

**UNCONDITIONAL CARE:
A STUDY OF PROFESSIONAL PRACTICE WITH
HIGH-RISK ADOLESCENTS**

A thesis submitted in fulfilment of the requirements for the degree
of Masters of Arts by Research

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DECLARATION BY THE CANDIDATE

I, Mirian Meade, declare that:

- a) except where due acknowledgement has been made, this work is that of myself alone;
- b) this work has not been submitted previously, in whole or part, to qualify for any other academic award;
- c) the content of the thesis is the result of work that has been carried out since the official commencement date of the approved research program;
- d) any editorial work, paid or unpaid, carried out by a third party is acknowledged.

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Date:

ACKNOWLEDGMENTS

We can never have too much gratitude in our lives

(Walsh, 2002, p. iii)

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...an inspirational leader in the Child Protection and out of home care field throughout the 1980's and 1990s in Australia. Robin died in 2001. However, her legacy continues due to her mentoring of social workers throughout her career and her numerous reviews and evaluation of Child Protection systems.

(Spall, 2002, p. 6)

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ACRONYMS

AASW	Australian Associate for Social Workers
AIFS	Australian Institute for Family Studies
BIST	Behaviour Intervention Support Team
BICPM	Best Interest Case Practice Model
BSV	Berry Street Victoria
CAMHS	Child Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CDI	Child Death Inquiry
CRIS	Client Relationship Information System
CSO	Community Service Organisation
CSV	Community Services Victoria
CSA	Child Sexual Abuse
CPA	Child Physical Abuse
CFAH	Centre for Adolescent Health
CYPA	Children and Young Persons Act 1989
CYFA	Children Youth and Family Act 2005
CYF	Children Youth and Families Division
CHART	Changing Habits and Reaching Targets
Child FIRST	Family Information and Referral Support Team
CSO	Community Service Organisation
DHS	Department of Human Services
DTD	Developmental Trauma Disorder
DoCS	Department of Community Services
ECO	Enhanced Client Outcomes
HRA	High Risk Adolescents
HRI	High Risk Infants
HRASQII	High Risk Adolescent Service Quality Improvement Initiative
HBC	Home Based Care
ICMS	Intensive Case Management Services
ITRS	Intensive Residential Services

IYSS	Intensive Youth Support Service
LAC	Looking After Children
MST	Multi Systemic Treatment
MSCP	Multi Service Clients Project
NASW	National Association of Social Workers
NCTSN	National Child Traumatic Stress Network
NWI	National Wraparound Initiative
NWAG	National Wraparound Advisory Group
NWMR	North West Metropolitan Region
OFC	Office for Children
PTSD	Post Traumatic Stress Disorder
PRB	Positive Response Bias
SWS	Secure Welfare Services
TFC	Treatment Foster Care
WTS	Working Together Strategy
VRF	Victorian Risk Framework
VSG	Victorian State Government
VCDRC	Victorian Child Death Review Committee
VCSB	Victorian Children Service Board
VCC	Victorian Children's Council

ABSTRACT

The complexity of providing care and protection to High Risk Adolescents is becoming increasingly apparent. In the State of Victoria, Australia, the response to this highly vulnerable population has remained the same for over ten years (1998- 2008). Victoria's response to High Risk Adolescents is focused around the three-pronged approach of Home Based Care, brokerage funding and Intensive Case Management Services. The Department of Human Services has not updated its program even in the face of evidence which demands change.

The method used in this research was action research. The aim of action research is to achieve action (solutions) and increased knowledge. It offers a structure for working collaboratively with other professionals to explore complex problems. The action research project described in this thesis attempted to address the question of how to improve the response to highly vulnerable young people who have suffered abuse and trauma. It brought together three groups of case managers from child protection and community sector organisations over 12 months to explore and test a practice approach titled Unconditional Care.

The Unconditional Care approach was written as an initial set of principles which was more fully developed in the research through the use of 19 reflective tools. These tools were based on concepts of critical reflection. The approach encouraged the case managers to examine the source of their professional knowledge and practice. Profiles of the case managers and young people were also collected as data and analysed. An extensive literature review informed the development of the principles.

Unconditional Care is built on concepts of persistence, stability and continuity. It holds that case managers and the service system should respond with endurance and consistency to build stability and relationships; no matter what. The approach involves both notions of care and control in statutory environments. Unconditional Care reflects an emphasis on valuing young people and interacting with them, accepting the validity of their

experience and right to human dignity and relationships.

This research achieved both action and increased knowledge. The first action was that case managers supported the application of Unconditional Care and believed themselves to be practicing in this way. The second critical action achieved was that the case manager's skills in critical reflection were substantially enhanced over the 12 month period. Thirdly they recognised the need for greater integration between 'what we think we do' (espoused theory) and what we actually do (practice in action). Such reflection resulted in the realisation that the existing Victorian system was not supportive of an Unconditional Care approach. Further, it often prevented case managers from enacting stable and consistent care.

This research highlights that solutions to providing care and protection for this group of highly vulnerable young people are currently available. It highlights that given resources and opportunity case managers will apply practice principles based on the notion of unconditional care. This research confirms that this approach reflects best practice and provides great opportunity for High Risk Adolescents.

CHAPTER ONE:

SETTING THE PARAMETERS FOR UNCONDITIONAL CARE

The Secretary must make provisions for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would.

(*CYPA, 1989, S.124 (2); CYFA, 2005, S.174 1(b)*)

1.1 Introduction

As indicated by the above quotation Child Protection Services in the State of Victoria, Australia were mandated under the Victorian *Children and Young Persons Act 1989 (CYPA, 1989)* to intervene when a child is likely to suffer, or has suffered, significant harm from sexual, physical, psychological and/or emotional abuse (*CYPA, 1989, S.63*). The Act provided the first legislative framework for young people considered to be at risk of harm, and has been replaced with the *Children Youth and Families Act 2005 (CYFA, 2005)*. This new legislation was enacted on 23 April 2007 and maintains the Victorian Department of Human Services (DHS) Child Protection Service mandate to intervene (*CYPA, 1989, S.63; CYFA, 2005, S.162*).

At times when abuse is proven, young people come under the care and protection of the State and are case managed by child protection and community service organisations. Whilst there are numerous approaches to case management with High Risk Adolescents (HRAs)¹, the focus of this research is the exploration of a new set of Unconditional Care principles. The research involves case managers' in an examination of the approach and whether it has the capacity to enhance outcomes for HRAs.

¹ Throughout this thesis high risk adolescents are referred to by the acronym HRA. The researcher wishes to acknowledge the inappropriateness and alienating effect of this language on young people as is consistent with labeling theory (Becker, 1963). Its use in this thesis does not reflect anything other than a consistent approach to language for the ease of readers. HRAs are young people and where possible the researcher has used this term.

This chapter provides an introduction to the notion of Unconditional Care, outlines the research, and discusses the setting in which it was conducted. It also explores the research rationale, objectives and scope.

1.2 Background

As the literature review in Chapter Two will show, the concept of Unconditional Care had its origin in the Wraparound service delivery approach to young people with emotional and behavioural disorders (Behar, 1985; VanDenBerg, 1993; MacFarquhar, Dowrick, & Risley 1993, Milton, 1995; Epstein, et al., 1998; Eber, 2002). Unconditional Care represents a significant part of Wraparound's philosophical basis and is named as one of the 10 essential elements of Wraparound (Bruns & Walker, 2008). Over time it appears that 'Unconditional Care' was removed from many program statements and replaced with the idea of 'persistence'. This, however, was overturned recently by the work of the National Wraparound Initiative (NWI) and the sector has been returning to the use of Unconditional Care.²

This research explored the concept of Unconditional Care from a fresh perspective. It was examined as an approach to professional practice defined by principles rather than by evaluation within a Wraparound program. Curiosity regarding professional practice (rather than systems) influenced the choice of action research methodology, which has intrinsic interest in both action (change) and increased knowledge. This focus on the professional practice of case managers was due to Unconditional Care not existing within a Wraparound setting in Victoria. Indeed, Victoria has not implemented a Wraparound system for HRAs.

Examining the history of the Victorian Department of Human Services (DHS) to HRAs over a ten year period allows identification of a complex set of interrelated reports and projects. One such document (one of the trigger for

² In 2007 the NWI Advisory Group did a surveyed its members on this issue. The results showed that 'persistence' did not adequately reflect the sentiment and benchmark of Unconditional Care. On that basis Unconditional Care was reinstated in the official Wraparound essential elements. For further information see Bruns, Walker and the NWI Advisory Group (2010).

the researcher's interest in HRAs) was the Victorian Auditor General's Report (1996) that identified a range of concerns about DHS's management of HRAs.

During 1999-2000 several quality improvement initiatives targeted adolescents receiving protection and care services in Victoria. They included: The Working Together Strategy (WTS) (1998), The Leaving Care Project (1998), The Intensive Therapeutic Service Project (ITS) "When Care is Not Enough" Report (Morton, Clark & Pead, 1999) and the Transforming Business 21- Multi Service Client (TB21MSC) Project (DHS, 2000f). Regional projects were also conducted (Kelly, 1999; Clarke, 1999b; Project Partners, 1999a; DHS, 2000; 2000, 2001a; Morton & Pead, 2000).

In addition to the above mentioned quality improvement initiatives, by the mid 1990s each DHS region had a specialist Adolescent Protective Team (APT) within its Child Protection structure (Berry Street Victoria (BSV), 2007). Over time this work was contracted out and since 1996 BSV has been the main provider of Intensive Case Management Services (ICMS) to young people identified as being at 'high risk' (BSV, 2007). Nevertheless, there are still regions without ICMS services for HRAs.

It was in 1999-2000, when DHS was exploring HRA solutions, that this research was initiated. The researcher's interest in youth had been longstanding after practising in the youth and community sector for some years prior to the transition into child protection work with HRAs. As the researcher worked to implement case management with HRAs, it became apparent that much could be done to enhance the service system's response to this highly vulnerable group of young people.

When the research commenced the researcher was an employee of DHS working in the Statewide Practice Leadership Unit (PLU) with an adolescent

portfolio. DHS supported the research, and it began with a memo from the Community Care Division³ requesting that case managers become involved.

1.3 Defining Unconditional Care

For the purposes of this research, Unconditional Care was defined by the researcher as the idea that: HRAs require a consistency of care that persists in the face of dangerous and challenging behaviour. An Unconditional Care approach never gives up. It never disengages the young person from service provision or severs the relationships that young people have with significant people. Unconditional Care maintains an intrinsic interest in a therapeutic approach and is based on the philosophy of Wraparound. The definition offered by the National Wraparound Initiative (NWI) of Unconditional Care follows:

A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

(Bruns et al., 2008, p. 3)

More recently, Sprinson and Berrick (2010, p. xxi) stated that a key tenet of Unconditional Care is “clients are never discharged from programs for showing the behaviour that led to their placement.”

This thesis contends that Unconditional Care can inform the process of bringing about sanctuary for HRAs so that recovery can begin. It questions how the State can act as a “good parent” (*CYPA*, 1989, S.124 (2); *CYFA*, 2005, S.174 1(b)). This thesis on Unconditional Care embraces the paradox that on occasion it takes ‘care’ and ‘control’ to create safety.⁴ It examines the dualism of the ‘victim’ ‘threat’ paradigm that plagues discourse on ‘troubled’

³ Known from August 2007 as the Children, Youth and Families Division.

⁴ See the literature review in Chapter Two for a much fuller discussion of Unconditional Care and Chapter Five for the analysis and final Unconditional Care principles as defined by this research.

or 'troublesome' youth and how to protect and promote their welfare (Hill, Lockyer & Stone, 2007).

The new legislation in the State of Victoria refers to concepts such as stability planning (*CYFA, 2005* S.166; S.3) and best interests planning (*CYFA 2005*, S.10). It will be argued later that - whilst this may be a step toward Unconditional Care service provision - DHS could consider more carefully the impact on young people of the trauma they have experienced and the responsibility of the State as parent to assist HRAs in recovery and healthy relationships.

The term Unconditional Care was coined by the researcher initially to defined the set of principles developed by the researcher. These were written largely from her own professional practice experience and early reading. Later the researcher made the connections with the significant work on Wraparound and other literature in the areas outlined in the literature review in Chapter 2. These principles were then tested by the case managers in the research⁵. The principles were;

1. Continuity of case manager wherever possible.
2. The ability to re-make personal work practice in line with evidence based practice and developments in the field.
3. Relationship as a base for practice.
4. Consistency of care within the placement system.
5. Honesty, integrity, respect and flexibility.
6. Persisting in the face of everything, no matter what.
7. Acceptance of the young person.
8. The need to work from a developmental perspective, which takes into account the difference between the biological and emotional age of the young person.

⁵ The researcher considered the addition and inclusion of full definitions for each of the principles however it was decided that the principles lend themselves to common and shared language in the sector and therefore could be understood. An additionally consideration was the significant amount of information collected during the data collection phase and the need to be conscious of managing this in a way that focused on the key elements of the research.

9. Commitment to identifying and/or helping to provide a significant person in the young person life.
10. Recognition that spirituality and moral development are protective factors which require acceptance and sometimes facilitation by the case manager.
11. The development of a young person's identity in conjunction with their culture is intrinsically protective and healing.
12. The ability to put responsibility and participation directly with the young person, according to appropriate developmental and emotional status.
13. The competency to make and implement hard line decisions when necessary and in line with the client's best interest and statutory standards.

These principles were considered and extended to include a further five principles during the action component of this research. There was not an assumption on the part of the researcher that the above unconditional care principles represented practice that 'should' be implemented. Rather the researcher was interested in a collaborative inquiry process with case managers.

1.4 Research Context

In 1998 DHS implemented the Victorian HRA Service Quality Initiative (HRASQII) with \$5.298 million dollars of recurrent funding (Successworks, 2001). The initiative was intended to strengthen case management utilising the ICMS⁶ provided by CSOs. This would provide greater continuity of care and consistency of relationships by introducing one to one Home Based Care⁷ (HBC) packages and brokerage funding⁸ (DHS, 1998). In 2010, the HRASQII (1998) remained the current strategy for the provision of care and protection for HRAs.

⁶ The ICMS was a component of the HRASQII program. It was conceptualised as an outreach service comprised of intensive personal support, assessment and individual service planning, monitoring, crisis intervention and case management (BSV, 2007).

⁷ Home based care is a model of residential accommodation based on one carer to one young person.

⁸ Brokerage Funding is designed to tailor a specific individual response that meets the young person's needs (DHS, 2007j).

The HRASQII (1998) Guidelines stated that a substantial body of research informed its development as a best practice initiative. HRASQII was an attempt to provide intensive and highly resourced responses to young people who present with serious personal or community risk issues and pose difficult management problems (DHS, 2001b). Unfortunately it has not been updated to reflect current evidential thinking⁹ it ignores notions such as: engagement, continuum of care and control, attachment, building of trust, trauma-informed practice, continuity, relational and change theory.

This thesis does not work to dispute the clear and essential mandate of Child Protection; rather, it argues for a strengthening of professional practice and the systems that support case managers in order to provide a more Unconditional response. The research grappled with the meanings of providing care and protection for traumatised HRAs in a political environment focused on risk management. It sought to explore the knowledge that informs practice.

1.5 Objectives and Research Questions

This research used action research methodology to test and explore the notion of Unconditional Care. The research design and framework are described further in Chapter Three. In essence, this research consisted of collaborative inquiry with case managers regarding whether the application of Unconditional Care would improve outcomes for young people. The design included a year-long program of focus groups in three regions in Victoria. The objectives of this research were to:

1. Provide a written set of practice principles and guidelines that contribute to positive outcomes for adolescents.
2. Explore and test the notion of Unconditional Care.

⁹ There are many sources of evidence on what works with HRAs which have not been explicitly implemented by DHS. Some of these are; the HRA Evaluation Report (2001), The Take Two reports from Berry Street Victoria (Frederico, Jackson, & Black, 2005; 2006), the DHS internal HRA review (2006) and the latest evidence on the impact of trauma, PTSD, attachment theory and many other research and evaluative discourses. This neglect of evidence is discussed in Chapter Two.

3. Contrast the existing case practice with the Unconditional Care approach.
4. Work in partnership with the DHS and funded agencies to explore the practice and case management issues surrounding HRAs and the results of the ICMS during the period 1998-2000.

The research questions were;

1. Are the Unconditional Care principles in their draft form a reflection of what other case managers consider to be best practice?
2. What other principles and guiding themes are present for case managers?
3. What is the underpinning professional knowledge for these principles from case managers and other research?
4. How much are these principles reflected in daily professional practice?
5. Is there a significant difference between employees of the DHS and contracted staff case managing in Community Service Organisations (CSO)?
6. Do values and personal background significantly impact decision-making?

1.6 Rationale and Scope of the Problem

This research was driven by the goals of improving practice and contributing to policy development. It was predicated on the argument that there was a no state-wide theoretical and practice framework model for working with HRAs. This deficiency was demonstrated in the HRASQII Guidelines and was evidenced by DHS regional staff who documented the best practice and the theoretical frameworks they used¹⁰ (see Appendix 1).

This research was timely due to the HRASQII Evaluation Report (2001) affirming what many internal practice documents had begun to address. The

¹⁰ The work practitioners and regional managers were undertaking in this area was identified via the research reference group (see Chapter 3), members of which were all either senior managers in DHS or CSOs.

concerns voiced related to considerable variations across the state in terms of logistical arrangements, planning and management, relationships, brokerage, expenditure and placement (DHS, 2001b, p. 94). The key concern was that the HRASQII (1998) had not provided an adequate model to govern practice¹¹ (DHS, 2001b).

Morton, Clark and Pead (1999) showed that varying interpretations of the *CYPA 1989* meant there was general uncertainty among staff about how to impose reasonable limits on the behaviour of young people in protective care. Their report stated that there were insufficient practice instructions to guide workers in balancing their duty of care with the civil rights of their clients.

This research on Unconditional Care examined ‘what works’ in case management of HRAs and questioned whether Unconditional Care would be an appropriate practice framework to apply in statutory settings. It was the first exploration of the concept of Unconditional Care as a foundational and critical component of care and protection for HRAs.

The research is also important because it highlights that DHS often failed to consider the needs of HRAs in sufficient depth. This is especially true when considering the historical tendency of DHS to apply popular program concepts without adequate consideration of the HRA population. This includes limited consideration of the cultural implications of transporting international programs into an Australian context, an example being the Looking After Children (LAC) strategy that was implemented in Victoria during the early nineties.¹² The DHS Report on HRA (2006) showed that fewer than 10% of HRAs had current LAC records. The Ombudsman (Brouwer, 2010) confirmed that LAC is not being practiced consistently and that this may be impacting on effective case management. The Ombudsman

¹¹ These concerns were later supported again in 2006 and 2007 in both DHS and BSV Reports on the HRASQII and the ICMS Service. Additionally, the every child every chance (ecec) strategy that DHS is implementing to embed the new *CYFA 2005* does not significantly or deliberately address HRAs.

¹² Lemay and Ghazal (2004) state that LAC is a strength-based, resilience-focused approach that systematically operationalises good parenting for children and youth who are in the care of the state (as cited in Leymay, Byrne & Ghazal, 2006, in Flynn, Dudding & Barber, 2006, p. 316).

also stated that imperfect LAC practice may be related to demand and capacity issues in the system.

When the HRASQII is compared with program areas like the High Risk Infants (HRIs) it is clear that the HRAs have not received adequate consideration. For example, the current *CYFA, 2005* is largely focused on early intervention, best interests and trauma theory and its impact on brain architecture for infants. It appears to have left the consideration of attachment deficits and neuro science in relation to HRAs to the Take Two (T2) ICMS program managed by BSV.¹³

This research was also timely due to the current NWI¹⁴ being conducted over a similar timeframe in the United States of America (USA). This highlights the need for the development of research in this area. The NWI consulted extensively on the 10 essential elements that make up Wraparound, with a view to articulating and refining the philosophy that underpins its success. One of these 10 elements is Unconditional Care. Wraparound will be explored in more detail in Chapter Two.¹⁵

1.7 Legislative Context and Policy Setting

This section examines in two parts the legislative and policy setting relevant to HRAs in the state of Victoria.

1.7.1 Legislative Context

The legislative context for this research is predominantly the *CYPA 1989* and later the *CYFA 2005*. The *CYPA 1989* was the first time all legislative provisions relating to children and young people who needed protection were

¹³ Who continue to provide intensive services, see, Frederico, Jackson, & Black (2010).

¹⁴ In June of 2003, the Research and Training Center on Family Support and Children's Mental Health hosted a national meeting in Portland, Oregon, and invited over 30 parents, parent advocates, wraparound trainers, practitioners, program administrators, researchers, and systems of care technical assistance providers. This was the first meeting of what became the Advisory Group of a new *National Wraparound Initiative (NWI)* <http://www rtc pdx edu/nwi/about.php> In 2004 The *National Wraparound initiative (NWI)* (USA) undertook a process of refining the original "10 essential elements" of the Wraparound process.

¹⁵ During the project the researcher was in contact via email with Janet Walker who is involved in the NWI and confirmed this information. A report can be found at www rtc pdx edu/nwi.

contained in one piece of Victorian legislation (Community Services Victoria (CSV), 1991b). The Act outlined the powers of the Children's Court and set the parameters for judicial processes.

Several key legislative provisions stand out in the *CYPA 1989*. These are: an emphasis on the role of the family, acting in *loco parentis*,¹⁶ the shift from residential to HBC and the funding changes from grant to contract system (Clark, 1999b, p. 18).

With the implementation of the *CYPA 1989* it was intended that adolescents would be looked after by the non-government¹⁷ sector, which would receive additional funding from DHS. The assumption was that the reduction in number of adolescents in the system, would free up resources that could be diverted into support for the non-government sector (Liddell, 2004).

In 1993 the Victorian Government proposed legislative changes to the *CYPA 1989* which made it mandatory for specific professional groups to notify suspected cases of child physical and sexual abuse (Australian Institute of Health and Welfare, 1999).

A further change was that the Act intended three groups of young people to be excluded from the Protective Services mandate. These were: those who were in conflict with their family; those chronically homeless and exhibiting severe behavioural difficulties; and those who might pose a risk to themselves (Gogorosis, 1991; Green, 1993).

The literature highlights that Child Protection has seen social work with children and families replaced by a forensic gaze, dominated by risk assessment and the collection of evidence and surveillance (Jack 1997, p. 659; Sharland, 1999, p. 303; Stuart, 1999; Trotter, 2001, p. 7; 2004, p. 49).

¹⁶ The term *in loco parentis* is Latin for 'in the place of a parent' and refers to the legal responsibility of a person or organisation who takes on some of the functions and responsibilities of a parent.

¹⁷ Now widely called the community service organisations.

This was an unexpected outcome from increased workload from notifications.

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Central to the legislative context is the issue of children and young people's rights.¹⁹ Reference to the rights of children and young people is found in the *Victorian Charter of Human Rights and Responsibilities Act 2006*. The *CYPA (1989, S.119; CYFA, 2005, S.17)* states that the welfare and interests of the child must be given paramount importance (DHS, 2008c).

There was no legislative intent to provide Unconditional Care, but, several relevant sections of the *CYPA 1989* set out the principles of case planning (S.119). More recently, the *CYFA (2005, S.10-11, & S.169-171)* outlined the importance of best interests, decision-making principles and stability in case planning (see Appendix 2).

The government began envisioning the *CYFA 2005* in the mid-1990s (Appendix 3). The foundation for the *CYFA 2005* is 'earlier intervention' in the form of the Child Family Information and Referral Support Team (FIRST),²⁰ stability planning,²¹ a focus on cumulative harm and cultural planning. *The Child Wellbeing and Safety Act 2005* is a further legislative framework and significant change which "promotes a whole of community approach to protecting children and requires all services for children and families to give highest priority to the promotion of child wellbeing and safety" (Victorian Child Death Review Committee (VCDRC), 2007, p. 33).

Other important sections of the *CYFA 2005* with respect to HRAs include the;

¹⁸The Australian Institute of Health and Welfare (2008) shows there were 36,805 notifications in the period 1999-2000 and 38,675 notifications in the period 2006-2007 reflecting a steady increase. It notes that the data may not be fully comparable due to new service system structures. This is consistent with the national picture of notifications.

¹⁹ Australia is a signatory to the United Nations Convention on the Rights of the Child and the World Declaration on the Survival, Protection and Development of Children.

²⁰ Child FIRST is an early intervention service designed to intervene and support families to prevent protective intervention. Child FIRSTs main purpose is to ensure that vulnerable children, young people and their families are effectively linked into relevant services. All Child FIRST sites must be registered and have three years to demonstrate compliance (DHS, 2006c). In August 2007 the Office for Children was renamed the Children, Youth and Families Division (CYF).

²¹ The focus on stability in the *CYFA 2005* can be found in SS.169-171. The Act states that "a stability plan may include details of steps to be taken by the child's carer to meet the developmental needs of the child, including steps relating to the child's health, emotional and behavioral development, education, family and social relationships and identity" (S.169.3.e).

Child Wellbeing report (S.28),²² Child Wellbeing Referral to Child FIRST (S.31), Therapeutic Treatment Report for Sexually Abusive Behaviours (S.185, Oct 2007), Information Sharing (S.3) and Compulsion Powers of the Secretary (S.195).

1.7.2 Policy Setting

As stated earlier in the period 1996-2001²³ HRAs were the subject of many projects and much interest. The following discussion of policy reflects multiple projects and processes within DHS. However, as discussed later, much of the activity (and funding) resulted in few improvements for HRAs.

Clark (1999b, p. 1) showed that the policy shifts that underpinned practice in Child Protection and CSOs in the last two decades were significant. They include:

- An emphasis on the role of the family.
- Increased expectations of those who act in loco parentis.
- An escalation in reporting of child abuse and neglect.
- A move away from residential group care for children in favour of home based care.
- Funding policies that have significantly changed the relationship between government and community based agencies.

(Clark, 1999b, p. 1)

Several factors led to changes to the DHS approach to working with young people, notably the sentencing of a 14-year-old boy in state care for murder in 1996. The subsequent criticism of the Victorian Protection and Care system by a Supreme Court Judge drew attention to the capacity of the system to adequately care for and manage young people requiring intensive

²² The word notification has been replaced in the *CFYA 2005* with report.

²³ Prior to 1996 there was only one manual to specifically to guide case management practice with young people. The three central principles of this policy were; protection, growth and development and safe and stable environment (CSV, 1991).

support. This, in addition to the Auditors-General's report *Protecting Victoria's Children* (1996), was the catalyst for a comprehensive review of service provision for high risk young people in state care (DHS, 1998b; Bath, 1998).

At the same time, DHS formalised the term 'high risk adolescent' by implementing the *Interim Practice Instruction: Identification and Management of High Risk Protection and Care Clients* in August 1996 (DHS, 1998b, p. 1). The secretary of DHS established the HRA Register

to monitor the circumstances, needs and service requirements of young people who pose a high level of risk to themselves or to the community. All young people on the Register were to receive a case management response based on an individual case plan, subject to regular review.

(as cited in Berry Street Victoria (BSV), 2007, p. 6)

The Analysis of Adolescent Child Protection Client Deaths (DHS, 1998) also highlighted the need to pursue a systematic response to issues arising from the investigation of individual client deaths. In 1996, as a part of a "rigorous quality improvement program" (HRASQII, 1998, p. 1) DHS also reviewed the status of adolescents via a working group. In 1997 the working group concluded that "as supported by overseas and local research, there are no absolute solutions as to how to better manage 'high-risk' adolescents given their extremely complex needs" (DHS, 1997b, p. 5).

The working group stated that, as a part of the enhanced service response to HRAs, intensive, expert case management and service coordination would be necessary for clients with high level needs who were placing themselves or others at high risk (DHS, 1997b). This led to the implementation of the HRASQII in 1998 (see Guidelines in Appendix 4).

The implementation of the Working Together Strategy (WTS) in 1998 was another important milestone. It was based on a shared acknowledgement by Child Protection, Mental Health Services, Drug Treatment Services and Juvenile Justice that there was a relatively small but highly significant number of vulnerable adolescent clients with complex and varied service needs which

could not be adequately met by a single program area (DHS, 2000h, p. iii). The WTS commissioned three recommendations, the most important being “The need to examine principles of service provision informed by literature and trends in best practice” (Morton et al., 1999, pp. xi-1).^{24 25}

1998 also saw the launch of the Victorian Risk Framework (VRF) as the new risk assessment framework for Child Protection in Victoria.²⁶ It was implemented with the Enhanced Client Outcomes (ECO) project. The combination of these two programs promoted practice principles that focused on the safety and well-being of the child or young person; the use of a child-centred family focused practice framework; the value of the client’s perspective; the promotion of inter-agency relationships; and professional practice (Armytage, Boffa & Armytage, 1998, p. 1; DHS, 1999d, p. 1).²⁷

In 2001 the HRASQII was evaluated by Successworks and was endorsed as an appropriate response to the management of HRAs, as it had resulted in “steady improvement” of circumstances for all but four of the 66 clients in the evaluation samples (BSV, 2007, pp. 9-10). The report did not make specific findings about the efficacy of the ICMS program itself, but did contend that ICMS was a strong and useful component of the HRASQII (Successworks, 2001; BSV, 2007). Further, “the evaluation did not propose any alternations to the original HRASQII Guidelines” (BSV, 2007, p. 10).

One of the main changes that has taken place in Victoria in during the last ten years in relation to the management of HRAs is the development of the

²⁴ The DHS response to the first recommendation was to fund the WTS continue to develop a collaborative response to HRAs in Victoria. The response to the second recommendation was the Intensive Therapeutic Services (ITS) Project. This has since resulted in the Hurstbridge farm pilot of a therapeutic residential setting for HRAs.

²⁵ In response to the third recommendation, from this review, were two projects which sought to examine trends in best practice: the evaluation of the HRASQII (2001); and the Achieving Service Quality Improvement: Best Practice Initiatives (ASQIBPI) in the Placement and Support Services (DHS, 2001c).

²⁶ The Best Interests Case Practice Model (BICPM) replaced the VRF in April 2007. It is a professional judgment model which relies largely on the expertise of its case managers rather than scripting or requiring case managers to tick boxes to complete an assessment.

²⁷ This reading has a full list of the principles that were going to be implemented during the ECO program. These principles were never fully taken up as the VRF continued to be the dominant focus. The BICPM attempts to incorporate a more reflective approach to practice. DHS provided statewide joint training for Child Protection and CSO staff on the best interests and new legislation during 2006-2007.

Take Two (T2) program. It provides a clinical service that works “intensively with children and young people who have suffered the trauma of family violence, child abuse and neglect to help them understand their pain and learn to trust again” (BSV, 2008) however, this service is not specifically for HRAs and not available in all DHS regions.

In summary, DHS has not reviewed its policies relating to HRAs in nearly ten years. As the above information shows, numerous projects and changes were underway in DHS that touched on the dilemmas that HRAs presented to those in government. Despite these projects, as this research will show, Victorian case managers felt unable to provide stable and consistent care for these young people.

1.8 Scope of the Problem

Action research methodology relies on the identification of a problem. The researcher practiced as a case manager in a DHS region and it was through this time that problems in the DHS approach were noticed. The essential problems were the systems inability to provide solutions for HRAs and the consequent frustrations faced daily by ICMS and Child Protection case managers. Consequently, in exploring the problem to be addressed by this research, the young people and the case managers were considered to have special dilemmas.

The case managers worked for Child Protection and CSOs funded to provide ICMS.²⁸ The challenges faced by case managers in these two services are well documented as being complex and challenging (Munro, 2002). Staff recruitment and retention in Child Protection has been a steady concern over many years; this has recently impacted regional unallocated case numbers as highlighted by the Ombudsman’s report in 2009 (Brouwer, 2009).

Case managers working for child Protection and CSOs have similar

²⁸ Case managers who work in the non government (community sector organisation) area are contracted by DHS to provide services to HRAs on the High Risk Register. The case contracting arrangements differ from region to region, but are currently provided almost entirely by BSV some regions do not have ICMSs at all, in this instance, the Case Management of HRAs.

responsibilities, but they differ in that DHS Child Protection case managers hold statutory responsibility for Protection and Care and ICMS case managers do not.

ICMS focuses on the provision of intensive support to young people with high needs, for whom less 'assertive' case management practice either has not previously worked or is considered unlikely to be effective. This proactive approach to case management is characterised by a high level of contact with the young person, with an intensity of relationship, and strong participation in decision-making by both the young person and, where appropriate family members or significant others.²⁹

(DHS, 2001b, p. vii)

The professional practice of case managers who work with HRAs is informed by several academic disciplines, primarily social work, youth work, psychology, education and various welfare and community certificates.

Internationally, statutory child protection services (CPS) experience difficulty in attracting and retaining professionals to provide direct services to children and their families and that Graduates are not 'job ready' for child protection roles - there is a need for specialist vocational training.

(Bromfield & Ryan, n.d.)

The researcher used Drury-Hudson's (1997) model of professional knowledge as a framework for data collection. This, coupled with the use of multiple focus groups, assisted exploration of the tacit (unconscious) and explicit (conscious) areas (Osmond, 2005a) of knowledge that inform case management. It is well known that there is dissonance between what case managers say they do in practice ('espoused theory'), and what they actually do (known as 'theories-in-use').³⁰ The need to further explore professional practice is also highlighted by Fook, Ryan and Hawkins (2000a) who state

²⁹ The BSV Evaluation reports show that most ICMS case managers spend about 30% of their time in direct contact with clients.

³⁰ Further information on the make-up and details of the case managers who took part in the research can be found in Chapter Four.

that “we need to be committed to researching and developing knowledge from the perspective of the practitioner” (p.247).

The other group of people involved in this research was, of course the young people. In Victoria, in the period 1996-1997, the total of young people aged 10-14 who were investigated regarding the need for Care and Protection by DHS totalled 32.2%. This related to the overall group of investigations, that is 2,582. By 2001-2002, the figures had dropped to 2,212 young people (DHS, 2003, p. 4). The HRA population is a subset of this population, consisting of about 200 young people at any one time (HRASQII, 1998, p. 1). Between 1998 and 2006 the number of young people recorded on the Register remained between 170 and 250, with 178 young people counted during 2006 (DHS, 2006, p. 8).

Young people who are placed on the Register all display challenging and difficult-to-manage behaviour. To be placed on the Register young people must:

- Be a client of Protective Services. Generally the young person will be on a custody or guardianship order.
- Be aged between 12 and 18 years.
- Present with multiple and complex behavioural and emotional difficulties such as;
 - Challenging behaviour at home, in placement and at school
 - Substance abuse
 - Suicidal tendencies
 - Aggression
 - Chronic running away
 - Prostitution
 - Association with paedophiles
 - Emerging or diagnosed psychiatric or psychological disorder
 - Consistent, escalating offending
 - Sexual offending
 - Estranged or non existent family relations.
- Require long-term care and substantial support.

(HRASQII, 1998, p. 9)

According to Clark (1999b, p. 50) young people who are considered to be high risk by DHS have had childhoods marked by abuse and neglect and demonstrate all the associated impairments. Many suffer from not having been affirmed;³¹ they have received little by way of love and as a result, they cannot give to others, especially adults.

Shonkoff and Phillips (2000) argue that young people who have experienced long periods of unstable care following abuse and neglect suffer poor emotional attachment and bonding³² (as cited in DHS, 2004, p. 5). In addition, Hunter 1997 and the American Psychiatric Association (APA) (2000) support the emerging view that:

Failure to address Post Traumatic Stress Disorder (PTSD) in young people increases the probably of serious conduct disordered behaviour which may become wide-ranging. This, in turn, may give rise to marked charaterological disturbances in adult life, including antisocial personality disorder.

(as cited in Wilcox, Richards & O'Keefe, 2004, p. 342)

As discussed later there is a growing movement toward a new classification in the DSM criteria for Developmental Trauma Disorder (DTD).

Few studies have examined the nature and characteristics of children and young people with high needs in Australia. Two relevant studies by Osborn and Delfabbro (2006) and Tarren-Sweeney and Hazell (2006) state found that of young people in foster care:

almost three-quarters of the children came from households with domestic violence or physical abuse; two thirds had parent with substance abuse problems, and almost three in five had been neglected. Half the sample had parents with mental health problems, significant financial problems or homelessness.

³¹ The word 'affirmed' used here means that young people have not received positive affirmation or encouragement from others in their lives.

³² The researcher notes that there is an important difference between bonding and attachment. Bonding refers to the capacity of the parent to connect with the child, whereas attachment refers to the emotional connection that the infant/child makes with the parent.

(as cited in Schmied, Brownhill & Walsh, 2006, p. 2)

Increasing complexity in these young people's lives, and the need for further consideration to practice has been a catalyst for this research. Case management can assist in the amelioration of harm. This research explores the relationship between case managers, best practice and the historical concepts of Unconditional Care. The desire to improve on past approaches provides the basis for this research.

1.9 Thesis Structure

Chapter Two 'Understanding Practice' reviews the literature relevant to Unconditional Care in four major themes: Unconditional Care definitions and values, contexts for Unconditional Care, evidenced-based practice and theory, and finally changing practice with critical reflection.

Chapter Three describes the methodology and examines why action research was chosen as the methodological framework. The chapter presents the research questions and objectives and discusses the challenges involved in applying action research.

Chapter Four provides an overview of the findings and describes the process and events of the 12 months of focus groups. It describes the case managers who were involved, discusses the role of the reference group and presents the dissonance between the case managers espoused theory and theory in use.

Chapter Five presents the results of analysis under a series of themes and examines; action outcomes and the research's contributions to knowledge regarding Unconditional Care.

Chapter Six discusses the findings and responds to the research objectives and questions. It acknowledges the silent voice of young people in this research and explores the strengths of collaborating with case managers as the 'experts'. It concludes by providing a set of recommendation for policy

and research on the management of HRAs in Victoria and Australia in 2011 and beyond.

CHAPTER TWO:

UNDERSTANDING PRACTICE

Strengthening students' and/or practitioners' ability to recognise and identify the basis of their professional behaviours is critical for clear, knowledge-guided practice.

(Osmond, 2005a, p. 881)

2.1 Introduction

This chapter provides an examination of the relevant literature related to Unconditional Care and professional practice in Case Management. In developing an understanding of theory and practice the researcher drew on the work of experts who have a longstanding engagement with professional practice, notably Schon (1973; 1983; 1987; 1995a; 1995b) and Fook (1996; 2000; 2000b; 2002; 2007). Their work highlights that professional practice is complex and messy (Schon, 1995) and that most case manager's work with the knowledge and resources they have, or can develop, whilst examining a case. They contend that practice often becomes a method of inquiry, which generates solutions to problems. As Osmond (2005a) states, "there is a need to identify the basis of their professional behaviour" (p.881).

The literature in this chapter is presented around four themes. The first theme defines Unconditional Care within Wraparound and then as an independent concept, this theme also examines the underpinning role of values in Unconditional Care. The second theme on the context of Unconditional Care examines therapeutic interventions, case management and the environment of risk. The third theme, presents a discussion on the role of professional knowledge and focuses on the expectations of Evidence Based Practice (EBP) and the knowledge that informs case managers; it also examines the theory that informs an Unconditional approach. The final theme reviews the literature on the relationship between critical reflection and changing practice.

2.2 Unconditional Care: Definitions and Values

This section presents and evaluates literature in three areas. It defines Unconditional Care, examines Wraparound as the founding influence of Unconditional Care, and thirdly it examines the role of values in practice and locates the discussion on Unconditional Care within this framework.

2.2.1 Unconditional Care Starts With Wraparound

The concept of Unconditional Care originates within a service delivery system³³ for children and young people known as Wraparound which is an approach to treatment that has evolved over the past 20 years and began in the United States of America.

Wraparound is a planning process that results in a unique set of community services and natural supports that are individualised for families. It is based on an Unconditional philosophy to identify the community services and supports a family needs and provide them as long as they are needed, without ejecting the young person from care (Behar, 1985 as cited in Kamradt, 2001, p. 14; VanDenBerg, 1993; Heckman, Carro, & Burchard, 1994; VanDenBerg & Grealish, 1996; Burchard, Bruns & Burchard, 2002; Kendziora, Burns, Osher, Pacciano & Mejia, 2001; Memorial Health Care System, 2006; Bruns & Suter, 2010).

