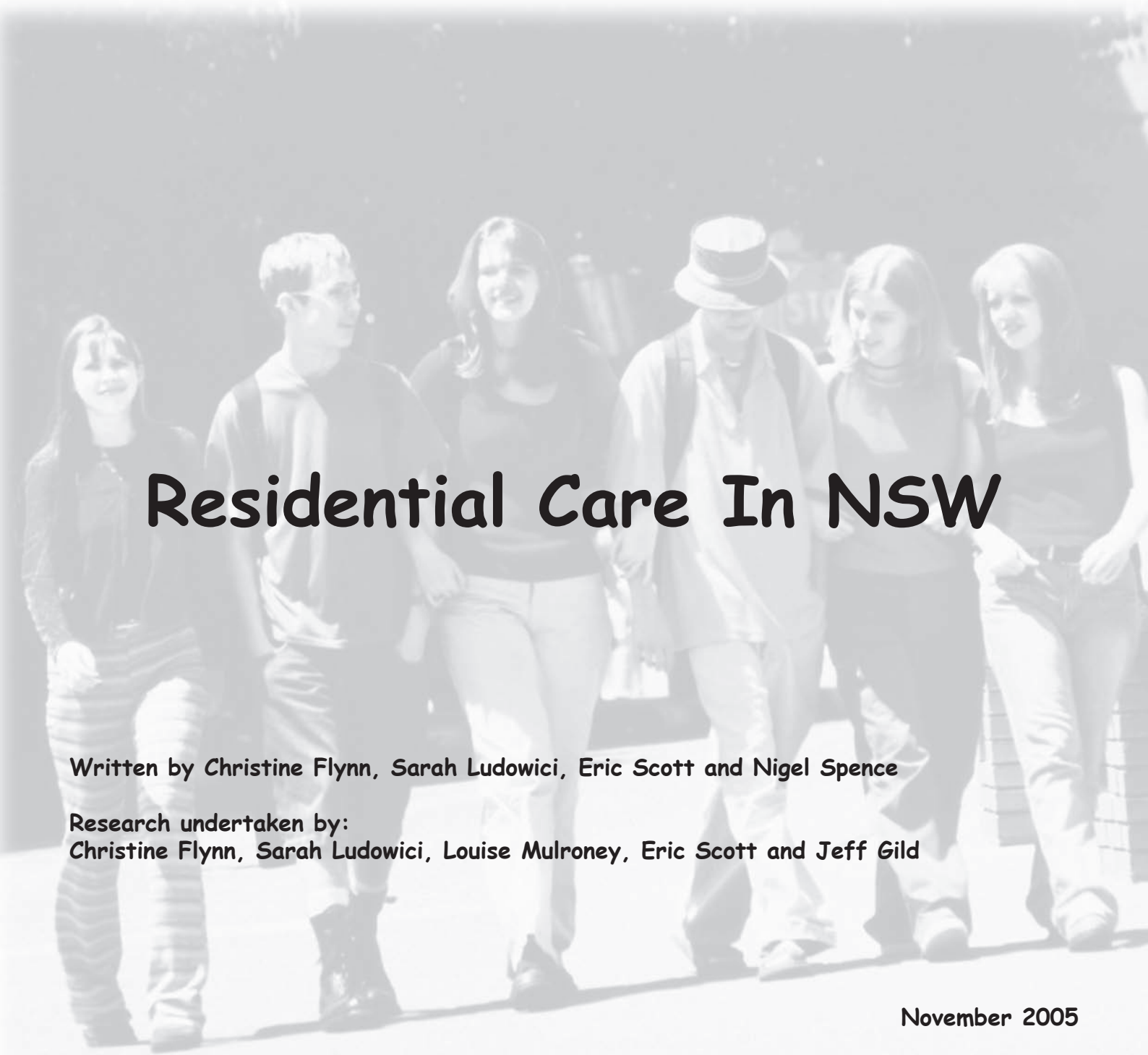
OOHC Development Project Report

ACWA Association of Childrens Welfare Agencies

CCWT Centre for Community Welfare Training



Residential Care In NSW

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November 2005

Published November 2005 by
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ISBN: 09578445 8 1

This research was conducted over a period of months with the resulting report taking a similar amount of time to finalise. While all care was taken to ensure the accuracy of the information presented, we recognise that policies and programs change over time and some material may not reflect current situation of the listed agencies or departments.

Acknowledgements:
Thanks to all participants in the research, to Pauline Mackiewicz, Susie Ramadan, Megan Mitchell and Jeff Gild, NSW Department of Community Services for assistance and support in planning and conducting the research, and to the Centre of Excellence in Victoria for assistance in arranging Victorian consultation. Thanks to Kym Pain for administrative support.

The ACWA Out-Of-Home Care Development Project is funded by the NSW Department of Community Services.

NSW Department of
Community Services

Residential Care in NSW

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Foreword

This report represents the first comprehensive appraisal of residential care in NSW since the early 1980s. Residential care is a small but vital part of the care system, however it has been largely ignored in terms of policy and service development since the closure of large institutions began in the 1960s. Family-based care options, rightly, have been the placement of choice for the majority of children and young people in care. But the need for some residential care remains evident. Questions arise about what types of residential care should be provided, for whom, the efficacy of different types of residential care and how much residential care is needed in NSW. These and other questions about residential care are explored in this report.

The research was made possible by the support and cooperation of current residential care providers and other out-of-home care stakeholders. It was undertaken as part of the Association's Out-of-Home Care Development Project with funding provided by the Department of Community Services. The participation of respondents and the funding from DoCS is gratefully acknowledged.

We hope that the report will make a significant contribution to discussion and debate about the place and future of residential care in NSW.

Nigel Spence
Chief Executive Officer,
Association of Childrens Welfare Agencies (ACWA)

November 2005

Executive Summary

Background

This is the final report of a research and consultation project undertaken in early to mid 2005 as part of the ACWA's Out-Of-Home Care (OOHC) Development Project.

A key reason for undertaking the research at this time is to inform the out-of-home care planning, reform and service development process, which is intended to include additional capacity for placement services provided by the non-government sector.

Residential care is a small but important component of the OOHC service system, comprising approximately 3% of placements. This compares to a very large reliance on relative and kin care (56%) and continuing high use of foster care (40%). The number of residential care placements has increased slightly in recent years after decades of gradual decline.

The report outlines the research context, provides a definition of residential care, explains the research method, summarises the findings and discusses issues regarding residential care service development.

Scope

For the purposes of this research, OOHC residential care is defined as:

> *Placement, funded by the NSW Department of Community Services (DoCS) under the Out-Of-Home Care (OOHC) Program or on a fee-for-service (FFS) basis, in a property owned or rented by an agency, in which one or more children or young people are placed and which are staffed by either direct care staff employed on a rostered basis or by house parents or principal carers, who are not regarded by the agency or themselves as foster carers.*

Disability, drug and alcohol rehabilitation and/or health services providing a residential care model were excluded from the scope of the research. Supported Accommodation Assistance Program (SAAP) residential services were included in this research only if the agency received some recurrent OOHC funding or had a Header Agreement to provide OOHC residential placements on a FFS basis.

Method

ACWA conducted face-to-face interviews with Chief Executive Officers (CEOs), program managers or coordinators of 42 non-government residential care providers in NSW. CEOs or senior managers of most other providers of other forms of OOHC placement, DoCS Regional Directors and peak organisations with an interest in the OOHC program were also interviewed by telephone.

ACWA conducted phone interviews with government and/or non-government representatives in other Australian jurisdictions, except for Victoria where both the ACWA researcher and a DoCS researcher conducted face-to-face interviews.

In total 109 interviews were undertaken between May and August 2005.

Interviews with residential care providers gathered facts regarding:

- location, capacity and current occupancy and utilisation trends
- target groups and exclusions for current services
- funding sources
- accommodation tenure
- philosophy, models, theoretical and/or therapeutic approaches
- programming, including day-to-day care, education support, case management and case work, behaviour management and critical incident support
- staffing structures, recruitment and competency development
- sibling placements
- individual residential placements
- duration of placements
- intended outcomes, progress measurement and evaluation
- links with other support services, agencies, networks
- aftercare services.

In addition, residential care providers and other interviewees were asked their opinions about the place and future of residential care, including

- target groups and characteristics of clients who may need residential care, or whether they believe fewer clients or no-one should be in residential care
- models of residential care required in the service system
- geographic gaps in residential care provision
- opinions on specialist assessment services with a residential component
- benefits of or issues with individual residential placements
- the roles of SAAP in OOHC
- research that is needed
- residential service development plans.

The research did not attempt to interview children and young people in care, nor did it aim to gather detailed information about particular residents. The focus was on programs and services and views about the place and future of residential care from the agency/provider and government/funder perspective.

Key findings

Residential care capacity

The research has identified that residential care is a small and active component of the current NSW OOHC service system. Residential care is characterised by a large number of providers offering small numbers of placements across the state. Forty-two providers of residential care were accommodating 330 residents in 181 properties at the time of interview. Total

capacity of all current providers was estimated at 420 placements, although estimations of capacity were problematic, as real capacity was limited by the need to keep resident numbers low and to address the needs and compatibility of residents.

While NSW has one of the lowest proportions of residential care compared to other states with only 3.0%, it has the largest number of provider agencies and the second highest number of children and young people in residential care.

There was an overwhelming view expressed by interviewees that while foster care remains the preferred form of out of home placement, there is a definite place for residential care in the service system and that residential care capacity should be increased.

Residential care services were found to be operating across all NSW DoCS regions although the number of services was particularly low in Western Region. Interviewees nominated all regions as needing more residential care.

Target groups & placement duration

Current provision of residential care in NSW is mainly targeted toward children and young people with high and complex needs. This includes children and young people with aggressive and violent behaviour, mental health issues, drug and alcohol problems, intellectual disability and sexualised or sexual offending behaviour. A small number of agencies provide residential care for children and young people with low or moderate levels of need. No Indigenous specific residential care services were identified.

Interviewees favoured residential care being selectively used for children and young people with high or complex needs, sibling groups, young people moving on to independent living, children and young people following foster placement breakdown. Residential care for Aboriginal children and young people was also identified as a priority.

The age range of residents at time of interview ranged widely with 18 of the 42 services providing residential care for children aged less than 12 years. This is despite the accreditation guidelines from the Children's Guardian specifying that residential care should only be provided to children and young people over 12 years of age. Many respondents questioned the rationale of limiting residential care to children and young people over 12 and were of the view that it should be a valid choice for younger children in certain circumstances.

Placement duration was found to be generally much longer than intended with placements of many years not uncommon. It is apparent that residential care is not only used for short-term placements or as a bridging option, but is also used as a long-term care arrangement for some children and young people. This may be planned or it may develop into long-term placement because of the view that the placement continues to be the most appropriate one for the resident or that no alternative placement is available.

Service models

The research confirms that 'individual residential care' has become a major component of residential care in NSW accounting for approximately one third of all residential placements. This trend has not developed to anywhere near the same extent in other states.

Views about the value and effectiveness of individual residential care arrangements differed markedly. Some respondents (particularly providers) were of the view that individual residential care was a necessary and effective way of containing some children and young people and meeting their needs. Some respondents (particularly non-residential care providers) were of the view that these arrangements were inappropriate, expensive and unable to provide the necessary therapeutic intervention.

Current residential care providers generally offered a program of individual case planning ('individualised programming'), structured household activities, an emphasis on school engagement and aftercare. Agencies named numbers of therapeutic approaches such as Therapeutic Crisis Intervention, although most did not systematically apply a clinical therapeutic regime in the service.

Interviewees and interstate consultations indicate a strong preference for the development and trialling of some treatment models of residential care.

Nearly all services used a rostered shift work model of staffing with on-call support supplemented by casework staff and/or psychologists. Only one Family Group Home model and one hybrid (partly family group home, partly staffed on rostered basis) was found in the research. This model of service is more common in other jurisdictions and some respondents favoured the development of more family group homes in NSW, particularly for sibling groups.

Strong support was expressed for improved assessment to inform placement decision making and promote better access to support services to meet individual clients' needs. Mixed views were expressed on whether specialist assessment with a residential component was desirable.

Funding & capital

The funding stream and the capital base for residential care was found to be tenuous for many providers. Residential care services reported being funded by DoCS through a mixture of program funded and fee for service arrangements, but with a predominance of fee for service funding. This is time-limited and tied to specific children and young people, which brings with it insecurity for the resident, the staff and the agency and provides a challenge to DoCS in terms of planning and financial management. Most program funded agencies had to contribute significant agency resources to funding in order to cover operating costs, while fee for service funding was more likely to meet full costs of services.

Of the 181 properties used to accommodate children and young people, most (109) were privately rented and another 20 were rented from the Department of Housing. Only 44 were owned by the agency. This indicates relatively insecure tenure for residents and provider agencies.

Conclusion

Residential care in NSW has drifted for a number of years without a coherent approach and without a clear or acknowledged place in the OOHC system. Yet it continues to be necessary and appears to be frequently used. In fact, use of residential care appears to be increasing in line with the changing nature of the needs and characteristics of children and young people requiring out of home placement. DoCS' intention to build capacity in OOHC provides an ideal opportunity for revisiting residential care and developing a coherent plan. This report is intended contribute significantly to the development of that plan.

Residential Care in NSW

1 Introduction

In early 2005 the Association of Childrens Welfare Agencies (ACWA), with the support of the Department of Community Services (DoCS), commenced a research project to document the current provision of residential out-of-home care (termed 'residential care' in this report) in NSW. This included consultation with all NSW out-of-home care providers, DoCS regional directors and selected peak organisations about the development of residential care as a component of the out-of-home care (OOHC) service system. A consultation with interstate government representatives and major non-government agencies providing residential care was also undertaken, in order to understand trends and issues in residential care around Australia.

There has been no comprehensive review of residential care services in NSW for many years, although the role and place of residential care has been considered in significant reports. One such report, the Community Services Commission's report of its inquiry into substitute care in NSW proposed that DoCS commission an independent study to determine the extent of need and appropriate models for residential services in NSW and that the study be completed as soon as possible[1]. Although the decision to undertake this research and consultation was not directly linked to that proposal, it does partially fulfil its intent.

A key reason for undertaking this research at this time is to inform the out-of-home care planning, reform and service development process. As part of the $1.2 billion DoCS budget enhancement package announced in December 2002, DoCS has indicated it intends to fund additional OOHC placement and support services provided by the non-government sector. One round of funding for placement services for children and young people with high and complex needs commenced in February 2004. This resulted in announcements of preferred providers in December 2004 and led, in mid 2005, to contracts being signed with a number of agencies for up to 220 placements in total. Some of those placements are residential care. Further funding rounds calling for expressions of interest for other target groups of children and young people and/or other service types are planned for late 2005 or during 2006.

This research will provide policy and decision makers and service providers with a good understanding of the current state of residential care in NSW, and with sufficient information about trends, views and issues to enable a planned approach to residential care services development.

[1] Community Services Commission (2000) Inquiry into the Practice and Provision of Substitute Care in NSW new Directions – from Substitute to Supported Care, Final Inquiry Report. Community Services Commission, Sydney. p.38

This report outlines the research context, provides a definition of residential care, explains the research method, summarises the findings, discusses issues and makes recommendations regarding residential care service development.

1.1 Context

Over the last 30-40 years, residential care has declined as a proportion of OOHC placement types, in favour of foster care and relative care, and support for birth families to keep children at home. This has followed national and international trends, favouring home and family based care. Bath, presenting at the 'Finding a Place' forum in 2001, confirmed that, nationally, group care numbers had gone from a 28,000 peak in the late 1960s to about 1,200 in 2000[2].

Since then the general trend downwards has continued, with about 4% (or 970) children or young people in care being in residential care placements in Australia at 30 June 2004[3].

As at 30 June 2004, 296 children and young people in NSW were identified as being in residential care, representing 3.0% of the 9,145 in OOHC[4]. This is a slight increase over the same time in 2003, according to the Australian Institute of Health and Welfare reported figures (267 of 8,636 in OOHC)[5]. However this is still only a small percentage of all children and young people in care, when compared to some interstate or overseas jurisdictions. NSW data, published in the Productivity Commission's report on government services in 2005, showed 46 indigenous children and young people were placed in residential care at 30 June 2004[6].

Most other Australian jurisdictions have a higher proportion of residential care than NSW, ranging from 4% – 10%, Western Australia being the highest. Queensland has a lower proportion at 1% and Tasmania appeared to have no children or young people in residential care at 30 June 2004[7],[8]

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[2] H. Bath (2001) *The role and future of residential care in Out-Of-Home Care*. Paper presented at the Finding a Place Forum, October 17, 2001, Sydney, Community Services Commission and ACWA.

[3] Australian Institute of Health & Welfare (2005) *Child protection Australia 2003-04*. Canberra, AIHW. June 2005 figures were not available at the time of writing.

[4] Australian Institute of Health and Welfare, (2005) *Child Protection Australia 2003-04*, Canberra: AIHW. Note: residential care figures in the DoCS *Annual report 2003/04* show slightly higher numbers in residential care at the same point in time (324 of 10,337 children and young people in OOHC). This difference is due to definition.

[5] Australian Institute of Health and Welfare, (2005) *Child Protection Australia 2002-03*, Canberra: AIHW. Note: The DoCS *Annual report 2002/03* reported that 214 children and young people were in residential care.

[6] Productivity Commission (2005) Report on Government Services 2005. Supporting tables !5A.12.

[7] Australian Institute of Health & Welfare (2005) *Child protection Australia 2003-04*. Canberra, AIHW.

The following table shows the number and percentage of children in out-of-home care by placement type across Australia as at 30 June 2004.

Table 1: Children in OOHC; type of placement, by state & territory, at 30 June 2004

Number of children in care by placement type[9]								
Placement Type	**NSW**	**Vic**	**Qld**	**WA** [(a)]	**SA**	**Tas**	**ACT**	**NT**
Foster care	3,633	2,343	3,271	856	945	217	151	173
Relatives/kin	5,077	1,345	1,095	623	194	113	111	60
Other home-based care		213			6	49		
Total home-based care	*8,710*	*3,901*	*4,366*	*1,479*	*1,145*	*379*	*262*	*233*
Family group homes					13	54		
Residential care	296	380	47	161 [(b)]	46		26	14
Independent living	130	28		32		30	1	
Other [(c)]	9			9		24	9	11
Total	**9,145**	**4,309**	**4,413**	**1,681**	**1,204**	**487**	**298**	**258**
Percentage of children in care by placement type								
Placement Type	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**
Foster care	40%	54%	74%	51%	78%	45%	51%	67%
Relatives/kin	56%	31%	25%	37%	16%	23%	37%	23%
Other home-based care		5%				10%		
Total home-based care	*95%*	*91%*	*99%*	*88%*	*95%*	*78%*	*88%*	*90%*
Family group homes					1%	11%		
Residential care	3%	9%	1%	10%	4%		9%	5%
Independent living	1%	1%		2%		6%		
Other				1%		5%	3%	4%

(a) The data include a small number of children who were placed with relatives who were not reimbursed.
(b) In Western Australia, the category 'residential care' includes children in family group homes.
(c) 'Other' includes unknown living arrangements.

Consultation findings, to be reported later, indicate that in some states residential care is still declining, while in others there have been moves to increase residential placements.

This compares with the United States, England and New Zealand where residential care was recently estimated to comprise 18%, 13% and 3% of all OOHC placements respectively[10].

[8] In Tasmania 102 of 468 (22%) children and young people were in residential care at 30 June 2003. Consultations confirmed that the Tasmanian government does not regard any placement type as residential care, however the state does have a number of group homes.
[9] Australian Institute of Health and Welfare, (2005) *Child Protection Australia 2003-04*, Canberra: AIHW.

The decline in both Australia and many overseas countries, can be attributed to:

- notions of normalisation grounded in traditional social constructs of 'family' and its importance to healthy development of children
- research into factors affecting children's emotional, social and cognitive development
- higher costs of residential care in comparison to foster care, and
- publicised cases of abuse and neglect in large institutions affecting public and government opinion.

Through the 1980s and 1990s all of the DoCS and many of the non-government sector congregate residential care facilities were closed. DoCS now operates only three family group homes, scheduled for closure when current residents leave care. Although some contracting out of residential care to the non-government sector occurred in the 1990s, the overall decline in residential care appears to have left a gap in the service system, particularly for young people who cannot be successfully supported in foster care placements.

In a 'market response' previously unknown in OOHC in NSW, there has been significant emergence over the last eight years of fee-for-service (FFS) placements offered by private for-profit companies and non-profit organisations. Many of the newer agencies offer residential care targeted to children and young people with high and complex needs. This trend has not been mirrored in other states.

Unlike out-of-home care program funding, which has never met the full costs of providing care, the FFS approach has allowed agencies to offer their services to DoCS for a price that meets all or almost all their estimated cost. For this reason, it has been a necessary development for both program funded and unfunded agencies from a financial point of view. It has also been somewhat easier to arrange FFS placements at a local level rather than secure new or increased program funding, which requires central involvement and usually an Expression of Interest (EOI) process. Although offering a more immediate option, this model is recognised to be a problematic development in terms of budgetary control. There are questions about the outcomes for children and young people, given the inherent insecurity of these arrangements.

[10] United States: U.S. Department of Health & Human Resources (2003) *Foster Care National statistics*; England: Department for Education & Skills (2004) *Children looked after by Local Authorities Year Ending 31 March 2004 Volume 1:Commentary and National Tables*, National summary table F; New Zealand: Department of Child Youth and Family (2001) *Submission to the government reviews of referrals and notifications and placement services*, Appendix two Placement Procedures. Number at May 2000.

1.2 Definition

For the purposes of this research, OOHC residential care is defined as:

> *Placement, funded by the NSW Department of Community Services (DoCS) under the Out-Of-Home Care (OOHC) Program or on a fee-for-service (FFS) basis, in a property owned or rented by an agency, in which one or more children or young people are placed and which are staffed by either direct care staff employed on a rostered basis or by house parents or principal carers, who are not regarded by the agency or themselves as foster carers.*

In the case of group homes, one house parent is usually salaried, rather than receiving a non-taxable allowance, as is the case in foster care. The other house parent may work out of the home and/or may be paid for a support role for some hours/days of the week.

The definition involves one criteria regarding property ownership, (eg if the staff member or house parent ceased to provide residential care, who if anyone would continue to live in the property) and another criteria regarding staffing arrangements and the nature of the relationship between agencies, care providers/staff and residents.

There are some services that could be considered residential care on one criteria but not the other. For example, Life without Barriers Short-term Assessment and Reception Service (STARS) program is regarded by some as residential care, but was not regarded as such in this research because of the application of this definition.

Whilst residential care is usually full-time (24 hours/seven days a week), some agencies have no direct care staff on duty at the residence if all residents are attending school or employment. A small number of residential care services provide care only during the week, with residents going home to birth family or other placements at weekends.

2 Research method

Following identification of residential care providers, with DoCS assistance, ACWA mailed a letter explaining the research and inviting participation to all residential care providers in NSW in late April. This was followed up with emails and telephone calls to arrange face-to-face interviews.

We identified 44 residential care providers in NSW at May 2005. Some agencies thought to be residential care providers were found not to offer, or to have discontinued offering, residential care. Face to face interviews with Chief Executive Officers (CEOs) or program managers or coordinators of 42 residential care providers were conducted[11].

The interviews covered:

- location, capacity and current occupancy and utilisation trends
- target groups and exclusions for current services
- funding sources
- accommodation tenure
- philosophy, models, theoretical and/or therapeutic approaches
- programming, including day-to-day care, education support, case management and case work, behaviour management and critical incident support
- staffing structures, recruitment and competency development
- sibling placements
- individual residential placements
- duration of placements
- intended outcomes, progress measurement and evaluation
- links with other support services, agencies, networks
- aftercare services

Profiles of these residential services, derived from key interview questions, appear at Appendix 1. Profiles were verified by participants in August - September 2005, although capacity, occupancy and after care clients numbers were not altered, so

[11] One agency, thought to be a residential care provider, declined to participate (Complete Care Team). One other agency, scheduled to be interviewed, was advised by DoCS the day before the interview that DoCS would not use the service from 1 July 2005, so it would have to close (Y-Young Youth Services). Four other agencies with Header Agreements allowing for residential care had decided not to continue to offer OOHC residential placements for various reasons and/or had not provided OOHC recently (Maitland Youth Crisis Centre, Tamworth Youth Refuge Care Inc., Mission Australia Triple Care Farm, Samaritans Foundation). The latter two were interviewed as part of the non-residential care provider group.

they reflect the situation at the time of interview. Other information not appearing in the profiles is summarised in the findings.

Further, the residential care providers were asked about the place and future of residential care, including

- target groups and characteristics of clients who may need residential care, or whether they believe fewer clients or no-one should be in residential care
- models of residential care required in the service system
- geographic gaps in residential care provision
- opinions on specialist assessment services with a residential component
- benefits of or issues with individual residential placements
- the roles of SAAP in OOHC
- research that is needed
- residential service development plans

Telephone interviews regarding the place and future of residential care (as outlined above) were also undertaken with:

- CEOs or senior managers of agencies providing residential care, if these people were not interviewed in the first round and wished to add to the comments provided by their staff member (12 interviews)
- CEOs or senior managers of most other providers of other forms of OOHC placement services (mostly foster care) (21 interviews)
- DoCS Regional Directors (seven interviews)
- Peak organisations with an interest in, or funded through, the OOHC program (four interviews).

Government and non-government representatives in other Australian jurisdictions, except Tasmania and Northern Territory, were consulted regarding residential care services, issues and developments in their states/territories[12]. Researchers visited Victoria, with six residential care agencies, one peak organisation and representatives of one government department being interviewed in person. People in other jurisdictions were consulted by telephone. (23 interstate interviews)

This totalled 109 interviews, including 86 interviews in NSW. (Joint interviews are counted as one interview). A list of all those agencies and people interviewed appears at Appendix 2.

All participants were informed how the interview results would be used, in terms of publication of agency profiles and non-identifying reporting of other information.

[12] Tasmania government representatives stated they had no residential care, therefore were not interviewed, however two NGOs regarded groups homes as residential care. In the NT only a government representative was able to be contacted.

All interviews used a structured interview guide to ensure consistency in data collection by five different interviewers (four ACWA staff members plus a DoCS staff member who conducted four of the Victorian interviews). Interview guides are attached at Appendices 3 and 4.

Progress reports were provided to the DoCS convened *OOHC Partners Reference Group* (PRG) in June and August 2005. This final report was tabled to the PRG and the DoCS Executive in September 2005.

2.1 Exclusions

Researchers did not seek to engage with residents or their families, nor did they seek information about the personal details, circumstances or characteristics of the residents. At times non-identifying verbal information was provided by agencies in order to illustrate aspects of the service's target group or program.

The Department of Community Services operated three family group homes at the time of this research. These group homes were not included in the research, as they were already scheduled to close due to a previous policy decision by DoCS, and because the ACWA focus was primarily on non-government services.

A number of disability, drug and alcohol rehabilitation and/or health services provide a residential care model. They were excluded from the scope of this research because they do not provide out of home care, as defined under the *Children and Young Persons (Care & Protection) Act 1998* and/or are not funded by DoCS to provide OOHC placements.

SAAP residential services were included in this research only if the agency received some recurrent OOHC funding or had a Header Agreement to provide OOHC residential placements on a FFS basis.

ACWA recognises that many SAAP services accommodate young people who are OOHC clients within their SAAP funded programs. Data from the Youth Accommodation Association (YAA) indicates that there are significant numbers of children under the age of 16 years in placement in SAAP services at any one time. The YAA snapshot survey in November 2003 identified 76 children under 16 years of age in 48 NSW SAAP services. Of these 43 were under a Children's Court order while the remaining 33 were effectively in voluntary care placements[13]. Children as young as 12 years were identified as being placed in SAAP services and duration of placement ranged from a few days to over twelve months. Thirty seven of the children had been in the SAAP service for a period of more than one month at the time the snapshot survey was taken. The data supported the view that SAAP services were being used to supplement the out-of-home care program for children and young people by providing a default system of additional residential care capacity.

The research did not include a comprehensive literature review, although relevant literature is referred to as necessary. In 2003 DoCS separately undertook a project to

[13] Youth Accommodation Association '*Children in SAAP'* The Grapevine, June 2004, pp 1-10.

document national and international developments in residential care and to identify a number of key issues in its *Residential Care – General Issues Paper* (revised May 2005, unpublished). This report has drawn from that paper, with DoCS permission.

3 Results - Residential care providers

3.1 Number of OOHC residential care providers

Forty two agencies providing residential care services were interviewed. This represented almost complete coverage of OOHC residential care providers in NSW at mid 2005.

3.2 Target groups, specialised services & exclusions

Agencies were asked about the target group and characteristics or needs of the children and young people for whom they currently provided residential care.

The vast majority of providers stated that their target group was children and young people with high and/or complex needs. A number of agencies specifically mentioned very high and complex needs children or young people as their main target group. Only a few mentioned moderate needs and/or specifically excluded high or very high and complex needs clients from particular programs or services. Only one agency included low needs children and young people in their target group.

Researchers did not define 'high and complex needs' clients, but understand it to mean those children and young people with experiences of multiple or traumatic placement disruption and abuse histories, present with challenging behaviours or socio/emotional difficulties, (often in combination) such as: poor impulse control and/or stress intolerance, high risk-taking behaviour, alcohol or other substance abuse, poor self image, self-harming behaviour, social isolation and limited capacity to form relationships, sexually inappropriate behaviour, anti-social behaviour including aggression or violence, criminal behaviour, mental heath issues, physical health issues, intellectual disability and educational difficulties[14].

The other main aspect of the target group was the age range for residential services. The Children's Guardian specifies as a condition of accreditation that, other than by exception, residential care may only be provided to children and young people aged 12 years and over[15]. However, two accredited agencies have as part of the condition that the agency may accommodate under 12 year olds with special needs. While 24 agencies specified the age range of their residential care program as 12 years or older, 18 agencies stated they had age range with a lower limit under 12 years. Many children under 12 were found to be in residential care at the time of the interview although researchers did not set out to count the number.

Three of the 24 agencies with criteria of 12 years and older qualified their response: two of them had a specific service or program for high needs clients being open to

[14] DoCS (Feb 2004) EOI for Children and young people in OOHC with high and complex needs.
[15] See the Children's Guardian web site at www.kidsguardian.nsw.gov.au

those 10 years and over; and one agency said it had once accommodated a 10 year old for a short term placement.

Among the agencies with a younger minimum age, four agencies stated they had an open age range, two gave the lowest age as six years, six stated the lowest age as eight years, four specified 10 years and two said 11 years. Some agencies were in negotiation with the Children's Guardian regarding age range as they prepared for accreditation. One stated it had received special permission to continue placements of younger children during a transition period.

In terms of specialised services for particular target groups:

- There were no residential care services offered specifically for indigenous clients by indigenous managed or owned agencies[16]
- There were no indigenous-specific services, except for one residence offered by a non-indigenous agency (employing an Aboriginal manager and coordinator)
- A small number of agencies said their clients included a large number of Aboriginal children or young people
- There was only one program for sexually offending clients, although some others stated they might accept a client with sexual behaviour issues for individual placement or in small congregate settings. if staffing was sufficient to provide a high level of supervision
- Children and young people with physical, intellectual or developmental disabilities and/or mental health problems, were specifically included in the target groups of seven agencies
- There were only two programs exclusively for females and two exclusively for males
- One program specialised in taking children and young people from a particular cultural background, while another had previously specialised in Indo-Chinese clients but had experienced reduced demand, so had changed this criteria to include generic intake.

Exclusions most commonly mentioned were children or young people with unmanaged mental illness, unmanaged drug or alcohol addiction, severe physical or intellectual disability if highly dependent for daily living support and extreme violence. Some agencies excluded sexual offenders or sexually predatory behaviour. Access issues prevented accommodation of clients with physical disabilities in some services. In most cases, agencies reported that exclusions were necessary because of funding levels that limited the number of staff providing direct care, while a lack of staff expertise in dealing with some types of disabilities or behaviour was also a consideration.

[16] One agency owned by an indigenous person and with a majority of indigenous staff catered for about 40% indigenous clients, on average.

Conversely a number of agencies stated they had no specific exclusions, saying each referral would be individually assessed. Acceptance would depend on levels of funding provided to enable the agency to meet the client's support needs.

3.3 Legal status of residents

The majority of children and young people in residential care were statutory clients. That is they had a legal status under the *Children and Young Persons (Care & Protection) Act 1998,* being either under the parental responsibility of the Minister or under the care of the Director General (of DoCS).

Twenty four of the 42 agencies reported that all their residents were statutory clients. Of the remaining 18 agencies:

- three agencies had only statutory clients in one residential service and a mix of voluntary and statutory clients in one or more other residential services.
- fifteen agencies had a mix of voluntary and statutory clients in their residential service.

By 'voluntary', we understood the term to mean entry to the placement through either direct family, community agency or self-referral without DoCS involvement, or involving a referral by DoCS, with no current or planned court involvement.

In these 18 agencies, the percentage of voluntary clients ranged from 2% up to 85%. Eight agencies had 10% or fewer voluntary clients, while three had over 70% voluntary clients.

The three agencies with over 70% voluntary clients contributed 25% or more to the funding from agency sources.

Some of the predominantly fee for service agencies stated they accepted voluntary clients. DoCS was funding the placement, but it appeared that not all these clients had finalised Children's Court proceedings which provided a legal status[17].

In some cases voluntary clients may be defined by agencies as such because residents must willingly commit to the program, even though they may have a legal status with DoCS. DoCS may or may not have been involved in referring the child or young person to the placement.

