity of care staff:

> There is such a wide range of personalities in our team that I think it's hard to find one strategy that allows us to engage with the kid consistently. One worker wants to sit outside and smoke with the kid while another wants to punish the kid because he smokes. I think it's impossible to agree on everything, but there is a need to agree on what behaviours are unacceptable or not allowed, that would be a good place to start (PC1).

Arguments from youth in multiple IPCs about the lack of consistency in how behaviour was managed were reported by most in the professional carer cohort to be a source of frustration. On the whole, this challenge was viewed and accepted as an ongoing problem and part of being a member of a care team with multiple people. One participant describes their attempt to assist the youth to understand why there is a variation in approaches to behaviour as an attempt to support the placement:

> I tell the young person that everyone has a different way of looking at things and because of this will do things differently. I have also told them that the one thing that is always the same for us is the priority to make sure we are doing what is in their best interests and it may not always be what they want. I try to show respect for how the others do things, but it is not always easy if I do not agree (PC10).

The expectation of presenting a unified team of professional carers often conflicted with an individual carer's understanding of a particular behaviour or approach to the presenting issue. Many professional carers reported that they frequently disagreed with practices established in an IPC, yet the need for adherence to organisational and systemic mandates with respect to punishment of behaviour outweighed the individual carer's practice views towards behavioural incidences and in many cases the needs of the youth, as the following extract suggests:

> I remember the night we were sleeping after an argument earlier in the evening. I could smell smoke and we discovered that he had set fire to the home. None of us wanted to go back to work with him because for so long we had been told that we could not punish his negative behaviour as it would not promote change. Instead he told us what we would be doing and when, leaving us to appeal to the case worker for a decision that would hold him accountable. This particular young man needed more structure than we were allowed to give in the placement. When he ran away for the fourth time, we simply followed the established process of calling the police who brought him back when he was found. I definitely wouldn't handle his placement the same as that of another child, he was unique and his behaviour was severe, I mean it's the whole point of calling these Individual Packages of Care (PC9).

This problem was reported by many professional carers when quantifying the disruption of a youth's behaviour on the wider community, including use of police resources and emergency medical care. Concern about the potential harmful outcomes of a youth's behaviour was displayed by professional carers by their desire to either use stronger consequences in order to protect other members of the community, or to adopt an overly permissive style of care where the young person was given what they wanted to stop them from placing others at risk. This further added to the challenge of meeting the needs of the individual youth whose behaviour is maladaptive in nature, and the needs of the others in an IPC for safety, socialization and interaction with peers, as the following participant describes:

> Because children in an IPC are isolated we make attempts to bring them together for peer interaction. This can be challenging when so many of the children have maladaptive behaviours and influence each other during their interactions. A number of kids come into group meetings yelling and swearing. This is definitely something that we have to think about because one badly behaving kid can push another to make poor choices. Some of our meetings end because of maladaptive behaviour as it creates a poor atmosphere for the kids to interact (PC13).

For some, the practice of cancelling group meetings due to maladaptive behaviour was justified by safety concerns of the group and the need for consistency across placements. This occurred at the expense of rewarding those who were making positive choices during the groups. Despite the challenge of simultaneously meeting the needs of several youth during group meetings, most carers maintained a primary focus on the youth whose care they were primarily responsible for, as one professional carer indicated:

> Despite our attempts to bring individuals from multiple placements together, I am still responsible for the young person in my care. If that youth is behaving badly, they are going to be removed as a consequence of their behaviour. If another youth is behaving badly I am still likely to remove mine from the situation because I don't want them to get hurt and I don't want them observing the behaviour and repeating it. If things are going well I will actively participate in making it a fun day for everyone but if something goes wrong, I have a direct responsibility and that is the youth in the IPC I am employed to serve (PC7).

Leaf (1995) reported that young people can flourish in care when a partnership is struck with care staff and a sense of identity is promoted. Leaf (1995) does however caution that too many people in care roles promotes a single model of care and excludes the role of relationships in favour of this. The data from this current study supports this assertion.

Severity of client behaviour and suitability to an IPC also appeared to be problematic in managing behaviour for participants in this study. Many individuals from the professional carer cohort gave examples of placements in which they had no influence about whether a young person would be placed with them by the statutory agency, as this extract suggests:

> When the IPC was first implemented the state was very picky about who they placed because they wanted us to be successful. But as stories started hitting the papers about kids in motels we started seeing a huge increase in placements that weren't so appropriate. So we got less say in who comes into our care. In some cases we don't have a choice about who we keep in an IPC either. We have behaviour problems ranging from

> fire lighting, to harming others physically and sexually, some of our placements have been very unsuccessful in stopping these behaviours but they continue anyway. We often get kids come to us after several other things have been tried and haven't worked. By operating in a crisis driven system it makes it harder to meet the needs of the youth who may benefit from our services more if they came to us earlier (PC11).

Unlike traditional residential options such as congregate care, IPC placements were reported by some carers to have the advantage of being isolated from others to prevent the behaviour of one young person influencing that of others and vice versa. Cohabitating young people with complex needs and behaviours is known to present management problems for staff and has resulted in conflicting priorities in meeting individual needs together with placement needs (Ainsworth & Hansen, 2008). In this study, professional carers in an IPC reported that this was only a problem during organized events and when individuals in various IPCs met without permission.

Previous research has documented experiences using group expectations and processesas a means for promoting behaviour management in placements (e.g., Vorrath & Brendtro, 1985). The distinction between universally applied expectations and individually triggered responses for problematic behaviour is worth consideration (e.g., O'Neill et al., 1997). The current research supports the view that there is a need to balance organisational expectations with individual needs. For example, it may be universally expected that a young person has a curfew during school days, but the response to the youth when they break curfew may be individually considered depending on the frequency of the behaviour and their regard for the rules in the home.

One difficulty encountered in an IPC when managing challenging behaviour was the need to adhere to organisational and systemic policy to be consistent across placements while simultaneously meeting the needs of each youth individually. That is, for professional carers to provide a consistent approach to all youth in line with organisational expectations and group norms, while at the same time ensuring that each individual being served in an IPC receives individual consideration.

5.7.3 Control and Support

The next theme examines the internal conflict that professional carers experience in their dual role as a carer. That is, the role of addressing maladaptive behaviour through boundaries, consequences and structure, while maintaining a supportive relationship with the individual. Unlike other themes, interview responses discussed in this theme present information about the management of a youth's behaviour and subsequent impact of that on the professional carer's relationship with the youth. Some participants had difficulty with the challenge of forming positive and supportive relationships while simulationously providing consequences, stopping negative behaviours, giving directives and manage crises that occurred. The following extract argues that the dual role negatively influences the worker/youth relationship:

> This job would have to be one of the most mentally challenging I have ever had. There are times I have been talking to the young person about their day one minute and then trying to deal with them hitting and punching me the next. Emotionally it is draining to

> be wondering when we are going to have another incident and never having a way to predict it. I think their behaviour is unavoidable because it's often not motivated by another event. That makes the need to respond equally unavoidable, so I try as hard as I can to do the minimum I need to when containing an incident. If I can push them away and leave the situation without restraining them, that is what I do (PC8).

In discussing restraint, some professional carers viewed themselves as going against the needs of the young person to address the crisis. Professional carers often felt conflicted aboutstopping disruptive behaviour, as it was often stressful and counterproductive to the overall aims of the placement, as the following participant details when describing time with the youth following a major incident:

> It is always tense after an incident. Once we have checked the well-being of the kid, it's hard to get the conversation going again. It can be difficult to pretend that it didn't happen and get on with the positive, supportive stuff that we want to do (PC6).

Participants attempted to justify their need to control behaviour with their desire to provide proper care. Their view was that limit setting, reasonable boundaried and rules for the youth demonstrated a level of concern for the young person's safety, as the following extract suggests:

> When we set boundaries and limits we are doing what is needed to care for the young person. I don't think that physically stopping behaviour should be a first choice, but it does become a case of necessity when they are smashing windows and cutting themselves and others with the glass. They need to know we care and caring isn't just about encouraging positive behaviour, it is about protecting them from their own negative behaviour (PC5).

The imposition of consequences for behaviour was viewed by many participants to have originated from previously experiencing poor parental boundaries and consequences that were either too permissive or authoritarian in nature. More restrictive behavioural interventions were justified by many professional carers as a method of communicating zero tolerance of harmful and dangerous behaviours:

> I look at it this way, when we are done with the incident, I talk about it if they want to. I don't focus on the behaviour and I don't criticize them for it. I believe the young person I work with knows that I have their back, that I want the best for them. They have never asked why I take them down later, they just don't do that. A lot of the time the incident is a talking point for change, I can tell them they don't have to act out to get what they want. I can work with them on alternative ways to express themselves. It is important to let them know we do things because we care, otherwise it is left up to them to decide why things happen and that can break the relationship in half (PC2).

Professional carers often felt that physically restraining the young person was necessary but emotionally challenging. Despite this, those carers who had been involved in administering a restraint of a young person felt that they could be used to diffuse dangerous situations and promote a change in the behaviour of the young person by demonstrating that dangerous and self-harming behaviour will not be tolerated. All participants in this cohort reported that they only restrained when necessary because they were concerned about the harm the young person may cause to themselves. None of the participants felt that use of restraint was a primary tool for addressing a situation unless the young person's behaviour was otherwise unmanageable:

> When it comes down to it, the kid has told me several times they appreciate me stopping them from doing things to themselves and others. I do care and they know it, they also know that I won't walk away, I will get them past their behaviours and poor choices (PC9).

In most cases the use of restraint could be avoided through the use of less intrusive and longer term strategies which were informed by different theories and promoted different methods of behavioural change. The application of behavioural methods as a form of behaviour management created some anger amongst professional carers who felt that some responses to behaviour were too lenient and less restrictive behaviour management would promote exploitation of the care team by the young person. Despite this there was evidence that structured behavioural approaches to behaviour were successful as this extract shows:

> We had a strike chart set up in the office for the kid we served. If he messed up enough he was struck out and had to wait until the next week to try again for a reward. He would get upset when we would tell him he didn't make his week and would have to try again next week, trash his room and break things. By becoming more focused on what he does do, there is a lot less aggression from him. We were worried at first, because, although it wasn't working well, it was all we had. Encouragers and even simple praise has promoted a lot more positive behaviour, I didn't think it would (PC13).

The place of consequences and controlling maladaptive behaviour in alternative care has often been debated. One author claims that restraint and other techniques impose control and reinforce negative emotions and do not promote self-control in youth (Morgan, 2004) and does not decrease likelihood of contact with police and other

authorities(Hillan 2006b). Hillan (2006) suggests that guidelines, policy and regulation of the use and review of restraint practices are largely under-developed in Australia (Hillan, 2006). This adds to the stress of caring for a youth in an IPC as there are limited guidelines on when and how to restrain an individual. Data in this theme suggests that the conflict between controlling maladaptive behaviour and supporting the young person is a concern for most if not all professional carers. Support for professional carers in maintaining positive relationships while administering consequences in the context of crisis situations is needed to ensure the success of the IPC.

5.7.4 Positive Placement Experiences for Youth

Participants interviewed for this study all expressed a desire to provide youth with a positive placement experience. In managing behaviour, some participants talked about doing so in a way consistent with a 'normal' placement experience. Participants shared views of how young people in an IPC were different from their peers, including being cared for by multiple people, being limited in their interactions with their peers due to placement constraints, and being treated differently by others their own age. Most professional carers emphasised a strong desire to prevent further isolation of young people and to promote peer relationships. Yet for some it was difficult to reconcile the importance of treating young people normally with the implicit culture of professionalising everyday interactions that the young person had. This limited the ability of those running an IPC to promote connection with peers.

One challenge associated with attempts to normalize the IPC was the varied definition of what is viewed as a positive placement. Concern was expressed by many professional carers about situations becoming unmanageable, rather than the youth's

actual behaviour being abnormal. The following extract illustrates the challenge in assessing youth behaviour in an IPC:

> After spending so much time with the young person our view of normal is changed by our experience with them. Sometimes they may be behaving in a way that is typical of others their age, but we find ourselves wondering what the fuck is happening, when really it's just typical teenage behaviour, occasionally a little more extreme. We get a bit clouded on our judgment of these things (PC11).

Conversely, many participants reported that some professional carers minimised the significance of some behaviours displayed by the youth in their care. In many instances behaviour was accounted for and viewed as 'normal', promoting a culture of accepting many behaviours with the exception of the most extreme behaviour. This response, details the subjective way in which 'normal' behaviour is defined in an IPC:

> The kid we have right now is pretty easy to manage. I say this comparing him to the last kid we dealt with. He doesn't do drugs or visit the city parks to prostitute himself like the last kid did, but he does try to drink every now and then. He does struggle with negative feelings about himself which has led to him leaving the home to try to meet some older women, which we do consider risky behaviour. I guess I still wouldn't say any more than any other 17 year old. I have worked with a lot of kids, this isn't abnormal behaviour any more than sneaking out to see a girl from school would be (PC14).

Problems such as this were reported by many participants to be overcome by agreeing on a definition of what was 'normal for kids in an IPC'; including behaviours that may not occur outside of alternative care. Examples of 'normal' behaviour within the

IPC included things like triangulating between workers by playing one against another and refusal to follow rules in the placement.

Despite a shared definition of normal behaviour, professional carers understandings of normal behaviour were in contrast withthe youth's experiences and views of normal. This included daily routines that were considered normal by professional carers being viewed as abnormal by the youth being served. All carers reported that this occasionally led to conflict between placement staff and youth due to carer attempts to get the youth to conform to their understanding of normal, according to normal family interactions (e.g., asking to use the phone, not leaving the home without permission), as the following extract explains:

> For years they have experienced the stranger side of normal with poor role models and extremely negative interactions. Yelling and arguing is common in our IPC because that is how the young person experienced home life. Our young person told us one night that they didn't know how else to tell people they were upset. As I try to explain that yelling most of the time is not a usual experience in the home, they get angry and argue that it is, because that is how they grew up (PC2).

Ward (2006) suggests official guidance of normal behaviour certainly has its value, yet its limitation is that by its nature it tends to be generalized rather than specific, and protective and cautious rather than creative and responsive. In particular he reports that guidance has adopted a tone of seeking to emphasize 'normal', 'ordinary' and 'mainstream' experiences for young people, in the hope of enabling them to remain or become more socially included and thus to have better life prospects, rather than

emphasizing their special, individual or therapeutic needs. Ward (2006) states that while these aims are admirable, they do not take account of the reality that, given the great level of difficulty which those currently using alternative care services bring with them, achieving the 'normal' and rejoining the mainstream is a much harder and more problematic proposition than it may initially appear, requiring professional help based upon theory and research as well as on individual insight and skill. Previous research has also suggested many professional carers may have past unresolved experiences that are difficult to acknowledge (Hillan, 2005b).

