Issues Paper Two

Their needs: appropriate service models for vulnerable children, young people and families

Protecting Victoria's Vulnerable Children Inquiry 2011

Centre for Excellence
in Child and Family Welfare Inc.

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Protecting Victoria's Vulnerable Children Inquiry 2011

Centre of Excellence in Child and Family Welfare (2011)

Their Needs: improving outcomes, options and systems in out-of-home care

Issues Paper Two
Protecting Victoria's Vulnerable Children Inquiry 2011

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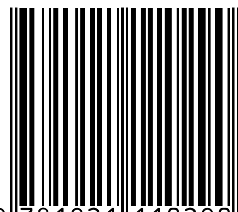

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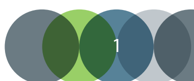
About the Centre of Excellence in Child and Family Welfare

The Centre for Excellence in Child and Family Welfare is a not-for-profit peak body for nearly 100 child and family services in Victoria.

Working for vulnerable children, young people and families, the Centre provides sector training, facilitates and publishes research, advocates through campaigns and media liaison, and sustains ongoing programs focusing on key areas of the State care system. These include the voice of children and young people, and specific programs for foster care, kinship care and residential care. The Centre also works and advocates for better transitions for young people leaving State care.

The Centre represents community service organisations of all sizes across the State, enhancing their capacity to deliver services through engagement and voice in State policy and service development.

An incorporated association, the Centre is guided by a board of 12 directors drawn from member organisations, together with a Chief Executive Officer and an expert academic member.



Contents

Introduction **3**
Glossary **4**
Abbreviations
Appropriate service models for vulnerable children, young people and families **6**
The Victorian context 6
Increasing demand 6
Expenditure on out-of-home care services 7
Placement matching and permanence 9
Home-based carers 9
The need for improved recruitment, training and assessment of home-based carers 9
Carer reimbursement 10
Alternative models of care 11
Therapeutic foster and residential care 11
Lead tenant arrangements 13
Professionalised models of foster care 13
Workforce issues 14
Effective prevention services 14
Placement prevention 14
Respite care 15
Home-based interventions 15
Compulsory participation 16
Conclusion **17**
Bibiliography **18**
List of figures and tables
Figure 1. Projected demand for of out-of-home care placements 2009–10 to 2013–14. 6
Figure 2: Real recurrent expenditure on child protection and out-of-home care services per child (2009–10 dollars). 8
Figure 3: Real recurrent expenditure on out-of-home care services by jurisdiction. 8
Table 1. Proportion of children (%) in out-of-home care, by living arrangements, states and territories, as at 30th June 2010. 7
Table 2: Standard subsidy payments by jurisdiction (as compared with McHugh's Foster Care Cost Estimates) as at July 2011 (weekly rates). 11

Introduction

In the Centre's submission to Protecting Victoria's Vulnerable Children Inquiry 2011 – '…it's their outcomes that matter' – the Centre argued for the adoption of a shared social responsibility model for vulnerable children, young persons, and families across Victoria.[1]
The Centre's belief is that this can be brought to life by the development of a whole-of-system Vulnerable Children, Young Persons' and Families Strategy for tackling vulnerability which includes an outcomes framework and a broad-based concept of vulnerability.

Central to this strategy is a robust protective system supported by broad and responsive promotion and prevention strategies which focus on early intervention to prevent progression to protective services. This system is specifically relevant to individual vulnerable children, young people and their families and should empower local communities in decision-making and responding to vulnerability. The Centre contends that prevention strategies are a vital, under-resourced and undervalued part of the current promotion, prevention and protection service system.

The Centre advocates the strengthening of families and supporting them to stay together wherever this is possible and appropriate. However, it is necessary to acknowledge that from time to time it is simply not possible for some children and young people to continue living in their family homes. These children and young people require safe, nurturing homes until such time as they can return to their families or permanent out-of-home care until they transition to living independently. In this paper the Centre focuses on options and models for out-of-home care. The support needs of young people transitioning from formal care is beyond the scope of this paper, but they are addressed in the Centre's submission to the Protecting Victoria's Vulnerable Children Inquiry 2011.

The Centre's submission outlined four issues of critical importance in ensuring the delivery of quality protective services in Victoria:

- the capacity to fully and appropriately meet demand
- the range of placement options available to vulnerable children and young people
- access to therapeutic services
- ongoing investment in workforce development.

The Centre made a series of recommendations in order to highlight the necessary steps to begin tackling these and other issues. Several key recommendations specifically related to prevention and protection service delivery were that:

- Family support, youth and all preventative services be funded on a demand model
- All out-of-home care be delivered in line with current successful therapeutic service models
- Whole-of-sector strategic workforce planning take place immediately, supported by adequate resourcing
- Rates of reimbursement for foster, kinship and permanent carers be immediately raised to cover the true costs of care
- Strategic and significant additional investment be made to allow for the state-wide provision and coordination of recruitment, training, assessment and support of foster, kinship and permanent carers.

This paper further discusses these recommendations and the issues that underscore them, with reference to alternative models and future directions for out-of-home care in Victoria.

Dr Lynette Buoy
Chief Executive Officer

1 Centre for Excellence in Child and Family Welfare, *Protecting Victoria's Vulnerable Children Inquiry 2011…it's their outcomes that matter,* Centre for Excellence in Child and Family Welfare, Melbourne, 2011, p. 6

Glossary

Out-of-home Care

Out-of-home care is care for children aged 0–17 years who are unable to live with their parents. In most cases, children in out-of-home care are also on a care and protection order.[2]

Residential care

Residential care is a form of out-of-home care where children and young people are cared for by professional staff in community-based residential facilities. Residential care includes family group homes. These homes have live-in, non-salaried carers who are reimbursed and/or subsidised for the provision of care.

Home-based care

Home-based care placements are provided in the homes of non-parent carers who are often provided with reimbursement for expenses relating to the care of the child. Home-based care has three main subcategories: kinship care, foster care, and permanent care.

Kinship care

Kinship or relative care is a placement provided by family members other than parents or by a person well known to the child and/or family (based on a pre-existing relationship). The kinship carer may or may not be reimbursed by the state/ territory for the care of the child.

Foster care

Foster care is provided by non-relative carers in their private residences. Foster carers undergo training and accreditation prior to providing care. The placement is authorised by the responsible state or territory agency and carers are reimbursed by the state/territory and supported by an approved agency.

Other care

Other forms of care include lead tenant arrangements and individual care arrangements such as secure welfare or emergency placement.

