Professional Carer Experiences of Working with Young People in Specialist Care Placements in South Australia

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Abstract

Despite the emphasis within Australian child protection upon family-based care as the preferred placement option, it has been increasingly recognised that some young people may be best served in specialist care placements such as residential or therapeutic care. This paper presents a thematic analysis of 20 interviews undertaken with professional carers who at the time were working in a specialist care programme in South Australia known as Individual Packages of Care. The analysis suggests that three key issues were at stake for participants: 1) the impact of role conflict between engaging in caring relationships with young people and maintaining professional boundaries, 2) the impact of additional stakeholders (such as mental health professionals) upon the stability of the placement, and 3) the use of restraint as a form of behavior management. The paper concludes by discussing the interesting relationship identified in the data between caring relationships and the use of restraint, and makes recommendations from the data for issues requiring further consideration in regards to specialist care placements.

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Introduction

Over the past decade in Australia, extensive and ongoing discussions in the context of out-of-home care have focused upon the role of congregate or specialist care options for young people who cannot live with their birth parents due to abuse or neglect. To a degree these discussions are a result of the emphasis placed upon family-based care as the preferred mode of out-of-home care. One outcome of this preference for placing children in foster families has been a continued reduction in the use of residential care options. Indeed, only a small proportion of children across Australia who are in an out-of-home placement live in residential care, and an even smaller number are in specialist care placements. For example, in South Australia (where the research reported in this paper took place) only 11.8% of the 2657 children in out-of-home care in 2013 were in residential care, and less than 8% were in specialist care placements (AIHW, 2014).

Delfabbro and Osborn (2005), however, question the preferencing of family-based care for two reasons. First, they suggest that the emphasis upon family-based care implicitly (and at times explicitly) depicts other modes of out-of-home care (e.g., residential care or specialist foster care services such as therapeutic care) as second best options. Second, Delfabbro and Osborn suggest that for some young people, congregate or therapeutic care options may be the best, rather than second best, option. They suggest that some young people may be better served by being placed in residential care or a therapeutic foster placement when they are first removed from their birth parents, rather than leaving them to drift between multiple foster family placements before being deemed 'unplaceable' and thus moved to a residential care facility as a 'final resort'.

We agree with Delfabbro and Osborn's (2005) assessment, and would further emphasise the assumptions that potentially inform the preferencing of family-based placements. Specifically, we would question how the assumption that a normative family environment (i.e., two parents and children) is the best context for all children who cannot live with their birth parents. Some children who are removed into care may never have experienced this mode of care. For such children, family-based care may be entirely non-

normative, and may contribute to poor outcomes, rather than automatically resulting in a stable long-term placement (Ogilvy & Riggs, 2014). Indeed, we would suggest that the term 'family-based care' is something of a red herring. 'Family' is not a homogeneous category, comprised solely of one or two primary parents and the children living with them. Rather 'family', we suggest, may be understood in a range of differing ways in the context of out-of-home care. For some young people, family may include meaningful and long-term relationships with the people who staff residential care facilities, or professional carers who provide therapeutic care placements, or any of a range of care options beyond the norm of 'family-based care' (Misca, 2014).

Australian and international research has increasingly recognized the important contribution that modes of out-of-home care beyond the traditional foster family can play in meeting the needs of young people who cannot live with their birth families. Importantly, this research highlights both similarities between a range of forms of care, as well as important differences. In terms of similarities, research on therapeutic foster care (Murray, Southerland, Farmer & Ballentine, 2010) suggests, much like research on foster families (Riggs, Augoustinos & Delfabbro, 2009), that best outcomes are achieved through placement stability and the formation of meaningful relationships between carers and children. In terms of differences, Australian research suggests that the development of meaningful relationships can be negatively impacted by high staff turnover in the context of congregate care, and that the stability of placements can be negatively impacted by differing approaches to practice between stakeholders and a lack of case planning or adherence to case plans (McLean 2011; McLean, Riggs, Kettler & Delfabbro, 2013). Thus whilst poor outcomes in some cases in the context of congregate care are attributed to the severity of the behavioural challenges that many young people in such care arrangements display, this is only one aspect that potentially impacts outcomes.