Underlying the push toward normality was an inherent failure to acknowledge mental health needs and the potential benefits of ensuring access to mental health care for young people in an IPC. The benefit of therapy was viewed by some professional carers as a burden on the placement due to the lack of frequency of sessions and the waiting list for the youth to be seen:

> We knew the young person had mental health problems but it took months just to get them in to be seen. When they were finally seen, they told the therapist to fuck off because they were trying to tell them what to do instead of build a relationship. It has been good to have someone to call about their behaviour so it isn't all bad, but they need someone they trust to work on things with. Our kid talked about not wanting to see them because they didn't think they understood them (PC6).

Psychologists, psychiatrists and counselors were viewed by all participants as removed from the care experience and unable to understand what the young person was experiencing or their maladaptive responses to stressors. Specifically, professional carers

felt that mental health professionals did not appear to understand the reasons youth were violent, engaged in injurious behaviours and refused to cooperate, which were all considered normal in the context of the IPC. This extract points out the caution that the carers in this study had about involving outside services to address mental health needs and potential implications of that for the professional carers:

> Meeting with someone to talk about the choices this kid is making is like throwing a bucket on a house fire. The worst thing is they use these sessions as another form of manipulation. They will go and say that we are abusing them or being unreasonable. Our kid went to one appointment and said that a carer was yelling at them and then restrained them one night. He never told the therapist that he trashed the house, set fire to it with two carers inside and then refused to stay when the police told us to keep him there. What makes it difficult is that the mental health workers then call the social worker and we get told we didn't manage a very difficult situation well and need to treat the young person better. In the end they get what they want, not what they need (PC7).

Addressing mental health problems was viewed by professional carers as labeling of youth and causing disruption in other areas of their life such as school and other activities; or it was usually more disruptive to the placement following a session. Mental health professionals were viewed as interfering in the care team's attempt to establish the youth's sense of normality in the placement. Mental health services were also viewed as demeaning to the care team with some suggesting that they felt that they were being told how to manage the young person instead of receiving suggestions for approaching maladaptive behavior. This extract illustrates one professional carer's perception of mental health workers and counseling support:

> There is a severe disconnection between what they decide and what we see. I frequently

> feel like what we think doesn't matter, because they have the training and the degree. From what I have seen and experienced, the mental health workers like to think they have the only solution. It would be helpful to take everyone's experiences into consideration (PC12).

All participants commented negatively on the involvement of outside mental health professionals. At the less intrusive end of their involvement, professional carers viewed mental health professionals as unknowledgeable of the IPC. Professional carers suggested that at the more intrusive end of their involvement mental health professionals were most damaging to the IPC when their recommendations were implemented and resulted in placement problems, as this extract states:

> For months we had been working on reducing the young person's impulsive behaviour and the therapist that we were working with kept suggesting to the youth that we were treating them poorly. They even told him that we didn't want him to be happy. He would come back from sessions and tell us we needed to stop being so restrictive. Eventually we were instructed to start letting him catch the bus to school against our experiences with the kid. He started calling, saying he would be late and then one night ended up in the city calling us to come and get him. By the time we got into the city he had been picked up by the police for disrupting traffic. We tried explaining this to the therapist but they suggested that this was their response to us controlling them for so long. When I asked what happens when they turn up drunk, I was told I better make sure that doesn't happen (PC1).

Despite the above example being a less common occurrence in an IPC, it does

illustrate the view that those who are external to the placement but are providing support have a poor understanding of youth behaviour in the context of an IPC.

There was an evident frustration experienced by participants in this study who were asked to conform to systemic and organisational requirements in their role. This finding is similar to those of previous studies (Berridge & Brodie 1998; Berridge 2002), that the IPC does not take into consideration the individual needs of young people and their mental health problems, as they are neither explicitly recognised nor individually addressed in their IPC. It was evident that where specific help was offered by the professional carers, they experienced an improvement in their relationship with the youth.

The IPC adds to the various typologies of home identified by researchers such as Berridge (2002) and is perhaps less dominant as a model of care but offers a solution to youth whose experience in care has been disruptive and inconsistent. Given the uniqueness of the needs of young people, normalizing their care can be a challenge and with the continuing lack of training and staff development opportunities available to many of them, professional carers are often left to interpret policy as they understand it, further isolating young people socially and developmentally.

There is a significant challenge in determining what is expected and ‘normal’ in an IPC. While other professionals who support IPC placements may be well intentioned, the youth may manipulate them into making assumptions about the treatment of the youth and subsequently make recommendations that are contrary to the needs of the young person. Developing consistent patterns of positive behaviour and thinking requires

persistent support for the young person.

5.7.5 Professional Carer and Youth Relationships

This theme reports the difficulty that professional carers had with forming consistent and supportive relationships with the young person being served by the IPC. All participants reported that experiences with young people were unpredictable at best and at times distressing. Professional carers discussed the difficulty they had in maintaining positive interactions with the young person. All participants stressed the importance of their relationship with the young person to positively influence, support and model appropriate behaviour, as the following extract demonstrates:

> I can't say it enough, we are all some of these kids have, if they don't have a relationship with us, they don't have much chance of having appropriate relationships. Normal for these kids has been years of abuse, lies and disappointment. Defining normal is hard to do but we try to care about them in a way that shows them what is acceptable. I don't know that I like the word normal, because it can mean so many different things, but in this place it means making life a little less like it was. I am available to the young person but not forceful, they don't need someone else telling them what to do all of the time (PC2).

Due to the extreme nature of the maladaptive behaviours experienced by professional carers, they all stated that at times they found the caring experience distressing, frustrating and overwhelming. Some participants reported that they felt targeted by the youth they served because they were not as close with the youth. The same participants reported that they experienced aggressive behaviour and verbal abuse

on a more frequent basis than other professional carers. One participant reported the following:

> Because I won't cross the line and have a more personal relationship with the kid like others do, they don't like it when I say they can't do something. They can be fine for one group of carers because they do whatever the kid wants, but then get pretty aggressive during a shift with me because I say no. Our care styles are different, it doesn't mean one is wrong, the kid doesn't get that (PC9).

All participants reported that they frequently experienced abusive behaviour as a result of the youth's feelings and responses to their decisions. They also reported that this impacted negatively on job satisfaction and their desire to continue caring for them:

> Some weeks we don't get a break from the violence and aggression in the home. It is hard to maintain a positive attitude when working so hard just to keep a young guy in a home. When they unleash on a daily basis like this, I have thought about whether it is worth staying or not. I mean, I need a job but in comparison to the stability of the employment, we are asked to endure a lot (PC13).

The negative experiences and subsequent effort required by professional carers were consistently viewed by all participants to be unequal to the progress and benefit produced by their effort, in terms of improvements in the young person's behaviour. Participants all felt that they were manipulated into arguments with their young person some of the time. This occurred through refusal to complete tasks, leaving the home without permission, name calling and negative statements about carers. More concerning

were arguments that occurred following extremely difficult situations requiring physically restraining the young person and locking down the home. Some participants stated that in some IPC placements they never connected with the adolescent and efforts to connect were unsuccessful. This poor connection made efforts to change behaviour and promote a positive environment for them very difficult. Despite this being the experience of some participants, most felt that they had positive relationships with young people who simply attacked them physically and verbally for reasons other than their relationship, as this extract explains:

> Their behaviour isn't personal; it's not about us and them. They have a bad visit, they have to take it out on someone. If the social worker says no, they have to take it out on someone. We just happen to be closer, we don't have to have done anything for them to go off, in fact half the time they don't want to hurt us, they don't have another way of expressing how they feel (PC7).

In addition to the stress resulting from the consistent need for participants to manage problematic behaviour, some participants also experienced anxiety because of the inability to predict the future actions of the young person in the home. Maladaptive behaviour was often unpredictable and unprovoked. Participants reported that it was not possible to continue to use the same behavioural management techniques to address negative behaviours as these techniques did not always work in similar scenarios. This reduced the effectiveness of the care team as they attempted to identify a positive behaviour management strategy for the IPC, as this professional carer identifies:

> What might one day, might not work the next for exactly the same behaviour. Sometimes we can try something for a week and it's really successful and then the young person

> loses interest a stops trying to maintain good behaviour. Last month we were taking the kid to school and he didn't want us to drop him at the gate. This month we let him catch the bus and it seemed to work for a while. Last week we went back to dropping him at the gate because he was found in the city by the police one afternoon. It may change again depending on how they continue to respond. If they completed the tasks assigned to them in the home they get game time, this is really effective right now. Last year when we tried it they just smashed everything in the home. We have also learned to set reasonable expectations, giving reminders when needed and not being critical when they don't get things right. This week he has got up on time and got ready. That has been helpful for us. Sometimes switching between strategies works also (PC8).

The IPC environment appeared to promote a flexible approach amongst participants including multiple strategies that they could use in problematic situations, as discussed in the previous extract. It was also identified that it was not possible to use one strategy multiple times and be successful all of the time as this extract suggests:

> The placement does have expectations and corresponding consequences, so it is quite choice and consequence based. Some of the time this works well, but it is not reasonable to assume that this will always have the desired effect. If we limit ourselves to one approach to managing the behaviour of young people in our care, we are depersonalizing the IPC and going against the intended purpose of this model of care, which is to tailor services to meet the particular needs of the client (PC6).

Concern was expressed by participants who felt they had a good understanding of the purpose and origin of a young person's behaviour and interacted positively with the young person, but felt ineffective when the young person displayed maladaptive

behaviour despite this understanding. Professional carers then felt the need to shift their thinking, explanations, solutions and consequences for behaviour. As a care team, participants felt that inconsistency was a key problem in the interaction between themselves, the young person and the team of professional carers in the home.

Some participants were critical of the young person's past and suggested that the reason for strategies being ineffective was the result of previous placement disruption and poor placement experiences prior to coming into the IPC. Because of these experiences, some participants felt that the youth's disrupted attachment impacted their ability to form current relationships. This thinking conveys a similar view expressed in the previous chapter that some youth do not want or need an attachment based relationship. Conversely, some participants felt that challenging behaviour was indicative of the importance of the carer's relationship to them. This points out the caution needed when identifying why a youth behaves the way that they do and supports the need for further research into the correlation between the behaviour of a youth and its relationship to the care experience.

Workers who had been in an IPC and witnessed a young person leave care following their time in an IPC discussed having motivation through hope, and ongoing belief in the possibility for change; which may occur sometime after care has ended:

> It would be nice to see the immediate impact of our work, but we do this for lasting change and I would be happy to hear a year from now that the young person is doing well. We can provide the environment for change, the support and the care needed and never see the actual change. It is good to be hopeful for the young person that change will

occur at a level that is lifelong. I love the thought of being a part of someone's life turning out well (PC1).

The views and experiences of professional carers suggest that ineffectiveness of relationships and the need for multiple strategies are stressful for professional carers as they perform their role in an IPC. The proportion of effort against change in behaviour and perceived control over maladaptive behaviour as well as views on reward are acknowledged as factors that need consideration in preventing burnout and carer turnover (Ward, 2006).

Others researchers have discussed the resistance and maladaptive behaviour frequently displayed by youth in care and disruptive emotions that carers could experience. The emotions experienced by profesionals carers have the potential to inhibit their understanding of the youth's behaviour and to respond in a constructive manner when negative (Fitzgerald, 1994). The findings in this theme suggest that training that promotes reasonable expectations and positive emotions regarding maladaptive behaviour would be helpful. This theme also confirms how the inconsistency in behaviour of youth and within the placement can present a stressful challenge to those who serve young people in an IPC.

5.8 Discussion and Summary

South Australian reviews of alternative care advocate for better training of workers including development of skills in and knowledge of issues related to mental health and the management of complex behaviours (Layton, 2004; Mullighan, 2008). While it is

essential for professional carers to be skilled and knowledgeable in the areas of practice that they may engage in during their time in an IPC, the findings in this chapter report many variables that need to be considered within an IPC that require careful consideration of the young person's needs as opposed to the imposition of standardized practices or procedures. A large number of the stressors and concerns identified in this analysis present a significant practice challenge in attempting to resolve them.

Conflicting demands on IPC placements between the carer group and the client; professional versus supportive roles; and the need to set boundaries while simultaneously maintaining a relationship with the young person are all delicate balances that are likely to be influenced by a combination of individual, organisational and systemic motivation. The struggle to balance such competing needs are best summarized in Maier's (2006) view of systems on relationships:

> It is true that individualism in the extreme is an antithesis to organisational order, yet the reverse is also the case: Organisational rigidity negates individuality, which is apt to receive less emphasis inorganisational deliberations (p. 3).

In some instances expectations within a placement need to be consistent across placements and may include rules about curfew, how people are approved to come to the home and other issues which require common guidelines. It is equally important to acknowledge that while there will be some consistent expectations, the approach taken to implementing these guidelines should be flexible and considerate of the feelings, needs and responses of the young person. One very contentious placement need that requires a general policy is the use of restraint. Carers in this study consistently reported their

preference to use other means to address conflict and danger but all conceded that some of the time restraint was essential to keep the young person safe. When associated with concern, the use of restraint could be argued to be a responsible and caring action for the protection of the youth and others.

It is essential that those who support IPC placements in other roles including mental health workers and social workers understand these role conflicts when seeking to engage with professional carers in order to support youth with behavioural problems. Professional carers could be concerned that professional from other cohorts do not understand the depth of the challenge they face in managing the behaviour of the young person on a daily basis and may therefore not feel supported (Nixon, 1997). Improved communication between stakeholders appears essential here to improve both communication about what is happening in the home, and knowledge sharing to aid in the development of strategies for improved outcomes and reduction in maladaptive behaviour.

Piersma (1985) argues that the commonality between birth family and alternative care experiences is found in the balance of time that is spent with the youth. In the traditional parenting relationship one parent is absent from the home for a large part of time so their view is different to that of the parent in the home. Similarly, with the therapist out of the home most, if not all of the time, the difference in opinion is created by the very different experiences that each cohort has. A professional carer is going to experience the behaviour of the youth on a more frequent and intense basis than any other stakeholder. Conflicts between cohorts include time spent with the youth, authority and

misunderstanding. These can reduce the positive impact of mental health workers on the placement when professional carers fail to trust them (Piersma, 1985).

This analysis supports the need for an improved understanding of behaviour within an IPC by those serving the young person from outside, including social workers and mental health workers. This is particularly relevant when those outside of the placement provide advice about the management and care of the young person including their maladaptive behaviour and mental health problems. It would be helpful for mental health workers and social workers to be aware of the stressors that professional carers experience when attempting to address the needs of the individual youth and the care group's need for rules and approaches that standardize the care experience. It is unlikely that professional carers will embrace the views of those outside of the placement without consideration, respect and concern for their experiences by those who are offering such advice. Professional carers can provide valuable details about the needs of the young person and describe the actual events as they occur to provide a clear basis for decision-making and diagnosing of problems by those outside of the placement.