Wraparound is shaped by a set of value based principles which include strengths-based practice, family-focused practice, parent involvement, Unconditional Care, building and maintaining normative life styles, valuing culturally competency and individualised care (Boyd, 1991; Burchard & Clarke, 1990; VanDenBerg & Grealish, 1996 in Malysiak, 1997, p. 399; Burns et al., 2000). These are known as essential elements (see Appendix 5). The elements of Wraparound were first developed in Canada in the 1960s and Chicago in the 1970s. Its current popularity is demonstrated by 2007 figures which show that “91% of U.S. states have some kind of Wraparound

³³ The term ‘System of Care’ is used predominantly in the United States of America as a term that describes the Australian equivalent ‘service system.’

initiative” (Bruns & Suter, 2010, p. 9).

VanDenBerg, Bruns, and Burchard (2008a) argue that “the intuitive appeal of the Wraparound philosophy, promising evaluation studies, and many success stories from communities around the nation have promoted explosive growth in the use of the term ‘Wraparound’ over the last two decades” (p.2).

Australia has not embraced Wraparound with as much enthusiasm as the (USA). There are only a few services in Australia that have developed their models based on a Wraparound philosophy. Here the term tends to be used in a broader sense to refer to individualised services “which address the needs of the child or young person in care, as identified through the assessment and case-planning process” (DoCS, 2007, p. 4).

2.2.2 Unconditional Care - An Independent Concept

Scant literature focuses specifically on the concept of Unconditional Care as a standalone model that underpins professional practice and treatment. The idea of Unconditional Care can be found in literature from around 1985, when it was used in the USA in community mental health programs designed for young people with emotional and behavioural disorders (see Behar, 1985; VanDenBerg, 1993; MacFarquhar, Dowrick & Risley, 1993; Milton, 1995; Eber, 2002), predominately as an essential element within Wraparound systems.

Definitions of Unconditional Care include the concept of service provision for as long as it is needed, and/or ‘a never give up’ philosophy. For example, Sprinson and Berrick (2010) recently defined Unconditional Care as never discharging clients from programs for showing the behaviour that led to their placement.

In Australia, Robyn Clark (1997)³⁴ named Unconditional Care in her work on exceptional practice.³⁵ A research project conducted by Clark (1997) focused

³⁴ Robyn Clark was an inspirational leader in the Child Protection and out of home care field throughout the 1980s and 1990s in Australia. Robyn died in 2001. but her legacy continues due to her

on expert practice in the out-of-home care setting in NSW; she found that expert practice with HRAs in residential care revolved around the attitude to 'hang in.' Further, she wrote "as bad as it gets, we will still care for you; you might run but we will still be here for you" (Clark, 1997, p. 48). Clark went on to state that "it was clear from the literature search and from what the exceptional practitioners said that the main ingredient of effective intervention with these (high risk) young people is the provision of Unconditional Care" (Clark, 2000, p. 59).

More broadly, Unconditional Care is represented in the organisational values and core principle statements programs across the world.³⁶ The researcher believes that Australia appears to have chosen only certain parts of the Wraparound philosophy though often not the Unconditional Care approach. Overseas literature reflects opposition to breaking up the elements of Wraparound as it is believed they are more effective when applied together. Burns (2004) claimed that splitting up the elements constitutes a problem with fidelity, the idea that a program should be implemented as closely to the intended design as possible for maximum outcomes.

In summary the concept of Unconditional Care makes up only a small part of the Australian story for approaches to HRA; it has not been embraced by DHS, Victoria. The strong associations Unconditional Care has with long term sustainable approaches such as Wraparound provide hope and credibility.

mentoring of social workers throughout her career and her numerous reviews and evaluation of Child Protection systems (Spall, 2002).

³⁵ Clark's legacy included practice "lessons" written by her colleague Pamela Spall (2002). These lessons included; using a systems approach, planning the ideal system, Child Protection within a family support framework, designing a system for maximum impact, taking affirmative action, choosing the best carers, professional knowledge and its role in creating the context of intervention and a commitment to research.

³⁶ Examples include: The Integrated Services Program (ISP) in Portland USA (2006), The Seneca Center for Children and Families in California USA (2006), The Texas Health and Human Services Commission (2006), Barnardos Australia (2006).

2.2.3 The Role of Values

A discourse on values is relevant to this research as Unconditional Care is primarily a values framework that practitioners have applied within various service responses. As Sprinson and Berrick (2010) stated there are “few explicit discussions of values in professional journals or in the literature concerned with treatment and intervention” (p. 229). This seems problematic given that the literature reiterates that values system and codes of ethics are used to educate and guide behaviour (Perlman, 1986 as cited in Furman, 2009, p. 82; Pollock 2007; Noble & King, 1981 in Mattison, 2000, p. 202).

According to Freeman and Harris (1996, as cited in Harris & Bergman, 1996, pp. 8-9) the influence of human values on case management is most clearly summarised by the work of Rapp (1996, pp. 143-164 in Harris and Bergman; 2006). Here Rapp consistently highlighted that good case management is a negotiated and collaborative process where the values of all parties are salient.

Given this absence of discourse on values in the literature it is worth considering the implications for professional practice. Hugman (2003) argues that postmodernism (and its tolerance for pluralism) has undone the universal (global) nature of historic social work values and that it has brought into question how social work values are defined.³⁷ In referring to social work Bisman (2003) argues that a “lack of adherence to the values in the codes is an indicator of the low level of commitment to their importance (Payne, 2002; McBeth & Webb, 2002) even though there is a widely held assumption that values are central to the profession” (Barlett, 1970; Reamer, 1999; Parsons, 2001 in Bisman, 2003, p. 101).

It is difficult to say that values do not continue to shape practice. For example the Australian Association of Social Workers (AASW) defines five values:

³⁷ Historically there has been a set of universal ethics. UN documents signed by most countries are based on human rights, so a common ethical framework is both possible and necessary (Hugman, 2007). In other words, it is possible to enact approaches to practice that are based on values or ideals that reflect global values.

human dignity and worth, social justice, service to humanity, integrity and competence (AASW, 1999, p. 9). Consideration can be given to how much these values shape professional practice. Even though the youth work sector in Australia does not have a national set of values, Corney's (2004) research suggests that Australia favours "a left-wing framework for the analysis of social justice, particularly the ideological and political frameworks of socialism, Marxism and feminism and the related values of anti-economic rationalism" (p.16).

The National Youth Agency in the United Kingdom (UK) argues that "Youth work is informed by a set of beliefs which include a commitment to equal opportunity, to young people as partners in learning and decision-making and to helping young people to develop their own sets of values" (The National Youth Agency (NYA), 2004, p. 3). The Youth Affairs Council of Victoria (YACVIC) (2007) has a statement of ethics that guides the sector, in which honesty, empowerment and participation are named as key concepts. (see also CREATE Foundation, 2000; Hepworth et al., 2010).

Corney (2004) explained that the helping professions such as youth work, are primarily determined in terms of the practitioner's adherence to values-based meaning systems. This was confirmed by Fook, Ryan et al., (2000). Corney (2004) who found evidence to suggest that implicit and explicit values define the very notion of disciplines such as youth work and social work. Values underpin both education and professional practice.

There is emerging acknowledgement of the relationship between values and professional knowledge. Goddard and Carew (1993, in Osmond, 2005a, p. 890) argued that values (can) determine the type of knowledge that individual social workers use and that case managers will, on occasion, call upon values and ethics as a basis for their practice activities (Banks, 1995; Demartini & Whitbeck, 1986). Furman (2009) argues that evidence-based approaches have yet to demonstrate a focus on the core social work values of emancipation, client empowerment, and freedom (Fook, Ryan & Hawkins, 1997).

According to Bisman (2004) writing about values in social work “a shift to skills and knowledge occurred very quickly in the professions development” (p.112), although the concept of utilising skills and knowledge had been present since 1964 when Loch stated that if we wish to improve the conditions of the poor we must adopt scientific measures (C.S. Loch as cited in Woodroffe, 1964, p. 485 cited in Bisman, 2004, pp. 112-113). More recently, Osmond’s (2005a, p. 890) research has shown that values, ethics, beliefs or moral principles can, at times, be conceptualised by case managers as knowledge.

Sprinson and Berrick (2010) discuss values as emotional states that can create and animate connections with clients. When practices are connected to values, “the worker is personally implicated in what he or she does every day in a different way” (Sprinson & Berrick, 2010, p. 229). The values they call ‘emotional tones’ present in work with clients are “love and compassion, respect, hope, courage and joy (pp. 230-233), a set of values is rarely discussed in the wider literature. These ideas are consistent with the existentialist ‘being-for-other’ (Bauman 1994, in Hugman, 2003, p. 1027). O’Connor, Wilson and Setterlund (1998) contend it is the “disciplined use of self, in a way that is helpful to the other”, that defines the client worker relationship (p.71). Bauman’s and O’Conner et al’s contentions are both value-based positions which reflect a commitment to the importance of human relationships.

The ethics and values of DHS Victoria with respect to collaborative relationships, client focus, professional integrity, quality and responsibility were called into question by the Ombudsman’s Report (Brouwer, 2009). This stands in contrast to Stroul (1995, p. 5) who contends that ‘Systems of Care’ should represent a philosophy about the way in which services should be delivered and that all systems should be guided by a set of basic values.

As Bisman (2004) states, “social work is not value free” (p.120). Instead, values are central to the profession as without them there is no social work. Husband’s (1995) concept of the ‘morally active practitioner’ may assist the sector to inquire about the role of values such as love, hope, compassion and

joy in practice.

2.3 Contexts for Unconditional Care

This section explores three contexts in which Unconditional Care operates; therapeutic interventions, case management and risk assessment. Also included is the work of Van Der Kolk (2005) which highlights the inadequacy of current responses to PTSD. The researcher believes it is one of the most significant bodies of knowledge that will shape the adolescent service response and may increasingly become a relevant intervention for HRAs.

2.3.1 Therapeutic Interventions and Service Models

Decades of service delivery and poorly performing programs aimed at the HRA population have produced only a handful of therapeutic interventions (Tomison, 2000; DoCs, 2006); these include Multi-Systemic Therapy (MST), Therapeutic Foster Care (TFC) and case management. As McClung (2007) states, “There is a lack of comprehensive research into the most effective interventions for traumatised children in care, with a corresponding lack of consensus regarding models of appropriate intervention” (see also Burnes, Schoenwalk, Burchard, Faw & Santos, 2000, p. 284; Caffo, Forresi, Strik Lievers, 2005, p. 422).

The work of BSV highlights Therapeutic Foster Care (TFC) as an important intervention. McClung (2007) defines TFC as a combination of the “normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant home” (Stroul, 1989, as cited in Jivanjee, 1999b, p. 451, as cited in McClung, 2007, p. 10). She stated that TFC is a cost-effective means of enhancing outcomes for children in care (McClung, 2007, p. 5).

In addition to this local knowledge, Macdonald and Turner (2008) published a Cochrane Collaboration³⁸ review of TFC in 2008, which defined it as a family-

³⁸ The Cochrane Collaboration is an international not-for-profit and independent organisation dedicated to making up-to-date, accurate information about the effects of health care readily available

based intervention with a tailored program designed to affect positive change. It was specifically designed for children whose difficulty placed them at risk of multiple placements and/or secure services. Macdonald and Turner stated that nothing could be said about the benefits of what is a relatively costly service, due largely to insufficient evidence. Furthermore, it was deemed impossible to make statements about TFC's effectiveness when compared to other composite interventions (Macdonald & Turner, 2008, p. 2).

A further therapeutic intervention is MST which is "an individualised treatment model in which families set treatment goals and collaborate with practitioners in designing and implementing interventions to meet these goals" (Henggeler, Schoenwalk, Boduin, Rowland, & Cunningham, 1998, p. 5). This intervention relies on two ideas; the first holds that even though empirical studies on multi system approaches are limited, they are promising³⁹ (Henggeler et al., 1998; Kazdin, Siegel, & Bass, 1992; Navaco, 1975 in Knorth, Klomp, Van den Bergh, & Noom, 2007), while the second is that interventions by multiple agencies with different personnel can actually worsen outcomes for young people with conduct disorder and attachment disorders (Shamsie et al., 1994). This perspective asserts that "systems that rely on the minimum of disruption, with a single well planned, structured transition from secure setting into the community, under an appropriate legal framework, are likely to be preferable (Gralton, Muchatuta, Morey-Canllas, Drew Lopez, 2008).⁴⁰

The next area includes a stronger focus on PTSD and the responses to

worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. The Cochrane Collaboration was founded in 1993 and is named after the British epidemiologist, Archie Cochrane. The major product of the Collaboration is the Cochrane Database of Systematic Reviews which is published quarterly as part of *The Cochrane Library*.

<http://www.cochrane.org/docs/descrip.htm>

³⁹ It is interesting to note that many of the recommendations made to DHS at the time of this research focused on the work of Henggeler, et al. (1998) and MST as the preferred model: see Appendix One-the Report for the Northern Region.

⁴⁰ Whilst it is beyond the scope of this thesis, it is an interesting side note that Armelius and Andreassen (2007) argue that for young people in residential care settings displaying antisocial behaviour, Cognitive Behavioural Therapy (CBT) has no stronger evidence of success than other treatments. Despite this lack of evidence CBT is heralded as one of the most effective treatments for young people. For example, the Victorian Youth Justice CHART program is based on a treatment framework of CBT.

children and young people. PTSD is related to the conditioning of neurobiological fear responses, underlying tendencies to react aggressively to protect the self when exposed to reminders of early trauma (Fletcher, 2003 in Blyth, Soloman & Baker, 2007). The literature shows a clear trajectory of poorer outcomes for those children left longer in abusive and harmful situations (Trickett, & McBride-Chang, 1995; Perry, 2002; Rutter et al., 1998). Hence, the importance of an adequate service response cannot be ignored.

This emerging research has the potential to enhance the Victorian service response. In Victoria, 24.2% of HRAs have a risk factor named as a diagnosed or emerging psychiatric disorder and 38% of admissions to Secure Welfare Services are listed as being for mental health concerns (DHS, 2006b). Given the current diagnostic tools and weaknesses in data collection processes, this statistic may not adequately capture the number of HRAs who suffer PTSD or related concerns. This is supported by the Ombudsman's Report (Brouwer, 2009) which stated that "investigators located numerous incomplete and inaccurate child protection client files" p.97).

This problem of inadequate response is recognised globally, and in the USA has led to the complex trauma taskforces of the National Child Traumatic Stress Network (NCTSN) (2003) being concerned about the need for a more precise diagnosis for children with multifaceted histories. In an attempt to more clearly delineate what these children suffer from and to provide a guide for therapy, this taskforce has conceptualised a new diagnosis provisionally titled Developmental Trauma Disorder (DTD).

Dwyer and Miller (2006) contended that understanding trauma helps people to appreciate the seemingly exaggerated responses of victims. Perry (2006) reiterates that "what works best is anything that increases the quality and number of relationships in the child's life" (p.80). Bloom (1999) states "that interventions strategies must focus on helping people to 'detox' from this behavioural form of addiction by providing environments that insist on the establishment and maintenance of safety" (pp. 9-10). The links between trauma and damaged relationships skills are now strongly established. There

is an understanding that young people who have experienced attachment disruptions and have been unable to develop effective internal working models are likely to require much more support during adolescent years, support that must include a stable and unconditional response (Sprinson & Berrick, 2010).

Bath (1997, as cited in Tilbury & Osmond, 2006, p. 267) contends that “multiple placements are a developmental hazard” (see also Cashmore & Paxman, 1996; Maunders, Liddell, Liddell, & Green; Bastian, 2002; Kiraly, 2002, as cited in Liddell, 2004, p. 63; Liddell, 2004; Sprinson & Berrick, 2010, pp. 24-26). Research undertaken by Holland, Faulkner and Perez-del-Aguila (2005) confirms that stability was created utilising individualised, flexible, multidimensional therapeutic care packages, compared with groups receiving standard packages.

The literature points to “issues surrounding attachment and trauma and the need for therapeutic environments” (Schmied et al., 2006, p. iv), yet the therapeutic options for HRAs on the HRA Register have only two ICMS services (WMR Westcare and SMR BSV) that have a full-time, dedicated mental health position on staff. Several other regions have established relationships with local Child Adolescent Mental Health Services (CAMHS) to access a clinician on a part-time basis. So, as far as can be determined, funding for the specific positions has been absorbed into the CAMHS general budget (BSV, 2007). The Ombudsman (Brouwer, 2010) concurs and noted that waiting lists for mental health services are too long and may not provide a timely response for children.

The work of the T2 program first mentioned in Chapter One delivers practice and research in the area of therapeutic intervention, even though it is not specifically tailored as a response to HRAs. Evaluation reports to date have been authored by a consortium, that includes employees of BSV, which may have compromised the objectivity of the research. The report states:

signs that Take Two is making a difference to the internal and external world of children are promising. Findings from multiple data sources are all in a

positive direction. However, the low number of outcome measures means that definitive conclusions cannot yet be drawn from these data. This limitation is balanced by the findings of the qualitative data such as the case studies, clinician surveys and stakeholder surveys which illustrate strong positive outcomes for children.

(Frederico, Jackson & Black, 2006, p. 156)

T2 could be strengthened with evaluation by independent researchers. This need for independent evaluation arises similarly in regards to TFC, where there is a clear discrepancy between the international literature and the internal findings of BSV.

In summary, the literature does not suggest any one model of therapeutic intervention for HRAs is superior to another. The Ombudsman (Brouwer, 2010) noted that new models for therapeutic care are being trialed and that the initial feedback for these programs was positive. The literature highlights that HRAs require care that considers the impact of attachment deficits and trauma and applies a willingness to remain engaged in relationships with the young person so that stability can be achieved.

2.3.2 Case Management

Case management is an important theme in this research because: (i) Unconditional Care has its beginnings in the mental health sector (Ziguras, Stuart, & Jackson, 2002); (ii) case management represents the current approach to HRAs (HRASQII 1998), and; (iii) Unconditional Care is most helpfully conceptualised as an approach to the delivery of case management.

There is a great deal of ambiguity in the literature on case management and a lack of research about what is good practice (Baker & Weiss, 1984 as cited in Radol, Raiff & Shore, 1993, p. 21; Harvey & Fielding, 2003, p. 178; Freeman & Harris, 1996; McDonald, 2005). Many case management models are defined as a process that includes assessment, planning and review (Mueser, Bond, Drake, & Resnick, 1998; Akintoye, Beck & Hardcastle, 2003). Case management includes a focus on a range of areas such as client rights, sustainable solutions, communication and acting with purpose (Trotter, 1999;

Gursansky, Kennedy & Harvey, 2003; Yagoda, 2004 & The National Association of Social Workers (NASW); Woodside, 2005; Maher & Cooper, 2008; Moore, 2009).

Case management almost always starts with an assessment of the client. While numerous types of assessment are possible (Akintoye, et al., 2003), it should be collaborative and dependent on the active involvement of the client (Kisthardt & Rapp, 1992; Saleebey, 1992; Sullivan & Fisher, 1994; Miley, O'Melia, & DuBois, 1998 as cited in Gursansky et al., 2003, p. 65).

It appears however, that the evidence regarding case management is contradictory. According to Ziguras, Stuart, and Jackson (2002), a much debated Cochrane review completed a meta-analysis of the effectiveness of case management in mental health services. The conclusions were scathing:

The statutory introduction of case management has been triply unfortunate. First health and social services, patients, and carers have been saddled with an unproven intervention whose main effect is likely to be a considerable increase in the demand for hospital beds. Second, the obligatory nature of the intervention is likely to impede attempts to introduce superior alternatives, or to further evaluate its effectiveness. Third, the intervention has become a political policy and hence has acquired a degree of support from vested interests whose motives for continuing to support the intervention are political rather than scientific.

(Marshall et al.,1996, in Ziguras, et al., 2002, p. 7)

This comment on the politicisation of interventions is particularly relevant for the HRA client group. An Australian assessment of the evidence, which recognised this contradiction, stated that case management is generally effective, but that Assertive Community Treatment (ACT)⁴¹ is a more

⁴¹ Because of positive findings in multiple randomised clinical trials, Assertive Community Treatment (ACT) is a recognised Evidence Based Treatment (EBT) for adults with Severe and Persistent Mental Illness (SPMI), (Bond, Drake, Mueser, & Latimer, 2001). ACT involves a multidisciplinary team serving as a fixed point of responsibility. That is, it delivers integrated treatment, rehabilitation, and administration and policy in Mental Health support services to individuals with SPMI living in the

successful intervention, particularly in terms of mental health; it also noted that the effectiveness of Case Management declines with higher caseloads (Ziguras, et al., 2002). Interestingly, Australia does not implement the ACT model in any service setting, although the Mental Health Service Delivery System utilises some of the components. As Yarmo Roberts (2002) stated, Case Management is “controversial, highly political and saturated with conflicting agendas among stakeholders” (p. 147) and is also “complex and confusing and not universally understood by health care professionals” (p. 150).

Mueser et al., (1998), stated that Case Management “is an addition to good treatment, not a synonym for it or a substitute for it” (p. 39). This idea that case managers should act in therapeutic ways but do not deliver therapy is important to understanding their purpose. Parker (2006) argued that a case manager ensures continuous coordination of services (Clark, Landis & Fisher, 1990 as cited in Radol et al., 1993, p. 21), rehabilitation, care and support of people with complex clinical needs.

Perhaps most powerfully, Sprinson and Berrick (2010) suggested five ideas as being crucially important. They are; Unconditional care, emotional availability, attunement, responsiveness, predictability and consistency. When workers undertake these ideas within a case management framework, progress may well be made.

2.3.3 The Environment of Risk – Assessment and Management

The literature on risk assessment and management has been included in this thesis because it has a direct relationship to the discourse on trauma (Bloom, 1999; Van der Kolk & Greenberg, 1989; Perry, 2001a, 2002; Perry & Szalavitz, 2006). Examining risk assists in consideration of how young

community (Stein & Santos, 1998). One of the barriers to widespread implementation of ACT is the lack of attention given to the organisational dynamics of the team, such as communication, decision-making, and/or leadership (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001). An effective ACT team operates as a single unit of expertise that continuously organises and reorganises itself in response to client needs. The ACT team is comprised of individuals from a variety of professions that may reflect distinct disciplinary and/or social cultures (Allred, Burns, Phillips, 2005).

people with significantly raised levels of endorphins, attachment disorders and deficits in self-regulation can be cared for and protected. This is especially vexing due to behaviours that can be self destructive and at times, harmful to others.

As seen in the previous section, case managers work within a therapeutic framework - not delivering treatment, but following a process that commences with assessment. Risk assessment also informs the case planning process. During times of crisis risk assessment forms the basis for containment and/or secure care and is the main influencing factor for decision-making. As a foundation for Case Management, it is less helpful than an Unconditional approach which has intrinsic interest in service provision regardless of the risk level.

The concept of risk has long been present in the youth sector. The “pervasiveness (commonness) of risk has seeped into the youth justice arena and more broadly into social policy conceptions and responses to youth (Kemshall, 2007), resulting in an increased ‘problematization of youth’ (Kelly, 2000). State-driven interventions regulate and control youth more than ever before (Kemshall, 2003, 2007 in Blyth, Solomon, Baker, 2007, p. 7). As Giddens argued:

risk discourses are dangerous in the sense that these discourses promise that the risks, the uncertainties and the contingencies of human behaviours, dispositions and interactions in complex settings can be objectively, scientifically or critically identified. Once identified, various programs and interventions can then be mobilized to regulate the dangers, the uncertainties and the contingencies of an age of “manufactured uncertainty.”

(Giddens, 1994 as cited in Kelly, 2000a, p. 464)

There is a substantial Australian literature on the problems of youth ‘at risk’. Many authors have written about the ways in which class, gender and race have been significant in conceiving youth as deviant, delinquent and/or disadvantaged and therefore in need of control (Beasley, 1991; Bessant,

1991; Carrington, 1991; Collard & Palmer, 1991; Irving, 1991; Maunders, 1991; Sherington, 1991; Wyn, 1991 in Kelly, 2000a, p. 463).

This issue of “dealing with troubled or troublesome young people” is now a major policy concern (Case, 2006). Kemshall stated that “identifying ‘at-risk’ youth has spawned an industry, and the risk agenda has tended to prioritise public protection and diminish the rights of children and young people” (as cited in Blyth et al., 2007, pp. 8-10). Kemshall also debated policy and practice regarding whether case managers are responding to ‘children in need’ or ‘risky youth’ (as cited in Blyth et al., 2007, p. 10; Dwyer & Miller, 2006⁴²). This debate in the literature about how to view young people represents almost a total polarisation of views. The ‘victim’/ ‘threat’ discourse continues to be a complex area with few answers offered. As Goldson (2004) argues

The means by which children are ‘socially constructed’ (James & Prout 1997) and formally conceptualised, lies at the root of such a paradox. The victim-threat dualism operates, whereby children can be perceived either as troubled and in need of protection (the child as victim), or as troublesome and in need of control, correction and punishment (the child as threat) (Goldson 2004). Despite such tidy conceptual differentiation, however, in practice children can rarely, if ever, be crudely dichotomised in this way.

(Goldson, 2004, as cited in Hill et al., 2007, p. 105)

Further, Kemshall (2007) contended that the language of ‘need’, ‘at risk’ and ‘vulnerability’ has begun to be eroded and is sliding into the language of risk, harm and danger (as cited in Blyth et al., 2007, p. 10). Milligan and Smith (2006) argued that there has been a shift from ‘needs to deeds’ and cites Goldson (2002), who claimed that society is shifting the concern away from welfare needs to the behavioural manifestations of these needs.

⁴² Dwyer and Miller (2006) have a similar debate. Their work revolves around trauma counseling with challenging young women, they discuss the victims or offender approaches.

Bessant (2003) referred to the work of Stanley Cohen's (1980), who offered an account of how contemporary societies come to see certain groups (namely young people) as threats, and how moral panics are manufactured. As Bessant described, Cohen tried to understand the relationships between the media, politicians, policy makers, the forces of law and order and 'public opinion'. According to Cohen (1980) a 'moral panic' happens when a condition, episode, person or groups emerge to become defined as a threat to societal values and interests. Bessant was writing in the context of the debate surrounding the chroming issue in residential care settings in Victoria in January 2002.⁴³

The Best Interest Case Practice Model (BICPM) is the risk assessment model for HRAs currently in use in Victoria. It is based on sound professional judgement, a culture that is committed to reflective practice and respectful partnership with the family and other service providers (DHS, 2008). However, the use of risk assessment tools in Child Protection settings has been questioned in the literature for some time. A professional judgement model implies that case managers are not scripted into a choice of answers but are expected to apply their professional knowledge.⁴⁴ As is discussed later this may be problematic when research has shown that practitioners' professional knowledge is weak at best.

The risk assessment models currently in use Australia are drawn from authors such as Brearly (1982), Meddin (1985), Hemsworth, MacNamara and McPherson (1997); Reid and Sigurdson (1990); Sigurdson, Reid, Christianson-Wood and Wright (1995) and Dalglish (1997). However, recently Gillingham (2006) provided a rebuttal of risk assessment as a helpful process and called for its review. He stated that "combining critiques of risk

⁴³ At this time there was a large amount of media attention on young people in residential services who were chroming. A residential service was allowing young people in care to chrome under supervision as the most effective method of intervention and harm prevention, but there was public outcry regarding young people being allowed to undertake such a dangerous activity while in state care. DHS took steps to prevent the agency from this practice.

⁴⁴ The BICPM was modeled from a recommendation from the VCDRC (2007) that suggested DHS review the VRF to incorporate a developmentally sensitive assessment of the cumulative impact of poor attachment and past trauma (VCDRC, 2007).

assessment and research that focuses on how risk assessment is used to inform decision-making in child protection practice demonstrates that risk assessment may be a seriously flawed practice” (p. 95).

In contrast Krane and Davies (2000) contended that decisions are not standardised. They argued that the problem is not the judgement itself, but the lack of reflexivity in the way judgements have been developed and applied. They pointed to Pecora (1991) who observed that individual social workers are often given insufficient time to assess and work within systems that focus on investigation and evidence gathering. Gillingham (2006) further questions the efficacy of risk assessment in child protection, especially when applied in uncritical and structured ways (see also Saunders & Goddard, 1998).

Risk assessment in Victoria is also impacted by a culture of defensive practice. There are two ways of using the term defensive practice. The first relates to self-protection where professionals are not prepared to take risks in case management or decision-making for fear that they may make an error and subsequently be vilified or sued (Parton, 1985; Sandor, 1988).

The second meaning relates to case managers operating in a risk adverse environment, where tolerance of a high level of risk is justified in order for a young person to achieve a goal or change. DHS (2000d) used defensible risk practice in this way in a document describing adolescent practice from a regional location. It states that “defensible risk practice centres on the dynamic between a worker’s preparedness to allow a young person to take a risk in order to achieve progress” (p.8). Further on DHS (200d) stated that defensible risk practice is about “taking an action or not (which has risk attached to it) which will in the long term reduce risk” (p.8). Either way the fact that case managers have to practice in this context demonstrates the existence of a risk adverse environment.

The process for managing risk within the HRA population in Victoria includes the use of risk assessment tools such as BICPM, which now replaces the VRF, along with the High Risk Register. The intention of the HRASQII (1998)

resonates with the risk discourse in the literature due to the way the initiative was the result of public concern (as seen in Chapter One), rather than a thoughtful progression of policy. Instead, the HRA Register and the HRASQII Guidelines (1998) are driven by political agendas surrounding the monitoring of young people. This politicisation was demonstrated in that the Register came about from the Minister's⁴⁵ interest in monitoring HRA behaviour. When the HRASQII (1998) was released subsequently it demonstrated intent to provide 'care' according to this social control mandate.

DHS does not publically declare the use of the Register as a control or risk management mechanism; rather, it states that "The purpose of the High Risk Adolescent Register is to identify young people at the highest level of risk and ensure that services can be effectively planned and delivered for them" (DHS, 2007h). This stated purpose has some credibility in that a young person has to be listed on the Register in order to receive access to one-to-one home based care, ICMS or brokerage funding. It would be worth exploring the level of control and management of HRAs in Victoria and whether it is influenced by political reasons. There is very little published evidence or comment that critiques the use of such a Register.

2.4 Evidence Based Practice and Theory for Unconditional Care

This section discusses: (i) the paradigm of EBP that pervades service delivery in Victoria; (ii) the implementation of Wraparound in the USA and how evidence informs it; and (iii) theories that inform Unconditional Care including attachment, control theory and trauma.⁴⁶

⁴⁵ The Hon Christine Campbell MP, Minister for Community Services

⁴⁶ DHS (2007d) have written about a 'multi-theoretical' paradigm through the every child every chance (ecec⁴⁶) strategy and accompanying publications. The theories informing the approach include gender analysis, ecological perspective, social exclusion theory, a systems perspective, resilience and wellbeing trauma and safety, development science and cumulative harm, attachment theory and stability (DHS, 2007d). The Wraparound program relies heavily on the theory of change (Walker, 2008).

2.4.1 Evidence Based Practice

The literature on what informs the professional practice of case managers demonstrates that over the last twenty years, social science and human services have undergone a marked shift toward being accountable for the evidence that informs practice (Webb 2001; Blackshaw & Ritchie-Wearn 2001; Hoagwood, 2005; Plath, 2006; Walker & Gowen, 2007, p. 3; Kirk & Kolevzon, 1978 in McNeil, 2006, p. 147; Gilgun, 2005 in Furman, 2009, p. 82). This means that the expectation of EBP and the application of scientific evidence to practice is employed to help demonstrate effectiveness (Walker & Gowen, 2007). As such, EBP is also becoming a condition for funding (Allred et al., 2005; Mowbray, Grazier & Holter, 2002).

The importance of evidence based practice and policy is highlighted in the work of the Productivity Commission (2009) in Australia which has highlighted that evidence plays a key role in guiding decisions about programs. The report also states that policy makers largely determine the quality of the evidence that they have available for making policy decisions.

There are many definitions of EBP which strive to reflect integration of knowledge into practice (Webb 2001; Blackshaw & Ritchie-Wearn 2001). Webb (2001) defines EBP as “the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare of services and carers” (p. 61). Given that Unconditional Care and Wraparound have their history in values and program philosophy rather than the articulation of evidential thinking (Bruns & Suter, 2010) the question of evidence remains important for the development of approaches to case management.

The EBP movement started in 1972 when Cochrane questioned the effectiveness of health services (Bradley & Herrin, 2004)⁴⁷. He challenged health professionals worldwide to examine their evidence for treatment. This work galvanised the need for ‘gold star’ evidence or research with

⁴⁷ As stated Earlier the Cochrane Collaboration was then founded later in 1993.

randomised controlled trials as the optimum level of evidence (the hierarchy for evidence can be found in Appendix 6).

The hierarchical approach to evidence attempts to rank evidence in terms of scientific rigor based on methodology, but other approaches exist. Kazdin (1999) provided four criteria for assessing the status of an intervention's evidence base:

1. A theory to relate a hypothesized mechanism to a clinical problem.
2. Basic research to assess the validity of the mechanism.
3. Outcome evidence to show that a therapeutic approach changes the relevant outcomes.
4. Process - outcome connections, which display the relationships between process change and clinical outcomes.

(as cited in Bruns & Suter, 2010, p. 2).

This set of criteria was used to assess the Wraparound process. Bruns and Suter (2010) argued that the most relevant of the four criteria to Wraparound, and the most important in evaluating it, was outcome evidence from rigorous studies.

Despite this quiet debate on the use of hierarchical evidence there remains an expectation that public sector programs should be able to objectively and scientifically demonstrate program success and client satisfaction. According to Tomison (2000), this expectation came about partly because of economic rationalism and partly because of poorly performing programs. Carr and Semel (2004) noted however, that "in spite of increasing focus on empirically-validated, cost-effective interventions, surprisingly little research has been conducted to examine what particular elements of comprehensive, home based services are related to positive outcomes".

There are some scholars in social science who debate the direction of EBP for instance, Gould (2006) asked:

Do the forms of knowledge promulgated by EBP readily transfer to the context of social care, or does an alternative approach need to be elaborated

that embraces the pluralism and diversity of social care, as well as a value base which explicitly democratizes knowledge?

(Gould, 2006, p. 111)

Similarly, Webb (2001, p. 31) argued that EBP is not a suitable model for social work settings. He contended that it proposes a particular deterministic version of rationality (consistency), which is unsatisfactory and does not support the application of professional knowledge to practice. Rosen et al., (2006) argued that social workers have not embraced this approach and that social workers do not rely on research-based knowledge as a basis for making clinical decisions (Proctor, Morrow-Howell & Staudt, 1995, in McNeil, 2006, p. 147). As Dybicz (2004), stated, from a social work perspective “practice wisdom is placed in a role that is subordinate to that of empirical analysis” (p. 197).

Webb (2004) also highlighted the work of Munro (1998) who argues that “social workers rely on vague assessments and predictions, rather than considering what is more or less probable” (p.160). Furthermore, Hoagwood (2005, pp. 545-560) argued that “a series of influential reports in the area of mental health have uniformly voiced a single theme: the gap between research and practice must be closed.”

Victorian Government policy states that EBP has been a focus from as early as 1998 when the HRA Register was formed, and more recently in the development of the *CYFA 2005*. DHS suggests that the reform process (of the *CYPA 1989*) was evidence-based, grounded in solid research and subject to evaluation (DHS, 2000g, p. 1; DHS, 2003b, p. 3; DHS, 2004b, p. 3). As Geary (2007) stated, “A great deal of time and energy has been invested across government and the community sector both nationally and internationally to refine a credible evidence base as a foundation for the reform of the Child Protection service system” (p. 85).

This is difficult to acknowledge given there are very few interventions (if any) for HRAs that demonstrate a high standard of evidence on a consistent basis. The international evidence for Wraparound as a significant service

delivery approach consists of nine controlled studies that were conducted over the last 10 years (Bruns & Suter, 2010, p. 2). This forms one of the most important sources.

The HRASQII (1998) has referred to evidence. However, statements from the sector suggest the ICMS was crisis-driven rather than informed by empirical evidence. Case managers appear to have had little time to regularly reflect on practice (Cowie & Saucer, 2002, p. 5).⁴⁸

One of the implications that stems from the lack of application of current evidence, is the need to examine what knowledge/evidence informs practice. Osmond (2005a) states that “few (researchers) appear to have mapped the kinds of knowledge that informs social work practice” (p. 882). Even with ‘state of the art’ practice knowledge being shared across the service system (Geary, 2007, p. 85),⁴⁹ the knowledge of case managers has not received enough attention. In referring to case managers, Munro (2002) states that they often “employ a number of ways of not recognising evidence that challenges their beliefs such as avoidance, forgetting, rejecting and reinterpreting” (p.149).

Statements made by the Child Safety Commissioner (Geary) regarding the reliability of child protection policy and practice must be viewed critically. Child Protection Victoria does not appear to have published evaluative frameworks or findings to establish whether attempts at changed practice have resulted in shifts to the forensic gaze, reductions in reports (notifications) or improved outcomes in families’ lives. The Ombudsman Report (Brower, 2009) confirms the need to improve data, available through the Client Relationship Information System (CRIS) (p. 78). This implies that data collection and analysis may be difficult.

Whilst broad changes in the reforms that impact HRAs were made over the past twelve years, DHS has made no changes to the HRASQII (1998)

⁴⁸ This is also indicative of the researchers experience as a DHS employee.

⁴⁹ Bernie Geary is the Child Safety Commissioner in Victoria.

Guidelines.⁵⁰ This is particularly disappointing given that *CYFA 2005* Section 174.b states that “in dealing with a child under Section 173 (placement of children) the Secretary must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would.”

The classic work of Schon (1995) states “we should think about practice as a setting not only for the application of knowledge but for its generation” (p. 3). This is a salient point especially as considerable research has led to the conclusion that practitioners *do not* utilise formalised knowledge in practice (Department of Health & Social Security, 1978; Carew, 1979; Corby, 1982; Drury-Hudson, 1999; Osmond, 2001; Rosen et al., 1995 cited in Osmond, 2004, p. 681).

Analysis of the literature cited in this section leads the researcher to contend that Schon’s (1987) approach to reflective practice may be relevant because it allows for a direct connection between epistemology (how do we know?) and reflective practice (how do we improve?). Schon (1987) says that when someone, in this instance a case manager, reflects-in-action they become a researcher in the practice (see Benyamin, 2000). It is the application of this knowledge learnt by case managers from practice that could inform policy development alongside empirical evidence.

The complexity in the literature is highlighted by Parton, Thrope and Wattam (1997) who state that the development of scientific and objective knowledge will assist professionals to intervene compassionately on behalf of children. The last 13-15 years have seen a considerable development in the knowledge that informs the sector. The struggle (as discussed later) is knowing how to apply the knowledge to complex governmental systems.

⁵⁰ In 2006 DHS reviewed the status of HRAs and found that there were 178 young people listed on the regional HRASQII Registers of whom 153 were living in out-of-home placements (DHS 2006b, p. 11). DHS chose not to make this document public and no comment has been made. It seems a number of areas of concern may have been confirmed by this report.

2.4.2 The Efficacy of Wraparound

Historically, Unconditional Care has been practiced within Wraparound service settings; this meant it was important to examine the evidence base of Wraparound. The literature on the effectiveness of Wraparound is scant at best; Rosenblatt's (1996) stated that "until now there has been no articulated theoretical base to support why there were favourable outcomes nor to understand when there are not" (as cited in Malysiak, 1997, p. 406). Whilst this differs from practice efficacy it is difficult to establish best practice without a well developed theoretical framework.

Walker and Schutte (2004) highlighted debates in the literature regarding the types of techniques, processes, or procedures that translate the value base of Wraparound into practice. This is exacerbated by the historical difficulties in reaching agreement about guidelines or standards for Wraparound practice and a lack of well-developed theoretical frameworks. Most recently it has been stated that:

the available research on the process is expanding (Bruns, 2008). Although many regard the evidence base as still "weak" (Farmer, Dorsey, & Mustillo, 2004), the number of quality research studies is growing (Suter & Bruns, 2007). The U.S. Surgeon General's report (2000) listed Wraparound as a "promising" intervention.

(Walker, Bruns, & Penn, in press as cited in VanDenBerg, 2008b, p. 2)

The work of the National Wraparound Initiative (NWI) in the USA has been informative and is advancing the collection of evidence. The founding advisors of the NWI set goals of creating materials and resources that would help the field better understand the Wraparound model, implement it with greater consistency and quality, and support research studies (Bruns & Walker, 2008, p. 2).⁵¹

⁵¹ For a more complete description of the methods of the NWI, see Walker and Bruns, 2006.