3.4 Placement duration

Agencies were asked about intended maximum duration of residential placements, average duration and longest stay (current clients, or a placement in the last 12 months).

[17] It is possible that some respondents have misunderstood the question and incorrectly thought that Care of DG before final court orders was 'voluntary care'.

Placements ranged in duration from overnight to eight years. Placements generally lasted longer than the maximum intended duration. Longest placements were found to often far exceed maximum intended duration.

Further details on intended duration, average duration and longest placements appear below:

- In agencies where placements were intended to last three months, average placements ranged from 6 weeks to two years. Longest placements ranged from two months to seven years.
- In agencies where placements were intended to last around 12 months, average placements ranged from 9 months to 2 years, with longest placements ranging from 15 months to 2.5 years.
- Longest placements overall were eight years, reported as occurring in two cases in two agencies.
- Two other agencies had placements lasting seven years and
- In seven agencies the longest placements were between four and six years.
- In four long placements (exceeding 4 years), the intended duration was three months.

Two agencies stated they had no upper limit on duration of placement, because they regarded the placement as long term, intended to last until the residents left care.

3.5 Capacity and configuration of properties

The researchers collected data on capacity and current number of residents at the time of interview (May – June 2005).

Capacity is an elusive concept given the extensive use of 3 or 4 bedroom properties (to accommodate both staff and residents) and the occupancy of many properties by only one resident.

Potential capacity of residential placements was estimated as between 422 – 437, with 330 residents in placements. The real capacity is much lower than 422 while individual residential placements continue to be a feature of the system. (*see also later results on 'Utilisation'*)

In terms of the size of congregate residences:

- the largest capacity in a single residence was 13 places, (an independent living transition program for young people)
- one agency had three units comprising eight places each.
- nine agencies had a total of 11 residences with a capacity of six places.

- two agencies each co-located two OOHC places in SAAP services, which had a total capacity of between 6 and 8 places.
- 21 agencies had a total of 83 residences with physical capacity for only one resident
- about 20 agencies had residences with a capacity of between two and five places, with the majority of these being two-place capacity.

3.6 Individual residential placements

At the time of interview 108 residents were placed alone with staff, 83 of them in premises designated for one resident only. This type of placement is also known as 'one-on-one'. In a few cases residents were alone due to a temporary vacancy in the residence, however the vast majority appeared to be intentional individual placements.

Eleven agencies only offered individual residential placements and 27 agencies had provided individual placements at some time in the last 12 months.

The vast majority of agencies said the main reason for DoCS seeking to place a resident alone was the resident's very challenging or violent behaviour, including assaults against other children or young people. This was regarded as posing a risk to other residents and, if not managed, could also pose risks to staff. Sexual offending, chronic absconding behaviour, self-harm and mental health issues were also mentioned as reasons for choosing individual placement. Safety of the child or young person and the safety of others were significant considerations. No individual placements operated as secure care, in that residents were not locked in at certain times, as to do so would be illegal. However strategies, such as having staff awake and monitoring beds at night, were used in cases where absconding or safety of residents was a particular issue.

All individual placements that are provided on a FFS basis require approval by DoCS, most commonly at the Regional Director level, because of their high cost. Information on the regional directors views on individual placements will be reported later, however in summary they appear to be very concerned about the continued use of such placements. Some agencies however, reported that they sought to transition particular residents to placement with other people but that DoCS staff preferred to keep the resident alone, on the basis of risk assessment, their understanding of the resident's needs and behaviour and the level of supervision that individual placement offered.

The table below shows details of average duration of individual placements.

Table 2: Average duration of individual placements by number of agencies[18]

Average duration	Number of agencies
0 – 4 weeks	1
5 – 8 weeks	3
9 -12 weeks	2
13 -26 weeks	4
27 – 52 weeks	6
1 year – 18 months	2
18 months – 2 years	4
2 – 3 years	1
over 3 years	2
No average estimated	2
Total	**27**

The average length of individual placements across these agencies ranged from 3 nights to 3.5 years, with the latter estimate reported as average by two agencies.

The child or young person was being cared for by staff working on a rostered basis in all but one of these placements. The other was staffed by nuns working in family group home style, although doing some specific shifts.

Most individual placements were staffed by only one person on duty at one time, although there may be additional staff in afternoons or evenings in some cases. Only a few agencies reported that they provided awake/stand up shifts when supervising clients with very high needs or complex behaviours.

Agencies identified the benefits of individual placement for the resident, as improved safety for the resident and staff and provision of the opportunity to stabilise behaviour and address underlying issues, with the assistance of direct care staff, counsellors or psychologists. Other residents were also protected by not co-residing with children or young people who could pose a risk to them.

Most agencies providing individual placements highlighted issues for the resident including:

- social isolation from peers, especially if the resident is excluded from school
- intense scrutiny, leading to a 'hothouse' unnatural atmosphere
- problem of having all the attention on one person
- setting up of unrealistic expectations about continued individual attention
- potential to develop abusive relationships
- failure to address issues if a containment rather than a therapeutic approach was used

[18] The number of individuals in placements of a particular duration was not possible to calculate, as the focus was on agency practice, rather than a census of actual residents.

- difficulty of ending the individual placement and transitioning the resident to living with others
- uncertainty about how long the placement will last and what will happen next
- difficulty in forming attachments because of many staff working short shifts
- potential for stigma of the resident.

Issues for the service system identified by agencies included high cost, stress on workers and the potential for workers to become over-involved with the resident.

Agencies used various strategies to overcome the issues, including provision of regular peer interaction (sometimes with other individually placed residents) and access to community-based activities; provision of clinical supervision of staff and clinical support for behaviour intervention.

Agencies that provide residential care, but not individual placements, expressed similar views about individual placement to those listed above and saw limited benefits, mainly in regard to safety. Some saw no benefits and raised serious concerns about the effectiveness and quality of such arrangements.

3.7 Utilisation of capacity

Full capacity was defined by the researchers as 90% or more, which allows a short time for vacancies of 4-5 weeks per place per year. Agencies were asked whether their capacity was fully utilised or if less than full, to provide an estimate of the percentage of utilisation, averaged over the last year.

The research found:

- 16 agencies reported their capacity was fully utilised
- 24 agencies reported utilisation of less than 90%
- 2 agencies reported one or more programs fully utilised and others slightly under utilised.

Of the 24 agencies utilised less than 90%, utilisation rates ranged from 5% and 85%:

- 10 agencies were utilised 60% or more
- 6 agencies were utilised 40% - 59%
- 4 agencies were utilised less than 40%
- 4 agencies did not provide a percentage estimate.

Utilisation figures are complicated by those agencies whose current houses are 'full' but who have in the past operated more houses and expanded to fit the referrals. They are less than fully utilised in the sense of their potential organisational capacity, but full in their current client capacity.

The low and very low utilisation figures came from FFS agencies (with one exception) and were largely due to a reduction in DoCS referrals, especially in late 2004 and early 2005. While 14 agencies reported insufficient referrals, some of these agencies reported a recent up-turn in referrals and an increase in the number of approved FFS placements. The only program funded agency reporting significant under utilisation is a service for low to moderate needs young women.

The other main reason for under utilisation of capacity, reported by 14 agencies, was consideration of the current residents' needs and compatibility – this may mean that a single resident was placed in a house with room for others or that in congregate settings, a vacancy was maintained because of the high or complex needs of the current residents.

Four agencies reported staff issues such as vacancies, recruitment issues, regrouping following critical incidents, shortages of particular skills or gender of staff members in mixed gender services. A couple of services were under utilised due to the requirement to keep one place as a crisis placement, for which occupancy was unpredictable. Refurbishment of premises or establishment of new properties also influenced utilisation in a couple of agencies.

Eight agencies reported over utilisation of official capacity at some point in the last year. Reasons for this included: clients in transition to new placements when new referrals were accepted; unpredictability of length of placements; short term emergency accommodation of a past client, either by DoCS arrangement or self-referred; or crisis or respite placement when a foster care placement had broken down. Some of this over-capacity use appeared to be informal (agency covering the costs), while in some cases DoCS arranged and paid for the placement.

3.8 Case management and casework

Agencies were asked about whether DoCS or the agency held formal case management responsibility, explained in the interview as responsibility for the oversight of implementation of care plans.

Thirty one agencies said DoCS held formal case management responsibility, five said the agency had responsibility and six said the arrangements were different for different clients or programs.

Further, agencies were asked whether the agency or DoCS undertook particular tasks. The table below summarises those responses.

Table 3: Case management & casework tasks undertaken by DoCS or Agency

Tasks	DoCS*	Agency*
Develop Care Plan for court	45	7
Develop Annual Care Plan	40	30
Convene case conferences	29	33
Undertake statutory reviews	27	26
Develop & implement individual plans	13	45
Casework with birth family	31	27
Manage and support family contact	19	44
Prepare transition or leaving care plans	22	29
Arrange next placement	36	26
Arrange accommodation on leaving care	18	24
Provide aftercare support **	18	26

* Agencies could indicate both DoCS and the agency undertook or shared the task, and some agencies had programs with different arrangements for different tasks, so numbers exceed the 42 residential care service providers.

** Aftercare not applicable in some agencies, due to age range of clients

A number of other tasks that could be thought of as 'case management' tasks appeared to be contributed to by both DoCS and agencies in many cases. These included developing annual care plans, convening case conferences and undertaking statutory reviews. While DoCS was reportedly mainly responsible for the development of care plans for court, a few agencies reported they contributed to the development of plans. Agencies frequently commented that they prompted DoCS to convene case conferences, but if DoCS did not take action, the agency would convene the conference itself. Some commented on the difficulty in getting DoCS staff to attend case conferences. DoCS was usually responsible for arranging the next placement if a client was continuing in care, although the agency would often be involved in transition after a placement was identified by DoCS.

Agencies were more likely to be involved in developing and implementing individual plans, doing casework with family, supporting family contact, preparing transition and leaving care plans, arranging accommodation and providing aftercare. Agencies could indicate that both they and DoCS shared responsibility for a task, which happened in many cases.

A key finding is that among those 31 agencies with DoCS nominated as formal case manager, there were two distinct sub-groups:

- those agencies, generally smaller and/or stand alone FFS agencies, where DoCS had major responsibility for most tasks, other than implementing individual plans and supporting family contact
- those agencies where agencies had major responsibility for most tasks, at times with little DoCS input.

The first group commented that they were generally satisfied with the division of roles, some reporting that arrangements were clear and they felt a genuine sense of partnership with DoCS.

The second group of agencies undertook some tasks that they thought DoCS should have undertaken. Some agencies were not so much concerned that they had to do the tasks, but that they were not funded for that work. Many were concerned at the lack of clarity over who should undertake what tasks and with the ad-hoc approach to case management. The potential for conflict with DoCS following action by agency was an issue for some. Another issue raised was the accreditation requirement to undertake case management and casework and the potential for this to conflict with the case management and casework expectations of DoCS.

3.9 Programming & support

Individualised programming was the commonly stated approach in the majority of agencies. That is, an individual plan was developed to address the developmental, educational, physical and social needs of each resident.

There was also evidence that routine and structure based on shared activities with other residents, or with other households of residents, featured in many residential programs. A small number of agencies appeared to have highly structured programs and a small number appeared to have an unstructured approach. Overall most seemed to provide a program that included attending school or other day time employment related activities, having free time, engaging in individual interests at home or in the community and being part of a household. Staffing levels at times affected how many individual activities could be accommodated in congregate households.

All agencies had a behaviour management policy and set of procedures to deal with behaviour issues and critical incidents. A focus of many agencies was on positive reinforcement and reward systems, in which natural consequences for breaches of rules were applied. Twenty three agencies reported that physical restraint was not allowed, while 18 did allow it to be used as a last resort. In those 18 cases, where restraint was allowed, many agencies reported that it had not been used for many years (2-8 years) and some said it had never been used.

Education support

Most agencies regarded school engagement and education support as very important aspects of their programs. Many agencies commented that most of their clients were excluded from school at the time of entry to the service or they had to change school, because placement was distant from the client's previous school. Most agencies attempted to re-enrol school age students in mainstream education or encourage their participation in alternative education or vocational programs, depending on their age and interests.

When students were excluded many agencies encouraged continuation of an education program by following a school routine and supervising school work as provided by the Department of Education.

A smaller number (about 10 agencies) provided structured programs staffed by tutors or support workers, which enabled students to undertake accredited distance education programs at home or in separate premises to their residence. One agency had a link to a special education program offered by the same auspice body. Two agencies ran accredited special schools exclusively for their residents.

Therapeutic services

Few agencies said they provided a therapeutic program, although some used this term in their description of the agency's philosophy or service model. One agency avoided the term 'therapeutic' as it perceived the term to imply a passive role for the resident who is the recipient of therapy.

Some agencies interpreted 'therapeutic' to mean any type of behavioural intervention or individually-focussed program, rather than a formalised and integrated programmatic approach to the operation of the service. Agencies named a number of models and therapeutic approaches that influenced their programs including: strength-based practice, cognitive behaviour therapy, solution focused brief therapy, Therapeutic Crisis Intervention, harm minimisation, dialectical behaviour therapy, family therapy, narrative therapy, sand play, art and music therapy, therapeutic community, trauma counselling, motivational interviewing, Positive Peer Culture

If 'therapeutic' was defined as a program developed with input from clinical psychologists or specialist social workers – then the majority of agencies had the potential to provide a therapeutic program. (See later section on employment of psychologists or contracting of psychology services.)

If 'therapeutic' was defined as a program systematically applying a formal clinical therapy, then only a very small number of programs, three or four, could be described as being therapeutic, based on the information provided at interview.

The research did not set out to evaluate the quality or effectiveness of these programs, nor was it in the scope of this study to do so. In some cases, programs appeared to be predominantly focused on the management of challenging behaviour, with some emphasis on improving life and social skills. Few programs appeared to be focused on addressing the underlying causes or effects of past abuse or neglect and the impact of being in care.

Aftercare

'Aftercare' in this context means services provided by the agency to former clients, rather than by specialist aftercare services, independent of the agency or by a separately funded program of the agency.

Twenty eight of the 42 agencies stated they provided aftercare services, of which 25 said aftercare was unfunded by DoCS. Two agencies stated that aftercare was partly funded (for certain contracts) and two stated that it was fully funded. One agency had two services where after care was unfunded and two where it was partly funded.

Another 14 agencies stated they did not offer aftercare, although one of this group said they do offer informal support to former clients who keep in touch and another said aftercare is not offered at present (due to age and retention of clients in the program) but that aftercare will be developed. One agency indicated that if former clients made contact, they would inform DoCS before becoming involved. DoCS was identified as being responsible for arranging aftercare support by these agencies.

Among the agencies offering aftercare, the number of active aftercare clients varied from 0 – 20 at the time of interview:

- 4 agencies had no active aftercare clients
- 11 had 1-5 clients
- 8 had 6-10 clients
- 2 had 11-15 clients
- 4 had 16-20 clients.

Total number of aftercare clients at the time of interview was not possible to calculate, as some people provided only rough estimates.

The type of aftercare services reported by agencies as being provided to former residents included:

- Medium to high level casework 11 agencies
- Low level casework 23 agencies
- Support to families after restoration 19 agencies
- Social contact, events invitations 21 agencies
- Information and referral 21 agencies
- Material support 17 agencies

Agencies indicated that aftercare may comprise active follow up in the period immediately after exit, restoration or transition to other placements; low level support in the majority of cases; agency-initiated invitations to agency-sponsored holidays or significant events; client-initiated contact of a social nature (sometimes this continued for many years, even in some fee for service agencies when time in placement has been short). It was reported that many clients make contact to celebrate successes or milestones such as graduation, engagement, marriage or the birth of children, while others periodically access the agency for support during times of housing or financial crisis many years after placement has ended. Medium to high level casework occurs in fewer cases, however it may be very complex and

time consuming. Agencies usually self-fund the work as they see it as a component of good practice, a requirement of the OOHC standards and part of their commitment to their clients.

3.10 Staffing arrangements

Of the 42 residential care providers, 40 used a shift work model of rostered staff to provide direct care, one operated a traditional family group home model with two residences and one operated in a hybrid model in which a small number of the same people work and sleep over in the residence each day and at weekends (religious order of Sisters). The family group home carers were employed under the *Social and Community Services Employees (State) Award (SaCS Award)*, paid a wage and various allowances and had regular time off away from the residence. The Sisters worked on a stipend basis, not subject to any Award, but consistent with Catholic Church religious orders.

Among the staffed models, all operated under the *SaCS Award.* Shifts range from eight hours to 25 hours, the latter including an eight hour sleepover.

In deciding whether to have shorter (8 hours) or longer (24-25 hour) shifts, agencies report they judge the degree of complexity in their target group and the likely stress on staff. Some shift arrangements were flexible according to the needs of residents and the preferences of staff. This was balanced with the desire to staff the roster with the minimum number of staff required to cover the hours in which care and supervision is necessary.

Awake shifts were not commonly reported and were only used in very high needs cases occasionally or in highly specialised programs.

3.11 Supporting the program: staff positions and external services

Apart from direct care workers agencies were asked about what other staff were employed or contracted to support the residential care program.

Coordinators or manager not providing direct (day-to-day) care
40 agencies employed a coordinator or program manager for their residential care service who does not provide direct care (on the roster)

- Coordinators or managers in 36 agencies were employed full time 35-40 hours per week).
- Four agencies employed less than full-time coordinators or program managers.
- Six agencies had more than one staff member in a management role providing some support to the residential program/s.

Caseworkers

21 agencies employed caseworkers or staff in similarly titled positions, undertaking the casework role

- 18 agencies employed caseworkers for the equivalent of full time (35--40 hours per week) with four agencies employing more than caseworker
- three employed part time caseworkers

In a number of agencies where no caseworker was employed, direct care workers undertook the casework role, sometimes using a key worker system, under the guidance of the program coordinator/manager or team leader/house manager. In some agencies, the team leader/house manager, the coordinator/program manager or director/owner of the business undertook the casework role.

There appeared to be a person/s nominated as responsible for casework in the vast majority of agencies, even in those agencies where DoCS generally had case management responsibility.

The depth and quality of casework was not assessed in this research, however many agencies reported they used a formal case management system, such as the Looking After Children system or a system developed by the agency.

Psychologists

14 agencies employed psychologists on staff:

- 3 agencies had full time psychologists (38 hours per week)(1 agency has more than one full time psychologist – working across different programs),
- 4 agencies employed psychologists from 15-30 hours per week
- 3 agencies employed psychologists 7-10 hours per week
- 1 agencies employed a psychologist 2 hours per week
- 3 agencies employed psychologists for an unspecified number of hours per week.

Other staff

Eight agencies employed teachers or tutors to support either special schools, registered distance education programs and to provide tutoring and education support.

Many agencies employed other staff including youth workers, mentors, family support workers, aftercare workers, cleaners, housekeepers, and/or handy persons, who supported the residential program.

External support

Twenty six agencies reported they contracted psychologists or social workers to provide support to the residential care program. This support varied from staff training and clinical supervision to development and oversight of individual programs for residents. A key focus was on behaviour management consultation. External staff debriefing was often made available in response to critical incidents. Among the 26 agencies, 19 had regular on-going arrangements, whereas seven others were arranged on an ad-hoc basis.

A number of other agencies referred to general community services that might be accessed by staff for the residents, such as community health, general practitioners, mental health services, counsellors, dentists, DoCS, education tutors, church pastors, youth organizations or programs, recreation programs or sporting groups.

3.12 Staff supervision and support

Back up to direct care staff was seen as important, as many residences were staffed by one person at any one time.

All residential programs offered a system of on-call and recall to support direct care staff, with usually one senior or experienced manager or coordinator available for support at any time 24 hours a day. The owner or director was the person responsible for back-up in the case of some private for profit companies.

Usually support was offered by telephone in the first instance, with in-person support being provided if necessary.

A number of agencies provided information about their policies and procedures for de-escalating situations, raising the alarm, responding to incidents and reporting and debriefing processes following incidents.

There was little to distinguish one agency from another in this respect, with most agencies reporting that they had a comprehensive approach to staff support.

3.13 Staff competencies

Agencies were asked about what competencies (skills, attitudes and knowledge) they sought in residential care staff.

Responses often contained two types of perspectives:

- Competencies focused on personal qualities and values, such as caring, compassion, patience, acceptance, empathy, non-judgemental attitude, flexibility, dedication, common sense, being well adjusted, achieving balance in life, self-awareness, having a sense of humour, being able to remain calm and unruffled, not into rescuing, maturity, being collaborative.

- Competencies related to the skills and knowledge in working with residents and how to meet their needs, including the ability to build rapport and relationships, ability to work in a team, communication and listening skills, skills in behaviour management, being able to implement a program consistently, understanding of child and adolescent development, awareness of child protection and out-of-home care issues, understanding of various disabilities and complex needs,

Many responses appeared to show that possession of personal qualities and acceptance of the values or philosophy of the agency was regarded as more important than specific skills or knowledge. It appeared that agencies thought skills could be taught through training and supervision.

Minimum qualifications

The vast majority of agencies had given thought to setting a minimum level of qualification or experience for staff at the direct care, house manager/team leader, caseworker or coordinator/manager positions.

Whilst in some cases agencies sought relevant experience or the right attitudes and values in staff, they also tended to see a qualification as desirable, if not essential.

Direct care staff
Certificate III or Certificate IV in youth work or an equivalent discipline were commonly stated minimum qualifications for direct care staff. Some agencies expected a diploma or degree in a relevant discipline plus experience in permanent direct care workers, with acceptance of a less qualified group of casual staff.

Twelve agencies had no set minimum for direct care workers, regarding experience as more important. In some of those services, staff were highly qualified and of long tenure while in others, training to bring staff up to Certificate III or Certificate IV level was provided.

Team leader/house managers and/or caseworkers
Generally a degree in social work or psychology was regarded as the minimum qualification for more senior positions. In some cases a qualification such as Certificate IV or Diploma along with extensive experience was accepted. Management experience was a desirable attribute.

Casework supervisors/coordinators or program managers
A degree was regarded as the minimum qualification for these positions, or a Certificate or Diploma qualification with extensive management experience. A number of agencies reported their current staff were highly qualified, some holding higher degrees and membership in professional associations.

Developing competencies

Most agencies reported that they supported development or training of their staff – through both Nationally Recognised Training and customised short courses to meet particular needs or address deficits in staff skills. Most commonly reported training needs were around behaviour management and understanding of working with people who have specific disabilities or complex needs and issues. A number of training providers were used by agencies, including the Centre for Community Welfare Training and the DoCS Non-Government Training Unit.

A small number of agencies supported the development of post-graduate tertiary or advanced level nationally recognised training in residential care, which they regarded as absent or under-developed in current training agendas. Agencies recognised that residential care was a small and highly specialised area of work. Cooperation in the provision of training was suggested by some agencies, given the small size of the sector and the high cost of accessing specialised training.

Structured and regular supervision was also regarded as an important opportunity to develop competencies. Some staff were provided with access to external clinical supervision or consultancy services.

3.14 Staff recruitment

The community services sector is often troubled by recruitment difficulties and we expected that recruitment difficulties would be widely reported.

Just over half the agencies reported they had difficulty in recruiting direct care staff (19 agencies) while 18 reported they had little difficulty. Four agencies answered both 'yes' and 'no'. (One agency gave no response to this question).

Twenty one agencies reported they had difficulties, while 16 said they had no difficulties in recruiting for management positions. One agency said 'yes' and 'no'. Some agencies made no comment.

Reasons for recruitment difficulty included:

- Lack of people with experience, skills or attributes required (despite many applications)
- Difficulty of recruiting for shift work
- Nature of residential care work – level of clients' difficulties or complexity of needs
- Applications from people who do not understand the task or have unrealistic expectations
- Low salaries (under the Social and Community Services [SaCS] Award) especially when compared with government positions
- DoCS recruitment of caseworkers and other staff

- Casual nature (insecurity) of the positions that can be offered
- Location of agency or service (rural areas, some suburbs.

Reasons for some agencies reporting few recruitment difficulties included:

- Good reputation or public profile of the agency
- Thorough recruitment process with orientation, shadow shifts and mentoring of new staff
- Low staff turnover, so do not have to recruit often
- Good employment conditions, such as above award salaries or salary packaging
- High level of supervision and support with commitment to staff development
- Word of mouth recruitment, waiting list of people seeking work with the agency
- Location in area of high unemployment or providing access to a pool of staff (eg university or TAFE students)
- Recruitment or advancement from within for management positions.

Agencies generally supported increases in the SaCS Award, to make salaries for non-government sector positions equivalent to similar positions in the public sector. There was no mention of a need for a different award or employment conditions specific to residential care, although the unique nature of residential care work was acknowledged.

Agencies reported that some residential care staff to see their positions as a stepping stone to other jobs, and as most appropriate while they were young and unattached, because of the shift work.

However, despite low pay compared to government positions and difficult working conditions, there were many reports of experienced staff staying in direct care positions for many years.

3.15 Funding

Agencies were asked about the nature of the major funding for their residential care services. Responses showed:

- 13 agencies were predominantly OOHC program funded
- 25 were predominantly Fee-for-service at time of interview
- 1 agency had one service OOHC program funded, another FFS with program funding being negotiated
- 2 agencies had one service OOHC program funded, another FFS
- 1 agency had 3 services FFS and one service unfunded by DoCS.

Fifteen of the agencies providing OOHC predominantly on FFS basis reported they received 100% of the cost of services from DoCS contracts.

Seven FFS agencies reported making a contribution to costs ranging from 1 – 10% at different times such as: during establishment; when carrying vacancies or being under utilised by DoCS for various reasons; and /or when experiencing delayed contract payments.

Two agencies operating on a FFS basis indicated a much higher agency contribution (over 50% in one case, 40 – 80% in another case).

OOHC program funded agencies reported they generally contributed much higher proportions of agency funds toward the cost of the residential service than FFS agencies, with contributions ranging from 5% to 50%, with an average contribution of 25%. Only one funded agency reported that program funding met 100% of operating costs.

3.16 Location of services and referral sources

Information was gathered on suburb location, the DoCS region in which the residences were located and which DoCS regions mainly referred to the residential service.

By cross referencing with funding data it was possible to determine whether DoCS regions were predominately provided with residential care on a funded or FFS basis, as illustrated in Table 3 below.

Table 4: Residential care services by DoCS Regiom and funding type

Region	Program funded	FFS	Total agencies**
Metro West	5	6*	11
Northern	2	9	11
Metro Central	6	2	8
Southern	2	5	7
Metro South West region	1	6	7
Hunter Central Coast	1	6*	7
Western region	0	1	1

* One agency located in Metro West declined to be interviewed and one agency located in Hunter Central Coast was about to close, so these agencies are not included in the numbers.

** Some agencies provide services in more than one region, so totals exceed 42.

From the table it can be seen that some regions rely heavily of FFS agencies and have few program-funded agencies located in their region. However, some

agencies operate in more than one region and some accept out-of-region referrals to services located in one region.

Although information was collected from agencies on which DoCS regions refer to and mainly use their services, it was not possible in this research to determine the extent to which out of area placement was used to supplement the lack of services in regions. Concerns were raised by a number of agencies about the use of out-of-area placement and some preferred to limit their services to one or two regions closest to their service delivery locations.

3.17 Tenure and design of properties

The majority of the 181 properties used for OOHC residential care in NSW were private rental properties, (109 properties, operated by 23 agencies). Although the majority of these were FFS agencies, two program funded services were using private rental properties.

Forty four properties were owned outright by the agency and five were under mortgage. The majority of owned properties belonged to program funded agencies (n=11) however eight agencies operating mainly or solely on a FFS basis also used properties they owned for residential services. A number of these properties were the larger configurations of congregate care (6-13 places).

Nine agencies had 20 properties rented from a public or community/charitable body (eg Department of Housing, local council, community housing association).

One agency did not own or rent any houses, rather contracted staff to provide supervisory services in rented motel rooms.

No residences were recently built with the purpose of OOHC residential care service provision in mind. One exception was a service co-located in a purpose-built SAAP residence, which was constructed in the 1980s. A number of agencies provided services in premises renovated for OOHC use.

Properties were not inspected, although some interviews took place in OOHC residences, either in offices or common areas when residents were not at home. From observation, it was clear that some properties appeared run down and a number of older properties could benefit from refurbishment or more substantial renovation. A number of properties visited appeared indistinguishable from their neighbours, were well furnished and appeared reasonably suited to their purpose, in terms of private, common and office/staff bedroom space.

4 Results: Place and future of residential care

In NSW, the 42 residential care providers plus 12 CEOs or other senior managers of those agencies, 21 agencies not providing residential care, seven DoCS regional directors and representatives of four peak organisations were asked a range of questions about the place and future of residential care. This section summarises the responses of those 86 interviews.

4.1 Children and young people who may need residential care

Age ranges

Of the 81 interviewees who specified age ranges of children and young people who may need residential care, 41% (n=33) supported residential care for children aged over 12 years and young people up to 18 or 19 years, while 59% (n=48) saw a need for residential care for children under 12 years.

The minimum ages mentioned by those 48 interviewees were as low as birth, in circumstances such as emergency placement, respite or for placement of sibling groups. More commonly the minimum was between eight and 11 years.

Interviewees saw a need for separate residences for different age ranges, and in some case, different models of staffing and style of operation. Explanation of these sub-groups is provided below.

- 8-11 years
  Some young children were thought to need residential care as opposed to foster care, if they had high or complex needs and their behaviour could not be managed or their needs could not be met in foster care. If younger children were placed in residential care interviewees suggested it should be in a home/family style, like the family group home model. It was felt that nurturing was particularly important for those under the age of 10 and that residential placement should only be a time limited option and part of a plan to place the child more appropriately. Residential care was not the first choice for placement.
- 12-14 years
  Residential care was thought to be appropriate when foster care had not worked, evidenced by multiple placement breakdown and for adolescents who had challenging behaviour. Once again most interviewees said that residential care should not be the first option.
- 15-18 years
  A large number of interviewees thought residential care was suitable and at times preferable for young people moving towards independent living.

Some interviewees did not express an opinion on age ranges, and a number who did mention age ranges also said they strongly preferred foster care, especially for

under 12 year olds. Best options were thought to be family restoration, followed by highly supported foster care.

Only one interviewee suggested there was no place for residential care, and that all children and young people requiring care, even very high needs clients, could be cared for in intensive foster care.

Characteristics

Interviewees stated that residential care needed to be available as a placement option for children or young people in the following categories:

- High/complex needs children and young people
  Most interviewees identified the 'high and complex needs' client group as a group that required access to residential care. This group included children or young people with sexualised behaviour or sex offenders, mild to moderate intellectual disability, people with drug or alcohol or mental health issues, dual diagnosis (disability and mental health, drug and mental health issues) and those who were risk taking and did not fit within a foster care environment.
- Adolescents, with moderate or high and complex needs
  Older teenagers for whom family environment did not work, who did not want to replace family because of strong family connections and those who did not want the intensity of foster care were seen as candidates for residential care. It was also stated that some adolescents were already moving towards independent living and were past wanting to fit into a family, therefore residential care could provide some support without the intensity of relationships.
- Sibling Groups
  Interviewees were concerned about the lack of placement options for sibling groups and identified that residential care often supported the placement of siblings together whether coming into care from birth family or from separate placements. Some thought residential care could be used as a base for restoration work. A number of agencies had difficulty recruiting foster carers with skills or capacity to care for sibling groups.
- Indigenous children and young people
  A number of agencies acknowledged that there was Aboriginal managed residential care offered exclusively for Aboriginal clients available in NSW and that this was a significant service gap that should be addressed.
- Gender specific programs
  A few interviewees identified the need for female only programs: one was proposed similar to agency's current boys only program with a focus on education and restoration, while another interviewee saw a need for greater support to young mothers, and to young women with mental heath issues, such as self-harming behaviour.

4.2 Models of residential care

Most interviewees suggested that small congregate models of two to four children or young people in each residence was the best residential care option, with attention being given to the "mix" of residents. Many shared the view that residential care needed to be non-institutionalised in both its size and style of operation. No-one supported large congregate residential care facilities, although some could see economies of scale by offering residences of a certain size (up to six places) or a number of residences that could share some infrastructure costs. One interviewee favoured larger numbers in a residence (8 places) as they thought that number made for positive group dynamics.

Many interviewees acknowledged that staffing was a key factor in terms of quality of care. Two main options around staffing were suggested:

- the house parent model, with one primary paid carer and a partner or other staff available at key times in support/respite roles, which would provide consistency for children and young people, and
- rostered staffing, which would provide a mix of skills among staff as well as a break for staff from dealing constantly with the demanding nature of residential care work.

Some interviewees thought that no-one should be cared for by rostered staff as residents need to be able to build relationships with their carers.

Specific populations or target groups were mentioned as needing particular models of residential care:

- Adolescents moving into independent living need a model where they can have a staff member living nearby or on site to provide support when needed, but not 24 hours supervision.
- Aboriginal children or young people needed a program that would meet cultural and emotional needs and reflect indigenous values and culture. Services would need to be placed close to communities. Elders should be involved in the programs and the staff should be known to the potential residents, through their ties to the community.
- Many interviewees thought that therapeutic residential care programs should be developed for the high and complex needs group. While behaviour management and modification was seen as a necessary component of such programs it was not the only aspect to be considered. Counselling and therapy was needed to address underlying issues, as well as programs that address living skills, education engagement and social and personal development.

The type of accommodation was mentioned as being important to the provision of residential care, with some interviewees seeing a need for purpose-built or purpose-renovated properties. Such properties, apart from providing for better safety and security, could incorporate features such as separate flats available for young

people close to leaving care age or for family members to stay over if restoration is planned.

