NSW Department of
Community Services

OUT-OF-HOME CARE SERVICE MODEL

INTENSIVE RESIDENTIAL TREATMENT PROGRAM

This service model for Intensive Residential Treatment Program has been developed by the NSW Department of Community Services in consultation with the non government sector. The paper describes the key elements of an Intensive Residential Treatment program which are considered to reflect best practice. As such, the service model is not designed to be prescriptive but should be read as a guide to current service development priorities.

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INTENSIVE RESIDENTIAL TREATMENT PROGRAM

Summary

There is a group of children and young people in out-of-home care with high needs and complex behaviours who require more intensive therapeutic, programmed support than can be offered in other services, such as intensive foster care or general forms of residential care. This support is time limited and should be provided in a stand alone facility.

This paper describes the features of a community based intensive residential treatment program that aims to address the needs of this group. These include:

- *a therapeutic program guided by evidence-based practice and underpinned by a coherent theoretical framework that is relevant to the client group;*
- *a maximum number of 4 residents per program;*
- *minimum age for entry is 12 years, although younger children could be considered if assessment indicates they have special needs that could not be met in a home-based setting;*
- *delivery of the program by multidisciplinary teams of professionals (including direct care staff, and a range of mental health, education and medical professionals);*
- *highly skilled direct care staff who receive ongoing on-the-job training and have access to regular supervision, clinical consultation, and advice/support when crisis situations arise;*
- *staffing rosters that ensure the safety of the children and young people at all times;*
- *program duration generally within the range 6 - 12 months;*
- *individual case planning based on comprehensive assessment of needs, and subject to regular review;*
- *an emphasis on developing educational/vocational skills;*
- *a focus on preparing children and young people to function with increased levels of confidence and independence in their future placement; and*
- *careful transition planning and consideration of the supports required to maintain the positive gains achieved during the therapeutic program.*

1. Introduction

This paper outlines the key components of an intensive residential treatment program for children and young people in out-of-home care with complex and high support needs. These children and young people typically exhibit an array of behavioural, social, emotional and educational difficulties that occur with such frequency and with such an adverse impact on their daily functioning that they require a specialised, intensively resourced form of intervention than can generally be provided in traditional home-based or residential care options.

While recognising the need to ensure a safe, predictable living environment, the intensive residential treatment program aims to also address the underlying issues confronting these children and young people in a planned, systematic way, so that

their longer term prospects can be improved, and they can return to a more normalised placement setting .

2. Definition of an intensive residential treatment program

There is no universally accepted definition of an intensive residential treatment program, or 'therapeutic residential care' or 'treatment residential care', as similar programs are also referred to in the literature (Bates et. al., 1997)[1]. Broadly speaking, these terms refer to residential care programs which aim to address the behavioural, social and emotional issues of children and young people with complex and high support needs through an intensive, time limited program of integrated, individually determined interventions.

Characteristics common to most intensive residential treatment programs include:

- interventions designed to achieve behavioural and attitudinal change as opposed to a medical/pathological view of problem behaviour;
- the use of the daily living milieu and direct care staff as primary agents for therapeutic change;
- highly skilled and trained staff, who have access to quality supervision and support;
- the involvement of multi-disciplinary teams of professionals (mental health, education, medical, direct care staff) to deliver a range of individualised and/or group interventions; and
- programs that are short to medium term in duration (generally up to 12 months duration)

Such programs generally incorporate a range of treatment approaches within the overall service.[2] However, as Delfabbro and Osborn (2005) point out, programs with too narrow a focus on behaviour management and control, without an accompanying attempt to address the underlying causes of the child or young person's behavioural and emotional difficulties, may fail to produce positive long-term outcomes for the child or young person[3].

The most commonly used approaches internationally have included:

- social learning approach, including the use of points systems and "token economies"[4];
- therapeutic community approach (also referred to as milieu therapy)[5];

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[1] Bates B.C., English, D.J., & Kouidou-Giles, S. *Residential Treatment and Its Alternatives: A Review of the Literature* Child and Youth Care Forum 26(1), February 1997 pp 7-51

[2] Bates et. al, ibid, pp 10-11; An overview of the most commonly used treatment approaches is included in: *A Review of Treatment Modalities for Children with Emotional and Behavioural Disorders in Out-of-Home Care* Delfabbro, P., Osborn A., & Barber, J (Draft paper being submitted for publication)

[3] Delfabbro, P. & Osborn, A. *Models of Service for Children in Out-of-Home Care with Significant Emotional and Behavioural Difficulties* Developing Practice, 14, Association of Children's Welfare Agencies (NSW), 2005, p 21

[4] This approach involves the application of learning theory principles to teaching new behaviours or modifying existing maladaptive behaviours. With older children/young people it may include the use of behavioural contracting and "token economies" in which secondary reinforcers or "tokens" are used as behavioural consequences.