Walker and Bruns (2006, p. 1580) noted that a positive research base for Wraparound began to emerge in the 1990s. Burns et al. (2000) contended that mental health service provision to youth with severe emotional disorders is characterised by a limited research base, but that the Wraparound process represents an outstanding innovative intervention. Unfortunately, only one journal article resulting from the 14 studies to date conducted on the Wraparound process (Burns et al., 2000, p. 301; see also Burchard & Burns, 2002; Burns, 2004b) relate directly to Unconditional Care.

This sole article presents an evaluation of client satisfaction which involved interviews with twenty young people. The researchers found that young people who felt involved in their treatment and felt that their care was Unconditional reported relatively high satisfaction with the services (Rosen, et al., 1994). In the *Promising Practices in Children's Mental Health Systems of Care – 2001 Series*, (Kendziora et al., 2001) wrote that:

within the literature, we find that youths' perception of their team as unconditionally committed is correlated with decreases in the severity of acting out behaviours, with decreases in depressed and self-injurious behaviours, and with increases in their overall satisfaction with services.

(Kendziora et al., 2001, p. 141)

The evidence base for Wraparound is being slowly built up due to the work of the NWI. The evidence for Unconditional Care however, remains more elusive. There has been no other research or evaluation of Unconditional Care that the researcher has been able to find.

2.4.3 Attachment Theory and the Relational Approach

The importance of considering attachment in therapeutic intervention and service delivery for HRAs has been clear since the work of Bowlby (1989) gained significance in the 1970s. According to Sprinson and Berrick (2010), Bowlby's work is "well beyond the theory phase and the implications of Bowlby's ideas have been well established in a variety of areas.

The work of Bowlby (1969; 1988) confirms that poor attachment with a mother or primary caregiver is associated with a host of emotional and behavioural problems later in life. This has been extended and confirmed by authors and researchers such as Perry (2002; 2001) (see also Dwyer & Miller, 2006; Cassidy, 2008). It is now well known that

children in foster care are likely to have difficulties in three main areas: attachment (they have frequently suffered multiple rejections and losses); behaviour (their behaviour is frequently difficult for those who live with them); and self-esteem (they typically lack the skills and success on which a sense of worth is built and have suffered numerous assaults on their picture of themselves).

(Wilson, Petrie & Sinclair, 2003, p. 998)

Further, it is known that a secure attachment is integral in helping adolescents achieve autonomy from their parents or carers. It is also important for the quality of ongoing peer relationships, social acceptance and functioning in romantic relationships. Secure attachment to parents or carers has been associated with a range of indices of wellbeing including high self esteem and low anxiety (DoCS, 2006; Allen & Land as cited in Cassidy & Shaver, 1999, p. 328). It is recognised that “Not having parents who provide unconditional love and care can represent a profound insult to a child’s self-image” (Franshel & Shinn, 1978; Wald, 1976; Weistein, 1960 as cited in Jenson & Fraser, 2006, p. 25). The literature confirms that

a secure attachment is fundamental to a child's development and is regarded as a key protective factor while an insecure attachment is a risk factor and is often associated with children who have experienced abuse and neglect.

(Golding, 2006, as cited in McClung, 2007, p. 6).

This robust body of theory on attachment drives the innovation and development of approaches to HRAs and can be found in many service models (see Sprinson & Berrick, 2010). It appears to have direct importance to the development of relational models of intervention. This seems logical when consideration is given to the damage that absent or abusive

relationships cause. Case Managers who can utilise relationships to strengthen a young person's attachment style, would experience greater outcomes. It has been confirmed that

that good case outcomes in Child Protection are found to be strongly associated with the quality of the relationship between the professional and the family; sensitive and informed case practices; a wide perspective on Child Protection; and on supervision emphasising practice development and interagency collaboration.

(Tomison, 1999b, p. 2; see also Goddard & Tucci, 1991; Stuart, 1999).

Similarly, Cohen, Medlow, Kelk and Hickie (2009) highlight that "interpersonal relationships that young people formed with mental health care providers were perceived to be the most crucial determinant of whether they had a positive or negative experience" (p. 170). This commitment to relationship as pivotal is echoed in youth work literature (see Bruce, Boyce, Campbell, Harrington, Major, Williams, 2009, p. 26; Rodd & Stewart, 2009).

Sprinson and Berrick (2010, pp. 77-112) took the application of attachment theory further in describing key differences between biomedical approaches and a relational approach. The table below highlights some salient points of difference.

Table 2.1 Two Diagnostic Models

Relational Model	Biomedical Model
(i) Interpersonal processes in evaluation	(i) Engagement is not stressed as part of a biomedical evaluation.
(ii) Evaluation involves active engagement with the child and the child's caretakers. This engagement clarifies patterns of relatedness. It is also the beginning of treatment.	(ii) Evaluations in offices can take place within 15-30 minutes and are focused on signs and symptoms
(iii) In evaluating responses to treatment, all social and relational factors in the child's life are taken into consideration.	(iii) In evaluating responses to treatment, medication is seen as the primary factor creating change, superseding social and relationship factors in the child's life.

(Stanton, 2007, in Sprinson & Berrick, 2010, p. 79)

The discourse on relationship-based approaches put forward above highlights that

A relational model is based on different assumptions: By identifying historical patterns of relatedness and the stability of current placements (including relationships with caretakers), the treatment team will discover the most useful information regarding a child's strengths and vulnerabilities. Such a model is also consistent with the experience of many clinicians, in many settings over many years, that current relationships, no medication, create the most powerful forces for change in a child's life.

(Sprinson & Berrick, 2010, p. 81)

Also relevant to this discussion on relational theory and engagement is that youth work has for many years highlighted the importance of relationships. New Zealand-based youth worker Lloyd Martin (2003) has argued that "it is the nature and place of relationships that distinguishes youth work from other disciplines" (as cited in Mood & Stewart, 2009, p. 4).

The importance of understanding the impact of disrupted attachment and the ongoing nature of relationships in therapeutic environments seems to significantly inform an Unconditional approach. Wyn and White (2004) affirm that the “Youth experience is a continual process of connection and reconnection with ‘significant others’ and the mainstream institutions” (p. 154).

2.4.4 Trauma Theory

Trauma theory makes the impacts of trauma explicit and explores treatment options and is shaping current responses to HRAs in Victoria. Perry (2006) confirmed that hundreds of studies around the world in several fields have documented various aspects of the negative impact of developmental trauma and other adverse childhood experiences (Perry, 2006b; see also Perry & Pollard, 1998; Bremner & Vermetten, 2001; Read, Perry, Moskowitz & Connolly, 2001; Teicher, 2003; Bremner, 2003).

The convergence of social science and neuro-science provides a more informed framework for practice with HRAs and Children in Care and Protection. Perry (2002) asserted that understanding the basics of human brain function and development can provide very useful and practical insights into the emotional behavioural, cognitive, social and physical problems that interdisciplinary teams face when working with maltreated children. This application of trauma theory assists case managers in understanding what occurs in a child and adolescent who has experienced harm. Indart stated that:

by its very nature, trauma is the occurrence of the unthinkable. Cognitively, a traumatic blow occurs outside the range of what the human mind expects. Therefore, the child cannot assimilate the experience because it is incongruent with past experience; the child cannot developmentally accommodate the meaning of the experience without revising his/her schema of the world. A traumatic event creates dissonance in a person’s life.

(Indart, 1999, p. 49)

Work on trauma by the National Scientific Council on the Developing Child (NSCDC) USA provides a set of new information that is starting to shape the response to HRAs. The reminder of the seriousness of the impact of stress has been shaping action from policy makers.

Sustained or frequent activation of the hormonal systems that respond to stress can have serious developmental consequences, some of which may last well past the time of stress exposure. For example, when children experience toxic stress, their cortisol levels remain elevated for prolonged periods of time. Both animal and human studies show that long term elevations in cortisol levels can alter the function of a number of neural systems, and even change the architecture of regions in the brain that are essential for learning and memory.

(NSCDC, 2005, p. 3)

This link between abuse and trauma and ensuing mental illness is well established. Spataro, Mullen, Burgess, Wells and Moss (2004) stated that there is substantial evidence linking child sexual abuse (CSA) and child physical abuse to a range of mental health problems in childhood (Spataro et al. 2004; see also Beitchman et al., 1992; Silverman, Reinherz, & Giaconia, 1996; Van Os, Morrison & Ross, 2005).

The complexity of HRA behaviours that result from the impact of trauma is well recognised. Bloom (1999) summarised Van der Kolk and Greenberry (1987) by stating that young people can suffer 'addiction to trauma' meaning that they cannot tolerate calm and will antagonise others until the stress levels are high enough for them to achieve some degree of internal equilibrium. Endorphins calm mood and decrease aggression, but they are also powerful analgesics since they are related to morphine and heroin. People who are exposed to repeatedly high levels of endorphins can become addicted, meaning they may only feel calm when under stress.

Wolff and Brandt, (1998 as cited in The Child Welfare Information Gateway (2001) argue that the child welfare system needs to address such deficits as described above, to provide consistency, repetition, nurturance, predictability

and control (returned to the child) to diminish the fearful nature of the interventions. A DoCS literature review (2009) notes that there are three effective adolescent focused interventions: Cognitive Behavioural therapy, Interpersonal Psychotherapy and Trauma Focused Cognitive Behavioural Therapy (TF-CBT).

The goal of Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) is to help address the unique biopsychosocial needs of children 4 to 18 years of age who are experiencing Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, particularly sexual abuse. TF-CBT is a model of psychotherapy based on social learning and cognitive theories and combines trauma-based interventions with CBT.

(DoCS, 2009, p. 15)

As understanding of the impact of trauma grows the service system in Victoria appears to be embedding this in policy and practice. The literature in this area demonstrates that there are various modalities for treating trauma. Further, there is a need for continued action in this area. Actively integrating trauma theory into future practice should enhance the system response.

2.4.5 Control Theory

The use of control and containment is an integral part of service delivery to HRAs. This section reviews a definition of control theory and examines its relevance to Unconditional Care. The politicisation of the HRA Register is also discussed. It discusses the continuum of care and control for practice which provides balance for case managers as being the most informative and helpful approach.

Discussion about control is essential given the nature of HRAs symptoms and behaviours. Kiraly (2002, p. 10) refers to the the VCDRC (1999) in stating that young people in this high risk group may die as a direct result of their own inability to keep themselves safe, or cause the injury or death of others. The behaviour of many HRAs places them outside the boundaries of what society deems to be the 'norm'.

The literature on control theory confirms that control is society's response to deviant behaviour (Edwards, 1988; Gottfredson & Hirschi, 1990; Cunneen & White, 1995; Hazlehurst, 1996; Roach-Anleu, 2003). Control theory views criminality as resulting from limited social control and poor social bonds (Coventry & Polk, 1985, as cited in Day & Howells, 2003, p. 10; see also Cunneen & White 2002).

The two control measures for HRAs are Secure Welfare Services (SWS) and the use of the high risk Register. SWS are utilised when there is a "substantial and immediate risk of harm" (CYFA, 2005 S. 173.2 b). Walker (et al. 2002) and Goldson (2007) point to the UN Convention on the Rights of the Child (CROC) which states that secure accommodation should only be used as "a measure of last resort and for the shortest appropriate period of time" and that "no child shall be deprived of his or her liberty unlawfully or arbitrarily (United Nations General Assembly 1989, Article 37b; as cited in Hill et al., 2007, p. 106). Muncie (2004) confirms that welfare services commonly face a dilemma as to whether to 'treat' children and young people or to 'control' their behaviour (as cited in Liscombe, 2006, p. 2).

According to Goldson (2007; as cited in Hill et al., 2007, pp. 180-109) there are three main purposes for the secure care of young people. They are; (i) sanctuary, because they are thought to be especially vulnerable and in need of concentrated forms of care and protection, (ii) containment, in order to protect others, to deter them from offending and/or guarantee that they attend court for trial or sentence and (iii) correction and punishment, because they have been convicted of offences.

Child Protection aims to provide the first option – sanctuary. In Victoria there is a distinct difference between the role of secure welfare as focused on care and protection and Youth Justice settings that are focused on reducing offending. The CYFA (2005, Section 482.b) draws this distinction and suggests that the State should not "detain in a community service or secure welfare service a person who is on remand or is serving a period of detention and is not released on parole."

Concerns and positive factors are associated with the use of secure settings. Research from the UK from five secure units suggests that admission to secure care reduces the overall amount of problems for a young person in terms of reducing immediate risks and needs. However, it does not offer improvement in all areas, including drug and alcohol misuse, relationships and education (Kroll, Rothwell, Bradley, Shah, Bailey & Harrington, 2002, p. 1978).

Harris and Timms (1993a, 1993b) claimed that in practice, secure accommodation tends to be used when no other viable alternatives are available. Fortunately, the *CYFA* (2005, Section 174 c) maintains that children and young people cannot be placed in SWS as a result of a “lack of adequate accommodation.”

The impact on young people of being detained in SWS also requires consideration. O’Neill (2001) cited research that young people who have been contained in the name of care and protection experience it as a punishment and receive little therapeutic intervention (as cited in Walker et al., 2002, p. 8). Galton, Muchatuta, Morey-Canllas and Drew Lopez (2008) concluded that secure settings for young people could be more informed of the current evidence.⁵²

The literature on Secure Welfare Services in Australia is limited. Nevertheless, work conducted elsewhere posits several positive outcomes related to secure care and containment. In writing about prostitution and secure care in Canada, Bittle (2002) made a case that a ‘culture of help’ has emerged from the victim discourse and that secure care has a place on the continuum of care. Sprinson and Berrick (2010) also articulate containment (sometimes physical) as an ongoing, important part of treatment.⁵³

⁵² Galton et al., discuss the use of neuro imaging evidence that could be incorporated into treatment and suggest implications for treatment; enhanced physical contact in the form of massage therapy, revision of diet to include omega 3, exercise which increases neural plasticity and brain repair, right brain therapies like art and music, rehabilitation systems built around minimum disruption, and structured transition into community. Finally, they suggest reviewing the work of Dr. Perry (2004) and the use of pharmacology, specifically Clonidine.

⁵³ Sprinson and Berrick (2010) do not explicitly mean use of secure care in this instance. However,

Power is an important concept in statutory work. Due to the political nature of Child Protection work, much of the literature questions the use of power in the field. Roach-Anleu (2003) cites Carrington (1993) and Foucault (1978) to argue that practitioners may place their clients “under surveillance and control through the maintenance of case files and direct intervention under the guise of therapy, treatment assistance and welfare” (in Jureidini & Poole, 2003, p. 232). This raises questions as to whether the HRA Register in Victoria has the primary goal of controlling the behaviour of young people in order to keep damaging press reports to a minimum and a secondary goal of providing care and protection. Additionally, Barber (1991) contended that:

work with involuntary clients must begin with the recognition that the interaction between worker and client is based on conflict rather than cooperation, that social work with involuntary clients is a political, not therapeutic, process involving the socially sanctioned use of power.

(Barber, 1991, p. 145)

Clark (1999b) stated the role of the Child Protection worker needs to be differentiated from those of carer and agency case worker/therapist (foster care support worker). The authority to make decisions on behalf of the state, and therefore of the society in relation to the care and protection of individual children is vested in the Child Protection service.

A more recent outlook was provided by Liscombe (2006; 2007) in research on workers in the foster care system in the UK who attempted to provide the care of a welfare system and the control of a youth justice system. It considered the ways foster carers attempted to manage these tensions and incongruities and tried to reach a balance between care and control. She suggested that the care and control debate is more effectively conceptualised

throughout their book are references to the stepped care model used in California which works from lowest to highest levels of care including secure facilities. The equivalent of the HRASQII (1998) 1:1 home based care appears to be level 14.

as a continuum with different mechanisms being situated at progressive points.⁵⁴

Davies (1998) and Trotter (1999, 2004) raised concerns about practitioners needing to work between the two roles of care and control. But, argued that competent social workers can negotiate between the two. Being consistent and building trusting relationships is seen as critical (Lipscombe, 2007; Sprinson & Berrick, 2010), as case managers who are able to combine investigatory and helping roles often achieve better outcomes (Trotter, 1999; 2004; Davies, 1998).

The report *A Child in Trust*, explicitly posed the issue of the compatibility of the functions of care and control in protective settings in the UK. It questioned the role of the social worker in fulfilling a firm and efficient policing approach, - particularly if he/she has also to gain a family's confidence and to convey the personal warmth and genuineness necessary for him/her to provide support the child's parents (Davies, 1998, pp. 115-116).

The HRASQII Evaluation Report (2001) acknowledged that two very different cultures were operating - a government bureaucracy which has particular standards and expectations, and ICMS which have a different set of expectations and priorities (DHS, 2001b, p. xv). These expectations and priorities relate more to the care of young people than control. It seems reasonable that case managers from disciplines such as youth work and social work feel some aversion to working in a controlling or containing capacity. The greater the needs of the client, the more likely that containment will be a necessary part of recovery and treatment.

⁵⁴ There is evidence of a shift in the Victorian Youth Justice policy to a focus on diversion and rehabilitation in 2000. The strategy aims to; prevent low risk young people from entering the YJ system, to rehabilitate more serious young offenders, and to support young offenders after release from custodial care (DHS, 2000g, p. 1). It's intent is to divert young offenders and expand pre-release, transition and post-release support programs for custodial clients (DHS, 2000i). The Victorian approach encourages young people to grapple with controlling their own behaviours and works from a developmental perspective, which is committed to rebuilding the young person's sense of identity. It aims to move young people from being anti social to pro-social (Day & Howells, 2003). The Changing Habits and Reaching Targets (CHART) program (DHS, 2007) is an example of a case management framework in YJ aimed at behavioural change and assisting the young person to develop the skills to find new directions.

2.5 Changing Practice with Critical Reflection

Piggot-Irvine (2001) explores that “individual change is the leverage point for producing organisational change” (p. 3) and connects a historical body of knowledge on reflection with change in professional practice. The theories of Schon “advocated a mode of knowing that can inquire into and transcend its own axioms (truisms) as well as transform one’s own practice” (Benyamin, 2000, p. 47). His work relied largely on the concept of reflection and is supported as a crucial feature of practice by an ongoing body of literature (Argyris & Schon, 1974; Schon 1983; Papell & Skolnick, 1992; Yelloly & Henkel, 1995; Fook, 1996, 1999; Gould & Taylor, 1996; Brockbank & McGill, 1998 in Osmond, 2005b, p. 3; Gardner, 2003; Fook & Gardner, 2007).

This discussion of changing practice through critical reflection is presented in two sections. Firstly, the definition of critical reflection is explored, and then a more specific discussion on changing practice is provided.

2.5.1 The Definition of Critical Reflection

Critical reflection is the process of analysing, reconsidering and questioning experiences within a broad context of issues. It is “the active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusion to which it tends” (Dewey 1933, in Fook, 2006, p. 11).

Other authors have suggested that taking timeout for the purpose of thinking about practice and making changes to it is critical (Fook, 1996; Taylor, 1998, as cited in Gardner, 2003, p. 198; Osmond, 2005).

A slight distinction between critical reflection and reflective practice can be made. Reflective practice is often conceptualised as a form of intentional ongoing learning that involves engaging with questions of practice that inform decision making. Critical reflection is interested in a close examination of events from different perspectives. In this way educators and practitioners often frame their reflective practice within a set of overarching questions (see Department of Education, Employment and Workplace, 2009).

Reflective practice can challenge understandings of existing defensive and proceduralised practice. According to Ruch (2005) the strength of reflective practice lies its focus on the complexities of human nature and its compatibility with relationship-based practice (see also Agass, 1992; Howe, 1997, 1998b; Parton, 1998b; Schofield, 1998; Sudbery 2002; Ruch, 2004 as cited in Ruch, 2005, p. 118). Further, reflective practice assists case managers in exploring the complexities of cases and decisions.

D’Cruz, Gillingham and Melendez (2007) reviewed three meanings of ‘reflexivity’ noting that the first has a focus on the individuals’ response to a situation, the second examines the processes of knowledge generation, and the third refers to critical awareness of how thoughts and feelings can influence practice. These three meanings contribute to understanding that “reflective practice is best conceived not as an end in itself, but as a mere beginning” (Cross, 2006, p. 1).

One key benefit of critical reflection identified by Fook (1996) is its usefulness in revealing practitioners’ implicit theories of action. Fook stated that:

The value of reflective practice relates to closing the gap between espoused theory and enacted practice, the learning of knowledge generating capacities, the potential for ongoing evaluation of practice and the integration of theory, practice and research and challenging dominant power structures.

(Fook, 1996, p. 5)

Reflexivity is related to the skill of theory creation as seen in the reflective process first discussed by Argyris and Schon (1976; Fook, 2004, p. 8). Professional expertise therefore, involves the ability to reflect and develop theory from practice (Fook, 2004; Daisy, 2004).

Some authors have raised criticisms and challenges associated with reflective practice. According to Raelin (2002), delaying decisions (while reflecting) is seen as a sign of weakness, even if the delay may subsequently produce a better decision. He asserts that as problems are encountered,

people tend to go no further than consulting their “solution database” to find an answer.

Schon (1973, as cited in Smith, 2001, p. 5) highlights the issue of case managers becoming vulnerable during reflective processes. In relation to the use of reflective journals as an example Thorpe (2004) wrote that:

to be effective in promoting learning, journal writing necessitates that students be honest and open in their entries. This type of disclosure places students in a vulnerable position. If confidentiality is not maintained, the true objective of reflective learning journals is lost.

(p. 340)

Similarly, Cox, Hickson and Taylor (as cited in Durgahee 1997, p. 140) argue that student nurses experience vulnerability in reflective groups. The work of Bennett-Levy and Beedie (2007, cited in Dallos & Stedmon, 2009) also asserts that “supervisees often feel vulnerable and fear negative evaluation by their supervisor.” Schon (1973, as cited in Smith, 2005, p. 5) contended that a learning system allows dynamic conversation to operate in such a way to permit a change of state. Case managers may take deliberate steps to create improvements in practice; however, the fear of anticipated loss can make changing practice difficult and case managers less than enthusiastic.

Finally, the literature is summed up by Ruch (2007) who contended that more can be done by organisations to support and facilitate reflective practice. He identified supervision, consultation and team-working as methods of assisting practitioners in reflection.

2.5.2 Exploring How to Change Practice

Analysis of the literature on how to change practice is most significantly represented by Schon’s work with Argyris (Argyris and Schon, 1974). Their starting point was that practitioners have mental maps with regard to how to act (practice) in different situations. This involves the way they plan, implement and review their actions. Furthermore, it is these maps that guide

people's actions, rather than the theories they explicitly espouse (Smith, 2001, p. 9).

Argyris and Schon (1996) argued that if people are intending to change their professional practice, they would make these maps explicit (overt and unambiguous) in order to change them. They believed that change requires inquiry that reaches down to the level of assumptions and values of the inquirer (Argyris, 1993; Argyris & Schon, 1996). In some of Lewin's earlier work (Lewin & Grabbe, 1945) on action research there was a tension between providing a rational basis for change through research, and the recognition that individuals are constrained in their ability to change by their cultural and social perceptions, and the systems of which they are a part (Smith, 2001).

Schon's process of reflective practice has been adapted and developed into a model by Redmond (2006) and shows that the practitioner can make phased progress through the steps listed below:

Knowing in Action: In the context of the performance of some task, the performer spontaneously initiates a routine of action, which produces an unexpected routine.

Surprise Result: The performer notices the unexpected result which he/she construes as surprise – an error to be corrected, an anomaly to be made sense of, an opportunity to be exploited.

Knowledge in Action: Surprise triggers reflection, directed both to the surprising outcome and to the knowing-in-action that led to it. It is as though the performer asks himself, 'What is this?' and at the same time, 'What understanding and strategies of mine have led me to produce this?'

Reflection-on Action: The performer restructures his understanding of the situation – his framing of the problem he has been trying to solve, his picture of what is going on, or his strategy of action he has been employing.

Reflection-in-Action: On the basis of this restructuring, he invents a new strategy of action.

Reflective Practice: He tries out the new action he has invented, running an on-the-spot experiment whose results he interprets, in turn, as a 'solution', an outcome on the whole satisfactory, or else as a new surprise that calls for a new round of reflection and experimentation.

(Adapted from Schon, 1983; 1992, cited in Redmond, 2006, p. 37)

Fook (2006b) and Fook and Gardner (2007) explored what happens in the change process in critical reflection and identified steps for undertaking reflection. They described (as their desired theory of practice) the pattern of learning as involving the first level of assumptions being unearthed, moving these to another (deeper) level through reflection, breaking through and making connections, evaluating the assumptions against current experiences and literature, and reframing old assumptions.

Newman and Hall (2002, p. 4) discuss three steps in the sequence of changing practice. These steps are focused on improving practice by making tacit knowledge explicit; they are self-awareness, self-acceptance and self-expression. These reflective steps assist the practitioner through the maze of change.

Despite the existence of such processes, the literature recognises that changing practice can be challenging. For example Fook (1996) reasons that the reflective approach acknowledges that theory is typically implicit in a person's actions and that it assists professionals in becoming aware of the theory or assumptions involved in their practice (see also Fook & Gardner, 2007). This idea about their professionals' practice, however, may not be congruent with the theoretical assumptions the person believes himself or herself to be acting upon. The case manager may require deliberate steps to create improvements in practice.

The fear of change is often a fear of anticipated loss including security, competence, relationships, direction and status or territory.⁵⁵ A fear of

⁵⁵Thus, the loss and grief cycle appears in the literature on change. This includes the five stages of: disbelief, anger (which may include resistance), bargaining and depression, acceptance and hope

change can make changing practice difficult. It requires the intuition of a practitioner to be articulated before they can examine it. This may assist in exploring and addressing the fears of practitioners. Tacit knowledge is often 'here and now' in a specific, practical context (Hayek, 1945) and perhaps more difficult to speak about than explicit forms of knowledge.

By definition explicit knowledge is much more overt and open than tacit knowledge and can be expressed more easily. Explicitness, that is, working with clients in as open and contractual a way as possible, has emerged as a key ingredient in effective helping over the last few decades (Sheldon & Chilvers, 2002). This idea is supported by the work of Ford and Walsh (1994) who demonstrated that espoused theories are frequently invalid or applied inappropriately to the complex and unique circumstances of nursing practice which has similarities to working with HRAs (as cited in Wilkinson, 1999).

These similarities are primarily that both professionals work with the expectations and difficulties of complex practice. In studying practice in midwifery Lange and Powell (2006) highlight that "the new midwife must decide whether the practices in use are compatible with her/his beliefs" (p. 72). They drew on Argyris and Schon (1974) who describe the theory-practice gap as the difference between an ascribed loyalty to a set of beliefs (espoused theory) and the actual values reflected in professional behaviour (theory-in-use). Argyris and Schon (1974) suggest that this gap can be linked to a decrease in professional power and self-esteem, potentially leading to professional demise. As Redmond (2006) stated, "both theorists and practitioners in social work have found Schon's work offers them an important tool for bridging the theory/practice divide" (pp. 31-32).

Finally, Munro (2002) contends that "the overwhelming problem with human reasoning is that people do not like changing their beliefs. Further, they go to great lengths to avoid the discomfort of having to revise their judgments" (p.

and positive activity. Munro (2002) confirmed that change is challenging for case managers in child protection.

150). This highlights the importance of change and the barriers that come with it. Most importantly, Munro's words reflect, that changing practice is not an easy task, requiring time as well as a commitment to the process of articulating and shaping practice.

2.6 Conclusion

The literature and evidence above coupled with that presented in Chapter One demonstrates the complexity of the area under study. It shows the linkages between theories that underpin intervention with HRAs. The influence of attachment and trauma theory stand out as key determinants in the development of any approach to HRA service delivery. The literature on change and EBP demonstrate that case managers are expected to not only be fully informed regarding the latest theories but be capable of changing their practice to reflect it. This is the case even in systems that are unable, unwilling or unprepared to support these attempts at change.

There is a distinct lack of clarity regarding the most effective method of support and/or intervention for HRAs. Many ideas are presented in the literature, most of which are empirically and ideologically based, but few provide evidence of sustained success. This speaks to the complexity of working with traumatised HRAs who have often floundered in a system that has not ameliorated harm.

A final conclusion to draw from the analysis provided in this chapter is the observable differences between HRA related practice in Australia and other countries, most notably the USA. The multidisciplinary teams that operate in the USA provide much greater interest and capacity when it comes to treatment and case management of HRAs.

CHAPTER THREE:

THE COLLABORATIVE CHALLENGE – ACTION RESEARCH

In the varied topography of professional practice, there is a high hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the use of research-based theory and technique. In the swampy lowlands, problems are messy and confusing and incapable of technical solutions.

(Schon, 1995, p. 2)

3.1 Introduction

This chapter sets out the methodology used in this research. By referring to the 'swamp' Schon (1995) highlighted the complexity of inquiry into professional practice and the difficulty often encountered in the attempt to articulate the practice and the knowledge that informs decision making. This research argues that critical reflection can be used to assist case managers to improve their practice, to reflect on their espoused theory and make changes based on their inquiry. Action research was chosen as the primary methodology for this research due to its capacity to support cyclic review and development of change (action) to improve practice.

The elements that added to the complexity of this research included; the context of evidence based practice, the care and control discourse, the stressful environment of statutory work and the seriousness of the risk involved. A further factor in regard to complexity was the nature of the data collection, which was evolving and cyclic, as prescribed by action research.

This chapter reviews the research objectives and questions, defines action research and presents the rationale for using it. An overview of the research design is provided, along with a description and discussion of the methods of data collection, and is followed by presentation of the focus group phases and tools used. The final section of this chapter explores the concept of validity as it relates to action research.

3.2 Research Objectives and Questions

The first objective of the research was to provide a written set of practice principles that could enhance positive outcomes for HRAs in the context of statutory intervention and case management. The second objective was to explore and test Unconditional Care as a framework for improving practice with HRAs. The third objective of the research was to contrast existing practice with the Unconditional Care approach.

The research questions asked:

1. Are the Unconditional Care principles in their draft form a reflection of what other case managers consider to be best practice?
2. What other principles and guiding themes are present for case managers?
3. What is the underpinning professional knowledge for these principles from case managers and other research?
4. How much are these principles reflected in daily professional practice?
5. Is there a significant difference between employees of the DHS and contracted staff case managing in Community Service Organisations (CSO)?
6. Do values and personal background significantly impact decision-making?

3.3 Action Research

This research explored Unconditional Care, in collaboration with case managers as an 'action' to improve professional practice with HRAs. It also attempted to document a theory of practice based on Unconditional Care principles and to capture the voices of the case managers 'knowledge'. This section describes action research and offers a rationale for its use.

3.3.1 What is Action Research?

Action research provides people with the means to take systematic action to resolve specific problems. This capacity to take action during the research distinguishes the approach from other forms of social research (Peters &

Robinson, 1984; Stringer, 1999). Action Research offers the structure to work collaboratively with other professionals to explore complex problems and is participatory by nature. Dick (1997) contends that “the level of participation, and the means used to achieve it, determines the effectiveness of both the action and the research” (p. 4).

A goal of this research was to enable case managers to work collaboratively with the researcher in relation to the research design, direction and conduct, which is confirmed by Kemmis and McTaggart in Brophy (2001) as a critical component of action research (see also Reason, 1999). Action research values transparency and the empowerment of all participants.

Action research concentrates on problem-solving through inquiry into human problems in real contexts, its tendency to “solve local problems” (Swepson, 2000, p. 2) takes practitioners to the heart of the issue. ‘Good’ action research according to Swepson (2000), is enquiry that seeks to overcome the human tendency to seek confirming rather than disconfirming evidence through formal cyclic review(s) of their values, methods and results.

Action research has an interest in both knowledge and action (change) that is directly useful to a group of people (Reason, 2001 in Henry, 2001, p1; Cherry, 1998). In this research the group of people being the case managers. Reason (2001) highlights the characteristics of action research as;

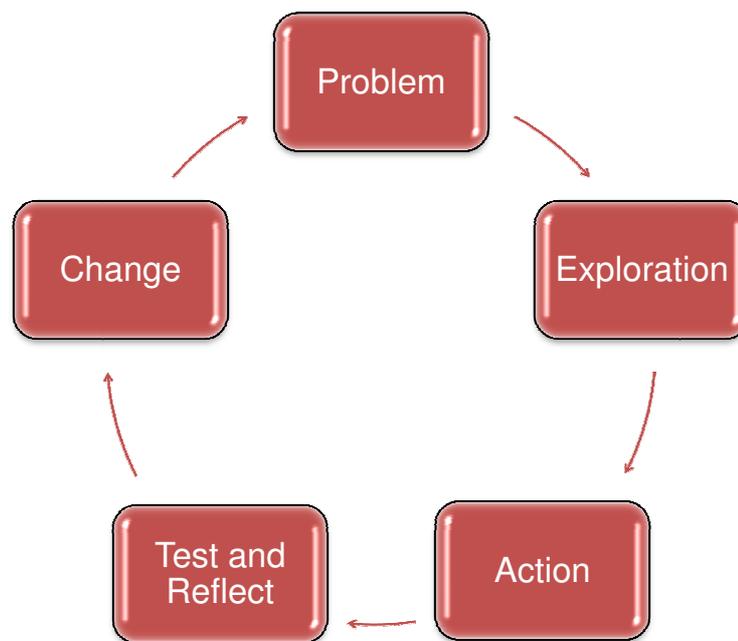
- The development of practical knowledge.
- To increase involvement in the creation and application of knowledge.
- To be grounded in participants critical and practical experience of the situation to be understood and acted in.
- It can account for many different forms of knowledge.
- Aims to develop theory which is not descriptive but is a guide to inquiry and action in the present time.

(Reason, 2001, p. 2)

Gaventa and Cornwall (2006, p. 76) state that the knowledge dissemination aspect of action research is one of its most important contributions.

“Action research developed out of the work of Lewin in the 1940s” (Mcniff, 2002; Reason and Bradley, 2001; Zeichner, 2001 in Harnett, 2007, p. 47). The central tenets of Lewin’s work were the ideas of group decision making and commitment to improvement. As seen in figure 3.1, action research moves in a cyclic motion which starts with the identification of a problem (Smith, 2001 based on Lewin 1946, reproduced in Lewin 1948, pp. 202-203). Communities come together to ask the question ‘How can we solve this problem?’ or ‘How can we do things differently?’ Action research has its origin in community activism (Cherry, 1998, p. 12) and provides the conceptual and practical tools for making improvements to services (Crane & Richardson, 2000, pp. 1-2).

Figure 3.1 Action Research Cycle Based on Lewin (1890-1947)



(Smith, 2001 based on Lewin 1946, reproduced in Lewin 1948, pp. 202-203)

Action research moves a community from the identification of a problem to the second step of exploration and gathering information about the problem. Questions are asked regarding the nature of the problem and the level of knowledge held about the problem.

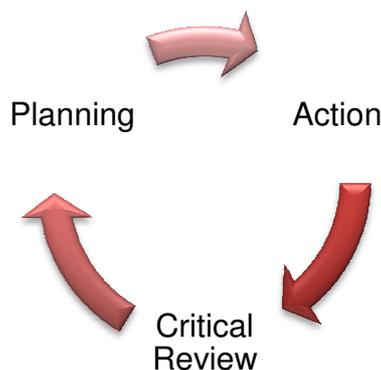
Action research has an interest in change and is fluid enough to take into consideration all the variations and debates in the ‘swamp’ where problems

are 'messy and confusing' (Schon, 1995). It brings about practical improvement, innovation, change or development of social practice, and a better understanding of practitioners practice (Cohen, Manion & Morrison, 2001). Action research encourages reflective practice.

A solution (or action) is developed that will be implemented. This action is designed to create change and provide solutions to the problem posed. McTaggart (in Reason & Bradbury, 2001) reiterated that "the aim of participatory action research is to change practices, social structures, and social media which maintain irrationality, injustice and unsatisfying forms of existence" (p. 1). The cycle shown in figure 3.1 includes a period of reflection and evaluation regarding the solution that has been tried. The outcome is often a repeat of the process with new problems emerging.

Figure 3.2 shows another version of the cycle put forward by Dick (2002). Who stated that "A cyclic process can be flexible and responsive. You don't have to design the research in detail before you start. Instead, you can refine your research design as you learn more about the situation you are researching. The design gets better, fits the situation better, as you proceed."

Figure 3.2 Action Research Spiral



(Dick, 2002).

Following the above cycle, this research posed the problem of how to improve professional practice for HRAs. It then explored with DHS and the case managers the possible directions for the research. The proposed solution (action) was developed and involved the use of critical reflection to test and reflect on the initial set of 13 Unconditional Care principles. The

change involved finalising a set of principles, strengthening critical reflection skills and closing the gap between 'what we say we do' (espoused theory) and 'what we actually do' (practice).

This action research provided a voice for case managers to describe their practice, reflect on it and test Unconditional Care as a possible solution.

3.3.2 Rationale for Action Research

The cyclic process of action research described in the previous section was the crucial reason this design was chosen. It has proven capacity to involve professionals who work directly with the clients (HRAs) and can provide insights that might otherwise not be available. The researcher wanted to capture the voice of the case managers and was interesting in generating immediate change. A contribution to the knowledge of the case managers, the researcher and the wider body of knowledge of practice involving HRAs was also desired.

The participatory nature of action research meant the researcher could be more intimately involved. The case managers were directly involved in the narratives that described and ultimately defined the Unconditional Care approach. In this co-operative inquiry the split between 'researcher' and 'subjects' was removed, and those involved acted together as 'co-researchers.' Peters and Robinson (1984) highlighted that, "theory and practice can develop together in a series of evolutionary steps designed to lead to improvements in practice during the life of the research project" (p. 122). The participatory nature of Action Research assisted in this practice development.

The depth that action research offers is another explanation for its use in this research. In this complex inquiry the inter-relationship between the focus groups, interviews (Appendix 7) and use of 19 reflective tools (Appendix 8) meant that the amount and depth of the data generated was significant. This mix of methods is known as triangulation (Walter, 2010), and has the effect of strengthening the analysis.

A further rationale for the use of action research was its capacity to explore other case manager's points of view. In designing the research, consideration was given to Cherry's work (1998) that discusses the 'desirability effect', this is when people respond to the research(er) in ways they think will be approved. She stated that the point of action research is not to gain evidence of the speaker's ideas and activities but to explore the way the other person sees the world. Awareness of this issue assisted the researcher to conduct this project and to focus on recording the case managers' practice.

Complementary to action research, Fook (2002) discusses accessing experiences rather than obtaining data. She contended that rather than collecting something (data) which does not already exist in a prescribed format, it is necessary to ask how frontline practice can be accessed in ways which will best enable practitioners to theorise from it. The use of action research allowed the researcher to explore the experience of case managers not just collect data in traditional ways.

The exploration of Unconditional Care involved the case managers considering their own responses. They examined whether they supported the approach made up of the 13 principles, then spent time theorising regarding their practice approaches, the evidence and developing further principles. As Reason (2001) argued, the process of self awareness and collective self-inquiry and reflection can assist practitioners to use their own knowledge.

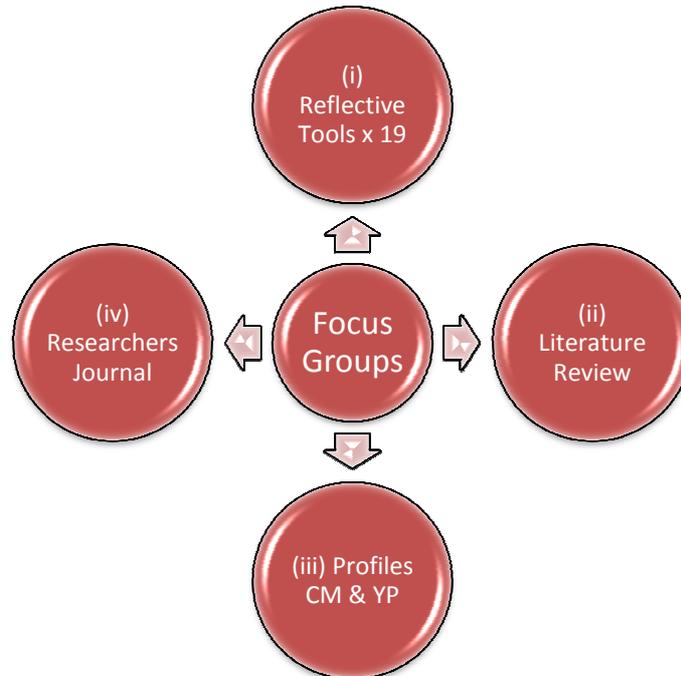
The ultimate reason action research was ideal for this study is that as Dick (1997) argued "the virtue of action research is its responsiveness" (p .5), hence it can be an intervention as well as research. As qualitative research often shows, letting the information that was available guide the direction of the research contributes to the development of innovation and creativity.