With all of the above points in mind, the present paper reports on interview data collected with 20 professional carers who were working in a form of specialist care that existed in South Australia up until 2012. Known as Individual Packages of Care (IPC), this form of care built upon a particular approach to care provision known previously as the

Special Youth Carer programme (Gilbertson, Richardson & Barber, 2005). In order to provide a background to the Individual Packages of Care approach, the following section briefly overviews the programme, and how it fits within a range of approaches to care that may alternately be referred to as 'specialist', 'residential', 'therapeutic' or 'congregate'. Following this, the method utilised within the research is outlined, before a thematic analysis is presented of the interview data. The analysis in many ways mirrors the previous research summarised above in terms of the need for stability and meaningful relationships between carers and young people, and how these are potentially undermined by systemic issues and individual approaches to care provision. The analysis additionally outlines how professional carers understand the role of behavior management practices involving restraint in the context of a specialist foster care placement. The paper concludes by discussing the implications of the findings in terms of service provision to young people with complex needs who, despite the findings presented in this paper (which highlight the challenges facing specialist care programmes), may best be served by a non-traditional placement.

Background to Individual Packages of Care

Several key reports released in South Australia over the past decade have indicated that family-based foster care options may fail to meet the needs of children and adolescents with complex behavioural problems (Layton, 2003; Mullighan, 2008). These reports highlighted the need for placements staffed by professional carers who are extensively trained and supported to meet the complex needs of young people. The reports suggested that the absence of such placements can result in young people staying in temporary residential facilities for extended periods of time due to difficulties in finding suitable long-term family-based placements. As a result, the reports recommended greater use of residential care as a primary longer-term option, together with a middle ground placement option in which professional carers are trained to work in smaller individual or group houses with young people.

Outside of South Australia, a similar approach has been advocated for in other Australian states and territories (see Department of Communities, 2011, for an overview). Placement options other than family-based care are typically guided by three differing considerations: 1) whether the placement serves only a small number of young people (typically one or two), or whether it is congregate care where larger numbers of young people reside together in one facility (such as residential care), 2) the existence (or not) of 'wrap-around' services aimed at connecting the young person in with support services as part of the placement itself (rather than these being optional extras outside of the placement), and 3) the degree to which the placement adopts a 'therapeutic approach'. In terms of the final point, we would argue that notionally all out-of-home care placements are therapeutic in the sense that they are intended to remove a young person from harm, and to allow them the opportunity to recover from the abuse they have experienced (Riggs, Augoustinos & Delfabbro, 2009). In the case of placements discussed in the present paper, however, 'therapeutic' refers specifically to placements where carers are highly trained in approaches to working with trauma and abuse, and/or where a range of therapeutic support services are made available to the young person within the placement.

In South Australia, Individual Packages of Care (IPCs) were one form of non-traditional care available for young people who otherwise could not be placed in family-based care due to significant behavioural issues. IPCs focused on matching this cohort of young people with professional carers who were recruited and trained specifically for the role. These were remunerated carer positions and include scheduled services for the young person. In this sense, the IPCs were wrap-around services intended to provide for all of the identified needs of the young people serviced by them. As Gilbertson, Richardson and Barber (2005) outline, the IPCs drew in part upon the previously established Special Youth Carer programme. This programme involved young people placed in a specialist care arrangement with professional carers in a home not owned by the carer. In some instances this was a residential facility, in other instances it was a home provided by the state. The intent behind the latter arrangement was that if the relationships between carers and young people occupying the home became dysfunctional, the carers could leave rather than the young people. Both the homes and residential facilities in which young people in

receipt of an IPC were housed typically accommodated a small number of young people, and were staffed by professional carers working in shifts.