[5] In this approach the controlled, predictable environment (often structured using behavioural principles) is combined with an attempt to create a safe, supportive environment where the child or

- positive peer culture model, in which positive peer interactions are used as a key strategy for supporting and maintaining attitudinal and behaviour change [6];
- approaches based on attachment theory; and
- psycho-educational approaches focussing on the development of appropriate social skills, including anger management strategies

In practice, many standard residential care services will incorporate elements from some or all of these approaches into their overall program. What is important is that the underpinning philosophy and treatment approaches adopted by an intensive residential treatment program be clearly articulated and used as a coherent framework for guiding decisions about suitability for entry into the program, as well as the choice of interventions for addressing individual behavioural, social and emotional issues following admission to the program.

What distinguishes intensive residential treatment programs from more traditional forms of general residential care is the increased focus on individualised and group programming to bring about positive behavioural and attitudinal change across multiple domains in the life of a child or young person (Bath, 2002/2003)[7]. These services provide a highly structured, time-limited therapeutic program, delivered by a multi-disciplinary team characterised by:

- direct care workers with a greater skill level than is usually the case in general residential care services;
- the pivotal role of a psychologist in providing assessment and intervention services, as well as contributing to program development; and
- greater involvement of other clinical and educational specialists in providing a fully integrated therapeutic program to children and young people in the service.

In order to be effective, these programs should be provided in a stand alone facility, not attached to another residential service. This does not prevent an agency operating a mix of services such as a treatment program and a general residential care service.

3. Research findings

The main research resources relied on to develop this model are listed in the research bibliography (Appendix A).

4. Outcomes of an intensive residential treatment program

The intensive residential treatment program is intended to improve all aspects of the development of the children and young people placed in the program, so that:

- they are progressively able to function with decreasing formal supports;
- they progress towards meeting the level of skills and competencies appropriate to their age/developmental level;

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young person learns to reflect upon their behaviour, and to learn more socially adaptive ways of responding through their daily interactions with staff and others. The approach was originally derived from Freudian concepts about ego-enhancement and the importance of developing a functional sense of self through interaction with others.

[6] Vorrath, H. & Brendtro, L. (1985) *Positive Peer Culture* New York: Aldine De Gruyter

[7] Bath, H. *Services for Children and Young People with High Support Needs - It's Time to Rethink* Developing Practice, No. 5, 2002/2003 Association of Child Welfare Agencies, Sydney, pp 5-10

- they progress towards meeting age/developmental appropriate educational and/or vocational goals;
- they progress towards integration into an educational or vocational setting in the community;
- the risk to the child/young person and to others of their behaviour is reduced; and
- they are able to make a successful transition to a less restrictive community placement setting, such as intensive foster care, a less structured residential care setting, or family restoration.

5. Target group for the model

The target group for an intensive residential treatment program is children and young people with complex and high support needs for whom parental responsibility has been allocated to the Minister, or who are in the care of the Director-General.

The minimum age for entry into the program will generally be 12 years, although younger children could be considered for admission if comprehensive assessment indicated they had special needs that would be best met in a more structured therapeutic setting than could be provided in a home based or other residential care option.

These children and young people present with a similar range of challenging behaviours and social/emotional difficulties outlined in the target group description for the residential care model, including:

- poor impulse control and/or stress intolerance
- high risk-taking behaviours
- alcohol and other substance abuse
- poor self image
- self-harming behaviours
- social isolation and limited capacity to form relationships with peers and/or adults
- sexually inappropriate behaviour
- anti-social behaviours, including aggression and or violence towards people, and, in some instances, criminal behaviour
- mental health issues
- physical health issues
- intellectual disability
- educational difficulties.

However, the frequency and intensity of these behavioural and social/emotional difficulties are at a significantly high level that they result in severe disruption to their daily functioning. They will often present behaviours that pose a high risk both to themselves and those around them (e.g. self harming behaviours, physical violence to others, frequent running away and placing themselves in dangerous situations). In many cases, there will be a history of unsuccessful efforts to manage these behaviours and adequately address underlying issues in foster care, general residential care and mainstream school settings - pointing to the need for a more holistic, structured therapeutic approach to stabilise and bring about positive behaviour change.

