New South Wales Government

Models of service delivery and interventions for children and young people with high needs

DoCS
NSW Department of Community Services

Introduction

This Research to Practice Note provides an overview of the key findings presented in the recent literature review of services and interventions for children and young people with high and complex needs in out-of-home care (OOHC).[1]

A range of models of service delivery and interventions are considered within the context of the nature and characteristics of children and young people with high needs who are in OOHC or at immediate risk of being placed in OOHC. Implications for service delivery and development are also considered.

Background

The number of children in OOHC has steadily increased over time and the needs of those requiring care have also changed, becoming more complex and multidimensional. Australian research has shown that approximately 15-20 per cent of children in Australian OOHC have significant emotional and behavioural problems that makes it very difficult for them to achieve placement stability in conventional family foster care.[2] In New South Wales this equates to around 500 such children and young people at any given time.

There is growing acknowledgement of the need for a wider range of services for the full spectrum of children and young people in OOHC, including those with high and complex needs. Due to the nature of their experiences and needs, this group is one of the most vulnerable within the OOHC system, requiring intensive support and integrated services to ensure their ongoing wellbeing and development.

Reform of OOHC is a critical element of the broader program of rebuilding the child protection system in NSW. It is within this context that a review of models of service delivery and interventions for children and young people with high needs was undertaken.

What are the characteristics of children and young people with high and complex needs?

Research in Australia and internationally highlights the following common characteristics:

Histories of trauma

Studies have found significant histories of trauma, abuse and violence at a young age amongst children and young people with high needs. For instance, a recent Australian study of high needs children and young people in OOHC found that the majority had suffered physical abuse (73.4%), sexual abuse (65.9%) and neglect (58.2%).[3]

Although behavioural difficulties are often a primary reason why these children are considered hard to place, these difficulties are often the culmination of a combination of traumatic early experiences in the families of origin and emotional and attachment problems arising from these early experiences.

Multiple needs

Children and young people with high needs generally present with complex problems including challenging behaviours, intellectual disability, mental health issues, educational difficulties, histories of school suspension/expulsion and difficult relationships with birth families. These children and young people will often have many of these characteristics in combination and are frequently involved in two or more service systems.

Pathways in care

A recent Australian study found that most children and young people with high needs first came into contact with the child welfare system at around the age of three but usually did not finally enter care until four years later.[4] This study also showed that children within this high needs population are usually around 12 to 13 years of age and have typically experienced ten or more previous placements. On average, these children had been in the care system for five years. The study found an over-representation of boys and an under-representation of Indigenous children, suggesting that non-Indigenous boys are the most likely to experience significant ongoing placement disruption.

Deteriorating life functioning

The frequency, intensity and duration of the challenging behaviours and the complexity of needs of these children and young people present extreme challenges for carers and service providers and can lead to multiple, crisis-related placement changes that often exacerbate underlying behavioural and emotional issues.

A Victorian study of young people in OOHC with severe emotional and behavioural disturbance found that services were often not equipped to address the level of disturbance of these young people and their level of functioning was typically found to have worsened during the course of their period in OOHC.[5]

Developmental consequences of placement instability have been found for children who remain unstable for more than 12 months, showing significant deteriorations in social functioning and a general trend towards an increase in anti-social behaviours, anger and frustration.[6]

Family factors

Families of children and young people with high needs are often characterised by low self-esteem, poor impulse control, aggressiveness, anxiety and depression.[7] Adverse environmental conditions such as poverty, unemployment, poor nutrition and lack of social supports often interact with parent and child factors to increase stress.

A recent Australian study of children and young people in OOHC with high needs found consistent histories of family disadvantage. Almost three quarters of the children came from households with domestic violence or physical abuse, two thirds had parents with substance abuse problems and half had parents who had significant mental health issues and/or parents who were unable to provide adequate housing.[8]

Models of service delivery

The literature review of service delivery and interventions for children and young people with high needs examines a number of evaluated service models. The following is a brief overview of three such models:

Therapeutic foster care

Therapeutic (or treatment) foster care (TFC) is an intensive family-based, therapeutic approach for children and young people with serious emotional and behavioural disorders. With the move away from residential care over the past two decades, TFC has gained popularity as a less costly alternative to residential group care. It is considered to function as either a step-down placement for children and young people leaving more restrictive settings (juvenile justice centres or psychiatric hospitals), or as a more intensive step-up placement for those with high and complex needs that cannot be met effectively in regular foster care.

The development of TFC has been heavily informed by social learning theory. Consequently, the establishment and maintenance of fair and consistent limits and predictable consequences for rule-breaking are considered to be important components of the program. This approach aims to reinforce positive behaviours and provide clear disincentives for inappropriate behaviours. The Oregon Social Learning Centre (OSLC) provides the best-researched model of TFC to date, though it uses the term multidimensional treatment foster care (MTFC).