The inability of professional carers to use their position as carers to encourage and develop positive change in young people, are concerns that mental health workers should be aware of in their attempts to offer support to the placement. Studies consistent with the current analysis have shown that ineffective care is linked to behavioural and mental health problems (Gelfand & Teti, 1990; Laub, Daniel & Sampson, 1998). It is important that professional carers balance their role with supportive interactions as well as structure

rules and other behavioural strategies for the young person. The role of the carer in an IPC is complex, and requires an acute awareness of the antecedents for behaviours and from there an understanding of how to most appropriately address the youth's needs. In some situations this may mean talking a young person through feelings of low self-worth while they damage property, to avert an escalation in behaviour.

An understanding of the professional carer's role in reconciling behaviour management with support for mental health needs is thus an important consideration when seeking outside support. For example, removing a youth from school or other activities for a weekly or monthly appointment is likely to be perceived as disruptive, and in some cases detrimental to the running of the placement. This may be because it is unlikely that a mental health professional will understand standards of 'normal' that are applied to an IPC; possibly raising frustration amongst carers, and increasing the frequency of maladaptive behaviour and personal attacks upon care staff. The risk of seeking outside help has been identified as of concern to all participants in this analysis and its impact upon the emotional resilience of youth in care is certainly something to consider in the ongoing implementation of IPCs.

Finally, and echoing the findings of Hillan (2008), this study suggests that a caring, nurturing relationship within the care team is an important factor in positive outcomes for youth in an IPC. It is unlikely that psychologists, case managers, social workers and others external to the IPC are able to provide the level of support required for the young person to feel nurtured. This analysis suggests that professional carers may be discouraged from such personal relationships by systemic and organisational policies,

despite the reality that many youth in an IPC do not have any other significant relationship and would benefit from a more personal approach to care. Adolescents who find themselves in an IPC may therefore benefit from strong interpersonal relationships with professional carers. It is important to value the complexity of the role of the professional carer, the daily challenge to manage maladaptive behaviour, and the constant stressors associated with the behaviour of the youth. It is important for other stakeholders to be inclusive of the views and experiences of the carer as they can be valuable in determining the individual needs of the young person.

CHAPTER SIX

Former Client Experiences of Being in an IPC

6.1 Overview

The literature reports that the voice of youth is an important consideration in research about alternative care and what is needed for positive change (Delfabbro, Barber & Bentham, 2002; CREATE Foundation 2004, 2005; Gilbertson & Barber, 2003; O'Neil, 2004). In 2003 Gilbertson and Barber published findings of a South Australian based research project which revealed poor social work practice impacted significantly on placements in the following ways: inadequate preparation of carers; poor communication with children and carers; and inadequate consultation. This chapter focuses upon the views and experiences of ex-guardianship clients who were previously placed in IPCs within the alternative care system in South Australia. Specifically, this chapter identifies former youth experiences with their IPC in terms of behavioural outcomes, support of family contact, relationships, education, health and identity needs. The importance of including young people in research about their care is documented by Fernandez (2007) who states that the voices of young people in care provide valuable insight into concerns, perceptions and experiences of those who are serviced in alternative care worldwide.

Gilligan (2002) further asserts that inclusion of young people in foster care research empowers them, placing them centrally in the process of informing policy and practice.

6.1.2 What is Known About the Views of Young People in Care

Osborn and Bromfield (2007) suggest that in a majority of cases young people in care consider foster placements to be secure, happy, and supportive and their case workers as helpful. The main complaint of those in foster care is that they would like to be more connected with their birth families and have more contact with them (Delfabbro, Barber & Bentham, 2002). Young people in care have also reported examples of unacceptable practice in care including high turnover of case workers and frequent disruption of foster placements (CREATE Foundation, 2004). The CREATE Foundation report also found systemic problems that create distress for young people in care, including slow procedures that prevent timely responses to needs, court processes that do not take into consideration the wishes of the youth, lack of resources and support, and lack of resources and inadequate support in leaving care. Where youth had experienced placement breakdown, a study by Gilbertson and Barber (2003) found that persistent problems included inadequate preparation of carers, poor communication with children and carers, and inadequate consultation between stakeholders. Their study also suggested that chronic distress was felt by most participants when placements broke down.

Young people in care have also noted the value of having trusting and supportive relationships with at least one person. O'Neil (2004) reports that children felt that adults who valued and listened to them were an important resource. The CREATE Foundation

report (2004) states that all participants in the study suggested that the carer was the most influential person in whether things went well for them or not. Cooperation within a placement and success was also suggested to be more likely to occur when the carer and others were considerate of the wishes of the young person (Delfabbro, Barber & Bentham, 2002; Mason & Gibson 2004). Previous research suggests that where a young person's views are taken into consideration, their care experience improves because self-esteem is enhanced when they have more control over their lives (Delfabbro et al, 2002).

For young people in care the importance of their relationship with their social worker is a theme that has been reported in previous research (see Baldry & Kemmis, 1998; Bell & Eyberg, 2002; Morgan, 2006; Winter, 2009). Research indicates that for some children in care, they have an opportunity to establish and maintain a good relationship with their social worker (Winter, 2009). Many researchers report that the qualities most appreciated in a good social worker by young people are: genuine concern for the young person; listening to the young person; and helping maintain contact with family (Baldry & Kemmis, 1998; Fletcher, 1993; Lynes & Goddard, 1995 & Morgan, 2006). What they ask for is a professional who takes an interest in them, wants what is best for them and enjoys time with the young person (McLeod, 2008). Relationships with social workers have been argued to be the least reliable that a child in care should expect (Le Grand, 2007).

While a positive relationship with a social worker is important, it has also been suggested that young people in care experience frustrations, disappointments and

negative experiences in their relationships with social workers (Morgan, 2006; Leeson, 2007; McLeod, 2007). A combination of infrequent and inconsistent visits, unreliability, frequent changes of social worker and competing role demands that prevent an effective relationship with the young person have all been reported to damage the relationship that the young person has with their social worker (Morgan, 2006; McLeod, 2007).

Yet despite the above findings on what produces best outcomes for children in care, Osborn and Bromfield (2007) suggest that decisions about the needs and experiences of young people in care are rarely informed by the viewpoints and experiences of young people themselves. Ongoing focus must be given, as this chapter does, to the voices of young people who have grown up in the care system, and the specific experiences of children across a range of locales. This chapter, with its focus on young people who have experienced an ICP, provides a unique insight into the experiences of this specific population.

6.3 Analysis and Themes

A thematic analysis was conducted on the nine interviews undertaken with former IPC clients as discussed in Chapter 2. Several themes emerged and reflect the care experience of this sample:

1) Care experiences before and after entering an IPC

2) Readiness of IPC placement for the youth

2) Professional carer attitudes and behaviours

3) Improving behaviour in an IPC

4) Social worker influence on an IPC

5) Improving outcomes in an IPC

6.3.1 Care Experiences Before and After Entering an IPC

In describing the time prior to entering an IPC all participants stated that they had entered care at a very young age, with most of their care experience being negative prior to entering an IPC. Participants in the former youth cohort stated several reasons for viewing their placement experiences as negative including: 1) multiple placement breakdowns; 2) lack of support in meeting health, education and social needs by the social worker; 3) poor birth family relationships due to lack of contact; 4) poor social and behavioural choices by the young person; and (5) negative relationships with Families SA social workers. In addition, some participants reported that they were physically and emotionally abused by foster carers with examples including being hit, kicked, locked in rooms, yelled at and given derogative names prior to entering their IPC.

When describing placements that occurred prior to entering an IPC seven participants felt that their placements were not compatible with their needs or were with carers who were not equipped with the skills to manage complex behavioural and mental health problems as this extract demonstrates:

> By the time I got into an IPC I had four placement breakdowns. All of the placements I had ended because the carer didn't want an older child and the Department placed me with them anyway. Because the Department was desperate they shoved me where the

> carer was free and needed a new kid to care for. They didn't care if I got along with the carer or if they could deal with my problems, they just had to make sure I had a place to go (FY1).

Eight of the young people in this study reported that their care experience gradually improved after entering an IPC. Some of the participants suggested that they were concerned about entering the IPC because of their poor history with suitable placements, but were relieved once they experienced the support of the care staff who engaged them and assisted them to settle into the placement. One participant advised that they were quite excited about the new experience and were hopeful that it would be an improvement on the series of negative placements experienced with traditional foster care. Another participant advised that they were open to a new experience with the IPC but were apprehensive about the placement being different to traditional foster care. All participants suggested that an IPC was better in some ways than traditional care, but was problematic in some areas common to traditional care including communication between agencies, poor placement structure and lack of consistency in the skills and abilities of carers.

Prior to entering the IPC relationships were problematic for a number of reasons. For six participants the IPC improved several aspects of the alternative care experience, including increased support, being the focus of the placement, more flexibility in how the home was maintained, and a general increase in the positivity felt about the relationship. There were systemic challenges reported that made it difficult to transition into the IPC

and some carers were viewed as problematic; this will be discussed in detail in a later theme. When reflecting on previous placements, several participants reported on their negative aspects:

> Every time I was dumped in a new placement, I hated the carer and always screwed up to get kicked out. They didn't even try and put me with someone who liked me or did stuff with me. They always yelled at me when I got into trouble and never supported me when I tried to fix things (FY3).

For some youth their experience was with older foster carers prior to entering an IPC. Five participants reported that they had lived with older people and suggested that they were more restrictive in what they allowed them to do and less tolerant of negative behaviour, which is illustrated in the following response:

> I had one carer who was so old that she never let me do anything. I couldn't make a mess in the house, I couldn't have friends over and she was always grouchy. Kids in care should be happy in their placements. It would have been so much better if they put me with someone who liked the things I did (FY6).

All participants reported that they wanted to have relationships with their birth families prior to coming into an IPC but experienced refusal to facilitate visits and in three cases participants reported that the carer told them their parents didn't want to see them as this former youth identifies:

> None of the carers I had understood why I wanted to see my mum, they didn't support it at all. It was shit because they always put a stop to it. Our families matter to us and

> people shouldn't be carers if they don't want to support that. If the Department wants us to be happy they should place us with carers who want to help us (FY9).

The above extracts describe the many challenges faced by youth in traditional care. Unlike the traditional forms of care, the IPC was experienced to be accepting of older youth and as actually targeted at young people who were older (13-17yo). One participant reported that while traditional carers placed too many expectations on the young person to conform to strict social norms including house rules, family practices, routines and general social expectations, a key advantage of the IPC was that it was more focused on them and their beliefs. Whilst structure and rules existed in IPCs, they were centred on the young person. Six participants felt that the carers in traditional placements did not place their needs first, and were often motivated to care for foster children by the payments they received and not due to a genuine desire. Despite professional carers being paid, participants in this study felt that they did not focus on payment when caring for them, as indicated in this extract:

> I never heard a carer in an IPC mention getting paid or that the job wasn't worth it because of the money. I never stopped hearing it in my last placement. Carers were supposed to be volunteers, but the foster placements usually sucked because they didn't give a shit about us or our needs, as long as they got paid (FY4).

Traditional placements have been reported to be ineffective in meeting the needs of young people (Delfabbro, Barber & Cooper, 2004). The above extracts point out the many challenges that youth face in care including: incompatibility with carers; restrictive placements that limit social and personal interactions; and poor frameworks for

maintaining identity as many carers do not support birth family contact. The IPC appears to be an improvement in these key areas as all participants reported feeling less pressure to conform to the norms and expectations of others in an IPC.

6.3.2 Readiness of IPC Placement for Youth

Despite the IPC being viewed as an improvement in some aspects by all participants, they also indicated that the transition from traditional care into an IPC needs to be handled delicately by the care team because of the often distressed state of young people who are placed in an IPC. Participants identified that they were placed into an IPC when they were experiencing a crisis in their foster placement, sometimes due to their own behaviour. Several participants stated that they were simply 'dumped' into the IPC without knowledge of the carers in the placement or how the placement functioned. The participants identified several reasons why the placement needed to be planned, with the most common being: 1) time to get to know the care team; 2) time to find out about the structure of the IPC placement; 3) time to terminate the relationship with current carer; 4) time to allow the care team to prepare for the young person; and importantly 5) time to rectify issues within the IPC including staffing and other shortfalls. Preparation to move into an IPC was expressed by 8 of the 9 participants as a helpful way to reduce stress and concerns for the young person. The following extract reports how one person felt when moving into an IPC from traditional care:

> When I moved into the placement I would have preferred to get to know people than being thrown in so I could suss the place out. It would have been nice to say seeya to the old lady who looked after me before it too, even though I didn't like her looking after me, I still want to know she thought the new placement was a good idea. It would

> have been nice too if the agency actually had real staff instead of ring ins all the time (FY3).

Whilst all participants acknowledged that it was not always possible to ensure a smooth placement transition during a crisis, many suggested that taking time to work with them to achieve the transition would be most helpful, as the following two extracts report:

> It's not ok to throw money at a placement with a bunch of people off the street and then send us there. It's worse than no placement at all in some cases. We need to be respected and made to feel like people care, I wanted to be comfortable in the new placement, not worried about whether the people were ok. The department needs to learn to take more care with this kind of placement, I would have done a lot better if they had (FY4).

> I was scared going into the IPC because they didn't tell me who was going to be looking after me. The foster carer packed my stuff up and the social worker picked me up and took me to the placement. Even if the social worker made a visit before to tell me what was going on, it would have made the whole thing a lot easier to deal with (FY2).

All participants made similar comments regarding transition into IPCs. They suggested that IPC placements should be carefully planned with a proper transition into the placement. Some participants reported being forced into an IPC quickly, following a placement breakdown, because there was nowhere else for them to go. All participants commented similarly that having time to adjust to the IPC placement format and the staff

in the placement would have allowed them time to feel comfortable with the placement and would have encouraged the natural development of relationships between the care team and young person including transitional weekends or visits with the care team. Stanley (2007) emphasises the damaging effects of lack of continuity of care. Stanley (2007) suggests that mental health and behavioural problems are associated with high placement turnover and abrupt disruption to placements. Concern about the transition and use of placements were echoed in all interviews. The following extract exemplifies this concern:

> Throwing us into an IPC because there is nowhere else is a bad reason to place anyone. I came straight from detention into an IPC and it was crap. Daily shift changes meant new people and the agency not being ready and I didn't even know who the long-term carers were for months. These things should be planned and one placement should flow onto the next. I get that the department has to pay for it, but they'll save money in the long run if they keep us in one place (FY9).