2 Australian Institute of Health and Welfare, *Child Protection Australia 2009–2010*, Australian Government, Canberra, 2011, p.4

‘Every out-of-home care program should have an articulated theoretical foundation’

Appropriate service models for vulnerable children, young people and families

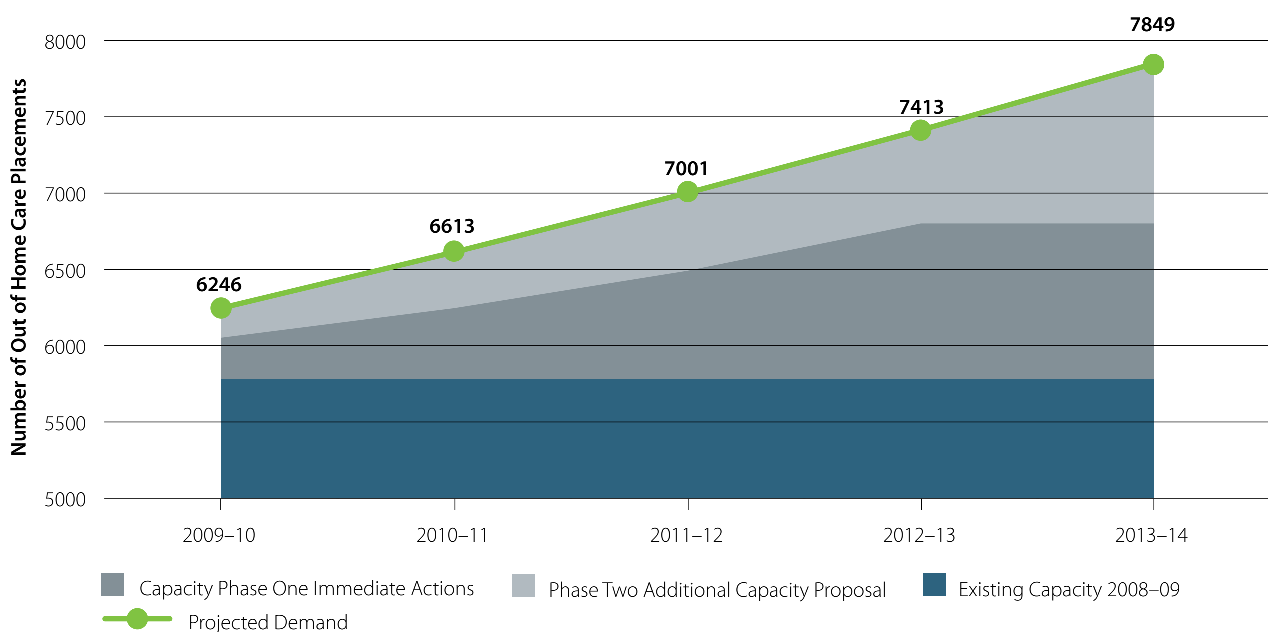
The Victorian context

Increasing demand

Out-of-home care has ceased to consist of simply helping look after children from the local neighbourhood. The need for out-of-home care is now commonly recognised to extend from simple neighbourhood care to highly specialised 24-hour therapeutic interventions for vulnerable children and young people. They require services that are appropriately resourced to provide a level of care that each individual needs to recover from the effects of trauma and abuse.

The number of children per 1,000 placed in out-of-home care in Victoria has risen from 3.8 in 2005 to 4.4 in 2010.[3] While this remains the lowest rate in Australia, there is reason to believe that this rate will continue to rise, placing further pressure on care services. Out-of-home care options currently available for vulnerable children and young people are showing considerable signs of strain. From March 2010-March 2011 foster care numbers increased by 4.5%, kinship care numbers increased by 14.6%, permanent care numbers increased by 28.4% and residential care numbers increased by 9.3%.[4,5] The Victorian Ombudsman has estimated that future demand for out-of-home care is likely to be greater than some projections provided by the Department of Human Services.[6] This is likely to mean that more and more frequently, appropriate placements will not be available for children and young people requiring care.

Figure 1. Projected demand for of out-of-home care placements 2009–10 to 2013–14.[7]



The nature of out-of-home care placements has also changed. Kinship care has continued to grow, and now provides 40% of the total number of placements in out-of-home care, despite a number of significant issues which have not been addressed since the development of the program model in 2008.[8] Foster care, which provides temporary homes for around 1,500 children and young people at any given time, also faces significant challenges including a growing demand for the professionalization of the service. Carers are being asked to provide care for children and young people with ever higher levels of need. Permanent care programs are struggling to deal with post-placement support, while the

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3 Australian Institute of Health and Welfare, *Child protection Australia 2009–2010*, Australian Government, Canberra, 2011, p. 54.

4 Department of Human Services. *Annual Report 2010–2011. Additional data* retrieved on 17 September 2011 at http://www.dhs.vic.gov.au/about-the-department/our-organisation/annual-reports/department-of-human-services-annual-report-2010-11/additional-data-in-support-of-the-2010-11-annual-report#content-heading-1

5 Department of Human Services. Source CRIS 31 March 2010. *Children Aged 0–17* Presentation at Coalition for Change 5 August 2010

6 Ombudsman Victoria, *Own motion investigation into Child Protection – out-of-home care*, Ombudsman Victoria, Melbourne, 2010, p.70.

7 Ombudsman Victoria, Op. Cit. p.69.

8 Department of Human Services, *A new kinship care program model for Victoria*, Department of Human Services, Melbourne, 2008.

beleaguered residential care system, which accommodates approximately 500 children and young people, continues to pilot therapeutic models of care in an effort to meet the needs of today's children and young people.[9]

The Australian Institute of Family Studies publication compares the usage of different forms of out-of-home care across jurisdictions as set out in Table 1 below. In Victoria over 90% of children and young people in out-of-home care are placed in a home-based setting, slightly below the Australian average. Conversely, Victoria has a higher percentage of children in non-home-based forms of out-of-home care than the Australian average.