3.4 Research Design and Data Collection

Research design and data collection involved a four-pronged approach as seen in figure 3.3. Focus groups were the central data collection method employed as a form of in-depth interviewing conducted with a group (Walter, 2006). The design included: (i) the use of 19 reflective tools based on the

Drury-Hudson (1997) model of professional knowledge, (ii) a literature review, (iii) a set of profiles developed by the case managers, including profiles of themselves and one of the young people they case managed and (iv) the researcher's journal and observations.

Figure 3.3 Research Design



Focus groups formed the central structure for the research. All data was collected from this point. A focus group can be described as “a loosely constructed discussion with a group of people brought together for the purpose of the research, guided by the researcher and addressed as a group” (Sarantakos, 2006, p. 194). Focus Groups are traditionally conducted with a series of questions that are put to the group for discussion and analysis. However, in this research the use of research tools provided a more structured and rigorous approach.

Sarantakos (2006) stated that focus groups also offer information about “reasons and explanation for attitudes and behaviours” (p. 195). It was necessary to maintain a dual focus while conducting the focus groups. The researcher had to manage the data collection process while simultaneously facilitating the group process.

Nineteen tools were used during the data collection process to assist the researcher in recording the case manager's ideas and reflections. The tools also assisted in data management by allowing the alignment of emerging themes. Using these tools, the case manager's were able to write down reflections that may have been difficult to discuss with the group⁵⁶. The use of these reflective tools also meant that questions were opened ended and provided a greater capacity to explore the in depth thoughts and ideas of the case managers.

The researcher decided that the data would be less open to interpretation if case managers recorded their thoughts and reflection via a series of written activities. The fluid nature of action research meant that as each region met they were able to work through the data collection tools and process. In region 2 and 3 the group process and agenda for the focus group was sometimes adjusted to assist in meeting timeframes for the research. For example if a focus group had not meet or had low attendance the researcher was able to streamline some of the process so that as many data collections tools as possible could be completed.

The second task involved consideration of the group management and group process meant that skilled facilitation was necessary. Given the expected complexity of the discussions in the focus groups and concerns that the researcher was at risk of becoming overly involved in discussion, it was decided that an external facilitator would assist.⁵⁷ This provided an independent mediator who was able to stand back and help the case managers decipher their key ideas for recording in the tools. The joint facilitation included implementation of group work theory and respectful inquiry, including application of Tuckman's (1965) four stages of group development.

⁵⁶ See the discussion in Chapter Five relating to the vulnerability that some case managers may have felt in discussing practice deficits.

⁵⁷ Mr. Best was a consultant skilled in group process training. He agreed to assist the researcher in managing the group process. The intensity of the sessions often meant that Mr. Best was a very helpful sounding board for the researcher in terms of the development of tools and focus group agendas.

Profiles were also used as a data collection exercise. Each of the case managers were asked to complete a profile of themselves (see profile questions Appendix 8.3.8). It inquired into their education, background and demographic information including age and gender. Additionally each case manager completed a profile for one of the young people from their case load to whom they would refer throughout the course of the research (see profile questions, Appendix 8.3.7).

The use of profiles stemmed from the researcher's interest in the link between values and background as it related to Unconditional Care. This idea is explored further in Chapter Five.

The final component of data collection was the researcher's journal which contained thoughts and reflections from each focus group. The journal helped provide insight into the complexity of the group dynamics and data provided by the case managers.

Interviews had been approved for case managers to conduct with a young person at the commencement of the focus groups and at the end of the twelve months. This would have established a benchmarking process, where changes in the case manager's professional practice could be analysed.⁵⁸

3.4.1 Details of the Research Process

In accordance with action research this study moved through a cyclic process from problem definition to action. The researcher explored the problem and the information that surrounded it including the research literature, and discussions with other Child Protection and ICMS staff. Following exploration that an action research study on professional practice with HRAs would be beneficial to the sector, the researcher commenced the more formal collaborative process.

After completing the ethics process (described further in this chapter) twelve

⁵⁸ These interviews were not completed due to reasons that are explored later in Chapter Six in the limitations section (see proposed interview questions in Appendix 8).

months of focus groups were held. There were four regions represented in the research. Case Managers from each of the four regions met in a regional focus group. These regional groups came together for a 'joint' focus group three times during the research. Table 3.1 below shows the schedule of focus groups.

Table 3.1 Focus Group Schedule

ID	Task Name	Start	Finish	Duration	2000			2001														
					Okt	Nov	Dez	Jan	Feb	Mae	Abr	Mee	Jun	Jul	Aug	Sep						
1	Information Sessions Held in Region	01.09.2000	29.09.2000	4,2w	■																	
2	Focus groups held in region 1 & 2 Reference group meeting	02.10.2000	31.10.2000	4,4w	■	■																
3	Focus group held in region 1, 2 & 3	01.11.2000	30.11.2000	4,4w		■	■															
4	Focus groups held in region 1, 2 & 3 Reference group meeting	01.01.2001	30.01.2001	4,4w				■	■													
5	Regions 1,2 & 3 together for a joint Focus Group	01.02.2001	28.02.2001	4w					■	■												
6	Focus groups held in region 1,2 & 3	01.03.2001	30.03.2001	4,4w						■	■											
7	Focus groups held in region 1, 2 & 3 Reference group meeting	02.04.2001	30.04.2001	4,2w							■	■										
8	Regions 1,2 & 3 together for a joint Focus Group	01.05.2001	30.05.2001	4,4w								■	■									
9	Focus groups held in region 1 & 2 & 3	01.06.2001	29.06.2001	4,2w									■	■								
10	Focus groups held in region 1 and 1:1 follow up in region 2 & 3 Reference group meeting	02.07.2001	30.07.2001	4,2w											■	■						
11	Focus groups held in region 1 and 1:1 follow up in region 2 & 3	01.08.2001	30.08.2001	4,4w												■	■					
12	Regions 1,2 & 3 together for a joint Focus Group (Final) Reference group meeting	03.09.2001	28.09.2001	4w																	■	■

The four regions were chosen in collaboration with DHS to provide a balance between regions who displayed best practice, and those that did not. The researcher was guided in this by the staff of the Practice Leadership Unit (PLU) at DHS. There researcher was also interested in representation from both rural and urban regions⁵⁹.

The research process involved

- Regional focus groups that met on a monthly basis over the 12-month period from October 2000 – October 2001.
- 30 focus groups representing four regions and three statewide joint focus groups.⁶⁰

⁵⁹ Additionally the research utilised a reference group (see section 3.6.4 for detail).

⁶⁰ The third region was added after the research commenced due to difficulties in retaining case

- Case managers from rural and urban regions.⁶¹
- Case managers with a current caseload of HRAs.⁶²
- Recruiting twelve case managers from each of the three regions, six from Child Protection and six from the ICMSs a total of 36.
- Case managers attending one three-hour monthly focus group and completing 19 reflective tasks in that time.
- A total of three reference group meetings⁶³

Over-recruitment was a deliberate strategy due to the researcher anticipating the difficulties in engaging case managers. At the end of the 12 months 13 case managers had participated in the year-long program and six completed a full set of reflective tools and all data collection processes. The case managers who completed the data collection represented the three regions. The reference group was not continued beyond the third meeting. The attendance rate of case managers was around fifty per cent. In other words, the majority of the case managers attended five out of the ten focus groups that were held during the 12 month schedule.

Towards the end of the 12 months the researcher occasionally gathered data from individual case managers. This entailed spending significant amounts of time in the regions, and repeated communication with the managers to maintain their involvement and support.

managers.

⁶¹ It is important to note that the research did not include any case managers a large distance from the Melbourne CBD. The greatest distance from the CBD where the Case managers were located was approximately 200kms. This is important for recognising that the research did not deal with the issues of remote and isolated workers in remote Victoria.

⁶² Case managers who work in the ICMS are contracted by DHS to provide services to HRAs on the High Risk Register. The case contracting arrangements differ from region to region. The research utilised the regional maps available at the time from the DHS to decide on the locations of the focus groups. This suited both the ICMS and DHS as they follow the same regional boundaries.

⁶³ At times these operated like focus groups completing various reflective tools similar to those conducted with the case managers. This provided a reference point for exploring differences between what managers were saying about practice as compared with the Case managers.

The constant turnover of staff and management had a significant impact on the research. For example case managers who were involved in the research were allocated new line managers who knew nothing of the research. This meant the researcher had to spent time with each new line manager to ensure their continued support. At times new line managers were reluctant to allow case managers to continue with the research. This was compounded by changes in staff in the PLU and at a more senior divisional level. Participation of case managers was also impacted by the researcher finalising employment with DHS and commencing employment with the Centre for Adolescent Health (CFAH).⁶⁴

3.4.2 Ethics and Anonymity

The researcher followed the internal DHS procedures in relation to research. These included;

- Application to the Branch (Head Office) Ethics Committee seeking approval.
- Application to the RMIT Ethics Committee seeking approval.
- Provision of project brief and timelines.
- Access to results in a timely manner.
- Utilising informed consent processes.

DHS and RMIT approved the research on 14th September 2000 (see Appendix 9). Following ethics approval, access to potential case managers was sought and maintained through discussions with managers in PLU at DHS and senior managers in the CSOs that operated ICMSs.

⁶⁴ The researcher returned to DHS during 2007-2008 for a short time, which provided a timely opportunity to examine progress and practice within the context of the *CYFA 2005* and to notice any differences in policy direction.

Regional information sessions were held after invitations had been issued in writing, via telephone and via personal invitations. Some case managers volunteered and others were nominated by their supervisors and invited to be a part of the research.

The researcher preferred involvement from case managers who had a desire to share practice ideas, inquire into their practice and in doing so be exposed to new learning and challenges. The researcher did not ask case managers to adopt an Unconditional Care practice approach but to contribute to the research by analysing their own practice action, theory and to consider Unconditional Care principles and approach.

The research offered case managers full anonymity as detailed in the Plain Language Statement offered to all potential participants. Case Managers were made aware that names and details would be changed to protect their identities and those of any young people involved. Even with this guarantee questions were raised in the information session by case managers regarding anonymity and the feedback of information to their line managers at DHS and ICMSs. The researcher quickly became aware that the case manager's involvement in the research relied heavily on assurance of anonymity. The case managers voiced concerns that if they disclosed error(s) in their practice in the research this may be reflected back to them in their annual performance appraisal processes.

The reference group members were drawn from the line management of case managers, four to five levels of management above. They too were offered anonymity and were aware of the importance of respecting this as stated in the Plain Language statement and consent.

Once the case managers were assured of anonymity they agreed to take part in the research. However, the case managers questioned their anonymity given the nature of the regions and the networks where 'everyone knows everyone.' The researcher reiterated to the case managers that the research was not about performance but about improvements and reflective practice.

Anonymity would be protected by ensuring the data had no names or identifying information attached to it.

The need for anonymity created no significant problems during the data collection phase, but did mean that no regional and urban comparison could be made. It also became impossible to distinguish between the comments of DHS and ICMS case managers. This was unless they were required to do so by the data collection Tool. There were some tools that specifically requested the case managers to state whether they were members of Child Protection or ICMS, but this was not standardised across the data collection tools.

A further ethical concern raised by the DHS ethics process related to a perceived power imbalance influencing the research due to the researcher being in a senior position within DHS. This position was perceived as being more senior to the case managers involved in the research even though the researcher was not in the direct line management of any research participant (or members of the reference group). To assist with this issue, the researcher decided to engage an independent group facilitator (Mr. Geoff Best), as stated earlier.

The strategy of involving an external facilitator was successful. There were times during the research when the researcher withdrew from the facilitation of the group and Mr. Best led discussions and/or activities. There were also times when his presence in the group assisted the case managers to discuss meaningful and more vulnerable parts of their experience. The case managers often approaching Mr. Best during the breaks was evidence of this. He built a significant level of connection and rapport with the case managers as did the researcher.

3.5 Design of Reflective Tools

The four pronged research design discussed previously focuses around the primary method of data collection of focus groups. There were Nineteen reflective tools that were designed over the course of the research that utilised the Drury-Hudson (1997, p. 39) professional knowledge model was used as a framework. The model was used to guide the data collection. The

researcher designed tools to specifically gather data in each of the professional knowledge areas. This assisted in systematic collection and consistency by focusing on one component of knowledge at a time. The components of knowledge addressed by the 19 tools are:

Procedural Knowledge: Knowledge about the organisation, legislative, or policy context within which social work operates.

Practice Knowledge: Knowledge gained from the conduct of social work practice, which is formed through the process of working with a number of cases involving the same problem or gained through work with different problems, which possess dimensions of understanding that are transferable to the problem at hand.

Theoretical Knowledge: A set of concepts, schemes or frames of reference that presents an organised view of a phenomenon and enable the professional to explain, describe, predict or control the world.

Personal Knowledge: An inherent or spontaneous process where the worker is necessarily committing him or herself to action outside of immediate consciousness, or is action based on a personalised notion of common sense. Such knowledge includes intuition, cultural knowledge and common sense.

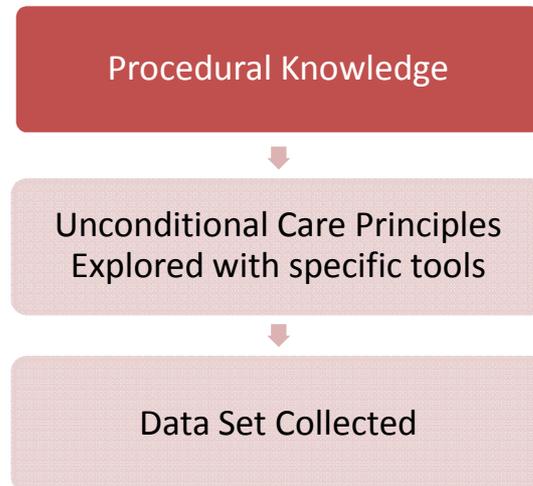
Empirical Knowledge: Knowledge derived from research involving the systematic gathering and interpretation of data in order to document and describe experiences, explain events, predict future states, or evaluate outcomes.

(Drury-Hudson, 1997, p. 38)

These five components assisted the researcher to categorise the knowledge as it related to the 13 Unconditional Care principles. If a case manager agreed with one of the principles, they were asked to record which of the knowledge areas informed their position. For example, when the researcher was exploring the procedural knowledge of case managers underpinning the principles, specific tools were used to collect that data. Figure 3.4 shows the

process of applying procedural knowledge to the reflective tools and then collecting the data.

Figure 3.4 Data Collection Process



This technique was similar to that of knowledge mapping. In the same way that knowledge maps assist organisations in capturing and integrating strategic explicit knowledge (Wexler, 2001) these tools assisted in capturing and drawing out a picture of the knowledge of the case managers, in particular the explicit practice that Case managers could articulate.

A certain amount of organised chaos occurred as the researcher sought to maintain the case managers' engagement in the process and at the same time gather data. As Reason (1999) stated "the best inquiry groups find a balance between chaos and order," he argued that the key validity issue is to "be prepared for the chaos, able to tolerate it, to go with the confusion, not let anxiety press for premature order and to wait until there's a real sense of creative resolution" (p. 8).

The methods of data collection in this research also supported the examination of assumptions behind practice. Fook (2000b, p. 3) noted that:

The basic reflective process, as developed by Argyris and Schon (1976) and Schon (1983), was the simple examination of practice to uncover hidden assumptions which are implicit in the activity. In this way the gaps between espoused theory and enacted practice are highlighted, enabling practitioners

to scrutinize, evaluate and change their practice, whilst at the same time develop and articulate the theory which is implicit in their actions.

(Fook, 2000b, p. 3)

Each focus group used the same data collection tools although these were often implemented differently in the group process (These tools are described in the next section).

Action research employs qualitative data analysis that occurs throughout a process in an ongoing cycle. In this research as each focus group occurred the researchers approach to the focus groups was shaped by analysis of the previous one. The researcher ensured that once a tool was designed it was used across the four regional focus groups. The researcher used the data from these focus groups to shape processes and facilitation in the subsequent focus groups. In this way the researcher's implementation of research tools became more sophisticated over time.

3.6 Focus Group Overview

Action research provides a mechanism for dealing with complexity and review progress toward change. Due to the unpredictability of case managers court appearances and other operational challenges, regional focus groups were often out of order. This meant the data collection tools 1-19 were not always conducted in chronological order or in the same order with each group.

This discussion is separated into three sections; phase one, which encompassed focus groups 1-3 phase two, focus groups 4-7; and phase three, focus groups 8-10. Each phase consisted of three focus groups and one statewide joint focus group (three regions together). The reference group met once during each phase. The section is written tool by tool and aims to describe each of the 19 reflective tools used (see Appendix 8).

3.6.1 Phase 1 Focus Groups 1-3

The first two regions commenced focus groups during October 2000.

Difficulty in recruiting case managers meant that the target of 12 case managers per region was not reached. It was decided that a third region should become involved and this was achieved on the 10th November 2000.⁶⁵ The third region remained behind schedule despite efforts by the researcher.

Even with the most senior DHS endorsement from the Director of the Community Care Division case managers felt unable to commit time to the research. An early journal entry by the researcher reflects frustration at not being able to get through by phone to the case managers to reschedule when focus groups had been not attended.

During these early focus groups the researcher concentrated on setting up the research process and introducing the case managers to the tasks to be completed over the 12 months of involvement. This included discussing; group process, establishing a common understanding about the purpose and focus of the research, the concept of Unconditional Care and professional knowledge as defined by Drury Hudson (1997). The research tools focused on hearing responses from the case managers about their use (or not) of Unconditional Care and their support (or not) for it as a practice approach. The timetable for the meetings, the expectations regarding attendance and completion of tasks were also covered during this early time as were ethical dimensions and anonymity.

Group process was addressed as a priority during the early focus groups. The first was an exercise regarding personal 'Expectations' (Group process 1, Appendix 8.2.1); this was completed along with the development of a 'Working Agreement' (Group process 2, Appendix 8.2.2). Both of these exercises helped to identify how the case managers wanted the focus groups to be facilitated in terms of behaviour and participation. The third process was called 'What's on Top' (Group process 3, Appendix 8.2.3) and was used

⁶⁵ There were then three regional groups meeting. One of these regional groups allowed a staff member from a fourth region to participate this meant that a total of four regions was represented in the research.

by the researcher to gather an initial reaction from the group about the Unconditional Care principles. Each Case manager had thirty seconds to contribute a word that described their 'off the cuff' reaction to each of the Unconditional Care principles. An in-depth discussion followed regarding where these ideas had arisen from. A significant amount of time was then dedicated to establishing and further exploring the case manager's responses to the Unconditional Care concept and principles.

When these introductory group processes were completed, the researcher facilitated a brain storming exercise to identify commonalities between DHS and ICSM. This process aimed to break down barriers that appeared to exist between some case managers from DHS and ICMSs in relation to current regional case decisions and actions. Breaking down these barriers was an important step in developing trust in the group so that in depth inquiry and reflection could take place.

The researcher found that case managers feelings of vulnerability remained an issue throughout the 12 months. The case managers often appeared unwilling or unable to discuss any deficits in their practice. As stated in Chapter Two this is consistent with Cox, Hickson and Taylor (as cited in Durgahee 1997, p. 140) and Bennett-Levy and Beedie (2007 cited in Dallos & Stedmon, 2009).

Conflict between case managers was more serious in some regions than others. At times the case managers would discuss current cases and in particular regions, there was disrespect between Child protection case managers and ICMS case managers. This meant that the facilitator and the researcher actively worked to reduce disrespect. Challenging this lack of respect between the case managers required time to work through so that discussion regarding the research could be commenced or returned too.

This dynamic of disrespect delayed one of the focus groups. Interestingly one region in particular displayed little conflict and was the group with highest participation rate. Their contributions to the project were also the most substantial in terms of consistency and completion of all the tasks. Table 2.2

below sets out the reflective tools that were undertaken during Phase one of the research.

Table 2.2 Phase One Reflective Tools 1-9

Reflective Tools – Phase One
1. What is your Practice Approach?
2. Reflections
3. Helper Protector
4. Suitcase Tool - Procedural Knowledge
5. Chart Exercise - Procedural
6. Learning Log (1)
7. Profiles of Young People
8. Profiles of Case managers
9. Knowledge Grid

The reflective tools were the focal point of focus groups. The first tool was a reflection for the case managers on how they would describe their current practice approach (Tool 1, Appendix 8.3.1). This reflection was completed individually and then discussed in the focus group. It assisted the case managers to commence examining and articulating their own practice approach. The data produced by participants using this tool was not collected by the researcher as a way of assisting the case managers to feel safe in the research environment and was not a key focus of this research.⁶⁶

⁶⁶ While the research encouraged the development of practice the focus was on the testing and exploration of Unconditional Care.

The second tool 'Reflections' (Tool 2, Appendix 8.3.2) was a matrix with the 13 principles in the left most column. Case managers were asked to nominate how often they used each of the 13 principles. They did this on a scale consisting of 'always, sometimes or rarely'. They then had opportunity to write comments that described each principle in practice or listed their reactions to the principle.

The next tool was another scaling exercise called 'Helper Protector' (Tool 3, Appendix 8.3.3). This was used to discuss how the case managers saw their roles in helping and/or protecting young people. This discussion was the catalyst for the researcher deciding to explore the notion of control both in the literature and in further focus groups. The first three tools were designed to initiate and capture the case managers reaction to the Unconditional Care principles.

The researcher then explored the case managers procedural knowledge using the 'Suitcase' (Tool 4, Appendix 8.3.4). Here the researcher and case managers brought a suitcase full of procedures (practice guides, legislation and policy from DHS and ICMSs). They then identified and discussed which procedures impact and direct their practice and/or that of Unconditional Care.

Following the 'suitcase', the case managers examined the procedural guidelines and chose the most influential and important procedures using 'The Chart' (Tool 5, Appendix 8.3.5). They then cut them up and glued them onto a poster underneath each of the principles. This allowed case managers to recognise the links between their knowledge of procedures and each of the Unconditional Care principles.

The theoretical knowledge component was introduced by the use of a reflection called the 'Theory Book'. In this activity the case managers were given a book, which had one Unconditional Care principle on each page but was otherwise blank. The task was for the case managers to write down the theories they thought related to each of the principles.⁶⁷ The researcher had

⁶⁷ The summary of theories provided by the case managers and then by the researcher is presented

expected this task to be completed within two months, but due to the case managers finding it difficult to name theories they were given a number of months to complete this exercise. As discussed later few were able to cite many theories.

The case managers were then asked to engage in the first of two reflections that were designed to assist them in deeper exploration. The Tool 'Learning Log (1)' (Tool 6, Appendix 8.3.6) required the case managers to write two narratives relating to a specific task they had undertaken with a HRA. One narrative was to be of a positive nature and one of a problematic nature. Once they had completed them they were asked to reflect on both of the narratives giving specific attention to external and internal areas of learning and feelings. The case managers were then asked to note what changes and/or applications they would make based on the Unconditional Care approach that had been presented and discussed over the previous two focus groups.

Also during Phase One, the case managers were asked to complete profiles of themselves and of a young person each case managed (Tool 7 & 8 Appendix 8.3.7 & 8.3.8)⁶⁸. In February 2001 a joint focus group was held to bring together the three regions involved in the research. It was an opportunity for the case managers to have interaction across regional boundaries and discuss and compare their thoughts on the Unconditional Care principles. It also provided an opportunity to see if views were consistent across regions.

Professor Jan Fook was invited to the joint focus groups to present on critical reflection and to assist case managers to explore their practice. She challenged the case managers to consider the following steps in the reflective process:

1. Whether our (the case managers) assumptions fit with theory

later in Chapter 4.6.1.

⁶⁸ They were also asked to attempt to conduct the first of two interviews with the young person they had chosen. The suggested questions that were provided for the case managers are found in Appendix 9. These are the interviews which did not occur (see above).

2. Where do the assumptions in our practice come from?
3. Whether our practice fits with theory
4. How do I need to change my theory?
5. Putting a label on our developing our theory of practice⁶⁹

The rationale for Professor Fook's presentation was the relevance of her work to the research design. It prompted the case managers in their reflection about Unconditional Care and its relationship to their own practice. This discussion also assisted them in the development of ideas about how their own practice might be described and recorded as 'theory'.

The final exercise for this phase of the research was the 'Knowledge Grid' (Tool 9, Appendix 8.3.9). It was designed to continue the exploration of professional knowledge informing Unconditional Care. The case managers were asked to respond positively or negatively about whether or not they were using the Unconditional Care principles. If they responded positively they ticked the area of knowledge which informed their practice, but only if they could describe and/or articulate the knowledge that related to their support of a principle

3.6.2 Phase 2 Focus Groups 4-7

These focus groups ran between March and June 2001 and included a joint focus group of case managers from all of the regions. Focus group four commenced with a presentation of the findings (including the profiles) from the previous focus groups. The number of tools had been reduced in an attempt to simplify the process to try and continue engaging the case managers in the research. The following reflective tools were all used during this phase of the research (Table 3.3).

⁶⁹ These steps were later developed and published by Fook, White and Gardner (2006, p. 12).

Table 3.3 Phase Two Reflective Tools 10-13

Reflective Tools Phase Two
10. Definitions
11. Testing
12. Learning Log (2)
13. Values

The first task was to work on defining the principles; Tool 10, 'Definitions', (Appendix 8.3.10) was used for this purpose. It listed the principles and required the case managers to complete sentences that further explain the Unconditional Care principles.

The case managers were then asked to complete the 'Testing Tool' (Tool 11, Appendix 8.3.11) which required them to consider whether or not they had continued or commenced practicing using the Unconditional Care Principles. They were asked to tick a yes or no box and then to comment about why they had or had not used the Unconditional Care principles and to write about the issues and/or inhibiting factors.

The second 'Learning Log' (Tool 12, Appendix 8.3.12) provided a case scenario for case managers to reflect upon;⁷⁰ it asked them to describe how they would respond and to prioritise their actions. Additionally, the tool asked them to examine their responses and consider their rationale for their actions. They were then asked to reflect on: (i) the presence and/or absence of Unconditional Care in their responses and (ii) whether or not their response reflected their own theories and ideas of practice that had been discussed with Professor Fook.

⁷⁰ This case scenario can be found in Appendix 8.3.11 and was based on a typical situation that would occur during case management of an HRA.

As the group began to explore the personal knowledge section of the professional knowledge model the 'Values Brick Wall' (Tool 13, Appendix 8.3.13) was used in a series of reflective steps to answer questions like; What are our own values? How do they impact on practice? How do they relate to the principles? When does our practice clash with our values?

A second joint focus group was held in this phase. A further presentation from Professor Fook attempted to resolve the continuing difficulty the case managers were having with both the application of theory to practice; they appeared to struggle with articulating theory and integrating it into practice. This was the case with their own practice and when testing and exploring the theory that related to the Unconditional Care principles.

As time progressed focus groups in some regions were unable to convene. This was due to lack of participation from the case managers and a decision by the researcher that no extra case managers could join the research after phase one (in order to maintain continuity). To continue data collection of the tools this reduction in case managers required a change in approach. The researcher met on an individual basis with the case managers who were willing and/or available; this provided opportunities to complete the reflective tools missed (otherwise completed in focus groups) and allowed the researcher to engage in in-depth conversation and reflection with the case managers.

These individual consultations enabled the researcher to discuss the principles of Unconditional Care and to complete any of the relevant reflective tools. During these sessions the case managers started to develop additional principles that would more fully capture the voice of the Case managers and enhance the Unconditional Care approach being explored. The new principles developed during these times included; family and defensible practice, reflective practice in the supervision process. In addition the care and control paradox was further explored.

3.6.3 Phase 3 Focus Groups 8-10

During this phase of the research the focal point was on completing the 12 month timeframe and assisting as many of the case managers as possible to remain engaged in the process. At the start of this phase there were 13 case managers still involved and attending focus groups, but this number continued to decline. At this point the rural region was the only region meeting as a group. The rural case managers had formed solid trust and a group process which allowed for the deepest reflective discussions.

The researcher conducted follow up meetings on an individual basis with case managers in the other two regions. A final statewide focus group was then facilitated. There were six case managers in attendance who had remained involved for the full 12 month process. At the completion of the research six case managers had completed the full set of 19 tools. In this phase the tools listed in table 3.4 were used.

Table 3.4 Phase Three Reflective Tools 14-19

Reflective Tools Phase Three
14. Inhibiting factors
15. Strategies
16. Habits
17. Implementation Ideas
18. Interview Summary from final joint focus group
19. Evaluation Reflection

The focus of this phase was to bring closure to the reflections and processes that had taken place over the previous 12 months. Chapter Four will discuss the analysis from the case managers which highlighted their support and for yet difficulty in implementing the Unconditional Care Principles. Due to the case managers' simultaneous apprehension about support for the Unconditional Care approach, the researcher designed the 'Inhibiting Factors' (Tool 14, Appendix 8.3.14). This tool represents the crux of action research (as applied in this research) in that it supports a responsive and collaborative discussion.

After completing the 'Inhibiting Factor' tool, case managers completed the 'Strategies' tool (Tool 15, Appendix 8.3.15). This asked them to consider and recommend the strategies they had been using and would like to see applied to improving conditions for practicing in an Unconditional way.

The researcher decided to facilitate a reflection on 'habits' with the case managers to examine strategies for 'changing behaviour' (Tool 16, Appendix 8.3.16). In this tool they were asked to reflect on the habits they recognised and how they could go about improving them. This was due to the difficulty most case managers displayed throughout the research in recognising their own deficits and desire for change. (Interestingly the six case managers who completed all the tools showed an explicit interest in developing their practice and learning).

Finally, the case managers completed the tool on 'Implementation Ideas' (Tool 17, Appendix 8.3.17) which looked at barriers to and application of Unconditional Care. In relation to the interview that were not completed (mentioned earlier) the case managers were asked to complete an 'Interview Summary' (Tool 18, Appendix 8.3.18), in which they discussed why they hadn't been able to complete the interviews with the young person. Finally they completed an 'Evaluation' of the action research project (Tool 19, Appendix 8.3.19).

3.6.4 The Reference Group

A reference group of senior managers met throughout the year to contribute to both the analysis of the data collected from case managers and to complete some of the tools themselves. The reference group members had practiced in the sector and progressed into managerial positions. This choice of reference group members was due to the nature of the inquiry being focused on practice and creation of theories of practice (action).

The role of the reference group was to maximise the validity of the research and provide a forum for the formulation and analysis of ideas. It was anticipated that the reference group would meet on a bi-monthly basis. The researcher reported to this forum and utilised it for direction and comment.

It was hoped that members would be able to provide an objective and informed point of view and assist with identifying themes in the data for further analysis. However, there were a number of issues that arose during the course of the research which hampered the intended role of the reference group. These are discussed in Chapter Four.

3.7 Validity

This chapter would not be complete without a discussion of validity. Sagor (2000) states that validity refers to the essential truthfulness of data, that when collected it should accurately measure or reflect the specific phenomenon claimed. These concepts highlight the importance of thorough consideration of methodological decisions.

Balance in the collection of case managers ideas was monitored because it was identified as an important influence on validity in this research. Reason (1990) stated that balance between reflection and case manager experience is critical to validity. Too much inclusion of experience will result in a

“supersaturated inquiry”⁷¹ and too much reflection can result in “intellectual excess” (pp. 46-48).

Reason (2005) also contended that quality inquiry actively experiments with re-description and draws on a range of presentational forms to turn stories and accounts upside down and express them in new ways. The aim of quality inquiry is to avoid the danger that co-researchers (in this research the case managers) will stay with the same old stories to recreate existing realities and confirm existing beliefs (Reason, 2005).

The researcher was also aware of the need for objectivity throughout the research process. Sager (2001) argued for collective effectiveness that adds to the knowledge base. In attempting to maintain a level of ‘truthfulness’ the research took steps including: involving an independent group facilitator, establishing the reference group, remaining reflective on the whole process of action and change and using research tools anonymously.

The technique of feeding back data to case managers was used throughout the research process. This gave the case manager’s an opportunity to reflect on the collective responses, not just their own. Reason (2005, p. 10), argues in support of Lather (1993) that researchers must move beyond concern for validity as a form of ‘policing’ research and move toward “validity as incitement to discourse” (p. 675). This was the case in this action research process. The continued visitation of the principles, under each of the knowledge areas, meant that the case managers were often reminded of what they had said and asked to consider the meaning.

Sager (2000, p. 3) suggests the question “Are there any factors or intervening variables that should cause me to distrust this data?” The researcher identified the following possible intervening variables;

⁷¹ Saturation is the idea that data collection can result in the same answers being given and/or no new information gathered (Alston & Bowles, 2003). It is usually at this point that data collection can be halted.

- The high levels of stress case managers work under on a continual basis.
- The fact that the researcher was employed in a position which was perceived as more senior than that of the case managers.
- The desire the case managers may have had to look expert in their practice and avoid performance criticism.
- A lack of trust in some focus groups which led to the possibility that members were not totally honest in their verbal responses.

In considering reliability Sager (2000) stated that problems can occur when researchers overstate the importance of data drawn from too small or too restricted a sample. Researchers should ask “is this information an accurate representation of reality?”

The reliability of the data was maintained by the researcher not drawing closely on examples, comments or responses which had not been repeated multiple times. “Action research is characteristically full of choices. So the primary ‘rule’ in approaching quality is to be aware of the choices that are made and their consequences” (Reason, 2005, p. 1).

The researcher contends that the most useful method of presenting the findings (in Chapter Four) and analysis (in Chapter Five) is thematically rather than in a chronological presentation as in this section.

3.8 Conclusion

This chapter has provided an overview of the research design. It has discussed the use of action research as the most effective methodological approach and demonstrated the complexity of the research. It has shown the strategies used to pursue reflective discussion and involvement of case managers. Finally, this chapter outlined the 12 months of focus groups research and provided some discussion regarding the validity of the research.

CHAPTER FOUR:

UNCONDITIONAL CARE – PRACTICE IN ACTION

A great deal of time and energy has been invested across government and the community sector both nationally and internationally to refine a credible evidence base as a foundation for the reform of the Child Protection service system.

(Geary, 2007, p. 85)

4.1 Introduction

The quote above represents the current voice of government as it attempts to convince the public that its daily decision-making is informed by a scientific body of knowledge. This statement may indicate a desire for change, but (as will be shown) the research, described in this thesis is consistent with previous research which demonstrates that case managers are often unable to articulate the credible evidence base that guides them through complex decisions.

The presentations of findings in this chapter are a representation of the case managers' reflections, actions and suggestions. The findings indicate that the espoused theory (saying) of case managers is different to their theory-in-action (doing). The Unconditional Care principles in this research often defined practice they envisaged themselves implementing (notwithstanding the restrictions they felt from the system they work in).

Due to the research involving 34 focus groups over one year, reporting the findings necessitated careful representation of the data. The findings are presented in the following order;

- Summary information from the two profiles that each case manager was asked to complete, one for themselves and another for a young person they case managed. The researcher's observations are included in this section.

- Data from the ten focus groups are presented in three phases, thematically rather than tool by tool (as was the case in Chapter Three).
- A discussion of the reference group and data.
- A presentation of the differences between the espoused theory and theory-in-use of the case managers.

4.2 Profiles and Researcher Journal Observations

The following profiles provided background and context to inform the research and were augmented by the researcher's journal observations and records.

4.2.1 Case manager and Reference Group Profiles

As discussed in Chapter Three the case managers and reference group members were asked to complete anonymous profiles for themselves and for a young person they case managed. This was undertaken as a way of gathering information about the case managers to enable the researcher to consider consistencies in personal backgrounds that may influence practice (see Appendix 8.3.8). analysis did not reveal significant consistencies or factors that could be attributed to specific practice.

The case managers and reference group members completed the profile task with varying degrees of enthusiasm, which meant that the profile data varied widely in quality and consistency. Some embraced the opportunity to reflect on links between their backgrounds and their current practice. Others in the group avoided completing their profiles and provided relatively scant information.

The case manager profiles provided a brief but informative overview of their backgrounds. They were professionals aged 24- 50 who had studied in a variety of disciplines including welfare, nursing, psychology, youth work, nursing, theology, business, arts and music. They were of mixed family and relationship contexts with 4 single, 6 married. They were all reticent to

identify their ideologies and beliefs although all went on to name a couple; these were feminism, 'left wing' and social justice. They all described themselves as middle class and were all of Anglo-Saxon descent. The following provides an example of the kind of information that was provided in the profiles by case managers.

The past six years have been by far the most rewarding of my working life. The fact that I am currently enthusiastic about my professional practice should be of benefit to my clients.

(Case manager profile)

I have been married for 10 years. I feel that if I didn't have a stable family life I'd struggle to cope with the demands of social work. Having a lengthy, stable marriage differs from the family life of most of my clients. But I don't think that this is a disadvantage, as I believe I have enough knowledge and insight to understand where my clients are coming from.

I case manage young people who are living at home and try to prevent them from living away from home. I have been working as a social worker for the past three years working with adolescents. I am permanently employed as a social worker and have been working with the agency for the past seven months. The fact that I am currently enthusiastic about my professional practice should be of benefit to my clients.

I come from a working-middle class background. My father was a German immigrant. However, he was an architect. So my family was potentially middle class. However, my father died when I was two years old and so my mother brought up four children as a single working parent. We had strong family values irrespective of financial security. I am certainly not affluent or wealthy.

The fact that I am middle class differentiates me from most of my client's and their families. Many of them are from an "underclass" background, although, a few of my clients and their families are more middle class than myself. I believe, as a generalisation social work is a middle class profession. I also believe that social class theory is relevant to my practice. As a generalisation

I believe life opportunities are limited or enhanced by the social class that one is born into.⁷²

(Case managers profile)

The most telling example of common motivating factors amongst the case managers was evident from a brainstorm on commonalities between DHS and ICMS case managers. The commonalities identified were interest in the human experience, a belief that relationship is important, loving young people, responding to injustice, the provision of redemption, and helping young people to 'reclaim' and create opportunities. In this same brainstorm the group showed an awareness and interest in how the young people and their families felt about their intervention and whether or not the families see an active demonstration of empathy, which is what they were intending to convey.

The reference group had eight members, only three of whom completed profiles. These three profiles showed a high degree of reflective analysis. It also showed that these reference group members were acutely aware of the relationships between their own backgrounds and the way they conducted themselves as professionals. Below are two examples:

I am an Australian, white with Anglo-Celtic heritage (Catholic). I enjoyed the community spirit and spiritualism of the Catholic Church. I now reject the church's hierarchy and organisational operation. I experienced discrimination as a child, which has stayed with me for a lifetime. Remain part of and identify strongly with Catholic community. My clients are often without any sense of spiritualism of any type. They do however often experience prejudice from others and the system.

(Reference group member profile)

Over time I have been associated with many different sub-cultures, these have included; punk, juvenile delinquent, drug, Rastafarian, Marxist/socialist, rugby, hippie, Christian. Again the contradictions are obvious and have left

⁷² The researcher has slightly edited the profile for readability. The majority of the text is from the data as a direct quote.

me with a general appreciation of all people and a particular affinity with people who feel that they don't 'fit' in with the majority of mainstream society. I think that I would have fitted the criteria for a high risk adolescent in my teenage years. This has influenced the level of understanding and tolerance I have for the acting out behaviour of young people. At times I have also found that self-disclosure has assisted in working with some high risk young people.

(Reference Group Member Profile)

The profile exercises provided a reflective opportunity for the researcher to consider significant consistencies between reference group members and the case managers.

4.2.2 Profiles of HRAs

The profiles of HRAs provided an opportunity to reflect on their characteristics. The themes were;

- A large number of case managers and placements.
- Inability to reason, derive meaning and interpret events in their life.
- Inability to protect self due to limited ability to understand risk and modify their behaviour voluntarily.
- Being subject to warrants and secure placements on a regular basis.
- Difficulties in forming and maintaining relationships.
- Impulsivity and defiance.
- Exposure to prostitution and/or other inappropriate sexual experiences.
- Case plan goals centre on stability of placement safety and engagement in meaningful relationships.

The HRAs' profiles provide some insight into this cohort of young people (see Appendix 8.3.7 for questions asked in profile activity). They were all aged 13-16 years. They were all being case managed due to the need for care and

protection under Section 63 *CYPA 1989*. All the HRAs had emotional or psychological abuse (Section 63e *CYPA 1989*) as the grounds for intervention. They were almost all on Custody to the Secretary orders⁷³ for one year. Their case plan goals centred on stability, substance abuse, education and family.