When participants were asked if they believed that the role of the carer was clearly explained to the carer when they entered into their IPC, they all argued that many carers did not appear to understand the care role, with observations such as carers sitting alone during shifts and reporting that they didn't know what to do some of the time. One participant felt that carers were simply pushed into the placement off the street with little preparation other than a brief history of the client and verbal discussion of the house rules. The same participant stressed that many of the carers in their placement were

recruited quickly and given shifts with little time between interviews and starting work, as the following suggests:

> When a carer was missing, I used to ask the coordinator all the time when they would be replaced, they would sometimes tell me that people were being interviewed on the day I asked and might start the same night. It was crazy, the really new ones who hadn't done it before turned up shitting themselves (FY3).

Another participant said that one new carer in their placement appeared nervous, lost, and asked many questions about what needed to be done. This created disruption in the placement when new carers arrived and they did not follow the established routines and would not assist the young person to complete and achieve tasks without checking with supervisory staff first. Several participants emphasised the disruption caused by carer turnover:

> I was in an IPC for over a year and the new carers were usually always hopeless. They never knew how to talk to me, what the go was around house, when to pick me up and drop me off places. They didn't even know what they were allowed to tell me and not tell me about. I had to go through the same shit with every new carer. The ones who got it were good, the ones who didn't were shit all the time, it was so hit and miss (FY8).

> Some new carers would arrive and ask me what was supposed to happen, including asking me what the routine was. Sometimes I couldn't be fucked, they were there to look after me not the other way around (FY5).

> Carers constantly turned up without knowing what they were doing, I might as well have been on my own, they didn't have a clue, I asked one of the carers one day if they had worked with kids before and they said they hadn't, the agency was desperate, not many of the carers I had knew anything about what to do (FY3).

Participants indicated that they felt many carers lacked the ability to manage daily issues as they arose, including issuing medication, planning and appointments. One participant said that some carers would panic when a program was cancelled and a supervisor was not available to make a decision about what to do instead of the program. Some participants emphasised that the major skill deficit amongst carers was their inability to handle conflict, with most carers calling supervisors and social workers to resolve it for them. Barber and Delfabbro (2004) have previously reported on this, suggesting that placement breakdown occurs when carers are poorly skilled or equipped to manage the complex maladaptive behaviours that young people present with. Other participants stated that some care staff were so ineffective that they could not complete basic daily tasks such as preparing food or washing clothes, as this extract identifies:

> Some carers were rubbish; they sat back and did nothing because they didn't know how. I had one carer who tried to help me wash clothes one day and didn't know that I needed laundry powder to wash them, I guess it explained why they stank all the time (FY3).

One participant reported that the carers would often argue about the requirements of their role, as some would do more than others. This confirms the findings in the previous

chapter which identified that carers were often inconsistent in their approach to the young person, with a variation in styles. The variation of interaction by carers with young people was reported by all participants and is demonstrated in this extract:

> Some carers in the placement would come over and do their own thing and leave at the end of the shift, others would do things with me, play games, take me places and do things for me. There was clearly nothing said to them when they started the placement, because I always noticed that the hard working carers would always get upset with the ones who chose to do nothing. One carer told me that if they hadn't worked somewhere else they wouldn't have known what being a carer was about, because the agency had told them nothing about the role (FY7).

Each participant commented on the ability of the professional carer to perform their role, and stated similarly that they thought that the ability to perform the role of carer in an IPC was usually dependent on each carer's knowledge about their role. In correlation with this view, many participants suggested that poor role knowledge translated to some carers lacking the ability to engage with them or meet their basic needs. Hicks, Gibbs, Weatherly and Byford (2008) suggest that the actions of a carer need to be supported by training and education that promotes cohesive strategies. Participants collectively stressed in similar ways that they did not feel that all carers had the experience or qualifications to appropriately support them in their placement as these extracts suggest:

> I asked my carer one night if they were qualified to do the job. They just laughed and said that they didn't need to be qualified to baby sit (FY2).

> Some of my carers were uni students, which was cool because we had stuff in common, but not so cool when stuff happened, because they always freaked out. Some even told me they didn't know what to do when I got into trouble or needed help, seriously, why bother (FY3).

Some participants stressed that some carers were so poorly suited to the role that they made irrational and inappropriate decisions about case management and other important areas of care without the social worker's or manager's support:

> Some of the carers I had were some of the dumbest people I have ever met. They lacked the basic skills to look after themselves; I shouldn't have had to be cared for by people like that (FY6).

Participants in the former youth cohort reported that the role of the professional carer varied depending on how the placement was managed by the statutory agency. The experiences of many participants suggested that it would be helpful for carers to enter the placement with some basic care skills, with many stating that they would prefer that carers came into the placements with the skills and ability to care for them, thus demonstrating that the agency is committed to providing a high level of service. Participants offered many suggestions for what kind of training should be conducted including: teaching living skills; conflict management; working with young people; managing crisis; and keeping clients safe. Participants felt that the carers should not be allowed to work in the placement until they: 1) clearly understood their role; 2) knew the other key positions and their roles including the FSA social worker; and 3) understood how to maintain the placement and interact with the young person. All participants felt

that this would be better managed if FSA adopted a service standard that was adhered to in all placements as this would eliminate role confusion and prevent crises as these extracts demonstrate:

> I don't care how the placement is run in the end, but it was fucking confusing when it changed with the social worker, they need to have a baseline thingy or something (FY1).

> I hated the changes to the placement all the time, there were new rules every day. Families SA should have stepped up and said that this is how it is (FY5).

> In fairness to the carers it was hard to know what they supposed to do because no one ever told them. I remember some carers starting their placements and me having to show them what to do (FY9).

Poor understanding of the professional carer role caused noticeable tension for many participants as there was no structure or established practices in the home. Seven participants felt that when left to do their own thing, some carers chose to do minimal work and showed little interest in them, as these extracts suggest:

> Seriously, these carers need to be given something to base their practice on, Welfare wants to use them, they should be setting the rules, I got sick of people sitting around doing jack shit because they didn't have to if they didn't want to. At least if there was a set of rules, everyone might have a chance to get on the same page (FY6).

> I just thought the placement would be made so much better if everyone knew what was going on. To me it would have made sense if there was one set of rules for every

> placement, which I am not sure if there was or not, but the rules changed every day in my placement and that was bullshit, kids aren't test toys to try things out on (FY7).

> Rules would get rid of the lazy ones and make sure the others can find out what they are supposed to do. Families SA could have made it clearer what the carer was supposed to do through writing rules, their job is to make sure we are looked after (FY9).

All of the participants reported similar experiences with carers who lacked the skills and abilities needed to perform their jobs. One participant felt that employing people with educational qualifications specific to youth work or foster care would have improved their performance as some of the issues resulted from carers simply not knowing what to do or say in particular situations. Other participants stated that ongoing training for carers would have allowed the carer to identify their own deficiencies and work towards improving the service they provided to the young person, as these extracts suggest:

> If the carer had training they wouldn't have screwed up as much as they did. Some carers were thrown into the placement and didn't have a clue what to do (FY3).

> There was definitely a difference between the carers who had training and the ones who didn't. I had one carer who sat on the phone all night and never spoke to me, it was crap. Another carer came on shift and did things with me, looked at homework with me and made me feel important, carers need to know that's how they should treat us (FY8).

Poor sharing of information about the client's history from the Department to professional carers contributed to their lack of preparation regarding the young person's needs and their reason for being in care. Participants reported that they never saw any carer reading a copy of their case plan including their case history, and several participants reported that the carer had told them that they had never seen a case plan or historical document prior to or during their work with the agency, in the house or anywhere else. Other participants reported briefly that having information about them helped the carer to do their job properly:

> If they know what they are in for, they are less likely to fuck it up aren't they? Otherwise they go in guessing, and they just shit me to tears half the time (FY3).

All participants reported experiencing carers who did not understand why they behaved the way they did or how to support them. Delfabbro & Osborn (2005) stress that one problem in residential placement options is the lack of ability of carers to meet the complex behavioural and mental health needs of youth in care and their tendency to see the behaviour as 'bad'. One participant reports on the complex relationship between past experiences and current behaviours:

> If the carers had of been told why I behave the way I did, not only would they know what I did but they would engage me more supportively. Carers would always tell me that my behaviour made more sense when the social worker explained the reasons for it (FY3).

All participants made comments about not feeling understood by their carers some of the time due to their apparent lack of understanding of reasons for maladaptive

behaviour. Their experiences also indicated that the carers did not have enough information about their recent placement to help them with their transition into the IPC. Three participants offered reasons for carers not having enough information about their history, including the social worker not communicating with the care team, carers simply being uninterested in the client's history and poor communication within the care team, as these extracts illustrate:

> The social worker never called the house and some of the appointments they had with the care team didn't happen because the social worker didn't let the care team know. They just refused to reschedule and said it wasn't important. In the end poor communication between everyone prevented the care team from getting to know about my past (FY1).

> One carer didn't know a thing about me and told me he wasn't interested. The first time I played up I said he didn't have a clue about me. The carer just said he didn't need to know and just wanted to do his job and go home. People who came through the placement like that just pissed me off, they weren't looking after a dog, I was a kid in care (FY4).

> Half the time a new carer would come into the placement and the other carers would ignore them. They would stuff up, because they didn't have a clue about me, where I had come from and what had happened before they came into the home. I wasn't pissed off, because I felt sorry for them (FY7).

When given information about the youth by social workers it was evident that opinions about the young person were negative and subjective, resulting in carers being

difficult to engage in the initial stages of the placement because of the negative information forwarded by the social worker about their behaviour and needs as this extract demonstrates:

> It was hard with the carers to start off with, because they all thought I was just a little fricken trouble maker. No-one told them about the good things I was doing, like working, staying away from trouble, it was a bunch of bullshit (FY3).

An objective, balanced sharing of information would provide the IPC with a foundation on which to build upon the strengths of the young person while maintaining an awareness of the young person's negative experiences and behaviours. The responses of all participants indicated that while they understood the need to share information about their complex behaviours and negative histories, they also preferred that both positive and negative information be relayed to care teams to provide a balanced view, which was contrary to their experience as stated in this extract:

> Carers always came into the placement extra edgy about me. It took weeks for them to get to know what I liked and needed, and yet they were all over me when it came to my bad behaviour. I would prefer that the carer knows what I need as much as what I do wrong (FY4).

Information related to the young person assists with the role of the carer (Mason & Gibson, 2004). Despite this view a varied response to this issue was elicited from participants. Participants in the former youth cohort stated that knowing their history should help the carer to understand what to expect and what their needs were. Given the complexity of a young person's history including placements, abuse and mental ill health,

participants suggested that sharing of information should assist the carer to support them according to their individual needs, which include understanding how to live without a birth parent's support. The follow extract demonstrates this view:

> If the carer understands that my mother abandoned me, it may help them understand why I am cautious about forming new relationships with people, that is very important (FY4).

Having an understanding of a youth's history is arguably helpful to the carer to understand why some practical, developmental and social needs are delayed. Some participants reported that knowing their history gave the carer a picture of their needs and this extract argues the importance of informing carers of young people's history:

> When the carer knows my history, it was much easier to understand my needs. My drug abuse caused delays in school and all sorts of other issues. If the carer knows about this and understands the impact of it on things like education, it's so much easier for them to understand what I need to move forward (FY8).

This theme identifies that for some former youth, the preparation of professional carers to implement and manage their care in an IPC was problematic, and information sharing limited at best. Poor information sharing led to many problems reported by the youth including reduced tolerance for behaviour in the IPC and a lack of understanding of their needs. The effectiveness of the IPC is compromised when carers are not prepared for their role due to process deficiencies such as a lack of communication, negative perceptions of young people, and poor training of carers, despite the responsibility of direct care resting with these unprepared professional carers.

6.3.3 Improving Behaviour in an IPC

This theme addresses the challenge of improving youth behaviour while in an IPC. Using their own words, participants identified several major behaviours that they engaged in that were detrimental to the placement. The common behaviours that participants reported included running away, taking illicit drugs and consuming alcohol, and engagement in illegal activities, such as property damage, theft and in some cases violence towards others. Participants candidly reported that they had threatened the stability of their own placements (some more frequently and intentionally than others), and some participants stated that youth behaviours would affect the future of an IPC, as suggested in these extracts:

> Half of the time my behaviour threatened the stability of the placement, running away, getting smashed from drugs and alcohol, and doing things to piss the carers off. I don't think there was a day when my placement wasn't at risk of being ended because of something I had done (FY3).

> The placement was almost bullet proof, they just didn't give up on us. These placements are designed to manage impossible and tough kids and I was definitely one of them. I suppose the only time when I could see the placement turning to shit is because it's so bad that the placement is pointless (FY6).

> I was locked up for six months, and when I got out, they were there for me. That is the type of placement I wanted, and it's what I got. It could have been a lot different if I

> left lock up and didn't have anyone willing to take me in or give a crap about me, I would've ended up on the streets or even dead (FY7).

All participants reported that the desire to change their behaviour increased once in the IPC. It appeared that at the core of change was the provision of a better home than they had previously experienced, which was characterized by less restriction, less requirements to conform to somebody else's norms, and improvement in general support. Participants consistently suggested other ways to improve behaviours in the IPC, including to: 1) provide opportunity for skill development; 2) encourage the young person to use more adaptive behaviours; and 3) keep the young person safe from others and their own behaviour. In terms of older clients in care, all participants were adamant that the placement should also be about preparing them for leaving care through development of job skills, living skills and assisting with achieving independence, as this participant asserts:

> The placement, regardless of type, should be the catalyst for us having the life we deserved, the life our parents failed to give us. Ideally, the care should be extraordinary and the outcome for our lives positive and lasting. In essence, we should be as successful as the next person, the next uni student, lawyer, doctor or even humble sales person. If I were to choose to be a mother, the placement should have prepared me for that. Foster care should be the chance we almost never had (FY1).

All participants stressed that placements could improve behavioural and mental health outcomes if used effectively. One consideration previously stated is the place of the non-traditional placement within the alternative care continuum (e.g., Delfabbro,

barber & Cooper, 2004; Gilbertson & Barber, 2005). Participants felt that the IPC would be best utilized earlier in the life of a youth, and not left as a last resort, as they had all experienced. However participants felt that whilst IPCs were a good idea, they were cautious about them replacing other forms of care such as residential facilities as suggested by these extracts:

> I don't think that this is the only way to care for kids. Some kids are so bad that they need to be in a place where they can be watched all the time, that can't happen in an IPC (FY5).

> I liked being in family care when I was a kid and I think kids should be able to have a chance at having a normal life with a normal family. The older I got, the less I needed it, but I am me and the next kid is them, the system has to make placements work for every kid and IPCs for everyone would be as bad as foster care for everyone (FY4).

By using IPC placements as a component of the entire alternative care system, participants in the former youth cohort suggested that the IPC could contribute to the alternative care system, achieving the goals of alternative care:

> On its own, using IPCs would fail to get the kids what they need. It is important to look at how the IPCs work in the system, and what they can do to make kids' lives better. Sometimes foster care can still be better (FY3).