Key features of TFC

There are a number of key features of TFC programs as follows:

- A coordinated team (to carry out the therapeutic plan for each young person), comprising trained foster parents, a full-time case manager, individual and family therapists, and other resource staff.
- Only one or two children or young people are placed with each foster family.
- Foster parents are seen as part of the treatment team; they maintain close communication, typically daily, with the case manager and help identify target behaviours and formulate plans.
- Foster parents participate in weekly supervision/support meetings with their case manager and other foster parents. Foster parents have 24-hour access to the case manager.
- Each child or young person is assigned an individual therapist who meets with them weekly and is available to the child on a 24-hour basis.
- Case managers carry smaller caseloads and program staff members pay close (daily) attention to the individual child or young person's progress/problems in the foster home and at school.
- Foster care allowances are substantially higher than those of traditional foster care.

- Birth parents, where possible, are involved in the treatment plan and receive family therapy, support and education to increase skills at supervision, limit-setting and reinforcement.
- Aftercare support and services are provided.

Characteristics of the program affecting outcomes

There are several key components of TFC programs identified in the literature that affect outcomes. These are:

- close supervision of child/young person
- establishing and maintaining fair and consistent limits
- predictable consequences for rule-breaking
- presence and quality of a relationship (alliance) with a mentoring adult (generally the foster carer)
- limited exposure and access to delinquent peers.

In addition, increased program length (over 12 months) and intensity has also been shown to positively affect outcomes. TFC appears to be most successful for boys and children under the age of 14 with less severe emotional and behavioural problems.

Residential care

Residential care is generally distinguished from community-based care in that staff are employed and rostered to work in a specifically identified residence where the children or young people live. There are various residential care models making an analysis of the efficacy difficult.

Early research on residential care has generally reported poor outcomes for children and young people. Partly as a result, the use of residential facilities has declined throughout the western world with an increase in alternative forms of care. For instance, in Australia in 1983, approximately 40 per cent of children in OOHC lived in some form of residential care. In 2004, less than 10 per cent of the total care population lived this way, with family foster care and kinship care being the options of choice for over 90 per cent of placements.

Some favourable findings have emerged from residential care programs that meet the best standards of care. Residential care can offer a supervised, structured, less emotionally charged placement than foster placement can, and a more consistently responsive environment for young people who require such intensive care and support.

Residential care service characteristics found to be beneficial or to provide protective factors for young people include:

- family involvement
- supervision and support by caring adults
- a skill-focused curriculum
- service coordination
- development of individualised treatment plans
- positive peer influence
- enforcement of a code of discipline
- family-like atmosphere
- after-care planning and support.[9]

It is suggested that the decrease in residential care over the past two decades has resulted in limited availability of flexible, high quality residential services that contribute to a range of services for children and young people with high needs. There is agreement that some young people can benefit from appropriate residential placement, particularly when it is time limited, has a therapeutic component and is part of a plan for transition to a more 'normalised' care environment.

Multi-systemic therapy

Multi-systemic therapy (MST) is not so much a specific therapy as an intervention strategy aimed at combining different therapies and services to maintain children and young people within their family and community environment. It is an intensive, goal-oriented, time-limited, family-focused treatment model.

Adolescents who are at risk of out-of-home placement are the usual target of this intervention, with most evaluations involving juvenile justice populations.

To maximise the likelihood of achieving change, MST treatments (involving both the child and their family) address multiple factors within their social or natural environments (e.g. home, school, peer group, community or neighbourhood) contributing to the development and maintenance of the problems.

MST usually involves a small group of specially trained clinicians. The first stage of the intervention is a systematic assessment of the young person's situation. Standardised assessment tools are used and detailed interviews are undertaken with key people including family members, teachers, significant others and counsellors. Based upon initial assessments, an individualised strategy is developed for each young person which might include for example, an educational plan, a recreational plan,

parent training, cognitive behaviour therapy and social skills training. Although different strategies may be required for different young people, the integrity of the MST process is maintained by the use of practice manuals and standards that are assessed during the course of the program.

The literature reports a number of positive outcomes for young people involved with MST including a reduction in antisocial behaviour, criminal activity and recidivism rates for arrests; higher family cohesion; lower peer aggression and reduced drug use.

Implications for service delivery and development

Several implications for policy and practice can be drawn from the review of service models and also from what the research tells us about the characteristics of children and young people with high needs in OOHC. These implications can be grouped under the following themes:

Timely and effective interventions

Consistent histories of early trauma and abuse, combined with common experiences of delayed entry into care, highlight the importance of appropriate support and intervention when children first come to the attention of the child welfare system. If entry into care appears inevitable, then it is important to establish certainty and stability early. Research has shown that those entering care at an early age are likely to experience more stability in care. Repeated attempts at restoration may not always be in the child's best interests.