Table 1. Proportion of Children (%) of children in out-of-home care, by living arrangements, states and territories, as at 30th June 2010.[10]

Type of Placement	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
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	–	10.5	–	–	0.2	9.4	–	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	–	–	–	2.3	–	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	–	–	0.7	0.4
Other	–	–	–	–	3.7	3.4	–	6.9	0.4
Total non-home based care	2.8	8.7	7.7	8.5	14.9	7.7	8.8	12.4	6.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Percentages in tables may not add to 100 due to rounding
Source AIHW, 2011, p.49

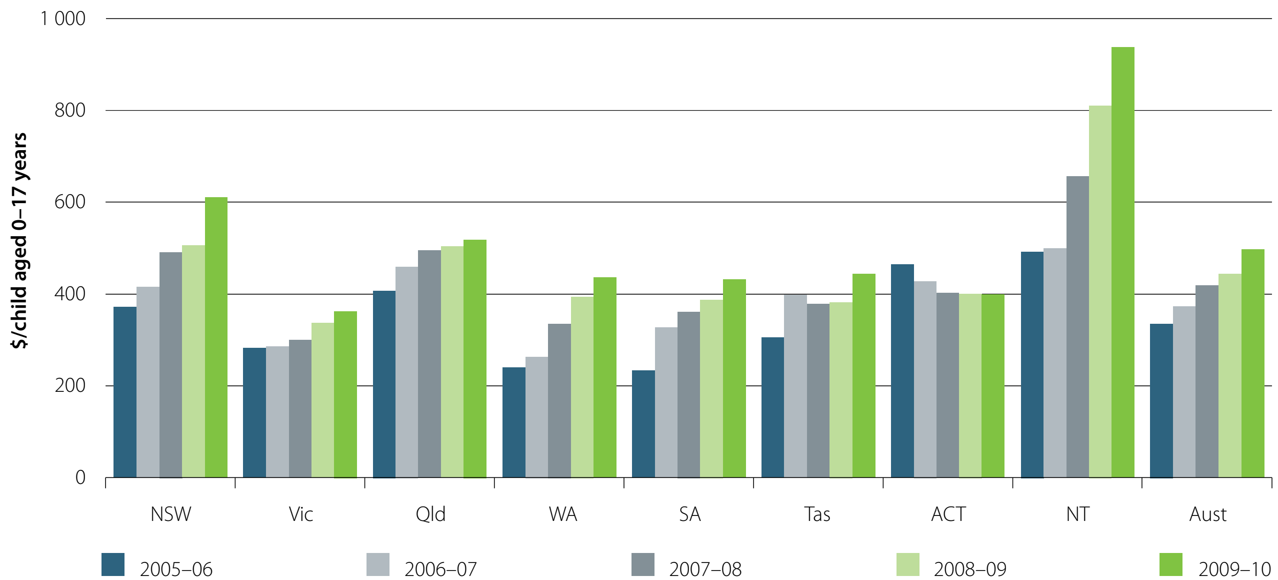
Expenditure on out-of-home care services

Over the last five years, Victorian combined expenditure on child protection and out-of-home care per child has grown, but remains lower than all other Australian jurisdictions. These differences, demonstrated in the figure below, could be accounted for by greater efficiencies in the Victorian system, the increasing reliance in Victoria on the less expensive model of kinship care, or divergence in the way cost components are taken into account by different jurisdictions. Nevertheless, outcomes for children and young people within the system strongly suggest that current expenditure is not sufficient to meet their needs.

9 Australian Institute of Health and Welfare, Op Cit.

10 A. Lamont, *Children in care*, Australian Institute of Family Studies Resource Sheet, National Child Protection Clearinghouse, Australian Institute of Family Studies Melbourne, 2011, p.3.

Figure 2: Real recurrent expenditure on child protection and out-of-home care services per child (2009–10 dollars).[11]



Over the past decade, real recurrent per child expenditure on all forms of out-of-home care services in Victoria has shown a steady increase. This increase is illustrated and compared to other states and territories in Figure 3 below. It is important to note that peaks in expenditure demonstrated below may reflect special budget initiatives, and that a decline in real per child expenditure may not reflect a decline in absolute expenditure but rather a change to the number of children in out-of-home care on the 30th of June in the relevant year.

Figure 3: Real recurrent expenditure on out-of-home care services by jurisdiction.[12]

11 Productivity Commission: Steering Committee for the Review of Government Service Provision, *Report on Government Services 2011*, Volume 2: *Health; Community services; Housing and homelessness*, Productivity Commission, Canberra, 2011, p. 15.14.

12 Productivity Commission, *Report on Government Services*, Chapter 15 Protection-Support Services. Attachment tables only retrieved on 15 August 2011 from http//www.pc.gov.au/_data/assets/excel_doc/0005/105359/075_chapter15_attachmentxls

Placement matching and permanence

The Victorian out-of-home care system is restricted by the limited number of care options and is struggling to meet demand. The placement of children and young people is typically driven by availability rather than individual need, resulting in poor placement matching and placement breakdown. Children and young people are being inappropriately placed in residential care or in contingency placements, and others are remaining in residential care long after they have been assessed as being appropriate for a home-based care placement.[13] If the current situation remains unaddressed, the projections of demand referred to by the Victorian Ombudsman would lead to a catastrophe.

It has further been shown that there are strong correlations between the number of case workers a child experiences due to worker turnover and the likelihood of placement permanency.[14] Children and young people who only have only one worker during their time in care have been shown to have a 74.5% chance of achieving placement permanency. This number drops to 17.5% for children who have two workers, 5.2% for those who have three workers, and falls as low as 0.1% for those who have six or more.[15] It is clear that workforce issues must be considered as a contributing factor to the ongoing challenges in achieving placement permanence.

Minimising the number of placements children in all forms of out-of-home care experience is essential. Multiple placement breakdowns may cause psychological damage to a child or young person that can impair their ability to establish intimate relationships and relate to others in the future. It can also result in an increased likelihood of behavioural problems. This, in turn, makes children and young people more difficult to care for. It has been shown that early entry to a permanent placement enhances the likelihood of a child achieving ongoing stability during their time in out-of-home care.[16] In addition, research indicates that when a child has experienced two or more placement breakdowns, there is a significantly increased likelihood of this pattern continuing.[17] Placement stability from the outset is therefore vital. Alongside the provision of holistic therapeutic care packages, one of the best ways to achieve this is through appropriate placement matching when a child or young person first enters care. Comprehensive, timely assessment of foster carers and the retention of a skilled service workforce are required, along with a number of alternative placement types to ensure stability for children and young people.

The Centre recognises that a robust residential care system is vital to ensuring that appropriate placement options are available for all children and young people. Many children and young people experience times when they are simply unable to live comfortably within a family setting. Quality, well-resourced residential care can provide an excellent substitute home environment for this group. However, home-based care should be the placement option of choice for the vast majority of children and young people requiring out-of-home care. The protective system must be sufficiently resourced in order to ensure a range of home-based and residential placement options and supports are available to all children and young people in out-of-home care, and that those same options are also available to those who experience placement breakdown.