Method

Participants

Participants were 20 professional foster carers working for one agency in South Australia that provided services for young people in receipt of an IPC. Of the participants, three held a bachelors degree, three held a diploma, and the remainder had no higher education training. All of the participants had received extensive training in working with young people who have experienced trauma in the context of abuse and neglect. Of the participants, 12 were male and eight were female. On average participants had been working in their current placement for 18 months. Half of the sample worked with young people within the age range 12-14, and the other half worked with young people within the age range 15-17. Just under half of the sample worked with young people on IPCs living in residential care settings, and the remaining participants worked with young people on IPCs living in specialist care placements (in which typically one, though in some cases two, young people were housed).

Procedure

Ethics approval for the project was granted by both the Flinders University Social and Behavioral Research Ethics Committee, and the ethics committee of the agency from which participants were recruited. Following ethics approval, the agency's IPC team supervisor was approached via email in order to provide information about the aims of the project and to call for professional carer volunteers. Participants who indicated their interest in being interviewed were emailed a brief description of the study and a formal invitation to participate. Following the provision of information about the study, the first author made a time to meet with each participant to conduct the interview. At the time of the interview each participant signed a consent form.

Interviews were semi-structured and focused on the participants' experiences of IPCs. Interviews were conducted over a three-month period. The subject of each interview was the IPC and the individual's experiences of the IPC in relation to three broad areas 1) their experience of working collaboratively with other stakeholders in supporting children with challenging behaviors, 2) their experience and understanding of challenging behaviours, and 3) their views about the utility of IPCs as a placement alternative. Specific examples of questions included in the interview schedule are "What is your role in achieving the goals of the placement", "what is your experience of behavior management in the context of the IPC", and "What, if anything, impacts upon your ability to achieve the goals of the placement". Interviews on average lasted for 55 minutes. All interviews were transcribed verbatim.

Data Analysis

The data were subject to thematic analysis according to the steps outlined by Braun and Clarke (2006). As they suggest, thematic analysis is "a method for identifying, analyzing and reporting patterns (themes) in the data" (p. 79). After reading through the transcripts several times, themes were identified by the authors, rather than the data being fitted into pre-existing coding or theoretical frameworks. This approach was considered appropriate due to the evaluative nature of the research. Due to the large volume of interview data collected, the data were analysed for themes and then grouped according to commonalities. Participant responses were examined for direct references to meaningful elements that could help accurately capture re-occurring patterns in the data. In the analysis below, representative extracts are presented for each theme.

Results

Through the analysis, the following themes were identified:

1) Role Conflict as Barrier to Relationships with Young People
2) Systemic Challenges to Placement Stability

3) The Use of Restraint in Behaviour Management

These three themes are now each discussed in turn.

Role Conflict as Barrier to Relationships with Young People

Most of the participants (n=16) reported that they experienced varying degrees of role conflict when working with the young people in their care. On the one hand, there was a clear expectation to maintain a professional boundary. On the other hand, there was the requirement to provide a supportive and nurturing environment akin to that provided by a parent. The experience of role conflict was more likely if participants felt that they were closely bonded with the young person. Almost all of the participants (n=18) reported a constant challenge in trying to balance being supportive whilst maintaining professional boundaries, and all of these participants noted that a failure to maintain the right balance could negatively impact their relationship with the young people in their care. The following extract provides an example of this:

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

More than half (n=13) of the participants reported that they were able to manage the conflicting demands placed upon them, though all of the participants felt that some individuals in their IPC team were unable to separate their emotions from their role as a professional carer. Aware of the negative judgments made about those who could not separate their emotions from their role, some of the participants (n=7) spoke of the need to be cautious about appearing too emotional. Some of the participants (n=5) reported not

fitting in with their care team because they felt closer to, or had a stronger relationship with, the young person in their care. Others were committed to challenging the use of professional distance, as the following participant reported:

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

A small number (n=4) of participants reported experiencing no difficulty in establishing a solely professional relationship with the young people in their care, primarily because they did not desire a close emotional relationship with the young person, as the following participant reports:

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

Participants who didn't struggle with role conflict were, however, in the minority. The majority of participants were clear that such conflict was a part of the job, and that working with the sense of conflict was important as to do otherwise would have been to dismiss the emotional aspects of the work which, they suggested, would have been detrimental to their relationship with the young people in their care.