Once in care, it is important that targeted intensive intervention, based on comprehensive initial and ongoing assessment, be directed towards children and young people where placement breakdown is most likely. It may be possible to flag those children and young people where placement instability is likely based on certain common characteristics and a prior history of placement breakdown due to behaviour. Early intervention for these children and young people and their carers could include: regular and planned respite care, appropriate psychological and counselling services, specialist medical and allied health services and educational support services.

Multiple and complex needs can sometimes make family based care a less viable option. Ideally this should be ascertained early on rather than after numerous placement breakdowns. Research into placement instability indicates the need for a continuum of services, including a wide range of more intensive services and an extended range of placement options.

Recent Australian research indicates that placement instability often occurs in bursts and it is at these times that the active mobilisation of additional supports is required. Identifying and responding quickly and appropriately to critical incidents may help to prevent the pattern of deteriorating life functioning commonly found amongst children and young people with high needs. Regular case reviews are required to ensure interventions are tailored to the child's changing needs.

Clear entry, placement and transition processes are also imperative to minimise placement drift and disruption and thereby improve outcomes. For example, children who are transitioning out of intensive services but are still young enough to be going to a less restrictive placement or to home, benefit from a gradual and staged transition process that includes preparation, continuity of key relationships and follow-up support. The transition of young people who are leaving the formal care system should also be actively managed. The provision of after care support and services has been found to contribute to a more successful transition to independence.

Underpinning most successful service interventions are highly skilled staff and carers who receive expert supervision, on-going training and support.

Case management

Case management is considered an essential component of each of the service models considered in the literature review. Given the range of interventions and supports required to adequately meet the needs of these children and young people, systematic and consistent case management is essential. Broadly, case management is a strategy that actively mobilises, coordinates and maintains a diversity of services for the child or young person and their family.

The basic elements of case management have been outlined as: assessment; service planning; service implementation, including linking, brokering (procuring), resource development, and troubleshooting obstacles; service coordination (ensuring multiple services are directed at the same goal); monitoring and evaluation; advocacy, including empowering families and overcoming barriers.

The term 'intensive case management' (ICM) is most commonly used in the literature that discusses case management for children and young people with high needs. However, ICM is often vaguely defined as meaning more 'intense' than usual case

management. Intensive models of case management provide direct support and clinical roles and can be distinguished from other models of case management by the frequency of contacts, generally lower caseload sizes, duration of service and, in some cases, authority for funding and accountability.

There have been a number of randomised trials of ICM with children and young people with high needs and most have demonstrated positive improvements over time. However, many of the reported improvements are found in service use and placement in less restrictive settings rather than in individual and family functioning.

Integrated multi-agency working

In order to achieve improvements in child and family outcomes, the literature review highlights the need for effective approaches to service co-ordination and integration at a broader systems level. Examples of promising models covered in the review include Wraparound*, and the US Systems-of-Care model†.

These models of service integration have as intended outcomes the establishment of new and improved systems and partnerships; improvements in accessibility, quality and quantity of services; and communication among services, leading to improvement for children, young people and families.

There are a number of factors that influence the success of these approaches to service and system integration, including:

- adherence to the elements and principles of the models and services
- availability of therapeutic and support services
- capacity to involve family members and draw on community supports
- organisational, policy and funding constraints
- the diversity in characteristics of children and young people, community and contextual factors.

In practice, a UK study of professionals working with children and young people with high needs stressed the need for good working relationships at grass roots level.[10] These relationships are underpinned by respect between individuals, valuing the work of others, recognising the constraints others are under, and good dialogue with and between managers.

Several suggestions for enhancing collaboration across all professionals who support children and young people with high needs include: co-location, joint training, regular forums with agencies working together, service protocols, role definition, clear assessment and case management guidelines.

Relationships

What appears to be most strongly related to positive outcomes for the service models considered is the quality and length of the relationship between those being cared for and those providing care. Establishing positive relationships between the child or young person and the residential staff, therapeutic foster carer/s and case manager appears to be a key component of the services and interventions reviewed. For instance, the match between the foster carer and the young person is considered one of the most important predictors of outcomes in TFC (as in all forms of foster care).[11]

In view of past experiences and the importance of attachments in addressing the needs of these children and young people, continuity of relationships should be actively supported. This might include (where possible) enabling the child to remain connected to supportive family members and significant others, minimising placement changes, providing a consistent key worker to remain involved with the child despite placement change, ensuring caseworkers have sufficient time and resources to engage with the child or young person and staff recruitment retention practices aimed at reducing staff turnover.