Home-based carers

The need for improved recruitment, training and assessment of home-based carers

Foster care has been the backbone of the Victorian response to protective intervention on behalf of children and young people for decades. However, continued underinvestment, a lack of recognition of the complexity of the work and the refusal to acknowledge that it is inappropriate to ask volunteers to shoulder the responsibilities of Government without adequate support is crippling the system's capacity to appropriately respond to the needs of children and young people.

The Victorian Foster Care Hotline is the only central information and referral service of its kind around Australia. With one free call or web enquiry, any Victorian can obtain all the information and advice required about foster care or becoming a carer in a comprehensive, clear and timely manner. The service model has proven so successful that other states and territories are currently developing services based on the Victorian model.

13 Ombudsman Victoria, Op. Cit.

14 C Flower, J McDonald & M Sumski, *Review of turnover in Milwaukee County private agency child welfare ongoing case management staff*, Wisconsin, 2005.

15 Ibid.

16 D Rubin, A O'Reilly, X Luan & A Localio, *The impact of placement stability on behavioural well-being for children in foster care*, Paediatrics, Vol 119, p. 336–344.

17 P Fisher, B Burraston & K Pears, *The early intervention foster care program: permanent placement outcomes from a randomized trial*, Child Maltreatment, Vol 10, p. 61–71.

Data collected through the Foster Care Hotline contradicts the perception that there is a declining public interest in providing foster care. In 2009 there were 1,908 enquiries from potential foster carers, compared with 2,067 in 2010 and 1,121 in just the first six months of 2011.[18] It is clear from these figures that any difficulty with maintaining an adequate carer pool in Victoria is not caused by a lack of interested community members.

It has been shown that increased recruitment budgets lead to increased numbers of potential carers attracted to the service system.[19] A minimal level of recurrent funding is provided to the centralised Hotline service, but consistent funding is not allocated for the ongoing promotion of foster care as a volunteering option to the general public . The last allocation of funds for state-wide promotion was provided as a one-off payment in 2006. This was to be utilised by the Centre on behalf of the sector across Victoria. Sustained effort is required if essential promotional activities are to be maintained. A website which accompanies the Hotline ('Foster A Brighter Future') requires updating, and promotional materials require development and distribution across the State. Additional capacity to respond to unexpected increases in the volume of inquiries which result from media or other coverage is also required if expression of interest is to be translated into recruitment of new foster carers.

Essentially, the number of foster carers remains insufficient due to the attrition of potential carers both before and after accreditation. Retention would be vastly improved by the provision of consistent resources to provide the information, training and support these highly valuable volunteers need. Due to a lack of resources, many service providers are currently contributing their own funds and staff time to maintain a minimum level of marketing, training, assessment, and volunteer management expertise. Obviously, this is not a sustainable solution.

Around 2,000 households formally inquire about becoming foster care families every year. However, without the necessary infrastructure to support their transition to becoming carers, the overwhelming majority fall by the wayside.[20] The training and assessment of carers is often an additional duty of casework staff, which means that in some cases, potential carers may wait up to 8 or 9 months to be assessed, and regularly wait months to enrol in pre-service training. Meanwhile, hundreds of children and young people across the state sit on waiting lists for respite care and permanent care, or are placed in residential care despite being assessed as requiring a home-based care placement. Carers also have ongoing learning and development needs, although few carers receive appropriate and relevant opportunities for further learning after their initial training.

Strategic and significant additional investment must be made to allow for the state-wide coordination of recruitment, training, assessment and support of foster, kinship and permanent carers. In 2007, the Centre's monograph 'Strengthening the Recruitment and Retention of Foster Carers in Victoria' called for the establishment of Regional Promotion and Recruitment Groups and the employment of Regional Promotion and Recruitment Coordinators.[21] Further changes to the system and increased public interest now necessitate the creation of regional Recruitment, Training and Assessment Units. This consolidation of efforts and expertise has been consistently supported by research and has been implemented or trialled in the United States of America, Australia and elsewhere.[22,23]

Carer reimbursement

Closely related to the ability to recruit and retain carers, and thus related to the system's ability to provide a diverse range of placement options, is the issue of carer reimbursement. In 2002, Marilyn McHugh identified the inadequacy of the standard carer reimbursement to meet even the most basic costs of providing care to a child or young person.[24] She recommended 'That all States review their level of standard subsidy (including higher payments for specified categories of need) paid to carers and increase levels to reflect the direct costs of fostering. The review process should include consultation with NGO agencies and carer associations.'[25] However, since the publication of that report almost ten years ago, rates of reimbursement in Victoria have remained well below the cost of caring for children.[26]

18 Internal data

19 The Fostering Network, *Improving effectiveness in foster care recruitment*, Department of Education and Skills, London, 2006.

20 Internal data

21 Centre for Excellence in Child and Family Welfare, *Strengthening the recruitment and retention of foster carers in Victoria*, Centre for Excellence in Child and Family Welfare, Melbourne, 2007.

22 Office of the Inspector General, *Recruiting foster parents*, Department of Health and Human Services, Washington, 2002.

23 Partners for Our Children, *Foster parent recruitment and retention: developing resource families for Washington State's children in care*, Partners for Our Children, Seattle, 2009.

24 M McHugh, *The costs of caring: a study of appropriate foster care payments for stable and adequate out-of-home care in Australia*, Social Policy Research Centre, Sydney, 2002.

25 Ibid.

26 M McHugh, *Carer reimbursements: their role in securing stability for children*, Social Policy Research Centre, Sydney, 2011.

The basic levels of reimbursement must be raised to meet the true cost of care, and accurate, clear information must be provided to carers regarding financial support. Victorian carers receive among the lowest average levels of reimbursement in the country, as demonstrated by McHugh in Table 2.[27]

Table 2: Standard subsidy payments by jurisdiction (as compared with McHugh's Foster Care Cost Estimates) as at July 2011 (weekly rates).

Age	TAS	WA	NT	SA	VIC	ACT	QLD	NSW	FCE
					($)				
0-1	182	172	168	145	153	224	211	207	211
3	182	172	168	145	153	224	211	207	210
6	208	176	222	169	153	251	233	232	225
10	208	208	222	169	165	251	233	232	265
14	240	252	248	241	242	251	253	311	325/333[(1)]

First amount (325) applies to boy aged 14, second (333) applies to girl aged 14.