Systemic Challenges to Placement Stability

A key issue described by all of the participants was the challenges that arise from having multiple stakeholders engaged with each young person. Whilst all of the participants acknowledged that the involvement of multiple carers and differing

professions constituted a strength of an IPC (in that it reduced carer burnout, and allowed young people to access the differing skill sets of each professional), they nonetheless emphasised the problems that arise in terms of placement stability. As the following extract suggests, participants struggled with differing rules as applied by members of the care team:

> There is such a wide range of personalities in our team that I think it's hard to find one strategy that allows us to engage with the kid consistently. One worker wants to sit outside and smoke with the kid while another wants to punish the kid because he smokes. I think it's impossible to agree on everything, but there is a need to agree on what behaviours are unacceptable or not allowed, that would be a good place to start, otherwise there is no continuity or stability. (PC1)

A belief in the importance of presenting a unified front to young people often conflicted with an individual carer's understanding of how particular issues should be handled. Many participants reported that they frequently disagreed with practices established in the IPC, yet the need for adherence to organisational and systemic mandates outweighed the individual carer's views. Furthermore, some participants (n=12) noted that over time it became harder to reconcile their own views of a young person's behaviours with those of outside professionals whom the young person saw less frequently. The following extract highlights this issue:

> After spending so much time with the young person our view of normal is changed by our experience with them. Yelling and arguing is common in our IPC because that is how the young person experienced home life in the past. Our young person told us one night that they didn't know how else to tell people they were upset. In a way we got used to this behavior, and accepted it as normal for the young person. But it became a problem when the mental health worker came into the house and the young person yelled and swore at them. The mental health worker then told us that we needed to curb that behavior, but that then put us in conflict with the young person. (PC2)

As a result of this type of response from another professional, some participants (n=8) reported hesitation in making referrals to external providers on the basis of the view that doing so may potentially undermine attempts by the care team to establish a sense of normality and stability in the placement. The majority of participants (n=15) indicated that being required to implement conflicting management techniques was experienced as undermining the stability of the placement due to the young people feeling that their needs were not recognized, in addition to the 'triangulation' produced by mental health workers and professional carers having differing views. When young people were aware of these differences some participants noted that they played the two groups off against one another (see also McLean, 2011).

Behaviour Management Including Restraint

As highlighted in this final theme, all of the participants spoke about the challenges of implementing behavior management practices that strengthened, rather than undermined, the placement. Echoing the role conflict outlined in the first theme, participants also indicated that the need to implement behavior management strategies resulted in a conflict between wanting to engage in caring relationships with young people, whilst also having to manage what were often serious and violent behavioural issues, as is highlighted in the following extract:

> This job would have to be one of the most mentally challenging I have ever had. There are times I have been talking to the young person about their day one minute, and then trying to deal with them hitting and punching me the next. I think their behaviour is unavoidable because it's often motivated by another event. That makes the need to respond equally unavoidable, so I try as hard as I can to do the minimum I need to when containing an incident. If I can push them away and leave the situation without restraining them, that is what I do. But if restraint is necessary, then that has to happen (PC8)

As is indicated in this extract, participants attempted to justify their need to control behaviour – sometimes through restraint – by recourse to an understanding of cause and

effect: just as young people's behaviours were seen as the product of a particular event, participants emphasized that if they *didn't* respond to a behavior then it could lead to another outburst.