Although interviewees were not asked specifically about the need for secure care, some support for secure care was expressed, in cases where children and young people had illnesses or exhibited behaviours that placed themselves at serious risk of self harm. A few people called for the proclamation of the compulsory assistance provisions in the legislation[19]. Some others thought that some extremely troubled children and young people needed to be supported in the mental health system, rather than the OOHC system.

Rather than advocating particular models, some interviewees commented that the intended outcome and function of the residential care would influence the model.

Interviewees expressed a range of views about how long residential care programs should last. These varied from short term (around three months, with therapeutic or intensive programs and interventions) to long term – until the child or young person leaves care. In some cases this could mean many years if the child entered the service at a young age. The view that residential care should only be provided as a last resort and temporary option was supported by some, but not by a majority of those who commented on the duration aspect.

4.3 Geographic gaps in availability of residential care[20]

Interviewees generally responded to the issues of gaps by naming regions or particular Community Service Centres. A number of the respondents stated a general concern about there being an insufficient number of residential placements, without specifying locations.

Of the seven regions, Southern NSW, Metro Central and Hunter & Central Coast regions had the highest rates of nominations as experiencing gaps in residential care service (10 times each):

- Within the Southern NSW region, Wollongong and Shoalhaven were repeatedly nominated, as well as the Illawarra area.
- In the Hunter and Central region particular mention was made of Forster, Cessnock and Maitland.
- In the Metro Central region, Sutherland, St George, Northern Beaches, the northern area of Sydney, and Redfern were singled out.

[19] *Children and Young Persons (Care & Protection) Act 1998*, part 3, ss123 – 133B

[20] The number of interviewees in each region affected the answers, so these numbers may not be a comprehensive or accurate reflection of gaps in NSW. More than one region could be named by interviewees, however some interviewees made no comments on gaps because of their lack of familiarity with residential care or with the NSW situation.

Northern Region received nine nominations, with Taree and Lake Macquarie, Yamba, Maclean, Tweed Heads, Coffs Harbour, Kempsey named as localities with specific service gaps.

Across other regions:

- Metro South West Region was mentioned four times, with Liverpool being singled out.
- Metro West was nominated three times, with Mt Druitt being identified as a gap.
- Western NSW region was also nominated three times.

Seven interviewees stated that there were gaps in rural areas generally.

Agencies providing residential care generally commented on the local area or region that their service was located in, or mainly served, although some were aware of other gaps because they received referrals but did not accept clients from other regions.

Non-residential care providers reported on the gaps from the perspective of them being unable to access residential care when they thought it was the appropriate or necessary placement option for a client in a vulnerable foster care placement or who could not be accommodated in their foster care program. This was a particular issue when most referrals to residential care places had to be made or approved by DoCS.

Young people from CREATE commented on gaps from the perspective of experiencing a lack of choice about placement and being moved across the city because no local options were available to them. Representatives of other peak organisations mentioned rural areas generally (1), the Western region especially the Far West (2) and the Illawarra (1).

Regional directors appeared to understand the gaps in their own regions well, with a common view prevailing among them that there was an insufficient number of residential care placements, particularly program funded places. Geographic gaps were widespread across some regions and, in others, were more related to specific target groups, for example Aboriginal young people or young people with intellectual disability. One Regional Director called for strategic planning to enhance residential care, including provision of a number state-wide specialised services. One commented on the need for a state-wide approach to referrals and vacancy management. Concern was expressed over the shortages of residential care, which has led to undesirable over-reliance on out-of-region placement.

4.4 Residential assessment services

Almost two thirds of the interviewees (63% (n=56)) were in favour of the provision of specialist assessment services with a residential component, while 34% (n=27) were against such services. Two interviews answered both 'yes' and 'no'.

A key view supporting a residential assessment service was that accurate assessment could identify issues to be taken into consideration when placing a child or young person, which would reduce breakdown of placement and support stability in care. The majority of participants also identified the need for up to date assessments, rarely available in the past. Ideally assessments would provide for specific outcomes and pathways for children and young people, identify best options and lead to better planned placements. Information needed to be current so accurate identification of problem behaviour could be made. A commitment to meeting the assessed needs was also required. Careful risk and needs assessment was important in terms of duty of care to the resident, as well as being part of the obligation of employers to provide staff with safe working environments.

The majority of interviewees, both those for and against residential assessment, identified a major concern if the assessment placement was not time-limited. They feared residents could remain in the assessment centres for extended periods, without an exit plan or placement being identified, even once assessment was completed. Many interviewees recommended three months as the maximum period for an assessment placement, with an exit point being identified early and available at the end of the assessment process.

No-one favoured a return to large assessment or reception services, similar to those that used to exist, as such services were seen as detrimental to the residents. Assessment services of only three or four places, in various locations close to potential placements, were preferred. It was seen to be necessary to build up the number of exit options before or at the same time as establishing an assessment service.

Aboriginal agencies identified the issue of cultural appropriateness of assessment services by non-indigenous services. Some interviewees felt that assessment by clinical psychologists, using mainstream assessment tools and instruments, would not be appropriate for use with Aboriginal children or young people. Other Aboriginal agencies were in support of specialist assessment services and suggested they would use them.

Views opposed to specialist assessment services, generally, included:

- concern over the lack of reliability of information provided from assessment
- concern that too many parties would be involved in the child or young person's life
- the potential for too many separate bodies to be involved in assessment, with no one taking responsibility for seeing the plan through, and

- the lack of services to act on the findings of assessment, such as counselling or other health services.

A number of interviewees thought that assessment should not be cut off from other aspects of care, as assessment in isolation could not account for the context that may dramatically affect observed behaviour. For example, behaviour in a congregate setting is influenced by group dynamics that cannot be assessed in individual sessions with a psychologist. There was also a need to recognise that some problem behaviour was an entirely reasonable response to events.

The young people from CREATE were against specialist assessment services, as they felt that what DoCS concluded following assessment did not reflect the young people's reality. They also felt that if they were getting settled they didn't want to be made to move again and often were not told how long the placement would last.

The three other peak organisations were among those in favour of residential assessment services.

Regional Directors held generally favourable views about residential assessment services, although these views were qualified by the comments about the need for time limits, action to be taken on assessments, integration with therapeutic services, and timely placement based on assessed needs. Three Regional Directors specifically mentioned the involvement of NSW Health personnel (that is, use of a multi-disciplinary approach). A proposal to extend an existing assessment service to include a residential component was being developed by one Regional Director for consideration by Central Office. This region had compiled a review of best practice in assessment to inform their planning. All Regional Directors recognised the lack of sufficient placement options (post-assessment) as a major issue.

4.5 Individual residential placements – views of non-residential care providers

This section reports the views of those interviewees that do not provide residential care. *(see also residential care providers views on individual placement in section 3.6)*

The majority of non-residential care providers were sceptical about the value of individual residential placement, although some acknowledged that it may be necessary in a small minority of cases, if it was offered in a very time limited way with an intensive therapeutic component.

Some interviewees were totally opposed to such placements in any circumstances, perceiving that if a child or young person's needs or issues were so great they had to be cared for alone by a team of people, then they probably needed intervention and care in a different service system, such as mental health or juvenile justice.

Some interviewees knew of clients who had been in individual placements and they were not impressed with the outcome for the children and young people. Many

were concerned about isolation and lack of normality for the resident, and the issues of the child or young person 'ruling the roost' was raised as a concern.

Young people had mixed views about individual placement, some seeing it as 'weird' and 'big brother' like and lonely. In contrast the view was expressed that workers were there to help the young person and that the residents were too young to live independently.

Regional Directors were generally very concerned about individual placements, both in terms of the intervention and the impact on the resident. Terms such as 'shocking' and 'a disaster' were used. The fact that most Regional Directors have approved individual placements demonstrates that they have thought it was necessary at the time. One Regional Director had not approved any individual placement in the previous 12 months because of concerns about their negative impact on clients.

Some Regional Directors questioned whether programs that are described by agencies as 'therapeutic' were in reality providing much therapy. Some had the impression that the placements emphasised 'containment' rather than therapy. This was not seen as satisfactory.

4.6 Sectors to operate residential care

Of 81 responses to the question regarding which sector should operate residential care, more than half (56%, n=45) of the interviewees favoured non-government organisations (NGOs) as sole providers of residential care. Less than half (43%, n=35) interviewees thought both government and NGOs could provide residential care. Only one interviewee thought that government only should provide residential care. As the vast majority of interviewees were from NGOs the response was expected to favour NGO provision.

A number of interviewees commented that sufficient resourcing and a commitment to meeting the OOHC Standards was needed for residential care, no matter which sector was the provider[21].

A number of interviewees in favour of NGO-only provision raised issues around the needs for statutory responsibility to be separate from day to day supervision and care. Others perceived DoCS as primarily concerned with financial management and that crisis-driven in its decision making around child protection and placement – these underlying issues were thought to be detrimental to provision of residential care. Interviewees felt that NGOs were better able to build relationships with children and young people, as they were smaller operations, with low supervision ratios and smaller caseloads than DoCS caseworkers. They felt that residential care needed to be run by people who had an understanding of residential care, greater

[21] Office of the Children's Guardian (2003) NSW Out-of-Home Care Standards. Downloadable from: http://www.kidsguardian.nsw.gov.au/accreditation/acc_standards.php

experience and commitment to good practice – as NGOs have more current experience, they were best equipped to continue or expand residential care. The NGO sector was also thought to be best placed to provide residential care because of its community orientation and responsiveness. This was seen as very important for Aboriginal children and Aboriginal communities, with the latter likely to be unwilling to use residential services provided by government.

Some interviewees commented on a lack of evidence that DoCS had run residential care well in the past, while others thought DoCS needed to achieve accreditation and improve the quality of its current direct care services before it considered providing residential care again.

Some interviewees expressed concern about DoCS funding of for-profit providers, and they raised the question of DoCS' ability to monitor quality of service provision and about the importance of accreditation processes. Criticisms of the funding of for-profit agencies also came up in general comments made by many agencies. These criticisms related to concerns about high cost to government, concerns about a profit motive potentially affecting service quality and concerns over the adequacy of the knowledge and experience of some for-profit agency Directors or owners to run residential care. Many agencies, including some 'for-profits', saw it as preferable for residential care to be provided by non-government not-for–profit organisations.

The young people surveyed felt that NGOs should be providing residential care, as they had better skills in communicating with residents.

Less than half (43%, n=35) interviewees thought both government and NGO could provide residential care. These views were often qualified with the comment that DoCS had the potential to develop, but it did not currently have the capacity, to provide residential care. Among other reasons given in favour of either government or NGO provision, was the desirability of a diversity of options and the potential for it to encourage DoCS to work in partnership with NGOs. Some interviewees in this category stated there should be more emphasis on the capacity of the system as a whole, as opposed to who was delivering the service.

Regional Directors were among those who felt either government or NGOs could provide residential care. While two thought a majority of residential care would be NGO provided, the role for government in specialist residential services such as assessment, secure care or very highly specific high/complex needs clients was mentioned by several of them. Regional Directors were aware of the need for agencies with the right skills and with adequate resources to run services. Two Directors were willing to look at mixed service proposals whereby both DoCS and a NGO would be involved in shared service delivery. Some Directors also suggested that specialist services needed to involve Department of Health, Department of Education and/or Department of Ageing Disability and Home Care, as well as DoCS.

One interviewee, a fee-for-service for-profit provider, thought only DoCS should provide residential care as they have the funds, and that funds were being wasted on high cost placements.

4.7 Cooperation between agencies

Interviewees were asked about the potential for cooperation in the delivery of aspects of residential care services, through consortia, regional or state-wide specialisation or joint proposals.

Of 82 responses, 51% (42) of interviewees generally supported increased cooperation between agencies, 12% (10) expressed sceptical or negative views and 37% (30) had mixed views, supporting the idea, but seeing various implementation difficulties.

Responses related both to the specific question, but also broader concepts of cooperation between providers of different types of OOHC services, between DoCS and agencies and between the OOHC sector, including DoCS, and other related human service government departments. The answers therefore go beyond residential care.

Some agencies thought that cooperation in service delivery would require a significant investment of time and human resources. The value of that investment was questioned by a number of interviewees, with some expressing a preference for developing a full continuum of service models within their own agency. Some pointed out that the concept had little relevance in rural areas where there may be no available or capable potential partners. Many interviewees acknowledged that the competitive environment and the time frames in which new funding was made available tended to detract from cooperation and increase an independent approach to submissions.

A vast majority of interviewees, representing OOHC agencies, were keen to cooperate with other NGOs in terms of referral and provision of complimentary services to ensure regional coverage.

Some agencies saw scope for cooperation between residential care agencies, in such areas as training, preparing for accreditation, staff sharing or secondments.

A number of agencies only providing residential care saw great value in building links and relationships with agencies that provide foster care, with a view to cross referral, especially exit from residential care to foster care in appropriate cases. Similarly, foster care agencies at times wanted to have access to residential placements.

Many interviewees reported that their agency had strong relationships with local or regional services such as mental health teams, community health, counselling services, psychiatric units or hospitals, drug or alcohol services, and Department of Education OOHC teams. In some cases these links took the form of Memoranda of Understanding.

The desirability of cooperation in providing wrap-around responsive services to meet all the needs of children and young people in care was recognised. One interviewee particularly mentioned the desirability of having a number of agencies

involved in the wrap-around services to enhance accountability and quality (by having people with different expertise involved).

4.8 Supported Accommodation Assistance Program (SAAP) role

Of 66 interviewees who expressed opinions regarding the role SAAP should play in residential OOHC:

- 22% (n=15) interviewees thought there needed to be recognition of SAAP's role in OOHC and that funding needed to be provided to support young people in OOHC who use SAAP services. One interviewee held the view that SAAP already provided considerable service to OOHC clients to the extent that some homeless clients were excluded from SAAP and that funding should support specific places for OOHC young people, whilst still maintaining standards of care as required by OOHC services.
- 21% (n=14) interviewees saw a definite role for SAAP services as a transition to independent living for young people in OOHC. The benefits they saw were that community connections would be ensured and that the SAAP sector has a high level of skills and experience in living skills education. SAAP could be an exit point for OOHC.
- 15% (n=10) interviewees thought that SAAP services had a role, but only for young people aged over 15 years. They thought it would work best when supplemented with wrap around support from other agencies. SAAP was a choice for older adolescents and provided more flexibility for this older group and a broader range of options with less intrusion on lives than more highly staffed models of care.
- 15% (n=10) interviewees said there was a definite role for SAAP in crisis and emergency accommodation and not for long term care. Placements in SAAP would need to be results driven. Some thought SAAP services would also be beneficial for some young people with disabilities.
- 19% (n=13) interviewees said that SAAP services should not play any role in OOHC residential care, as they both had a different purpose. That is, SAAP was a response to homelessness and provided support in transition to independence, while OOHC was provided for the care and protection of children and young people. Interviewees also stated that they thought SAAP was inappropriately being used by DoCS as pseudo-residential care and as a screening service for young people in OOHC.

Young people surveyed made no specific comments on SAAP and did not differentiate SAAP from OOHC. They referred to all congregate facilities as 'refuges', irrespective of the funding source. They saw (real) SAAP refuges as just another place they might go.

A number of interviewees (n=16) expressed no opinion on the role of SAAP. In two other interviews the question was not asked (trial interview & one other which ran short of time).

4.9 Research into residential care

The majority of respondents stated that there needed to be research into residential care in Australia, although some said that existing research should first be reviewed and acted upon. The need to gather information from the perspective of service users, the children and young people, was emphasised by several interviewees. Others highlighted the value of research in exposing government and service providers to scrutiny.

Particular areas for research suggested were:

- Longitudinal study of children and young people who have used residential care:
    - outcomes for children and young people, particularly young children
    - importance of relationship versus therapeutic programs
    - effectiveness and availability of sibling placements
    - use of residential care as a stepping stone to other community placement
    - effect of movement through a variety of programs
    - whole of government costs
- Best practice in residential care:
    - service models for different age groups, or aiming to achieve particular outcomes
    - size of residences linked to effectiveness of outcomes
    - ways of promoting stability
    - assessment models and practice
- Indigenous clients and communities:
    - what models work and how to best support indigenous young people
    - cultural mixing of different indigenous groups
- High/complex needs clients:
    - effective therapeutic approaches
    - comparative study of what has worked, across NSW
    - effectiveness of newly funded (High Complex needs) programs
    - working with OOHC clients with disabilities
- Staffing:
    - effective training and it's impact on outcomes and retention of staff
    - optimal staffing level to provide services
    - recruiting and maintaining carer/staff pool

5 Interstate consultation summary

Researchers consulted a sample of non-government agencies providing residential care and at least one government representative in each state or territory of Australia. The intent was to gain an overview of current residential care provision and identify key issues and trends around Australia, in order to inform discussion and the interpretation of the NSW research findings.

The list of those people interviewed appears at Appendix 2. Appendix 5 contains a table of the collated results for each state and territory.

It is recognised that each state and territory is unique, with different demographics, geography and influences affecting the development and current provision of residential care. It is difficult to make direct comparisons, however this summary aims to provide an overview of key observations.

Across the board we found that

- Residential care still plays an important place in the OOHC service system in all but one jurisdiction – Tasmania – where some family group homes exist but are not defined as residential care by government.
- In all states people consulted thought there needed to be improved planning, a greater diversity of models, and increased emphasis on development of therapeutic models, for dealing with clients with high and complex needs.
- In most other jurisdictions, there was unmet demand for residential care. Many people thought there should be increased capacity in residential care. Some caution was expressed in estimating a number of places required, because of a recognition that any places made available would most likely be quickly filled.
- Although residential care has continued to decline overall as a proportion of OOHC places, there are now moves in several states to increase residential placements, partly as a response to lack of capacity in the foster care system and partly due to a perception that a quality residential program would better meet the needs of some children and young people, especially those with high and complex needs.
- In some jurisdictions recent reviews have recommended an increased role for residential care (ACT, Qld, SA). Reviews are underway in several other jurisdictions (Vic, WA).
- Numbers and proportions in residential care: NSW was among the lowest states in terms of proportion of OOHC clients in residential care, but it has the largest number of residential care providers (44) and the second largest number of actual clients in residential care (296 at 30 June 2004)
- Numbers in residential care are trending slightly upwards in NSW and in some other jurisdictions (eg Queensland), although some other states still experiencing some decline (Victoria).

- All jurisdictions appear to be interested in developing therapeutic residential care programs, although they are in an early stage of planning. Detailed models and evidence bases for such services are still under developed.
- Placement referral and exit processes in a number of jurisdictions were characterised by cooperative arrangements, partnership and some decision-making control resting in the hands of the receiving agency (ACT, Qld, Vic). Victorian had a centralised vacancy management system that appeared to be working well.
- Most jurisdictions do not have a costing or resource allocation model that recognises the full cost of providing residential care. In the few states that did have some costing model, many agencies thought the funding was inadequate to meet costs. In some jurisdictions reviews of costing were underway.
- Throughout the country there has been little independent evaluation of residential care programs, although many acknowledged that such evaluation is necessary. Many services appear to be continuations of traditional programs, operating on a slightly smaller scale. A clear evidence base for most programs appears to be limited.

Outstanding differences were noted between NSW and other jurisdictions:

- Extent of fee-for-service funding: Occasional or no use of fee-for-service arrangements in most states, extensive use in NSW, by both recurrently program funded agencies and otherwise unfunded agencies
- Role of private for-profit providers: none active in any other states, although Life without Barriers (a not-for-profit agency) is a new provider in several jurisdictions. Whereas a large number of private providers operate in NSW (between 15 and 20 – corporate/legal status of some agencies not known).
- Extent of individual residential placements – a few or none in most other states, over 100 children or young people in individual placements in NSW.
- Family group homes have virtually disappeared as a model in NSW, however they are still an important service model in many other jurisdictions. In places where family group homes exist there are issues with recruitment of suitable staff willing to work the long periods for fairly poor remuneration, compared to rostered staff working under the SaCS Awards. Family group homes are seen as a preferable model for younger children, some sibling groups and Aboriginal children.
- NSW is the only state with an accreditation system for OOHC providers, although some other jurisdictions have standards and/or licensing systems and some have external scrutiny via a community visitor system. Some states are emphasising continuous quality improvement.

6 Discussion

6.1 Place of residential care in the service system.

Residential care is regarded as an essential part of the OOHC system.

Residential care is required as a placement option for some children and young people with high and complex needs who cannot be accommodated in general or intensive foster care. A number of other specific groups such as Aboriginal children and young people, older young people in transition to independent living and sibling groups, who may or may not have high and complex needs, also require access to residential care.

Whilst many people stated a preference for foster care, especially for younger children, only one participant in the 109 interviews commented that they saw no place for residential care.

Interviewees recognised that residential care needed to be provided at a high standard, not simply aim to comply with minimum standards. Provision of quality programs, informed by research and practice evidence and subject to independent evaluation, requires an injection of additional funding. Whilst ever funding does not meet full costs or is only provided on a quarterly individual contract basis, agencies will find it difficult to provide residential care at a 'best practice' standard. Many agencies inject additional agency or personal funds and volunteer effort to the service in order to improve their standard of service.

6.2 Capacity and distribution of residential care

There are increasing numbers of children and young people in care overall, and residential care will best meet the needs of some of them. There appears to be insufficient residential care to meet that demand.

The research found, in May to July 2005, some 330 residents occupying a notional 420 places, (based on the number of bedrooms in a house that could accommodate clients). Real capacity is limited by the need to keep resident numbers low (at times as low as one resident) and to match, as far as possible, clients who will live together for compatibility, and with staff who can competently and safely care for them.

Nearly all NSW people interviewed believed there were insufficient residential care placements available in many parts of the state. A heavy reliance on fee-for-service, and in some cases, for-profit, providers, has alleviated the shortfall to some extent, but as stated elsewhere this approach has inherent problems. The rise of FFS system has seen an increase in residential care places, which reinforces the view that closures of residential beds in the past may have gone too far.

It is difficult to determine how many more funded residential care places are needed. It is impossible to systemically assess every child or young person in care to determine whether residential care is the best placement option for them, although every individual case conference or review meeting may well be attempting to do that. It is predictable that whatever number of places are added to capacity in the short term, they would quickly be filled.

One can predict:

- Some children and young people in care will have high and complex needs that cannot be managed in foster care, even with a high level of support provided to carers
- Some children and young people will have specific needs and very complex issues to address that will require a therapeutic intervention, and for whom a residential care placement will be the best environment to support that intervention
- Some children and young people in care are aged 14 years or over and will soon need targeted programs, to support their transition to independence
- Some successful foster care placements of younger children will be stressed and may break down when the child reaches adolescence
- Some Aboriginal children and young people cannot be placed in Aboriginal foster care families and residential care, managed by Aboriginal agencies, may be a suitable alternative for some
- Some large sibling groups will not be able to be placed in foster families.

Further planning and consultation is needed at a regional level to determine the models, targets and locations of additional services, however additional capacity appears to be needed in most regions. Demand may be higher in parts of NSW with: high population growth; high internal migration; low socio-economic status; high child protection intervention; with low access to child care, family support or other community services.

6.3 Target groups – age range

The policy requirement for only children 12 years of age and over to be placed in residential care does not reflect practice in almost half the agencies providing residential care.

The research showed that although policy preference is for residential care to only be used for children aged 12 years and over, (and young people), there are many agencies that see a need for placement and who do place younger children in residential care in certain circumstances, dictated by the needs of the child.

As DoCS funds and approves these placements, it presumably sees a need for residential care for some young children. The Children's Guardian appears to have recognised the need for some flexibility in the case of two agencies, which have as

a condition of accreditation that children under 12 may be placed in residential care if they have special needs.

Use of residential care for children under 12 appears to be mainly due to the increased complexity of presenting behaviours and characteristics in younger children and the inability of the foster care system to care for these clients at present.

The preference for only older young people to be placed in residential care is based on a concern that children should not be cared for by high numbers of staff working shifts, because of potential for attachment issues. Family-based placement, such as foster care, is preferable to residential care because it is understood to be more normalising and less intrusive in the life of the child.

These concerns are exacerbated by the reduction in availability of family group homes, which have some family/home like features.

The legitimate concerns with lowering the minimum age for children to be allowed in residential care placements are acknowledged. Enhancement of the foster care system to enable highly supported foster care placements is required.

However, it appears to be unreasonable to deny a residential placement to a child solely on a set age basis, when to do so may mean a further period of unstable, unsuitable or unsafe foster care or relative placement until the minimum age dictated by policy is reached. A clear framework is required for determining whether a residential placement is the most appropriate option.

6.4 Target groups – Aboriginal children and young people

There is no Aboriginal managed residential care offered specifically or solely for Aboriginal children and young people in NSW.

NSW data, published in the Productivity Commission's report on government services in 2005, showed 46 indigenous children and young people were placed in residential care at 30 June 2004[22]. As there was no indigenous-managed residential care services operating at that time, all those children and young people can be assumed to be placed in non-indigenous agencies.

Aboriginal agencies interviewed, funded by DoCS to provide foster care and some other family support or early intervention services, all supported the development of Aboriginal managed residential care services. A family group home model was strongly preferred. They identified children and young people with high and complex needs and adolescents approaching leaving care age as being particularly in need of residential care as an option. In most cases they supported residential care for some children under 12 years of age, especially large sibling

[22] Productivity Commission (2005) Report on Government Services 2005. Supporting tables !5A.12.

groups. Some interviewees acknowledged that while some Aboriginal people may not be able to undertake foster care in their own homes, they could work in residential care services.

During this research a number of non-Aboriginal agencies advised that they included Aboriginal children in their target group and/or had numbers of Aboriginal residents in their programs. One had developed an Aboriginal specific program employing Aboriginal staff and others planned to develop Aboriginal specific services. No information is available on the extent to which mainstream programs employ Aboriginal staff or on the nature of their programs in terms of cultural sensitivity or appropriateness, although we acknowledge that the OOHC Standards do address this area.

There is a need for non-Aboriginal agencies that currently provide residential care for Aboriginal children and young people to develop and maintain formal partnerships or links with Aboriginal OOHC services in their area. These partnerships/links could be used to enhance the development and provision of culturally appropriate services in non-Aboriginal agencies, until such time as sufficient Aboriginal managed residential care services are provided.

6.5 Individual placements

Individual residential placements are used in NSW to a far greater extent than any other Australian jurisdiction. Yet it is unlikely that NSW children and young people have much more difficult behaviours or more complex needs than those in other places. Such arrangements are thought by nearly all participants in this research to be problematic for most current residents.

Individual residential placements appear to be used on a regular basis, sometimes for extended periods and without clear programs designed to address the issues leading to individual placement of residents. Our research found approximately 108 residents placed alone, most of these intentionally. It is the only type of placement offered by a number of agencies.

Most people consulted in this research believed that individual residential placement, while it may be necessary in a very small number of cases, has many negative features. Concern was expressed about the isolation of the resident from peers, the high degree of invasiveness of privacy and lack of normalcy and potential for problematic relationships between residents and staff. Some people thought there should be no individual residential placements.

A number of factors have been impacting to reduce the number of individual placements in recent times:

- DoCS imperatives to rein in fee-for-service expenditure especially on individual placements

- funding of some increased program-funded capacity for the very high and complex needs clients, using models of small congregate residential and intensive foster care and
- appointment of intensive support placement coordinators and intensive support caseworkers, who are reviewing all high needs clients and high costs placements and aiming to find more appropriate, affordable services.

Further work in this direction may see time limited individual placements reduced to only those considered necessary and appropriate.

6.6 Programming

Very few residential care services can be characterised as therapeutic. However there is a strong view that more therapeutic residential care is needed.

Whilst the exact meaning of 'therapeutic' is debatable, it is not questioned that some children and young people have suffered and continue to suffer considerable trauma due to their abuse, neglect or abandonment, their grief and loss on entry to care, and sometimes from their experiences in care. While all children and young people in care need support, some need a more coherent therapeutic intervention that aims to address their needs.

While a clinical program of intervention deriving from a medical/illness model was not widely supported by interviewees, a therapeutic approach was seen to require more than care and support. Involvement of clinical psychologists or experienced social workers was an important aspect of a number of services, with a small number of programs employing such professional staff to develop and monitor individualised and group programs for residents.

There needs to be more discussion about what form therapeutic programs should take in NSW, acknowledging that residential treatment models used in other countries may not be appropriate in the NSW context.

During this research, some support was indicated for secure care, for very small numbers of clients in very specific circumstances. In the context of developing therapeutic residential care, the need for and arrangements regarding entry to and exit from secure care may also need to be considered.

6.7 Case management

In the majority of agencies providing residential care DoCS retained formal case management responsibility, which at a minimum meant in practice that DoCS was responsible for high level planning and decision making such as preparing care plans to the Children's Court and developing annual plans.

There were many casework and some case management tasks where agencies reported they were working in partnership with DoCS, or where the agency had lead responsibility, whether intentionally or by default, as DoCS had not acted.

Some agencies reported concern about the lack of clarity over the roles and responsibilities of the agency or the Department. In some cases agencies undertook case management roles without being provided with funding for that work.

The current work of DoCS in developing a case management policy is acknowledged and supported. This research lends additional weight to the recognised need for that work to be finalised, through the OOHC partners Reference Group process, and for the policy to be circulated widely to both agencies and DoCS staff.

6.8 Residential assessment services

Strong support was expressed for improved assessment to inform placement decision making and promote better access to support services to meet individual clients' needs. Mixed views were expressed on whether specialist assessment with a residential component was desirable. Although almost two thirds of interviewees favoured residential assessment units, this support was qualified by the view that assessment placements should be time limited and that a lack of capacity in other parts of the service system may mean clients could not be moved in a timely way to long term placements.

Other concerns were expressed about whether an assessment in one setting would be relevant to the context of the child or young person in their on-going placement. It is arguable that assessment in-situ may be preferable and more accurate. It would also reduce the need for a placement change after an assessment phase concludes.

The need for sufficient information to be gathered to inform the initial placement decision, in order to make it as safe and appropriate as possible, is acknowledged. It may be necessary to separate the need for intake or crisis placements from assessment processes. The latter may need to occur over a longer time frame and not be crisis driven. Where little or no information is known about a client, a highly supported residential placement may be preferable to a potentially less supported foster care placement.

Further work is needed to determine the feasibility and appropriateness of specialist assessment services with residential components. At this stage, and until more capacity in all types of placements are available, there appears to be potential for any residential assessment units to quickly become blocked and for this to have a negative impact on the residents who cannot be moved on to more suitable placements.

6.9 Funding & costing

The research highlighted the difference between the funding provided for recurrently program-funded residential care services and funding provided to contractors working on a fee-for-service basis.

Program funding appears to be inadequate. Although data was not collected on funding levels or pricing, agencies wholly or totally reliant on program funding for their residential care service had to contribute substantial amounts to operating costs on a regular basis. Some program funding is historically based, and has tended to decline as a proportion of full costs over time. Some program funding arose from contracting out in the 1990s or due to renegotiations of specifications for particular services – in only one case did a program funded agency regard the funding as sufficient to cover the full cost of operating the service.

Fee-for-service agencies tended to be more likely to be funded for 100% of the operating costs, and some owners admitted the agency made a profit. However use of fee-for-service arrangements is inherently insecure for agencies and residents and it poses financial predictability and accountability challenges for DoCS.

It is recognised that DoCS is moving in the direction of reducing reliance on fee-for-service contracts, out of financial necessity and in order to bring the system under some rational budgetary control, as well as to better address the needs of residents.

This research highlights the problem of the lack of a properly costed rational basis to the funding of residential care. We acknowledge the current work being undertaken by DoCS, peak organisations and a sample of agencies to develop a *Costing Manual* and to provide information to agencies on costing principles and methods applicable to OOHC, as well as to other funded services. This process commenced in late 2004 and will result in a series of workshops, planned for early 2006, to inform OOHC and Early Intervention agencies of the progress to date and to provide tools which agencies may use to better determine the cost of services. Some data has been collected through the costing manual process about the estimated costs of residential care in a small sample of OOHC agencies. As the draft manual is not yet finalised, it is not appropriate to indicate those costings in this report. They may provide some useful information and should be considered in the context of action arising from this report.

The research showed that aftercare services, provided by more than half the residential care agencies, were generally not included in program funding, as that funding is usually limited to placement services. Some fee-for-service contracts did explicitly include an aftercare component. It is true that DoCS separately funds specialist leaving care and aftercare services and these services are a valuable part of the service system. However they are not accessible to or used by the vast majority of clients who leave care, due to their limited funding and their geographic location (in some cases). Agencies are expected under the OOHC Standards to offer aftercare services, therefore funding should include an aftercare component. As the research showed at times some aftercare support involved moderate to high

levels of casework for small numbers of former residents. Low level support was sought by some clients for a number of years.

Although not a major element of service provision in all cases, a number of residential care providers do offer and provide support to families following restoration. At times, this is jointly provided with DoCS. As with aftercare services, such work beyond placement is unlikely to be funded however it is arguable that some funding should be provided, until such time as families function independently or are linked with accessible and appropriate family support services.

6.10 Capital program for residential care

There is no purpose built residential care accommodation in NSW and no capital program for purchasing, building or renovating properties for residential care purposes.

In NSW there is heavy reliance on private rental properties in which residential care services are provided. A few agencies have accessed public rental or community-housing rental properties. While some properties are owned by agencies, none of these are purpose-built for out-of-home care. A few buildings were originally used for purposes such as boarding schools, hospitals and convents, so they still have an institutional feel despite alterations to smaller configurations of residential units. Modifications have been made to some public rental and owned properties to add self-contained staff accommodation and to ensure compliance with licensing requirements and safety standards. While necessary these changes are not enough.