When asked why they did not think the IPC should be utilised for all young people, some participants stated that it did not provide a consistently emotionally supportive environment for the very young. One participant felt that younger children needed a consistent relationship to be supported during their earlier time in care. The following extracts detail views on the use of IPC placements for younger children:

> When I first entered care, I needed something consistent and a place to feel safe. In the IPC, I still needed to feel safe, but it was more important to feel safe from judgement than safe from the world (FY8).

> I came into care when I was five years old. I wanted a mum and dad and don't think a bunch of carers would have been good at all. My sister was in a group home when she was really young, and she ran away a lot because she had so many different people telling her what to do. The IPC has a time and place, as teenagers we don't need parents, we need people to care about us and guide us, younger kids need a lot more than that (FY3).

The IPC has many benefits for young people whose placement in traditional foster care has been problematic and unviable. The IPC provides a place where youth can engage in their own identity and are not criticized for who they are. The IPC is also centrally focused on the care of the youth and not just a component of what is happening in a home. For some individuals traditional care may continue to be a better option, including for younger individuals and those who require a more traditional family structure. The IPC should be considered a placement option at any point in the care continuum. Despite the identified advantages of the IPC, all participants in this study

reported that they entered the IPC at a late point in care and could have benefitted from an IPC at a much earlier time.

6.3.4 Social Worker Influence on IPCs

This theme reports the difficulty that young people had in forming and maintaining relationships with their social worker and the subsequent influence social workers had on the IPC. All participants reported that they thought that the role of the social worker affected the IPC in both positive and negative ways. They stressed that the attitude and motivations of the social worker contributed to whether their impact upon the placement was positive or negative. Five young people stated that social workers were disrespectful to them and their carers. The level of disrespect experienced by these participants was found to be so unsatisfactory they didn't want contact with their social worker. McLeod (2008) suggests that most young people in care want a social worker who has an interest in them, is concerned for them and enjoys interacting with them. This theme confirms McLeod's (2008) finding. The disrespect shown by social workers was characterized by demands to carers, contacting clients and arguing with them about issues, making decisions about the placement without involving the care team, ignoring contact from clients and carers, and making negative remarks about both the care team and young person in the presence of others. Winter (2009) suggests that in successfully executing their tasks, social workers should hold in balance conflicting and competing demands, whilst also always anchoring their practice within human rights and social justice frameworks which emphasise the principles of empowerment, equality, respect and

dignity. Responses from the participants in this cohort indicated an absence of these characteristics some of the time.

Despite the problems identified by participants, five also reported that their experiences with their social worker were positive some of the time. Many reported that their experience was positive when the social worker was respectful to both the care team and clients. Respect was characterised as social workers including the care team in decision-making, seeking regular feedback about interventions attempted, working through a crisis with the care team and client, engaging the young person professionally and with the appropriate use of language, and remaining professional in their contact with the care team at all times. Many participants stressed that the role of the social worker was critical to them receiving ongoing benefit from the placement as indicated in this extract:

> I know that at times the social worker was hard to work with, because we disagreed a lot on things, but they knew me and knew what I needed. They weren't easy to pull one over on, and definitely weren't prepared to put up with my bullshit. If it was just the carers and me, I know for sure it wouldn't have worked (FY6).

A unique change to the traditional role of the social worker in an IPC is that they are involved less in the management of the young person's needs (including transporting to appointments and managing funding for daily living), and more involved in the decision-making in the daily running of the placement. Participants suggested key aspects of the role of the social worker in an IPC, including supporting the client with direct contact, supervising the placement, and providing ongoing behavioural advice and direction for

the placement to achieve positive outcomes. Some participants stated that social workers approached IPCs differently to traditional placements as they had greater expectations of the care team to do more for the young person, as these extracts detail:

> When I was in the foster placement, the social worker used to make me call them if I needed anything, including going to the doctor. When I got into the IPC, the social worker would ring the house all the time and make the carers who work for them do things like take me to appointments and help out with getting things I needed (FY2).

> I rarely had contact with my social worker. I don't even know if they had a real impact on the placement except when I did something really wrong. They were there when things got bad, but it would have been nice to have them around a lot more (FY1).

All participants reported that some of the time their social workers did not appear to be interested in their role or meeting their needs. Social workers were unavailable some of the time and this was viewed as unsupportive by all participants. Reported problems with social workers included: 1) they avoided calls; 2) they frequently cancelled appointments with the client; 3) they would not attend the house; and 4) frequently requested that the client attend the office to meet with them instead of going to the house. The following extract demonstrates the impact of these concerns:

> Every day was hard for me and I needed someone to be there for me. Anyone who doesn't give a crap about their job including the social worker, puts the placement at risk of falling apart. The motivation of a social worker has to include a genuine hope for us to make it in the world (FY3).

The social worker role assists the IPC placement by organising the services outside of the placement that the carers do not have the connections or ability to do. Participants reported that they had experienced support during court appearances and other professional settings by the social worker, which helped to alleviate concerns and fears by helping the client to understand what was happening:

> The social worker helped me understand what was happening when I was in court. The carers never knew what was going on, because they weren't trained to know. Without the social worker there I wouldn't have felt as comfortable about what was going on (FY4).

Prohibitively large caseloads were suggested by seven participants as reasons the social worker could not meet their needs. The same participants stated that it was often difficult to gain continuous support, because the social worker was assisting other clients when they called. Many of the participants felt that the social workers who demonstrated that they cared were as available as they could be but were limited due to workloads and high caseloads. The following extracts point out the frustrations felt by the youth who experienced difficulty with social worker contact:

> My social worker was out all the time when I would call for help with something. They were good when they were able to help, but I think there is a big need for more social workers, kids in care deserve to have someone available most of the time. I don't think I was demanding, but it was hard to get what I needed, let alone what I wanted (FY4).

> The social worker needed to be able to help me get ahead, not just put out the fires when the shit hit the fan. They do a good job of helping when they are around, but the

department needs to wake up and realise that planning to help a young person is way better than dealing with the shit as it happens. I know it's not always the social worker's fault that they aren't free to be there, but something has to change. The placement would have been way better if they were free to help get stuff sorted before it happened (FY7).

When the shit hits the fan, the social worker I had usually knew how to get things back to normal. Sometimes this meant helping me understand where I went wrong, and other times, it meant helping the care team understand what to do to help me. Either way, I am sure the placement wouldn't have been as steady without the social worker around. Sometimes the agency forgot that and things turned to shit again quickly because they didn't involve the social worker. I guess what proved the social worker was needed was how good things turned out when they were around compared to when they weren't (FY3).

Despite social workers being difficult to contact or being generally unavailable during times that contact was needed, all participants conceded that their own difficult behaviour was at times challenging for the social worker to respond to and work with. One participant said that they would deliberately use the social worker's time to prevent them from meeting the needs of other clients as explained in this extract:

There are some situations that the social worker just can't get ahead with. I used to call the social worker twelve times a day just to piss them off and stop them from being able to help anyone else. Half the time I didn't even need anything I just wanted to make sure that I was their focus for the day. When the social worker got me in to see the psychologist, we worked out together it was part of my attachment disorder. I

> wouldn't have found this out without the social worker's help. I think this shows that we have to cooperate for the placement to work too, and that means giving the social worker a break sometimes (FY4).

The role of the social worker was viewed by all participants to have both a positive and negative influence on the IPC. Common complaints amongst participants included the lack of availability of the social worker due to large caseloads and other tasks that prevented them from being available. Participants did however recognise the organizational skills that social workers bring to the IPC and the inherent value of their professional knowledge in resolving conflict and behavioural problems. The role of the social worker in the IPC was viewed by all participants to be more direct than in traditional placements, as they are heavily involved in decision-making and resolving problems which can be problematic with their limited availability, but valuable in solving problems and establishing sound care practices.

6.3.5 Improving Outcomes in an IPC

This theme documents the overall views of young people relating to outcomes in an IPC. Despite the aim of the IPC to improve all outcomes for youth, attitudes towards various issues by carers continued to have an impact on some outcomes even in specialized packages of care. The findings on outcomes are reported below.

All participants felt that there were several advantages to the IPC, but the most significant was the individualization of the placement towards the young person and their needs rather than being a place where the young person had to mould themselves into the

expectations of the care team. The following extracts point out the advantages of a tailored intervention:

> For once I didn't have to wear stupid clothes or play family games, I was me and could be me, at least most of the time. I did get told off a lot, but it was better than being made to be someone I wasn't (FY3).

> I liked dressing Goth and the foster carers hated it. When I went into the IPC I was told I could dress in what I wanted as long as I kept doing the right thing. I was just happy to be somewhere I could dress as the person I wanted to be (FY4).

> You have no idea how good it felt to be free from the bull crap the carer used to give me. I mean seriously, she would take me to her friends every weekend while she went out and got pissed. At least in the placement I didn't have to go places I didn't want to and sit around bored all weekend (FY6).

The IPC was reported by all participants to have a higher source of funding than traditional care. The advantages of having additional funding in an IPC were many and are reported below in extracts from each participant:

> My foster carers never paid for anything I wanted to do including sport. In the IPC, if the social worker thought it was a good idea, it was paid for (FY1).

> In my package, I had fast access to programs and stuff because the agency were paid to find things for me to do. In the foster placement the social worker had to find things

and it was sometimes hard because it cost money and my carers wasn't paid enough (FY2).

Get this, they had so much money in the placement, I got to do everything I always wanted to (FY3).

In foster care, I couldn't go on camps or get new things. When I went into the youth worker placement they sent me on camps and bought me new things, I even remember the clothes I bought. The IPC had a lot of money because things just seemed to happen (FY4).

I desperately needed help with getting sorted out when I went into the IPC. I had a lot of people looking after me to start off with and saw a lot of doctors and counsellors. When I was in foster care I had to go on waiting lists, but they told me because I was in a specially paid for placement I could get help quicker (FY5).

It was hard to get used to things just getting done when I went into the package. I guess they called it a package because it was full of stuff, like, TAFE courses, sports and I even got help with buying stuff for the house. Lots of money in the placement made a big difference, because things got done and I got help. If they paid the carers in the packages the same as foster carers, there wouldn't be any, and there wouldn't be money to do what I needed (FY6).

It was always shit when I heard the foster carer say, I can't afford that, and then watch them pay for their own kids to do the same thing. In the IPC, if it wasn't something

> stupid I usually got to do it, because it helped me to get ready for living on my own (FY7).

> I can't believe how much changed when I went into the IPC, it was so fricking awesome. I got good food all the time, did some wicked courses that I had always wanted to do. It was the first time ever that I thought the department gave enough of a shit to spend some money caring for me, I almost felt like saying, was it really that hard to do (FY8).

Other improvements in the overall care experience reported by participants included better responses to health and education needs.

All participants said that the roles of IPC carers and their traditional counterparts were significantly different. All participants stated that the most significant difference was that foster families attempt to provide a home environment in which the client experiences traditional lifestyles by integrating into an established family, while the IPC was more like residential care with a single person being cared for. One participant characterised the home environment as one in which live-in parents are present:

> It's like having another mum and dad in a different house. They weren't as fucked up as mum and dad were, but they were there all the time, and I had fights with them about dumb stuff, they were good to me mostly, it was just hard for me to fit in all the time (FY3).

In comparison to traditional placements, all participants felt that their IPC was different because of the absence of the aspects mentioned above. Participants had to adjust to the IPC, as its underlying purpose was viewed as mentoring rather than parenting the client. Some participants suggested that the IPC staff engaged outside assistance to stabilise the placement better than the traditional carers because they had direct contact with agency supervisors, Departmental social workers and funding to access counselling, health care and other services. One participant emphasized that the placement was more 'geared' to meet the specific needs of the young person:

> In a traditional placement, the challenge for the carer was to get me to conform to their rules and expectations. In the IPC the challenge was to make up a set of rules and norms that didn't let me get away with too much but were about me and what I needed. Setting up my own set of rules meant that the carers could show me that the placement was about me (FY7).

Each participant contributed a comment on how they thought the IPC had changed their situation during their placement. All reported that they felt that the IPC provided greater support when compared with traditional foster care. On the other hand a major complaint stated by all participants was the lack of structure and poorly defined role of carers, social workers and other team members in helping achieve the desired outcomes in each life domain, as suggested in the follow extract:

> The placement met my needs better than the other carer ever could have. There was more support in getting places like school and to my youth programs. There was even better access to medical appointments because the carer could take me. It wasn't

> always perfect, but the only thing was that the social worker didn't communicate with the carers sometimes and things did get a bit messy (FY6).

All participants reported negative health experiences in the IPC, due to poor decisions by carers regarding appointments and issuing of medications. Some participants said that they had avoided appointments that carers were supposed to take them to. Most participants stated that they could generally refuse to attend an appointment without consequence and felt poor understandings of medical needs being met with appointments often resulted in a lack of effort to help them attend, as suggested in this extract:

> I yelled at the carer one night when they tried to get me to go see my psych. They just gave up and the next worker came on and thought I had gone to the appointment. Because of the changeover of carers, this was easy to do all time. The problem was that I wasn't taking my medication and this made it harder to manage me in the placement (FY4).

Some of the former youth interviewed, stated that their placement had been at risk of termination due to their mental health issues that could have been avoided if the social worker's direction had been followed. These participants stressed that IPC policy should require that the agency follow the direction of the social worker in relation to all medical issues. The following extract emphasizes the importance of following social worker direction:

> The social worker had my health records and knew what I needed. The carers usually don't know any more about us than what they learn while they are on the shift, which

> makes it more than important for the social worker to be giving direction about serious things like health (FY3).

Participants felt that the carers who engaged and supported them made it easier to succeed educationally; however, the same participants also reported that the inconsistency amongst carers made it difficult to maintain motivation and sometimes led to poor educational outcomes including failed work, suspensions from school or dropping out of school. Many participants reported that they had experienced incidents where neither the social worker nor carer arrived to support them in meetings, as it was not clear whose role it was. The same participants reported that this left them to resolve issues on their own. The deficiency in support appears to relate to a poor understanding of roles within the IPC care team. In traditional foster care participants reported that their carer would always attend school meetings as the 'parent' and the social worker would always attend as the professional. In professional care there appears to be role confusion about who has the primary connection with the youth.

Family contact did not appear to improve, increase or change once participants entered their IPC. Professional carers consistently stated to participants that they did not consider it their role to support family contact and often referred them to the social worker to establish and organise contact. Carers frequently made derogatory remarks to all participants about their family including identifying that they were the cause of their current care arrangement. Participants found this behaviour offensive and had considered leaving their placement because of this, as suggested in this extract:

> I told my carer one day about my mum, she told me not to talk about her, because she was the piece of crap that brought me into care. Carers aren't there to decide who is a good person and who is not, I hated her for that (FY2).