Some participants (n=8) endorsed the view that imposing limits, boundaries and control over a young person demonstrated a level of caring concern for the young person's safety, as the following extract suggests:

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

Another participant similarly echoed the belief that restraint specifically, and behavior management in general, was a way of showing young people that they were concerned with their best interests:

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

Despite the view amongst some of the participants that restraint was necessary, they nonetheless found it emotionally challenging. All participants in this cohort reported that they only restrained when they were concerned about the harm the young person may cause to themselves. Importantly, none of the participants felt that the use of restraint should be a primary tool for addressing a situation, unless the young person's behaviour was otherwise unmanageable:

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

Notable, then, amongst participants who endorsed restraint as one form of behavior management, was an emphasis upon restraint in the context of the caring relationship. Indeed, the subset of participants who spoke about the use of restraint (n=10) was comprised of participants who in the first theme spoke about struggling with role conflict between caring and being professional. In other words, restraint was not a feature of those participants who in the first theme experienced no emotional connection to the young people in their care. Instead, restraint was a behavior management technique used by participants who *were* emotionally connected to the young people in their care, a relationship we now explore in further detail in the discussion.

Discussion

South Australian reviews of alternative care models have advocated for better training of workers, including development of skills and knowledge in issues related to mental health and the management of complex behaviours (Layton, 2004; Mullighan, 2008). While it is essential for professional carers to be skilled and knowledgeable in the areas of practice that they may engage in during their time in a residential or specialist care placement, the analysis presented in this paper suggests that there are other variables that need to be addressed within any form of specialist foster care placement, such as an IPC. Key amongst these are the skills that professional carers may (or may not) have for managing the competing role demands of having an emotional connection with a young person, whilst also maintaining a professional boundary.

The challenges associated with having an emotional connection to young people was especially notable in regards to the use of restraint. As we noted in the third theme, those who spoke about utilising restraint as a form of behavior management also spoke about

feeling an emotional connection with young people in their care. Whilst it is beyond the scope of the data to definitively comment in more detail on the relationship between these two factors, we take as salient a point made by Day, Daffern and Simmons (2010), who suggest that restraint may not "assist young people to acquire strategies for self-regulation or teach them how to relate to others more pro-socially when distressed" (p. 239). Thus whilst some of our participants indicated that they practiced restraint in order to show that they cared about the young person and that they had their best interests in mind, in reality this may not have been the message received by the young person.

Furthermore, it is possible that whilst utilising restraint in a particular instance may have curbed a specific behavior, it may have done nothing in the longer term to encourage the young person to develop their own skills in exercising restraint. This, we would argue, is precisely the point where the blurry line between parent and professional becomes most problematic: a parent might acknowledge, over time, that restraining a young person does nothing to teach them how to manage their own emotions, whilst a professional faced with significant behavioural issues might see restraint as an ongoing requirement. This suggests the need for clearer policies around when a professional carer might usefully engage as a parental figure (i.e., showing care and concern), but that this should be distinct from when they make professional decisions about behavior management (which should be driven by procedural directives where restraint should only be used in exceptional circumstances, rather than as a way of showing care or concern).

In terms of the involvement of multiple stakeholders, it is essential that those who support specialist foster placements (including mental health workers and social workers) understand the potentially conflicting needs of young people in such placements (i.e., needing both clear rules guided by established behavior management strategies whilst at the same time needing acknowledgement of their individual cases and histories). Importantly, our suggestion is not that all professionals involved in a placement should defer to either the decisions of the professional carers or the views of the young people. Rather, our suggestion is that all professionals should take into account the need for case plans that can be consistently and realistically implemented at the coalface in ways that do

not undermine placement stability. Ultimately this requires case plans that are endorsed by those most likely to be implementing them (i.e., professional carers).

Finally, and echoing the findings of Hillan (2008), the research reported here suggests that a caring nurturing relationship between young people and professional carers is an important factor in positive outcomes for young people. The analysis suggests, however, that professional carers may be discouraged from developing such relationships due to systemic and organisational policies, despite the reality that many young people in a specialist foster placement may not have any other significant relationships and would benefit from a more personal approach to care. How this is implemented, then, is an issue for future research and policy debate.

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