The promotion of the active involvement of the family in the program or service (where possible) and maintaining community connections for children and young people is also considered an important component of the service models and interventions discussed here. Research related to these models indicates that achieving family and community involvement is often limited by the lack of extended familial and community networks and supports and the family's limited capacity to access and remain connected to therapeutic interventions. These difficulties are compounded by the concrete obstacles of time, transportation, child care and competing priorities which also determine service use.[12]

* Wraparound is a 'planning process involving the child and family that results in a unique set of community services and natural supports individualised for that child and family to achieve a positive set of outcomes' (Burns, B. J., & Goldman, S. K. (1998). Promising practices in wraparound for children with serious emotional disturbance and their families. Systems of care: *Promising practices in children's mental health,* Volume IV (pp. 144). Washington DC: American Institutes for Research).

† The Systems-of-Care model represents an attempt to achieve an integrated approach at the broader level of systems and organisations to address the multiple service requirements of children and young people with high needs. There is a growing body of evidence suggesting that Systems-of-Care lead to improved interagency working.

Therapeutic approaches to dealing with trauma and attachment

An understanding of both the causes of challenging behaviours and the most appropriate responses to these behaviours is guiding a shift towards a more therapeutic approach to the care of children, young people and their families.

New models and approaches facilitating therapeutic environments for children and young people with high needs (for example the Sanctuary model and Stop-gap model in the US and Turnaround and Take Two in Australia) are indicative of a shift from care settings that focus intently on behaviour management to settings incorporating a more therapeutic model of care which promotes a safe and supportive environment for children and young people within which to heal psychological and social trauma experiences.[13]

Conclusion

The review of models of service delivery and interventions for children and young people with high needs indicates that there are potential benefits from each of the interventions examined. What appears to be connected to positive outcomes for these children and young people is consistent, high quality and coordinated services and care which offer continuity of positive relationships and systematic therapeutic interventions. Thorough and ongoing assessments and reviews are required to ensure interventions are timely and responsive to the changing individual needs.

References

1 Schmied, V., Brownhill, S., & Walsh, P. (2006). Models of Service Delivery and Interventions for Children and Young People with High Needs, NSW Department of Community Services Research Report.

2 Osbourne, A., & Delfabbro, P. (2006a). An analysis of the social background and placement history of children with multiple and complex needs in Australian out-of-home care, *Communities, Families and Children Australia*, 1(1), July, p.33.

3 Osbourne, A., & Delfabbro, P. (2006b). National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care, p.6.

4 Osbourne, A., & Delfabbro, P. (2006a). op cit, p.39.

5 Morton, J., Clark, R., & Pead, J. (1999). *When care is not enough – A review of intensive therapeutic and residential service options for young people in out-of-home care who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood*, Melbourne, Victoria, Department of Human Services, p.viii.

6 Barber, J.G., & Delfabbro, P.H. (2004). *Children in foster care*, London, Taylor and Francis.

7 Vig, S., Chinitz, S. & Shulman, L. (2005). Young children in foster care: Multiple vulnerabilities and complex service needs. *Infants & Young Children: An Interdisciplinary Journal of Special Care Practices, 18*(2), pp. 147-160.

8 Delfabbro, P. & Osbourne, A. (2005). Models of service for children in out-of-home care with significant emotional and behavioural difficulties, *developing practice: the child youth and family work journal*, 14: Summer, pp.17-29.

9 Whittaken, J.K (2000). What works in residential care and treatment: partnerships with families. In Kluger, M., Alexander, G., & Curtis, P. *What works in child welfare?*, Washington, DC, Child Welfare League of America.

10 Worrall-Davis, A., Kiernan, K., Anderton, N. & Cottrell, D. (2004). Working with Young People with Complex Needs: Practitioners' Views, *Child and Adolescent Mental Health, 9*(4), pp. 180-186.

11 Smith (2001) Smith, D. K., Stormshak, E., Chamberlain, P. & Whaley, R. B. (2001). Placement disruption in treatment foster care. *Journal of Emotional & Behavioral Disorders, 9*(3), 200.

12 Carr, E., & Semel, M. (2004). *Predictors of efficacy in wraparound care with severely psychiatrically disturbed adolescents.* Paper presented at the Georgetown Institute Conference, San Francisco, CA, USA.

13 Schmied, V., Brownhill, S., & Walsh, P. (2006). op cit.

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Centre for Parenting and Research
NSW Department of Community Services
4-6 Cavill Avenue
Ashfield NSW 2131
02 9716 2222

www.community.nsw.gov.au
researchtopractice@community.nsw.gov.au

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