Children and young people with a significant, complex mental health condition who require close psychiatric monitoring and treatment will need to be carefully assessed as to their suitability for this program. Rather than the intensive residential treatment program being viewed as a placement of last resort, assessment for suitability for the

program needs to include a judgement about whether the child or young person is likely to derive benefit from the program, or whether they have a significant disability (either intellectual or psychiatric) that may be better managed in another setting or program.

There may be particular sub-groupings within the broader target group for whom a specialised intensive residential treatment program could be considered, for example, children and young people with sexually abusive behaviours.

6. Key program features

The program should have an evidence-based theoretical basis that takes into account the characteristics of the target group, and is clearly articulated and documented.

Although a range of theoretical/clinical perspectives may be adopted, there are a set of common components that should be incorporated into all programs:

- the creation of a safe, stable, consistent, predictable living environment ;
- highly skilled direct care staff able to work collaboratively as part of a multi-disciplinary team in promoting a therapeutic milieu;
- individualised case planning based on comprehensive assessment of needs, and subject to a regular review process;
- maintaining the child/young person's family, community and cultural connections as far as possible whilst they are in the program;
- individualised educational/vocational programs for all children and young people in the program;
- access to the range of specialist clinical services that might be required to achieve the objectives identified in individual case plans, and to provide consultation and advice to direct care staff;
- understanding that the challenging behaviour of residents often has its basis in past traumatic experiences, and that this is taken into account when responding to the behaviour so as to avoid inadvertently inflicting further trauma
- programming that takes into account the group dynamics within the residential unit; and
- availability of support for children and young people when they transition and exit from the program.

6.1 Program duration

Program duration will be in the range 6 - 12 months, with flexibility allowed to take into account individual variability in achieving case plan goals within the program. Placements of more than 12 months in a highly structured, controlled environment such as an intensive residential treatment program increase the risk of institutionalisation, and should only be considered if there are clear indications that an extension beyond 12 months would be of benefit to the child or young person. Conversely, a child or young person may reach their program goals in less than 6 months, and an early exit from the program could be considered.

6.2 Referral for entry into the service

DoCS has responsibility for referral of children and young people to the service taking into consideration their views and compatibility with other residents in the residential care unit. The agency providing the service has responsibility for

developing processes for receiving referrals as well as responsibility for assessment, case management and case planning.

It is not intended that high needs children and young people requiring emergency/crisis placements would be placed in this program.

6.3 Number of residents

The number of residents in the program will be within the range 2 - 4. Although a higher number of residents in a program may increase the complexities of managing the group dynamics, it may also increase the opportunities for using peer group interactions in a therapeutic way[8]. At the same time, agencies need to ensure the safety, compatibility and likely success of children and young people in the service at any one time.

This program is **not** aimed at individual ('one-on-one') residential care placements. The benefits of these placements, which usually revolve around safety considerations, are generally outweighed by the costs, including the possible adverse impacts on the child/young person[9].

6.4 Physical environment

The program will be community-based. The living environment needs to comply with requirements for safety, and to promote, as far as possible, a home-like setting that offers individual privacy[10]. In choosing the location of properties, consideration should be given to selecting sites that take into account factors such as the availability of mental health, medical and educational services, and the likelihood of disturbance to neighbours. Properties could be either rented or owned by the agency operating the service.

6.5 Staffing

6.5.1 Program Manager

Key functions of this position include:

- overseeing the running of the service in accordance with DoCS policies and Out-of-Home Care standards specified by the NSW Office of the Children's Guardian;
- actively promoting a positive culture within the service, which is reflected in the organisation's policies and procedures;
- ensuring that the program's goals and philosophies are understood and implemented by all staff;
- providing supervision that aims to support direct care staff in providing a consistent quality service;
- facilitating ongoing staff training; and
- ensuring that the program is objectively evaluated, and reviewed in the light of evaluation.

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[8] This is the rationale underlying the Positive Peer Culture approach (Vorrath and Brendtro, 1985).
[9] These concerns are summarised in: Flynn, C., Ludowici, S., Scott, E., & Spence, N. *Residential Care in NSW* Association of Children's Welfare Agencies, 2005, pp 14-16
[10] OCG NSW Out-of-Home Care Standards (2A.1, 2A.2, 2.10); Children and Young Persons (Care and Protection) Regulation 2000, Schedules 2 and 3.