Several key features of HRAs were evident;

- The case managers were 'unsure' about the progress of the young people's identity.⁷⁴
- The HRA crisis plans were managed by DHS rather than ICMS.
- The young people had between one and 10 case managers over the period of time they had been involved with DHS.
- The case managers had worked with these young people for between two and eight months.
- Between three and six other services were involved.
- There was one aboriginal young person.
- Developmentally the young people were two years below the age normal range on average.
- The young people had experienced 7-12 placements in 12 months.
- Four out of nine young people attended day programs.

The case managers described the young people strengths as 'streetwise, socially adept, storytelling and manipulative as well as intelligent, friendly, determined, strong willed, optimistic and loyal. The risk factors included crime, heroin, suicide, self harm, prostitution, eating disorders, and exposure

⁷³ This means a magistrate has granted the Secretary to the DHS sole custody of a child because the child needs protection. For the length of the order, the Secretary has the power to make day-to-day decisions about the care of the child, such as where the child will live, with whom, and what activities they will undertake. Legal guardianship of the child remains with the parent. This means that the parent makes long-term decisions for the child, for example about their education or medical needs. (see http://www.dhs.vic.gov.au/data/assets/pdf_file/0004/584338/custody-to-secretary-order-info-parents.pdf).

⁷⁴ Identity refers to the period of time in a young person's development when they are establishing a view of themselves that is independent from their parents and/or carers. It is a critical point at which young people draw conclusions about who they are and how they will live (see adolescent development theory such as Erikson, 1996).

to pedophiles. Hygiene was also an issue identified by the case managers.⁷⁵

4.2.3 Researcher's Journal and Observations

The researcher's journal consisted of hand-written reflective analysis and thoughts that were noted after each focus group and at other appropriate times. These were stored chronologically. All relevant correspondence such as emails, letters and telephone records was added to the file.

A key theme evident in the journal was the difficulties in recruiting and retaining case managers due to workforce instability and pressures. An excerpt from the journal stated:

The biggest problem I have faced in this research is the difficulty in establishing who the case managers will be. I have experienced a lot of travelling and communication. Sometimes two and three visits to a region just to meet with a line manager (not case manager). The rate of change or turnover is also impacting the research. Often when I have found a case manager who is interested they leave their employment or change positions. In two of the regions there has been complete changes in line management of the case managers which meant that I have spent all of January repeating myself to a new set of managers to free up the case managers and in some cases locate case managers who could be involved.

(Meade, Journal Entry 2001, January 25)

As time went on the journal showed that the case managers believed participating in the research was seen as a 'luxury' by other staff. They stated that participating was 'something for me', 'an opportunity to talk about and think about myself', 'a time to think about what I do.' Even so none of the case managers "arrived on time" (to the appointments made with them)

⁷⁵ This narrative provides some insight into the young people that are represented in this research and the difficulty the case manager experienced in engaging them for research purposes. Excerpts from the HRAs profiles (written by case managers) can be found in Appendix 10. The young people's profiles closely matched the description of HRAs provided in Chapter One. Their stories are consistently marked by the impact of trauma and adverse life experiences.

(Meade Journal Entry Oct, 2000).

Significant changes occurred in the line management of case managers during the research period. As each new line manager was appointed, he or she would question the case manager's time spent on the research. The case managers were often unable to formulate a strong enough argument for support. Information was rarely adequately supplied to management (either acting up or newly appointed). Several case managers decided to leave the research due to these management pressures they said; two typical reasons for leaving are quoted below:

I'm afraid I'll have to remove myself from participation in the group for a few reasons, namely workload, stress and lack of progress with my own participation.

(Email from case manager dated 6th July 2001)

Our response team is functioning at quarter capacity... I am very tired and stressed. I might not be here that long there is a lot of uncertainty within the office structure and we've had a lot of changes within our management that is adding to everyone's anxiety and stress.

(Email from case manager 10th August 2001)

The journal shows that case managers were occasionally angry, teary, tired or frustrated. This stress was more pronounced in the rural region due to both DHS and CSO staff being on the on call roster system in addition to a fulltime workload. This kind of stress was not as obvious in the urban groups. During the course of the research some case managers were fully engaged in the reflective process, but early on several were unable or unwilling to engage in critical self-reflection. The researcher's journal entry in February stated;

This focus group was a joint meeting of all three regions. Most concerning for me was the results or comments made on the reflective task and comments made at the end of the presentation which were blaming and pointing at other issues rather than self critique of practice.

(Meade, Journal Entry 2001, Feb 6)

This case manager subsequently attended a couple of focus groups, and then withdrew from the research without stating her reasons. So disconcerting was this response that the researcher felt it necessary to meet with the University Supervisor during February 2001 to review the research methods. At the conclusion of that meeting a data map had been constructed which clarified the progress and validity of the processes being used and highlighted that some case managers were uninterested in reflection or unwilling to reflect.

The gap between the case managers espoused theory of practice and their practice in action was also evident.

The use of reflection was valuable in assisting the case managers to address the gap; as Fook (1996, 2000a) highlighted one of the most effective ways of dealing with practice complexity is the use of reflection and theory development. It provided them with a method of recording and discussing what they were doing while they were involved in the research.

4.2.4 The Gap between Theory and Practice

This research has highlighted the third action outcome which relates to the case managers recognising and starting to address a gap between theory and practice. Argyris and Schon (1974) showed that when a practitioner is asked about how they might behave under certain circumstances, they would give their 'espoused theory' for that situation. However, what the practitioner actually does in the situation may not reflect their espoused theory; this is called their theory of action (Argyris & Schon, 1974, p. 6).

Likewise, in this research there were distinguishable differences between what the case managers said about their behaviour (espoused) and what they actually did (theory in action). These gaps are shown in table 4.1 below.

Table 4.1 Unconditional Care Theory and Action

Espoused Theory Principles	Theory in Use Reflections
1. Continuity	Lack of continuity
2. Remake practice from evidence	No time to reflect, no access to research
3. Relationship as a base for practice	Surface relationships
4. Consistency of placement	Little control over consistency
5. Honesty, integrity, respect and flexibility	Honesty, integrity, respect and flexibility
6. Persisting	Persisting
7. Acceptance	Acceptance
8. Developmental perspective	Developmental practice
9. Identifying significant person	Difficult, at times achievable
10. Protective factors	Achievable
11. Identity and culture resiliency	Identity and culture resiliency
12. Responsibility and participation	Responsibility and participation
13. Hard line decisions	Hard line decisions
14. Joint responsibility	Can't control the response to collaboration
15. Working with family	Working with family
16. Connectedness to community	Connectedness to community
17. Defensible risk practice	Defensible risk practice
18. Trauma informed	Not explored

Table 4.1 shows that case managers supported the principles in an overall way which was their espoused theory; concurrently the data showed their inability to implement a number of the principles. For example Principle 1 which states “continuity of case manager wherever possible” was seen as very important by the case managers yet in data such as the young person’s profiles and reflections on this principle it was clear that most HRAs have very little continuity.

4.3 The Focus Group Findings

This section is written thematically rather than tool by tool, as it describes the data and findings from the focus groups. The discussion is presented in three phases. As data were gathered regarding the problem (improved responses to HRAs) and the solution (Unconditional Care) they were presented back to the focus groups, enabling in-depth inquiry. The complexity was ever present as the researcher attempted to weave together the responses into a systematic set of concepts. This would then contribute to the development of the final theory of practice for Unconditional Care via the initial 13 principles and additional principles.

The first step was to determine whether there was support for the Unconditional Care principles and whether they were present in the practice of case managers. The goal of editing or developing new principles was also progressed along with reflecting on how these principles were implemented (or not).

4.3.1 Phase One Focus groups 1-3

In the first phase of the research the data highlighted the following themes; A. The case managers support and application of the Unconditional Care principles, B. Difficulty in articulating theory for the principles, C. Struggle with procedural knowledge, D. The lack of professional knowledge informing case managers practice.

A. SUPPORT AND APPLICATION OF THE UNCONDITIONAL CARE PRINCIPLES

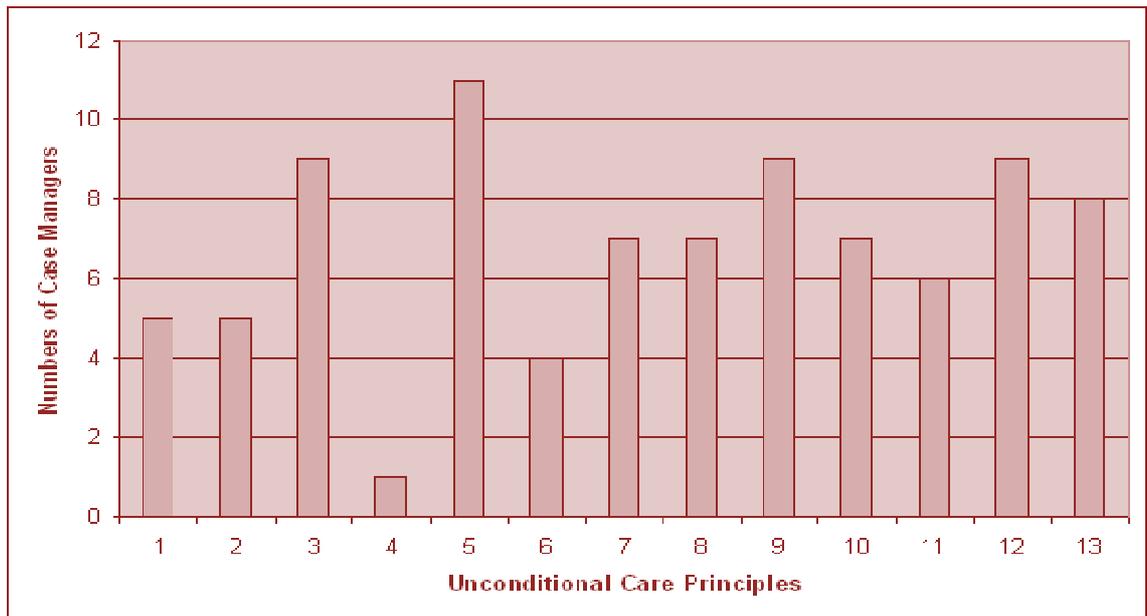
The first theme involved case managers expressing their support for Unconditional Care. The data shows that the initial 13 principles represented best practice, but case managers held the view that some of them were impossible to enact. The case managers stated that the principles could be further developed. This improvement occurred in a later phase of the research in the form of additional principles.

This view of the case managers did not change throughout the life of the research. After repeated reflections and discussions with case managers they continued to credit difficulty in applying the principles to the nature of the current service system. They stated that the system did not provide the resources and time needed. The case managers used words to describe Unconditional Care such as; wishful thinking, seldom used, not always achievable, causes burnout, is essential, overlooked, under-recognised, challenging, scary and difficult (see Group Process 3, Appendix 8.2).

The 'Reflections' Tool (2) (Appendix 8.3.2) asked case managers to identify whether or not they believed they practised any of the 13 principles. The scores indicated in figure 4.1 demonstrate that more than half of the principles were routinely applied in practice. The lowest scoring principles were 1, 2, 4, and 6 which focus on continuity, re-making practice, the provision of consistency and the application of persistency.⁷⁶

⁷⁶ A set of the Unconditional Care principles can be found in Chapter 1.2 for cross-reference; legend used throughout this chapter provides only a one or two word description of each principle.

Figure 4.1 Reflections (Tool 2)



Legend

- | | | |
|--------------------|------------------|------------------------|
| 1. Continuity | 5. Honesty | 9. Significant Person |
| 2. Remake Practice | 6. Persisting | 10. Spirituality |
| 3. Relationship | 7. Acceptance | 11. Responsibility |
| 4. Consistency | 8. Developmental | 12. Joint Decisions |
| | | 13. Hardline Decisions |

Case managers made the following comments while completing this same 'Reflections' Tool (#2):

Principle 1 - "Case contracting to a CSO agency will require a change of case manager so whilst the principle is sound, clients best interests may not be met on the occasions of a change of case manager."

Principle 2 - "The demands of the job rarely offer the opportunity for reflection on practice or professional development."

Principle 4 - "Whilst this (consistency of care) is generally the ideal, in reality this is often compromised."

Principle 6 - "Sometimes the need to balance pressure, workloads, personal coping is to acknowledge that persistence is limited."

Tool 3 called “Helper Protector” was designed to assist the case managers explore their perspectives on ‘why they do what they do’. The data showed that the case managers saw themselves as providing care rather than control (protection) with only one DHS case manager indicating the preference for both ‘care’ and ‘protection’.

During the first joint focus group participants undertook a mapping discussion regarding the enactment process of the Unconditional Care principles. This explored what Unconditional Care might look like in practice. It assisted the exploration of how change might occur within the case managers or wider system and how it could be measured.

The most important method of measuring change in the case manager’s practice during the research was going to be a pre and post interview with the young people (before and after the twelve months of focus groups). As these interviews did not occur, the researcher instead explored with the case managers how they could identify or be aware of change in their practice that may have taken place over the course of the year long research. The case managers responded by talking about the need to be aware of how we practice, identify which of the principles we use and how, and to notice what the practice outcomes of their use are.

B. CHALLENGES OF THEORY IDENTIFICATION

The second theme the data highlighted in this phase was the difficulty that case managers had in identifying formal theory. From the outset of the research the case managers struggled to identify the theoretical knowledge that underpinned their practice. They were given an opportunity over six months (from focus group 3-9) to complete an exercise called ‘theory book making’. This book was empty and they needed to fill in the theory for each Unconditional Care principle.

They were initially reluctant to complete this task. They voiced concern about the difficult nature of the task and the time it would take. Due to the participatory nature of action research the researcher negotiated with the case managers to take one or two principles each rather than attempt the full

set of 13 principles, but this did not assist them in completing the task. Even when they had been provided with relevant readings they were unable to write down much of the theory that informed their practice.

The case managers nominated theories (as listed below in Table 4.2) such as systems theory, yet when it was discussed the case managers application of this theory was not comprehensive. They could not comfortably discuss the application of any theory beyond general statements that reflected only a minimal level of application to practice. The exception to this was the developmental theory which many were aware of yet, even when this was explored the case managers could not discuss the stages of adolescent development (Erikson, 1987) with accuracy and ease.

Table 4.2 Theoretical Knowledge

Theories listed by case Managers	
Organisational theory	Family focused theories
Case management theories	Resiliency, risk and protective factors
Adolescent development	Solution focused therapy
Models of learning	Multisystemic Therapy
Attachment theory	Conflict (resolution)
Community development theory	Trauma
Child development	Systems
Client centred practice	Narrative
Risk assessment theories	Critical Reflection

The profile quotes below provide another indication of the case managers struggle with theory.

My frame of reference is internal and intuitive. I understand the world and my experiences of the world by being as present to each moment as it unfolds. I know how to proceed in each situation by being present to my feeling in that moment and the actions my feelings are prompting me to take.

(Case manager profile)

I loosely follow a few social work theories including Structuralism in that I believe to a certain extent in Social Class Theory. I also believe in Structural Family Theory in that I believe all of the family subsets make the whole family story. I believe Maslow's Hierarchy of Needs is relevant especially to my client group. Also I see merit in Narrative Theory in hearing a client's story. I am somewhat ideologically driven and believe in truth, justice and access of opportunity.

(Case manager profile)

C. APPLICATION OF PROCEDURAL KNOWLEDGE.

The third theme the data highlighted during this phase was the case managers difficulty with procedural knowledge.⁷⁷ While procedures were seen as an informative source of knowledge the case managers struggled to cite which pieces of legislation and procedures guided their practice. The exception was sections of the *CYPA 1989* used regularly like *CYPA 1989 S. 63*, Grounds for protective intervention.

This lack of familiarity with highly relevant procedural knowledge was further indicated when Tool 4 (Appendix 8.3.4) required the case managers to bring to the focus group copies of policy, practice guides and legislation that formed procedural knowledge. The majority of them did not bring anything stating that they had been unable to complete the task due to lack of time (see later).

Being mindful of the need for collaboration the researcher decided to provide some of the policies and legislation to support further exploration. The

⁷⁷ The overview of the data provided in relation to the five areas of professional knowledge and Unconditional Care is provided later in this Chapter (see 4.6).

researcher drafted a document that aligned the principles of Unconditional Care with policy and legislation across both DHS and ICMSs. This draft document was shared with the case managers. When presented with this knowledge, the case managers stated it had provided helpful insight regarding which policies and legislation (procedural knowledge) held relevance to Unconditional Care. They stated that these procedures informed their practice.

- Collaboration; Working Together Strategy.
- Risk Management; Victorian Risk Framework (Since replaced with the BICPM).
- Family Focused Practice; The Enhanced Client Outcomes (ECO).
- Cultural Sensitivity; Aboriginal initiatives at DHS (Later enshrined in the changes to the *CYFA 2005*).
- Case Planning; Section 119 *CYPA* 1989 and the case planning project then underway in the PLU.
- Use of Secure Settings; the When Care is not Enough Report and policy for secure welfare services.
- Regional Contributions included The Adolescent Statutory Framework (Loddon Mallee), Adolescent Services Exemplary Practice Project (Northern), Early Intervention System (Gippsland), High Risk Coordination Project (Hume), Front End Response to Leaving Care (Eastern).

When the second reflective process for procedural knowledge was undertaken (Tool 5 Appendix 8.3.5) the group was more competent at matching the procedures against the relevant Unconditional Care principles. While this Tool was completed there was significant discussion led by the case managers regarding the issues involved with operating under strictly

applied legislation, policies and practice guidelines. Questions were asked included;

- Do these procedural guidelines accurately reflect the way we work?
- Discussion- Why and why not? What are the issues?
- How do they relate to the Unconditional Care principles?

This discussion was consistent with data the researcher had developed to document each of the principles and the relevant procedures. The consolidation of this data concurred with what the case managers had been saying-that some of the Unconditional Care principles appeared to be outside the current procedural guidelines available for case managers of HRAs. The following principles were difficult to align with current procedures; 2- relationship, 3 - consistency, 5 - persisting, 6 - acceptance, 14 - reflective practice and 16 defensible practice.⁷⁸ This highlighted the gap between what the case managers said they wanted to do in practice and the pressure of what the procedures demanded.

During the completion of Tool 6 (Appendix 8.3.6) one case manager said that she experienced a situation in which she was unclear about the use of authority (procedural knowledge). The case manager described a situation where the young person was requesting leave from placement over the weekend. The case manager was unsure about her capacity to authorise such a request without consulting the supervisor. In this discussion the case manager acknowledged the stress resulting from uncertainty about procedures.

Further evidence of this uncertainty arose during the discussion on defensible practice. Case managers stated that they could only soften the application of the legislation and the policy if they could demonstrate a clear

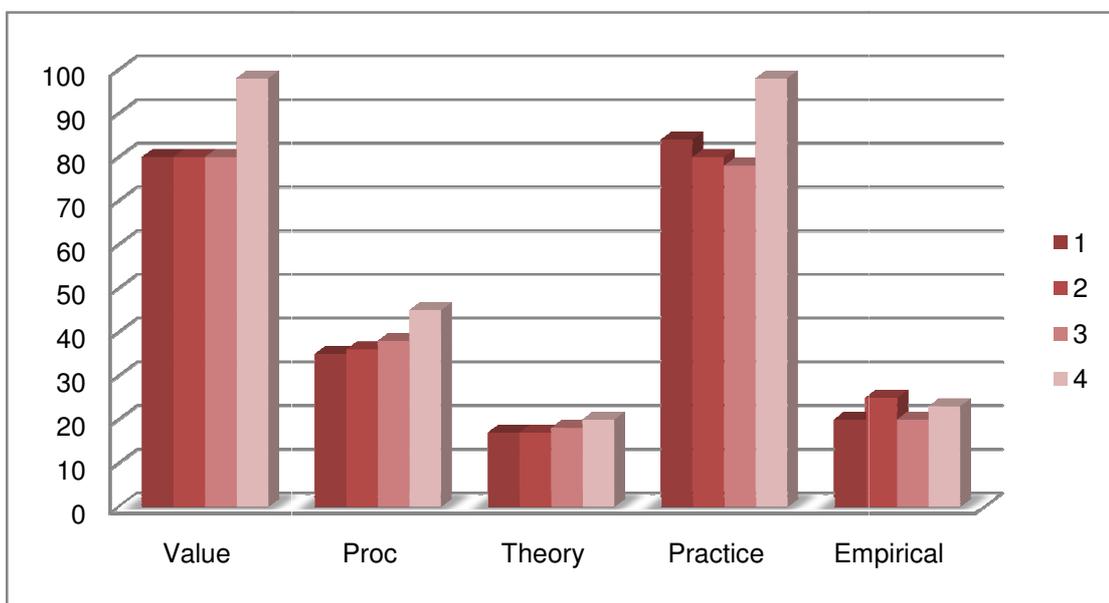
⁷⁸ This principle was added in the later phases of the research but was still identified as procedurally difficult.

defence or rationale for their action(s). An example was not seeking a warrant for a missing young person when the case manager's view was that the young person was capable of independent living and did not intend to return to Victoria.⁷⁹ Due to the young person having an order that demanded care and protection meant that a warrant had to be issued. Case managers indicated they were committed and interested in contributing to improvements to professional practice.

D. PROFESSIONAL KNOWLEDGE AND PRACTICE

The final theme discovered in this phase was that case managers based their assessment of Unconditional Care as best practice on personal and practice knowledge. This was also reflected in the reference group represented in figure 4.2 by the right-hand columns in each group of four. It shows the professional knowledge that the focus groups and reference group identified to support their position. The Y-axis represents the percentage of case managers support.

Figure 4.2 The Knowledge Grid



⁷⁹ Each Australian State and Territory has its own child protection legislation.

In figure 4.2 above 1, 2 and 3 represent regional focus groups and 4 represents the reference group. The findings show that the case managers were much clearer about the values and practice knowledge that inform their work and much less confident in articulating the procedural, theoretical and empirical knowledge. The reference group were more values-driven than case managers. The reference group reflected an overall deficit in naming the theory and empirical basis of their practice just as the case managers had done.

This representation of the use of professional knowledge by the case managers is entirely consistent with the literature in Chapter Two which reflects that theory does not tend to inform decision making and professional practice in social work and case work. See Chapter Five for further discussion.

During this phase Fook and Gardners (2007) model of critical reflection was used to 'unsettle implicit assumptions'. This resulted in the case managers exploring the following assumptions in order to link them to the tacit (silent) models they were using. Case managers highlighted the following assumptions underpinning and informing their practice:

1. Everybody works the way I do.
2. I accept all young people's need for support, why don't others?
3. Young people should be supported in attempts to make their own choices and then to take responsibility, unless their choices are in some way impaired by extenuating factors such as the impact of abuse, developmental delay or disability.
4. That the young person should be fully informed as to the role and mandate of protective workers and CSO staff and that this should form the basis of discussion with the young person on a regular basis.
5. That the case manager values the young person and is intrinsically interested in the provision of care which **does not** fluctuate based on behaviour.

6. At times the provision of Unconditional Care includes; secure settings, court intervention and behavioural intervention focused on treatment.

(p.44)

4.3.2 Phase Two Focus Groups 4-7

This phase ran from March to July 2001. The two themes that emerged from the data were: A. participation and completion of reflective tools, and B. case managers were committed to a set of common values.

During this phase the case managers indicated overwhelmingly that they had been practicing Unconditional Care at the commencement of the research and were continuing to do so. The principles which case managers were not using as frequently (Principles 1, 2, 4 & 6) still received high scores, except for Principle 2 which refers to the capacity to remake their practice based on evidence. In regard to this principle they said.

“not enough time to research and practice new EBP developments.”

“Sometimes I get so caught up in busyness that there is little time for reflection.”

“I’m not reading practice research.”

(Case managers Tool 12)

Time spent in this phase involved collaboratively examining the data collected to date. The case managers continued to make statement like “we like the 13 principles; we’re exploring the knowledge base, trying them out, and sorting out what they look like in action.”

A. PARTICIPATION OF CASE MANAGERS

The data from the second phase reveal a theme of participation, which began to decline. The case managers continued to identify issues of frustration around systems and workloads. Focus groups were consistently hampered by the case managers need to debrief. Assisting the case managers to reflect on their practice became increasingly difficult. A process of ‘catch up’ was

used by the external facilitator to assist the group to focus and build trust. This allowed the case managers time to discuss how they were 'travelling' and to 'deal with' issues so that reflection and inquiry could continue.⁸⁰

The case managers stated that they were not provided with any assistance or 'back fill'⁸¹ while they were attending focus groups. This was highlighted when one case manager on her departure from the research stated "due to the huge change of staffing in our program it was impossible for us to delegate any of my other tasks": hence, she was unable to remain involved in the research. A further reason for difficulties in participation was court attendances, which interrupted the research on a regular basis.

The following narrative shows that even though they were tired and stretched the case managers were still able to recognise changes in their practice as a result of the research.

The Narrative of a case manager

Approximately 2.5 years ago I was allocated a client who was 16 years old. The client had been in the system since he was a baby and was extremely damaged by the emotional, psychological and psychical abuse by his father. His mother had abandoned him at nine months of age and she remained unknown for most of his life.

This client demonstrated some significant behavioural difficulties. His IQ was 70 which indicated he was borderline IQ. Some of the behavioural issues included fire-lighting, daily marijuana use, alcohol usage, attachment and

⁸⁰ This was decidedly worse in the rural region where staff were rostered to the 'on call' system. This meant that case managers might have been out during the night conducting a protective investigation and still working the next business day. Some case managers made the effort to attend the focus groups citing the fact that it helped them make sense of their practice. The researcher was unsure about the impact of such extended work hours on the research. On the one hand it demonstrated trust and helpful process for the case managers but on the other they brought all the emotions and exhaustion with them which meant a lot of facilitation was necessary to move them beyond their immediate debriefing needs. However, the rural region ended up being the only region to complete the research.

⁸¹ The case managers used this term to mean there would be no reduction in their workload due to their involvement in the research. For example, no-one would cover their phone calls or deal with any of their cases other than by informal negotiation with their colleagues.

bonding issues and his very bizarre interpretation of events in the world. These interpretations were often seen as forms of psychosis.

I suppose my job was to ensure that his safety and well being were being looked after whilst in care, as well as linking him to other support services or educational/employment services. I began to work more intensely with the client given his father's suicide so I now see him at least 2-4 times per week. The difficulty about this relationship with the client is that I became too involved and felt the responsibilities for making sure he was going to survive too great. Also no other services were willing to provide support, because it was not easy to 'pigeon hole' him to particular services - but generally because he was the 'too hard' type client. Recently he was made ineligible for a DHS funded program for long-term protective clients to meet their accommodation needs after age 18. This client is now homeless and I feel burnt out.

Significantly this case manager noted a change in her practice during the research, and stated that she would be "more hard-line when liaising with other services, such as emailing, writing letters, not always accepting 'no' as the answer" (Case manager Personal Learning Log (1)). This was a positive step forward and demonstrates the change possible in action research.

B. COMMON VALUES OF CASE MANAGERS

This theme explores the data on personal knowledge of case managers according to the Drury-Hudson (1997) model (See Chapter Two - further discussed in Chapter Five). The finding showed that most of the case managers were committed to valuing young people; it was the one factor that underpinned their practice.

The values listed below were all named by case Managers as a part of Tool 13 (Appendix 8.3.13).

- Sanctity of Life - All human life is sacred and valuable.
- Acceptance.
- Respect – family value/ organisational value/professional value.

- Honesty.
- All people are - Valuable/ Worthy.
- Genuinely Wanting Best /Better Outcomes.
- All people are created in God's image – life consists in a journey of discovery and a movement, fulfilment of that image.
- Nothing is irredeemable – we all make mistakes and that these can be worked with, work with these each day.

(Comments documented by case managers in Reflective Tool 13)

The case managers adhered to a similar set of values that reflected the value of human life and the need to treat all people with respect.⁸² They were also asked to reflect on where these values had originated and how much these values had changed over the years. Most of them stated that their values had not changed over many years, yet they believed they were open to changing them.

During these discussions the case managers identified a consistent assumption, which was that "everybody works the way I do". The ensuing discussion reflected the idea that if a case manager had personal knowledge (values/ethical framework) that guided them toward honesty and transparency, they would then expect the same from other professionals. They expressed surprise and disappointment when other professionals did not act in the same way. This appeared to be the most significant area of professional knowledge that confronted them. Encountering a deficit in this area in other professionals often meant that trust was more difficult to develop, especially after times where one had made incorrect assumptions about another.

⁸² The researcher considered whether the project had appealed to case managers with these values as the title Unconditional Care may imply some of these values.

The data from Tool 2 demonstrated that the case managers gave the highest score to Unconditional Care principle 5 which is predominately based on values. It simply reads “Honesty, integrity, respect and flexibility.”

Finally, in this phase the groups commenced discussion on new Unconditional Care principles. These included concepts of resiliency, creativity and diversity. Additional principles were not formalised until the last phase.

4.3.3 Phase Three Focus Groups 8-10

The data in the final phase showed; A. systemic issues preventing Unconditional Care being implemented, B. Increased understanding of the evidence and knowledge underpinning practice.

At the completion of the focus groups 13 case managers had participated throughout, and six completed a full set of reflective tools. There was representation from two regions within the six who had completed the all the reflective tools.⁸³ These case managers were committed to the process and stated they were enjoying their involvement. They discussed openly the rigour and courage involved in undertaking the level of reflection required, including their successes and failures.

A. SYSTEMIC ISSUES PREVENTING THE IMPLEMENTATION OF UNCONDITIONAL CARE

Data collected showed the case managers believed they were prevented from practicing Unconditionally due to systems and legislation that did not encourage such an approach. They cited working in a non-reflective environment and lack of theoretical underpinnings being available to them to reflect upon their practice. The ICMSs were slightly better than DHS in terms of considering the adolescent response needed; this was evident in the different levels of training and support provided. The researcher sought to determine the inhibiting factors that prevented the implementation of

⁸³ Most of this phase was completed in one-on-one settings with the researcher or in groups of two or three.

Unconditional Care (Tool 14, Appendix 8.3.14). The responses from case managers included;

- Workload and throughput pressure imposed by DHS management and service contracts.⁸⁴
- Lack of Resources.
- Case managers with no desire to work with young people.
- Training that does not specialise in adolescent development.
- Systemic conflicts between CSOs, DHS and other service providers.
- Problems engaging young people including rejection from young people.
- Exhaustion and burnout due to lack of support and helpful supervision processes from management and supervisors.
- Little or no access to current developments in local and international research outcomes.

(Comments documented by case managers)

Case managers examined the ‘inhibiting factors’ (Tool 14, Appendix 8.3.14) which included internal and external factors that prevented them from practicing in an Unconditional Care manner. The internal factors related to the case managers direct actions, the external related to DHS and/or ICMSs.

Internal inhibiting factors raised by all were a lack of “stamina” and “time”. One case manager said that the “stress of the job eventually tires” and that “case managers lose hope in the system” (case managers, Tool 14). They talked about time for “reflection and reading being premium and not generally encouraged.” This was consistent with the researchers observations of the case managers capacity to engage in reflection over the course of the 12

⁸⁴ It is typical in funding arrangements for case managers to be impacted by ‘targets’ and other key performance indicators that can govern elements such as time spent with clients, services accessed and case allocation.

months. They nearly always stated that any reflection or reading they had done for the research such as the preparation of profiles had to be done in their own time. They did not feel supported or able to complete these tasks while at work. Comments from case managers who did not continue to participate in the research were similar.

The external inhibiting factors focused on systems and a lack of commitment from management to see these kinds of Unconditional Care principles supported and implemented. One case manager said “I have felt a subtle pressure about attending the focus groups and the time involved.” Case managers highlighted that their managers failed to fully support their attendance (the rural region was an exception to this).

One case manager stated that their manager had raised the importance of ‘professional distance’ between workers and their clients and that Unconditional Care did not support this professional distance. This report demonstrated to the researcher that the line manager did not understand the purpose of the research or the principles of Unconditional Care. Whilst it was the role of the researcher to continue to ensure line managers like this one were informed and supportive, it became too time consuming to meet with new line management staff of case managers across three regions.

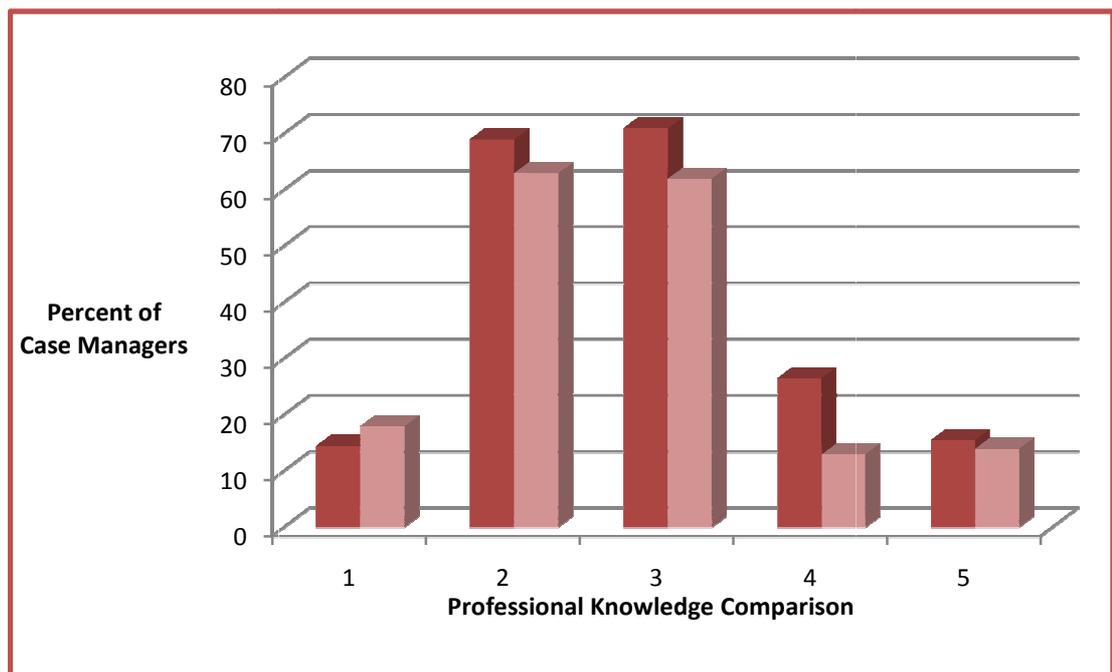
Given the inhibiting factors described above the case managers were asked to consider how Unconditional Care might be promoted and/or implemented. Tools on ‘strategies’ (Tool 15, Appendix 8.3.15) and ‘implementation ideas’ (Tool 17, Appendix 8.3.17) were used to assist with these reflections. The data showed that case managers believed an appropriate training and professional development strategy would be effective. They also stated that much of what they had completed during the focus groups could be used in group supervision processes.

B. INCREASED KNOWLEDGE UNDERPINNING PRACTICE.

The case managers generally believed that they were practicing Unconditional Care both prior to and at the end of the research. What changed for them was that they had developed a greater understanding of

the evidence and knowledge that underpinned practice. In this final stage of the research the case managers were asked to repeat Tool 9 (Appendix 8.3.9) the 'knowledge grid'. Figure 4.3 below provides a summary of the before and after scores on professional knowledge that the case managers provided on the first 13 principles. These findings include a higher knowledge score on theory and lower scores across the other five knowledge areas.

Figure 4.3 Final Comparison of Professional Knowledge



Legend

- 1. Theoretical Knowledge 2. Personal Knowledge 3. Practice Knowledge
- 4. Procedural Knowledge 5. Empirical Knowledge

First Application of Tool 

Second Application of Tool 

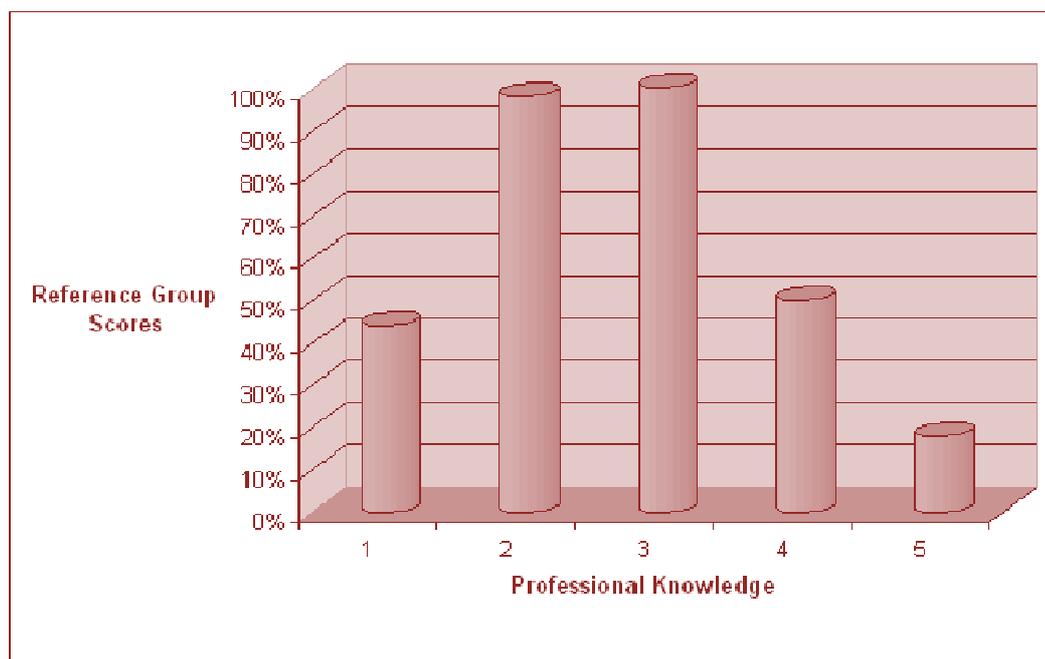
The researcher attributes this lower score to the trust that had built in the group over time. The case managers began to feel more comfortable and were more willing to state a deficit in practice. On this basis these lower scores are likely to be a more accurate representation of the professional knowledge associated with Unconditional Care.

4.4 The Reference Group

The role of the reference group was explored in the first meeting. It was clarified that their role included consideration of the case managers data and their views regarding Unconditional Care. The reference group members also examined change and how to measure it.

The reference group was (at times) conducted like a focus group. The researcher asked the reference group to complete several of the reflective tools that the case managers had completed. Figure 4.4 shows that reference group scores on the professional knowledge that informs Unconditional Care were similar to those of the case managers. Personal and practice knowledge was consistently the most informing source of professional knowledge.

Figure 4.4 Reference Group Scores



Legend – Professional Knowledge underpinning Unconditional Care Principles

1. Theoretical

2. Personal

3. Practice

4. Procedural

5. Empirical

The reference group was presented with an overview of action research methodology and its history along with its incorporation with the reflective approach to inquiry. The project was discussed in detail including the commitment of the case managers and the necessity to have them in attendance. The role of the reference group was to assist case managers to participate by communicating about the research in their region. This was achieved by one reference group member from an ICMS who encouraged and supported the involvement of case managers throughout the life of the research project. Many of the other members did not remain actively engaged in the process.

By the third meeting of the reference group, only two of seven initial participants were present. These participants were provided with a research and data collection update. The reference group did not submit theories for each principle and there were only three of seven profiles completed. The reference group spent time examining how each of the five professional knowledge areas was progressing. They completed the 'Values Brick Wall' (Tool 13).

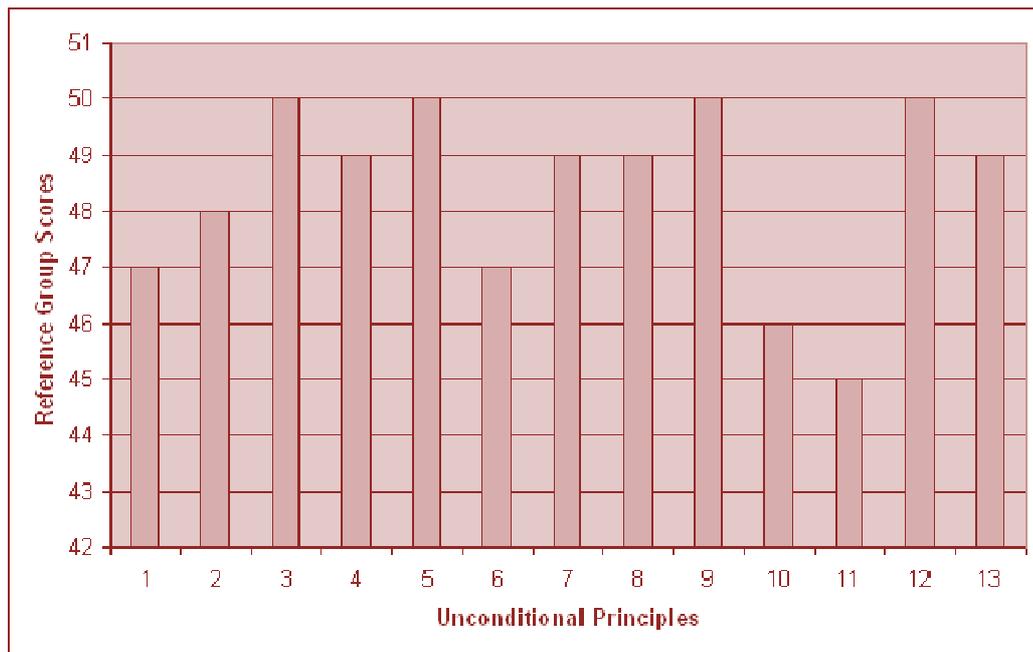
The reference group members were provided with the additional Unconditional Care principles 14,15,16,17 for comment. They supported the incorporation of the new principles subject to minimal intervention. The researcher added principle 18 during the analysis phase (see Chapter Five).