It is unrealistic and unfair to expect that Victorians with the requisite skills, commitment, passion, and expertise will also be able to subsidise the provision of services to children and young people whose care is the responsibility of Government. McHugh has proposed a national framework of carer allowances to address some of these discrepancies, and supports the Centre's supplementary submission to the Protecting Victoria's Vulnerable Children Inquiry in calling for carer reimbursements to be immediately raised, with further future increases to be tied to the Consumer Price Index.[28,29]

Alternative models of care

Therapeutic foster and residential care

Models of therapeutic or treatment foster care operate in Victoria and around the world. The Department of Human Services has repeatedly recommended increasing the availability of therapeutic care.[30,31] Limited progress has been made in achieving this aim, with the Centre estimating as little as 4% of children and young people in care in Victoria are placed in an out-of-home care model with an articulated and adequately resourced therapeutic framework. This is despite international evidence showing that children and young people in therapeutic forms of out-of-home care:

- are up to five times less likely to experience placement breakdown even though they typically have an elevated level of social and behavioural problems compared to children and young people in general foster care placements[32]
- have a reduced incidence of substance abuse, antisocial behaviour, recidivism and involvement in the justice system[33]
- have foster carers with greatly reduced stress levels
- experience an increased rate of successful reunification with their birth families
- are less violent[34]
- experience an increased rate of participation in school.[35,36,37]

27 Ibid.
28 M McHugh, *Levels of subsidies for all states & territories and foster care estimates 2000–2009*, National Foster Care Conference, Hobart, 2010.
29 Centre for Excellence in Child and Family Welfare, *…it's their outcomes that matter: supplementary submission to the Protecting Victoria's Vulnerable Children Inquiry*, Melbourne, 2011.
30 Department of Human Services, *Specialised In-Home Care – draft program model*, Department of Human Services, Melbourne, 2009.
31 Department of Human Services, *Public parenting: a review of home-based care in Victoria*, Department of Human Services, Melbourne, 2003.
32 P Westermark, K Hansson & B Vinnerljung, *Does multidimensional treatment foster care (MTFC) reduce placement breakdown in Foster Care?* International Journal of Child & Family Welfare 4, 2008, p. 155–171.
33 Multidimensional Treatment Foster Care England, *Multidimensional treatment foster care in England – annual project report 2010*, Department of Education, London, 2010.
34 Task Force on Community Preventive Services, *Therapeutic foster care for the prevention of violence*, Center for Disease Control and Prevention, Atlanta, 2004.
35 P Fisher, P Chamberlain & L Leve, *Improving the lives of foster children through evidence-based interventions*, Vulnerable Children and Youth Studies, Vol 4, No 2, 2009, p. 122–127.
36 D Smith, P Chamberlain & J Eddy, *Preliminary support for multidimensional treatment foster care in reducing substance use in delinquent boys*, Journal of Child & Adolescent Substance Abuse, Vol 19, 2010, p. 343–358.
37 P Westermark, K Hansson & M Olsson, *Multidimensional treatment foster care (MTFC): results from an independent replication*, Journal of Family Therapy, Blackwell Publishing, UK, 2010.

The benefits have been shown to be similar across all forms of out-of-home care, including residential care. In financial terms alone, these benefits have been calculated as having the potential to save communities up to fourteen dollars in future justice system costs for every dollar invested today.[38,39] Over the past thirty years governments around the world have acknowledged this reality and established therapeutic out-of-home-care programs.

Every out-of-home care program should have an articulated theoretical foundation.[40] These foundations are central to therapeutic programs which generally have a strong focus on healing and providing interventions to assist children and young people to overcome experiences of trauma, abuse, and neglect. This enables them to develop in a more healthy and positive manner than most general out-of-home care programs allow. Therapeutic programs are almost always well-resourced in comparison to other, more basic out-of-home care programs, and may utilise a number of different styles of intervention including a focus on environmental, behavioural, and/or psychotherapeutic interventions.

Environmental intervention is perhaps the most common therapeutic out-of-home care intervention. All therapeutic care aims to create a safe and nurturing environment for vulnerable children and young people. Depending on the resources available to the program, every detail of the individual child or young person's daily environment will be attuned by the child's care team to be most conducive to healing. This can range from their diet to the layout of their bedroom, their exposure to natural light or management of violence and conflict.[41] Environmental intervention can be seen to some extent in Victoria's own Circle Program, among other international examples.[42]

Behavioural interventions are used to some extent by most parents. They range from common but vital behaviour management techniques such as simple rewards systems (such as 'do your chores and you will receive pocket money') to highly structured sets of carefully coordinated consequences. Multidimensional Treatment Foster Care (MTFC), practiced across Europe and the United States of America, is a multi-modal treatment approach to out-of-home care. It is targeted at children and young people with serious behavioural problems and delivered in the homes of highly-trained foster carers. MTFC programs have used behavioural interventions with such success that many programs have begun to specialise in providing placements for juvenile offenders in an effort to decrease rates of recidivism among vulnerable young people.[43]

Psychotherapeutic interventions include art therapy, play therapy, counselling and psychiatric services. Interventions of this nature are used within many therapeutic out-of-home care programs with some success, including Victoria's Circle Program. The Circle Program provides children and young people who are likely to benefit from psychotherapeutic intervention with access to a paediatric therapist who works with them throughout their time in care. In addition, practitioners within the program have access to brokerage funding which they can use to provide other forms of therapy, such as art or play therapy, to children and young people who may benefit.

One excellent international example of therapeutic care in practice is Jasper Mountain, a therapeutic residential care program located in Oregon in the United States of America. Jasper Mountain has provided a continuum of programs to emotionally disturbed children and their families since 1982, including an intensive residential treatment program, a therapeutic school, a treatment foster care program, and crisis response services. It utilises environmental, behavioural, and psychotherapeutic interventions alongside its' own brand of intervention used to develop self-esteem. It combines aspects of therapeutic care programs from throughout the world to provide holistic care for the children who live at the facility.[44]

Local examples of therapeutic residential care have been in action since 2007 when a series of pilot programs were implemented across Victoria as the basis for the development of a new service delivery approach for residential care services in Victoria.[45] Working in conjunction with therapeutic service providers such as Australian Childhood Foundation and Take Two, organisations such as Menzies have been providing therapeutic residential care placements to young people for several years.

38 National Centre for Health Marketing, *Guide to community preventative services*, National Centre for Health Marketing, Atlanta, 2004.

39 National Guideline Clearinghouse, *Therapeutic foster care for the prevention of violence: a report on recommendations of the task force on community preventive services*, National Guideline Clearinghouse, Maryland, 2008.

40 F Ainsworth, *Residential programs for children and young people: what we need and what we don't need*, Children Australia, 32(1), 2007, p. 32–36.