All participants were adamant that they wanted to maintain their relationships with their birth families and that having a positive relationship with them meant that they felt more settled in the IPC. It was also felt by five participants that if the carers were able to see the connection between behaviour in the IPC and contact with the birth family, it might have improved the amount of support they gave to their family contact. O'Neil (2004) has previously found that while youth want to be accepted in their new placement they also want to maintain a connection with their birth families, as this extract demonstrates:

> When I called mum to say I wasn't allowed to see her it upset her. I didn't like her being upset and considered running away because of it. The carers aren't my parents, and although they do a good job and my parents might have fucked up, I still care and want to see them (FY5).

All participants agreed that there was no expectation to conform to the identity of another family in the IPC. O'Neil (2004) found that youth want to be able to choose how they explain their background and who to call 'Mum' and 'Dad'. This appears to be achieved in the IPC as all participants reported a sense of freedom and absence of expectation to identify as part of another family, as identified in this extract:

> For the first time in care, I didn't have to belong or be someone's kid. I could be me and the carers made sure that I knew that was ok. This made the placement worth it (FY7).

All participants stressed that the placement was a safe haven in which they could rely on most carers to accept them and continue to work with them. Some participants said that their behaviour was at times dangerous to themselves and the carers continued to work through this with them without judgment in most cases:

> It was so important that I could go to the carers to sort things out no matter what I did. I needed to know I could trust them. In the foster placement, the carer just got pissed off when I did something wrong, which just made me angry. I didn't feel judged in the IPC (FY4).

Gilbertson and Barber (2003) argue in their study that when placement breakdown is experienced a lack of support appears to be a prevailing theme. Participants in the current theme stated that they did not receive consistent emotional support from the care team in the IPC and felt that the placement was at risk of breakdown some of the time because of this. Participants reported that their carers were either unable to support them due to lack of training or were unwilling to. This extract demonstrates the challenges youth faced in an IPC when seeking emotional support:

> I had one carer who would talk through things with me and always tried to understand how I feel. Two of the other carers used to say they weren't trained to deal with my emotional problems and told me to get onto my social worker (FY1).

All participants agreed that the agency supervisor and coordinators should ensure that the carers are performing appropriately in their role as carer. All participants said they experienced a poor response to their complaints about carers and were not taken seriously when they had an issue with a carer, as indicated in this response:

> I might have been a trouble maker in the placement, but when I call a supervisor to tell them the carer has threatened me, I expect them to at least check it out, they just told me I was causing problems and that I couldn't call them anymore (FY3).

In response to a question about recruiting carers, some participants suggested that while the care agency should be able to recruit its own carers, they should still undergo screening and assessment with FSA and be subject to criteria that are consistent with good practice. All participants qualified this by stating that their own experiences demonstrated that when the care agency was short of workers they were allowing people with poor skills to work in placements. It is suggested by responses in relation to this theme that external screening processes would allow greater accountability in terms of the quality of people being utilised as carers. A few participants stated that it would also be useful to place FSA social workers on interview panels, as they know what the young person needs and what skills and abilities are required to meet these needs.

It is clear from responses in this theme that the IPC is a valuable placement option when used as it was designed and intended. It has been identified that external factors including training and recruitment of carers will continue to have a negative impact on the outcomes for young people in an IPC if they are not addressed. Participants stressed

that the IPC should be considered a possibility after any placement breakdown, and should not be used exclusively as a last resort.

All participants reported that with the support of IPC staff they had developed positive social behaviours and made better choices than they felt they would have if they had not been supported after leaving care. Despite past experiences with birth families it was consistently reported that there was a strong desire to maintain contact with them and for carers in their IPC to be respectful in their approach to supporting contact with them. It is reasonable to conclude from the findings in this theme that the IPC does improve outcomes for young people overall, but caution about the implementation of the model is needed to ensure that extraneous variables such as the ability of carers and attitudes towards the youth do not hinder the success of the IPC.

6.4 Discussion and Summary

The findings presented in this chapter indicate that a number of benefits and detriments exist in the delivery of IPCs that can challenge young people who are served by them. It is obvious that deficiencies exist due to poor communication and a lack of role definition. Improving both of these factors may be a catalyst to improving the overall quality of the placement. All participants in the study indicated that elements of the IPCs were of significant benefit to them as clients in care by providing a neutral environment that supports the youth in the development of their own identity. Despite the data indicating that the IPC placements were a positive change for youth, it was also suggested that IPCs

could still benefit from revision, including changes to recruitment of carers and more accessible arrangements for funding to agencies to ensure long-term stability and greater permanency for the individuals who are served by the placements.

All participants also reported other difficulties. These difficulties included several key themes of which the most significant appeared to be: 1) Transitions from traditional placements appear to occur quickly after placement disruption, adding to the stress experienced by youth; 2) Some IPCs do not appear ready for the youth with low staffing levels and lack of interaction with the young person before commencement of the placement; and 3) Carers do not appear to have training or skills to meet basic needs some of the time.

All participants identified that due to role confusion between carers and social workers, the placement was at times chaotic and underserviced. It is likely that this could be remedied by standardising the individual roles across all IPC placements and providing the carers with a focus for their ongoing work with clients in care. All participants also said that there was a need to develop further the roles of the professionals, using training and recruitment of already trained and qualified individuals and providing closer supervision to professional carers assigned to an IPC.

An interesting finding of this study was that in some cases young people initially felt forced into the IPC, largely due to the breakdown of their previous placement and the urgency of sourcing an alternative care arrangement. This implies that the trauma

suffered through placement disruption can be difficult to manage in the early stages of an IPC and presents a care challenge. The findings were also unanimous in arguing that the IPC had provided the young person with some comfort about being in care through provision of a consistent placement regardless of the behaviour or choices of the young person.

Despite the many shortfalls identified in the IPC it is evident that care teams in an IPC are more persistent in their efforts to sustain youth in a placement than in traditional placements. Variables such as personality conflicts and youth behaviours are difficult to accommodate in all cases, but all participants expressed that their IPC was a placement where they could be themselves, in some cases for the first time in their lives.

Many of the young people reported having less respect for workers who demonstrated low levels of competence, which was characterised by deliberately engaging them in inappropriate behaviours and tasks, and making comments about their abilities and how they felt about them. This suggests that the use of carers who are less competent in IPC placements can be detrimental to the ongoing relationship with the young person. It is important that coordinators are aware of dysfunctional care teams and use their leadership to address these problems to promote open communication and thus free flowing information between members of the care team.

CHAPTER SEVEN

Discussion and Conclusion

7.1 Overview

As stated in Chapter 1, this research was developed after a crisis began to unfold in foster care in South Australia in October 2006. By 2008 executives from the state's Department of Families and Communities told the legislative council that a 16 million dollar budget deficit occurred because the number of children in state care outstripped the number of available foster carers, with an unprecedented number of carers giving up the fostering role (Anglicare SA, 2008) prompting prohibitively expensive arrangements for care to be provided. One of the consequences of this crisis was young people being placed in motels and hotels with around the clock care, a matter of concern not simply in terms of the financial cost to the government, but also in terms of the psychological cost to the young people.

The second concern identified above is significant given the high rates of behavioural and mental disturbance present amongst youth in alternative care (e.g., Barber & Delfabbro, 2003). It is of further concern that those in residential and other alternative placements are considered more mentally disturbed and behaviourally

challenging (Triseliotis et al., 1995; Sinclair & Gibbs, 1998). Australian data on maladaptive behaviour in alternative care are consistent with international research in this regard, and point out the fact that disorders of conduct and mental disturbance are experienced more frequently in this population of young people and present a unique challenge for alternative care in managing the needs of youth (e.g., Oosterman, Schuengel, Slot, Bullens & Dorelijers, 2007). Efforts by mental health professionals and social workers to support youth with complex needs are, however, complicated by the delicate balance of the symptomatic presentation of maladaptive behaviour and their bio-psycho-social problems (Kortenkamp & Macomber, 2002).

Constructive intervention for maladaptive behaviour requires the collaboration of several professions, systems, and services to achieve common goals regarding behaviour change, improved emotional conditioning and improvement in social functioning of youth in care (Katz & Hetherington, 2006; McLean, 2011). Yet despite this need for collaborative practice, previous research suggests that the implementation of such practice is hindered by differences in conceptual frameworks and causal attributions for behaviour amongst individuals working with young people in care.

Even if those working with young people were to engage in truly collaborative practice, previous research to date has generated very little empirically supported interventions for young people in professional care including residential placements. Evidence based practice with this population is limited in Australia (Osborn, 2006),

suggesting that South Australian professionals may have poor conceptual frameworks and lack abilities and skills in effective behavioural interventions and care strategies.

Conceptually, this research aimed to accomplish two outcomes. First, it aimed to evaluate the level of success with interagency and interdisciplinary collaboration amongst services for young people in an IPC in South Australia. By engaging in this exploration the thesis sought to contribute to the paucity of research into collaboration in alternative care considering perspectives of three cohorts in this unique sector whose views and experiences have not been considered in previous South Australian research. Second, the research explored the causal attributions applied to maladaptive behaviour by social workers and professional carers in IPC placements in South Australia. This exploration sought to identify the theoretical frameworks and perceived attributions for behaviour through the accounts given by the two cohorts to promote greater awareness of the psycho-social framework in which attempts to deliver specialized care were made.

The use of Individual Packages of Care (IPC) in South Australia has to date been viewed as a way of placing difficult to manage young people in the least restrictive placement option, and children have continued to move into an IPC from motels as they become available. IPCs are provided through private agency contracts with Families SA. Given the vulnerability of this population of young people and the importance of the IPC to changing the lives of those living in motels, the importance of researching the use of IPC placements is evident. While the IPC is only one alternative to placements in motels and hotels and in preventing placement drift for those in traditional care, it appears to be

an option that has now been integrated into care in South Australia, pointing out the importance of researching its success, and demonstrating a need to determine its effectiveness as it continues to be used.

7.2 Discussion of Results

The analysis of professional carer and social worker experiences of working together confirmed several issues that have been identified previously regarding collaboration (Darlington, Feeney & Rixon, 2005 a, b; Horwath & Morrison, 2007; McLean, 2011). Examples of problems include human resourcing issues such as prohibitively high workloads, time constraints and demands, social worker and professional carer turnover and the poor implementation of IPCs. This suggests that problems in collaboration may be experienced globally, regardless of the purpose of collaboration, the collaborators, or population of individuals served by the collaboration.

Reports of poor communication, both verbal and written, were given by all participants in both professional carer and social worker cohorts in this study, and involved problems such as the use of different explanations of behaviour between cohorts, poor information sharing that resulted in limited access to essential information during an IPC, and poor preparation between cohorts when commencing an IPC. Information sharing and communication become particularly important when the focus and aim of collaboration is to meet the young people's care and mental health needs and address their complex behavioural concerns. Regardless of the treatment modality employed for addressing maladaptive behaviour, information that may contextualise

behaviour – including abuse history and previously successfully strategies employed to address the same behaviour in the past – is essential to promote continuity of care and thus success in an IPC. The absence of essential background information when implementing an IPC leads to unnecessary conflict between professional carers and youth alike. The greatest concern is the potential for the youth and professional carers to be exposed to catastrophic harm through physical confrontation or placement disruption and often self-harm.

Issues of dominance and manipulation between professions have been discussed previously, particularly in relation to a lack of consultation between cohorts in decision-making about daily needs (Darlington, Feeney and Rixon, 2005a). This can occur in the form of refusal to provide referral information to prevent unappealing details being shared which may cause a placement to be declined (e.g., Gilbertson & Barber, 2003; Okamoto, 2001; Scott, 2005). It is concerning that factors such as this remain a feature of alternative care even when placements are considered specialised. Such negative treatment of professional carers by social workers was found in this research to lead to conflict within the placement as carers attempted to assert limited authority with a perception that social workers were interfering regularly with the running of the placement. Given their limited sense of control in the placement, it could be viewed that young people are below them in the authoritative structure of the placement, thus reducing the desired central focus intended for the young person in an IPC.

Some themese that emerged have provided new information about the

professional, organisational, and systemic dynamics that occur when implementing an IPC, and prompt a call for further examination. The dismissive view of professional carers' behavioural approaches by social workers (who viewed carer knowledge as inferior) is alarming. It is, however, encouraging that many participants in both cohorts expressed a willingness to improve their understanding of organisational, systemic, and professional context of each of their roles.

The actions of young people that functioned to manipulate other stakeholders involved in an IPC were reported by many to have a significantly negative impact upon the effectiveness of the IPC and relationships between cohorts and the youth. This finding confirms previous research (see McClean, 2011), and points out the negative effect that youth can have when they 'triangulate' between social workers and carers to achieve outcomes or avoid consequences. It is argued that the key cohorts interviewed in this study – social workers and professional carers, along with the former youth – provided an opportunity to illuminate these problems.

Following the analysis of each cohort's experiences of interagency collaboration, the thesis examined the way in which maladaptive behaviour was understood by participants. This was accomplished by an analysis of participant views and experiences of maladaptive behaviour and its purpose for the young person. The results of this analysis demonstrated that there are several different understandings of behaviour, and subsequently there is a lot of complexity that arises from this in managing negative behaviour in an IPC. Accounts of behaviour in the social worker cohort were not

consistent, indicating that understanding of behaviour is a unique experience for each individual. Despite this finding, professional carers consistently gave a consistent understanding of behaviour, one in which personal choice by the youth to engage in behaviour featured strongly in their views about causation of maladaptive behaviour. Participants in the professional carer cohort were also dismissive of environmental influence on behaviour including histories of abuse.

Despite inconsistency regarding views of maladaptive behaviour, agreement amongst participants about the importance of stucture, boundaries, and routine was consistently offered as a way to reduce maladaptive behaviour. Professional carer accounts that placed emphasis on behaviour as a choice, suggested that individual therapy was simply another means to manipulate stakeholders and reduce the effectiveness of carers in the placement. Placement with professional carers as a form of therapeutic care, together with the above minimisation of the importance of individual counseling, is alarming. Improvement of behaviour through placement stability and continuity is similarly concerning when viewed in the context of the placement offering nothing more than continued care. Given the potential for a long-term placement to offer nothing more than consistent care, further research is warranted exploring the impact of placements that do not seek to improve behaviour concurrently with providing continued care. It could be argued here that a placement is no more stable or successful despite its continuity if it does little to improve behaviour or outcomes for young people. In a placement such as the IPC the real danger is that while the physical placement remains the same, carer turnover due to low success with the young person could be a replication of placement

dirsruption similar to traditional placements.

The analysis of individual accounts provided in Chapter 4 identifies the dominant understanding amongst social workers and professional carers in an IPC. Specifically the recurrence of purposive behaviour explanations for behaviour existed amongst those supporting youth in an IPC. For many participants it was recognised that behaviour served as a means to control a situation, communicate distress, or cope with a situation. Given the intention of behaviour in this context, it is argued that the IPC could serve the client well by teaching new strategies that serve the same purpose to reduce the potential for dangerous, harmful and violent maladaptive behaviours. One example could include teaching young people assertiveness skills so that they stop using violence to communicate dissatisfaction.