There are many issues surrounding the properties: a suburban family home may not be an appropriate design for residential care; there may be inherent safety and security problems, such as poor line of sight for supervision and fixtures that could be a hanging point; property damage costs may be high if walls and doors are not strongly constructed; neighbours may be concerned about the nature of the service and its clientele; location may not be suitable for the purpose and access to educational and community facilities may be limited. Rental properties may be subject to the vagaries of market forces and leases may be vulnerable to termination. Rent may add significantly to the cost of services in some metropolitan areas and rural towns.

On the positive side rental properties can be accessed quickly and new premises can be established in response to referrals. If being used for a small number of residents, they do not require the submission of development applications to local councils.

Contrast this situation with Victoria's Department of Human Services (DHS) capital redevelopment project. That project aims to purchase and upgrade or knock down and rebuild all existing residential care properties to purpose-built design specifications. The program requires adherence to detailed specifications about location and site planning, and involves neighbour consultation and a public communication strategy explaining the program. We recognise that in Victoria the

DHS has responsibility for housing as well as community services, whereas in NSW these separation of Departments, may impact on the management of any capital program.

6.11 Staffing

Family group homes have virtually disappeared in NSW and most services have rostered staff working on a shift basis, yet some people see merit in the group home style of accommodation and staffing. Family group homes were thought to be particularly useful for younger children requiring residential care and sibling groups who do not have additional high or complex needs.

Rostered staff models appear to be accepted as the most appropriate model of staffing when the residents have high and complex needs.

In NSW there was wide variation in the expectations of agencies regarding minimum qualification and experience levels of residential care staff. Although traditionally residential care has been thought of as a somewhat poor relative to foster care programs, because of shift work and the demanding nature of working with high needs clients, the research found there were many highly qualified people managing residential services and both qualified and experienced staff providing direct care. This trend was hampered in some agencies by the need to engage casual direct care staff because of the insecure nature of contract funding.

All agencies interviewed provided their residential care staff with supervision and support in the event of emergencies, and the vast majority were provided training and staff development opportunities. One shortcoming identified in NSW was the lack of training courses specific to residential care and offered at a sufficiently advanced level for experienced staff. In Victoria the peak organisation, the Centre for Excellence, with strong sector involvement and support, has developed a comprehensive training strategy for residential care at a nationally recognised qualification level. Implementation of that strategy is underway.

6.12 Evaluation of and research into residential care

Despite support being expressed for it, this research found limited evidence of independent systematic evaluation of residential care programs and services in NSW or other jurisdictions. This appeared to be due to a lack of time and funding to support such work.

There also appeared to be little current research in an Australian context of models, effectiveness or outcomes of residential care. Although existing research needed to be reviewed for its relevance, there was strong support for additional research on a wide range of topics.

ACWA has a commitment to promoting the conduct and dissemination of research in OOHC through its Research Forum. This report will be disseminated to forum

members. We note that DoCS also promotes a broad research agenda, through internal and commissioned research projects. Despite its current small scale in the OOHC system, residential care should be included in the DoCS research agenda.

7 Conclusion

Residential care in NSW has drifted for a number of years without a coherent approach and without a clear or acknowledged place in the OOHC system. Yet it continues to be necessary and appears to be well used. In fact use of residential care appears to be increasing in line with changes to the nature of the needs and characteristics of children and young people requiring out of home placement. DoCS' intention to build capacity in OOHC provides an ideal opportunity for revisiting residential care and developing a coherent plan. This research report will contribute significantly to the development of that plan.

A rejuvenated residential care system, that demonstrates a commitment to quality programs would be characterised by:

- Qualified staff with particular interpersonal qualities, training and competencies suited to residential care
- Low total numbers of staff or group home 'parents' who have sufficient time and skills to engage positively and build relationships with residents characterised by trust and hope
- Programs that provide structure and consistency, allow for individual free time and community engagement, promote self-development, independence and responsibility, and build in or access specialist and therapeutic services when needed.
- Clear entry, placement and exiting processes, which give the agency sufficient information and control to allow for assessment of the agency's capacity to meet clients' needs
- Clear arrangements for the division of case management and casework responsibilities
- Generally, a small number of residents per household
- Sufficient numbers of different types of residential care places in each DoCS region, including some specialist and therapeutic models
- Recurrently and adequately funded services, in which a component of aftercare support and family support following restoration is included.

Appendix 1 Residential Care agency profiles

Agency	**Allambi Youth Services Inc**								
Accreditation status at August 2005	Designated agency								
Target Group	M&F; High & complex needs clients; Open to any age. OCG lower age limit not appropriate as some eight year olds may be in need of residential care because of high & complex needs. Restoration focus for younger clients. Siblings have been placed in service.								
Exclusions	No stated exclusions - but extreme care is needed in matching and compatibility of clients and staff/carers								
Philosophy	Agency as a whole: Offer a holistic range of accommodation & support programs aimed at uniting children and young people with their families and communities. One-on-one res care program: Get them in and then home as soon as possible.								
Model or theoretical approaches	Range of behaviour management programs (advised by Equalis). Will be employing a psychologist soon. Strengths based model.								
Any specific therapeutic approach	None stated								
Intended outcome	Return to community - family home or independent living; Increase in community connections - sport, school, social networks								
Name of program or property	No 1-14	**Suburb/ town**	Charlest'n Toronto Cardiff Redhead	**DoCS region**	Hunter /CC	**Capacity**	1, tot 14	**No resi-dents**	1, tot 14
DoCS regions referring	Hunter only (Lake Macquarie / Newcastle preference)								
Status of properties	All private rental. Paying rent on some vacant properties.								
Utilisation	Current residences fully utilised, but can open more houses in response to referrals. Up till 6 months ago was operating at full capacity, then received fewer referrals. In transition to program funding which will increase capacity.								
Average placement	8 months			**Longest placement**		11 months			
Nature of program	Stand alone OOHC individual placements								
Percentage of statutory clients	50%								
Funding	Fee for service & unfunded, agency contribution 1%								
Aftercare	Unfunded, 5 active clients + former residents invited on snow trip each year.								
Notable features	2 to 3 Shifts plus sleepover, depending on complexity of client's needs; contracted psychologist develops individual behaviour management plans. Thorough recruitment & orientation process for new staff, with shadow shifts & mentoring.								

Service development	In negotiation with DoCS for recurrently funded high/complex needs placements, comprising 1, 2 and 3 place residences and generalist & intensive foster care. Would also like to develop services for young parents (mothers) requiring res care with support; young people with Mental health problems; young people with disability where they don't fit the DADHC criteria; Early intervention support for 8-14 year olds. Would focus on local area: Lake Macquarie LGA.
Contact	Peter Walsh, CEO & Simon Walsh, case manager tel (02) 4944 5900 email: peterw@allambi.org

Agency	**Anglicare Child & Family Services (part of Sydney Anglican Home Mission Society Council, Anglicare Diocese of Sydney**								
Accreditation status at August 2005	Designated agency, accredited 5 years to 1 April 2010								
Target Group	M & F; 12-18 years; parental responsibility to the Minister; High & complex needs including challenging behaviours, mental health issues. Siblings have been placed in service.								
Exclusions	Serious drug & alcohol issues; moderate to severe intellectual disabilities; serious sexual offending behaviours								
Philosophy	Provide stable, consistent care & accommodation, with a view to improving kids' self esteem; teach kids they are lovable and loved; build a stable foundation to take with them in life. Teach life skills and prepare for future placements and independent living. To ensure that young people have access to appropriate therapeutic and community services. To assist and support the young people to develop a social and community network that will assist and support them after leaving Paul Street' s care.								
Model or theoretical approaches	Strength based, solution focused basis & building resilience; strong focus on education, although different for different kids								
Any specific therapeutic approach	Therapeutic crisis intervention for crisis and behaviour management								
Intended outcome	The program aims to prepare young people for a future family placement (either with a foster family or restoration to a birth family setting) or independent living. Young people participate in full time education and/or work place training, life skills training, social and recreational training and therapeutic interventions as set out in their individual case plans. Staff use each crisis situation with young people as an opportunity to teach them better coping skills and therefore modify their maladaptive behaviours.								
Name of program or property	Paul Street Adol-escent Program	**Suburb / town**	Blacktown	**DoCS region**	Metro West	**Capacity**	6	**No residents**	4
DoCS regions referring	Mostly Metro West, but referral accepted from all regions.								
Status of property	Owned by agency								
Utilisation	Fully utilised, 90% or more for 5 places. One placement reserved for crisis - 2-3 crisis placements per year lasting 3-4 months, so there are some times when the crisis place is not filled.								
Average placement	2 years			**Longest placement**			8 years		
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	OOHC program funding, agency contribution 20%								

Aftercare	Unfunded. All kids who have lived in the residence since 2000 (when reconfigured) maintain some contact 15-20 kids, with 5 getting a reasonable level of casework services.
Notable features	Staff undertake 5 shifts/fn, 2pm – 10am, including sleepover, 2 staff all times, rarely stand up shift. 24 hours shifts at weekends including sleepover. For students excluded from school, formal distance education program provided by agency off-site, staffed by education support worker & teacher's aide 4 days/week. Caseworker in agency's Child & Family team. Life skills assessment tool applied on entry and exit and used to guide goal setting & review progress monthly. Program was externally evaluated 2002/03.
Service development	Have two houses potentially available for OOHC use in Metro West. Seeking to develop therapeutic / treatment program for very high needs children & young people, a transition to independence (semi-supported) program, assessment aspect to service and another similar program to the current one. Willing to consider expansion anywhere in Sydney Metro area.
Contact	Linda Griffiths, Residential Coordinator, tel: 02 9890 6800, email: lgriffiths@anglicare.org.au

Agency	**Anglicare Youth & Family Services (St Saviours Neighbourhood Centre)**								
Accreditation status at August 2005	Designated agency								
Target Group	M&F; Extremely high & complex needs - due to mental health issues and/or behaviour; large sibling groups; not aged under 12-14 generally. Services developed in response to needs - negotiable if DoCS provides resources. Siblings have been placed in service.								
Exclusions	No expertise for high levels of physical disabilities								
Philosophy	Respond to the needs of the community through provision of quality services. Assessment of individual needs - individual programs developed around behaviour, rules, strategies - clinical involvement in planning								
Model or theoretical approaches	High level of review & monitoring; high level of training provided to staff								
Any specific therapeutic approach	Using specialist clinical psychologist consultancy services (Equalis) to plan programs and train staff. They also provide clinical supervision.								
Intended outcome	Achieving the original goal - will vary - safe & secure accommodation while issues are addressed - then restore home or move to other placement or independence								
Name of program or property	No 1	**Suburb / town**	Orange	**DoCS region**	Western	**Capacity**	1	**No. of residents**	1
Name of program or property	No 2	**Suburb / town**	Orange	**DoCS region**	Western	**Capacity**	1	**No. of residents**	1
Name of program or property	No 3	**Suburb / town**	Wagga Wagga	**DoCS region**	Western	**Capacity**	1	**No. of residents**	1
Name of program or property	No 4	**Suburb/ town**	Nowra	**DoCS region**	Southern	**Capacity**	2	**No. of residents**	2
Name of program or property	No 5	**Suburb/ town**	Moruya	**DoCS region**	Southern	**Capacity**	5	**No. of residents**	5
DoCS region referring	Southern & Western Regions								
Status of properties	All private rental								
Utilisation	Fully utilised, 90% or more.								
Average placement	12 months			**Longest placement**		3 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								

Funding	Fee for service & unfunded, agency contribution 1%
Aftercare	DoCS funds some aftercare if restoration support is part of the ICA. Most aftercare is unfunded. 20 active clients
Notable features	8 hours shifts, plus sleepover, 1 – 2 staff on duty depending on number of residents; Caseworker on staff, contracted psychologist services assist in program development, review & supervision & training of staff.
Service development	Agency has responded to referrals by establishing placements. Seeking to expand in Nowra area particularly; would like recurrent funding for very specific services. Need to avoid ad-hoc responses, due to loss of expertise when contracts end.
Contact	Tracey Mayo, Director ACT Youth, Orange & South Coast tel: 0438 288 930 email: tracymayo.anglicare@bigpond.com.au

Agency	**Bankstown Handicapped Children's Centre Association Inc. (The Centre)**								
Accreditation status at August 2005	Designated agency								
Target Group	M&F; Very high & complex needs, often with learning disabilities and/or conduct disorder and/or personality disorder. Many have past criminal behaviour and Juvenile Justice involvement. Siblings have been placed in service.								
Exclusions	None								
Philosophy	To provide high quality, individualised services that make a real difference to the lives, independence and social integration of children and young people regardless of background, and to provide support to their families and carers. Unconditional service provision - will not walk away. Maximise ability to move to least restrictive environment, independence or restoration. Independence through tailored support.								
Model or theoretical approaches	Individualised approach. Multi-disciplinary and multi-elemental approach. Try to provide consistency in staffing & as much family type activities as child/ young person would have if not in care. Participation, mutual respect & responsibility are emphasised.								
Any specific therapeutic approach	none stated								
Intended outcome	reaching goals; maximum potential & maximum level of independence possible; for some staying alive is a good outcome								
Name of program or property	No 1	**Suburb/ town**	Bankstown	**DoCS region**	Metro SW	**Capacity**	2-3	**No. of residents**	1
Name of program or property	No 2	**Suburb/ town**	Bankstown	**DoCS region**	Metro SW	**Capacity**	2-3	**No. of residents**	1
Name of program or property	No 3	**Suburb/ town**	Bankstown	**DoCS region**	Metro SW	**Capacity**	2-3	**No. of residents**	1
Name of program or property	No 4	**Suburb/ town**	Bankstown	**DoCS region**	Metro SW	**Capacity**	2-3	**No. of residents**	1
Name of program or property	No 5	**Suburb/ town**	Campbelltown	**DoCS region**	Metro SW	**Capacity**	2-3	**No. of residents**	3
Name of program or property	No 6	**Suburb/ town**	Blacktown/Mt Druitt	**DoCS region**	Metro West	**Capacity**	2-3	**No. of residents**	2
Name of program or property	No 7	**Suburb/ town**	Blacktown/Mt Druitt	**DoCS region**	Metro West	**Capacity**	2-3	**No. of residents**	2
Name of program or property	No 8	**Suburb/ town**	Blacktown/Mt Druitt	**DoCS region**	Metro West	**Capacity**	2-3	**No. of residents**	2
DoCS region referring	Metro West and Metro South West. Work closely with high needs support panel in Campbelltown re South West referrals. Metro ISS team is negotiating about ISS placements.								
Status of properties	All private rental								

Utilisation	50-70% utilisation, due to consideration of residents' needs & compatibility.		
Average placement	2 years	**Longest placement**	7 years
Nature of program	All stand alone OOHC residence		
Percentage of statutory clients	100%		
Funding	Fee for service, DoCS covers full cost.		
Aftercare	Unfunded, no active clients.		
Notable features	Individualised programs - therapeutic & skill development. Five distinct models (which make up the ASPIRE Program) - depending on needs. Ability Plus model specifically supports young people to transition to their own accommodation. Most clients have intellectual disabilities & are enrolled in special schools. Up to 10 hours shifts, sleepover or awake shifts depends on client's needs. Caseworker (38 hours/week) and psychologist (30 hours/week) employed - audit tools (LAC Project pro forma) used to review progress at regular intervals. Various independent & external reviews have been completed with no adverse findings & agency has addressed any relevant concerns that were raised. Some past allegations, reported in the media, were found to be without foundation.		
Service development	Willing to offer services in all Sydney metropolitan area. In negotiation with DoCS for up to 150 recurrently funded high & complex needs placements.		
Contact	Philip Petrie, Deputy CEO tel: (02) 9708 3677, email: philip@bhcca.org.au or Cheryl Moore, CEO tel: (02) 9708 0755, email: cheryl@bhcca.org.au		

Agency	**Baptist Community Services NSW & ACT**								
Accreditation status at August 2005	Designated agency								
Target Group	12 -16 yrs; m/f; unable to live at home full-time due to family conflict; living on Central Coast; must be in education/ training								
Exclusions	Young people unable to live safely in group environment eg repeated violent assaults								
Philosophy	Both young people and their families are the client because all family members need to take responsibility for issue								
Model or theoretical approaches	Systematic approach; strengths based								
Any specific therapeutic approach	Family therapy; solution focused interventions								
Intended outcome	Learn new ways of relating as a family; young people learn living skills; work through issues with support								
Name of program or property	Pathways	**Suburb/ town**	Wyong	**DoCS region**	Hunter Central Coast	**Capacity**	6	**No. of residents**	6
DoCS region referring	Hunter Central Coast								
Status of properties	Owned by agency								
Utilisation	Fully utilised, 90% or more.								
Average placement	11.2 months			**Longest placement**	2.5 years				
Nature of program	Stand alone OOHC								
Percentage of statutory clients	50%								
Funding	OOHC program funding. BCS provides and maintains the building, and makes a cash contribution in excess of $35,000 pa.								
Aftercare	Unfunded, 3 active clients								
Notable features	5 day/ week program due to limited funding – residents return to family at weekends; families attend fortnightly counselling; 8 hours shifts 2 staff on duty day/evening, 1 on sleepover. Psychologist part-time 7 hours/week.								
Service development	7 days operation to be funded, then replicate more residences, and provide complimentary services.								
Contact	Samantha Gribble, Youth Services Manager tel (02) 4351 2736 or 0409 079 525 email: sgribble@bcs.org.au								

Agency	**Barnardos Australia**								
Accreditation status at August 2005	Designated agency, accredited 5 years, expires 5 March 2009								
Target Group	Young people from CALD preferably from South-East Asia; M & F; 12-18 years. Siblings have been placed in service.								
Exclusions	Not psychotic; not excessively violent; not intellectually disabled; not hard drug addicted								
Philosophy	Unconditional care; never give up; to provide secure (safe) accommodation with therapeutic approach to care								
Model or theoretical approaches	none stated								
Any specific therapeutic approach	none stated								
Intended outcome	1 keep them alive; 2 change any self harming behaviour; 3 engage in education or employment; 4 enhance contact with family; 5 secure income/ obtain documentation; 6 shelter/place to go to next (Maslow's Hierarchy).								
Name of program or property	Kingston House	**Suburb town**	Camper-down	**DoCS region**	Metro Central	**Capacity**	6	**No. of residents**	5
DoCS region referring	Any DoCS region								
Status of properties	Public rental								
Utilisation	4 funded places fully utilised, 2 fee-for-service places - not used to date. Rarely go to 6 places, due to consideration of current residents' needs & compatibility.								
Average placement	12-24 months			**Longest placement**		2.5 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	30% in last 12 months								
Funding	OOHC program, agency contribution 25%								
Aftercare	Unfunded, 3-4 clients / month. In preparation for independence - staff may engage with another agency to transfer knowledge of the resident to support transition & may visit new program in early stages.								
Notable features	Culturally diverse residents and staff (originally Indo-Chinese focussed, now extended). Very stable, experienced & highly qualified staff a key to success. Staff undertake 24 hour shifts, including sleepover.								
Service development	No plans for additional residential care.								
Contact	Bill Hoyles, Senior Manager Youth Services & After Care tel (02) 9281 7933 email: bhoyles@barnardos.org.au								

Agency	**Boys Town Engadine**								
Accreditation status at August 2005	Designated Agency								
Target Group	Adolescent boys - Yrs 7-10 - 12 - 14 years 9 months on entry; who need family restoration or restoration to foster care; needs to be a home to go to at weekends - family home or foster care. Voluntary involvement in program - so 100% clients are voluntary, but a few (3 of 20) have orders (parental responsibility to Minister). For a number DoCS is involved in referral & placement.								
Exclusions	Moderate to severe intellectual delay; serious psychiatric illness; dependent on drugs & unable to be drug free while in program.								
Philosophy	Salesian philosophy: being present with the young person, walking alongside & relating to the young person. Working in partnership with families and carers.								
Model or theoretical approaches	Wrap-around model - young person at the core. Program built around their needs.								
Any specific therapeutic approach	Solution-focused brief therapy; Dialectical behaviour therapy - trying to get young people to understand & be aware of their feelings & that feelings won't last forever. Deal with & acknowledge feelings. Reflect on them and their actions in response.								
Intended outcome	Family restoration & have some level of positive functioning in the family & be bale to get into education, TAFE or work.								
Name of program or property	Dunlea	**Suburb/ town**	Engadine	**DoCS region**	Metro Central	**Capacity**	8	**No. of residents**	7
Name of program or property	Power	**Suburb/ town**	Engadine	**DoCS region**	Metro Central	**Capacity**	8	**No. of residents**	8
Name of program or property	Fleming	**Suburb/ town**	Engadine	**DoCS region**	Metro Central	**Capacity**	8	**No. of residents**	5
DoCS region referring	Referrals accepted from Sydney metro area & Illawarra.								
Status of properties	Owned by agency. Three units on one site, but units deliberately operate independently to ensure small group dynamics maintained.								
Utilisation	85%, due to consideration of residents' needs & compatibility.								
Average placement	9 -12 months (a school year)			**Longest placement**		1 year, plus 1 term			
Nature of program	All stand alone OOHC								
Percentage of statutory clients	15%								
Funding	OOHC program funding, agency contribution 30%								
Aftercare	Unfunded 4-5 active clients. Kids can visit staff in office areas (usually time arranged rather than drop in). Not allowed to visit residences as not appropriate. Follow up support of 1-2 kids per unit for 1 term after leaving.								

Notable features	One of few restoration programs. Accredited Special school on site – three separate 8 student education units. Consistent 5 person staff team for each education and residential unit. Program runs Monday morning to Friday middle of day. Boys into creative arts and maintaining produce gardens in their units. Structured approach to evaluation: Achenbach scales, Family Coping Scale, applied at entry & when leaving program; plus survey of residents, families & staff re what works in the program on exit. Started a longitudinal study of residents from 2001 on, results now in, indicating 80% of clients from that time are re-engaged positively in the community.
Service development	Accommodation for weekends when kids are unable to go home; Girls services - would look at satellite programs in other areas. Already offer school holiday programs for girls and boys from local area.
Contact	Bronwyn Towart, Manager, Family & Residential Services tel (02) 9520 8555 email: bronwyn@boystown.net.au

Agency	**Careforce Support Services Pty Ltd**
Accreditation status at August 2005	Designated agency
Target Group	11-17 year olds, M & F, diverse CALD, high to challenging needs, some with mild intellectual disability; therapeutic care environment
Exclusions	No stated exclusions
Philosophy	Agency fosters the belief that children and young people are entitled to • dignity, respect, privacy and confidentiality • be valued as individuals • feel secure and nurtured within a stable environment • the respect and recognition of their cultural and linguistic background • enjoyment of lifestyles free from abuse • access mainstream and specialist services on a non-discriminatory basis • participate in the development and contribution to their future • pursue achievable and positive goals Agency is committed to • the provision of a secure, caring and supportive residential care environment and other identified service models such as professional carers and independent living • meeting the emotional and therapeutic needs of young people • meeting the physical, recreational and spiritual needs of young people in care • assisting in the development of relationships between the children in care, their parents and significant others • the restoration of children to their own families, when in the best interest of the children and to follow up with the family where appropriate or required. • the provision and encouragement to the children and young people to value educational / vocational achievement • to assist the children and young people to develop independence in an environment of positive growth • assisting young people with independent living and self care skills • supporting permanent placement for a child or young person on discharge with after care support as required.
Model or theoretical approaches	Involved in multi-disciplinary approach to care with consultation and collaboration with other professional services
Any specific therapeutic approach	Positive solution-focused brief therapy

Intended outcome	• to provide an environment of therapeutic care to stabilise clients behaviours and reconnect them with family, community, education and employment • support children and young people's physical health and well-being • provision of an exemplary service to the youth in agency care; displaying honesty, respect, integrity, empathy and trust • to support and participate in the provision of access to information to clients from culturally and linguistically diverse backgrounds • to foster cross cultural communication skills and values • to commit to a reputation of open communication, transparency, consultation and collaboration.								
Name of program or property	Croydon Park crisis service	**Suburb/ town**	Croydon Park	**DoCS region**	Metro Central	**Capacity**	3	**No. of residents**	2
Name of program or property	Canterbury	**Suburb/ town**	Canterbury	**DoCS region**	Metro Central	**Capacity**	1	**No. of residents**	1
Name of program or property	Winston Hills	**Suburb/ town**	Winston Hills	**DoCS region**	Metro South West	**Capacity**	2	**No. of residents**	1
DoCS region referring	Mainly metro Central, will accept referral from any region.								
Status of properties	Private rental								
Utilisation	50-60%, due to insufficient referrals meeting criteria. DoCS trying to place elsewhere and using agency as last resort because fee-for-service and perception of high needs costs								
Average placement	12 months			**Longest placement**		4 years			
Nature of program	All stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Fee for service & unfunded, agency contribution 10%								
Aftercare	Not offered								
Notable features	Education background & disability services background of senior staff lead to informed individual programming regarding education needs, health & personal development and behaviour management, with external professional clinical support. Coordinator undertakes casework role. Home school program run for excluded students, maintaining school routine, using thematic approach to learning. High level of resident involvement in community & recreational activities. Karaoke machines in each house are a particular favourite of the residents, boosting self-esteem and providing good fun.								
Service development	Willing to go anywhere to build the service, would like to develop transition to independent living program.								
Contact	Pauline O'Leary, Director or Helen Parkes, Coordinator tel (02) 9744 5867 Email: careforcesupport@iprimus.com.au								

Agency	**Caretakers Cottage Inc.**								
Accreditation status at August 2005	Designated agency								
Target Group	Short term (up to 12 wks) crisis arrangement for young people (12-18yrs) under court orders and deemed 'high need'; kids with behavioural issues that prevent them living in a foster care setting at times and need high level supervision; all referrals from DOCS. Siblings have been placed in service.								
Exclusions	Exclusions relate to existing residents needs and occur when there is significant possibility that new referral would disrupt existing placements. Placement is controlled by a DoCS placement panel in which the agency does not participate. DoCS and Entity addressing this in a protocol.								
Philosophy	All young people are entitled to be cared for and loved.								
Model or theoretical approaches	No specific model used. Model of service developed through the years of accommodation management at Caretakers Cottage documented in the policy and procedure manual, as well as throughout the agency's accreditation documentation.								
Any specific therapeutic approach	none stated								
Intended outcome	To provide a breathing space in a crisis while longer term arrangements for young person are put in place. In practice the agency prepares young people to be able to transition into less intensive living arrangements.								
Name of program or property	Entity	**Suburb/ town**	Hurstville	**DoCS region**	Metro Central	**Capacity**	4	**No. of residents**	4
DoCS region referring	Metro Central only								
Status of property	Private rental								
Utilisation	80% utilisation, due to insufficient referrals meeting criteria' consideration of residents' needs & compatibility and referral procedure of Regional OOHC team.								
Average placement	2 to 3 months			**Longest placement**		12 months			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	OOHC program funding, agency contribution 5%								
Aftercare	Unfunded, 12 active clients								
Notable features	8 hours shifts, plus shorter support shifts, caseworker on staff, psychologist contracted as needed								
Service development	No expansion plans								
Contact	Julie Booler, coordinator tel (02) 9554 5017 email: entity1@ihug.com.au								

Agency	**Caringa Enterprises Inc.**								
Accreditation status at August 2005	Designated agency								
Target Group	13 - 18 yrs; m/f; Intellectual disability (prerequisite for all referrals)								
Exclusions	Evidence of extreme sexually predatory activity								
Philosophy	Positive approach to challenging behaviour; a focus on training rather than support and building self esteem a fundamental issue								
Model or theoretical approaches	Understanding of intellectual disability and need to work towards independence								
Any specific therapeutic approach	Individually focus on needs of each child; Routines and consistency are important to help modify challenging behaviour								
Intended outcome	Behaviour settles; achieve at school; get employment; get friends; have social interaction								
Name of program or property	Powell Street	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	2	**No. of residents**	1
Name of program or property	Villiers Street	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	Queen Street	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	Dobie Street	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
DoCS region referring	Referrals taken from all areas of NSW								
Status of properties	Two owned by agency, two private rental								
Utilisation	Fully utilised, 90% or more.								
Average placement	Long term, no-one has left yet.			**Longest placement**		7 years			
Nature of program	Three stand alone OOHC residences, one co-located with one DADHC client.								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Not offered								

Notable features	6-8 hours shifts, plus sleepover, 1 person on duty. Part-time caseworker, plus contracted clinical psychologist services.
Service development	Willing to develop more services in Yamba/Maclean area.
Contact	Deidre Jones, Team Leader & Janet Master, General Manager tel (02) 6642 6183, email: office@caringa.com.au

Agency	**CASPA (Child & Adolescent Specialist Programs & Accommodation, formerly North Coast Children's Home Inc.)**								
Accreditation status at August 2005	Designated agency								
Target Group	Residential Unit: 12-15 years, M/F, willing to come to program with challenging behaviour including perpetrators of sexual assault, self harm; ISP 10 - 15 years, willing to come to program, very challenging behaviour including self harm								
Exclusions	untreated/unassessed addiction to drugs; currently experiencing psychotic episodes; active participation in criminal behaviour; extreme physical disability								
Philosophy	All young people have the right to freedom from abuse, to experience well-being and have the opportunity to reach their full potential.								
Model or theoretical approaches	Models and theories / theorists who have influenced CASPA approach include systems thinking, understanding of transference issues, Winnecott's attachment theory, and a child (adolescent) focused approach.								
Any specific therapeutic approach	Narrative and brief solution therapy								
Intended outcome	Reduce challenging behaviour that stop the young person from forming positive relationships; Introducing routine that the young person 'owns'; To assist the young person to get an understanding of what the next step will be.								
Name of program or property	Robinson Residential Unit	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	4	**No. of resi-dents**	4
Name of program or property	Intensive Support Project 1	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	2	**No. of resi-dents**	1
Name of program or property	Intensive Support Project 2	**Suburb/ town**	Ocean Shores	**DoCS region**	Northern	**Capacity**	1	**No. of resi-dents**	1
DoCS region referring	Mainly Northern region, although other regions may refer especially if the child/young person have family or siblings in the region								
Status of properties	One owned, two private rental								
Utilisation	Fully utilised, 90% or more. Over capacity at times as one extra bed is available in res care unit for short-term placement, including foster care breakdown.								
Average placement	12 - 18 months (Robinson), 2 - 3 months (ISP)			**Longest placement**		12 months (Robinson), 4 months (ISP)			
Longest placement	12 months (Robinson), 4 months (ISP)								
Nature of program	Stand alone OOHC								
Percentage of statutory clients	90%								
Funding	OOHC program funding & fee for service, agency contribution 15%								
Aftercare	Unfunded, 8 -10 active clients								

Notable features	Learning Support program offered to excluded students involves: distance education with one-on-one support from teacher / youth worker, based on indigenous principles, or individualised activity program designed to meet their learning/developmental needs. These programs are held off the premises to establish a routine of attendance. Students are then transitioned into mainstream education. Transition is often based the school premises. Holiday programs include mural painting, theatre, music, camps, cultural tours. Shift hours vary 8-12 hours, including sleepover, plus shorter support shifts, 1-2 staff on duty, stand up as necessary. Key worker system, plus caseworker, education worker part-time (30 hours/week) and contracted psychologist in support. Agency also has semi-independent living program, with initial live-in then stepped down levels of visiting staff support. At the time of the interview, over one third of clients were indigenous children or young people.
Service development	Would like to offer additional services in Tweed Heads area. Would like to offer more early intervention work in OOHC to reduce breakdown in foster placements and pre foster care placements.
Contact	Lisa Gardiner, General Manager tel: (02) 6621 4556 email: lisag@ceinternet.com.au

Agency	**Centacare Catholic Family Services Diocese of Broken Bay**								
Accreditation status at August 2005	Designated agency								
Target Group	High & Complex needs; male/female; 12-17 yrs								
Exclusions	Severe drug & alcohol issues; acute mental health issues; medical needs requiring nursing ; severe physical disabilities								
Philosophy	Importance of developing personal community support network for young people. Helping kids to feel safe and meeting their basic needs. Raise kids sense of worth and reach their potential.								
Model or theoretical approaches	Ecological framework								
Any specific therapeutic approach	Solution focused								
Intended outcome	DOCS make short term (3 months maximum) placements, but inevitably this will stretch out. Therefore agency aims for young person to experience something more than a bed & breakfast, but to have a positive experience of community involvement.								
Name of program or property	Sherbrook	**Suburb/ town**	Asquith (moved to Epping Sept 05)	**DoCS region**	Metro Central	**Capacity**	4	**No. of residents**	2
DoCS region referring	Metro Central ISS								
Status of property	Private rental								
Utilisation	50%, due to consideration of residents' needs & compatibility.								
Average placement	6 months				**Longest placement**		7 months		
Nature of program	Stand alone OOHC								
Percentage statutory clients	100%								
Funding	OOHC program funding, agency contribution 35%								
Aftercare	Not offered								
Notable features	8 hours shifts, 2 on duty day time, 1 awake shift at night, Contracted psychologist supports staff.								
Service development	Agency has contracted with DoCS for recurrently funded high / complex needs placements, covering assessment services, intensive foster care and residential places.								
Contact	Jean Murray, Manager OOHC Services, tel 02 94853034, email: jmurray@brokenbay.catholic.org.au								