41 D Ziegler, *A residential care attachment model*, Jasper Mountain: Hope for Children & Families.

42 Department of Human Services, *The Circle Program – a therapeutic approach to foster care*, Department of Human Services, Melbourne, 2009.

43 National Centre for Health Marketing, Op. Cit.

44 Jasper Mountain retrieved on 17 August 2011 at http://www.jaspermountain.org/treatment_foster_care.html.

45 Department of Human Services, *Essential service design elements: therapeutic residential care*, Department of Human Services, Melbourne, 2009.

Providing placement for up to four young people at any given time, Menzies therapeutic residential care program is tailored to the needs of young people 12 years and over who have a mild to moderate intellectual disability. The residential unit is decorated and laid out in a manner which allows for the creation of an environment as close as possible to that of a family home.[46] A therapist is based in the home, supporting residential care staff and working with the young people. The specialisation of the unit has also allowed for the development of improved relationships with disability services. All staff are trained to recognise the underlying issues and the way that past events in the lives of the young people may result in their trauma, current behaviour and potentially their disabilities. They are supported by the therapist and disability services in responding appropriately to the young people's needs. Reports indicate that the implementation of the therapeutic residential care program has caused a ripple effect, resulting in positive changes to practice across Menzies residential care programs. Young people from the program have identified positive change in themselves and their life outlook.[47]

Given international evidence of the effectiveness of therapeutic models of care in meeting the complex needs of a range of children and young people, all out-of-home care in Victoria should be delivered in line with successful therapeutic models.

Lead tenant arrangements

Under lead tenant arrangements, young people reside in a home with an adult who takes responsibility for the household and who is compensated by the provision of free accommodation. Lead tenants are usually employed in another setting or are studying and their main engagement with the young residents is after hours. Any support of young people provided by the lead tenant is informal and the role is often described as a 'mentoring' role. Lead tenant arrangements have traditionally been a pathway to independent living for young people leaving care. However, whilst presenting an option for young people approaching independence, lead tenant arrangements have not been underpinned by an agreed and funded program model.[48]

MacKillop Family Services has developed a model of Enhanced Lead Tenancy where additional support is provided to the young persons by caseworkers and youth workers. This enables higher levels of independence for young people while at the same time ensuring that they receive the type of support that most young people would expect to receive from family.[49] Lead tenants themselves report that they feel more supported in their role.

MacKillop Family Services' model incorporates a 'cluster' arrangement similar to historical campus-based family group homes. Feedback on this approach has indicated additional stability for both the arrangements themselves and for the support of young people. MacKillop has also aligned the lead tenant arrangements with a transitional housing model. This allows young people to move to independent living with support following their time in the lead tenant arrangement and their formal discharge from care. The MacKillop model thus provides an option for planned transition to independence and is designed to ensure optimal outcomes for the young people. It recognises that young people exiting care require support which extends after formal discharge from care and ensures adequate access to specialist and educational and health services.

Professionalised models of foster care

Professionalisation of foster care ensures that carers are not being exploited and that their expertise and contribution to the lives of children and young people are properly recognized.[50]

In 2003, the Department of Human Services released the report Public Parenting: A review of home-based care in Victoria.[51] The report noted the increasing level of care required by children in out-of-home care across Australia and identified the need for more responsive service models, stating that 'the available evidence points to the importance of being non-prescriptive in placement type and having a range of types available'. Since the release of the report, there have been attempts to introduce models of professionalised foster care in Victoria.

In 2009, a Specialised In-Home Care model was developed by the Department of Human Services in consultation with relevant stakeholders across the out-of-home care sector. The model featured several aspects of typical professionalised

46 M Baird & Y Baliz, *Menzies' therapeutic residential care pilot program*, Menzies & Take Two, Melbourne, 2010.

47 M Baird and Y Baliz, Ibid.

48 MacKillop Family Services, *Service Review: Lead Tenant Services* October, 2009. (Unpublished)

49 MacKillop Family Services, *Submission to the Protecting Victoria's Vulnerable Children Inquiry. Supplementary Response* April 2011 retrieved on 6 August 2011 from http://www.childprotectioninquiry.vic.gov.au/images/stories/submissions/mackillop-family-services.pdf.

50 D Kirton, *Step forward? Step back? The professionalisation of fostering*, Social Work and Social Sciences Review, Vol 13, Number 1, 2007, p 6–24.

51 Department of Human Services, *Public parenting: a review of home-based care in Victoria*, Department of Human Services, Melbourne, 2003.

foster care programs including requirements for foster carers to have enhanced professional skills, capabilities, qualifications, and supports.[52] As part of the model foster carers would receive greatly increased levels of remuneration – comparable to a living wage. However, several impediments were identified during the model development. A number of other states and territories are also facing similar issues with developing professionalised models of care, primarily relating to difficulties with the taxation system.

Successful professionalised foster care programs are utilised in several parts of the world. The Professional Foster Care Program, run by The Baby Fold, has been operating in Illinois, USA, for several years. The program provides the most intense support and supervision available in the state, aiming to meet the needs of children and young people who are unable to be placed in general foster care programs.[53] It is viewed primarily as an alternative to residential care for children and young people, providing a structured, nurturing home-based environment designed to meet the individual needs of each child and young person.

The Professional Foster Care program and many others like it treat their experienced foster carers as paid employees who require a certain level of experience and qualifications. These carers are members of a 'treatment team' who provide the day-to-day care and services to the children and young people. The teams are essentially heightened forms of the care teams found in Victoria's Circle Program, often featuring counsellors, therapists, teachers, educational experts, and disability specialists.

Professionalisation of foster care has its challenges. Caution must be exercised to ensure that measures do not undermine the personal and familial aspects of foster care which are a critical part of its success.[54] However, the current situation in which ever-increasing demands are placed on volunteers is unsustainable and must be supported by a base of semi-professional foster carers who are reimbursed for their work with the most vulnerable children and young people.