The final reference group was a brainstorming session about implementing the Unconditional Carer practice approach. The group discussed forums and/or days of reflection that would help to consider further what it means to practice Unconditional Care. It also discussed the need to continue clarification of workers understanding and giving them time for reflection. They suggested team building, networking and trying to implement some standardisation around practice.

Figure 4.5 shows the results of the final grid completed by the reference group members. There were five members present and scores were taken out of 50. A score of between 40 and 50 was considered high. Figure 4.5

shows the reference group was very supportive of all the Unconditional Care principles initially put forward with the lowest score being for Principle 11. This principle examines the responsibility of case managers to assist young people to participate and take responsibility, according to their appropriate developmental and emotional status.

Figure 4.5 Reference Group Scores on Unconditional Care



Legend – Unconditional Care Principles

- | | | |
|--------------------|------------------|--------------------------|
| 1. Continuity | 5. Honesty | 9. Significant Person |
| 2. Remake Practice | 6. Persisting | 10. Spirituality |
| 3. Relationship | 7. Acceptance | 11. Responsibility |
| 4. Consistency | 8. Developmental | 12. Joint Decisions |
| | | 13. Joint Responsibility |

The reference group viewed the Unconditional Care principles similarly to the case managers. There were also similar concerns regarding participation and attendance which were most significantly impacted by the instability of the staffing at DHS and the researchers decision to leave DHS during the we months of data collection.⁸⁵

⁸⁵ It appeared that membership in the reference group may have been motivated by remaining up to date with (and contributing to) current DHS work. When the researcher and the adolescent practice

4.5 Conclusion

This chapter has provided an overview of the findings from the research. It has shown that the case managers supported the application of the Unconditional Care principles. It has shed light on how an action research method can be used to explore concepts of professional knowledge that can be difficult to articulate. The profiles were able to draw commonalities and links between the case managers and the reference group members that influenced the way they view practice. The researchers journal was useful in providing reflections regarding the challenge of assisting case managers engaged in the research process.

The discussion presented in this chapter shows that in most cases the case managers' support for an Unconditional approach was unqualified. Nevertheless, knowledge that informed this view was difficult to substantiate from an empirical positivist perspective.

framework development was ceased by DHS this impacted reference group members enthusiasm for the research. At the time it has been considered that this research may have been able to contribute to the work on the adolescent practice framework that DHS was involved in (although subsequently never appeared to complete).

CHAPTER FIVE:

A BRIDGE ACROSS THE SWAMP

Reflection allows for the practitioner's own theory to be developed directly from her or his own experience.

(Fook, 1998, pp. 6-8)

5.1 Introduction

The findings in this research confirm that case manager's ideas regarding best practice can be developed through critical reflection and are robust when compared with the literature. Fook's (1998) substantial contribution follows on from the work of Schon (1984) who argued that the articulation of 'what we do, can shed light on 'why we do it', therefore illuminating both practice (action) and knowledge.

This chapter describes the results of analysis which brings together the two goals of action research, to encourage solutions through action and to provide a contribution to knowledge (Peters & Robinson, 1984; Dick, 1997; Cherry, 1998; Stringer, 1999; Swepson, 2000). Accordingly, this chapter is structured in two sections. The first section presents the two action outcomes. The second section examines two contributions to knowledge.

This discussion draws on the reflective tools and repeated themes in the data. It does not discuss the research tools in chronological order, nor does it analyse each of the research tools individually. This appeared to be the most effective way to present the overarching findings for discussion.

5.2 The Action Outcomes

This section presents the two outcomes where the action of examining and testing the Unconditional Care principles resulted in action: The two outcomes were:

1. The case managers were able to finalise the set of Unconditional

Care principles to inform their practice approach.

2. The case manager's capacity to apply critical reflection showed improvement. This created change in their practice and helped identify the gaps between their espoused commitment to Unconditional Care and how they were practicing it.

5.2.1 The Finished Unconditional Care Principles (Action 1)

This research produced a finished set of Unconditional Care principles; that were tested, explored and informed by the case managers. It combined the 13 initial principles introduced in Chapter 1 with five new principles that were added throughout the course of the focus groups.

The research sought to define Unconditional Care as a standalone practice approach in contrast to its existence as one of the ten essential elements that inform Wraparound (see Bruns, et al., 2008; Bruns & Suter, 2010). The case managers successfully explored this approach to professional practice when Unconditional Care is applied as the central tenet. The final principles were a response to the Victorian context and are considered applicable to a wide-ranging audience working with high risk young people.

This research demonstrated that Unconditional Care is an effective approach because it reflects the literature and in many cases represents well-known best practice. There were a number of systematic complexities in the service system which mean that whilst the case managers supported the principles their capacity to implement them was restricted.

Data from the case managers demonstrated significant support for five principles (of the initial 13). These were the concepts of 'Relationships' (Principle 3), 'Honesty' (Principle 5), 'Significant Persons' (Principle 9), 'Joint decision making' (Principle 12) and 'Hardline decision-making' (Principle 13). Case manager's support for all these principles was confirmed via Tool 2 and 9. Each is briefly discussed here.

The first principle that case managers believed was critical stated that relationship's should be embedded in practice. This focus on 'Relationship'

(Principle 3) relates to the connection between the case manager and the young person and was often referred to as foundational. The strength of the relationship between client and case manager as an indicator of positive outcomes is well established. Cohen et al. (2009) highlighted that relationships have been perceived by clients in mental health to be the most crucial determinant of whether they had a positive or negative experience (see also Bruce, et al., 2009; Stanton, 2007 in Sprinson & Berrick, 2010, p. 79).

Nevertheless, this focus on relationships with HRAs requires careful consideration and does not imply that the relationship would proceed without challenges. The data from case managers in this research stated that whilst the formation and maintenance of relationships was important, it was often tumultuous, tenuous and stressful (Tool 13) for both parties.

Honesty (Principle 5) was the second principle strongly supported by the case managers. It has been a long standing component of values, ethical codes (AASW, 1999; YACVIC, 2007) and professional practice (see O'Connor, et al., 1998; Drury-Hudson, 1997; Hepworth, et al., 2010). The case manager's highlighted honesty as a critical part of their interaction with clients and reflected the ongoing importance of values in case management. This principle is discussed in greater detail below in the contribution to knowledge area.

The third widely held principle focused on the importance of significant people in a young person's life (Principle 9). This was informed by the attachment literature which highlights the link between healthy development and carers who provide love and nurture (see Bowlby, 1989; Perry, 2002; 2001; Wilson et al., 2003; Schmied, et al., 2006, p. iv; Cassidy, 2008; Sprinson & Berrick, 2010). Case managers agreed that practice which facilitates relationships between young people and caring people assists them to progress toward stability and recovery from trauma. However it is important to note that the case managers also stated that this concept was difficult to practice.

The fourth principle seen as a cornerstone of practice by the case managers related to the participation of young people in decision making (Principle 12). This concept is interconnected and relates to approaches which all presuppose that when given the opportunity, young people will enjoy contributing to and planning their own future. Further, this contribution enhances their motivation to stay engaged in the process of care and protection provided by the State. The work of organisations like YACVIC (2007) and the CREATE Foundation (2000) have long advocated this point of view. Corney (2004) and Fook (1996) also provide insight into the long history of empowerment and emancipation in youth and social work as critical.

The fifth most supported principle was for case managers to make 'hard line decisions' (Principle 13). By using the term 'hard line' case managers were referring to decisions that the young person may not voluntarily agree with. This position taken by the case managers to actively support 'involuntary' strategies (when all other options are exhausted) probably reflects the statutory nature of the work. This is in contrast to the literature from the youth work discourse where the prominent view is that young people should not be 'controlled'. This is because the perception of whether or not a young person needs to be 'controlled' can be based on factors such as class, gender and race (see Beasely, 1991; Bessant, 1991; Carrington, 1991; Collard & Palmer, 1991; Irving, 1991; Sherington, 1991; Wyn, 1991 in Kelly, 2000a, p. 463). There is also a discourse on case managers' and policy makers' dilemma about whether to perceive their clients as 'children in need' or 'risky youth' (as cited in Blyth et al., 2007, p. 10; Dwyer & Miller, 2006).

Nevertheless, two points seems clear. First those decisions regarding control or containment strategies always follow the exhaustion of other options,⁸⁶ and second that neither a 'care' nor 'control' approach used alone with the HRA population is effective; a combination of both approaches is needed.⁸⁷

⁸⁶ Consistent with the United Nations Convention on the Rights of Children (CROC).

⁸⁷ Case managers appear to be operating from a medical model focused on the damage trauma causes, rather than a sociological model which is interested more in concepts like class and power.

The idea that practice with involuntary clients is enhanced by the use of restrictive interventions and containment, holds relevance due to the complexity of the behavioral manifestations of trauma. The case managers in this research acknowledged the difficulty of this dilemma (via Tool 3). The data highlighted their desire to 'help' young people rather than impose sanctions or containment and that the dualism of the 'victim'/'threat' paradigm continues to plague the decisions regarding how to protect and promote their welfare (see Hill, et al., 2007). A further discussion related to secure care and containment is presented later in this chapter (see 'contribution to knowledge').

ADDITIONAL PRINCIPLES

In addition to these five original Unconditional Care principles receiving support, four principles were added by the case managers which further developed the concept of Unconditional Care. It became clear that these additional principles reflect the ongoing systemic problems of the Child Protection system (see Brouwer, 2009; Baillieu & Wooldridge, 2010). The addition of these principles helped address the case managers desire to produce a set of principles (theory of practice) that applied evidence and contributed to the collection of knowledge. These new principles were developed towards the end of the 12 months of focus groups. A process of discussion and reflection was used (Learning Logs 1 & 2, Tools 6 & 12). Consultation with the reference group also assisted in the development of these ideas for additional principles.

The first of these four additional principles was 'The recognition that acting in a protective manner is the joint responsibility of service providers and case managers from all service sectors and the most basic form of caring for a young person' (Principle 14). This principle reflected the ongoing commitment to the protection of children as belonging to the whole community. This has been a long-standing theme of government which has been present in policy responses that highlight joint strategies and the 'earlier intervention' of Child

FIRST (see DHS, 1999b; 2000h; 2004; 2007k). Yet, this principle also embodies the frustration of case managers who consistently request assistance for their clients such as mental health services, placement services, educational and other services only to receive an inadequate service response. It reflected their ongoing desire for continued collaboration and service delivery (see Tomison, 2000; NCTSN, 2003; Wierenga, et al., 2003; Docs, 2006; DHS, 2006b; Brouwer, 2009).

The second principle that case managers added to the approach was “The family is the foundational context in which we work with young people” (Principle 15). This reflected the case manager’s support for inclusive practice, and the importance of attempting to connect family members and young people. It highlights the value of family systems as being critical and linked to the application of attachment theory to practice (see Allen & Land cited in Cassidy, Shaver, 1999, p. 328; DoCS, 2006).

Following on from the idea of family was interest in community. Principle (16) stated that ‘Connectedness to community including education is a stabilising and supporting factor.’ Here the case managers were mirroring Rapp’s (1992; 1994; 1996; 2006) idea that the community is an ‘oasis’ of resources for case work. Community forms the central place where young people are connected, strengthened and over time recover from the harm to which they have been exposed.

The fourth Principle (17) added by the case managers related to the use of ‘defensible risk practice, which relies on a balance of statutory responsibility and the innate nature of risk that adolescent’s experience.’ This principle appeared to be a reflection of the pressure that case managers felt, in being asked to provide evidence for their practice. The literature in this area underscores the need for case managers to utilise evidence in practice and has highlighted the move in this direction for over a decade (see Webb 2001; Blackshaw & Ritchie-Wearn 2001; Hoagwood, 2005; Plath, 2006; Walker & Gowen, 2007; Kirk & Kolevzon, 1978 in McNeil, 2006; Gilgun, 2005 in Furman, 2009, p. 82). This is discussed later in this chapter as a problem for

case managers who utilise interventions and practice that may not meet a required level of evidence.

The final Principle (18) was added by the researcher based on the profiles of the young people and discussion with the case managers which highlighted the damage that trauma causes (see Van Der Kolk, & Streeck-Fisher, 2000; Perry, 2002b; 2006; 2006b). The Principle (18) states 'The application of trauma-informed, age appropriate practice contributes to the amelioration of the effects of harm.' This principle was also informed by the significant literature on trauma and its relationship to the development of interventions (see Perry & Pollard, 1998; Bremner & Vermetten, 2001; Read et al., 2001; Teicher, 2003; Bremner, 2003; Frederico, et al., 2005; 2006; 2010; Perry, 2006b; NSCDC, 2005; Stringer and Berrick, 2010). At the time the focus groups were held this literature on trauma was not actively accessed in Victoria. It was only more recently that the researcher became aware of its prominence and importance.

DIFFICULTY IMPLEMENTING ALL PRINCIPLES

There were four principles which consistently scored slightly lower levels of support (see data from Chapter 4.3.1, Tools 2 & 9⁸⁸). The case managers considered that these four principles were difficult to implement. Inclusion of these principles in the final set could be attributed to the case managers' belief that the principles demonstrate best practice if they could be achieved.

The first principle to show a lower score was Principle 1 'Continuity of case manager wherever possible.' The case managers voiced concerns regarding the amount of times HRA case management was changed between workers. Given that the child protection system operates on a three-tiered model of intake, response and investigation, there are inherent changes of case managers within the system (see DHS, 2007j). When this is added to other staff changes due to retention and transfer between regions, it became clear

⁸⁸ Tool 1 required the case managers to complete a reflective piece on their practice, but this was deliberately not collected by the researcher as a way to establish trust in the groups. It was used for discussion purposes only.

that continuity was difficult to achieve.

The second principle with lower scores was Principle 2. "Case managers should demonstrate the ability to re-make personal work practice in line with evidence based practice and developments in the field. Practice should be driven by the reflective process." Lower scores appeared to show that case managers were not provided with time to reflect. They were also generally uncomfortable naming and discussing the theoretical knowledge they were using (as shown by the 'Theory Book' exercise undertaken during the research). They were still committed to reflection and implementing knowledge into practice, but needed more time to conduct reflection. Tool 19 noted that case managers had experienced personal learning and developed their own theory of practice based on Unconditional Care throughout the research. This was consistent with the literature on critical reflection (see Ruch, 2005; Fook, et al., 2006) and evidence based practice (see Webb 2001; Blackshaw & Ritchie-Wearn 2001; Hoagwood, 2005; Plath, 2006; Walker & Gowen, 2007; Kirk & Kolevzon, 1978 in McNeil, 2006, p. 147; Gilgun, 2005 in Furman, 2009, p. 82).

The third principle with less support was Principle 4 "Consistency of care within the placement system." While considered important the case managers were concerned about the system's capacity to provide consistent placements. The profile data from the young people discussed in Chapter Four confirmed that many of the HRA population have had over five and up to 30 placements during their case management period. This need for stability is voiced by DHS in the *CYFA* 2005 and other DHS documentation (see DHS, 1997b; 1998; 2007f; 2007k) and is also echoed by Tilbury and Osmond (2006) and Sprinson and Berrick (2010).

Finally, Principle 6 'Persisting in the face of everything no matter what,' received lower scores. The case managers stated (See Tools 18 & 19) that while they wanted to persevere with HRAs, they often felt unsupported by the system. This doubt regarding the capacity of the current system is consistent with the lack of investment in the child protection workforce (see Auditor-General of Victoria, 1996; Brouwer, 2009). The ongoing relevance of this

principle focused on persistence was echoed the National Wraparound Initiative (NWI). They reaffirmed the value of persistence when it supported a move for the Wraparound element to return to the concept (and term) Unconditional Care rather than persistence on its own.⁸⁹ The general consensus reflected a commitment to remaining involved and that not withdrawing services and support for HRAs is an essential part of any practice approach.

The finished Unconditional Care principles were put forward as a best practice approach to case management. The case managers in this research clearly articulated concerns regarding the capacity of the child protection system and funded ICMSs in Victoria to support and/or implement Unconditional Care. Whilst exploration of the service system was not within the scope of this research, it is worth observing that the Wraparound system would provide the most effective structural (systemic) support to deliver Unconditional Care in professional practice (see Chapter Six for further discussion).

The implementation of the *CYFA 2005* enacted in April 2007, provides a legislative beginning for supporting case managers in both Child Protection and ICMSs to practice in an Unconditional manner.⁹⁰ However, it does not provide an ongoing mandate or the resources required.

5.2.2 Critical Reflection Helps Identify Gaps in Practice (Action 2)

The second area where the action of examining Unconditional care resulted in an outcome related to an increase in the case managers critical reflection skills. This assisted them in identifying when they were practicing Unconditional Care and how they could develop strategies for change. There

⁸⁹ As stated earlier, in 2007 the NWI Advisory Group surveyed its members on the issue of whether the term Unconditional Care should be reinstated into the Wraparound model to replace the concept of persistence. The results showed that persistence did not adequately reflect the sentiment and benchmark of Unconditional Care; on that basis it was returned to the official Wraparound essential elements. For further information see the Resource Guide to Wraparound by Eric Bruns and Janet Walker and the NWI Advisory Group.

⁹⁰ The specific procedural sections of the *CYFA 2005* were detailed in the latter part of Chapter Four and relate to the emphasis on stability.

were a number of areas that influenced this outcome. They are discussed below.

THE USEFULNESS OF THE CRITICAL REFLECTION MODEL

The first was the inclusion of Fook and Gardners (2007, p. 44) model of critical reflection which was a key consideration of the focus group design. This model highlighted the importance of learning through dialogue, individual reflections and listening to multiple perspectives. The focus groups employed two processes based on this model, firstly, to 'unsettle implicit assumptions,' secondly, to examine how practice might change as a result of the new awareness.

Following these two process the case managers discussed their practice by attempting to make their internal knowledge and thoughts external (see Osmond, 2005a, p. 881). This process of articulating knowledge that informs decisions is well known. It has the capacity to transform unconscious knowledge to conscious knowledge (Schon, 1983, 1995; Newman & Hall, 2002; Fook, 1996; 1998; 2000a; 2007; Osmond, 2005b). The Case managers appeared to have a starting point similar to a mental map with regard to how to act in practice, but in order to change their practice they had to make these 'maps' explicit and/or record them (Agyris & Schon, 1996). To a large degree the case managers believed that Unconditional care represented their own practice maps. They then set about reviewing and comparing them.

The case manager's skills in reflection were also developed due to the difficulty of the task. It is known that much of what is done in practice is deeply rooted in procedures, values and emotions (see Schon, 1983; Cohen & Bacdayan, 1994; Winter, 1994). This meant that the case manager's explorations of their practice were often intertwined with emotions. The data from the researcher's journal (see Chapter 4.2) shows that at first the case manager were unable to acknowledge deficits in their own practice. This improved over time as shown by the findings (Profiles, Tool 14 & 19). The improvement enabled them to articulate and refine Unconditional Care, their

own practice and explore gaps in the service system. This was consistent with Fook (1998, pp. 6-8) who argued that reflection supports case workers in the development of their own theory of practice.

The researcher was particularly interested in exploring the practice which case managers found difficult to explain. For example, they appeared to have implemented robust, effective relationships with their clients (see profiles), but were then unable to cite in-depth theory or professional knowledge as to why they thought relationships were so important (See Tools 6 & 12). This intuition related to relationships influencing their practice and is often referred to as 'tacit' or 'implicit' knowledge. Meinel (2001, p. 494) supports the articulation of tacit (silent) mental models as key factors in creating new knowledge.

The enhanced ability to reflect also meant that some of the case managers became more confident and were able to shift the 'problem' to the system. This meant that they were able to separate their own efforts at best practice from the limits of the service system. As Fook (1996, 2000a) highlights, one of the most effective ways of dealing with practice complexity is the use of reflection and theory development. It provided the case managers with a method of recording and discussing what they were doing while they were involved in the research.

CRITICAL REFLECTION EXPOSED THE GAP BETWEEN THEORY AND PRACTICE

A further area where the benefit of increased reflective skills had impact was that case managers recognised differences between their espoused theory and their theories-in-action and were able to begin addressing this by implementing changes. The case managers professional knowledge informing their use of Unconditional Care did not increase over the period of the research, however, their level of self reporting and understanding appeared to improve (see learning logs Tool 6 & 12).

They were able to recognise and address the concern that their stated practice wasn't always reflective of their actions. Argyris and Schon (1974) showed that when a practitioner is asked about how they might behave under

certain circumstances, they would give their 'espoused theory' for that situation. However, what tends to happen is that what the practitioner actually does in the situation known as theory-in-action (Agryis & Schon, 1974, p. 6) and may not reflect their espoused theory.

The data showed that the case manager's espoused theory was to support the Unconditional Care principles (Tool 2 & Reference group). Yet, their theory-in-action (practice) was limited by the difficulty they experienced implementing all the principles. Their practice reflected there was a gap between what they wanted to practice (espoused) and what they actually achieved (theory-in-action). For example, Principle 1 which states "continuity of case manager wherever possible" was seen as best practice by the case managers, but, in data such as the young person's profiles, it was clear that most HRAs have very little continuity and that the systemic barriers are significant.

As time progressed and case managers became more aware of this gap between their ideal (espoused) practice and their actual practice (theory-in-action) it also became a source of distress for them. This resonates with the work of Lange et al., (2006, p. 72) who drawing on Agryis and Schon (1974), argued that a difference between espoused and actual practice (a gap) can be linked to a decrease in professional power and self-esteem and could potentially lead to the professional's demise.

In specific reference to Unconditional Care there were a number of principles (1, 2, 3, 4, 9, 10 & 14) that the case managers (espoused theory) represented. In one instance the case managers stated that their practice reflected Principle 9 involving "Commitment to identifying and/or helping to provide a significant person in the young person's life," but when practice was discussed, it was clear that their practice (theory-in-action) did not reflect any level of follow up or planning related to significant people in the young persons life. Additionally, more than half of the case managers (Tool 2) indicated that they practices with a focus on significant people (Principle 9) in mind. When asked later in the research to rate their use of the principle, it again scored very high support from all the case managers (Tool 9 & 11).

This dilemma of a gap between espoused theory and practice was further compounded in that the case managers were aware of the importance of a significant person being a necessary part of the therapeutic process for HRAs as supported in the literature (Allen, et al., 1999, p. 328; DoCs, 2006, p. 1). This literature also shows the critical role of attachment figures, significant others and relationships. It is also clear that without these relationships, a young person may fail to experience healthy developmental processes (Bowlby, 1969; 1988; Perry, 2002, p. 95; 2001; see also Dwyer & Miller, 2006; Golding, 2006 as cited in McClung, 2007, p. 6; Cassidy, 2008).

The key question is “How is this gap closed?” In this research, the answer to how to close the gap was addressed by using the professional knowledge model (Drury, 1997, p. 39). This provided a useful strategy for assisting case managers to recognise gaps in their professional knowledge and practice. It allowed time to reflect and discuss possible changes and solutions.

This research has taken a first step to identify the case managers’ ideal (espoused) practice, which is aligned with an Unconditional care approach. Taking the second step of providing the systems and the resources so that case managers can implement many of the principles is a much larger question that will require changes to resources as well as significant structural change.

CHALLENGES IN APPLYING CRITICAL REFLECTION

Whilst the case managers were positive regarding the need for critical reflection there were a number of barriers identified. The case managers acknowledged in Tool (19) that the process of coming together to reflect on practice could be destabilising and foster a feeling of vulnerability. This was due to the realisation that their practice may be limited in certain areas (see Chapter 4. 4.3.b) and that this disclosure may take place in a group setting, where trust may not have been established. This issue of vulnerability produced a reluctance to reflect on professional practice and is consistent with the literature (Durgahee, 1997, p. 140; Raelin, 2002; Thorpe, 2004; p. 340; Bennett-Levy, et al., 2007).

It was vital that the focus group environment was safe so that open and frank discussion between the case managers could occur. This appeared to be achieved although unfortunately a number of case managers left the research due to feeling unable to resolve this vulnerability (see Chapter 4).

A second challenge that case managers faced in implementing critical reflection during the research was workload. Attending the focus groups and setting aside time for critical reflection appeared to be impossible even though they had supported Principle 2⁹¹ which refers to its importance. This struggle with workload existed not only for the period of the research, but appeared to be a broader ongoing concern. Cowie and Saucer (2002) acknowledged this issue, as has the Ombudsman (Brouwer, 2009a). A non-reflective environment has also been linked to a low level of compliance with practice standards (see Brouwer, 2009a, p. 14, p. 27).⁹²

The idea that reflection is a time consuming task is also highlighted by Fook (2000) who states there are many voices of dissent who argue that reflection flies in the face of current managerial and cost cutting trends.⁹³ The researcher believes it would be important to assess how much difference a reflective culture would make to decisions. It could have impacted on a number of areas given that recruitment and retention issues have remained a consistent challenge for DHS over a number of years (see Gibbs, 2001; Hodgkin, 2002; Bromfield & Ryan, 2009; Brouwer, 2009, 2009a).

This lack of time to reflect was also highlighted by Morton and Pead (2000, p. 24) who argued that practitioners are faced with life threatening behaviour which can provoke high levels of anxiety, defensive practice and crisis driven responses. In this environment the need for reflection and self care seems critical (see DHS, 2009).

⁹¹ Principle 2 states Case managers should demonstrate the ability to re-make personal work practice in line with evidence based practice and developments in the field. Practice should be driven by the reflective process.

⁹² It echoes the Ombudsman's report which discussed the increase in workload for case managers as a result of the new client management data management system (Brouwer, 2009, p. 27).

⁹³ DHS appears to encourage critical reflection with publications such as Reflect (DHS, 2008b) which attempts to encourage case managers to practice reflectively. However, beyond this there seems to be little that evidences a reflective culture.

A third barrier for applying critical reflection is the impact of reactive practice. The research showed that the case managers often intend to work on long term outcomes for young people, but felt they were prevented by systemic and resource issues. This contributed to Principle 17 on defensible practice being developed. It also highlighted the stress involved when case managers cannot reflect. It appears to impede longer term sustainable interventions. In other words, case managers who are placed under enormous workload pressure have little choice but to work in a short sighted way (even when their intentions might be otherwise). The profiles of the young people showed intent to undertake longer term planning such as stability (see Chapter 4.4.2).

It appeared to the researcher that the case managers felt safer when they could defend and argue for their actions and take proactive action. This pressure for case managers to defend their practice is evident in the literature from DHS as far back as 1988 (Parton, 1985; Sandor, 1988; DHS, 2000d, p. 8). DHS does not appear to actively promote defensible practice; rather it supports the application of evidence into practice (DHS, 2000g, p. 1; DHS, 2003b, p. 3; DHS, 2004b, p. 3; Geary, 2007, p. 85).

The researcher believes this non reflective culture has evolved over time and is acknowledged by Minister Neville during an interview in November 2009 following the Ombudsman's report cited above (Brouwer, 2009; 2009a). Ultimately, case managers do not welcome being over scrutinised by their line management, yet recognise the need to provide an evidence base for their decisions and to work in planned ways. Case managers attempts at evidence based practice are not fully resourced and may result in practice that is reactionary and defensive rather than planned.

5.3 Contributions to Knowledge

This section reviews two areas where a contribution to knowledge related to professional practice with HRAs was made. A contribution to knowledge involves extending the knowledge already known, developing the current understanding and applying ideas. They are organised into sub themes. These were:

1. Unconditional Care with HRAs is informed by a balanced application of care and control which operates on a continuum.
2. Professional knowledge and evidence inform both the context and the application of an Unconditional Care approach and is underpinned by professional values such as hope, persistence and relationships.

5.3.1 Unconditional Care and Control in the Risk Environment

This area relates to the discourse on care and control and how it informs approaches to HRAs. These two aspects of case management were acknowledged by the case managers as being intrinsically important. The data from the profiles and Learning Logs (Tool 6 & 12) shows their attempts at practicing in caring, yet at times controlling ways. The research confirms that case managers prefer to work in ways that are focused on the provision of a nurturing and caring relationship but that when necessary they will move into a more controlling mode of practice.

The case managers utilise strategies such as secure care, containment and legal interventions like warrants, but only when all other options are exhausted. This is reflected by Trotter (1999; 2004) who maintains that coming to terms with the dual role of legalist (control) and therapist (care) is one of the greatest challenges for case managers and that they often find it easier to focus on one to the exclusion of the other. This notion of working at the care end of the spectrum rather than control was observed in Phase one of the research in Tool 3 where all but one of the case managers viewed themselves predominately as helpers (care) rather than protectors (control).

Trotter (1999) discusses the difference between investigators (control) and helpers (care) and highlights that the most effective practice usually employs a balanced approach and does not lean more toward coercive protection or overfriendly helping. The need for case managers to move across both roles is consistent with the 'ideal' view of practice (Lange, et al., 2006, p. 71-77). In other words case managers who can display both engagement with clients as well as achieve a clear set of boundaries (that at times include constraining strategies) are the most effective in their practice. However, the

literature does not appear to recognise the difficulty and complexity involved in such an approach.

There were two key factors identified that encouraged case managers practice toward the control end of spectrum. These were;

- The Impact of trauma on the behaviour of young people, which leads to difficulty engaging in caring relationships.
- A lack of stable environment in placement and difficulty accessing services, which leads to a lack of trust and the complexity and dysfunction of the service system.

IMPACT OF TRAUMA

In exploring the first key factor in case managers applying more control than care, the research substantiates that practice is substantially impacted by the behaviour of the young people who have been exposed to abuse, trauma and an absence of secure attachment. Further, the experience of multiple rejections often translates into young people being incapable of responding to any demonstration of care. Wilson et al., (2003, p. 998) states that any absence of relationship may create difficulty in engaging a young person. Further, that case managers face a struggle in knowing how to build and manage these relationships in appropriate ways. This difficulty in engaging the young person often necessitates the use of control strategies because the young person will not respond to demonstrations of care.

Evaluative work such as Tomison (1999b, p. 2) highlights that good outcomes in Child Protection are associated with the quality of the relationship between the professional and the family. Therefore, finding ways to strengthen relationships based on care remains an interest for future research.⁹⁴ The consideration of trauma theory (see Perry, 2001a; 2002; 2006; 2006b; Stringer & Berrick, 2010; Frederico, et al., 2010) will also assist.

⁹⁴ Relationship based practice is increasingly a focus of research and is set as a priority for Child Protection. See Australian Institute for Family Studies.

O'Conner et al., (1998, p. 75) expand on the nature of caring relationships when they state that helping (or caring) relationships are not friendships. They state that self discipline is critical in helping relationships. It is the case manager's intelligent use of emotion that should be directed to benefit the young person. DHS appear to have started promoting an approach that is interested in case managers ability to become self aware (see DHS 2009).

The case managers expressed concern that when they use a containment strategy (after all care options have been tried) what is intended to create safety is not always experienced by the young person as a process that leads to their wellbeing. This issue of caring for young people in a professional context is informed by the ideas of Fook and Gardner (2007, p. 33) who suggest that there can be differing sets of assumptions about the approach being used and the supposition of the case manger (see also Rose, 2000). For example a case manager may intend an action to be caring (like secure care in order to prevent a young person from suicide) yet be interpreted by the young person as problematic and restrictive.

The combination of young people who are unable to respond to demonstrations of care and who have a capacity for difficult and challenging behaviour, means that case managers are often placed in the position of needing to exercise control in order to keep the young people safe. The work of Bloom (1999, p. 9) summarises Van der Kolk and Greenberry (1987) which shows that young people can suffer 'addiction to trauma'. This addiction relates to their inability to tolerate calm and often results in antagonising others until the stress levels are high enough for them to achieve some degree of internal equilibrium. Case managers believe that such extreme behaviour often leads to their use of power and control in order to 'protect' the young person. Case managers refereed to this levels of discomfort in doing this (see Chapter 4).

Similarly, the case managers' verbal descriptions of the difficulties they faced in engaging the HRAs to conduct the research interviews showed that whilst the formation and maintenance of relationships was important, it was often tumultuous, tenuous and stressful.

Whilst the case managers supported Principle 13 on 'hard line' decisions they agreed with the CROC that Secure Services should only be used in limited ways and for limited amounts of time (see Walker, et al., 2002, p. 7; Goldson, 2007; CROC; UN General Assembly 1989, Article 37b; as cited in Hill, et al., 2007 p. 106). It can be hard for some case managers to use containment, as one case manager said in reference to Principle 13⁹⁵, "some workers are not comfortable with this" (Tool 14). Whilst the case managers were not specifically asked to document responses to their use of secure care, they grouped many difficult decisions together, with admission to Secure Welfare being one of the most challenging to manage.

The case managers appeared to practice on a scale of interventions which was based on caring options and moved toward containment when necessary. This reflects Liscombe's (2006) idea of a continuum as the most helpful way of conceptualising the application of care and control in professional practice. This means the case manager would engage the young person with actions that foster trust, respect, warmth and stability. However, when the young person shows that they are unsure of how to respond to this demonstration of care or reject these actions, the case manager may then move steadily up the continuum to a more controlling relationship and interventions with the young person.⁹⁶

LACK OF STABLE ENVIRONMENT

The second key factor in case managers applying control rather than care relates to the system not providing stable environments and/or access to treatment for HRAs. In this research the profiles of the young people

⁹⁵ Principle 13; The competency to make and implement hard line decisions when necessary and in line with the client's best interest and statutory standards.

⁹⁶ As the interventions and relationship have certain restrictions and consequences placed upon them they move up the continuum. This may also include the use of warrants and eventually secure care and or breaching youth justice orders leading to incarceration and/or involvement by psychiatric services. The intricate decisions involved in recognising and interpreting the young person's behaviour are pivotal to assessments that are accurate and that can develop case planning decisions that respond to the need for treatment. Systemic distractions such as many changes of case managers and/or residential placements make these assessments and planning difficult, repetitive and complex. The young person may tell their story many times and tire of engaging a service system incapable of providing stability and care (let alone Unconditional Care).

demonstrated they had experienced very high numbers of case managers and residential placements. They displayed distrust of, and fear of being let down by the system. This creates a substantial barrier to implementing best practice.

The current *CYFA 2005* stability planning in S.169 (2.3) stipulates that “A stability plan for a child must plan for stable long-term out of home care for the child.” This legislation is considered by the researcher to be useful and will provide the foundation for further policy responses that lead the way in implementing Unconditional Care. DHS (2007f) *Guidance on Promoting Children’s Stability* shows intent to implement more stable case decisions for children and young people. This will ultimately assist in the case managers attempts at a more caring approach.

In order to provide a caring approach access to treatment services also central. The findings show consistent frustration from case managers at the lack of resources provided by mental health services which support or provide a therapeutic approach. These services are limited (see McClung, 2007, p. 5). Read and Ross (2003) argue that treatments should be made available to everyone diagnosed as psychotic, including especially, those who have been traumatised as children (as cited in Spataro et al., 2005, p. 344). There is a need for new diagnostic tools such as Developmental Trauma Disorder (DTD) as put forward by Van der Kolk (2005, pp. 401-408). This would help adequately treat those who have suffered trauma but who do not currently receive services.

The last factor relates to the service system and barriers which led the case managers to address to write Principle 14, which states “the recognition that acting in a protective manner is the joint responsibility of service providers and case manager from all service sectors and the most basic form of caring for a young person.” This principle reflected the case managers desire to involve professionals and the community in supporting families. This principle was discussed in the focus groups with most case managers agreeing that even though it is difficult to involve organisations in joint service delivery for young people, it has a significant place in any approach.

5.3.2 Professional Knowledge and Unconditional Care

This second area where a contribution of knowledge was made relates to the case manager's use of the professional knowledge model as defined by Drury Hudson (1997). The breadth of this model assisted in exploring the knowledge that informs Unconditional Care. The researcher grouped the Tools (1-19) in the five knowledge areas (Theory, Empirical, Personal, Practice and Procedural as defined by this model.

This discussion on professional knowledge is provided in two sections. The first discusses the case managers theoretical, empirical and procedural knowledge. The second examine their personal and practice knowledge.

THEORETICAL, EMPIRICAL AND PROCEDURAL KNOWLEDGE

The first two areas of Drury (1997) model relate to the theoretical and empirical knowledge of the case managers. The findings shows that case managers need to strengthen their ability to articulate formal theoretical and empirical knowledge. The case managers had difficulty in discussing these formal theories that informed their work in any great depth. This difficulty in articulating theory concurs with Munro (1999), Fook (1999) and Osmond (2000) who have shown that practitioners struggle to articulate the theory that underpins their practice. This affirms the current policy direction that the development of evidence based practice must remain a priority (see Productivity Commission, 2009).

Given the low scores of the case managers in this research regarding their capacity to name and apply theory, (see Chapter 4) it becomes arduous to establish how the concepts of attachment, trauma and engagement translate into meaningful outcomes. An added difficulty that results from weak theoretical knowledge is that case manager's actions are (at times) a simplistic application of evidence, which can lead to problems in practice.

The researcher believes that this struggle to identify theory does not indicate a vacuum of knowledge or a lack of understanding of the issues. Rather, the case managers were more competent in describing the application of a

theory. For example, they may not have been able to give a comprehensive description of attachment theory (as described by Bowlby, 1989; Greenberg, et al., 1990; Oppenheim, et al., 2007; Cassidy, et al., 2008; Sprinsson, et al., 2010, p. 32), yet they understood the importance of a focus on relationships, stability and nurture. They could also describe what was involved in the development of the relationship and why the knowledge that informs it was important. In this way the research has achieved Reason and Bradbury's (2001b, p. 2) aim of action research, to produce practice knowledge that is useful to people.

The theoretical knowledge area the findings have also shown that the underpinnings of professional practice with HRA are drawn from a wide ranging collection of theories (see Chapter 4.3.1). The use of a number of theoretical paradigms is consistent with the multi-theoretical discussion in the Best Interest documentation (DHS, 2007d). Case Management theory also suggests a series of theoretical and informing platforms from which to work (see Gursansky, et al., 2003; Woodside, 2005). Added to this were the diverse educational backgrounds of the case managers, which included; theology, nursing, psychology and youth studies (CM Profiles).

Reflections on the professional knowledge in the areas of theory and empirical research assisted the case managers to develop their own approaches. Theory, in relation to professional practice and how ideals can be implemented, is informed by Fook (2002, p. 83) who states that theory can vary from a single descriptive idea, concept or label, to more complex sets of related ideas. Often just naming or labelling a piece of behaviour can provide some explanation, or connect the behaviour with related ideas. This was a valuable process for the case managers and the researcher.

Fook (2000, p. 170) states that expert practitioners must be able to quickly devise new categories of experience, transferring relevant knowledge from other domains, to be able to perceive and prioritise relevant knowledge and action.

The case managers who took part in this research were able to capture and record practice situations and utilised knowledge from numerous areas. This was evidenced by the breadth (not depth) of the theory they named (see chapter 4) they believed discretion in how they apply some of the principles was important. An example was Principle 10 which states “Recognition that spirituality and moral development are protective factors which require acceptance and sometimes facilitation by the case manager.” This was an area that the group found hard to find consensus on. This was largely due to some of the case managers having quite strong religious beliefs and others not. This principle remained important to the case managers due to their empirical knowledge of risk and protective factors which highlights the importance of spirituality⁹⁷ (see Bond et al., 2000, pp. 28, 24, 378).

Finally, the area of procedural knowledge relates to whether the case managers used policy and/or legislation to inform their daily practice. Toward the end of the research the case managers appeared to be clearer regarding procedural knowledge such as *CYPA, 1989*, DHS practice guidance and CSO organisational policy. They were able to explore if legislation and policy supported Unconditional Care. They recognised by examining the procedural knowledge, that the system did not encourage them to practice Unconditional Care as it was not recorded in any legislative or policy documentation (see Tool 4 &5).