Agency	**Churches of Christ Greenacre: Nick Kearns House**								
Accreditation status at August 2005	Designated agency								
Target Group	12-18 yrs; M & F; Most OOHC clients high needs. Siblings have been placed in service.								
Exclusions	High level drug problems; physical disabilities due to access issues; Mental health issues - if serious or acute - where person is constantly a danger to others								
Philosophy	Mission: Agency exists to provide a safe and supportive place in which young people can be heard and encouraged towards positive living, for self and others. People are valuable, responsible; people can change; people live in the real world. See crisis as an opportunity to work with the young person								
Model or theoretical approaches	Preventative & therapeutic approach; Harm minimisation; focused on resolving crisis; empowering young people								
Any specific therapeutic approach	none stated								
Intended outcome	Stable, home-like accommodation then move on to permanent accommodation elsewhere								
Name of program or property	Nick Kearns House	**Suburb/ town**	Bankstown	**DoCS region**	Metro SW	**Capacity**	2	**No. of residents**	2
DoCS region referring	Referrals from any area								
Status of properties	Council owned, rent free								
Utilisation	Fully utilised, 90% or more								
Average placement	12 months			**Longest placement**		4 years			
Nature of program	Co-located in SAAP service: 2 OOHC places, 6 SAAP places								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost OOHC places								
Aftercare	Unfunded, casual contact with 12 former residents. Staff do follow up visits if they are living independently. Counsellor may be involved. Return for occasional meals.								
Notable features	Although co-located in SAAP funded service, there is little distinction between the clients and their levels of need/complexity. The larger number of residents is believed to be positive for group dynamics; group discussions work well and constructive resident relationships are fostered. Staff work 8-10 hours shifts. Coordinator does stand up shifts if necessary. Use a Virtual Baby - a doll that cries and needs to be cared for 24/7 like a real baby - to educate young women & young men about the realities of parenting. Have a carpentry workshop – residents can make gifts & do repairs								

Service development	Keen to expand to four OOHC places. Would also like a separate OOHC facility for short term placements, to have a medium to long term house and to run transition to independent living program
Contact	Jill Short, coordinator tel (02) 9709 3520, email: jillshort@optusnet.com.au

Agency	**Community Connections North Coast Inc**								
Accreditation status at August 2005	Designated agency								
Target Group	10-16 year olds with a range of issues and various needs.								
Exclusions	Currently psychotic or detoxing								
Philosophy	To make a positive difference to lives of children and young people, to enable them to reach their highest potential, to empower them to make changes								
Model or theoretical approaches	Development milestones & capacity; systems theory; participation; attachment theory; social learning theory								
Any specific therapeutic approach	Solution focused counselling - strengths; narrative work								
Intended outcome	Facilitating a significant change in the life of the child/ young person - can be in health and/or social skills and/or education etc.								
Name of program or property	24/Seven	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
DoCS region referring	Referrals can come from any region however current referrals are coming from DoCS in Lismore and Ballina								
Status of properties	Public rental								
Utilisation	40% utilisation, due to insufficient referrals related to cost of service								
Average placement	3 months			**Longest placement**		4 months			
Nature of program	Co-located with SAAP service, 25 places								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Aftercare can be offered on a needs basis								
Notable features	Agency has a pool of trained Indigenous workers now so can meet more culturally appropriate care. Sibling placements a speciality. Staff work 8 hours shifts, plus sleepover, awake shift if necessary. Part-time psychologist available. The capacity is at any one time: 1 high need client to 1 worker, 1or 2 medium need clients to 1 or 2 workers; 1-3 low need clients with 1 worker. Costs vary accordingly..								
Service development	Agency would like to develop culturally appropriate accommodation for indigenous young people.								
Contact	Michelle Wainwright, Client Services Manager, tel: 66223143								

Agency	**Community Programs Inc. (registered business name Clarence Valley Community Programs)**								
Accreditation status at August 2005	Designated agency								
Target Group	no limits								
Exclusions	none								
Philosophy	Keeping kids located in the environment from which they come. Individually tailored to meet identified need and young persons' articulated aspirations								
Model or theoretical approaches	Eclectic approach								
Any specific therapeutic approach	Solution focused therapy; Have regular programming and activities to bring consistency into young person's life.								
Intended outcome	That they will be able to transition to independent living with a reasonable skill set, eg living skills, and feel connected								
Name of program or property	CP 1	**Suburb/ town**	Ulmarra	**DoCS region**	Northern Region	**Capacity**	2	**No. of residents**	1
DoCS region referring	Northern region: North Coast Area – Far North Coast Network and Mid North Coast Network								
Status of properties	Under mortgage								
Utilisation	50% utilisation, due to consideration of current resident's needs & compatibility.								
Average placement	7 months			**Longest placement**		11 months			
Nature of program	Stand alone OOHC residence								
Percentage of statutory clients	95%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Unfunded, 5 active clients								
Notable features	19 hours shift, including sleepover, not staffed 9.30am – 2.30pm, except weekends, key worker system. Caseworker employed, other services contracted as needed.								
Service development	Agency would expand to offer more in same location. It would ideally be structured with a continuum from one on one rostered 24 hr care to care where the main support worker provided the majority of care with other people working limited shifts.								
Contact	Jane Allen, Executive Officer, tel: 02 6642 7257 email: jallen@communityprograms.org.au								

Agency	**De's Consultancy Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	High needs, M & F, aged 6-15 years; Siblings have been placed in service.								
Exclusions	nil								
Philosophy	none stated								
Model or theoretical approaches	A strength based approach (re both clients and staff) is used								
Any specific therapeutic approach	Solution focused approach								
Intended outcome	An environment for a child / young person to be safe and process their experiences								
Name of program or property	Yamba	**Suburb town**	Yamba	**DoCS region**	Northern	**Capacity**	1	**No. resi-dents**	1
Name of program or property	Tucabia	**Suburb town**	Tucabia	**DoCS region**	Northern	**Capacity**	1	**No. resi-dents**	1
Name of program or property	Tucabia	**Suburb town**	Tucabia	**DoCS region**	Northern	**Capacity**	1	**No. resi dents**	1
Name of program or property	Brooms-head	**Suburb town**	Brooms-head	**DoCS region**	Northern	**Capacity**	1	**No. resi-dents**	1
Name of program or property	Brush-grove	**Suburb town**	Brush-grove	**DoCS region**	Northern	**Capacity**	1	**No. resi-dents**	1
Name of program or property	Grafton	**Suburb town**	Grafton	**DoCS region**	Northern	**Capacity**		**No. resi-dents**	
DoCS region referring	Northern (North Coast, Mid North Coast, New England)								
Status of properties	All private rental								
Utilisation	Fully utilised, 90% or more								
Average placement	18-24 months			**Longest placement**		3.5 years			
Nature of program	Stand alone OOHC residences, individual placements								
Percentage of statutory clients	100%								

Funding	Fee for service, DoCS covers full cost
Aftercare	Not offered
Notable features	8 hours shifts, plus sleepover, 1 person on duty. Caseworker & part-time psychologist (10 hours/week) employed, plus contract psychologist & social worker in support.
Service development	De's Consultancy will be closing on the 18 November 2005, as all of the children are being transitioned to other funded placements. No new DoCS referrals are being made.
Contact	Debbra Wilkinson, Director tel 02 66461382email: debbra@desconsultancy.com.au

Agency	**For the Children Ltd**								
Accreditation status at August 2005	Designated agency								
Target Group	High needs; some less high needs clients as emergency placements; M & F; short – medium term. Agency has accommodated children aged between 8 and 15 years in the past, keeping the age range within three years of each other, unless in a sibling group.								
Exclusions	serious mental health issues, serious mobility disabilities because of sloping site and stairs in the house; sexual offending; current drug & alcohol issues.								
Philosophy	Belief that every child should be afforded the opportunity to grow up in a healthy, safe home environment with appropriate adult roles models.								
Model or theoretical approaches	Staffed group care model; model closely resembles the'Sanctuary Model' by Dr Bloom. (undergoing service/ program evaluation by the Thomas Wright Institute Dr Howard Bath and Dr Diana Boswell)								
Any specific therapeutic approach	Therapeutic program with 14 aspects								
Intended outcome	Equip child with skills to move to more permanent LT care (restoration, kin or foster care) and more affordable for DoCS								
Name of program or property	For the Children	**Suburb/ town**	Kirrawee (now in Sutherland)	**DoCS region**	Metro Central	**Capacity**	6	**No. of residents**	5
DoCS region referring	only Metro West at this time								
Status of properties	Private rental								
Utilisation	0 – 80% utilisation. Service operating for 2 years –in last year have had two periods of 3 months with no residents								
Average placement	6 to 7 months			**Longest placement**		9.5 months			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Fee for service								
Aftercare	Not offered								
Notable features	Agency is a limited company. Directors do not receive dividends or director's fees. One male & one female staff member on each sleepover (where possible). Short shifts – 7 to 10 hours, so up to 11 individuals involved in roster.								
Service development	After a period of this residence operating at full capacity, the agency may set up premises in Metro West as this is source of current referrals.								
Contact	Alison Serena, General Manager, tel: 02 9545-4807 or 0404227928 Email: forthechildren@optus.net								

Agency	**Hunter Support Services Pty. Ltd.**								
Accreditation status at August 2005	Designated Agency								
Target Group	12 - 18 yrs old, high needs, challenging behaviour. Siblings have been placed in service								
Exclusions	Nil								
Philosophy	To empower life's possibilities								
Model or theoretical approaches	Young person is an individual who can make self-determined choices								
Any specific therapeutic approach	Solution focused therapy								
Intended outcome	Competence, accountability, responsiveness, diversity, integration, collaboration								
Name of program or property	HSS 1 - 7	**Suburb/ town**	Port Mac-quarie	**DoCS region**	Northern	**Capacity**	1 x 7 total	**No. of resi-dents**	7 total
Name of program or property	HSS 8	**Suburb/ town**	Picton	**DoCS region**	Southern	**Capacity**	1	**No. of resi-dents**	1
Name of program or property	HSS 9	**Suburb/ town**	Thirlmere	**DoCS region**	Southern	**Capacity**	1	**No. of resi-dents**	1
Name of program or property	HSS 10	**Suburb/ town**	Tahmoor	**DoCS region**	Southern	**Capacity**	1	**No. of resi-dents**	1
Name of program or property	HSS 11	**Suburb/ town**	Tahmoor	**DoCS region**	Southern	**Capacity**	1	**No. of resi-dents**	1
Name of program or property	HSS 12	**Suburb/ town**	Killarney Vale	**DoCS region**	Hunter CC	**Capacity**	1	**No. of resi-dents**	1
Name of program or property	HSS 13	**Suburb/ town**	Quean-beyan	**DoCS region**	Southern	**Capacity**	1	**No. of resi-dents**	1
DoCS region referring	Referrals accepted from any region.								
Status of properties	Two under mortgage, rest private rental								
Utilisation	Under-utilisation of capacity in last 12 months, due to non-referral by DoCS for a period while accreditation status clarified. Increased capacity now available as various matter have been resolved.								
Average placement	6 months			**Longest placement**		12 months			

Nature of program	All stand alone OOHC residences, individual placements
Percentage of statutory clients	100%
Funding	Fee for service, DoCS covers full cost
Aftercare	Funded, 2 active clients
Notable features	Full time caseworker, psychologist and part time education worker (30 hrs/week) on staff. Direct care workers undertake 8 hours shifts, plus sleepover.
Service development	Would expand on same program basis, to offer services in more locations on Eastern seaboard
Contact	David Fleming, Operations Manager tel 1300 887 990 email: david.fleming@huntersupportservices.com.au

Agency	**Impact Youth Services Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	Children and young people (M & F) between 8 and 17 years with challenging behaviours and with mild intellectual and/or physical disabilities								
Exclusions	Severe intellectual or physical disability; Sexual offenders (may take as one-on-one)								
Philosophy	To raise the self-esteem, aspirations and achievements of young people in our care, working in partnership with DoCS, families, the community and the young people								
Model or theoretical approaches	Strength based solutions focused								
Any specific therapeutic approach	None stated								
Intended outcome	Enhanced behaviour, able to manage anger, achieve independence and social skills, self- esteem, self control and coping in the community. Aim is restoration, foster care or independent living								
Name of program or property	Impact 1	**Suburb/ town**	Blacktown	**DoCS region**	Met Wes	**Capacity**	3	**No. of residents**	2
Name of program or property	Impact 2	**Suburb/ town**	Blacktown	**DoCS region**	Met Wes	**Capacity**	3	**No. of residents**	2
Name of program or property	Impact 3	**Suburb/ town**	Woodcroft	**DoCS region**	Met Wes	**Capacity**	3	**No. of residents**	1
Name of program or property	Impact 4	**Suburb/ town**	Oakville	**DoCS region**	Met Wes	**Capacity**	3	**No. of residents**	1
Name of program or property	Impact 5	**Suburb/ town**	Woonona	**DoCS region**	Southern	**Capacity**	2	**No. of residents**	1
DoCS region referring	Referrals from any Sydney metro regions accepted, most referrals from Metro West.								
Status of properties	All private rental								
Utilisation	50% utilisation, due to considerations of residents' needs & staff shortages / recruitment issues. Increased capacity not yet utilised								
Average placement	12 weeks			**Longest placement**		2 years			
Nature of program	All stand alone OOHC								
Percentage of statutory clients	95%								

Funding	Fee for service, DoCS covers full cost.
Aftercare	Unfunded, 0 clients at present. Available in principle, but not been taken up to date.
Notable features	Staff undertake 10 or 24 hours shifts, depending on level of high needs residents. Client / Employee Services Manager undertakes casework role. Contracted psychologist support available. Use various standardised tools and checklists to monitor progress.
Service development	Seeking to expand, in a planned way, number of residences in Sydney city & eastern suburbs. Development of Aboriginal residential and support services to take place in latter part of the year.
Contact	Patrick Gosselin, Managing Director, tel: 0403 070 419, email: Patrick@IYS.net.au

Agency	**Intensive Support Pty Ltd**								
Accreditation status at August 2005	Designated agency at August 2005. (This agency has since withdrawn from accreditation process and is no longer a designated agency. The agency provides other non-placement services.)								
Target Group	High risk adolescents 12 - 14 where placement has broken down. Siblings have been placed in service.								
Exclusions	No stated exclusions								
Philosophy	Whatever identified to assist children, families to achieve goals by reducing risk of problematic behaviour								
Model or theoretical approaches	Attachment theory								
Any specific therapeutic approach	Client focused, solution oriented								
Intended outcome	Reduce problem behaviour and achieve goals								
Name of program or property	Not named, numbers vary	**Suburb/ town**	Various in metro area	**DoCS region**	Metro Central (East)	**Capacity**	5-10	**No. of residents**	5
DoCS region referring	Mainly Metro regions								
Status of properties	Agency has no residences, rather provide staff in motels, at various metropolitan Sydney locations.								
Utilisation	Fully utilised, 90% or more.								
Average placement	3 nights			**Longest placement**		15 months			
Nature of program	OOHC clients only, usually in motels								
Percentage of statutory clients	90%								
Funding	Fee for service, agency contribution 2%								
Aftercare	Not offered. No formal or funded after care responsibility but do support and help any kids who seek to keep in touch.								
Notable features	Unusual model – at DoCS request, agency provides staffing to support placements in motels – no residences of their own. All staff are casual, full-time and undertake 8 – 10 hour shifts.								
Service development	Would like to offer 2 resident placements in rented premises. Can expand capacity easily.								
Contact	Stephen Howald, CEO tel (02) 9144 1447 email: support@intensive.com.au								

Agency	**Links Youth and Disabilities Services Pty Ltd**								
Accreditation status at August 2005	Designated agency								
Target Group	Young people 12 - 17 with high and complex needs and under 12s with the permission of the OCG								
Exclusions	No absolute exclusions - each referral is individually assessed								
Philosophy	To provide holistic quality care and treatment that empowers people to believe in their own ability and make the right life choices, and through providing solid foundations, creative and structure programs and support to help in creating a brighter future to help people who are disadvantaged in society								
Model or theoretical approaches	Holistic programs that focus on treatment, care and the individual to ensure that each client has the right to be involved in the decision making process and to provide and environment that is conducive to their ongoing development								
Any specific therapeutic approach	Their own "Windows" strength based model - a non invasive approach aimed at strengthening the individual and rewarding positives								
Intended outcome	Settlement, structure, predictability, sense of self and community								
Name of program or property	Links 1	**Suburb/ town**	Blacktown	**DoCS region**	Met West	**Capacity**	2	**No. of residents**	2
Name of program or property	Links 2	**Suburb/ town**	Blacktown	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 3	**Suburb/ town**	Blacktown	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 4	**Suburb/ town**	Blacktown	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 5	**Suburb/ town**	St Mary's	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 6	**Suburb/ town**	Stanhope Gardens	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 7	**Suburb/ town**	St Clair	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links 8	**Suburb/ town**	Werrington Downs	**DoCS region**	Met West	**Capacity**	1	**No. of residents**	1
Name of program or property	Links Farm Prgram	**Suburb/ town**	Berrima	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
DoCS region referring	DoCS Metro Sydney all areas, Central Coast - Gosford, Charles Town.								
Status of properties	Four owned by agency, five private rental								

Utilisation	Fully utilised, 90% or more. Over capacity: Had one out-of-area young person, referred by DoCS, but moved after six months to a lower cost placement.		
Average placement	12 months	**Longest placement**	3.5 years
Nature of program	All stand alone OOHC residences, individual placement		
Percentage of statutory clients	100%		
Funding	Fee for service, DoCS covers full cost OOHC places, also DADHC funding 10%		
Aftercare	Not offered		
Notable features	24 hours shifts, including sleepover. 3 caseworkers employed. Contracted psychologist undertakes case reviews. Tutors are brought in and an activity based learning program is designed for each excluded student in consultation with the school.		
Service development	Would need infrastructure resources to build an arc around services with a five year plan to consolidate and grow. In negotiation with DoCS for recurrently funded high & complex needs placements (at time of interview).		
Contact	Katrina Hyland, Senior Manager tel (02) 9897 7485 email: katrina.links@bigpond.com		

Agency	**Lutanda Children's Services**								
Accreditation status at August 2005	Designated agency								
Target Group	8 - 18 years; m/f; attending school								
Exclusions	Very high and complex needs; pregnant								
Philosophy	Installing Christian family values as a base to develop their residents' living strategies and an alternate worldview								
Model or theoretical approaches	None stated								
Any specific therapeutic approach	Individual approach; looking at all the needs and history of the child and then formulating appropriate therapeutic style for that child								
Intended outcome	Children & young people to have strategies to maintain themselves and deal with past issues and current challenges, and have a value base to build on up experience strong model of family								
Name of program or property	Lutanda 1	**Suburb/ town**	Baulkham Hills	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	3
Name of program or property	Lutanda 2	**Suburb/ town**	Glenmore Park	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	4
DoCS region referring	all Sydney Metropolitan regions								
Status of properties	Owned by agency								
Utilisation	Fully utilised, 90% or more								
Average placement	3 – 4 years			**Longest placement**		8 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	90%								
Funding	OOHC program funding (2 places) & fee for service (6 places). Program funded placements: agency contribution about 25%. The fee for service beds 100% funded if full, but subsidised when carrying vacancies (for various reasons) while operating costs remain the same.								
Aftercare	Unfunded, 8-10 active clients								

Notable features	Family group home model of staffing: Married couple with one partner in external employment, plus youth worker who spends 2 afternoons a week at each house; main care is salaried plus various living expenses and direct care costs paid; respite program for children, where they spend one weekend a month with a family from their own social context. Part-time social worker (15 hours/week) undertakes case work.
Service development	Agency willing to replicate same model as Lutanda, including in rural areas.
Contact	Shaunagh Fowler, Social Worker tel 02 9481 9855 or 0411 202 584 Email: sfowler@lutanda.com.au

Agency	**Macleay Kalipso Inc**								
Accreditation status at August 2005	Designated agency								
Target Group	Very high & complex needs; m/f; 8 years and over								
Exclusions	Sex offenders (serious offences on a repeated basis)								
Philosophy	A place for children to grow, learn and be safe. The agency has a long term commitment to the child, so he/she can develop trust. Behaviour is a form of communication.								
Model or theoretical approaches	Attachment theories; Ecological framework; positive approach using least restrictive practice								
Any specific therapeutic approach	Cognitive behaviour therapy								
Intended outcome	To stabilize behaviour and then to be able to reduce intensity of service to sustain a residential care placement within the agency								
Name of program or property	Macleay Kalipso	**Suburb/ town**	Kempsey	**DoCS region**	Nth Region DOCS	**Capacity**	2	**No. of residents**	2
DoCS region referring	only Metro ISS team Parramatta								
Status of properties	Private rental								
Utilisation	Current premise fully utilised, but could take extra referrals & set up new premises. So insufficient referrals meeting criteria.								
Average placement	2.5 years			**Longest placement**		4 years			
Nature of program	Stand alone OOHC residence								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Not offered at this stage								
Notable features	1:1 staff where required / indicated, 7 hour day shifts; 12 hour sleepover shifts; contracted clinical team available for consultation & on-call.								
Service development	Willing to establish more residences in Kempsey								
Contact	Col Williams, Assistant Manager tel: (02) 6563 1411 email: kalipso@bigpond.net.au								

Agency	**Marist Youth Care Ltd**								
Accreditation status at August 2005	Designated agency								
Target Group	Catalyst program (incorporating the St. Vincent's Adolescent Care Unit including Minahan Independent Living Skills program, SAAP services and The Hebersham Aboriginal Youth Service) Young people with moderate to high support needs who are homeless or likely to become homeless; problems in relationships with family; where possible focused on family restoration, or transition to semi-independent or independent living. Age range: St Vincent's 12-16, Minahan 16-19, SAAP 15-18/21 for the female SAAP unit, HAYS 15-20. Siblings have been placed in service. Compass program (incorporating ISS contracted & FFS): High and complex needs clients; referred though DoCS Intensive Support team at Parramatta. First see if referral meets high/complex needs target group and then young person is placed in the most appropriate agency unit in the community. Placement negotiations are carried out through the MYC Senior Case Coordinator. Siblings have been placed in service.								
Exclusions	Catalyst program: No clearly defined guidelines established for kids with moderate to high support needs for these programs. Every referral is considered on its merits. Refusal can occur due to long term drug abuse or psychiatric illness. Compass program incorporating ISS contracted & FFS: Refusal may occur due to long term drug abuse or psychiatric illness.								
Philosophy	The agency takes the most difficult kids and helps those who have fallen out of other placements; the Agency prides itself on looking after the most difficult kids; provides opportunities for easing emotional pain and developing life skills. Mission statement: Marist Youth Care, in the spirit of Marcellin Champagnat, stands in solidarity with young people at risk in their struggle for wholeness of life. We endeavour to nurture these young people with care, love and understanding, and where possible, attempt to reconcile them with their families. In working with children and adolescents we are prepared to go beyond recognised limits of care and tolerance. Through a variety of programs we invite these young people to take charge of their lives. Agency recently adopted a statement of Key Concepts and Values for Res Care Units. In addition in the ISS program: will take kids back after DJJ detention.								
Model or theoretical approaches	Brendtro model of skills development; Strengths-focused, developing and strengthening resilience. Conjoint family therapy undertaken with families in the St. Vincent's restoration program.								
Any specific therapeutic approach	Agency prefers not to use the term 'therapeutic' as it implies treatment or therapy. That gives the impression of the young person being a passive recipient of agency services.								
Intended outcome	Community integration with aftercare support if needed.								
Name of program or property	Catalyst program (St Vincent's Restoration) Egan	**Suburb/ town**	Westmead	**DoCS region**	Metro West	**Capacity**	6	**No. of residents**	4
Name of program or property	Catalyst (St Vincent's Restoration) Quinlan	**Suburb/ town**	Westmead	**DoCS region**	Metro West	**Capacity**	6	**No. of residents**	3

Name of program or property	Catalyst (St Vincent's) TILP Minahan	**Suburb/ town**	Westmead	**DoCS region**	Metro West	**Capacity**	6	**No. of residents**	4
Name of program or property	Ashworth	**Suburb/ town**	Windsor	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	2
Name of program or property	Freehill	**Suburb/ town**	Greystanes	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	4
Name of program or property	Greentree	**Suburb/ town**	Parramatta	**DoCS region**	Metro West	**Capacity**	3	**No. of residents**	2
Name of program or property	McKenna	**Suburb/ town**	Westmead	**DoCS region**	Metro West	**Capacity**	2	**No. of residents**	2
Name of program or property	Barnes	**Suburb/ town**	Toongabbie	**DoCS region**	Metro West	**Capacity**	2	**No. of residents**	2
Name of program or property	Heydon	**Suburb/ town**	Stanhope Gardens	**DoCS region**	Metro South West	**Capacity**	2	**No. of residents**	2
Name of program or property	Duggan	**Suburb/ town**	Colyton	**DoCS region**	Metro West	**Capacity**	1	**No. of residents**	1
Name of program or property	Coogan	**Suburb/ town**	Winston Hills	**DoCS region**	Metro West	**Capacity**	1	**No. of residents**	1
Name of program or property	Emu Plains (not opened yet)	**Suburb/ town**	Emu Plains	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	0
DoCS region referring	Compass/ ISS contracted services: through DoCS ISS team Metro based in Parramatta; Catalyst services: Referred through St Vincent's program at Westmead.								
Status of properties	Three Catalyst houses at Westmead owned by agency, Compass houses: Five privately rented, one government owned and two owned by agency.								
Utilisation	Fully utilised: 90% or more. Some vacancies occur due to young people transitioning to more appropriate placements and others because of the need to "match" young people with special needs.								
Average placement	6 months in Catalyst. 12 months in Compass/ISS			**Longest placement**		18 months – 2 years			
Nature of program	All stand alone OOHC residences								
Percentage of statutory clients	Compass & ISS contracted: 100%, Catalyst 70%								
Funding	Catalyst: OOHC program funding, agency contribution 15%; Compass: Currently fee for service. Soon to be program funded through DoCS contract, DoCS covers full cost								
Aftercare	Funded for Catalyst clients, 10 active clients. Aftercare worker linked to the Transition to Independent Living Program based from St Vincent's. The agency will provide aftercare for Compass ISS clients who move to independent living. No current aftercare clients for ISS.								

Notable features	Catalyst is one of few restoration focused residential care programs. Pete's Place is an alternative education program off site run by agency for excluded students. Staff work 8 hours shifts, plus sleepovers, due to complexity of clients' needs and in the interests of OHS
Service development	Contracting with DoCS for approximately 20 recurrently funded H/C needs placements, involving transfer of some existing clients from fee for service and some new clients. Now need to focus on quality improvement and full attainment of the NSW Out of Home Care Standards.
Contact	Ken Buttrum, CEO tel: 9853 0303 email: KenB@maristyc.com.au

Agency	**Meeting Ever Changing Needs (MECN) (legal name: Community Works Pty Ltd)**								
Accreditation status at August 2005	Designated agency								
Target Group	The child or young person is between the ages of 12 & 18, or is under 12 years old but is being placed with an older sibling or is under 12 and has a disability; M & F. Challenging behaviour or high needs. Requiring short to medium alternative family placement, in need of crisis accommodation, requires group home accommodation and is engaged in a permanent planning process. Siblings have been placed in service								
Exclusions	Children and young people must fit the selection criteria above								
Philosophy	MECN aims to provide a high standard of Residential Out of Home Care Services that promote the safety, welfare and well being of each child, young person in our homes. Principles reflect: planning to meet all the individual's needs, involving clients in decision making, regarding the residence as the home of each resident, arranging or accessing disability and community services, respecting values, cultural and religious needs of clients and their families and supporting maintenance of family relationships. Clients will be provided with a safe, nurturing and learning environment in which to develop skills and autonomy. Staff will have a safe and supportive working environment.								
Model or theoretical approaches	Eclectic model								
Any specific therapeutic approach	Strength based practice								
Intended outcome	Achieve goals, reintegrate into society, employment, education, family and independent living.								
Name of program or property	MECN 1	**Suburb/ town**	Homebush	**DoCS region**	Metro Central	**Capacity**	2	**No. of residents**	1
Name of program or property	MECN 2 & 3	**Suburb/ town**	Bass Hill	**DoCS region**	Metro South West	**Capacity**	2 each	**No. of residents**	1 each
Name of program or property	MECN 4	**Suburb/ town**	Croydon	**DoCS region**	Metro Central	**Capacity**	2	**No. of residents**	2
Name of program or property	MECN 5	**Suburb/ town**	S. Strathfield	**DoCS region**	Metro Central	**Capacity**	2	**No. of residents**	2
Name of program or property	MECN 6	**Suburb/ town**	N. Strathfield	**DoCS region**	Metro Central	**Capacity**	2	**No. of residents**	2
Name of program or property	MECN 7, 8, 9 & 10	**Suburb/ town**	Campbelltown	**DoCS region**	Metro South West	**Capacity**	7: 2 8: 2 9: 1 10: 1	**No. of residents**	2 2 1 1
DoCS region referring	Metro West, Metro South West, Metro ISS & country Regional Offices								
Status of properties	Private Rental								

Utilisation	Fully utilised, 90% or more. Capacity of max 2 per house is policy, but all houses are big enough to take more		
Average placement	5 months	**Longest placement**	12 months
Nature of program	Stand alone OOHC		
Percentage of statutory clients	90%		
Funding	DoCS covers full cost		
Aftercare	Children and young people are provided with transition support at the time of their discharge in accordance with their Transition Case Plan developed in consultation with DoCS. Children & young people may make contact with their MECN staff or management, but MECN staff will not become directly involved in their case without informing and receiving instruction from DoCS.		
Notable features	Casework Supervisors undertake casework role; MECN has the facilities & resources to take emergency placements		
Service development	MECN is currently in continuous Quality Improvement and is planning to go for Accreditation in August 2006. MECN is working in partnership with DoCS on Audit Systems to improve services to Children and Young People in its Residential Care houses. MECN will look to apply for any future EOI's for Out of Home Care Services.		
Contact	Mili Kato, Client Services Manager, tel 0404 448 945 email: mili.kato@mecn.com.au or Alan Bourel, Operations Manager) tel 0425 337 070 email: alan.bourel@mecn.com.au		

Agency	**Missionary Sisters of Mary Queen**								
Accreditation status at August 2005	Designated agency								
Target Group	12 - 18 year old; F only; children who need care because of family problems, crisis, homeless, victims of abuse; Low to moderate needs; referral from Metro West & Metro SW regions. Siblings have been placed in service.								
Exclusions	Violent behaviour; severe mentally ill or intellectual disability								
Philosophy	The program provides a caring, supportive residential care environment for children and young people that focuses on their need for physical, recreational and social care. The residence is based on Christian values. Aim to integrate residents in to community, maintain family links, assist them to develop capacity and awareness to live fulfilling and productive lives.								
Model or theoretical approaches	none stated								
Any specific therapeutic approach	not applicable to target group								
Intended outcome	Community, family & education connection; positive attitudes & values; able to live independent full lives, be well adjusted good citizens.								
Name of program or property	St Therese House	**Suburb/ town**	Granville	**DoCS region**	Metro West	**Capacity**	4	**No. of residents**	1
DoCS region referring	Metro West only								
Status of properties	Owned by agency								
Utilisation	25-50%, due to insufficient referrals meeting criteria								
Average placement	6 months to 1 year			**Longest placement**		3 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	OOHC program funding & fee for service, agency contribution 20%								
Aftercare	Unfunded, 5 active clients, low level support. Past residents have phone number and are told they can ring if they want to								
Notable features	One of few girls only programs. Religious order Sisters act as 'mother' or 'sister' role models to the residents, providing care in a family group home model. Same four Sisters involved as direct care workers, covering 24/7 on a shift basis, with same two Sisters sleeping at the residence. Supervisor undertakes casework. Sisters are from Vietnamese cultural background, initially program focused on clients from same background, but reduced demand, so no longer specialises.								