Essential requirements for this position include (a) a degree in social work or psychology, (b) significant experience working with children and young people with behavioural and emotional difficulties in therapeutic contexts, and (c) significant management experience, particularly management of staff who regularly face crisis situations in the course of their work.

6.5.2 Direct care workers

In addition to ensuring that basic care and accommodation needs are met, direct care workers play a crucial role in facilitating the therapeutic goals of the program. They are key agents in the development and implementation of behaviour management plans. Through their daily interactions with children and young people in the program, and modelling appropriate behaviour, they promote the development of social skills across a range of domains.

Direct care workers should be suitably qualified, with an expectation there would be involvement in on-going training to further build on existing knowledge and skills. Experience in working with children and young people with challenging behaviours would also be essential, with demonstrated competencies in areas such as communication with children and young people who have experienced trauma and rejection, implementation of individual behaviour management interventions in a planned, systematic way, effectively dealing with crisis situations, and applying social learning principles in promoting social skills development

6.5.3 Caseworker

Agencies are responsible for undertaking case management functions and performing casework tasks in accordance with the each child's case plan, the Office of the Children's Guardian's Out-of-home care standards and policies, the *Children and Young Persons' (Care and Protection) Act* and *Regulations* and the Service Agreement and Specifications.

Key case management tasks include:

- working in collaboration with other agencies, relevant professionals, children, young people, families and appropriate cultural and community representatives to ensure that all relevant parties are involved in case planning and review processes;
- coordinating the range of services identified in the case plan so that they are provided in a timely way, and effective channels of communication between the service providers are maintained;
- arranging regular meetings of the multi-disciplinary team to review progress in meeting the objectives and goals of the case plan, and recording the outcomes of these meetings;
- maintaining comprehensive care records and ensuring that the content accurately reflects the reasons for key decisions made whilst in the placement, and important events and achievements during this period;
- implementing the cultural placement principles of the *Children and Young Persons (Care and Protection) Act 1998.* This includes the principles relating to culture, language, religion and other components of diversity, and the Aboriginal and Torres Strait Islander principles of self-determination, participation and placement[11]; and
- addressing cultural issues in the case plan for children and young people from culturally and linguistically diverse family backgrounds.

[11] Sections 9 (c), 9 (e) 11,12, and 13 of the *Children and Young Person's (Care and Protection) A*ct 1998

Key casework tasks include:

- providing advice and support to children and young people;
- involvement in delivery of particular therapeutic interventions for individual children and young people, as a member of the multi-disciplinary team;
- facilitating contact arrangements with family members, siblings and other significant people as outlined in the case plan in order to promote the maintenance of identity, culture and religion and to meet the identified needs of children and young people;
- undertaking activities that support the child or young person in maintaining their identity through, for example, regular life story work;
- arranging or providing timely and appropriate transitional and/or aftercare services for young people who exit the program.

A degree in Social Work or Psychology, together with demonstrated experience working with children and young people with similar characteristics to the target group, would be essential requirements for the Caseworker position.

6.5.4 Psychologist

The psychologist is a pivotal member of the multi-disciplinary intensive residential treatment team, providing assessment and intervention services for the children and young people in the program, as well as consultation and support to staff about the range of issues arising around program implementation and development. The psychologist should be suitably qualified and have significant experience working with children and young people with challenging behaviours.

The psychologist's role will include:

- providing advice about behaviour management issues, including the development of individual and group behaviour management plans;
- individual, group or family counselling;
- staff training and support;
- conducting assessments of children and young people as part of the case planning review process; and
- contributing to the ongoing review and development of the therapeutic program.

There are a number of options for engaging the services of a psychologist for the program:

- the agency operating the program may choose to employ a psychologist specifically for the program, or allocate a psychologist already employed within their organisation to the program; or
- the agency may enter into agreements with a government provider, such as the Department of Health, or the Department of Ageing, Disability and Home Care (DADHC), about the provision of psychological services; or
- the agency may enter into a contract with a psychologist in private practice to provide services on a sessional basis.

These options are not necessarily mutually exclusive.