The procedural knowledge of case managers was lower than personal and practice knowledge but higher than theory and empirical knowledge. The procedural knowledge Tools (4 & 5) showed that the case managers did not have strong ideas and commitment to policy and legislation. They felt more driven by responding to the needs of the client. This is consistent with the Ombudsman’s recent report (Brouwer, 2009, p. 30).

The DHS (2006) report acknowledges that the system is not ready to implement Unconditional Care. The confirmation that broad areas of

⁹⁷ Also known as ‘religiosity’. The definitions of spirituality and religiosity are many and diverse but appear to relate predominately to a transcendent relationship.

professional knowledge underpin the use of Unconditional Care provides support for the ongoing need to develop and explore practice from an eclectic discourse. Evidence based practice must be wider than empirical and theory knowledge to adequately inform models of professional practice such as Unconditional Care. Drury's (1997) model appears to assist in this regard.

PERSONAL AND PRACTICE KNOWLEDGE

This section examines the role of values in Unconditional Care and confirms that it is the central tenet of the approach. It discusses the strength of the case manager's personal knowledge as being a key factor informing their practice and explores how this contributes and confirms the existing body of knowledge. This research has shown that Unconditional Care not only has its history in the application of values (see Burchard & Clarke, 1990; Boyd, 1991; VanDenBerg et al., 1996 in Malysiak, 1997, p. 399; Handron, et al., 1998, pp. 69-70; Burns et al., 2000, p. 295; Sprinson & Berrick, 2010) but continues to rely on a consistent and predictable set of values related to valuing young people.

This research used Tools 2, 9, 10 to explore personal knowledge with case managers⁹⁸ and Tool 13 to specifically explore values. The researcher has combined the discussion on values and personal knowledge. This is due Drury's (1997, p. 38) definition of personal knowledge relating closely to the idea of values.⁹⁹

The strength and influence of a case manager's personal knowledge has been an underpinning rationale for their support of Unconditional Care. This has been evident in the research findings. Personal knowledge was very prevalent in Tool 2, conducted early in the research and it remained high throughout. The case managers espousing a value base consistent with an

⁹⁸ These three tools looked at all five areas of professional knowledge. This section of the discussion focuses primarily on the data that relates to the personal knowledge area.

⁹⁹ Drury (1997) defines personal knowledge "as an inherent or spontaneous process where the worker is necessarily committing him or herself to action outside of immediate consciousness, or is action based on a personalised notion of common sense. Such knowledge includes intuition, cultural knowledge and common sense" (see Chapter Two).

Unconditional approach may be due to the prominence of the social work values in the child protection sector.

The reference group, supported personal knowledge very important. Principle 5 (“Honesty, integrity, respect and flexibility”) was the most popular amongst the 13 initial principles, again close to the highest score possible. This shows that case managers will, often call upon values as a basis for their practice activities (Demartini & Whitbeck, 1986; Banks, 1995; Drury-Hudson, 1997; 1999). It also reinforces the idea that values, ethics, beliefs or moral principles can, at times, be conceptualised by case managers as knowledge (Osmond, 2005a, p. 890). One case manager said, “I think honesty is the single most important attribute of a case manager” (Tool 2). The case managers had strength and conviction regarding this principle.

The above view is in complete contrast with the concern the Ombudsman expressed regarding data manipulation (see Brouwer, 2009, p. 112). While there may be pressures on case managers that may lead them practice which changes data and/or outcomes, ultimately it is not congruent with the intent displayed in the literature and in this research. Interestingly, DHS has said “The KPMG review, completed in May this year, did not find any examples of ‘intentional manipulation’” (Rood, 2010).

The data (Tool 13 & Profiles) showed that the case managers also held common values primarily focused on concepts of respect, the value of human life and honesty. These values were one of their key motivating factors in practice decisions. The values impacted on their practice, motivated them and shaped their decisions; it also strengthened their resolve.

Historically, there has been a recognised set of universal social work ethics. UN documents signed by most countries are based on human rights, so a common ethical framework is both possible and necessary (Hugman, 2007). Even with cultural relativity allowing difference among underpinning values,

the case managers in this research reflected the ideals stated by most social work codes.¹⁰⁰

This research confirmed that the case managers relied more heavily on their values than any other source of knowledge. The literature on the role of values in practice is scant but points to the significance of values in decision-making practice. Research confirms that value systems guide behaviour (see Perlman, 1986 cited in Furman, 2009, p. 82; Pollock, 2007, p. 189; Noble & King, 1981 in Mattison, 2000, p. 202). Bisman (2004) further suggests that the work of Rapp (1996), which focuses on strength based practice, demonstrates that effective case management is achieved when the values of all parties are prominent.

Additionally, Goddard and Carew (1993, p. 93 in Osmond, 2005a, p. 890) argue that values (can) determine the type of knowledge that individual social workers use. Early indicators from the case managers and reference group members (Group Process 3) demonstrated that many of them held the belief that whilst Unconditional Care was a worthwhile research topic it was unrealistic and an area fraught with difficulty. This was due partly to dealing with people's emotions and values, and partly because they understood the difficulties cited in the previous section in terms of applying the principles within the current system.

Historical approaches to practice also inform the values underpinning Unconditional Care. Rogers' (1979, pp. 1-2) person-centred approach which is built on the three elements of genuineness, acceptance (Unconditional positive regard) and empathetic understanding is an example of values underpinning practice over many years. Acceptance featured heavily in the 'values brick wall' (Tool 13), and in Principle 7 which reads "acceptance of the young person." Rogers' (1979, pp. 1-2) contention was that as a person is accepted and valued they develop a more caring attitude toward him or

¹⁰⁰ The AASW define the five values of human dignity and worth, social justice, service to humanity, integrity and competence (AASW, 1999, p. 9) as pivotal. These appear to align well with the Unconditional ideals.

herself (Rogers, 1979, pp. 1-2). More than half of the case managers scored Principle 7 as having their support.

Corney (2004, p. 11) expands this concept and explains that helping professions such as youth workers are primarily determined by the practitioner's adherence to values-based meaning systems. This is confirmed by other authors such as Maunders (1990, p. 48), Fook, et al., (2000, pp. 243-244) and Phillips, et al., (2000). Corney (2004, p. 18) also found evidence to suggest that implicit and explicit values define the very notion of youth work and underpin both the education and the professional practice.

The desire of case managers to practice Unconditional Care is shown in Tools 2, 9, 11, 12, 17. The literature confirms that when professionals work in areas where their values are not reflected by the organisation, it leads to stress and eventual retention problems (Lange & Powell Kennedy, 2006; Argyris & Schon, 1974; Redmond, 2006)

Therefore the unrest case managers feel may also be attributed to their desire to practice in more unconditional ways in a system that does not support the approach. That case managers are dissatisfied in this area is consistent with the long standing retention and recruitment issues for DHS (see Gibbs, 2001; Hodgkin, 2002; Bromfield & Ryan, 2009; Brouwer, 2009, 2009a).

Finally in the area of professional knowledge the practice knowledge of case managers was a high scoring area. It was beyond the scope of this research to fully explore all the themes presented by the case manager. In summary the findings show that case managers rely on their previous successes in practice and repeat them as needed. This is similar to Munro (2002) whose work broadly assesses this as problematic and argues that case managers learnt poor habits can result in less than ideal outcomes. The work of Fook et al., (2000a) also highlights the importance for case managers to be organic and creative in their application on knowledge to each new case and young person.

This section has discussed how this research contributes to the

understanding that case managers rely very heavily on their personal knowledge. Whilst these values are represented largely by the social work codes of ethics and value statements it highlights that values have a legitimate role in the definition of approaches to professional practice.

5.4 Conclusion

The analysis presented has highlighted the action outcomes from the research and the two areas where knowledge has been further developed. It has examined the complex and challenging nature of case management and the dilemmas case managers face in making decisions about the HRA under their supervision.

The actions and change has shown that the case managers finalised a set of Unconditional Care principles to inform the approach; their capacity to apply critical reflection showed improvement which created change in their practice, and; the case managers were able to close some of the gaps between their espoused commitment to Unconditional Care and how they were practicing this daily.

The research also contributes to knowledge confirming that Unconditional Care is informed by a balanced application of care and control. Professional knowledge and evidence inform both the context and the application of an Unconditional Care approach and that case management professional practice is underpinned by professional values such as honesty, acceptance and relationships.

CHAPTER SIX:

SYSTEM READINESS FOR UNCONDITIONAL CARE

The provision of Unconditional Care and support requires both system readiness for this approach and staff able to engage with young people in an Unconditional manner.

(DHS, 2006b, p. 17)

6.1 Introduction

This research has shown that case managers support the use of Unconditional Care, yet echo the sentiments in the above quote from DHS. They state that if a service system could be designed to support continuity and case managers were enabled to practice reflectively, inroads to the impact of trauma for HRAs may be possible.

Evident also is the complexity of the changes needed to current structures, funding, policy and legislation. This research has highlighted not so much a reluctance of policy makers and managers to talk in terms of Unconditional Care but a profound recognition of the difficulty of the task. The provision of Unconditional Care demands an approach which does more than is currently offered and would likely require additional funds.

This chapter will provide a brief discussion of the strengths and limitations of the research and address the research objectives and questions. Finally it will provide a number of recommendations for future research.

6.2 Strengths and Limitations of the Research

6.2.1 Strengths

A number of strengths can be listed

1. The first strength was the action research design chosen for the study. It provided an opportunity to reflect on what case managers thought of an Unconditional Care approach to professional practice. They were

able to critique, consider the evidence and reflect on the merit of each of the principles. Through in depth focus groups they were able to develop a final set of principles. The case managers contributed to change, improved knowledge and action.

2. The second strength in this research relates to it being the first project in Victoria since the inception of Wraparound in the USA in the early nineteen eighties to specifically examine the question “can practice with HRAs in Victoria be improved by case managers using an Unconditional Care approach?” This opportunity to explore practice in such an in-depth way is rare and has allowed the consideration of practice, knowledge and evidence which has informed the development of the concept to a significant degree.
3. A further strength was the amount of data collected across thirty four focus groups in the twelve month period. It was significant and underpinned the robust nature of the research design. The level of critical reflection achieved during this process meant that complex ideas could be discussed and analysed at length. This combined with the profiles and literature made for an effective triangulated methodology.
4. A final strength in this research was that it achieved two action outcomes (solutions). These were a tested and finished set of Unconditional Care principles including a number of new principles, and that case managers who utilise critical reflection change their practice and close the gap between theory and practice. There were also a number of areas where contribution to knowledge was made. These areas were in the care and control discourse, professional knowledge and finally the role that values play in Unconditional Care.

6.2.2 Limitations

A number of limitations in the research need to be noted.

1. The first limitation was the case manager's workload. The stress and under resourcing impacted this research because it reduced the continuity and capacity of the researcher to conduct concurrent discussions and the group to move systematically back through focus group data and reflections.

Related to this was the reference group who lost their capacity to be effective when the researcher finished employment with DHS. This was of great disappointment to the case managers and the researcher. Nonetheless, what contributions they did make were valued and in the light of the stress in the sector is somewhat explained.

2. A further limitation related to the possibility of bias in the research. Walter (2006, p. 320) provides a timely reminder that participatory action research (PAR) has been strongly criticised by social researchers and that these criticisms have focused on how the participation, democracy, and external ownership aspects of the method can greatly reduce the validity of the research and the rigour of the methods used. In this research various strategies were in place to reduce this criticism such as the use of the external facilitator and the reference group.
3. This research may also have been vulnerable to a positive response bias. Ordinarily a research concept applied to quantitative survey research, this occurs when respondents in research are given multiple desirable options to choose from making it more difficult to know which option they really prefer (Muijs, 2004, pp. 49-50). Given there was little in the Unconditional Care principles that could be conceived as problematic case managers may have found it difficult to discard principles. This meant that this positive bias was likely to have had some impact on the research results.
4. A further limitation was that the interviews with young people were not completed. This meant changes in practice could not be examined as

easily. It also meant that any change in practice that the case managers experienced had to be recorded via the case managers self reports in the reflective tools.

6.3 Addressing the Research Objectives and Questions

In considering whether or not this research has met the objectives it is vital to note that action research differs from traditional research methods in its purpose of creating action. This research has achieved the goals of an action research design and as Lingard, Abert and Levinson (2008, p. 461) suggest, the researcher has understood the problem through a collaborative research partnership. The case managers recognised action research as a learning process where real changes occurred in: what people do, how they interact with the world and with others, what they mean and what they value, the discourses in which they understand and interpret their world (Kemmis & Wilkinson, 1982).

There were four research objectives in this research. Within these objectives there were six related research questions (see Chapter 1.5).

The objectives in this research were to;

1. Provide a written set of practice principles and guidelines that contribute to positive outcomes for adolescents.
2. Explore and test the notion of Unconditional Care.
3. Contrast the existing case practice with the Unconditional Care approach.
4. Work in partnership with the DHS and funded agencies, to explore the practice and case management issues surrounding HRAs and the results of the ICMS during the period 1998-2000.

This section is presented primarily as a discussion on the research objectives. The research questions are discussed within the objectives and not necessarily in chronological order. The headings represent these

objectives.

6.3.1 Provision of a Set of Principles to Define Unconditional Care

The first objective was to provide a set of principles that could help define the Unconditional Care approach. Research Question 1 reflected this and asked “Are the Unconditional Care principles in their draft form a reflection of what other case managers consider to be best practice?” It was noted earlier in Chapter Three that this was the first study to examine the notion of Unconditional Care as a single motivating influence on Case Management. Its origin rests in the ten essential elements that have defined and shaped the Wraparound service system for over twenty years (Burchard & Clarke, 1990; see Boyd, 1991; VanDenBerg et al., 1996 in Malysiak, 1997, p. 399; Burns et al., 2000, p. 295).

The case managers agreed on the final seventeen principles that contributed to a fuller understanding of Unconditional Care¹⁰¹. These principles were developed from the initial thirteen that the researcher had prepared prior to the focus groups commencing.

Research Question 2 asked “What other principles and guiding themes are present for case managers?” After some months in the focus groups the case managers were ready to finalise the principles. This was done by reflecting on accepted best practice and collaborative discussions regarding empirical evidence. A further five principles were added.

It was shown in Chapters One and Two that DHS implemented the HRASQII (1998) as its current strategy for managing HRA in the state of Victoria. This research has consistently shown that this approach has struggled to achieve a significant substantial amelioration from the impact of trauma. More recently it appears that the essence of these principles was embedded in the *CYFA 2005* and ecec strategy. However, the concepts do not seem adequately resourced or implemented in a way that would ensure the policy

¹⁰¹ See earlier in Chapter Five for the discussion pertaining to the final principles the researcher added. This principle related to the inclusion of trauma theory.

intent of consistency and stability.

In a similar area related to what informs an Unconditional approach this research also asked Research Question 6 “Do values and personal background significantly impact decision-making?” The research has shown that it does and that Unconditional Care has its history in ideology that values people and provides an unswerving commitment to the provision of care as long as it is needed. This ideology continues to be a formidable backbone of effective service delivery. This is especially true with the work of the NWI now documenting and evaluating the work of Wraparound programs.

This achievement of a final set of principles that underpin an Unconditional approach to practice adequately addressed whether there were other principles and guiding themes are present for case managers when reflecting on their practice.

6.3.2 Explore and Test Unconditional Care

The second objective was to explore and test Unconditional care and was reflected in Research Question 3 which explored “What is the underpinning professional knowledge for these principles from case managers and other research?” The research utilised the model of professional knowledge defined as theory, empirical, personal, practice and procedural knowledge (Drury Hudson, 1997). The researcher grouped the focus group tools (1-19) to in these five knowledge areas which was an effective process for exploring and testing an Unconditional approach.

The discussion and analysis of research findings presented in Chapter Four and Five shows that case managers were unable to articulate relevant theoretical and empirical knowledge at a significant depth. This difficulty in articulating theory concurs with Munro (1999), Fook (1999) and Osmond (2000) who have shown that practitioners struggle to articulate the theory that underpins their practice. The research has shown a need to strengthen case managers ability to articulate knowledge, and apply theoretical and empirical knowledge.

The use of critical reflection (Fook, 1996; 1999) assisted the case managers in testing the principles and linking them together to form a practice theory. The finding that the case managers have limited knowledge of the legislation and procedural knowledge that relates to their area was concerning. Such concerns were also raised by the Ombudsman's Report (2009) (see Brouwer, 2009, p. 30).

It can be argued that with considerable staff retention problems, staff with well developed knowledge of the complex system and legislative requirements do not stay in the sector long enough to make inroads in this area. The newer staff would undoubtedly find it hard to learn and apply the legislation quickly. The case managers highlighted the deficits in the systems and clearly articulated that whilst they could define the principles they were often unable to implement them due to a system that did not support a consistent and stable approach.

6.3.3 Contrast Current Case Practice with Unconditional Care Principles

This third objective examined the change element of an action research cycle by analysing the current practice and change that occurred toward an Unconditional Care approach. It was hypothesized at the beginning of the research that the case managers would not be practicing Unconditional Care as defined by the initial thirteen principles. The researcher thought there would be a change from current practice toward more use of Unconditional Care principles. However, the case managers stated that in their view they were already practicing in this way, albeit with some limitations from the system.

There are two factors worth considering in relation to this discussion. Firstly measuring change regarding the actual practice of the case managers proved difficult because the interviews with young people did not take place. This meant that there was an absence of a benchmark to compare changes in practice over time.

Secondly, the case managers consistently stated that they were practicing Unconditional Care, yet, at the same time they stated that they were

prevented by the system from practicing a number of the principles. These principles related to, difficulty in reflective practice, continuity, consistency of care in the placement system and applying evidence. Therefore it was difficult to compare and contrast existing practice and Unconditional Care.

In this area Research Question 1 also asked “Are the Unconditional Care principles in their draft form a reflection of what other case managers consider to be best practice”? The case managers stated that the principles did represent their views of best practice. The statements made above highlight that in response to Research Question 4 which asked “How much are these principles reflected in daily professional practice?” There was a gap between support for the principles and their implementation.

6.3.4 Work in Partnership with DHS and ICMS Providers

This fourth objective of the research was to work in partnership with DHS and ICMS to explore the practice during the period 1998-2000. The researcher achieved a positive partnership. This was particularly the case in the early days of the research when the ethical processes and recruitment of case managers was taking place. When the researcher left DHS it became more difficult to sustain close ties with both DHS and ICMS.

Collaborative ties with DHS were a priority during the research. It can be difficult to work with DHS due to the turnover in staff at every level and constant changes to the machinery of government. Limited correspondence between DHS and the researcher has taken place after the researcher left DHS.

In addressing research Question 5 which asked “Is there a significant difference between employees of the DHS and contracted staff case managing CSO?” It was found that action research involving research partnerships is not always straightforward. Such partnerships are difficult to develop and sustain. In this research a professional relationship existed with a number of the case managers before the research began. The established trust and rapport along with genuine respect of each other’s knowledge and skills assisted in the development of effective research focus groups. In those

groups where new relationships were formed the use of group process activities assisted.

Professional understanding grows when individuals share knowledge and adopt it or adapt it for themselves. This research has seen the case managers engage in democratic and open relationships often in the face of different interests, strengths and levels of commitment to the research process. Involving the case managers from the start of the process was an effective way of fostering ownership on the process. This became slightly more difficult with the third region added a few months after the other two regions had commenced.

This research shows that case managers generally adhere to the principles of Unconditional Care. It does not show any significant differences in the responses of case managers other than a slightly different focus on their role which reflects the dichotomy between DHS and CSOs. However, one area that appeared to be difficult was the nature of the relationship between DHS and ICMS in that DHS holds the statutory decision making power.

6.4 Recommendations for Future Research

As shown in Chapter Three this research has used an action research design. It included case managers working in a collaborative process, which lead the researcher to rely heavily on the focus group tools and profiles. This provided a substantial depth, quantity and quality of data. Consequently these recommendations are made with confidence that they adequately represent the voice of case managers. The researcher acknowledges the passage of time between when the research was conducted and when it was finalised, but believes the findings still provide a significant contribution to knowledge. This is particularly because of the absence of change to the HRA SQII initiative not significantly changing.

The following recommendations for further research could enhance case manager's application of Unconditional Care as defined by the principles in this research. They also consider improvements to policy for consideration.

1. This study confirms case manager support for the use of Unconditional Care as an approach to professional practice with HRAs. Further research is needed to consider how Unconditional Care could be applied to the current Victorian Child Protection and CSO system. DHS appears hesitant to get involved in provision of Unconditional Care. This is perhaps due to the label 'Unconditional' implying an onus on government that is far beyond what is currently offered. It could cost government a great deal more in resources if services were perceived as Unconditional or not ending until the need was met. Burns (et al., 2000, p. 296) comments "the Wraparound process stresses Unconditional Care (That is, a no reject, no eject policy) it could conceivably never end for a child" (Burns et al., 2000, p. 296). This is especially true for a HRA with PTSD that has impacted their mental health and/or other developmental health areas.
2. Further research regarding what constitutes EBP and its application to social work and youth work practice with young people is required.. The case managers in this cohort scored lowest on their ability to cite empirical and theoretical evidence for their practice. This was supported by the literature and indicates a need to further explore and provide education on the concept of evidence and how it can be translated into practice decisions and outcomes.
3. Further research into how professional development and education can be developed in line with the evidence could be considered. This includes a review of DHS partnerships with the tertiary education sector and its own internal training structures. The training unit would be enhanced by utilising post graduate, education qualified staff who have a deeper level of understanding regarding the combination of service delivery knowledge with evidence.

Child Protection in Victoria can do more to support and train case managers in their application of theories such as change, attachment and trauma. The DHS approach to learning employs the philosophy

that case managers require skills rather than the capacity to apply theory to practice. Yet, the BIPM is based on a professional judgment model where case managers are required to apply theory to practice. Also related to this issue is that DHS (2006) recommends that “the evidence base for responses to HRA is enhanced” (p. 3).

4. Further research on successful models of intervention for HRAs continues to be an area needing investigation. The efficacy of TFC has typically been evaluated by quantitative measures (such as length of placement, number of placements). Recent research has called for the inclusion of additional outcome measures in evaluation to be explored. Redding and colleagues (2000) note the limitations of previous quantitative research in TFC and state that, “Although these measures are valuable in measuring placement success, they do not provide adequate information regarding child and family functioning and adjustment, nor do they provide a systematic evaluation of placement satisfaction” (p. 428). It should be noted that there is little research contributing to long-term outcomes for children in any kind of placement, whether that is traditional fostercare, therapeutic foster care or residential care (McClung, 2007, p. 24).
5. Further research into the Housing options for HRAs is critical. DHS (2006b, p. 12) note that HBC is likely the most effective model yet, only 2% of the HRA population in 2005 were housed in HBC (p. 12). This shows a need to review and change the HRASQII (1998) which still focused on HBC. The Hurstbridge Farm pilot appears to have been a significant investment for DHS however it is difficult to find published findings of effectiveness.
6. Research into the use of secure care services is critical. Case managers and DHS appear to recognise that secure care is a vital part of a broader continuum to contain and stabilise young people. Secure care transition out of secure welfare must be supported to ensure that those benefits are not lost (DHS, 2006b, p. 79).

7. Research into a new partnership with Mental Health Services and the Office of the Chief Psychiatrist is required. This research has shown the frustration of case managers accessing treatment services. Consideration could be given to the current neuro science related to the impact of trauma on development, the treatment responses and the current responses for PTSD offered by CAHMS.

A review of the mechanisms and pathways for HRAs accessing mental health services is also required. This review could examine evaluation data from services such as Headspace (Federally funded) as alternatives to current access pathways. The partnership mentioned above could broaden the therapeutic and treatment options available to HRAs.¹⁰²

8. Further research into outcome measures that accurately reflect any impact the *CYFA 2005* may have on the stability and consistency of care for HRAs is needed. This research and the literature confirm a lack of data and evaluation information regarding the efficacy of DHS interventions that is published on a regular basis.
9. Further research into cross government 'joined up' initiatives and responses that provide more options for HRAs that specifically involves Psychiatric Services, Youth Justice, Drug and Alcohol Services, Housing and secure care. Further investment in the enablers and success factors put forward by State Services Authority (SSA) (2007, p. 27) one of which highlights the need for "high levels of political and bureaucratic commitment and leadership" can be made.

Wierenga, et al., (2003, p. 18) investigated how the delivery of youth

¹⁰² The researcher has worked in both the mental health and child protection system in the State of Victoria and neither of these systems appears to offer the depth of response that is written about, in particular by the NWI or Sprinson and Berrick (2010). This includes concepts such as twenty four hour care and multidisciplinary teams who know and respond to each other's clients. They inform assessment and ongoing treatment planning using collaborative and empirical approaches. To the researcher a starting point would be to shift the Victorian rhetoric of 'whole of government' approaches closer to reality.

services can be supported by government and discuss important issues needing to be tackled locally and holistically. Further, they argue for the creation of hope (Botsman, 2000) and certainty that things can change for the better. They cite the WTS as an example of networks that bring people together and an example of a 'joined up' initiative. These examples could assist in the focus of future research.

6.5 Conclusion

The research provides a theoretical and practical contribution to child protection practice and should raise awareness about the complexity of such work. The research findings have ramifications for policy and practice.

This research has shown that the current approach to HRAs in the state of Victoria has not sufficiently considered the benefits of an Unconditional Care approach. It has shown that case managers supported the approach but felt that they were unable to implement a number of the key principles.

The work of Robin Clark (2000) which focused on expert practice within the residential care setting was distinctly different from this research on Unconditional Care. However, the central tenant of practicing Unconditional Care with young people affirms case managers who are committed to 'never giving up'. Unconditional Care focuses on establishing significant people in the lives of young people and takes a long term view of the impact of these relationships on recovery and resiliency.

This research has shown that Unconditional Care is an approach to professional practice that is supported by case managers from both DHS and ICMS. It has demonstrated strength in the articulation of a professional knowledge framework and encourages further application and exploration of what is in the best interests of high risk young people.

This research has explored the proposition that "individual change is the leverage point for producing organisational change" (Piggot-Irvine, 2001, p. 3). The case managers in this research experienced change in their capacity to reflect and apply professional knowledge.

The case managers in this research had 'Unconditional' intent to apply as much of the approach as possible, within the current service system. Ultimately, this research concurs with the DHS Strategic HRA Report that states "The provision of Unconditional Care and support requires both system readiness for this approach and staff able to engage with young people in an Unconditional Care manner" (DHS, 2006, p. 17).

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APPENDICES

Appendix One:
Regional Summary

1. REGIONAL SUMMARY

1. In June 2000 the Loddon Mallee region produced its own adolescent statutory practice framework (DHS, 2000d). This document was the result of five years of voluntary time of the Case managers and line managers. (see Department of Human Services. (2000d). *Adolescent statutory practice framework for workers*. Community Care Division, Loddon Mallee Region. Victorian State Government, Melbourne, Victoria, Australia).
2. In 2001 the Child Protection After Hours Service concerned with the high percentage of their work pertaining to this category also commissioned a report into practice (DHS, 2001) Among the concerns outlined in this report it highlighted the differing practice across the state as it related to the management of the HRA.¹⁰³ (see Department of Human Services. (2001a). *After Hours Child Protection Service: "High-Risk" Adolescent Project*. Victorian State Government, Melbourne, Australia).
3. In 1999 the Barwon Regions' Benchmarking project by Clark resulted in development of an Adolescent Protective Team (APT) (Clark, 1999b, p. 1 & 54). (see Clark, R. (1999b). *The Benchmarking and Improvement Project*. Child Protection and Placement Co-ordination Department of Human Services, Barwon South-West Region, Victoria and Kelly, M. and Associates. (November, 1999). High Risk Adolescent Project: Final Report. Mackillop Family Services Barwon Regional Office North Geelong).
4. In June 1999 the Hume region Goulburn and Wodonga Area Mental Health Service funded by HRASQII completed a piece of work developing protocols for working with HRA's (Project Partnerships, 1999b). (see Project Partnerships. (June 1999a). "High-Risk" Adolescent Coordination Project: Protocol for Cooperative Arrangements. Goulburn and Wodonga Area Mental Health Service).

¹⁰³ This part of Protective Services is well situated to make this assessment because it deals with the after hours work from many differing regions across the state.

5. In May 2000 the North Western region published the following report.
Morton, J. & Pead, J. (2000). Working together in the northern metropolitan region: Towards an integrated service system for young people at risk who have Complex Needs. Preston Melbourne: Department of Human Services, Northern Metropolitan Region).

Appendix Two:

Legislation

2.1 CYPA 1989 Section 63

2.2 CYPA 1989 Section 119

2.3 CYFA 2005 Section 10

2.4 CYFA 2005 Section 11

2.5 CYFA 2005 Section 162

2.6 CYFA 2005 Section 168, 169, 170, 171

2.7 CYFA 2005 Section 173, 175, 242 and 482

2.8 Therapeutic Treatment Order Information

2. LEGISLATION

2.1 CYPA 1989 Section 63

Section 63 of the CYPA (1989) outlines the mandate of Protective Services it states that; a child in need of protection when;

- a) the child has been abandoned by his or her parents and after reasonable inquiries-
 - I. the parents cannot be found; and
 - II. no other suitable person can be found who is willing and able to care for the child;
- (b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;
- (c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- (d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- (e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- (f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

2.2 CYPA 1989 Section 119

Section 119 highlights that;

- a) the welfare and interests of the child must be given paramount importance;
- b) if the child is not living with his or her family, a primary goal is to reunite the child with his or her family if that is for the welfare and in the interests of the child;
- c) when considering the welfare and interests of the child, due consideration must be given to immediate and long-term effects of decisions on the welfare and interests of the child and on the maintenance of the family relationships of the child;
- d) any decisions made to protect the safety and well-being of the child must not be more than sufficient to achieve this;
- e) the child (except if his or her participation would be detrimental to his or her safety or well-being) and the family of the child (except where its participation would be detrimental to the safety or well-being of the child) must be encouraged and (through consultation and discussion) given adequate opportunity to participate fully in the case planning process and must be given a copy of any proposed case plan and sufficient notice of any meeting proposed to be held;
- f) the child and the family of the child must be provided with the opportunity and assistance to involve other persons to assist them to participate fully in the case planning process in accordance with paragraph (e);
- g) the case planning process must be conducted in such a way that the persons involved are able to understand it;
- h) the case planning process must take into account the views of all persons who are directly involved;

- i) decisions are to be reached by collaboration and consensus;
- j) decisions are to be made with as much speed as a proper consideration of the case permits;
- k) if a person attending meetings occurring as part of the case planning process has difficulty in communicating in the English language, an interpreter must be present;
- l) if meetings are held as part of the case planning process and the child comes from an ethnic background, a member of the appropriate ethnic community who is chosen or agreed to by the child or by his or her parent may attend;
- m) in the case of an Aboriginal child-
 - (i) decision-making should involve relevant members of the Aboriginal community to which the child belongs; and
 - (ii) in recognition of the principle of Aboriginal self-management and self-determination, arrangements concerning the child, and his or her care, supervision, custody or guardianship, or access to the child, must be made in accordance with the principles listed in sub-section (2).

2.3 CYFA 2005 Section 10

Division 2—Best Interests Principles

10. Best interests principles

- 1) For the purposes of this Act the best interests of the child must always be paramount.
- 2) When determining whether a decision or action is in the best interests of the child, the need to protect the child from harm, to protect his or her rights and to promote his or her development (taking into account his or her age and stage of development) must always be considered.
- 3) In addition to sub-sections (1) and (2), in determining what decision to make or action to take in the best interests of the child, consideration must be given to the following, where they are relevant to the decision or action—
 - a. the need to give the widest possible protection and assistance to the parent and child as the fundamental group unit of society and to ensure that intervention into that relationship is limited to that necessary to secure the safety and wellbeing of the child;
 - b. the need to strengthen, preserve and promote positive relationships between the child and the child's parent, family members and persons significant to the child;
 - c. the need, in relation to an Aboriginal child, to protect and promote his or her Aboriginal cultural and spiritual identity and development by, wherever possible, maintaining and building their connections to their Aboriginal family and community;
 - d. the child's views and wishes, if they can be reasonably ascertained, and they should be given such weight as is appropriate in the circumstances;

- e. the effects of cumulative patterns of harm on a child's safety and development;
- f. the desirability of continuity and stability in the child's care;
- g. that a child is only to be removed from the care of his or her parent if there is an unacceptable risk of harm to the child;
- h. if the child is to be removed from the care of his or her parent, that consideration is to be given first to the child being placed with an appropriate family member or other appropriate person significant to the child, before any other placement option is considered;
- i. the desirability, when a child is removed from the care of his or her parent, to plan the reunification of the child with his or her parent;
- j. the capacity of each parent or other adult relative or potential care giver to provide for the child's needs and any action taken by the parent to give effect to the goals set out in the case plan relating to the child;
- k. access arrangements between the child and the child's parents, siblings, family members and other persons significant to the child;
- l. the child's social, individual and cultural identity and religious faith (if any) and the child's age, maturity, sex and sexual identity;
- m. where a child with a particular cultural identity is placed in out of home care with a care giver who is not a member of that cultural community, the desirability of the child retaining a connection with their culture;

- n. the desirability of the child being supported to gain access to appropriate educational services, health services and accommodation and to participate in appropriate social opportunities;
- o. the desirability of allowing the education, training or employment of the child to continue without interruption or disturbance;
- p. the possible harmful effect of delay in making the decision or taking the action;
- q. the desirability of siblings being placed together when they are placed in out of home care;
- r. any other relevant consideration.

2.4 CYFA 2005 Section 11

Decision-making principles

In making a decision or taking an action in relation to a child, the Secretary or a community service must also give consideration to the following principles—

- (a) the child's parent should be assisted and supported in reaching decisions and taking actions to promote the child's safety and wellbeing;
- (b) where a child is placed in out of home care, the child's care giver should be consulted as part of the decision-making process and given an opportunity to contribute to the process;
- (c) the decision-making process should be fair and transparent;
- (d) the views of all persons who are directly involved in the decision should be taken into account;
- (e) decisions are to be reached by collaboration and consensus, wherever practicable;
- (f) the child and all relevant family members (except if their participation would be detrimental to the safety or wellbeing of the child) should be encouraged and given adequate opportunity to participate fully in the decision-making process;
- (g) the decision-making process should be conducted in such a way that the persons involved are able to participate in and understand the process, including any meetings that are held and decisions that are made;
- (h) persons involved in the decision-making process should be—

- (i) provided with sufficient information, in a language and by a method that they can understand, and through an interpreter if necessary, to allow them to participate fully in the process; and
- (ii) given a copy of any proposed case plan and sufficient notice of any meeting proposed to be held; and
- (iii) provided with the opportunity to involve other persons to assist them to participate fully in the process; and
- (i) if the child has a particular cultural identity, a member of the appropriate cultural community who is chosen or agreed to by the child or by his or her parent should be permitted to attend meetings held as part of the decision-making process.

Division 4—Additional decision-making principles for Aboriginal children

12 Additional decision-making principles

- (1) In recognition of the principle of Aboriginal self-management and self-determination, in making a decision or taking an action in relation to an Aboriginal child, the Secretary or a community service must also give consideration to the following principles—
 - (a) in making a decision or taking an action in relation to an Aboriginal child, an opportunity should be given, where relevant, to members of the Aboriginal community to which the child belongs and other respected Aboriginal persons to contribute their views;
 - (b) a decision in relation to the placement of an Aboriginal child or other significant decision in relation to an Aboriginal child, should involve a meeting convened by an Aboriginal convener who has been approved by an Aboriginal agency or by an Aboriginal organisation approved by the Secretary and, wherever possible, attended by—
 - (i) the child; and
 - (ii) the child's parent; and

- (iii) members of the extended family of the child; and
 - (iv) other appropriate members of the Aboriginal community as determined by the child's parent;
- (c) in making a decision to place an Aboriginal child in out of home care, an Aboriginal agency must first be consulted and the Aboriginal Child Placement Principle must be applied.
- (2) The requirement under subsection (1)(c) to consult with an Aboriginal agency does not apply to the making of a decision or the taking of an action under Part 3.5.
- (3) In this section **Aboriginal organisation** means an organisation that is managed by Aboriginal persons and that carries on its activities for the benefit of Aboriginal persons.

2.5 CYFA 2005 Section 162

PART 4.1—CHILDREN IN NEED OF PROTECTION

162. When is a child in need of protection?

(1) For the purposes of this Act a child is in need of protection if any of the following grounds exist -

- a) the child has been abandoned by his or her parents and after reasonable inquiries—(i) the parents cannot be found; and (ii) no other suitable person can be found who is willing and able to care for the child;
- b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;
- c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

g) (2) For the purposes of sub-sections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.

2.6 CYFA 2005 Section 168, 169, 170, 171

168. Review of case plan

The Secretary must ensure that the case plan is reviewed from time to time by the Secretary as appears necessary.

169. What is a stability plan?

- (1) A stability plan is a plan prepared by the Secretary for a child.
- (2) A stability plan for a child must plan for stable long-term out of home care for the child.
- (3) A stability plan may include details of—
 - (a) the proposed long-term carer of the child or the type of carer who should be sought to provide for the long-term stable care of the child;
 - (b) the appropriate Court order under this Chapter that the Secretary considers best supports the long-term stable placement of the child;
 - (c) matters relevant to the out of home care of the child that may relate to the family or environmental circumstances that caused the child to be placed in out of home care and that may give rise to particular needs or requirements in relation to the child;
 - (d) planning for arrangements for access by the child to the child's parent and siblings;
 - (e) steps to be taken by the child's carer to meet the developmental needs of the child, including steps relating to the child's health, emotional and behavioural development, education, family and social relationships and identity.

170. Preparation of stability plan

(1) The Secretary must ensure that a stability plan is prepared for each child who is in out of home care as a result of—

- (a) an interim accommodation order made by the Court; or
- (b) a protection order.

(2) The stability plan for a child must be prepared by the required time after an interim accommodation order or protection order or either of them placing the child in out of home care is first made by a court for the child.

(3) The required time for completing a stability plan is—

- (a) in the case of a child who is under 2 years of age at the date of the order, once that child has been in out of home care for one or more periods totaling 12 months;
- (b) in the case of a child who is 2 years of age but under 7 years of age at the date of the order, once that child has been in out of home care for a period or periods totaling 18 months;
- (c) in the case of a child who is 7 years of age or over at the date of the order, once that child has been in out of home care, for a period or periods totaling 2 years within a period of 3 years from the date of the order.

(4) A stability plan can only be prepared for a child who is in out of home care.

(5) The Secretary must provide a copy of a stability plan within 6 weeks after it is prepared to—

- (a) the parent of the child; and
- (b) if the child is of or above the age of 12 years, the child.

(6) A stability plan for an Aboriginal child must accord with the Aboriginal Child Placement Principle.

171. When is a stability plan not required?

(1) The Secretary is not required to prepare a stability plan for a child within the required time under section 170 if the Secretary considers that the completion of a stability plan for a child is not in the best interests of the child.

(2) If the Secretary decides not to prepare a stability plan for a child, the Secretary must provide an explanation as to why a stability plan should not be prepared—

(a) in the disposition report or in an additional report provided to the Court in respect of the child; and

(b) in writing to the following persons within 6 weeks after making the decision not to prepare the stability plan— (i) the parent of the child; and (ii) if the child is of or above the age of 12 years, the child.

2.7 CYFA 2005 Section 173, 175, 242 and 482

173 Placement of children

- (b) place him or her in a secure welfare service for a period not exceeding 21 days (and, in exceptional circumstances, for one further period not exceeding 21 days) if the Secretary is satisfied that there is a substantial and immediate risk of harm to the child;

175 Support for child moving from secure welfare service

If a child is placed in a secure welfare service under section 173, the Secretary must plan for and support the transfer of the child to and integration of the child in another suitable placement in order to reduce the need for the child to be placed in a secure welfare service again.

242 Actions on taking child into safe custody

- (1) A protective intervener must on taking a child into safe custody under section 241 give to—
 - (a) the child's parents, unless they cannot be found after reasonable inquiries; and
 - (b) the child, if he or she is of or above the age of 12 years—
a written statement containing the prescribed information relating to the taking of children into safe custody under that section.
- (2) Subject to subsection (4), a child taken into safe custody under section 241 must be brought before the Court for the hearing of an application for an interim accommodation order as soon as practicable and, in any event, within one working day after the child was taken into safe custody.
- (3) Unless a child is brought before the Court under subsection (2) within 24 hours after the child was taken into safe custody, he or

she must, subject to subsection (4), be brought before a bail justice as soon as possible within that period of 24 hours for the hearing of an application for an interim accommodation order.