Workforce issues

'Protecting Victoria's Vulnerable Children Inquiry 2011…it's their outcomes that matter' cites workforce issues as a major factor which has consistently constrained service responses to vulnerable children, young people and families in Victoria.[55] The Australian Services Union has pointed to issues of gender, the aging of the workforce, pay rates, conditions such as portability of long service leave and ongoing professional education as significant workforce issues which must be addressed for the community services sector in the immediate years ahead. Several iterations of a workforce strategy have been developed by the Department of Human Services but these have related more to their own workforce than a system-wide approach incorporating community services sector staff. The lack of a consistent, holistic and forward-thinking workforce approach continues to hamper the provision of quality services to those in need. Consistent turnover of service staff also has significant negative impact on placement stability for children and young people in out-of-home care.[56]

The provision of training and ongoing development opportunities to staff is of vital importance; not only to improve staff effectiveness and ability, but also to reduce staff turnover. A report on the Centre's Residential Care Learning and Development Strategy completed in 2006 showed elements of the Strategy had contributed to a significant reduction in the rates of staff turnover in some parts of the sector.[57] Further, over 60% of residential care workers who were involved in the study stated that their job satisfaction had increased as a result of the Strategy.[58] The Centre proposes that an over-arching, ongoing Out-of-Home Care Learning and Development Strategy be developed and implemented across Victoria with the aim of meeting the ongoing learning needs of foster, kinship, permanent and residential carers as well as staff in community sector organisations and staff of government departments involved in the provision of out-of-home care.

Effective prevention services

Placement prevention

The Centre recognises that preventative secondary services which respond quickly to harm, abuse and neglect are a vital but under-resourced part of the promotion, prevention and protection system. In the 2009/10 financial year only 11% of

52 Department of Human Services, *Specialised In-Home Care – draft program model*, Department of Human Services, Melbourne, 2009.
53 The Baby Fold, Professional Foster Care Brochure retrieved on September 14 2011 from http://www.thebabyfold.org/pdf/Professional_Foster_Care_brochure.pdf
54 D Kirton, Op.Cit.
55 Centre for Excellence in Child and Family Welfare, Op. Cit..
56 C Flower, J McDonald & M Sumski, *Review of turnover in Milwaukee County private agency child welfare ongoing case management staff*, Wisconsin, 2005.
57 Success Works, *Residential Care Learning and Development Strategy training report*, Centre for Excellence in Child and Family Welfare, Melbourne, 2006.
58 Ibid.

Child Protection funding was spent on intensive family support, compared with 89% spent on protective intervention and out-of-home care.[59] It is clearly in the best interests of children that help is provided early and quickly, yet many of Victoria's vulnerable children, young people and families who are desperate for family support services and other secondary interventions fail to receive anything more than the most cursory attention until it is almost too late.[60]

Placement prevention programs of varying degrees of intensity have proven to be highly effective in reducing the need for out-of-home care around the world. Meta-analysis of the cost benefit evaluation of programs which reduce juvenile offending and its impacts could be of relevance here, given the substantial overlap in juvenile out-of-home care and juvenile justice populations. Programs demonstrated to have highest impact include early childhood education for children of low-income families, nurse and family partnership programmes for women in low-income families, dialectical behaviour therapy for juvenile offenders and multidimensional treatment foster care.[61] At the more intensive end of the spectrum are home-based interventions, where child and family welfare practitioners work with children, young people and their families in their home environment.[62]

In order to produce better outcomes for the most vulnerable members of our communities and decrease the pressure on the protection end of the spectrum it behoves us to greatly increase our investment in prevention.

Respite Care

Respite care can play a key role in strengthening families, improving child and family wellbeing, and preventing abuse, neglect and family breakdown.[63] In Victoria there is currently no consistent, discrete funding to support the provision of respite care to families. Voluntary respite care is provided in pockets across the state as part of existing foster care programs, but services are often stretched to the limits. Many are forced to close their doors to families seeking voluntary respite care and to focus almost exclusively on providing care for children and young people involved in protective intervention. A lack of investment in and recognition of the value of respite care is increasing the fragility of the Victorian out-of-home care system, as families who could have been assisted through respite care ultimately reach breaking point and become involved in child protection.

It is of the utmost importance that our out-of-home care services have the capacity to respond to community need for respite care and that there is acknowledgment that reaching out for support in this manner is a sign of strength, wisdom and good parenting. Models like the Aunties & Uncles program in New South Wales provide an excellent service to local families. Aunties & Uncles accepts referrals from community service organisations and parents. They provide a caring, non-judgemental pathway into receiving community support, acknowledging that 'it takes a community to raise a child'.[64] This is in stark contrast to the current situation in Victoria where families receive inconsistent responses to requests for assistance due to the absence of funding and lack of dedicated staff to manage, supervise and monitor respite care services.[65]

Availability of respite care for kinship carers and long-term foster carers, in particular, is becoming a major problem. The provision of respite care to these groups is admittedly complicated by the fact that many of the children and young people in these situations are protective clients, and as such are subject to a whole range of requirements that other children and young people in the community are not. Nevertheless, if adequate, regular respite continues to be out of reach of the majority of full-time carers, particularly those who work with more complex children and young people, rates of placement breakdown and carer retention will continue to suffer accordingly.

Home-based interventions

One example of secondary service delivery that can strengthen families and reduce the level of progression to protective services is multi-systemic therapy (MST). MST is an intensive, family-focused program targeted at young people. It is being implemented across Canada, Scandinavia, the United Kingdom and New Zealand, and currently operates in over thirty states across the United State of America with great success. Utilising Masters-level therapists, MST aims to improve the ability of young people to make good decisions and the ability of families to monitor and influence their behaviour through flexible interventions tailored to each unique situation.

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59 L Bromfield, P Holzer and A Lamont. *The economic costs of child abuse and neglect*. Australian Institute of Family Studies. 2011 retrieved on 19 July 2011 at http://www.aifs.gov.au/nch/pubs/sheets/rs2/rs2.pdf.

60 E Munro, *The Munro review of child protection-Interim report: the child's journey*, London,2011.

61 L Segal and K Dalziel, *Economic evaluation and priority setting in child protection*, Presentation for ARACY Access Grid, Australian Research Alliance for Children and Youth, 2008, retrieved on 5 September 2011 at www.aracy.org.au.