Service development	No expansion plans due to limited number of Sisters
Contact	Sister Justina Pham, Director, tel: (02) 9637 1827 Email: admin@maryqueen.ngo.org.au

Agency	**Premier Youthworks Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	8 - 17 years; M & F; High & complex needs; Siblings have been placed in service.								
Exclusions	Extreme violence, unless additional support/staffing is funded.								
Philosophy	They are kids - we treat them as children. Aim to move them on from one-on-one residential care								
Model or theoretical approaches	Individual program								
Any specific therapeutic approach	Psychologist consultancy service (Gary Raftl, SAC Consulting) provides staff training & support for the kids. Assessment model - looking at where kids are at & putting in supports to assist them.								
Intended outcome	Stabilise & move forward								
Name of program or property	No 1	**Suburb/ town**	Adamstown	**DoCS region**	Hunter CC	**Capacity**	2	**No. of residents**	0
Name of program or property	No 2	**Suburb/ town**	New Lambton	**DoCS region**	Hunter CC	**Capacity**	3 in 2 units	**No. of residents**	1
Name of program or property	No 3	**Suburb/ town**	Seahampton	**DoCS region**	Hunter CC	**Capacity**	1	**No. of residents**	1
Name of program or property	No 4	**Suburb/ town**	Argenton	**DoCS region**	Hunter CC	**Capacity**	1	**No. of residents**	0
Name of program or property	No 5	**Suburb/ town**	Boolaroo	**DoCS region**	Hunter CC	**Capacity**	2	**No. of residents**	1
Name of program or property	No 6	**Suburb/ town**	Boolaroo	**DoCS region**	Hunter CC	**Capacity**	2	**No. of residents**	1
Name of program or property	No 7	**Suburb/ town**	Boolaroo	**DoCS region**	Hunter CC	**Capacity**	1	**No. of residents**	1
Name of program or property	No 8	**Suburb/ town**	Boolaroo	**DoCS region**	Hunter CC	**Capacity**	1	**No. of residents**	1
DoCS region referring	most referrals are from out of area – all over Sydney metro area.								
Status of properties	All private rental								
Utilisation	50-70% utilisation, due to insufficient referrals meeting criteria, consideration of resident's needs & compatibility, and staffing issues following two assaults on staff by residents. Reduced referrals from DoCS for a time, but now 4-5 referrals per week.								
Average placement	6 months			**Longest placement**		24 months			

Nature of program	All stand alone OOHC
Percentage of statutory clients	100%
Funding	Fee for service, DoCS covers full cost, Agency contribution to establishment & when few referrals.
Aftercare	Unfunded, 6 active clients. Director's mobile phone number given to all residents. Some ex-residents use it a lot. Others have more casual contact. Staff do become very important in residents lives, even if only a short placement. Relationships are built up & ongoing contact in support is vital.
Notable features	Staff & their families involved in social / recreational activities with residents. Isolation of individual placements overcome by provision of supervised & supported social interaction between two residents with their direct care workers. Distance education program implemented for 2 excluded students, structured as a school day. Contracted psychologist supports director, caseworker and casework support worker in developing & reviewing plans. Recently started to allow pets to be kept at the residences, but issues for some when residents move on.
Service development	Wants to keep agency at a size where director has active involvement & knows all the kids. Would like to work more with girls that self-harm or with mental health issues and young mothers (under 18 years).
Contact	Lisa Glen, Director, tel (02) 4954 4085, email: lisa@premieryouthworks.com.au

Agency	**Rainbow Home & Respite Services Pty Ltd**								
Accreditation status at August 2005	Designated agency								
Target Group	ST & emergency up to medium term accommodation; Age range open 0 -18 years: in last 12 months have accommodation some young children in crisis/ overnight; M & F; challenging behaviours; Siblings have been placed in service								
Exclusions	Extreme mental health / psychotic issues; extremely suicidal								
Philosophy	To give the best service we can; make life as normal as possible; usually not a long term option. Supported accommodation aim: provide a comfortable home-like environment; increase independence; provide a feeling of security; provide flexibility in meeting needs of the consumer; programs designed for each consumer to reach their full potential. Youth services aim: develop educational, social and living skills; increase independence; enhance integration in the community; enhance relationships with family, friends and social networks; network with existing appropriate services to maintain continuity; provide flexibility in catering for individual needs								
Model or theoretical approaches	none stated								
Any specific therapeutic approach	Therapeutic Crisis Intervention								
Intended outcome	Depends on individual plans & DoCS								
Name of program or property	Teal	**Suburb/ town**	Glenmore Park	**DoCS region**	Metro West	**Capacity**	3	**No. of residents**	2
Name of program or property	Ultramarine	**Suburb/ town**	Penrith	**DoCS region**	Metro West	**Capacity**	3	**No. of residents**	1
Name of program or property	Aqua	**Suburb/ town**	Glossodin	**DoCS region**	Metro West	**Capacity**	2	**No. of residents**	1
Name of program or property	Sapphire	**Suburb/ town**	Windsor	**DoCS region**	Metro West	**Capacity**	2	**No. of residents**	1
Name of program or property	Cyan	**Suburb/ town**	Glossodin	**DoCS region**	Metro West	**Capacity**	1	**No. of residents**	1
DoCS region referring	Metro West and Metro South West								
Status of properties	Two owned by agency, three private rental								
Utilisation	60-70% utilisation, due to insufficient referrals meeting criteria. Less referrals recently; some other residents moved home or to other care. Uncertainty about how long placements will last, so at times accept more referrals than official placements available. Had 20 homes in the past.								
Average placement	12 months			**Longest placement**	2 years				

Nature of program	All stand alone OOHC
Percentage of statutory clients	98%
Funding	Fee for service, DoCS covers full cost
Aftercare	Not offered
Notable features	8 hours shifts, plus sleepover, small consistent staff numbers per residence. One residence is a flat for one person, co-located with another unit, able to be used for transition to independent living.
Service development	Reduced referrals in recent times, however agency would be willing to open services in areas of need if had recurrent funding.
Contact	Marvic Aquilina, Management Coordinator tel: 4588 5866 email: marvic@rainbowhrs.com.au

Agency	**Sheach Consultancy Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	10-15 years, M/F, high needs and challenging behaviour, includes indigenous children. Siblings have been placed in service.								
Exclusions	Severe physical and intellectual disabilities, psychotic episodes								
Philosophy	Giving young person choices and goals, looking after outcasts, promoting growth and change, planting seeds for the future.								
Model or theoretical approaches	Adventure therapy, Celtic tribal approaches, mentoring approaches, rather than a youth work model.								
Any specific therapeutic approach	Providing physical, emotional and intellectual challenges in a fun environment, particularly through outdoor activities. Sand play, art and music therapy are incorporated.								
Intended outcome	Assist child to develop skills to function in the community and to sustain permanency in their living. To build a sense of esteem in each child.								
Name of program or property	No 1	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 2	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 3	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 4	**Suburb/ town**	Alstonville	**DoCS region**	Northern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 5 The Church	**Suburb/ town**	Lismore	**DoCS region**	Northern	**Capacity**	2	**No. of residents**	2
DoCS region referring	mainly Northern Region								
Status of properties	One owned by agency, four private rental								
Utilisation	60% utilisation, due to insufficient referrals meeting criteria. Note: capacity relates to casework capacity, not residential or direct care worker limits, as premises and mentor teams can be established quite easily if a referral is received. Over capacity last Christmas, one child additional to usual capacity was housed for one week.								
Average placement	6 -12 months			**Longest placement**		over 2 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								

Aftercare	Unfunded, 10 active clients
Notable features	Individualised education program for excluded students may include distance education, activities adventure therapy activities, informal activities with mentors or camps (small groups or one-on-one). Staff work 9 hour shifts, plus sleepover, key mentor system. Two part time social workers are also employed.
Service development	Willing to expand to different regions where needs identified.
Contact	Libby Sheach (Manager) tel (02) 6622 8165 email: sheach@bigpond.com.au

Agency	**Shoalcare**								
Accreditation status at August 2005	Designated agency								
Target Group	Young people must have no other alternative for a safe living environment; no younger than 8 years old; M & F; extreme challenging behaviours, so that foster care or paid professional care in a family setting in not workable and would place the child at risk or other family members/carers at risk; DoCS agrees to fund, to ensure stability while needs are assessed for future living arrangements; placement will be individual, unless placement of two children is seen as meeting the needs of both young people. Reviewing the 8-11 year olds in light of OCG requirements.								
Exclusions	Not children with disabilities; not able to offer culturally specific programs (although have indigenous or other CALD clients at times).								
Philosophy	Never give up; provide a continuity of options. Aims: to empower the young person and family in achieving the best possible relationship with each other; to assist the young person in acquiring the skills necessary to care for themselves in daily living situations and to relate appropriately with others; to support & encourage the young person in their education thereby assisting in developing vocational options; to enhance quality of life through leisure and lifestyle experiences; to communicate to the young person & their family that they are valued & respected; to promote a holistic approach to health & well being.								
Model or theoretical approaches	Individual planning								
Any specific therapeutic approach	Therapeutic program guided by clinical psychologist & manager. Team meetings weekly to develop & review progress of individual behaviour management programs that address concerning behaviours and key learning areas. The psychologist guides & supports the carers, rather than works directly with the residents for individual therapy. There is too much chaos/turmoil for one-on-one therapy to be effective.								
Intended outcome	Stability and addressing behaviour issues								
Name of program or property	No 1	**Suburb/ town**	Nowra	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 2	**Suburb/ town**	Bomaderry	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 3	**Suburb/ town**	Berry	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
Name of program or property	No 4	**Suburb/ town**	Shoalhaven Heads	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
DoCS region referring	Accept referrals from any DoCS area if there is a good reason for the child to be placed in southern area								
Status of properties	One owned, three private rental								
Utilisation	Current houses fully utilised, however agency willing to set up new houses. High cost service due to clinical (therapeutic) component, so potential referrals are not pursued by DoCS.								
Average placement	18 mths-2 yrs			**Longest placement**		3.5 years			

Nature of program	All stand alone OOHC, individual placements
Percentage of statutory clients	100%
Funding	Fee for service, DoCS covers full cost, Agency contribution to establishment & when few referrals, vacancies
Aftercare	Not offered at present, but will be developing as clients move on.
Notable features	One of few residential care services with a full time clinical psychologist on staff (20 hours/week res care, 18 hours foster care) & stated intent on offering a therapeutic program. Family mentor engages with families & oversees transition to other care or restoration. Distance education program supervised by staff for excluded students. Staff work 8 hours shifts, no more than four shifts/week, due to complexity of client's needs.
Service development	Need stable funding & consistent referrals to support current program & staff. Would need a change in management structure (middle level staffing - clusters or teams to expand. No large expansion desirable in short term.
Contact	Chris Stubbs, Therapeutic Res Care Manager, tel: 02 4423 6833, email: chris.stubbs@shoalcare.com.au

Agency	**S.O.S Visiting Nursing Service Home Help and Cleaning Agency (Haven Wax Pty Ltd)**								
Accreditation status at August 2005	Designated agency								
Target Group	0-18 yrs; M/F; no specific limits including intellectual or physical or developmental delay; up to 3-4 months (short term)								
Exclusions	No (but depends on having available staff) to meet particular client needs								
Philosophy	Provide flexible, immediate & home like care for children and young people								
Model or theoretical approaches	Individually tailored to each child, working within behaviour management plan								
Any specific therapeutic approach	none stated								
Intended outcome	Improved behaviour enabling child/ young person to be assimilated into foster care or home environment. Child to have a positive experience of care								
Name of program or property	New England	**Suburb/ town**	Tamworth	**DoCS region**	Northern	**Capacity**	4	**No. of residents**	0
Name of program or property	Nth Tablelands	**Suburb/ town**	Glen Innes	**DoCS region**	Northern	**Capacity**	8	**No. of residents**	0
Name of program or property	Central Coast	**Suburb/ town**	Woogarrah	**DoCS region**	Hunter & Central Coast	**Capacity**	4	**No. of residents**	0
DoCS region referring	Take referrals from all regions								
Status of properties	Two under mortgage, one private rental								
Utilisation	5%, due to lack of DoCS referrals meeting criteria, renovations to one house & Central Coast house only newly established.								
Average placement	6 to 8 weeks			**Longest placement**		8 weeks			
Nature of program	Stand alone OOHC residence								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Not offered								
Notable features	Started out as a disability services, then moved into OOHC provision. 24 hours shifts, including sleepover. Shorter shifts for higher needs clients, usually 1 person on duty.								

Service development	Agency would like to replicate existing model in rural areas eg Dubbo, Moree, North West NSW
Contact	Rosemary Hyles, Managing Director tel: 02 67549302 email: moree@sosservice.com.au

Agency	**Southern Youth & Family Services Association Inc.**								
Accreditation status at August 2005	Designated agency, accredited 5 years to 12 November 2009								
Target Group	12-17 year olds; high or complex needs; Males & Females; Kambiyo - medium term; ISS - ST/crisis - one place is in SAAP crisis refuge, one place in the SAAP Link Inn Medium Term service. The ISS bed at Link Inn is most appropriate for older age group 15 plus. Other SAAP beds were opened to replace these two beds.								
Exclusions	Each referral will be assessed and there are no blanket exclusions. The presence of the following may mean the service will consider strategies to minimise the risk. However there will be instances when the service is unable to adequately support the client and keep the other clients and staff safe. These include the presence of:- • Drug addiction including the use of drugs such as "crystal meth" if the client is unwilling to accept appropriate treatment • The risk of sexual assault of other clients • Violence • Severe physical and/or disability where intervention such as medical, access and other is required and unable to be provided with the agency's resources.								
Philosophy	Work with disadvantaged young people and their families to ensure young people are adequately cared for, receive the services they need and are safe from harm; reunite or reconcile with families if possible or prepare them for independent living and assist in that transition.								
Model or theoretical approaches	Model is of a modern residential service. Provision of a secure and safe environment and meeting basic needs and then supporting and assisting the young person to gain an improved lifestyle. Provides services through case management and case work including referral, advocacy and information provision. Preparation for independence through living and social skills education; teaching, guiding, empowering the young people to develop problem solving and coping skills. Uses early intervention where possible such as early assessment and identification of risks of drug and alcohol use, risk of entering the Juvenile Justice system, early identification of early onset mental health problems, enhancing safety through protective behaviours education and implementing strategies to prevent these problems. Behaviour management in cases of extreme behaviours.								
Any specific therapeutic approach	none stated								
Intended outcome	To secure and sustain permanent, long term, stable accommodation; To function acceptably in society and community								
Name of program or property	Kambiyo	**Suburb/ town**	Keiraville	**DoCS region**	Southern	**Capacity**	4	**No. of residents**	4
Name of program or property	Intensive support program place 1	**Suburb/ town**	Wollongong	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1

Name of program or property	Intensive Support program place 2	**Suburb/ town**	Wollongong	**DoCS region**	Southern	**Capacity**	1	**No. of residents**	1
DoCS region referring	Southern region only								
Status of properties	All public rental. Kambiyo - owned by DoCS, peppercorn rent, agency pays for maintenance (DoCS used to pay for it).								
Utilisation	Fully utilised, 90% or more.								
Average placement	Kambiyo 12 months, ISS 6 weeks			**Longest placement**		Kambiyo 4 years, ISS 6 months			
Nature of program	Kambiyo Stand alone OOHC; ISP Co-located in SAAP service, with other SAAP places								
Percentage of statutory clients	Kambiyo: 100%; ISS: 90%								
Funding	OOHC program & unfunded, agency contribution 10%								
Aftercare	Aftercare work funded by SAAP, not OOHC. 8 – 10 active clients Independent Living Scheme worker does home visits/outreach. Casual drop in support provided as required. Header agreement arrangements have been used for high needs young people.								
Notable features	Part of a medium sized agency with a range of services: independent housing; outreach housing support including brokerage; medium term accommodation services; JPET, Family counselling - these may provide exit points & support services. Generally 7 to 8 hours shifts, plus sleepover, 1-2 staff on day/evening duty, 1 on sleepover. Awake shift if necessary & additional funds may be required for this. Program manager supervises and supports Co-ordinator. Co-ordinator provides direct care & casework supervision & service co-ordination. External clinical supervision. Tutors or extra youth workers – contracted if funding is provided.								
Service development	Agency would be willing to develop more transition to independence options, where young people still have workers to support them. Would keep current 4 place medium term service. Would like another option for OOHC clients like YIPIH (6 x 1br flats + 3br flat for staff) & an OOHC Outreach worker to provide aftercare support.								
Contact	Kevin Crowe, Program Manager, tel (02) 4228 1946 email: kcrowe@syfs.org.au								

Agency	**St Joseph Cowper Inc.**								
Accreditation status at August 2005	Designated agency								
Target Group	Up to 15 years; M/F; challenging behaviour. Siblings have been placed in service.								
Exclusions	Proven sexual offenders; extreme violence								
Philosophy	Philosophy based on that of Catherine McAuley and the Sisters of Mercy, which includes helping the poor and disadvantaged without being discriminatory or judgemental. Been in operation since 1913. St Joseph's aims to make a difference by repairing damaged children and assisting children and young people to establish a better life - either with their own families or in another setting such as a foster care placement or supported independent living. To empower young people to be in control of their lives. Emphasis is on the possibility of behaviour change, and the child or young person owning his/her own program. This is based on strong boundaries and individualised behaviour programs. There is also a strong emphasis on, and commitment to, education for the children. St Joseph's is a non-profit agency.								
Model or theoretical approaches	Models and theories that have influenced the program include: Ian Martin (informal education empowering individuals to make change); Steve Biddhulph's work about masculinity; Glasser's choice therapy and 'Choose with Care'.								
Any specific therapeutic approach	Program is tailored to individual children but involves developing clear boundaries and routines, and developing concept of choice and consequences / rewards. Strong emphasis on use of professional support of psychologists, social worker and sand play therapist on staff.								
Intended outcome	Change behaviour and develop relationship building skills so the child / young person can live in a family situation								
Name of program or property	Cottage 1	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	3	**No. of residents**	1
Name of program or property	Cottage 2	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	3	**No. of residents**	1
Name of program or property	Cottage 3	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	3	**No. of residents**	3
Name of program or property	Cottage 4	**Suburb/ town**	Grafton	**DoCS region**	Northern	**Capacity**	3	**No. of residents**	3
DoCS region referring	Northern region								
Status of properties	Owned by agency								
Utilisation	60% utilisation, due to consideration of current residents' needs & compatibility.								
Average placement	12 months			**Longest placement**	2 years				
Nature of program	Stand alone OOHC								

Percentage of statutory clients	100%
Funding	OOHC program funding & fee for service, agency contribution 20%
Aftercare	Unfunded, 1 active client. Some kids move outside of area so cannot access agency, and visits of young people back to agency are discouraged in order not to disturb current residents. However, there is phone contact with former residents.
Notable features	All cottages on one campus. Staffing – 7 hour shifts, plus sleepover, 2-3 on duty day time in multi resident cottages, 1-2 on sleepover. Director is a psychologist, Caseworker & youth worker full time, sand play therapist, plus a small number of hours for clinical psychologist and education worker. Intensive assessment process on entry, staff complete resident behaviour checklists on entry, and use psychological assessments and presenting behaviours to review progress.
Service development	Agency is developing a foster care program to enable internal transitions. Would also like to develop more residential services on same site and additional services at other locations to enhance transition of adolescents to independent living.
Contact	Sue McKimm, Director, tel (02) 6642 3022, email: sjcowp@iprimus.com.au

Agency	**Sydney Stepping Stone Inc.**								
Accreditation status at August 2005	Designated agency								
Target Group	Young people (M & F) 14-18 years in need of secure and safe accommodation who need to live away from home								
Exclusions	Sex offenders, severe mental health diagnosis and severe physical disability								
Philosophy	To reach the lives of young people who are living in dysfunction and disharmony in the family setting and through compassion and interventions, help them reach their full potential								
Model or theoretical approaches	TCI; Problem solving; Solution focused brief therapy; motivational interviewing								
Any specific therapeutic approach	none stated								
Intended outcome	Achieve goals, reintegrate into society, employment education and family								
Name of program or property	Stepping Stone House	**Suburb/ town**	Dulwich Hill	**DoCS region**	Metro Central	**Capacity**	4	**No. of residents**	4
DoCS region referring	Any region may refer, used mainly by Metro South West								
Status of properties	Owned by agency								
Utilisation	Fully utilised, 90% or more. Can be over capacity if residents come back for a night or two in crisis								
Average placement	2 years			**Longest placement**		2.5 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	50%								
Funding	Fee for service, agency contribution over 50%								
Aftercare	Unfunded, 6 active clients								
Notable features	Staff undertake 7 hour shifts, plus sleepovers								
Service development	Extending to 7 place capacity soon. Would like to establish similar service in other areas. Volunteers involved in mentoring and education support.								
Contact	Finn Callinan, Supervisor or Jaya Kudhail, team leader, tel (02) 9958 3529 email: steppingstonehouse@bigpond.com								

Agency	**Stretch-A-Family Inc.**								
Accreditation status at August 2005	Designated agency, accredited 5 years to 16 Nov 2009								
Target Group	15-18 yrs, M&F; willing to be involved in education arrangements or looking for work; potential for independence - must be willing to work toward progress to independence; DoCS gatekeeper of referrals (Metro Central & SW - recent boundary change). Siblings have been placed in service.								
Exclusions	Current drug users; psychiatric illness when referred; young people not able to progress towards independence - eg high level of disability.								
Philosophy	Break the cycle of homelessness for young people; young people have a say in decisions; their wishes and views are respected; strong philosophy as a service for young people, not a service for staff; this is their home; they choose to stay here								
Model or theoretical approaches	Individual approach to each young person - not one size fits all. Clients are seen and treated as individuals; rules are different for different young people (in sense of greater expectations and freedoms of those that have demonstrated responsibility; started to bring in strengths perspective more formally although have always done it informally.								
Any specific therapeutic approach	Harm minimisation is a general practice approach, eg smoking rules - discourage it, but can smoke outdoors, safety & health issues discussed, staff not allowed to smoke when on duty.								
Intended outcome	Young person will be able to live independently in the community successfully.								
Name of program or property	On Track	**Suburb/ town**	Roselands	**DoCS region**	Metro Central	**Capacity**	6	**No. of residents**	6
DoCS region referring	Metro Central								
Status of properties	shared ownership agency 30% & Dept of Housing 70%								
Utilisation	80% utilisation, due to thorough assessment process (2 months), always more referrals than places available. On Track may have more than six clients in program, but not in residence during transition time.								
Average placement	2.5 years			**Longest placement**		4 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	OOHC program funding, DoCS meets full cost								
Aftercare	Unfunded, 10 active cases and several others in regular contact, across both programs. On Track does not provide aftercare to family, as usually the young people don't go home.								

Notable features	Homework support has improved educational engagement & outcomes for residents. Youth workers undertake 25 hour shifts (including sleepover), key worker system in place. On Track Youth Workers have hours not tied to a roster which they can use for one-on-one time with their key work young person. Resident's place in On Track held open for 3 months during transition to independence. Caseworker covers both OOHC and SAAP program. SAAP funded service operates likes OOHC program for younger clients (12-16 years) with a medium term residential service and a foster care / community placement service with an emphasis on restoration.
Service development	In short term, would like to offer long term residential care for 12-14 year age group, when cannot be restored or a foster family is not appropriate. In longer term, possibly another program similar to On Track and/or develop semi-supported transition to independent living option.
Contact	Narelle Gurney, Manager, Direct Care, tel (02) 9569 6933 email: narelle@stretch-a-family.com.au

Agency	**Trustees of the Christian Brothers: Edmund Rice Community Services**								
Accreditation status at August 2005	Designated agency								
Target Group	12-18 years, priority to under 16 years; M & F; low to medium needs; medium to long term placement; Some voluntary clients - all referral are through regional placement panel. Not all clients are under parental responsibility of the Minister.								
Exclusions	all young people will be considered, but if a young person's needs are beyond the capacity of Eddy's Place resources, the placement will not proceed. The only exception is young people with physical disabilities, given the current environmental layout of the premises.								
Philosophy	Mission of the Catholic Church & the Christian Brothers is to help disadvantaged and poor through education and housing services. Edmund Rice Community Services is a ministry of the Christian Brothers that builds on the ethos and inspiration of Edmund Rice, Gospel values and Catholic Social Teaching. As an organisation, all staff members will work together to respond to the needs of young people and their families; to empower young people to achieve and reach their full potential within the wider community; and to build partnerships with those on the margins and advocate for justice and positive social change.								
Model or theoretical approaches	Life skills/ living skills education to assist young people to become independent. Provide incentives, promote acceptance of responsibility and minimise risk to the young person								
Any specific therapeutic approach	Edmund Rice Community Services is exploring a number of models, including strengths based practice.								
Intended outcome	To be able to live independently or enable restoration to family								
Name of program or property	Eddy's Place	**Suburb/ town**	Wollongong	**DoCS region**	Southern	**Capacity**	4	**No. of residents**	2
DoCS region referring	Southern region only								
Status of properties	Public rental. Eddy's Place is owned by the Christian Brothers and in keeping with reflecting the true costs of managing a program, the agency pays rent to the Christian Brothers. This money can be donated back, if needed.								
Utilisation	50% utilisation, due to insufficient referrals meeting criteria, changes to DoCS referral processes & for a time only male direct care staff, so DoCS reluctant to refer females.								
Average placement	18 months			**Longest placement**		2 years			
Nature of program	Stand alone OOHC residence								
Percentage of statutory clients	50%								
Funding	OOHC program funding & unfunded, agency contribution 10%								
Aftercare	Unfunded, 3 active clients								
Notable features	24 hours shifts, including sleepover. Volunteer student mentors from school as needed								

Service development	In Wollongong area would like to develop transition to independence models involving other forms of housing; would also want to develop community placement model and foster care for young kids, so the agency can offer a variety of options. Edmund Rice Community Services has formed a partnership with Southern Youth and Family Services in relation to a community placement program. Also wish to develop mentoring program - was done for a while on a fee-for-service basis in order to better support foster carers and families where young people have been restored.
Contact	Ms Juanita Winks, Director, Edmund Rice Community Services tel: (02) 9745 9700/0407 252 416 email: juanitaw@erc.org.au

Agency	**Uniting*Care* Burnside**								
Accreditation status at August 2005	Designated agency, accredited 5 years, to 10 November 2009								
Target Group	13-18yrs; m/f; medium support needs with some social interaction skills and do not require management by more than one staff at a time; voluntary and statutory placements. Siblings have been placed in service								
Exclusions	Young people with high physical and behavioural support needs								
Philosophy	Strengths based approach, not deficit based; The care offered is long term "hope it is your last placement"; the key elements are education, contact with families/significant others and preparation for independent living								
Model or theoretical approaches	Combination drawing on a range of approaches								
Any specific therapeutic approach	Narrative; cognitive behavioural therapy; and solution focused brief therapy								
Intended outcome	Get support with education and vocation choices; Have positive relationships with family and significant others; Able to live in the community with own network								
Name of program or property	Gordon	**Suburb/ town**	Pennant Hills	**DoCS region**	Metro Central	**Capacity**	6	**No. of residents**	4
Name of program or property	Minnamurra	**Suburb/ town**	Denistone East	**DoCS region**	Metro Central	**Capacity**	6	**No. of residents**	6
Name of program or property	Byrnes	**Suburb/ town**	Minto	**DoCS region**	Metro South West	**Capacity**	6	**No. of residents**	5
DoCS region referring	Metro Central, Metro South West and Metro West								
Status of properties	Owned by agency								
Utilisation	Fully utilised, 90% or more								
Average placement	2.5 years			**Longest placement**	5 years				
Nature of program	Stand alone OOHC residence								
Percentage of statutory clients	80%								
Funding	OOHC program funding, agency contribution 25%								
Aftercare	Unfunded, 15 active clients. Includes therapeutic counselling; access to files and information; legal support/advocacy; help moving etc								

Notable features	25 hours shifts, including sleepover, 1 person on duty. Learning program devised for each child / young person according to need (not only excluded students) & tutoring provided when excluded or as needed. 1.5 part-time education workers employed (0.5 for each program), other support services contracted as needed. Byrnes program has one place for independent living support, which takes different forms according to young persons needs eg share/rental/ semi – independent.
Service development	Agency would like to reproduce current services within close distance of existing res units, in order to benefit from economies of scale and to have good network of support for res care staff and residents. eg SW Sydney Liverpool/Bankstown; Toongabbie / Northmead.
Contact	Andrew O'Brien, Manager, Western Sydney Youth Services tel: 02 9768 6889 aobrien@burnside.org.au

Agency	**Wendy's Home Services Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	13-18 years of age, in accordance with accreditation requirements. But offer voluntary OOHC for any age group.								
Exclusions	Severely challenging behaviours - as cannot manage high level property damage; identifiable OHS risks to staff								
Philosophy	Provision of quality, professional home and family care by experienced and caring staff with dignity, honesty and attention to the needs of clients. The agency values its reputation and its ability to provide a range of services from emergency care to long term support.								
Model or theoretical approaches	No explicit model - going through accreditation process								
Any specific therapeutic approach	none stated								
Intended outcome	Restoration to family or long term placement.								
Name of program or property	Bligh Park 1	**Suburb/ town**	Bligh Park	**DoCS region**	Metro West	**Capacity**	2	**No. of residents**	0
Name of program or property	Bligh Park 2	**Suburb/ town**	Bligh Park	**DoCS region**	Metro West	**Capacity**	3	**No. of residents**	1
Name of program or property	Kingswood	**Suburb/ town**	Kingswood	**DoCS region**	Metro West	**Capacity**	1	**No. of residents**	1
DoCS region referring	Metro West								
Status of properties	All private rental								
Utilisation	Fully utilised, 90% or more								
Average placement	6 to 12 months			**Longest placement**		3.5 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	40%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Not offered unless part of contracted service								

Notable features	Policy & Individual behaviour plans developed by DADHC psychologist - as all residents have intellectual disabilities. All staff are casual due to nature of placement contracts. Staff undertake various shifts shorter length, plus sleepover in one residence and stand up shifts in the duplex. Agency not funded for or undertaking casework.
Service development	No plans for service expansion.
Contact	Alannah Norman, General Manager tel (02) 4587 5999 email: wendyshome@bigpond.com.au

Agency	**Wesley Dalmar Child & Family Services (Uniting Church of Australia Property Trust NSW)**								
Accreditation status at August 2005	Designated agency, accredited 5 years to 16 November 2009								
Target Group	Gateway: 12 - 15 years, M & F. Can include moderate and high needs kids. Carlisle Cottage: 10 - 17 years, M / F, high needs kids. Siblings have been placed in service.								
Exclusions	No mobility. Gateway exclusions are based on existing residents needs.								
Philosophy	Every child has a right to be safe and to access programs to aid their well-being and their functioning capacities.								
Model or theoretical approaches	Therapeutic crisis intervention framework informs all aspects of language, documentation, strategies and evaluation.								
Any specific therapeutic approach	Solution focused approach and narrative.								
Intended outcome	Gateway: Provide therapeutic intervention to work towards stability prior to more permanent placement Carlisle: Provide intense intervention to work towards stability prior to more permanent placement								
Name of program or property	Gateway	**Suburb/ town**	Lewisham	**DoCS region**	Metro Central	**Capacity**	6	**No. of resi-dents**	5 + 1 respite
Name of program or property	Carlisle Cottage	**Suburb/ town**	Bidwill	**DoCS region**	Metro West	**Capacity**	2	**No. of resi-dents**	2
DoCS region referring	Carlisle: Metro West; Gateway: Metro Central and Metro South West								
Status of properties	Gateway owned by agency, Carlisle public rental.								
Utilisation	Fully utilised, 90% or more.								
Average placement	4 months			**Longest placement**		Gateway 7 months, Carlisle 11 months			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Gateway: OOHC program funding, agency contribution 20%; Carlisle: Fee for service, DoCS covers full cost.								
Aftercare	Unfunded, 1 active client								
Notable features	Gateway's capacity to provide respite placements for Dalmar's foster care programs and for other NGOs was commented on positively by others. Excluded students go to different location, have one-on-one supervision/tutoring or school program, using school timetable. Staff work 9 hours shifts, plus sleepover, with additional peak time short shifts. 2 on duty day & evening, one on sleepover. Carlisle: 25 hour shifts								

Service development	Develop a res care model that included a more formal educational program, and used in house staff for supervised access. In addition replicate Gateway, and have a pool of trained carers able to staff a number of units.
Contact	Annette Posimani, Manager Residential Services, mobile: 0438 136 048

Agency	**Wundarra Services Pty. Ltd.**								
Accreditation status at August 2005	Designated agency								
Target Group	Very challenging behaviour; 12-18 years; m/f; Siblings have been placed in service. High proportion of indigenous clients (average 40%), although target is not exclusively indigenous clients.								
Exclusions	none advised								
Philosophy	Importance of providing children with a safe place, which includes boundaries where they are accepted, and their identity as Aboriginal kids is supported.								
Model or theoretical approaches	Each child is treated individually with a case plan adapted to their own needs which is clearly communicated to the child								
Any specific therapeutic approach	An emphasis on looking for behavioural triggers, so that behaviour does not escalate and underlying causes are dealt with								
Intended outcome	The child to feel safe and exhibit improved behaviour								
Name of program or property	1 - 15	**Town**	Sawtell & Woll-goolga	**DoCS region**	N'thern	**Capacity**	1 x 15 total	**No. resi-dents**	1 x 15 total
DoCS region referring	Referrals accepted from all regions								
Status of properties	2 units owned by agency, rest private rental								
Utilisation	Fully utilised, 90% or more								
Average placement	4 to 6 months			**Longest placement**		2 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Fee for service, DoCS covers full cost								
Aftercare	Unfunded, 20 active clients								
Notable features	Wundarra is owned by an indigenous person, with indigenous managers and indigenous field staff. The agency has indigenous programs and primarily caters for indigenous children.24 hours shifts, including sleepover. Part-time psychologist, 3 caseworkers employed, plus casual art therapist.								
Service development	Would like to extend services in North Coast area, so that there are lots of options to place kids in the right location (not necessarily their own home town).								
Contact	Ernie Lovelock, Director or Larry Barber, Manager tel (02) 6651 2991 email: lovelock@wundarra.com or larry@wundarra.com								

Agency	**Youth First (formerly Sydney Emergency Accommodation Service)**								
Accreditation status at August 2005	Designated agency, accredited 1 year to 8 October 2005								
Target Group	High & intensive needs - eg challenging behaviour; No placements available in funded service; DoCS referrals only; 10-14 years current clients (interim accreditation as SEAS). Those clients under 12 were transferred only recently to Youth First responsibility as special case approved by OCG after negotiation. Siblings have been placed in service.								
Exclusions	High mental health issues - but depends on the additional support required; physical disability if clients highly dependent for daily living support.								
Philosophy	Set up a homely atmosphere - making a home for the children and encourage participation in their household and decisions about their lives								
Model or theoretical approaches	Individualised programming & planning								
Any specific therapeutic approach	Solution-focused; harm minimisation (in context of risk assessment).								
Intended outcome	To move residents on to a long term option - eg foster care - in own program or another agency.								
Name of program or property	Res 1	**Suburb/ town**	Narara	**DoCS region**	Hunter	**Capacity**	2	**No. of residents**	1
Name of program or property	Res 2	**Suburb/ town**	Narara	**DoCS region**	Hunter	**Capacity**	2	**No. of residents**	1
Name of program or property	Res 3	**Suburb/ town**	Wyong	**DoCS region**	Hunter	**Capacity**	4	**No. of residents**	4
DoCS region referring	Referrals may be made by any DoCS region. Acceptance depends on circumstances and agency able to meet clients needs.								
Status of properties	All private rental								
Utilisation	60-80% utilisation, due to insufficient referrals meeting criteria & consideration of resident's needs & compatibility. Some residences have room for two, but needs of current clients dictate one resident only. In last year or so there have been fewer referrals - previously operated many more houses. Flexible capacity: Can set up new households to accept new referrals, especially when they operated more crisis services in past.								
Average placement	2 years			**Longest placement**		4 years			
Nature of program	All stand alone OOHC								
Percentage of statutory clients	100%								
Funding	Fee for services, agency contribution 5-10%								