6.5.5 Other clinical or counselling specialists

Other clinical specialists may be engaged to provide services to the program. These may include:

- *Child and Adolescent Psychiatrist:* To provide consultation around diagnosis and management of children/young people who present with significant mental health issues, to prescribe and monitor medication when this is part of the management plan;
- *General Medical Practitioner:* To monitor the physical health needs of residents;
- *Specialist counsellors:* To provide counselling in specific areas such as Alcohol and Other Drug issues, or Sexual Assault issues.

Their services will usually be engaged by either:

- agreed arrangements negotiated with a government provider (i.e. Department of Health, Department of Ageing, Disability and Home Care (DADHC)); or
- contracted sessional arrangements with private practitioners.

6.5.6 Specialist teachers/tutors

The service should work in close collaboration with the Department of Education and Training (DET) and/or non-government educational agencies to support children and young people in school placements. Whenever possible, it is preferable that children and young people attend schools in the community, but for those excluded from school, home-schooling programs need to be developed to assist them in reintegrating back into school or to provide them with vocational skills. Home schooling programs should be endorsed by the Department of Education and Training. Where a home-schooling program is being implemented, there needs to be appropriate accommodation for this purpose, preferably providing some degree of physical separation from the day-to-day living environment.

Specialist education staff should be engaged to support the individual education plans of children/young people in the program. These will include:

- suitably qualified and experienced teacher(s) to facilitate the home-schooling program for excluded children and young people, and/or to provide individualised tutoring support for those attending school;
- youth worker(s) to provide support to the teacher facilitating the home-schooling program.

6.6 Staffing rosters

Staffing rosters should be designed to ensure the safety of the children and young people at all times.

6.7 Management of crisis situations

Direct care workers need to be provided with training and support in dealing with crisis situations that may arise. Strategies for achieving this include:

- ensuring that each child or young person has an individual critical incident management plan included their case plan;

- clear guidelines around the involvement of the Police in response to crisis situations, with an understanding that attempts should be made to minimise Police involvement wherever possible;
- developing written procedures to be followed in the event of, and following a crisis;
- clear guidelines around when it might be appropriate to separate a child or young person from the group program, and how such separations should be managed;
- access to training around management of crisis situations (e.g. the Therapeutic Crisis Intervention (TCI) training program[12]). Key topics that need to be included in this training include: early identification and de-escalation of potential crisis situations, use of safe, appropriate physical restraint during a crisis, assisting the child or young person in recovering from a crisis, and self-management in the aftermath of a crisis;
- provision of on-call management advice and support when a crisis occurs; and
- access to appropriate debriefing for staff following a crisis.

It should be noted that secure care is not included as a crisis management strategy in this model.

6.8 Transition planning and post-placement support

Keeping in mind that the intensive residential treatment program is time limited, planning for the transition to the post-program placement needs to commence from the point of entry into the program. Exit from the program is guided by progress in achieving agreed goals within the treatment program, and this is reviewed on a regular basis as part of the case management process.

It is important that the child/young person is aware of, and engaged in the process of planning for their likely future placement following completion of the intensive residential treatment program. There should be close liaison between the intensive residential treatment placement and the 'exit' placement, during the period, say the month prior to and immediately after the transition, in order to promote information exchange between the services, especially around issues relating to behaviour management.

Common exit ("step-down") pathways could include placement in a small residential care setting that was less structured and therapeutically resourced than the intensive residential treatment program, or an intensive foster care placement.

6.9 Participation of children, young people, and their families

The intensive residential treatment program will:

- conduct genuine, ongoing consultation and facilitate participation of children, young people, and their families in the making of decisions that affect them; and
- provide children, young people and their families with information (in a manner and language that they can understand) which facilitates their participation.

6.10 Promoting the rights of children, young people and families

The intensive residential treatment program will:

[12] Bath, H. (1998) *Therapeutic Crisis Management: Training Manual* Canberra, Marymead Child and Family Centre

- inform children, young people and their families of their rights (in a manner which is appropriate to their age, developmental capacity and cultural and linguistic background). This includes information about their rights under the *Children and Young Persons (Care and Protection) Act 1998* and information about complaint and appeals processes;
- provide all children and young people with the *Charter of Rights* and ensure the agency advances and complies with the Charter;
- ensure that the privacy of children, young people and their families is respected, confidentiality is maintained and information is collected and exchanged in accordance with the *Children and Young Persons (Care and Protection) Act 1998*; and
- have policies and procedures in place to appropriately process complaints and appeals by children, young people and their families within clearly stated timeframes.

APPENDIX 1: RESEARCH BIBLIOGRAPHY

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