62 E Munro, Op. Cit..

63 P McNamara, *Respite care project – findings from the scoping exercise*, Latrobe University, Melbourne, 2010

64 http://www.auntiesanduncles.com.au/ Austice-Uncles. retrieved on 3 September 2011 from http//www.auntiesanduncles.com.au

65 P McNamara, Op. Cit..

MST has nine guiding principles:

1. The primary purpose of assessment is to understand the 'fit' between the identified problems and their broader context.
2. Therapeutic contacts should emphasise the positive and should use systemic strengths as levers for change.
3. Interventions should be designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
4. Interventions should be present-focused and action-oriented, targeting specific and well-defined problems.
5. Interventions should target sequences of behaviour within or between multiple systems that maintain the identified problems.
6. Interventions should be developmentally appropriate and fit the developmental needs of the young person.
7. Interventions should be designed to require daily or weekly effort by family members.
8. Intervention efficacy is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions should be designed to promote treatment generalisation and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.[66]

Therapists working within MST programs have small caseloads of up to five families at a time, with treatment generally lasting between three and six months. Over this period, the therapist interviews the young person, their family, peers, and school to identify problem behaviours and their causes as well as the young person's strengths and opportunities within their lives for positive social interaction. The therapist sets goals in conjunction with the young person and with the family which must be achieved prior to the cessation of the therapy. Progress towards these goals is carefully monitored, and therapists are available around the clock to assist in removing obstacles to the goals' achievement. Throughout this process a well-defined supervisory system is in place to ensure fidelity to the program model.[67]

Multi-systemic therapy across Europe and North America has been shown to reduce the likelihood of children and young people requiring out-of-home care by between 47% and 64 %.[68,69,70,71] The Washington State Institute for Public Policy evaluated local multi-systemic therapy programs and estimated that the savings to taxpayers as a result of engaging vulnerable young people and their families in multi-systemic therapy were $31,661 USD in future criminal justice costs alone - a total of $28.33 USD for every dollar spent once they took into account the benefits to victims of crime.[72] A similar study in Michigan demonstrated that benefits of their multi-systemic therapy programs could be as great as $200,000 USD.[73]

Compulsory participation

Compulsory participation is increasingly considered for community-based intervention in relation to vulnerable children, young people and their families. However, while orders under the Children Youth and Families Act can provide for the compulsory participation of parents in programmes, the Centre contends that active engagement should be the preferred approach. Active engagement requires families to have a voice in the type of services they wish to receive, as well as being supported to participate in both practical and financial terms where necessary. Where compulsion is required to ensure the wellbeing of children, the circumstances in which it applies should be set out clearly in legislation and any decision to invoke compulsory participation should remain with courts or tribunals. As far as possible, vulnerable families should have the same rights and responsibilities in relation to their children as families not identified as vulnerable.

66 MST® Multi Systemic Therapy retrieved on 5 August at http://www.mstservices.com/index.php/what-is-mst/nine-principles.

67 http://www.mstservices.com/

68 S Henggeler, G Melton & L Smith, *Family preservation using multisystemic therapy: an effective alternative to incarcerating serious juvenile offenders*, Journal of Consulting and Clinical Psychology, Vol 60, 1992, p. 953–961.

69 S Schoenwald, D Ward, S Henggeler & M Rowland, *MST vs. hospitalization for crisis stabilization of youth: placement outcomes 4 months post-referral*, Mental Health Services Research, Vol 2, 2000, p. 3–12.

70 T Ogden & C Halliday-Boykins, *Multisystemic treatment of antisocial adolescents in Norway: replication of clinical outcomes outside of the US*, Child & Adolescent Mental Health, Vol 9(2), 2004, p. 77–83.

71 L Stambaugh, S Mustillo, B Burns, R Stephens, B Baxter, D Edwards & M DeKraai, *Outcomes from wraparound and multisystemic therapy in a center for mental health services system-of-care demonstration site*, Journal of Emotional and Behavioral Disorders, Vol 15, 2007, p. 143–155

72 S Aos, M Miller & E Drake, *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates*, Washington State Institute for Public Policy, Olympia, 2006.

73 S Kleitz, C Borduin & C Schaeffer, *Cost-benefit analysis of multisystemic therapy with serious and violent juvenile offenders*, Journal of Family Psychology, Vol 24, 2010, p. 657–666.

Social labelling, which may occur when parents are compulsorily involved in services such as income management, can have a negative effect on parenting perceptions and participation. For example, parents receiving income support are required to have their child engage in early learning and educational settings and medical checks for as long as they receive social security, and must provide proof of attendance or enrolment. However, there is no legal requirement for other parents to ensure that their children under school age attend early education and medical check-ups. In circumstances such as this, compulsion has the capacity to further marginalise and label parents as 'incapable'. The social dynamic of 'labelling' may mean that parents withdraw completely from engagement, undermining the capability of services to support effective parenting. The active engagement of vulnerable people through the provision of services and supports which are important to them is more likely to lead to a sustainable solution to vulnerability than the imposition of mandatory participation.

Conclusion

A major challenge for Victoria is to ensure that the available options for out-of-home care provide for the needs of vulnerable children, young people and their families. This paper has presented the challenges constituted by increased demand and lowered capacity to manage the diversity of need within the current care models in Victoria. An earlier publication of the Centre for Excellence in Child and Family Welfare identified three dominant psychological processes which constituted the struggle and challenge for 'congruence in service of the children's best interests'.[74,75] These were the extra familial living environment, responding to pain and pain–based behaviour, and developing a sense of normality. These psychological challenges must be addressed in every out-of-home care situation. The therapeutic approaches demonstrated in innovative models of both home-based and residential care provide the capacity for carers to address these critical psychological processes for the benefit of vulnerable children and young people through the provision of skilled therapeutic input and additional resources which 'enrich' the care environment.

If we are to fulfil our shared social responsibility to vulnerable children and young people we must know and understand their needs. This requires systematic assessment and analysis of the population profile and needs of children and young people being referred to out-of-home care with particular attention to the impact of trauma, abuse and neglect. Such assessment and analysis relies on a strong knowledge of the care population so that the provision of services can be properly planned, and also thorough assessment of the needs of individual children and young people so that their particular requirements are considered in placement decisions. A comprehensive assessment and understanding of an individual child or young person does not necessarily result in a good placement if services are not available. Conversely, knowledge about the population of young people requiring care and comprehensive service planning does not ensure a good placement if individual assessment fails to identify the needs of the child or young person.

The challenges for Victoria in the provision of out-of-home care are great. The Protecting Victoria's Vulnerable Children Inquiry offers the possibility of system-wide reform, improving the lives of vulnerable children, young people and their families and ensuring that their outcomes are a priority for all the community.

74 Centre for Excellence in Child and Family Welfare, *Residential Care: Not the last resort: An Intervention to meet the needs of children and young people.* Centre for Excellence in Child and Family Welfare. 2007.

75 J Anglin ,*'Pain, normality and the struggle for congruence': Reinterpreting residential care for children and youth'*, Birmingham, N.Y. Hayworth Press 2002.

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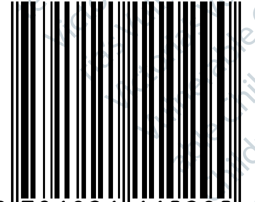

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