Aftercare	Partly funded, 0 clients at present
Notable features	Shifts vary – 6 to 24 hours, 2 staff on duty in residences with higher numbers of clients. Direct care workers undertake case management role. Support workers implement a school day program at Head Office for excluded students. Strong emphasis on life story work. Redeveloping staff structure to introduce higher level of minimum requirements.
Service development	Agency aiming to establish a foster care program – negotiating extension of header agreement with DoCS. Willing to establish more residences on Central Coast. May accept Sydney referrals, but want to keep all residences on Central Coast.
Contact	Skye Williams, Director, Program Services tel (02) 4389 7449 email: youthfirst@hunterlink.net.au

Agency	**Youth Off The Streets Ltd. McIntosh House** (note: 4 separate profiles for different YOTS programs)								
Accreditation status at August 2005	Designated agency								
Target Group	16-19 year olds, M&F, 2 year program - so can be 16-21 (if entered program at 19); Young people working towards independence, referred from other YOTS programs & drug rehab services; have dealt with most serious drug & alcohol issues.								
Exclusions	Females with disabilities as female bedrooms are upstairs and no disabled access; don't take two sexual offenders at one time, but can have one.								
Philosophy	Ethos: Non-denominational and non-discriminatory, YOTS provides care for all children and young people in need. Mission statement: reclaiming & empowering chronically homeless youth by restoring social bonds & providing accommodation, education, vocational counselling & outreach services that respond to the spiritual, physical & emotional needs of youth, in a way that respects the dignity of each individual without reference to race or creed. McIntosh service - mission - to get young people ready for independent living. YOTS works from a strength-based perspective. There is strength within all young people; programs are structured to provide a stable homelike environment; education and vocational programs & assistance given to enable young people to make positive choices in their lives.								
Model or theoretical approaches	Case work model in all programs - other programs intertwined - mentoring, sheltered workshop; Strengths based approach; Address all levels of residents' needs; holistic approach to assist children and young people deal with trauma, within a CBT-based therapeutic treatment framework.								
Any specific therapeutic approach	Solution focused brief therapy								
Intended outcome	Transition to independent living, with better life skills								
Name of program or property	McIntosh House	**Suburb town**	Merry-lands	**DoCS region**	Met West	**Capacity**	13	**No. resi-dents**	8
DoCS region referring	Referrals from all DoCS areas, some residents placed from Western & Hunter Central Coast regions.								
Status of properties	Owned by agency								
Utilisation	About 80% utilisation. Less than fully utilised due to insufficient referrals meeting criteria, consideration of current residents needs & compatibility and staff shortage/recruitment issues.								
Average placement	9 months			**Longest placement**		2 years			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	10%								
Funding	Combination of fee for service & unfunded. McIntosh: agency contribution 95%								

Aftercare	Unfunded, McIntosh 1 active DoCS client (9 others)
Notable features	YOTS has variety of programs, some specialising in drug & alcohol rehabilitation – harm minimisation - abstinence models (while in residence).
Service development	Aim to focus on improving quality and best practice before expansion.
Contact	Kevin Ko, Manager, City & Northern service cluster, tel (02) 9721 5709 email: kevink@youthoffthestreets.com.au

Agency	**Youth Off The Streets Ltd. Holborow House** (note 4 profiles for different YOTS programs)								
Accreditation status at August 2005	Designated agency								
Target Group	12-18 years, males only, young kids who want to address homelessness, educational and vocational issues; behaviour issues; middle level needs group (next down from high / complex needs) Often have drug & alcohol issues, but not a criteria for entry.								
Exclusions	Primary mental health issues; no exclusions if can be managed with other residents								
Philosophy	Ethos: Non-denominational and non-discriminatory, YOTS provides care for all children and young people in need. Mission statement: reclaiming & empowering chronically homeless youth by restoring social bonds & providing accommodation, education, vocational counselling & outreach services that respond to the spiritual, physical & emotional needs of youth, in a way that respects the dignity of each individual without reference to race or creed. YOTS works from a strength-based perspective. There is strength within all young people; programs are structured to provide a stable homelike environment; education and vocational programs & assistance given to enable young people to make positive choices in their lives.								
Model or theoretical approaches	Case work model in all programs - other programs intertwined - mentoring, sheltered workshop; Strengths based approach; Address all levels of residents' needs; holistic approach to assist children and young people deal with trauma, within a CBT-based therapeutic treatment framework.								
Any specific therapeutic approach	Some aspects of therapeutic community; emphasise shared responsibility; peer information sharing; peer responsibility								
Intended outcome	Transition to independent living, with better life skills								
Name of program or property	Holborow House	**Suburb/ town**	Muswell -brook	**DoCS region**	Hunter CC	**Capacity**	5	**No. resi-dents**	5, 4 DoCS
DoCS region referring	Referrals from all DoCS areas, some residents placed from Western & Hunter Central Coast regions.								
Status of properties	Peppercorn private rental								
Utilisation	Fully utilised, 90% or more.								
Average placement	12 months			**Longest placement**		18 months			
Nature of program	Stand alone OOHC								
Percentage of statutory clients	20%								
Funding	Combination of fee for service & unfunded. Agency contribution 80%,								
Aftercare	Unfunded, 5 active clients.								
Notable features	YOTS has variety of programs, some specialising in drug & alcohol rehabilitation – harm minimisation - abstinence models (while in residence).								

Service development	Aim to focus on improving quality and best practice before expansion.
Contact	Kevin Ko, Manager, City & Northern service cluster, tel (02) 9721 5709 email: kevink@youthoffthestreets.com.au

Agency	**Youth Off The Streets Ltd. Southern Highlands services** (note 4 profiles for different YOTS programs)								
Accreditation status at August 2005	Designated agency								
Target Group	13-18 years, no more than 16 on entry; high to intensive high needs category. Header Agreement states it is possible to have low to moderate needs clients, but they don't get referrals in that category. Saroy: girls only; Foundation & Lois – boys only, Lois is predominantly Aboriginal. Siblings have been placed in service.								
Exclusions	Severe physical or intellectual disability; Young people who are psychotic. Have had approaches from interstate - non accepted								
Philosophy	Ethos: Non-denominational and non-discriminatory, YOTS provides care for all children and young people in need. Mission statement: reclaiming & empowering chronically homeless youth by restoring social bonds & providing accommodation, education, vocational counselling & outreach services that respond to the spiritual, physical & emotional needs of youth, in a way that respects the dignity of each individual without reference to race or creed. YOTS works from a strength-based perspective. There is strength within all young people; programs are structured to provide a stable homelike environment; education and vocational programs & assistance given to enable young people to make positive choices in their lives.								
Model or theoretical approaches	Case work model in all programs - other programs intertwined - mentoring, sheltered workshop; Strengths based approach; Address all levels of residents' needs; holistic approach to assist children and young people deal with trauma, within a CBT-based therapeutic treatment framework.								
Any specific therapeutic approach	Aiming to develop consistent treatment approach; creating a therapeutic community within the residential care setting. A clinical trauma specialist is working on re-designing the model with staff psychologist and program counsellor. At present use Cognitive Behaviour Therapy & Motivational Interviewing & solution focused brief therapy. Bringing in Positive Peer Culture and TCI. Training to be implemented across all Southern programs, eventually to extend to all agency programs.								
Intended outcome	Overall goal includes healing the effects of past trauma; successful transition to home or semi/independent living.								
Name of program or property	Saroy House	**Suburb/ town**	Canyon-leigh	**DoCS region**	Metro South West	**Capacity**	4	**No. resi-dents**	3
Name of program or property	Found-Ation House	**Suburb/ town**	Canyon-leigh	**DoCS region**	Metro South West	**Capacity**	8	**No. resi-dents**	7
Name of program or property	Lois House	**Suburb/ town**	Marulan	**DoCS region**	S'thern	**Capacity**	5	**No. resi-dents**	5
DoCS region referring	Referrals from all DoCS areas, some residents placed from Western & Hunter Central Coast regions.								
Status of properties	FH and Lois owned by agency; Saroy House: peppercorn private rental								
Utilisation	Fully utilised, 90% or more. Waiting list for referrals								
Average placement	12 – 18 months			**Longest placement**		2 years			
Nature of program	Stand alone OOHC								

Percentage of statutory clients	80%
Funding	Combination of fee for service & unfunded. Saroy, Foundation & Lois: agency contribution 40%
Aftercare	Partly funded for Southern Highlands, low level, number active clients not known - maintain social contact if whereabouts is known; proactive support immediately post discharge, long term support is usually at client or family instigation rather than proactive.
Notable features	YOTS has variety of programs, some specialising in drug & alcohol rehabilitation – harm minimisation - abstinence models (while in residence). School on campus site is attended by residents from Southern highlands residences. Usually staff work 8 hours shifts, plus sleepover. 2 staff on duty in larger residences or where extreme high needs clients are located, & stand up shifts, if funded, as required
Service development	Southern Highlands: Agency would like to develop semi independent options, smaller units for those who have settled & are approaching leaving care age; plus in process of developing a cluster of indigenous programs - Lois property at Marulan will be sold - relocation to Canyonleigh (one house currently available & proposing to build 2 new houses on the property. Indigenous program is coordinated by an indigenous Cluster Manager and Indigenous Services manager. Bargo House - is closed at present - will open soon as boys / generalist house.
Contact	Jayne Power, Assistant Services Director Programs Southern tel: (02) 4878-9297 Email: jaynep@youthoffthestreets.com.au

Agency	**Youth Off The Streets Ltd. New Pathways (formerly Mirvac)** (note: 4 profiles for different YOTS programs)								
Accreditation status at August 2005	Designated agency								
Target Group	Males, 13 - 16 years on entry; proven sexual offending (conviction or confirmed report); willing to participate; admit they have a problem & want to work on it; prefer court-mandated. Can accommodate special needs eg Asperger's Syndrome. Extensive risk assessment process required before entry. Referrals from all regions.								
Exclusions	Severe physical or intellectual disability (due to premises and nature of the program - need to engage in counselling); young people with mental health issues which cannot be stabilised through medication.								
Philosophy	Ethos: Non-denominational and non-discriminatory, YOTS provides care for all children and young people in need. Mission statement: reclaiming & empowering chronically homeless youth by restoring social bonds & providing accommodation, education, vocational counselling & outreach services that respond to the spiritual, physical & emotional needs of youth, in a way that respects the dignity of each individual without reference to race or creed. YOTS works from a strength-based perspective. There is strength within all young people; programs are structured to provide a stable homelike environment; education and vocational programs & assistance given to enable young people to make positive choices in their lives.								
Model or theoretical approaches	Case work model in all programs - other programs intertwined - mentoring, sheltered workshop; Strengths based approach; Address all levels of residents' needs; holistic approach to assist children and young people deal with trauma, within a CBT-based therapeutic treatment framework. New Pathways Treatment Program for Male Adolescents with Problematic Sexual Behaviour uses individual and group therapy within a residential care setting, providing treatment and education to meet needs holistically and with a view to stopping sexual offending behaviour.								
Any specific therapeutic approach	Positive Peer Culture, Good Way Model; Therapeutic Crisis Intervention TCI, Relating to the Reluctant-RAP, Trauma Sensitive Treatment all staff trained. Key staff trained in Life Space Crisis Intervention, Clinical staff and consultants accredited through CSOCAS.								
Intended outcome	to cease offending; to equip YP with insight, empathy & understanding of their behaviour.								
Name of program or property	House 1	**Suburb/ town**	Sutton Forest	**DoCS region**	Metro South West	**Capacity**	6	**No. of residents**	3
Name of program or property	House 2	**Suburb/ town**	Sutton Forest	**DoCS region**	Metro South West	**Capacity**	2-4	**No. of residents**	2
Name of program or property	House 3	**Suburb/ town**	Sutton Forest	**DoCS region**	Metro South West	**Capacity**	2-4	**No. of residents**	1
DoCS region referring	Referrals from any region								
Status of properties	Owned by agency. NP campus model.								
Utilisation	Partially utilised, 60% or more. Frequently only have one person in a house - due to behaviour, safety, high supervision needs. Houses have space for up to six, but that is not real capacity.								
Average placement	14-16 month program			**Longest placement**		24 months			

Nature of program	Stand alone OOHC
Percentage of statutory clients	100%
Funding	Combination of fee for service & unfunded. Agency contribution 40%.
Aftercare	Unfunded, Lengthy reintegration process at New Pathways with follow up through client initiated contact
Notable features	New Pathways is the only specialised residential service for sexual offenders in NSW. New Pathways has 2 staff on duty, awake shifts including bed checks to closely supervise residents, given the nature of the residents' issues.
Service development	No specific development plans for new Pathways.
Contact	Jayne Power, Assistant Services Director Programs Southern tel: (02) 4878-9297 Email: jaynep@youthoffthestreets.com.au

Appendix 2 Agencies and people interviewed

NSW residential care agencies

Agency	Detailed interview	Other interview
Allambi Youth Services	Peter Walsh & Simon Walsh	
Anglicare Child & Family Services	Linda Griffith	Peter Gardiner
Anglicare Youth & Family Services (Canberra & Goulburn)	Deb Tozer	
Bankstown Handicapped Children's Centre	Cheryl Moore & Philip Petrie	
Baptist Community Services	Helen Isenhour	
Barnardos Australia	Bill Hoyle	Louise Voigt
Boystown	Bronwyn Towart	Jim Doyle
Careforce Support	Pauline O'Leary & Helen Parkes	
Caretakers/Entity	Laurie Matthews	
Caringa Enterprises	Deidre Jones & Janet Master	
CASPA	Lisa Gardiner	
Centacare Broken Bay	Jean Murray	
Community Connections North Coast	Julie Leete & Michelle Wainwright	
Community Programs	Jane Allen	
De's Consultancy	Kim Whitney & Cath McGrath	
Eddy's Place	Karen Grant	Juanita Winks
For the Children	Alison Serena	
Hunter Support Services	Chris Langham	David Fleming
Impact Youth Services	Warren Sedman	
Intensive Support	Stephen Howald	
Links	Katrina Hyland	
Lutanda	Denise Lloyd & Angela Thomas	
Macleay Kalipso	Col Williams	
Marist Youth Care	Ken Buttrum	
Meeting Ever Changing Needs	Patrick Kearns	
Missionary Sisters of Mary Queen	Sister Justina Pham	
Nick Kearns House	Jill Short & Peter Holt	
Premier Youthworks	Lisa Glen	
Rainbow Home & Respite Services	Donna Reid	
Sheach	Peadhar & Libby Sheach	
Shoalcare	Chris Stubbs	Andrew Munro
SOS Visiting Nursing Service	Rosemary Hyles & Elizabeth Piper	
Southern Youth & Family Services	Kevin Crowe & Helen Ngaau	Narelle Clay
St Josephs Cowper	Sue McKimm & Mick Smart	
Stepping Stone House	Finn Callinan	
Stretch-A-Family	Narelle Gurney	Lilian Camenzuli
Uniting*Care* Burnside	Andrew O'Brien	Jane Woodruff
Wendy's Home Services P/L	Kate Buchan	
Wesley Dalmar	Annette Posimani	Sue Sarlos
Wundarra Services	Larry Barber	
Youth First (formerly SEAS)	Skye Williams	
Youth off the Streets	Brendan McNicholl	Kevin Ko; Jayne Power

NSW non-residential care OOHC agencies

Aboriginal Children's Service	Bev Coe
Albury Wodonga Youth Emergency Service	Di Glover
Burran Dalai	Dana Clark
Centacare Newcastle	Maureen O'Hearn
Centacare Sydney	Maureen Eagles
Centacare Wollongong	Kathleen McCormack
Great Lakes Macquarie Aboriginal Children's Service	Amanda Bridge
Hunter Aboriginal Children's Service	Steve Larkins
Kari Aboriginal Resources	Paul Ralph
Life Without Barriers	Ray Dunn & Rob Dawson
Macarthur District Temporary Family Care	Annamaria Wood
Mallee Family Care	Meaghan Harris
Mission Australia: Triple Care Farm	Gabriella Holmes
Ngunya Jarjum Aboriginal Corporation	Lenore (Mina) Marlowe
Phoenix Rising	Christine Lyle-Williams
Relationships Australia Aftercare Resource Centre	Vanessa Harnischmacher
Samaritans	Cec Shevels & James Marshall
Shoalhaven Aboriginal OOHC service	Jannice Lurland
The Burdekin Association	Karen Berman
United Protestant Association	Jeff McDonald
William Campbell College	Bill Campbell

NSW Peak organisations

Aboriginal Child, Family & Community Care State Secretariat	Kate Lindsay
CREATE Foundation	Young consultants
Foster Care Association	Mary Jane Beach
Youth Accommodation Association	Michael Coffey

DoCS Regional Directors

Metro South West	Anne Campbell
Hunter	Anne Maree Gleeson
Southern	Jill Herberte
Western	Glynis Ingram
Northern	Denis Myer
Metro West	Marg Oldfield
Metro Central	Anne Maree Sabellico

Other jurisdictions

ACT

Dept Disability, Housing & Community Services, Office of Children, Youth & Family Support	Brenton Alexander
Marymead Child & Family Centre	Dawson Ruhl
Richmond Fellowship	Wilf Roth

NT

Family and Children's Services	David Richardson

QLD

Dept of Child Safety	Belinda Hersey
Pathways South West (Churches of Christ Care - Family and Community Care Division)	Shelley Wall
Anglicare Brisbane (SE Qld)	Steven King
Save the Children Qld	Lisa Hillan

SA

Dept of Child, Youth and Family Services	Shaun Lappin
Baptist Community Services (Youth Care)	Phil Dunkley
Salvation Army (Muggys)	Dianne Jarrott

Tasmania

Clarendon	Marian Rainsford
Glenhaven Family Care	Cheryl Jones

Victoria

Dept of Human Services	David Clements & Helen Brain
Anglicare Victoria	Sue Sealey
Berry Street	Marg Hamley & Jenny Cummings
Centre of Excellence (The Centre)	Sunitha Raman & Michael White
Mackillop Family Services	Paul Linossier, Anne Condon, Greg Broadbent & Carla Cotter
Menzies	Ian Berry
Salvation Army	Chris Jones, Peter Mulholland, & Glenys Bristow
VACCA	Gwen Rogers, & Alison Clarke

WA

Department of Community Development	John Carter
Mercy Community Services	Francis Lynch

Appendix 3 NSW interview guide

Agency name: _____

Person interviewed: (name & position) _____

Interviewed by: _____ Date of interview: _____

By residential OOHC care, we mean OOHC placement in a property owned or rented by the agency, in which one or more children or young people are placed, and which are staffed by either direct care staff working on a rostered basis or by house parents, who are not regarded by the agency or themselves as foster carers. It may also include support to transition to independent living households if funded by DoCS OOHC program/ffs arrangements, but that may not be staffed full-time.

1 Does your agency provide any residential OOH care services?

Yes ☐ No ☐

Instruction: If no res care program/service, go to Q 64

Current residential care providers

Introduction
The following is a series of questions about your residential OOHC projects/services. After that we'll ask questions about the place and future of res care in the service system. The focus of information collection is on services and programs, not on personal details of current or past residents.
The whole interview may take about 1.5 hours.

The information in this first part of the survey will not be confidential – it will be used to develop a summary profile of the res care services your agency provides. This will be included as part of a public report, which will be provided to DoCS and participants. You can ask for any answer to be OFF THE RECORD – your request will be respected. Detailed information about your service will only be used in an aggregated and non-identifying way. Results from second part (future of res care) will be collated and reported in a non-identifying way.

Are you okay with that? (record answer) _____

If your agency is mainly a SAAP or a disability service, we will note that, but we would like your answers to relate to the OOHC component of your service.

2 Residential OOH care project name/s & location (of residence):

name/suburb *DoCS region/network*

_____

3 Is the residential OOHC service stand alone or accommodated in another type of service?

Stand alone ☐ in SAAP ☐ in Disability service ☐

Interviewer tip: Could be different answers for different residences or funded projects – be careful to differentiate answers, or fill out additional forms, if needed.

Target group & exclusions, if any

4 What is the stated target group for your OOHC residential service(s) – advertised age range and any defining characteristics (eg gender, high needs; challenging behaviour; age-based only; sibling groups; disabilities)?

Use Excel profile provided by DoCS for program-funded to check still same, write down if different. Tip: may be different in different residences)

_____

5 Are there any exclusions from target group, apart from age (eg sexual offending, disabilities)?

_____

6 Were any exceptions made to accepting referrals, outside the advertised target group, in the 2004 calendar year?

Yes ☐ No ☐

6a If Yes, what 'excluded' children or young people were admitted? On what basis were exceptions made?

_____

7 Usually, what percentage of residential clients are voluntary (placed by parents/self or DoCS without court involvement) or statutory (under court orders, parental responsibility of the Minister/care of the DG)?

Voluntary ☐ % Statutory ☐ %

Capacity

8 What is the maximum OOHC capacity, current OOHC occupancy and total capacity in each residence (if other SAAP, DADHC places)?

	Capacity	Current number tot OOHC+other)	
Residence 1:	☐	☐	☐
Residence 2:	☐	☐	☐
Residence 3:	☐	☐	☐
Other houses:	☐	☐	☐

9 Is OOHC capacity generally fully utilised (say 90% or more, ie 4-5 weeks vacancy per place per year)? Yes ☐ No ☐

9a If No, what is average number of places occupied OR what is the percentage of utilisation, averaged over last financial year?

Number ☐ Percentage ☐ %

9b If No, why was capacity under-utlilised in that year? (may be more than one reason)

Insufficient referrals fitting target and exclusion criteria ☐
Delays in assessment of appropriate referrals ☐
Considerations re current residents needs & compatibility ☐
Staff shortages/vacancies/recruitment issues ☐
Staff skill/experience deficits ☐
Other (specify)_____

10 Was maximum stated capacity ever exceeded in the last financial year?

Yes ☐ No ☐

10a If Yes, by how many places and for how long was it exceeded? Why was it exceeded? And what additional money (if any) was received from DoCS?

_____

Funding

11 What is the nature of core/major funding of OOHC res care program?

OOHC Program funded only ☐
Fee-for-service only ☐
Combination Program funded & FFS ☐
Unfunded (by govt)/agency funding ☐

12 If possible to estimate, what percentage of the residential care service is funded by DoCS & what is percentage is agency funded?

DoCS OOHC funded ☐ % Agency/other funded ☐ %

13 Does the agency charge board/ rent to be paid by residents or family?

Yes ☐ No ☐

If Yes. details _____

Housing stock

14 Is the accommodation for the residential service owned, being purchased or public or community housing or other low rental rented or privately rented?

	Owned	Mortgage	Public rent	Private rental
Residence 1	☐	☐	☐	☐
Residence 2	☐	☐	☐	☐
Residence 3	☐	☐	☐	☐

Other residences _____

Philosophy, model and therapeutic approach:

15 What philosophy underpins the residential care program?

_____

16 What model/s or theoretical approach/es, is applied in the residential care program?

_____

17 What, if any, specific therapeutic approach is used? – prompt: have multi-systemic therapy; harm minimisation; solution-focused therapy; been implemented?

_____

Case management and case work

18 Does agency use a structured approach to case management and casework? (Prompt LAC or other propriety or own system)

Yes ☐ No ☐

18a If Yes, briefly describe/name system?

_____

19 Does DoCS or the agency formally hold case management responsibility, ie responsibility for oversight of implementation of short and long term care plan?

DoCS ☐

Agency ☐

Different for different clients ☐

Not sure who has case management responsibility ☐

Unclear what is meant by case management ☐

19a Any additional comments

_____

20 Of the following tasks, what do agencies usually do and what does DoCS usually do, in relation to most clients? *(can be both)*

Task	DoCS	Agency
Develop Care Plan for court		
Develop Case Plan (annual)		
Convene case conferences		
Undertake statutory reviews		
Develop & implement individual client plans and programs with clients		
Casework or support work with birth family		
Manage and support family contact		
Prepare transition or leaving care plans		
Arrange next placement (if still in care)		
Arrange/help young person to arrange accommodation on leaving care		
Provide aftercare support		

Program – what happens in the household

21 Is school /TAFE/univ attendance or employment seeking/work assumed/required?

Yes ☐ No ☐

22 What happens if kids are excluded from school (suspended/expelled)?

Supervision only, recreational activities ☐

Tutoring/Education program provided by agency ☐

Alternative education program other provider ☐

22a If own program, briefly describe

_____

23 What happens in the day for older young people who have left school and are unemployed?

_____

24 What usually happens after school or work or at weekends? *(can be more than one)*

Activity	Daily	Several days/week	At least once a week	Less than once a week	Not at all
Homework time					
Homework support (staff time, formal)					
House-based formal / set recreational activities					
Community based activities (sport, hobbies)					
Free time, such as seeing friends, TV, video or computer games					
Formal Living skills program					
Household duties/chores					
House meetings					
Family visits to residence					
Family contact (outside residence)					
Other (add anything else significant)					

24 additional comments on program:

_____

25 (question deleted)

Family

26 How are birth families involved in the program?
(prompt: is involvement structured, integral or informal, incidental to program?

_____

27 Are siblings ever placed together in your residential care?

Yes ☐ No ☐

27a If Yes, think about the current or the most recent siblings placed with in your res care services: Why were they placed in your res care program? *(prompt: was this only option due to difficulty in placing in foster care? Was res care determined as option that best met their needs?)*

_____

Behaviour management / critical incidents

28 What is the agency approach to behaviour management? (eg Agency policy; Individual behaviour plans; use of physical restraint)

_____

29 What arrangements are there for staff support in the event of emergencies/critical incidents during the day?/after hours?

_____

Staffing & rosters in rostered staff models (if only group home, go to >>>>Q31

30 Describe the staffing structure in each OOHC residence (numbers, position titles, roster arrangements, sleepover/stand up shifts)

Position	Total no. to cover 1 week (FTE)	Number on duty day	Number on duty night (asleep or stand up)	Shift hours (if applicable)	Hours/per week
Direct care (res care/youth workers)					
House manager/senior worker at house (if applicable)					

May need additional forms, if structure different in each residence
If not running family group home, group home , go to >>> Q34

Family group home/ Group home

31 How is group home staffed? (one/two people; married/single/defacto; one person working in home only, partner employed out of home)

_____

32 How much respite is provided to house parents?

No regular planned respite ☐
In event of crisis/illness ☐
2 days per fortnight ☐
2 days per month ☐
Other amount ☐

32a Where is respite provided?

House parents go elsewhere ☐
Kids go elsewhere ☐

33 How are group home staff (house parents) paid?

Salaries/wages	
Stipend, honorarium	
Standard foster care allowances only	
Higher than standard foster care allowances	
Other (eg car/house/meals provided)	

33a If Other, add details

_____

ALL TO ANSWER FROM HERE

34 What other staff are directly involved in managing or supporting the res care service?

Position	Number (FTE)	Hours per week employed	Hours spent at residence /week
Coordinator/manager (not doing direct care)			
Caseworker			
Psychologist/counsellor			
Education specialist/tutor			
Youth workers/mentors			
Other			

35 What position is responsible for supervision of direct care staff?

_____

36 What external additional support is available & where does it come from ? (prompt: contracted consultant, DoCS, private practice/ffs, other)

_____

37 What is the caseworker to resident ratio?

38 What is the supervisor to caseworker ratio?

39 If your agency sets a minimum qualification or experience level for residential care staff, what is it?

Direct care staff/House parents _____

House managers/coordinator _____

Caseworkers _____

Casework supervisors _____

40 What are the key skills, attitudes and knowledge (competencies) you look for in residential care staff?

_____

41 Does your agency have difficulty in recruiting residential care staff?

Yes ☐ No ☐

41a If Yes, briefly describe the difficulties.

_____

41b If No, briefly describe why you have little / no difficulty?

_____

42 Are there difficulties in recruiting people with competencies for management positions in residential care services?

Yes ☐ No ☐

43 How can competencies in residential care work be developed? (prompt: more in-service or external courses in res care; NRT in res care; tertiary courses specialising in res care)

_____

Individual residential placements (one-to-one, two-to-one)

Only answer these questions if your agency has provided individual residential care (one child or young person per household, rostered staff) on more than two occasions in last 12 months.

Do not answer if this occurs only occasionally, due to temporary vacancy in a residence, reducing resident number to one.

If No individual residential placement, go to >>> Q49

44 What are the circumstances which would lead to a decision to have one resident placed alone with (rostered) staff?

_____

45 Thinking about any such placements that occurred in the last 12 months, how long do such placements continue on average?

☐

46 What usually happens at the end of the individual residential placements, thinking about any in the last 12 months?

Placement in your agency with other residents	☐
Mental health service /hospital	☐
Continues indefinitely / doesn't end	☐
Resident goes home (birth family)	☐
Resident goes to another OOHC agency	☐
Other	☐

If other, add details

_____

47 Are children or young people in individual residential placements prevented from leaving the residence, by the level of supervision and/or locked doors or gates at all times (not just at night)?

Yes ☐ No ☐

48 In your opinion, what are the benefits of and/or issues with individual residential care?

_____

ALL to Answer from here

Duration of residential placements

49 What is the intended maximum length of stay in the residential program?

☐

50 What was the average length of stay of the residents in last completed financial year?

☐

51 What was the range of length of stay in the residential care program of the residents in last completed financial year or calendar year? (note: longest stay may be longer than 1 year)

Shortest ☐ Longest ☐

Progress and outcomes

52 What, if any, are the broad stated or intended outcomes for individuals in the program?

_____

53 Is there any staged approach, by age or behaviour, involving different levels of support and/or supervision in the residential program?

Yes ☐ No ☐

54 How is success or progress measured? (prompt: is there formal checklist or assessment, on entry, during placement)

_____

55 Have any service evaluations been done?

Yes ☐ No ☐

56 Have any evaluations of client outcomes been done?

Yes ☐ No ☐

57 Who usually decides when the resident will exit the program?

Agency ☐ Resident ☐

Family members ☐ DoCS ☐

Combination ☐

57a If a combination of people, briefly describe

_____

58 Does the agency have a formal transition to independence program?

Yes ☐ No ☐

58a If yes, briefly describe the program

_____

(note: Aftercare questions come later)

Boundary/linkages

59 How does the residential care service relate to other services provided by same agency (referrals, continuum, transition, exit points)?

_____

60 Does the residential care service make referrals to or plan transition to other agencies, if a different service is needed not provided by your own agency?

Yes ☐ No ☐

61 What relationships/links do your agency have with DET, NSW health, other professionals or govt service sectors (other than DoCS)

_____

Aftercare (post-placement & post-OOHC) services – including restoration/ transition to independence)

62 Does the agency offer any aftercare (or continuing care) to residents after they leave placement with your agency and/or the care system (discharged from care)?

Yes ☐ No ☐

62a If yes, what type of services are offered? (can tick more than one)

- Casework support (medium to high/intensive) ☐
- Casework support (low level) ☐
- Support to family following restoration ☐
- Maintenance of social contact/events ☐
- Information & referral ☐
- Material support/goods/money ☐
- Other (specify) _____ ☐

62b What number of former residents currently receive after care contact or support from the agency? ☐

63 Is the aftercare funded by DoCS?

Yes ☐ No ☐ Partly ☐

About residential care in general (ask Residential Care providers and non-Residential Care providers)

Introduction: (for people who didn't answer first part)
The following is a series of questions about the place and future of res care in the service system. Answers will be collated and reported in a non-identifying way.

64 For what age ranges, target groups, and/or characteristics should res care be available as an option (not necessarily provided by your agency)? Prompt: is there a place for a standard res care, not high/complex needs focussed?)

Age ranges/s _____

Target group/s _____

Characteristics _____

No-one should be in res care
(please add details about your view) _____

65 Where are the geographic gaps (DoCS region/network area) in provision of residential care?

_____

66 (question re estimating how many places needed: deleted)

67 Is there a place for specialist assessment services (residential facility-based) that could assess then make referrals for longer term placements or other support to more than one agency?

Yes ☐ No ☐

67a Any additional comments on assessment services?

_____

68 In your opinion, what are the benefits of and/or issues with individual residential care (placement of one resident with rostered staff care 24/7)? *(ask this if not a provider of individual res care, same as Q48)*

_____

69 Name (& briefly describe) any innovative models you are aware of, in Australia or overseas, that warrant exploration to see if they fit NSW? (note: if not formally & independently evaluated, innovative may not mean better or best practice.)

_____

70 Which sector should operate residential care facilities?

NGOs ☐ DoCS ☐ Both ☐

70a Any additional comments on which sector?

_____

71 How could agencies cooperate in delivery of aspects of residential care services – for example assessment; critical incident response services? (through consortia, specialisation – regional or statewide, joint (2 agency)

_____

72 What role, if any, should be played by SAAP services in OOHC residential care?

_____

73 What research, if any, is needed into residential care?

_____

74 If agency had sufficient funding, would the agency provide residential care / expand current residential care?

Yes ☐ No ☐

74a If Yes, would that be in any particular location or of any specific type?

_____

75 Do you have any other comments about residential care that we haven't covered in the interview?

_____

Thanks for your cooperation!

Appendix 4 Interstate interview guide

Name of person, position:_____

Dept or Agency:_____ State or Territory: _____

Interviewed by: _____ Date of interview: _____

Introduction

Explain the nature of the research project and intended outcome: report to DoCS & participants, to inform future development of the OOHC system, esp. res care component. Focus is on key policy directions in residential care and on key aspects of the residential care models operated in your jurisdiction. Not on clients. Responses will not be directly attributed to you, but will be used to collate a picture of the situation in your state / territory regarding residential care.