A particularly encouraging finding was the representation of accounts of the environment affecting behaviour. According to ecological systems theory, both the youth's behaviour and those of their carers occur interdependently following stressful life transitions and relationship difficulties. Given the complex problems presented by maladaptive youth behaviour, this theory has significant implications for the management of a youth in an IPC. The implications of this theory include: 1) it is relational in nature and offers solutions that are deliverable by the client; 2) it helps clients assess the effectiveness of particular coping strategies for specific situations; 3) where appropriate the theory advocates for the use of case management which improves social supports through linkages to supportive others in a variety of clusters; 4) it recognises carers are

sources of stress as well as support; and 5) it helps clients to connect current stress with patterns of past functioning, with the aim of improving coping methods (Hutchinson, 2003). In future research, more precise views of causes of behaviour could be gained through evaluation of specific behaviour (e.g., self-harming), rather than broad questions about the cause of negative behaviour.

Experiences of professional carers - who were serving in an IPC, were also analysed. Professional carer accounts indicated that they were actively discouraged from forming long-term relationships or assuming a family role with youth due to professional boundaries. This was despite their obligation to maintain the daily care of the young people served by the IPC and spend time with them on a daily basis. Carers reported feeling conflicted between the needs of the agency and consistency of approach between carers over the needs of the young person, especially when they preferred to meet their needs with individual treatment.

The constant need to physically restrain young people engaging in violent behaviour represented a challenge for most participants in the carer cohort, as they viewed their role as sometimes contradictory between supporter of the youth and authority over them. Positive relationships were viewed as the primary agent for change in a youth's behaviour, but were difficult to maintain, stressful at times, and often sabotaged by the young person. Normality was desired for the youth by most carers but was difficult to define given the young person's experiences and care histories. Data presented documents the need to fully assess the environmental context in which

behaviour management occurs and the challenges unique to professional care. This is particularly important for mental health professionals making recommendations for behavioural interventions based sometimes on a limited understanding of the environmental context in which the behaviour is occurring. These data demonstrate the benefit of the researcher focusing upon the views and daily experiences of one cohort in an IPC, and suggest that there would be benefit in expanding the focused studies to include other key stakeholders who service IPCs including mental health professionals, supervisors of child protection agencies and other key role or cohort.

In consideration of the results from the analyses of the views of the young people, three common problems have emerged and could have implications for practice and policy. Most commonly identified was the ineffectiveness of stakeholder groups when young people are able to manipulate social workers to avoid consequences for their behaviour. Secondly, the intolerable criticising by social workers of the accounts of professional carers, and a poor tolerance for discrepancy between their own accounts of behaviour and those of others (in which social worker understanding of behaviour was viewed as more valid than those of the care team in an IPC). The lack of tolerance and acceptance of the perspectives held by others was reciprocated in the views expressed by professional carers, who expressed distrust of those external to an IPC, perceiving them as having a poor understanding of the unique challenges faced in managing a young person in an IPC. This caution has important implications for social workers seeking to support and manage IPC placements.

Another theme was the pressure amongst professional carers to normalise the care experience for adolescents being served in an IPC. This ambition arose out of a desire to improve their lives, and not further marginalise a young person whose life is different to other same aged peers due to their care experience. However, there appeared significant barriers to achieving this within a professional placement. For example, professional carers frequently did not want to have other children in the home, limiting normal social experiences because of the placement being a professional environment. Many professional carers cautious of further stigmatization of young people through interaction with mental health services which were limited in availability in the first place. Confidentiality that is driven by a perception that the young person should be treated with dignity, often overrode the safety needs of the youth and others working with them, leading to dangerous situations and outcomes for the child including fire lighting in homes and self-injurious behaviour. One possible policy outcome arising from this desire for normalisation is the potential to make mental health services more accessible to youth in an IPC and more relevant to the placement as a whole. By more intimately involving mental health professionals in the placement experience, this could eliminate the need for them to make assumptions about experiences in IPC placements and promote a more accurate level of treatment for young people.

Another major theme that presented across all analyses involved placement problems relating to all aspects of the young person's relationships including the ability to form and maintain helpful relationships. Triangulation (McLean, 2011) of relationships and family structure was evident in many respondents' answers, especially professional

carers who had daily care of the youth. Triangulation resulted in the exacerbation of maladaptive behaviour cause by restrictions on professional carers' to respond to conflict in a timely manner. This issue could potentially be addressed by giving professional carers more control over daily decision-making so that the urgency of resolving a behaviour or conflict can be met. Many stakeholders claimed that the role confusion between social workers and professional carers had contributed to the power play between the two groups. This could be alleviated with improved understanding of roles.

7.3 Limitations of the Research

Several design deficiencies need to be taken into consideration when reviewing the analysis of this research. A primary challenge was the difficulty in including one group; namely the young people themselves. Despite offering a unique contribution because the research takes into consideration the views of young people who at the time had been recently served by an IPC, it is nevertheless limited by its failure to consider views of young people who were currently being served in an IPC. There are clearly ethical limitations to accessing young people in care, particularly when behavioural change and mental health are being discussed. Use of former foster youth was one way to explore the beliefs youth had about behaviour and interagency experiences without threat of repercussion for them speaking openly about their experiences.

Second, generalization of the research could not be accomplished due primarily to the qualitative nature of the research. This study has, however, provided an evidence base upon which structured quantitative questionnaires may be developed. One example could

include more specific focus to elicit responses about managing various specific situations depicting a range of scenarios in an IPC. This would be one way to expand research in this area.

Finally, whilst participants were asked to discuss their experiences of behaviour, all offered varied responses that provided insight into the challenges posed by maladaptive behaviour. Participants in all cohorts expressed experience with similar behaviours including violence, aggression, verbal abuse and defiance although specific incidents involving other maladaptive behaviours were important contributions to the research (e.g., self-harm, stealing from local retailers, drinking alcohol). Interview questions allowed for the participants' interpretation, providing a richness of data that contributed to the evaluative nature of the research. Nonetheless, quantitative research examining specific behaviours could provide a more definitive account of common behaviour experienced in an IPC. For example, participants could rate the frequency of a behaviour within an IPC to determine the most common forms of maladaptive behaviour experienced in an IPC.

Another point to note in regard to the limitations of the research is that no attempts were made to separate organisational identity from professional identity. This was because there was nothing in the liteature to suggest that group identity could be considered more important to an individual organisational identity or vice versa. Scott (2002a) reports that much of research on collaborative care is limited to professional, rather than interagency differences, as was confirmed in this thesis. Given that

professional identity appeared to create differences between professional carers and social workers, some effort would assist with the separation of these identities by conducting specific research which considers the differences of each cohort. A primary challenge in achieving this in South Australia is that some agencies (e.g., BCSYC) are staffed by a range of professionals who fill care roles including many without formal qualifications.

From a methodological viewpoint, recruitment of participants is important an important consideration. Establishing participants was lengthy and undermined by numerous challenges, including access to young people and agency approval to conduct the research, potentially leading to only those feeling most compelled to participate offering insight about the use of IPC placements. The political climate at the time of the research together with logistical restraints limiting availability to participate in the research makes this most likely.

It is concluded that the results presented in this thesis reflect the unique situation of managing young people in an IPC at the time of data collection. Practice factors including development of carer skills, fragmented support services, and the structure of the IPC all impact on the effectiveness of IPCs and could produce positive or negative outcomes depending on how efficiently each of these factors is addressed.

Since data were collected, related practice changes and reccommendations have been made within Families SA (Parliament of South Australia, 2009). One of the most

significant developments is the emphasis on collaboration between cohorts who serve younh peopl, and an across government rapid response to the needs of young people. It is also important to note, collaboration has improved between government departments. In one example, mental health services have established a protocol where they move children and young people in care to the front of waiting lists to provide intensive counselling, assessment, and advice for them and those who care for them. This has been achieved through legislated changes requiring that children in care are given priority access to all services needed.

Finally, the research is succeptible to criticism that could be aimed at any qualitative evaluation. The over-reliance on small studies that are qualitative in nature has been stated previously (Cashmore et al, 2006). The results support the need for further enquiry and the expansion of data into quantitative analysis. It is argued, however, that due to relatively little being known about the use of IPCs, qualitative research is relevant here. Similarly, Scott (2002a) argues that qualitative research has great potential to be subjective as it requires the researcher's interaction and involvement. Consideration of the researcher's background, who is both a mental health professional and former social worker (Families SA). It is also important to consider the involvement of many private agencies and stakeholders in the provision of IPCs at the time the data collection occurred.

7.4 Benefits of Improving Individual Packages of Care

The analysis documented here leads to several suggestions for increasing collaborative

care and thus developing better understanding of the collaborative and care practices of stakeholders when implementing an IPC. The first recommendation involves the establishment of training that improves the knowledge and abilities of both social workers and professional carers, focusing on alternative perspectives, policies and needs of each professional group. It is argued that this would assist each agency to understand others and improve intraprofessional relationships when serving young people in an IPC. This type of training could occur at the TAFE (Tertiary Adult Further Education) or during induction employment training or during staff training days. It should be noted that training of carers and professionalisation of their role was a key recommendation of the Mullighan (2008) report.

To promote ongoing cohesion amongst key individuals serving in an IPC, it is suggested that ongoing education, with a focus on specific, relevant, and teachable topics would benefit the effective running of an IPC. It is reasonable to suggest that training budgets could provide funding for carers to receive training that is needed in order for them to be effective in their role. In order for training to be possible, carers need time to undertake this in addition to their care duties. It is not reasonable to expect that carers undertake such training in their own time and without reimbursement. Several options exist to meet the training needs of care staff without impacting placement budgets including additional funding from Families SA, computer based training that can be accomplished in a short space of time, and allocated training days in which staff are paid to engage in training.

Other possibilities including joint training could provide both an interagency connection and economical means for training to occur. Training or development on a placement issue that would improve collaborative efforts between stakeholders (such as responding to threatening behaviour) would be an example of joint training that would benefit all stakeholders. Similarly, the mutual inclusion of professional carers and Department workers in formal training or team meetings and placement support sessions could help reduce the division that exists between these stakeholder groups, potentially reducing the manipulation of relationships that young people were argued to engage in by participants. Other ways of informally improving understanding of the roles that others engage in could include discussion groups, placement visits by social workers, and regular stakeholder meetings that specifically discuss differences in practice and the needs of the youth being served by an IPC.

Further, in terms of collaboration, more thorough training to assist each cohort to understand what is essential information to share, how it should be shared, and when, would ultimately benefit IPCs. Such training may also include what constitutes essential information about incidents that needs to be shared between stakeholders, and when it is acceptable to keep information confidential for the privacy of the young person. Many of the ways in which collaboration could improve can be found in responses provided by participants in this thesis. Combined training that promotes a common understanding of behaviour and how to address it was viewed as a way to improve the overall understanding amongst stakeholders of what negative behaviour is and how to address it. Arguably, the learning could examine ways to improve high levels of collaboration that

could be problematic without training. One example might be developing ways to respond to critical incidents in the home so as to improve both the response to the young person and management of the incident from start to end. This approach to training would identify specific roles in various processes from start to finish so that stakeholders could understand the role that they play in the collaborative continuum. The involvement of professional carers in training would also assist social workers to understand how they can best support care teams in implementing and maintaining an IPC.

Given the ever increasing fiscal constraints affecting alternative care, sharing of resources and services in a manner negotiated by key stakeholders could increase the likelihood of a more individualised approach to care, including use of public housing, office spaces for meetings and materials that assist with the ongoing running of an IPC. The Layton Review (2003) suggested implementation of external monitoring for collaboration between agencies that serve vulnerable young people (see Chapter 2). Such a recommendation is consistent with the findings of the present research, which has identified substantial conflict between stakeholders about how services should be delivered. It is possible that an independent party could assist with promoting the cohesion required to improve outcomes for youth in an IPC.

This thesis strongly suggest that there is a need for policy and practice to be developed which improves understanding of the importance of timely and accurate information sharing. Such policy should carefully detail what considerations and circumstances warrant the requirement to exchange or withhold information regarding

past abuse, placement histories, youth behaviour and relevant care strategies. It is not enough to assume that information will be shared because it will meet the needs of the youth. Accountability clauses should be developed for failure to provide information. Such policy should include ways in which information delay will be remedied and ways in which information can be obtained when it is not provided according to policy. Informative written agreements, detailing whose responsibility each task is and basic decisions to professional carers, could alleviate the delay experienced by carers in receiving a response to incidents within the placement, and reduce the 'manipulation' reported in this thesis. In addition to the implications of this research for policy, there are also several implications for practice. The varied accounts and explanations of behaviour and its causes amongst stakeholders presents an interesting problem when seeking to collaborate with other stakeholders about negative behaviour. When the interplay between environment, relationships and individuals is considered it is argued that greater success can be achieved.

Despite different views about behaviour being shared, points of collaboration can be achieved when views about behaviour are considered. Assumptions regarding young people's ability to control their behaviour and subsequent responsibility to make better choices are likely to influence professional carer responses and thought about maladaptive behaviour if the underlying belief is that the youth are choosing not to behave in an appropriate way. On the other hand, assisting carers to develop their understanding of the impact of placement disruption and negative environmental experiences in the past could increase optimism for change, because behaviour has an

origin and is explainable. The findings of this thesis indicate that many stakeholders lack a clear awareness of the role of past abuse in young peoples' lives, and could have poorly developed understandings of behavioural problems due to their limited exposure of these behaviours with the young person in their IPC. Such understandings are in conflict with the theoretical literature about 'person-in-environment' (see Hutchinson, 2003). It is suggested that viewing a young person's behaviour in terms of function or purpose creates a framework for stakeholders to explain and understand maladaptive behaviour.

Social workers and mental health professionals seeking to influence youth behaviour in an IPC with strategies and decisions must ensure adequate awareness of the unique components and behaviors that will be experienced in the IPC. In formulating behaviour management plans, the findings further suggest that mental health workers must be mindful of the IPC environment before recommending strategies to improve and address behaviour. Professional carers are unlikely to support intervention suggestions and directions from individuals who are viewed as having a significant distance from their IPC, are largely out of touch with the realities experienced by carers and are not viewed as competently understanding the relationship between youth and professional carers.

7.5 Summary

Above all, the analysis presented here supports the inclusion in this study of those individuals who come from varied backgrounds, qualifications and experiences that are frequently involved in lives of adolescents who are placed in an IPC. It is implied that the

review, of professional carers, social workers, and former foster youth perspectives has allowed complex placement dynamics to be explored and issues identified that have implications for the support of youth who are being cared for in an IPC. The results of this research strongly advocate for the ongoing inclusion of all cohorts in future research and potential expansion of the research to include larger scale studies that focus more intensively on the issues documented in this research. Essential to the ongoing success of the IPC as an option of care, in the need for it to continue to be evaluated to ensure that optimal performance of this care option is achieved. Likewise the input of young people served by these placements should continue to be sought to identify areas of practice where deficits exist and success is achieved.