By residential care we mean:

placement in a property owned or rented by the agency, in which one or more children or young people are placed and which are staffed by either direct care staff employed on a rostered basis or by house parents or carers, who are not regarded by the agency or themselves as foster carers.

Service Providers and Models

1 GOVT: Which sector operates res care (govt, NGO, both)?: Are for-profit agencies involved in res care service delivery in your jurisdiction?

- ☐ Government
- ☐ NG not-for-profit
- ☐ NG private for profit

2 GOVT: What types of residential care are provided in your state/territory?
NON_GOVT: What types of residential care does your agency provide?

- ☐ Small Congregate care 2-4 places in one residence
- ☐ Medium congregate care 5-8 places in one residence
- ☐ Large congregate care 9 or more in one residence
- ☐ Individual res care (one person in one residence
- ☐ Other number/size

3 What staffing arrangements are used in res care in your agency?

- ☐ Rostered staff 8-10 hours shifts
- ☐ Rostered staff longer, up to 24 hour shifts (with sleepover)
- ☐ Rostered staff over 24 hours (describe)_____
- ☐ House parents/family group home
- ☐ Any other staffing arrangements?

_____

4 For what age range is res care usually provided? _____

4a Are children younger than the lower age that ever placed in res care?

- ☐ If, yes (how young?)_____

4b GOVT: Are there policies or regulations that set the minimum preferred age for entry to res care or actually preclude res care for children under a certain age? If yes, describe

_____

5 What duration is usually intended for res care? (can tick more than one)

- ☐ crisis, ST (up to 3 months)
- ☐ medium term (up to 12 months)
- ☐ long term (over 12 months)

5a Any other comments on duration:

_____

6 What, if any, specialised models of res care are provided for particular groups:

- ☐ indigenous ch & yp
- ☐ CALD ch & yp
- ☐ high/complex needs ch & yp;
- ☐ sexual offenders
- ☐ ch/yp needing secure care
- ☐ Sibling groups
- ☐ Adolescents (Semi-independent / transition to independence)

If yes, seek more info on each group/model

_____

7 Is any res care characterised as therapeutic? yes no

7a If yes, what aspect of the service or program is 'therapeutic'?

_____

7b How are specialist therapeutic (including educational) services accessed?

_____

8 Have any of these specialised models (or your res services in particular) been independently evaluated?

_____

9 Are any of these specialised models evidence based?

_____

10 If any individual res care is used, ask for more info (entry processes, programs, exit, issues)

_____

11 Which agency does case management of res care clients?

☐ Government ☐ Agency ☐ Negotiated shared responsibility

12 How is referral and placement in res care managed?

_____

13 How is exit from res care managed?

_____

Funding

14 How is NGO res care currently funded?

☐ Recurrent funding – one year, usually renewed

☐ Recurrent funding – longer periods (usually renewed 3 yrly)

☐ Contracted funding - fixed term

☐ Fee-for-service short-term

15 Have costing or resource allocation models / formulae been developed to provide a rational basis for funding of res care?

☐ Yes ☐ No

15a If YES, seek more info

_____

15b Do you think the amounts are adequate for the purposes?

☐ Yes ☐ No

15c Are different amounts allocated for government/NG providers?

☐ Yes ☐ No

☐ Not applicable (one sector not doing res care)

15d Is aftercare service included as a component of res care funding?

☐ Yes ☐ No ☐ Partly funded

16 Are contracts or funding agreements specific about vacancy / occupancy levels?

☐ Yes ☐ No

Policy and changes in policy direction

17 What is your view on the place and role of res care as part of OOHC placement options?

_____

18 Have any planned or unplanned changes occurred in last five years in the policy regarding or provision of res care? Are there any current plans being implemented? ie reduction, increase, decisions taken to develop, improve or change the types or models of res care in particular, reasons for the changes?

19 Are current models the ones you want/need?

_____

Monitoring, accountability and standards

20 Do you have a system of accreditation of OOHC in general or res care in particular? If yes, seek more info

_____

21 Do you have a system of independent visiting/scrutiny of res care placements or agencies providing res care? If yes, seek more info

---

22 How is agency performance in provision of res care monitored by the funding body?

Client related:

- ☐ Regular written reports regarding residents
- ☐ Casework visits or meetings

Agency /program level:

- ☐ Regular visits to agency (not specific to clients)
- ☐ Performance reports or reviews
- ☐ Data collection

23 Any other comments

Thank you!

Appendix 5 Interstate consultation results

ACT	
Interviewees	Two non government agencies interviewed, plus one government representative
Age range	Policy 12-17. On occasion children under 12 placed in residential care. Minimum ages of these younger children could not be specified. The Care and Protection manual and contracts between government and non-government providers specified minimum age for children in residential care. Actual 10-17, min 8 years placed by two agencies
Types	Small congregate care (2-4 places in one residence) Medium congregate care (5-8 in one residence) Individual residential care (one person in one residence)
Duration	Placements could be: • Crisis, short term (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months) One agency provided crisis/short term residential care, but stay could go over 3 months. One resident had stayed 250 days. Normally that agency cared for 150 children a year: One third stayed less than 21 days, with the remainder staying between 30-60 days.
Staffing models	Rostered staff on 8-10 hour shifts, and longer shifts of up to 24 hours with sleepover.
Specialised models	Specialised models of residential care were provided for the following groups: • High/complex needs children and young people • Sexual offenders • Sibling groups • Adolescents (semi-independent/transition to independence) One agency had developed a model for sexual offenders: a two bed unit for boys who had been bailed to stay there by the courts. They also had a two-bed unit for girls, which operated as respite care. Both services were highly supported by staff and counsellors. The other agency stated that their models were developed in response to individual needs. A specialised model for adolescents was not common and only occurred on special arrangement in a residential care unit. Some residential care was characterised as therapeutic, although the Act has no provisions for a therapeutic order. Therapy was provided (in particular for young people with sexually inappropriate behaviours) but was not included in Care Project (case plan). Non-government agencies provided counselling and support, specialised behaviour programs and individual plans for each child. One agency accessed specialist support services through the Office of Child, Youth and Family Support, whilst the other agency said that funding levels did not allow any external resourcing.
Individual placements	One agency had occasionally provided individual residential care, in response to a Departmental request. Young people only stayed in individual residential care for 3-4 months, then they were transitioned into traditional residential care or to family.
Evaluation/ evidence base	There had been no independent evaluation of models used by agencies and none of the models were reported to be evidence based.
Case management	The government held case management responsibility, with one agency stating that they had a negotiated shared responsibility. *Looking after children* system is used in the ACT.
Referral & exit	A placement review committee consisting of representatives from

processes	government and non-government agencies considered referrals. Lack of capacity led to a less systematic approach than was desirable. When exiting care, transition plans were worked out with government, families and carers. All agencies fully utilised the Federal government's Transition into Independent Living Allowance.
Accreditation/ monitoring	No system of accreditation of OOHC in general or residential care in particular. The Office of the Community Advocate provides Official Visitors, but agencies reported that the Community Visitors do not visit general residential care facilities, only specialist facilities (i.e. "lock-up") and are crisis focussed. Reporting mechanisms included: • Regular written report regarding residents • Casework visits or meetings • Regular visits to agency (not specific to clients) • Performance reports or reviews • Data collection
Funding	Funding arrangements were in transition from annual to triennial funding. Two resource allocation models were used: one model included staffing, SACS awards and costing for the child and the other model was costed for government housing. Agencies stated that the rationale for costing models had not yet been validated, due to changes to procurement processes. Both agencies believed that the amounts allocated for funding were not adequate for the purposes, whereas the government representative thought they were. After care service was partly funded by government. Both the government representative and one agency said that contracts or funding agreements were not specific about vacancy/occupancy levels, whereas the other agency said that their agreement was specific.
Developments/ trends	Agreement was expressed that residential care had a role in OOHC. The identified age group were 13-15 year olds, as virtually no foster care placements available for that age group. Residential care was seen as a good option for young people who had experienced continued breakdowns in placement and for young people whose characteristics determined their placement needs. Agencies reported an increase in the number of high needs young people coming through their services. Recent changes in the ACT as a result of *The Territory as Parent: Review of Children in Care in the ACT and of ACT Child Protection and Management*[23]. Additional funding was made available, including an increase of 50 beds in residential care. The new tendering process recognised different levels of needs (general, crisis, therapeutic). Agencies shared the view that residential care was receiving increased recognition by government, but there was concern about lack of funding for services and models. Agencies agreed that the current models were not adequate, but were the only ones able to be provided, given available funding. A range of options and flexible funding arrangements were needed. A range of models were under consideration by government (process underway at August 2005).

[23] Cheryl Vardon (2004), *The Territory as Parent: Review of Children in Care in the ACT and of ACT Child Protection and Management*, ACT Government.

Northern Territory	
Interviewees	A Department of Family and Children's Services representative was interviewed: the Department was starting to provide residential care itself. A non-government agency, previously the main provider, will be providing a stabilising program of 3-6 months and emergency placements. The NGO was not interviewed.
Age range	Policy stated age is 12+ years. Residential care was usually provided for children and young people 10+ years of age. Children younger than 10 years of age were sometimes placed in residential and these placements related to capacity and behaviour.
Types	Types of residential care provided were: • Small congregate care (2-4 place in one residence) • Individual residential care (one person in one residence)
Duration	Placements could be: • Crisis, ST (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months)
Staffing models	Staffing arrangements consisted of rostered staff on 8-10 hour shifts and a mixture of carers, youth workers and professional staff.
Specialised models	Specialised models of residential care were provided for the following groups: • Indigenous children and young people • High/complex needs children and young people • Children and young people needing secure care • Adolescents (semi-independent/transition to independence) Up to 70% of children and young people in care were indigenous, therefore some services were solely for indigenous kids. 'Stabilisation units' were classified as secure care. Transition into individual care was a model developed for adolescents. No residential care characterised as therapeutic. Specialist therapeutic services accessed through government departments or via individual providers.
Individual placements	Planned to be integrated as part of services.
Evaluation/ evidence base	No independent evaluations. Models were not evidence-based.
Case management	The Government department held case management responsibility.
Referral & exit processes	Referral and placement in residential care was by an assessment panel. Exit from residential care was a joint decision between stakeholders.
Accountability/ monitoring	No system of accreditation of OOHC in general or residential care in particular. Standards were in place and requirement for accreditation would be addressed in proposed legislation. There was no system of independent visiting or scrutiny of residential care placements or of agencies providing residential care. Reporting mechanisms included: • Regular written reports regarding residents • Casework visits or meetings • Regular visits to agency (not specific to clients) • Performance reports or reviews • Data collection
Funding	NGO residential care was funded as follows: • Recurrent funding – one year, usually renewed • Recurrent funding – longer periods (usually renewed 3 yearly) • Fee-for-service short-term (6-12 months)

	Costing and resource allocation models and formulae had been developed for residential care funding and funding was thought to be adequate for the purposes. The amounts funded were the same for NGO and government agency. Aftercare service was not included as a component of residential care funding. Contracts or funding agreements were not specific about vacancy/occupancy levels.
Developments/ trends	The current models in the NT were not seen as appropriate, but the reform process underway would address this issue. In recent changes the Department had established residential care as an exceptional needs program and as a transitional needs program. The NG agency was moving into providing emergency and stabilising programs of 3-6 months. The government agency was going to provide medium and long-term programs and aftercare as legislated.

Queensland	
Interviewees	Three non-government agencies and one government department providing residential care were interviewed. Residential care is operated by: • Government • NG not-for-profit agencies • NG private for profit agencies
Age range	The Department of Child Safety policy stated the minimum age for residential care was 12 years. Residential care is usually provided for children 12+ years, with exceptions for younger children if part of a sibling group. Non-government agencies accommodate children 12+ years, with children as young as seven being placed in residential care at times.
Types	Types of residential care provided were: • Small congregate care (2-4 places in one residence) • Medium congregate care (5-8 places in one residence) • Large congregate care (9 or more in one residence) • Individual residential care (one person in one residence)
Duration	Placement could be: • Crisis, short-term (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months)
Staffing models	Rostered staff on 8-10 hour shifts, rostered staff on longer shifts (up to 24 hours with sleepover), rostered staff over 24 hours (staff sleepover but this is not counted towards the 38 hr week) and house parents in family group home setting
Specialised models	The following specialised models of residential care were provided for particular groups: • Indigenous children and young people • CALD children and young people • High/complex needs children and young people • Sibling groups • Adolescents (semi-independent/transition to independence) Two non-government providers and the government department characterised residential care they provided as therapeutic. Agencies accessed specialist therapeutic services through Department of Child Safety and via private providers.
Individual placements	Individual residential care was offered by the two NG providers and the government provider. The focus of placement of young people was to move towards re-entering them into a more normal setting.
Evaluation/ evidence base	Two NG providers had their specialised models independently evaluated. None of the models were evidence based.
Case management	The government department held case management responsibility.
Referral & exit processes	Entry into residential care results from joint referral meeting between agency and department, with agencies choosing whether to accept the young person into their program or not, depending on how well they feel they can support them. Exit from residential care is jointly managed by NG agency and government department, and has been written into case plan.
Accountability/ monitoring	All agencies need a license to operate. Independent scrutiny provided by the Commission for Children and Young People and Official Visitors. The following reporting mechanisms were practiced by NG and government agencies: • Regular written reports regarding clients • Casework visits or meetings • Regular visits to agency (not specific to clients)

	• Performance reports and reviews • Data collection
Funding	Non-government residential care was funded recurrently (usually 3 yearly) and fee-for-service short-term. Although costing or resource allocation models/formulae had been developed, agencies thought that the funding was not adequate. The government agency said that government had not developed costing models, but that funding was deemed adequate. Indicative funding levels stated in a 2004 funding information paper provided $75,000-85,000 per place per annum for moderate to complex needs clients and $100,000 - $150,000 per place per annum for extreme needs clients[24]. Some funding is available for aftercare, although only two agencies interviewed accessed that funding. Only one NG provider had a contract or funding agreement specific about vacancy/occupancy levels.
Developments/ trends	All agencies agreed that residential care had a definite place in the OOHC system. Residential care was seen as important for young people not wanting a replacement family. Services needed to have a therapeutic component as well as offer integrated services. In 2003/04 the Queensland Government's Crime and Misconduct Commission (CMC) held an inquiry into the abuse of children in Foster Care resulting in a report[25] and the development of a blueprint[26] for implementing recommendations. Action on one recommendation will see increased non-family based care, including residential care, from 4.4% to a target of 10.5% of placements[27]. A funding round in mid 2004 sought proposals for enhanced and new residential care for moderate to extreme needs clients. Funding has changed to allow/promote holistic models and "packages" which can include using motels as an option for residential care for young people. All agencies agreed that the current models met some of the needs of children and young people. It was also stated that resourcing of models was an issue and that new models needed to be developed that were not stand-alone services.

[24] Queensland Government – Department of Child Safety (2004) *Funding information paper 2004/2005 Alternative Care Services.*
[25] Queensland Government Crime and Misconduct Commission (2004) *Protecting Children: An Inquiry into Abuse of Children in Foster Care*.
[26] Peter Forster for the Queensland Government (2004) *A Blueprint for Implementing the Recommendations of the January 2004 Crime and Misconduct Report "Protecting Children: An Inquiry into Abuse of Children in Foster Care*
[27] Queensland Government – Department of Child Safety (2004) *Funding information paper 2004/2005 Alternative Care Services, attachment 1, rec 7.2*

South Australia	
Interviewees	Representatives of two NGO's (not-for-profit) and one government department (Child Youth & Family Services CYFS) were interviewed. These interviewees represented the major providers of residential care.
Age range	Operating procedures outline the age range. Residential care is usually for children 12 - 18 years, although children as young as nine have been placed in residential care because of their needs. One agency interviewed provided residential care for 14-18 year olds only. The other agency provided residential care for 16-18 year olds, with young people aged 15 years sometimes being accepted.
Types	Types of residential care provided were: • Small congregate care (2-4 places in one residence) • Medium congregate care (5-8 in one residence) • Large congregate care (9 or more in one residence) • Individual residential care (one person in one residence)
Duration	Placements could be: • Crisis, short term (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months) Length of stay depended on the program. One agency aimed to prepare young people to move into an outreach house, and then into a direct lease with the Housing Trust. In one government run program comprising 10 emergency houses for up to 3 young people each, transition to other care arrangements was intended in less than 6 months. Other agencies supported placements lasting from 3 days to over 4 years.
Staffing models	Rostered staff on 8-10 hour shifts, rostered staff on longer shifts (up to 24 hours with sleepover) and house parents in family group homes.
Specialised models	Specialised models of residential care were provided for: • Indigenous children and young people • High/complex needs children and young people • Children/young people needing secure care (used for young people with a mental illness, closely supervised with some restrictions on movement, but not totally secure) • Adolescents (semi-independent/transition to independence) The model for indigenous children and young people operated under Juvenile Justice, but included young people in care. One non-government agency offered a program for high/complex needs young people (in operation for last 12 months) based on a Core and Cluster model: Core (residential care facility) and Cluster (transition into independent living). Also recently started a 'stabilisation and transition' therapeutic model. They also provided SAAP services for up to 8 adolescents, with 2 of the beds used as emergency beds. Some residents in SAAP were OOHC clients with assigned caseworkers. The other non-government provider designed programs around each individual. Some residential care was characterised as therapeutic. The Department interviewee said that a psychologist was employed to establish a therapeutic house. One NG agency had a caseworker working in conjunction with a clinical psychologist at intake. The other NG agency provided intensive counselling and worked at connecting young people up to the community. Staff members were trained to deal with a variety of complex issues. Agencies accessed specialist therapeutic services through government services. CYFS contracted outside specialist services via Child Adolescent Health Service (CAHS), Department of Education and Training (DET) and

	provided tutors on site and off site. CYFS also used the Behavioural Intervention Service (a tri-partied agreement between DET, CAHS and CYFS in operation for 8 years). Residents have individual education plans in place and training is provided for all DET staff, social workers and youth workers to support implementation of these plans.
Individual placements	Individual residential care could be provided by all agencies. Referrals are identified through the Central Alternative Care Unit (CACU). CACU fund up to $60,000pa for 1:1 residential care per individual. CACU liaise with providers to see where they best fit. Some high needs young people are proposed as individual care placements to a CACU panel. The panel assesses then later approves proposed placements, negotiated between case managers and providers. One NG agency provided a specialised individual care model called 'Exhaul'. Most young people only transitioned from individual residential care when they left care, following independent living assessment. An Exceptional Needs Unit ensured that specialised support was provided when young people transitioned out of care.
Evaluation/ evidence base	The 'Exhaul' model was evaluated 3 years ago by university students. This was the only independent evaluation of models. None of the models were reported to be evidence based.
Case management	The government held case management responsibility, with one agency reporting they had shared responsibility.
Referral & exit processes	Referrals to all models of residential care managed through CACU.
Accountability/ monitoring	Agencies carried a Foster Care Licence and/or the Children's Residential Care Facility Licence. No system of independent visiting or scrutiny of residential care placements or agencies providing residential care. Reporting mechanisms included: • Regular written report regarding residents • Casework visits or meetings • Regular visits to agency (not specific to clients) • Performance reports or reviews • Data collection •
Funding	Funding may be: • Recurrent funding – longer periods (usually 3 yearly) • Contracted funding – fixed term • Fee-service short-term – Individual Care Packages, usually 12 months but sometimes shorter periods No costing or resource allocation models or formulae for funding residential care. One agency thought funding level was adequate following negotiation for increased funding. CYFS and the other agency thought funding was not adequate, especially in comparison to other states. CYFS said that some funded services had only been in operation for 12 months, therefore it was difficult to gauge funding adequacy. Different amounts allocated for government and non-government providers, depending on the model. CYFS provided some funding for aftercare services with some agencies, although the two NG agencies interviewed did not receive any aftercare funding.
Developments/	All agencies agreed residential care was needed. The number of children

trends	and young people in care with high/complex needs had increased over the last five years. More funding to existing services was needed to provide stability for longer-term placements. Smaller models (up to 4 residents) were preferred, as they provided home type environments and options for specialised care, with fewer potential problems such as contamination of behaviours and difficulties in relationship between staff and young people. In 2001/02 the government implemented 'Individual Package Care', and the Core and Cluster alternative care model was introduced, which provided an increase of 10 Transition Linked Care houses. Current models were thought to provide a good foundation for residential care, but were not meeting all needs. CYFS identified that services were not well integrated: better continuum of care and better interface between agencies was needed. This would need to involve all stakeholders in transition processes in order to provide continuity of relationship.

Tasmania	
Interviewees	Two non-government agencies, providing family group home care. A government representative was not interviewed, as those contacted said no residential care was provided in Tasmania.
Age range	Both agencies provided residential care from 0 – 18 yrs with one agency saying that the system was changing so they would review their age range with the possibility of 6 years being the youngest age for a child in residential care in their service.
Types	Types of residential care provided were: • Small congregate care (2-4 places in one residence) • Medium congregate care (5-8 places in one residence)
Duration	Placements could be: • Medium term (up to 12 months) • Long term (over 12 months) Long-term duration of residential care was problematic given the young age of children and young people entering into residential care on a care order until 18 and the difficulty of maintaining continuity of carers.
Staffing models	House parents in family group home
Specialised models	No specialised models of residential care were provided. No residential care was characterised as therapeutic. Agencies engaged contractors when they required specialist therapeutic services.
Individual placements	Concern was raised around the high expenditure on 1:1 placements. The agencies said that this was provided by the government, even though the government said that no residential care was provided in Tasmania.
Evaluation/ evidence base	N/A as no specialised models
Case management	The government held case management responsibility and utilised LAC.
Referral & exit processes	Referral and exit managed by Child and Family Services.
Accreditation/ monitoring	No system of accreditation of OOHC in general or residential care in particular. No system of independent visiting/scrutiny of residential care placements or agencies providing residential care. Reporting mechanisms included: • Regular written reports regarding residents • Casework visits or meetings • Regular visits to agency (not specific to clients) • Data collection
Funding	Tasmania is currently in transition from a subsidy system to service agreements with government. The subsidy system consisted of a fortnightly Board Payment and a Bed Subsidy Rate (per child). Under that system agencies had been funded up to 40% of their running costs. Aftercare service had not been included. Future service agreements would be based on a costing model that would fund aftercare and improve funding levels. One agency will be signing a service agreement, however the other agency has decided to move out of residential care and focus on early intervention services.
Developments/ trends	Agencies agreed that there was a definite place and role for residential care. It was important to provide a choice for young people and their different needs. Agencies identified a need for therapeutic models to be utilised, as current models did not meet the needs of children and young people. A three year strategic Plan was developed by government 4 years ago, but only half of the plan has been implemented. Transition into independent living had been redeveloped.

Victoria	
Interviewees	Representatives of six non-government residential care agencies and one government department (Department of Human Services DHS) were interviewed face-to-face. The NGOs are the major providers of residential care in metropolitan Melbourne and outer-metro regions. In addition two representatives of the child welfare peak organisation were interviewed. Rural agencies were not able to be interviewed in timeframe for consultation. NGOs and government provide residential care, although government only operates secure care.
Age range	Policy: 12 years and over in residential care. Exceptions for younger siblings or children with high support needs. Three agencies have policy of 12 years and over, but occasionally place younger children. Four others regularly place younger children in residential, youngest age being 3 years. One has open age range. Usually younger children are part of sibling groups placed in family group homes
Types	Five agencies provided only small congregate facilities (2-4 places), while one also provided medium sized residences (5-8 places) and the other also provided individual residential placements (1 person in residence) and lead tenant houses. Three categories & funding levels of residential care: RP1 – family group homes, low to moderate needs, generally younger, clients; RP2 moderate needs and RP3 high and complex needs clients.
Duration	Placements could be: • Crisis, short term (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months) While some agencies reported durations varying from short term to 2-3 years, others provided residential care as long as needed, in some cases until the resident leaves care at 16-17 years. Some residents in family group homes had been in placement for 10-13 years.
Staffing models	Rostered staff (8-10 hours shifts), and longer shifts (up to and over 24 hours) and house parents in family group homes. Two awards: SaCS and Residential Care Award. The latter, being renegotiated, allows half day and longer shifts, provides poorer conditions and lower rates of pay than the SaCS Award.
Specialised models	While some agencies have developed specific expertise in response to existing residents needs (eg conduct disorders) and a few residences have then accepted particular clients (eg younger age group, sex offenders, clients with disabilities) there are few specialised residential care programs. The Aboriginal agency interviewed runs family group homes specifically for Aboriginal children. Some NG residences are set up for sibling groups. No programs exist for CALD clients, who tend to be under-recognised in the system. One agency runs a residential school with a therapeutic program, recently independently evaluated and undergoing some changes. Some agencies operate transition to independent living programs or lead tenant programs. The latter programs support young people leaving care through provision of housing with a lead tenant who acts as mentor, role model to the young person/people. Size of region and emphasis placed on local placement prevents specialised intake in some regions. Government runs secure care program (two residences by 10 places each, one male, one female) – multidisciplinary team, placement up to 21 days renewable for further 21 days, usually shorter stays, average 9 days. Government commented that secure care is less costly than RP3 model. Agencies may access specialist clinical consultation service (Take Two intensive therapeutic service) but this is for all high risk clients, not only

	those in care, so access is limited to only some residential care clients.
Individual placements	Individual placements rarely used – 3 agencies never provided them and 3 provided only one or two in recent years. Note that Victoria has an intensive foster care program for individual young people, called 'one-on-one'. Duration of individual placements was intended to be short to medium term, but one agency reported one placement continuing for 18 months.
Evaluation/ evidence base	There has been limited independent evaluation of programs or services. Audit processes related to residential care standards were seen by some to be evaluation. Some agencies have researched their model, articulated theoretical underpinnings. Small number of agencies are trialling or have implemented evidenced-based models which will be subject to evaluation.
Case management	DHS retains case planning responsibility in all cases. Case management may be held by the agency (for long term clients), by the DHS (for clients with court matters pending or short-term cases) or by another agency with contracted case management responsibility for high needs cases (Intensive Case Management Services (ICMS), 1:5 caseworker/client ratio). Agencies concerned about some DHS managed cases and some ICMS cases where action not taken in timely way for clients, or potential for differences with placement provider. Looking after Children system being implemented or in use throughout state.
Referral & exit processes	DHS placement coordination unit manages referral, placement and exit processes through regional weekly or fortnightly meetings with all OOHC agencies. Vacancies are reported weekly to DHS Placement & Support team. Detailed information presented to agency before placement accepted. Negotiation occurs, with some agencies more satisfied than others with the process of shared decision making about accepting placements. Demand and shortage of options drives some placement decisions. All agencies engaged in the exit decision process, most reporting it works well.
Accountability/ monitoring	No accreditation system in place. Agencies being audited against residential care standards – self-study and independent site audit process underway. Peak body and agencies also promoting quality improvement system applying Australian Business Excellence Framework. No system of independent visiting or scrutiny of residential care in place. Peak organisation & NG sector involved in developing nationally accredited training in residential care, involving 15 core competencies. Peak has also developed templates for Policies & Procedures to assist agencies in compliance of residential care standards. Some concern expressed that system has become compliance driven rather than quality improvement driven.
Funding	Funding is generally recurrent (3 yearly renewal) and some fee-for-service contracts for short-term additional support services or staff or for individual placements. Costing model developed in 2000 with input from NG sector. Indexation has led to adjustment of the levels to approximately $80,000 per place, per annum for RP1, $130,000 for RP2 and $180,000 for RP3. Costings under review as part of the *Family and Placement Services Sector Development Plan* process. One agency thought funding levels were adequate, five others thought them inadequate, Some agencies made a significant contribution in terms of volunteer effort and fundraising. Wide variation in estimation of overheads and in application of two different Awards influences adequacy of funding. Some RP1 services being closed, more RP2 & RP3 services needed in some regions, operating under the SaCS Award and with more complex clients, so costs increasing. Most agencies

	reported that funding contracts specified occupancy levels (targets), with targets usually achieved. No agency reported reduction in funding due to not meeting targets, although at times the issue has required explanation to DHS.
Developments/ trends	Place of residential care in OOHC supported by both DHS and NG interviewees. Numbers in residential care still falling slightly. Emphasis in recent years on home-based care to the detriment of residential care. Residential care has been running in an ad hoc way, except for some rationalisation of service types (closures of RP1 houses and opening RP3s with same funds, fewer clients) at regional level. Some thought the residential care system was in crisis, with no clear plans for what is needed. General support for increased emphasis on development of therapeutic services and some specialised models, including semi-secure care to supplement the secure care option already available. Gap in indigenous services as only RP1 available for younger children, no Aboriginal managed residential care available for older Aboriginal young people. DHS & a number of agencies are keen to develop therapeutic services, with one government project in the pipeline, possibly targeted to sexual offenders. A recent budget bid for enhancement of therapeutic services (residential and foster care) was unsuccessful. Major sector development process underway, which will address projections for foster care, kin care and residential care in the next 11-12 years. Report expected in September / October 2005. Shortages in foster care and increasing complexity of clients is likely to lead to increased demand for residential placements. DHS Placement and Support capital redevelopment project underway – involves DHS purchasing and refurbishing NG sector properties used for residential care or purchasing land and building new premises according to purpose built designs. Designs were developed with NG input and range from 2 bed homes (with staff accommodation additional) through to 6 bed homes. Some designs have semi-independent unit within the building for family members or young people in transition to leaving care. DHS aims to own all accommodation used for residential care.

Western Australia	
Interviewees	Residential care was provided by a number of non-government not-for-profit and government agencies in Western Australia. Representatives of one NGO and Department for Community Development (the Department) were interviewed.
Age range	No policies or regulations set the minimum preferred age for entry into residential care or precluded residential care for children under a certain age. The Department said that residential care was usually provided for children 12-18 years of age. The NG agency usually provided for children and young people aged 11-17 years. Children as young as 7 years had been placed in residential care, according to both interviewees.
Types	The types of residential care provided were: • Small congregate care (2-4 places in one residence) • Medium congregate care (5-8 places in one residence) • Individual residential care (one person in one residence)
Duration	Placements could be: • Crisis, short term (up to 3 months) • Medium term (up to 12 months) • Long term (over 12 months)
Staffing models	Rostered staff on 8-10 hour shifts, rostered staff over 24 hours (carers did both 4 day shifts and 10 day shifts), and house parents in family group home.
Specialised models	Specialised models of residential care were provided for the following groups: • Indigenous children and young people • High/complex needs children and young people • Adolescents (semi-independent/transition to independence) • Sibling groups 3 indigenous services funded: ❖ an assessment centre for all indigenous children and young people that researches placement options to ensure that all possible family connections had been explored, especially when placement into non-indigenous families was considered. ❖ a cottage focussed on restoration for children and young people. ❖ a farming property run by Aboriginal staff and community, where young people from both rural and metropolitan areas were placed. An assessment centre for all children and young people was set up 3 years ago. It worked well initially, but high needs children and young people ended staying longer than the assessment period, due to bed shortages in other services. The Department operates a Preparation for Placement program for young people who enter care. The Department also runs a therapeutic model for groups of young people called the “Equip Program” based on a U.S. model, using a psychosocial behaviour approach conducted over a 17 week period. The NG agency accessed specialist therapeutic services via government funded services or application from funding body for specialist support.
Individual placements	Entry into individual residential care was via evaluation from a panel that consisted of a psychologist, placement officer, team leader and social worker. Children and young people were then referred to non-government agencies, who then assessed whether they could support the young person and provide residential care. Exit from individual residential care was via a weekly panel meeting. Young people were moved to non-government agencies, back home, into foster care or to another residential care program.
Evaluation/	There had not been any independent evaluation of specialised models of

evidence base	residential care. The "Equip Program" was evidence based.
Case management	The government held case management responsibility for all children and young people in care.
Referral & exit processes	Exit from NG agency was via government panel or through planned reunification with family.
Accountability/ monitoring	No system of accreditation in OOHC in general or in residential care. Service agreements contained an accountability component. The Department visited non-government agencies every 18 months and interviewed agencies on practices. No independent visiting or scrutiny of residential care placements or of agencies providing residential care. The following reporting mechanisms were practiced by both agencies: • Regular visits to agency (not specific to clients) • Performance reports or reviews • Data collection The following was practiced by government agency only: • Regular written reports regarding residents • Casework visits or meetings
Funding	Funding is recurrently every 3 years, as well as on a fee-for-service short term basis when required. No costing or resource allocation models in place. The NG agency said it was common practice for non-government agencies to subsidise government funding, as the funding received was not enough to run safe services. The amounts funded were not seen as adequate. Different amounts were allocated for government and non-government providers, due to the different models utilised. Provision for aftercare was not included in residential care funding. Some agencies contracts/funding agreements were specific about vacancy/occupancy levels.
Developments/ trends	Interviewees agreed that residential care had a definite role. Residential care had provided stability for some young people who had experienced a number of placement breakdowns and was suitable for some young people as an emergency placement. The current models were not regarded as adequate to meet needs. Agencies required therapeutic models to better respond to the needs of children and young people. Additionally models needed to provide a continuum of care from family through to 1:1 residential care. Agencies said that there needed to be more 1:1 residential care and smaller units. WA had experienced a major restructure over the last 2 years that saw the introduction of new programs (Equip Program) and new buildings. Non-government providers now reported to Director of Placements. The Department had employed 7 psychologists and there was a new 12 bed youth support program. Residential care was undergoing a major review in WA. The *Judy Ashton Report* on the state of residential care was due for release end of September 2005.