APPENDICES

APPENDIX A

INFORMATION FOR PARTICIPANTS

Professional foster care has only been introduced in South Australia over the past few years. There has been very little research into the use of professional foster care system in South Australia (or, indeed, in Australia). One problem identified in the general foster care literature is a confusion of roles between various parties to foster care arrangements (for example, social workers, placement workers, foster carers, treating professionals etc). My research will provide much needed data on the experience of professional foster carers, and their understanding of their role. It will also provide indirect information on how this type of foster care is serving young people in these placements. It is expected that the research will identify service decrements, as well as aspects of professional care which are providing positive outcomes.

It is hoped that your participation in an interview will provide valuable information which contributes to the knowledge of worker experiences. You will be required to answer a series of questions which will identify your opinion and experiences in foster care.

You may choose during the interview to decline to answer any question, or alternatively may withdraw from the study completely. You may also contact me at any stage to withdraw your responses from the study completely.

The research has been approved by the Flinders University Social and Behavioural Research Ethics Committee and compliance with the conditions of the approval will be monitored by the project supervisor Dr Robyn Gilbertson.

Should you experience a negative emotional response to any of the questions, you will be directed to one of several free counselling services, including:

- Lifeline on 131114 (24-hour service)
- Kids Helpline 1800551800 (24-hour service) (for individuals up to 25yo)
- The Second Story Counselling Service via the youth health line on 1300131719

Should you have any enquiries about the research please contact Robyn Gilbertson on the above contact number.

All interviews will be identified by a number and your personal details will not be recorded to ensure your privacy. All tape recordings of interviews will be stored on a password protected Laptop (digital recordings), which is stored in a locked filing cabinet when not in use. As this research is conducted on a voluntary basis respondents will be compensated with $30 to cover their expenses, time and travel.

It is hoped that the research will provide findings which will identify areas for improvement of professional care services to young people in statutory care. The researcher hopes to identify common themes in professional foster care and issues which require improvement. Such findings may be published as an article in a professional journal or as a complete publication. It is hoped that the findings will contribute to improvements in service delivery to young people in care, and improve the overall experiences that Professional Carers, social workers and young people have in professional alternative care placements. A summary of the research findings will be provided to participants on completion of the project.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.

APPENDIX B

CONSENT FORM FOR PARTICIPATION IN RESEARCH

I ….....
being over the age of 18 years hereby consent to participate as requested in the Interview for the research project on Individual Packages of Care Provided to Children in Out-of-home Care in South Australia.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
5. I agree to an audio recording of my information and participation.
6. I understand that participation or refusal to participate in this research will not have any impact on any services which I currently receiving or participating in.

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….…….....

Researcher's signature……..Date…….
NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature……Date……...

I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature……Date……...

APPENDIX C

PUBLIC FLYER FOR PARTICIPATION IN FORMER YOUTH STUDY

From: Ryan Ogilvy
PhD Candidate
Flinders University of South Australia

- WERE YOU IN STATE CARE?
- DID ONE OR MORE OF YOUR PLACEMENTS INVOLVE A PROFESSIONAL CARER?
- WOULD YOU BE PREPARED TO DISCUSS THESE EXPERIENCES IN AN INTERVIEW?

Potential participants are invited to contact Ryan Ogilvy at ryan.ogilvy@flinders.edu.au to obtain more information about the research project and register an interest.

The interview will involve approximately one hour of your time and you will be paid $30 for your participation.

Ryan Ogilvy
BSSc, BSW, MCM, MSW
PhD Candidate

APPENDIX D

LETTER OF INTRODUCTION

Dear Sir, Ma'am,

This letter is to introduce Ryan Ogilvy who is a PhD Candidate in the School of Social Work at Flinders University. He will produce his student card, which carries a photograph, as proof of identity.

Ryan is undertaking research leading to the production of a thesis or other publications on the subject of *Examining Individual Packages of Care in the South Australian Out-of-Home Care System*. He would be most grateful if you would volunteer to assist in this project, by granting an interview which covers certain aspects of this topic. The interview will take approximately one hour to complete.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Since Ryan will record on audiotape the answers provided in the interview for preparing the thesis, report or other publications, this will be done on condition that your name or identity is not revealed. A copy of the interview answers will be made available to you at your request.

Any enquiries you may have concerning this project should be directed to me at robyn.gilbertson@flinders.edu.au, telephone 82012206 or fax 82013760
Thank you for your attention and assistance.

Yours sincerely
Dr Robyn Gilbertson
Lecturer

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.

APPENDIX E

FLYER FOR PROFESSIONAL CARER STUDY

Are you currently a Professional Carer in an Individual Package of Care?

Would you be willing to talk about your experiences in an interview?

Please contact:

Ryan Ogilvy
Flinders University
School of Social Work
0403656183
Ryan.ogilvy@flinders.edu.au

Interviews will take approximately one hour and information provided will be kept confidential.

You will be paid a stipend of 20 dollars for your time.

APPENDIX F

PROFESSIONAL CARER INTERVIEW FORM

Carer Number: (This Number will be used instead of your name to identify you)
Date:

1. How long have you worked as a carer in Individual Packages of Care (IPC)?
2. Gender
3. Placement Type: Long-, Mid- or Short-term?
4. How long has this placement been in place?
5. What is the age of the young person? 5 – 10 years 11 – 14 years
6. Before becoming an IPC carer, did you have any experience as a foster carer or similar?

The following questions relate to your experiences as a carer in an IPC Foster Placement

1. Has your role of carer been clearly explained Y/N If yes can you describe your role.
2. In general how would you rate the behaviour of the young person most of the time?
    a. *Excellent/Good/Fair/Poor*

    If *Fair* or *Poor*, is the behaviour threatening the stability of the placement?
3. Over the last year would you say that the young person's behaviour has changed?

    Worse Unchanged Improved
4. In the last month, has the young person
    a. Physically abused you?
    b. Verbally abused you?
    c. Abused another child?
    d. Abused another adult?
    e. Damaged property?
5. Are you clea**r** about this young person's history? If yes, please describe how this assists you with your role as carer.

6. Prior to placement of the young person, were you given adequate information about the young person's behaviours?
    a. If no, have you since been given this information?
    b. Yes/No,
7. Does the social worker's input have an impact upon your role as carer?
8. Has the young person derived any benefit from this placement?' If yes, please list benefits.
9. Has the placement been detrimental for the young person in any way?' If yes, please list adverse outcomes
10. Are you clear about the goals of the placement for this young person?
11. What is your role in helping to achieve these goals?
12. Are there any barriers to you helping to achieve these goals?

<u>THE FOLLOWING QUESTIONS RELATE TO YOUR ATTITUDES ON CARING FOR THE YOUNG PERSON.</u>

Ranging from important to not important at all, how important are the following aspects of caring for a young person?

Scaling from Very Important (1) – Important (2) – Not Sure (3) –Might be Important (4) Not Important at All (5).

A. Providing the young person with support to achieve their goals?

B. Maintaining a relationship with the birth family?

C. Role modelling appropriate behaviour to the young person.

D. Ensuring that the social worker is aware of any crises that occur.

E. Providing consistently supportive care to the young person.

F. Having an understanding of the young person's current issues.

E. Supporting the young person to prepare for their future including leaving care.

The following questions relate to your attitudes about the current processes in place in the young person's placement.

1. When a problem arises do you think that the agency's current case management is adequate and appropriate in dealing with this?
    a. Always__ Sometimes __ Never__ Not Sure__
2. Is it important to involve the social worker in resolving any problems or incidents that may arise?
3. Can you list three positive and three negative things about being a carer?
    a. Positive Negative
    b. (i)
    c. (ii)

4. Do you have any other comments about your experiences as a carer in an Individual Package of Care?
5. How long do you intend working as an IPC carer?

APPENDIX G

SOCIAL WORKER INTERVIEW FORM

Ex Social Worker Number: (This Number will be used instead of your name to identify you)
Date:

1. How long did you work as a social worker in statutory long-term out-of-home care?
2. Gender M/F (put the demographic questions together in one section)
3. What was your caseload at time of leaving the department?
4. How many of the young people on your caseload were in Individual Packages of care IPCs with private agencies?
5. What was the age of the young people on your caseload in IPCs?
6. Before working as a social worker in out-of-home care, did you have any experience or training in working with troubled young people?

The following questions relate to your experiences as a social worker in an IPC Foster Placement

1. Did you learn about case management as part of your Social Work degree? If yes, 'were you clear about the case management role?'
2. In general how would you rate the behaviour of the young people on your last caseload most of the time?
3. *Excellent/Good/Fair/Poor*
4. If *Fair* or *Poor*, did this behaviour threaten the stability of the placement?
5. Over the last year of your employment did the behaviour of your clients in IPCs
6. Improve?
7. Deteriorate?
8. Stay about the same?

9. Would you say that of those young people placed in professional care placements that their behaviour improved, remained the same or did not change?
10. Do you believe that it is important for the private agency to be clear (pass on a full history of the young person prior to placement?) about a young person's history? If yes, please describe how this assists the professional carer to support the management of the client.
11. Do you believe that you provided the agency with adequate information about young people's behaviours when they were placed in care?
12. Does the professional carer have an impact upon your role as social worker?
13. Is this different from the impact of a non-professional carer?
14. If yes, to 15, what are the differences?
15. Did the young people on your caseload in IPCs derive any benefit from this type of placement?' If yes, please list benefits.
16. Was the use of IPCs detrimental for young people on your caseload in any way?' If yes, please list adverse outcomes
17. Did you convey the goals of the placement to the professional carers maintaining the IPC? (Was it your standard practice to give the carers a copy of the case plan?)
18. What was your role in (working towards achieving) helping to achieve these goals?
19. Were there any barriers to your helping to achieve these goals?

<u>THE FOLLOWING QUESTIONS RELATE TO YOUR ATTITUDES ON CARING FOR THE YOUNG PERSON.</u>

How important were the following in your role as social worker for a young person in an IPC?

Scaling from Very Important (1) – Important (2) – Not Sure (3) –Moderately Important (4) Not Important at All (5).

A. Providing the young person with support to achieve their goals?

B. Promoting a positive relationship with the birth family?

E. Providing consistently supportive case management to the young person.

F. Having an understanding of the young person's current issues.

F. Supporting the young person to prepare for their future, including leaving care.

The following questions relate to your attitudes about the processes that were in place in the young person's IPC.

1. When a problem arises in an IPC do you think that the care provider agencies case management is adequate and appropriate in dealing with this?
2. Always__ Sometimes Never__ Not Sure__
3. 23. In your experience, does the use of an IPC assist in achieving positive outcomes in the following domains?
4. Health Yes No
5. Education Yes No
6. Family Connection Yes No
7. Identity Yes No
8. Social Connections Yes No
9. Emotional Yes No
10. Development Yes No
11. Is it important to involve the professional carer in resolving any problems or incidents that may arise in the placement?
12. When should IPCs be used?
13. Were IPCs ever used when another arrangement might have been better?
14. Do you have any other comments about your experiences as a social worker, case managing IPCs?

APPENDIX H

FORMER YOUTH INTERVIEW FORM

Respondent Number: (This Number will be used instead of your name to identify you)
Date:

1. How long ago did you leave care?
2. What type of placement were you in?
3. Was your experience in care a positive or negative one?

The following questions relate to your observations of the foster care system

1. Do you believe that the role of the carer is clearly explained to all carers when they enter into a care arrangement Y/N
2. What carer actions do you believe can threaten the stability of a foster care placement?
3. What actions and behaviour of a young person would you consider to threaten the stability of a placement?
4. Are there other issues that threaten placement stability?
5. Do you believe that all placement options should be considered equally? If no what considerations should be given to what type of placement?
13. Should carers be given information about the young person's history? If yes, please describe how this assists with the role of carer?
6. Do you believe that carers in current placement options are given enough information about young people?
7. Does the social worker's (case manager) input have an impact upon the role of carer?

<u>The following questions relate to your view of the comparison between 'traditional foster care placements' and 'Youth worker models of care'</u>

1. Are youth worker models of care suitable for all young people in care?

2. If no who are the placements suitable for and why?
15. When would a 'youth worker' model of care be considered unsuitable and why?
3. Please list five advantages and five disadvantages of traditional foster care.
4. .Please list five advantages and five disadvantages of a 'youth worker' model of care.
5. When using 'youth worker' models of care for emergency respite or short-term placements, what consideration should be given to ensuring minimal disruption to the young person? Are there problems with this type of placement being used temporarily if the intention is to place the young person back in family-based care?
6. When transitioning a young person from traditional foster placements into 'Youth Worker' models of care what considerations should be made?
7. Are youth worker models of care detrimental for the young person in any way?' If yes, please list adverse outcomes.
8. What should the core goals of a foster placement be?
16. Are these goals achievable in a youth worker model of care?
9. What is the role of the foster carer in helping to achieve these goals?
10. Is the role different for traditional foster carers and carers who work in a 'Youth Worker' Model of care?
11. Are there any barriers for the young person in achieving these goals?
12. Are the barriers different for carers in traditional placements and carers in 'Youth Worker' models of care?

<u>THE FOLLOWING QUESTIONS RELATE TO YOUR ATTITUDES ON PROVIDING CARE FOR A YOUNG PERSON IN A YOUTH WORKER MODEL OF CARE.</u>

Ranging from important to not important at all, how important are the following aspects of caring for a young person?

Scaling from Very Important (1) – Important (2) – Not Sure (3) –Might be Important (4) Not Important at All (5).

1. Providing the young person with support to achieve their goals?
2. Helping the young person to maintain a relationship with the birth family?

3. Role modeling appropriate behaviour to the young person?
4. Ensuring that the social worker is aware of any crises that occur?
5. Providing consistently supportive care to the young person?
6. Having an understanding of the young person's current issues?
7. Supporting the young person to prepare for their future including leaving care?

The following questions relate to your attitudes about the current processes in place in privately managed 'Youth Worker' models of out-of-home care.

1. When a problem arises do you think that private agency case management is adequate and appropriate in dealing with this?
2. Always__ Sometimes X Never__ Not Sure__
3. Should carers require qualifications to provide care to young people?
4. What sort of ongoing training should carers be required to undertake?
5. How should such placements be funded and why?
6. What is the role of the agency supervisor in maintaining the placement?
7. What is the role of the agency care team leader?
8. How should private agency carers be recruited and why?
9. Is it important to involve the social worker in resolving any problems or incidents that may arise in a youth worker model of care?
10. What is the role of the social worker in maintaining the placement?
11. Do you have any other comments about 'Youth Worker' models of care?

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