- (4) A child of tender years need not be brought before the Court under subsection (2) or a bail justice under subsection (3) unless the Court or bail justice otherwise orders but the Court or bail justice may deal with the application in the absence of the child.
- (5) Until a child taken into safe custody under section 241 is brought before the Court or a bail justice for the making of an interim accommodation order, the child may only be placed—
 - (a) in an out of home care service; or
 - (b) if there is a substantial and immediate risk of harm to the child, in a secure welfare service; or
 - (c) in other accommodation approved by the Secretary in accordance with the prescribed criteria (if any).

482 Form of care, custody or treatment

- (1) The Secretary must—
 - (a) determine the form of care, custody or treatment which he or she considers to be in the best interests of each person detained in a remand centre, youth residential centre or youth justice centre; and
 - (b) not detain in a community service or secure welfare service a person who is on remand or is serving a period of detention and is not released on parole; and
 - (c) separate persons who are on remand from those who are serving a period of detention by accommodating them separately in some part set aside for the purpose unless—

- (i) the Secretary considers it appropriate not to separate them, having regard to the best interests, rights and entitlements of the persons on remand; and
 - (ii) the persons on remand consent; and
 - (d) separate persons held on remand who are under the age of 15 years from those held on remand who are of or above the age of 15 years unless exceptional circumstances exist.
- (2) Persons detained in remand centres, youth residential centres or youth justice centres—
- (a) are entitled to have their developmental needs catered for;
 - (b) subject to section 501, are entitled to receive visits from parents, relatives, legal practitioners, persons acting on behalf of legal practitioners and other persons;
 - (c) are entitled to have reasonable efforts made to meet their medical, religious and cultural needs including, in the case of Aboriginal children, their needs as members of the Aboriginal community;
 - (d) are entitled to receive information on the rules of the centre in which they are detained that affect them and on their rights and responsibilities and those of the officer in charge of the centre and the other staff;
 - (e) are entitled to complain to the Secretary or the Ombudsman about the standard of care, accommodation or treatment which they are receiving in the centre;
 - (f) are entitled to be advised of their entitlements under this subsection.
- (3) It is the responsibility of the Secretary to make sure that subsection (2) is complied with and he or she must, at least once each year, report to the Minister on the extent of compliance with subsection (2).

2.8 Therapeutic Treatment Order Information

Applications for therapeutic treatment order & therapeutic treatment (placement) order.

A therapeutic treatment order ['TTO'] and a therapeutic treatment (placement) order ['TTPO'] are new orders which were not available under the CYPA. They became available under the CYFA as and from 01/10/2007.

A TTO requires a child aged 10-14 who has exhibited sexually abusive behaviours to participate in an appropriate therapeutic treatment program. The relevant statutory provisions are in ss.244-251, 255-258 & 349-355 of the CYFA.

A therapeutic treatment (placement) order ['TTPO'] grants sole custody to the Secretary of a child in respect of whom a TTO is in force. A TTPO does not affect the guardianship of the child. The relevant statutory provisions are in ss.252-258 of the CYFA.

Application for therapeutic treatment order

If the Secretary is satisfied on reasonable grounds that a child aged 10-14 is in need of therapeutic treatment for sexually abusive behaviours, the Secretary may by notice direct-

- (a) the child to appear; and
- (b) the parents to produce the child before the Court- for the hearing of an application for a TTO [s.246(1)].

In some instances it is mandatory for the Secretary to refer a case to the Therapeutic Treatment Board ['TTB'] for advice prior to an application for a TTO being made. In other instances it is discretionary. Provisions relating to the establishment, constitution, functions, committees and procedure of the TTB are in ss.339-343 of the CYFA. Under s.245, if the Secretary receives-

- a report from a member of the police force under s.185; or
- a referral from the Court under s.349(2)-

about sexually abusive behaviours exhibited by a child aged 10-14, the Secretary must refer the matter to the TTB for advice, *inter alia* as to whether it is appropriate to seek a TTO in respect of the child. If the Secretary receives a report from any other person under s.185, the Secretary may refer the matter to the TTB for such advice.

Application for therapeutic treatment (placement) order

The Secretary may apply to the Court for a TTPO in respect of a child in relation to whom a TTO already exists or an application for a TTO has been made but not yet determined [s.252].

Appendix Three:
History of *CYFA* 2005

3. HISTORY OF CYFA 2005

DHS has undergone a reform that aims to provide more child centered practice and a more integrated service system. In March 2005 the Office for Children (OFC) was established. It recognised the importance of early childhood and utilised expert advice via the Victorian Children's Council (VCC) (of experts) to establish the Victorian Children Service Board (VCSB) which enabled key agencies in government to come together to take part in the national reform agenda. Child Protection states that

Child Protection Services provides child centred family focused services to protect children and young people from significant harm as a result of abuse or neglect within the family unit and to ensure that children and young people receive services to deal with the impact of abuse and neglect on their well being and development.

(DHS, 2007e, p. 2)

The table below shows the reports and process that lead up to and informed the reform process.

REPORTS LEADING UP TO PROTECTING CHILDREN

- Putting Victoria's Children First - Ministerial Statement
- Ministerial Discussion Paper and 2004 launch and speech
- Technical Options Paper
- The report of the panel to oversee the consultation on protecting children: the Child Protection outcomes project (also known as the Kirby Report)
- Protecting children: the Child Protection outcomes project (also known as the Allen Consulting Report) (White Paper) 2005
- An integrated strategy for Child Protection and placement services
- Public parenting: a review of home based care services in Victoria
- Aboriginal Services Plan, key indicators interim report June 2003 - June 2004

One of the main platforms of the *CYFA 2005* is Section 10, the Best Interests

principles “provide a unifying set of principles across the Family and Placement Services sector, Child Protection and the Children’s Court that guides all decision making and service delivery” (DHS, 2008a). One of the priority reforms was improving the stability of children and young people to promote their development (DHS, 2007g, p. 1).

Appendix Four:
HRASQII Guidelines (1998)

4. HRASQII GUIDELINES (1998)

The HRASQII (1998) guidelines outlined the following service principles:

- ◆ Be specific to, appropriate for and relevant to young people
- ◆ Be accessible and appropriate to young people, regardless of gender, race, culture, language and location differences
- ◆ Be flexible and operate collaboratively
- ◆ Provide stable placement and continuity of care
- ◆ Promote the well being of young people by strengthening links with family and significant others
- ◆ Seek to increase young people's skills and capacity to manage their own lives
- ◆ Involve young people in case planning decision-making and case review.

(DHS, 1998, p. 5)

Appendix Five:
Wraparound Essential Elements

5. WRAPAROUND ESSENTIAL ELEMENTS

1. Family voice and choice
2. Team based
3. Natural supports
4. Collaboration
5. Community based
6. Culturally competent
7. Individualised
8. Strengths based
9. Unconditional
10. Outcome based (Doyle, Castillo, Champion & Evora, 2008).

Appendix Six:

History of Evidence Based Practice (EBP)

6. HISTORY OF EBP

In 2000, The National Health and Medical Research Council in Australia published a document titled *How to Use The Evidence; Assessment And Application Of Scientific Evidence*.

This publication outlined a table with the designation of levels of evidence. These levels helped to categorise research and were designed to assist practitioners in decisions about which evidence/research was the most reliable and which evidence should be incorporated into practice. The intention was to assist in applying practices that had the highest standard of evidence. These levels are:

Level I	systematic review of all relevant randomised controlled trials
Level II	one properly designed randomised controlled trial
Level III (1)	well-designed pseudo-randomised controlled trials (alternate allocation or some other method)
Level III (2)	comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group
Level III (3)	comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group
Level IV	case series, either post-test or pre-test and post-test (National Health and Medical Research Council in Australia, 2000, p. 8)

The use of these categories means that any intervention used, must produce evidence for its effectiveness within one of these categories. This has also led to confusion in the sector where unfortunately many have taken evidence based practice to mean what Ramchandani, Joughin & Zwi (2001, p. 60) said, that

practice should be based upon the evidence of randomised control trials alone, and that all other practice is either not evidence based or of a lower quality... this narrow approach whilst not one envisaged by the original

proponents of evidence based medicine (Sackett, et al.), is a common misunderstanding of the paradigm.

(as cited in Tomison, 2002, p. 3)

More recently, the adequacy of the above structure, with its prominence of randomised control trials, has been questioned. This is because the structure fails to recognise the role of expert practitioners and does not give enough weight to the qualitative methods, which are more often used in disciplines such as social work (Gould, 2006, pp. 109-111). Webb (2004, p. 48) raises the question 'What counts as evidence?' and highlights that there "are differences within the evidence based movement about what counts as evidence".

Appendix Seven:
Interview Questions

7.1 Questions for Young People

7.2 Closure Interview Questions

7. INTERVIEW QUESTIONS

7.1 Questions for Young People

- ◆ What order are you on?
- ◆ How long have you had a Case manager from DHS
- ◆ How many other Case managers or workers do you have and where are they from (What service do they provide)?
- ◆ As far as your aware do these Case managers and/or workers talk to each other? (in what setting?)
- ◆ Where are you currently residing?
- ◆ How many placements have you been in during your involvement with DHS?
- ◆ How many DHS Case managers have you since the beginning of you involvement with DHS?
- ◆ How does the number of Case managers affect you and your family?
- ◆ How often have you seen your Case manager in the past?
- ◆ Are you satisfied with this arrangement?
- ◆ During visits with your Case manager what do you do?
- ◆ Is there anything you would like to change about your appointments with your Case manager?
- ◆ What are some of the helpful actions your Case manager has done?
- ◆ Is there anything you are not happy about with the way your being case managed?
- ◆ Would you like to see changes in the way that I work with you? Why/Why not.
- ◆ Do you feel that our discussions are honest on both sides? Do you feel that I am fair with you?
- ◆ Understanding that my role is to help protect you and plan for a safer future; do you think that I have helped in this way? Why or Why not?

- ◆ Do you think that your opinions are heard and that your previous Case managers and I have listened to you?
- ◆ Do you think that your Case manager understands you and/or youth issues?
- ◆ Do you go to case plan meetings? Are you involved in the case plan decisions?
- ◆ (If you are over 15) Are there plans for the future? Ie; after you turn 16 or 17?
- ◆ Is there anything else you would like to say about the way DHS case manages you?

7.2 Closure interview questions;

- ◆ How many other Case managers or workers do you have and where are they from (What service do they provide)?
- ◆ Looking back on the last six months, what are some of the helpful or unhelpful actions your Case manager has taken?
- ◆ Have there been any changes in the way you've been case managed? I.e. more visits vs. fewer visits.
- ◆ How often have you seen your Case manager in the past six months?
- ◆ Are you satisfied with this arrangement?
- ◆ During visits with your Case manager what have you done?
- ◆ Is there anything you would like to change about your appointments with your Case manager?
- ◆ What are some things you are happy or unhappy about with the way your being case managed?
- ◆ Would you like to see changes in the way that I work with you? Why/Why not.
- ◆ Do you feel that our discussions are honest on both sides? Do you feel that I am fair with you?
- ◆ Understanding that my role is to help protect you and plan for a safer future; do you think that I have helped in this way? Why or Why not?
- ◆ Do you think that your opinions are heard and that your previous Case managers and I have listened to you?
- ◆ Do you think that your opinions are heard and that your listened to by Case managers?
- ◆ Do you think that your Case manager understands you and/or youth issues?
- ◆ Do you go to case plan meetings? Are you involved in the case plan decisions?
- ◆ Is there anything else you would like to say about the way DHS case manages you?

Appendix Eight:

Focus Group Tools

8.1 List of Tools

8.2 Process Activities

8.3 Reflective Tools

8. FOCUS GROUP TOOLS

8.1 List of Tools

- 8.3.1 Tool 1 What is Your Practice Approach?
- 8.3.2. Tool 2 Reflections – The Starting Place
- 8.3.3 Tool 3 Helper Protector Scale
- 8.3.4 Tool 4 Unpacking the Suitcase
- 8.3.5 Tool 5 Chart Exercise – Cutnpaste Procedural
- 8.3.6 Tool 6 Learning Log (1)
- 8.3.7 Tool 7 Young People Profiles
- 8.3.8 Tool 8 Case manager Profiles
- 8.3.9 Tool 9 Knowledge Grid
- 8.3.10 Tool 10 Definitions Grid
- 8.3.11 Tool 11 Testing
- 8.3.12 Tool 12 Learning Log (2)
- 8.3.13 Tool 13 Values Brick Wall
- 8.3.14 Tool 14 Inhibiting Factors
- 8.3.15 Tool 15 Strategies
- 8.3.16 Tool 16 What are Habits?
- 8.3.17 Tool 17 Implementation Ideas
- 8.3.18 Tool 18 Interview Summary
- 8.2.19 Tool 19 Evaluation Reflection

8.2 Process Activities

8.2.1 Process 1 Personal Expectations

Instructions: When entering new situation we all come with different expectations. This sheet is an opportunity for you to think about your expectations for your involvement in this research project.

WHAT I WANT TO HAPPEN!	WHAT I DON'T WANT TO HAPPEN!
HOW I WILL MAKE THIS HAPPEN!	HOW I WILL STOP THIS FROM HAPPENING!

8.2.2 Process 2 Working Agreement ¹⁰⁴

To create a safe environment for the group, it is important to have well-defined limits. Rather than having to make rules (“you must do this” - “don’t do that”) Below are 4 principles. The Working Agreement is negotiated at the beginning of each focus group and it is not intended that people will not break the principles. We ask that people try to live by the agreement. In this sense, the working agreement becomes a group goal and a set of standards to operate by.

The Four Principles

1. Participation: to be present at each activity or session and be part of the group.

2. Respect; respect for self, for others and the environment. A commitment to work towards changing behaviour that is in some way putting down yourself or others.

3. Safety; a commitment to take responsibility for both physical and emotional, safety for self and the group.

4. Legal; a commitment to work within the framework of the law.

¹⁰⁴ Adapted from Outlook Training and Resource Certificate

8.2.3 Process 3 What's on top?

Principles	Comment
1. Continuity of Case manager where ever possible	
2. The ability to re-make personal work practice in line with evidence based practice and developments in the field.	
3. Relationship as a base for practice	
4 Consistency of care within the placement system	
5 Honesty, integrity, respect and flexibility	
6 Persisting in the face of everything, no matter what	
7. Acceptance of the young person	
8. The need to work from a developmental perspective, which takes into, account the difference between the biological and the emotional age of the young person.	
9. Commitment to identifying and/or helping to provide a significant person in the young person life	
10 Recognition that spirituality, culture, moral development and identity are intrinsically linked to the young person's healing, growth, resilience and ultimately their protection.	

11 The ability to put responsibility and participation directly with the young person, according to appropriate developmental and emotional status.

12 The competency to make and implement hard line decisions when necessary and in line with client's best interest and statutory standards.

13. The recognition that acting in a protective manner is the joint responsibility of service providers and Case managers from all service sectors and the most basic form of caring for a young person.

The following may be used in group discussion and/or in journal reflections, and are presented merely as a guide and stimulus to thinking. Some of the questions overlap, and some lead onto others. You may develop your own set of questions as well.

- 1) What stands out for me from my interviews? Do certain patterns or themes emerge (e.g. are particular words or phrases used repeatedly? are some missing which I would expect to be there?)
- 2) Can I identify and differentiate thoughts, feelings, actions and interpretations?
- 3) What kinds of interpretations did I make, and what are possible alternative interpretations? How many other players were in the situation and what might their interpretations have been? How many other possible interpretations are possible? Why did I select the interpretation that I did?
- 4) What assumptions did my thoughts and actions imply, and what are possible alternative assumptions? (eg. how did I see the young person and what did I assume about her or his rights or power? What did I assume about my own role? What are my assumptions about priorities?)
NB. MIRIAN – you might want to add lots more examples here in relation to the idea of unconditional care
- 5) Why did I make those particular interpretations and assumptions and where did they come from? (e.g. did I think this is the way I am supposed to think in the department, or from my professional education? my personal background? my practice experience?).
- 6) Are these particular interpretations or assumptions associated with particular formal theories to which I subscribe?
- 7) Are my actions and assumptions congruent with these “espoused” theories?

- 8) How did I personally influence the situation (e.g. through my experience and background; my interpretations or assumptions; my actions and interactions).
- 9) If I were in the same situation again, what would I do differently and why? What assumptions am I making about what works and what doesn't?

8.3.2. Tool 2 Reflections – The Starting Place

Principles	Always	Sometimes	Rarely	How do you use it? What does it look like?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13.				

8.3.3 Tool 3 Helper Protector Scale

Helper

Protector

1 2 3 4 5 6 7 8 9 10

8.3.5 Tool 5 Chart Exercise – Cutnpaste Procedural

This activity involved making a chart from pieces of procedures that the Case managers believed represented their knowledge. This was a second attempt at engaging Case managers in the discussion about procedural knowledge that informed Unconditional Care

1. Continuity	2. Re-Make Practice	3. Relationship	4. Consistency	COMMENT
5. Honesty	6. Persisting	7. Acceptance	8. Developmental	
9. Significant Person	10. Spirituality	11. Responsibility	12. Hard Line Decisions	13. Joint Responsibility

8.3.6 Tool 6 Personal Learning Logs (1)

Context: Job role (at the time) _____
Agency or DHS _____
When (approx date) _____

The Narrative - Positive

The Narrative – Negative

What Happened?

Issues;

Successes

Challenges

So What? (External)

Learnings

Feelings

So What? (Internal)

Learnings

Feelings

Now What?

Actions

Applications

Changes

Notes

8.3.7 Tool 7 Young People Profiles

- ◆ Age
- ◆ Gender
- ◆ Number of siblings
- ◆ Family structure and/or genogram / Parent previous clients? And age.
- ◆ Interests, sports.
- ◆ Strengths
- ◆ Current indicators and/or risk behaviours
- ◆ Sexually active/ appropriate or inappropriate
- ◆ Type of order
- ◆ Length of order
- ◆ Length of time case managed by yourself
- ◆ Number of Case managers in total
- ◆ Placement location and description
- ◆ Total number of placements
- ◆ Section of the CAYPA state care relates to ie source of harm
- ◆ Case plan goals and progress
- ◆ Crisis Management plan in existence/ who coordinates this
- ◆ Health status including substance use/abuse
- ◆ Education status school history/issues
- ◆ Self care skills
- ◆ Identify status
- ◆ Family and Social Responsibilities
- ◆ Development progress/level
- ◆ Social presentation
- ◆ Future plans
- ◆ Number of services involved/ forum for communication

8.3.8 Tool 8 Case Manager Profiles

1. Draw up a list of social features (past and present) of yourself and your life, which you think influence, and have influenced the sort of person you are today. The list might include:

- marital status/identity
- occupation
- employment situation
- social class
- educational type and level
- family type and background
- ethnicity, nationality, cultural and racial background
- religion
- membership of particular groups or sub-cultures
- gender
- sexual orientation
- health
- physical/mental ability
- age
- particular historical period
- social labels
- particular ideologies/theories or social movements

2. Try to identify who you are in relation to each of these features.

3. How has each of these features influenced you?

4. In what ways might each young person you work with differ, or be similar to yourself, in relation to each of these features?

5. How do you think these similarities and differences influence the ways you practice?

8.3.10 Tool 10 Definitions Grid

Phase Two – Focus Groups 4-7

PRINCIPLES	DEFINITIONS	QUESTIONS
<p>1. Continuity of Case manager where ever possible</p> <p>2. The ability to re-make personal work practice in line with evidence based practice and developments in the field.</p> <p>3. Relationship as a base for practice</p> <p>4 Consistency of care within the placement system</p> <p>5 Honesty, integrity, respect and flexibility</p> <p>6 Persisting in the face of everything, no matter what</p> <p>7. Acceptance of the young person</p> <p>8. The need to work from a developmental perspective, which takes into, account the difference between the biological and the emotional age of the young person.</p> <p>9. Commitment to identifying and/or helping to provide a significant person in the young person life</p> <p>10 Recognition that spirituality and moral development are protective factors which require acceptance and sometimes facilitation by the Case manager</p> <p>11. The development of a young persons identity in conjunction with their culture is intrinsically protective and healing.</p> <p>Both 10 and 11 contribute to and support resiliency</p>		

<p>12 The ability to put responsibility and participation directly with the young person, according to appropriate developmental and emotional status.</p> <p>13 The competency to make and implement hard line decisions when necessary and in line with clients best interest and statutory standards.</p> <p>14. The recognition that acting in a protective manner is the joint responsibility of service providers and Case managers from all service sectors and the most basic form of caring for a young person.</p> <p>15. Personal, Professional and Systemic practice should be driven by the reflective process which uses theorising as a basis for change.</p> <p>16. The family is the foundational context in which we work with young people.</p> <p>17. Connectedness to community both family and educational is a stabilising and supporting factor which underpins stability.</p> <p>18. Defensible risk practice which relies on a balance of statutory responsibility and the innate nature of risk that adolescent's experience.</p> <p>Comments</p>		
--	--	--

8.3.11 Tool 11 Testing

Have I been able to commence or continue practicing like this?

	Yes	No	Why?	Why Not?	Issues/Inhibitors
1. Continuity					
2. Re-Make Practice					
3. Relationship					
4. Consistency					
5. Honesty					
6. Persisting					
7. Acceptance					
8. Developmental					

9. Significant Person					
10. Spirituality					
11. Responsibility					
12. Hard Line Decisions					
13. Joint Responsibility					

SCENARIO

The Scenario: Substantiation Decision

The substantiation rationale has been made after gathering and analysing information provided by the parents, Bananas hospital (Psych unit) and CAMHS. Sue is in need of protection for the following reasons:

s.63 (e) Emotional or psychological harm

s.63 (c) Physical harm

INVOLVEMENT IN HIGH RISK/SELF HARM ACTIVITY

Sue is exhibiting multiple high risk behaviours and requires substantial support to meet her needs for care and protection. Whilst Sue's parents are willing and actively seeking to be involved in protecting Sue, they are unable to secure her safety at this time. This is largely due to Sue refusing to accept their support, and possibly due to (in the opinion of CAMHS) historic attachment difficulties and inability of the mother and father to parent with consistent limits, both of which have now led to high levels of anxiety and perceptions of parental rejection for Sue. Sue's high risk behaviours include:

estranged relationships with her immediate family

emerging diagnosed psychological disorder (Attachment Disorder diagnosed by CAMHS)

current detachment from professional networks and community supports (except CAMHS)

ongoing suicidal ideation and extreme life threatening behaviours (last night's talk of suicide and standing on train tracks)

escalating running away behaviour

involvement with a high risk peer group in New York

possible alcohol misuse which place her at sexual risk

The consequences of such harm to Sue are serious.

YOUNG PERSON HOMELESS

Whilst Sue can return to either parent's home she currently refuses to do so, and her recent placement with her maternal aunt in New York was only temporary and may no longer be viable. At this point Sue has no long term accommodation option arranged. Whilst Sue is in this situation, and thus without clear direction, limits, structure and support, she remains vulnerable and the probability of her continuing to engage in the previously mentioned high risk behaviours seems highly likely.

Describe any other aspects of risk to the child or young person which are relevant to the current decision making which have not been included in the above risk analysis

Sue has been involved with the Bananas from the age of 8 and has a lengthy history of suicide and CAHMS involvement.

Sue has not attended any formal schooling since primary school due to high levels of anxiety. She has successfully attended artist drama classes and young women's groups but not complete any.

Sue is sexually active. It does not appear to be prostitution at this stage, although it is not unusual for her to have more than one partner in an evening.

Case Transfer Summary:

Sue's whereabouts are currently unknown. A warrant was issued on the 26th of October with instructions to return her to Happy Street accommodation unit with Smiling Services for Youth. During this time Sue has made sporadic contact with her brother who has stated that it seems unlikely that Sue will return of her own accord.

On 18th September, Sue presented at the Bananas hospital requesting to be admitted due to suicidal feelings and sadness. Sue slept most of the

morning while AHS arranged for her to return to Happy Street. Sue stated emphatically that she did not want to be placed anywhere and left the hospital. Her whereabouts continue to be unknown.

The previous Case manager has written a letter to sue in the hope that she will make contact. It appears that she is currently homeless and does not have somewhere stable to reside. There has been some discussion about the removal of the warrant in order to encourage her to contact DHS however, the previous assessment is that Sue does not want to be placed and that this is what prevents her return more so than the warrant.

ASSESSMENT

This assessment has been taken from previous reports. It does not appear to the writer that the assessment is in need of review. Sue's issues continue to need addressing.

Sue Sunshine:

Mr Ever Hope from the Bananas Hospital has clarified to the writer that Sue does not currently suffer from any form of mental illness. The family appear to have concerns regarding Sue's ongoing need's and have requested further consultation regarding the future direction and possible treatment for Sue.

The Bananas have clarified their position in relation to Sue and made the following recommendations for Sue and her future, these include;

A need for stability and safety. Sue requires strong limits and those caring for her need to implement consequences and rewards for behaviour.

Working through the issue of attachment and belonging within or without her family unit. This needs to be coupled with acceptance for who she is and a working through of her personality style.

The need to address the emotional developmental delay which Sue suffers from in conjunction with ongoing support from doctors and counsellors.

Included in this treatment would be her anxiety issues relating to her need for security.

However, in examining Sue's behaviour it is the writer's assessment that a large part of Sue's presentation relates to attachment disorder or a lack of attachment to either parent. Some of the factors that disturb the attachment process are; The lack of a consistent parenting figure, physical separations from the parent, parental rejections (such as the mother placing the younger siblings as a priority), psychological absence of the parent through stress, conflict or separation, temperamental traits in the child interfering with normal attachment responses in the child.

Sue displays various features of the child with serious deficiencies in attachment. These features are; Active and/or passive resistance to being controlled by adults, repetitive and persistent pattern of aggressive or non-aggressive conduct (including the self), lack of appropriate conscience development with no show of appropriate guilt or remorse, failure to establish a normal degree of affection or empathy, developmental delay of cognition and emotion, chronic unfillable emptiness, repeated running away from home or school.

This perceived attachment disorder appears to have been foundational to the current situation Sue has grown into. The anxiety and panic attacks and suicide ideations are all behavioural indicators that Sue continues to have unresolved issues that have prevented her from developing at the normal emotional rate.

If Sue is to enjoy changes in her life that will bring about stability and fullness of life she will require the support of those who love her. This support will need to involve quality one on one time and devotion to getting to know Sue even when times are tough. Sue will also require the support of therapy and medical practitioners to continue to address her suicidal tendencies and anxiety/panic issues.

8.3.12 Tool 12 Learning Log (2)

Using the following scenario;

What is your course of action in order of priority	Why What is Your Rationale?
Example: I will ring Protective Services in Happyville for an update <u>today</u>	Because they will have the most recent information.

How does this reflect the 13 Principles?

How does this reflect your own theory?

8.3.13 Tool 13 Values Brick Wall

Foundational Value

8.3.14 Tool 14 Inhibiting Factors

Inhibiting Factor	Source
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

8.3.15 Tool 15 Strategies

Name four strategies for the implementation of Unconditional Care

8.3.16 Tool 16 What are Habits?

--

WHAT	WHY	ACTION

8.3.19 Tool 19 Evaluation Reflection

Over the course of the research the most valuable experience was. Why?

What have you learnt during your involvement with this project?

Do you believe that you practice Unconditional Care?

Yes No

Why?

Do you believe that you practiced Unconditional Care prior to your involvement in this project?

Yes No

Would you say your practice has changed during the course of the 12 month project?

Yes No

If so How?

In your opinion has this project had any affect on the system/agency you work in?

Yes No

Why?

What steps (if any) would need to be taken to create change in your organisation regarding the implementation or use of this practice approach?

What has been your biggest struggle in relation to this project over the last 12 months?

Have you been able to define your own practice approach?

Yes No

What does it look like?

Appendix Nine:

Ethics

9.1 Ethics DHS

9.2 Ethics RMIT

9.3 Participant Ethics Information

9. ETHICS

9.1 Ethics DHS



Department of Human Services

Incorporating: Health, Aged Care, Housing, Aboriginal Affairs and Community Services

ETHICS COMMITTEE

44/00



205 Spencer Street
Melbourne Victoria 3000
GPO Box 16708
Melbourne Victoria 3001
DOC10081

Telephone: (03) 9637 4000
Facsimile: (03) 9637 4779

Our Ref:
Your Ref:

14 September 2000

Ms Miriam Martin *20/955*
Senior Project Officer
Practice Leadership Unit Child Protection Community Care
Justice and Youth Studies
RMIT
Plenty Road
BUNDOORA 3083

Dear Ms Martin

**Re: Unconditional Care A Study of Professional Practice with
High Risk Adolescents**

The Committee notes that this is on the borderline between research and improvement of an existing program with a systematic evaluation of that which shares many things in common with quality assurance and quality improvement and organizational culture change.

Thank you for responding to Professor Fos's requests and your revised submission of the above project. The Department of Human Services Ethics Committee, at its meeting of 6 September 2000, considered and **approved** this re-submission on condition of the following:

In the Plain Language Statement, clarify the rough time commitments involved and that there will be no adverse consequences from a decision not to participate or withdraw from the project.

Thank you for the paper on Unconditional Care which was most helpful.

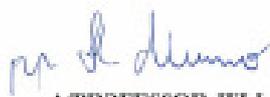
Researchers must obtain the approval of the institution at which the research will be conducted or the institution which is responsible for the care or management of the participants.

To enable the Committee to fulfill its obligations in relation to monitoring the program you are asked to provide a report within 12 months or on completion of your project whichever is earlier. Additionally the Committee requests a summary of the research findings of less than half a page, including when the study was completed.

You must ensure that the Department of Human Services Ethics Committee is notified immediately of any matter which arises that may affect the nature of the approved program.

Should you have any queries please do not hesitate to contact our Executive Officer, Ms Kay Munro on 9637 4239.

Yours sincerely



A/PROFESSOR JULIAN SAVULESCU
CHAIR

9.2 Ethics RMIT

Form No 1: Application Form

RMIT University
HREC Register No:
Date Application
Received:
University HREC Use Only

RMIT **HUMAN RESEARCH ETHICS COMMITTEE**

APPLICATION FOR APPROVAL OF PROJECT INVOLVING HUMAN SUBJECTS

Note: No handwritten applications can be accepted. This form is available on Disk from your Faculty Office or from:
<http://www.rmit.edu.au/departments/secretariat/hrec.html>

Section A: Approvals and Declarations

Project Title: Unconditional Care: A Study of Professional Practise With High Risk Adolescents

1. Complete this column if you are undertaking Research for a Degree Awarded by RMIT or another university. (Bachelor/Masters/PhD).	1 Complete this column if your Research is Not for Any Degree.
Investigator Name: Mirian Martin Student No: 2005355J Qualifications: Bachelor of Arts Youth Affairs Department: Justice and Youth Studies Address: RMIT Bundoora Phone: WK 9616 75 32 HM 5289 6630 Email: mimand@pipeline.com.au	Principal Investigator Name: Qualifications: Department: Campus: Phone: Email:
Degree for which Research is Undertaken: Masters of Arts	
Supervisor: Name: David Maunders Qualifications: BA, MA, M Ed PhD Department: Justice and Youth Studies Campus: Bundoora Phone:	Other Investigator/s: Name/s: Qualifications: Department: Campus: Phone:

Section A3

Project Title:

Unconditional Care: A Study of Professional Practice With High Risk Adolescents

Declaration by the Head of Department

Statement on the adequacy of the project's experimental design:

*The project's experimental design appears to be sound
(as outlined in Section 2.9 of the attached proposal).*

Ethical issues that are to be addressed by the Human Ethics Committee:

The project set out in the attached application, including the adequacy of its experimental design and compliance with recognised ethical standards, has the approval of the Department/Faculty.

Signed: *[Signature]* Date: *31/7/2010*
Signature of Head of Department

Department: *Justice & Youth Studies* Extn: *57935*

Faculty: *FLACS* Campus: *Bundoora West*

Should substantive amendments to the proposal be sought by the HREC or its Faculty Sub-Committee, these are to be endorsed below:

Amendments made at the date indicated:

Signed: Date:
Signature of Head of Department

Section A4
Faculty Human Research Sub-Committee Use Only

Date application received: 31-7-2000 Faculty HRE Sub-Committee.
 Register No.: 141-07/00 ✓

Recommended project classification: AR MR NR (circle one)

Approved by Faculty Sub-Committee: Date: 3-8-2000

Period of Approval - From: To:

OR

Referred to RMIT HREC: Date:

Comments/Provisos:

Signature:  Date: 12-8-2000
 Faculty HRE Sub-Committee Chair

Date PI notified/sent to RMIT HREC:

Section A5
University Human Research Ethics Committee Use Only

(b) AR Project RMIT HREC Register No.

Period of approval: From: To:

Comments/Provisos:

Signature: Date:
 (HREC Chair)

Date PI notified/returned to HREC Sub-Committee:

For completion by the investigators as an attachment

9.3 Participant ETHICS Information

Case managers

Together with the Practice Leadership Unit of Protective Services I am seeking to undertake research and development in the area of professional practice with adolescents. The attached information invites you to consider taking part in an action research project. I am enrolled for the degree of Master of Arts by research at RMIT University. In addition I am employed in the Practice Leadership Unit at Department of Human Services Head Office. In this role am responsible for the research and development of a child protection adolescent practice framework. The plain language statement attached will provide the details of the project. A consultative and collaborative action research model has been chosen to test and discuss practice notions.

Below are the requirements of co-researchers. Both supervisors and case managers will need to be aware of the time commitment involved with the understanding that staff will need to be released from duties to attend focus groups and forums to conduct their role in the project. The action plan is attached in the proposal and provides a guide to time lines. The information below will explain time commitments needed from case managers. All case managers will remain anonymous. This project is in no way an audit or performance measure and does not focus on more effective case managers or less effective case managers. Please note that you will be able to withdraw at any time.

Co-researchers will need to:

1. Be interested in positive change and better outcomes for young people in the statutory system and have a desire to be involved in learning, reflection and discussions. Case managers with differing levels of experience are welcome to participate.
2. Be available and supported by managers to attend three-hour focus groups held in conjunction with the stages of the research. (Monthly for 12 months).
3. Be willing to participate in discussion, self-analysis and reflections on your own practice, including the provision of a self-profile i.e.; training, development of personal theory and wisdom's.
4. Conduct two interviews with one high risk young person who they case manage. An initial and closure interview regarding the young persons experience of practice. You will also need to compile of a profile of the young person. You will be required to record and transcribe the interview. This will contribute to the data.
5. Participate in confidentiality, anonymity and privacy restrictions regarding research and client information as the ethics guidelines provide and legislation in the Children and Young Persons Act 1989.

Benefits for Co-researchers:

1. Exposure to input on a direct level to the state-wide practice development initiative.

2. Discussions and contributions from senior, experts from a range of professions. Including RMIT Lecturers in the Justice and Youth Studies Department, authors, consultants and Head Office contributions from a range of areas.
3. Exposure to current and international evidence based practice guidelines and their outcomes.
4. The opportunity to take time out to reflect on professional development.
5. The chance to develop personal practice with a view to better outcomes for young people.
6. The opportunity to develop relationships and partnerships with other case managers.

Expressions of Interest to: Mirian Martin BA(YA) Mon-Wed on 9616 7532 or Th-Fri 5226 4671 Practice Leadership Unit Head Office Department of Human Services

Plain Language Statement - Case managers

This is a letter of explanation regarding the invitation for you to take part in improving the services for Protective Clients and their families. The current commitment to improving services for adolescent involves a research project in which I will be looking at how the Department of Human Services and contracted agency staff work with adolescents and their families.

My name is Mirian Martin and I am enrolled for the degree Master of Arts by research at RMIT University. I am undertaking to write a thesis titled *Unconditional Care: A Study of Professional Practice With High Risk Adolescents*. I am also responsible for the research and development of a professional practice framework for adolescents in the Department of Human Services.

If you would like to contribute to this work you will need to read the following information regarding privacy and consent.

1. All case managers who agree to take part will need to sign a consent form.
2. If you decide to take part in the project, you will:
 - a. Consider providing an anonymous profile or description of yourself and your background.
 - b. Choose a young person whom you case manage. The young person will be chosen in consultation with your supervisor. The young person will need to be Registered on the high risk schedule with Department of Human Services or identified as being a substantially challenging young person to case manage in terms of practice issues.
 - c. With this young person you will be asked to;
 - (1.) conduct two interviews. The interviews will be conducted six months apart. They will be regarding the experience of practice with the current/past case managers and expectations that have or have not been met by the young person.
 - (2.) Provide a profile of the young person, with pseudonyms and change of detail to protect the identity of the young person
 - d. Be aware that time commitments include; attending monthly focus groups to analyse and reflect on your own case practice, the completion of reading, interviews and profiles.
 - e. Agree to contribute your findings to the pool of data.
3. You will **remain anonymous**. All names and some detail i.e. location can be changed by you to protect privacy. You can complete a profile and will be able to withdraw from the project at any time. All material relating to you will be removed from the project.
4. I will not have access to your case notes at any point. I do not have access to client information and files.
5. The data which is made up of two interviews with a young person, profiles of yourself and the young person and your analysis will be gathered and analysed by all those involved in the project. The Reference group will consist of five people identified from within the field as experienced and able to contribute. At times the guests invited into the group will also be consulted regarding the progress and analysis of the action research.
6. On completion of the research a thesis will be published, a framework developed from the findings and a book will be published. In these materials all case

managers, young people and identifying information will be protected by anonymity including agency and geographical details.

7. There will be no adverse consequences from a decision not to participate or to withdraw from the project.

Please note that participation in the research is entirely voluntary and people may withdraw at any time in the research. A reference group has been set up for any problems arising during the course of the Research and can be accessed via the Department of Human Services or the University ethics committee as detailed below.

Please find attached a letter of consent to be signed and returned. If you have any questions please contact myself on 9616 7532 or my senior supervisor David Maunders on 9925 7796

Mirian Martin BA(YA)
Practice Leadership Unit
Head Office Department of Human Services

Any complaints about your participation in this project can be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO 2476V Melbourne 3001. The telephone number is (03) 9925 1745

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

DEPARTMENT OF JUSTICE AND YOUTH STUDIES.....

FACULTY OF EDUCATION, LANGUAGE AND COMMUNITY SERVICES

Name of participant:
.....

Project Title: Unconditional Care: A study of professional practice with high risk adolescents.

Name(s) of investigator(s): Mirian Martin.....Phone 9616 7532

1. I have received a statement explaining the interviews involved in this project.
2. I consent to participate in the above project, the particulars of which - have been explained to me.
3. I authorise the investigator or her assistant to include my data with the pool of data for analysis.
4. I acknowledge that:
 - a. Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
 - b. I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
 - c. The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
 - d. The anonymity of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
 - e. The security of the research data is assured during and after completion of the study. The analysis of the data collected during the study may be published, and a report of the project outcomes will be provided to The Department of Human Services. There will be no identifying information used.

Participant's Consent

Signature:Date:.....
(Participant)

Signature: Date:
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed. Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Questions about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.

Young People and Their Families

Plain Language Statement For Young People and Their Families

This is a plain language statement, which invites you to take part in improving the services for Protective Clients and their families. The current commitment to improving services for adolescent involves a research project in which I will be looking at how the Department of Human Services and contracted agency staff work with adolescents and their families.

My name is Mirian Martin (Meade) and I am enrolled for the degree of Master of Arts by research at RMIT University in the Department of Justice and Youth Studies. I am undertaking to write thesis titled *Unconditional Care: A Study of Professional Practice with High Risk Adolescents*. In addition I am employed in the Practice Leadership Unit at Department of Human Services Head Office. In this role am responsible for the research and development of a child protection adolescent practice framework.

Below are the requirements you will need to consider. Both parents/guardians and you will need to be aware of the time commitment involved and the process by which the research will be undertaken. All young people and their families will remain anonymous. I will not have access to your identity or any case notes or files. Your case manager will be required to protect you by providing information with your name and some details changed.

If you would like to contribute to this work you will need to read the following information regarding privacy and consent.

1. If you agree to take part, you will need to sign a consent form with either your parent or guardian.
2. Please note that you will be able to withdraw at any time
3. You will remain anonymous. All names and detail ie location will be changed by your case manager to protect privacy. Your case manager will complete a description with details changed prior to handing up to the researcher and reference group. You will be able to withdraw from participation at any time and material relating to you will be removed from the project.
4. You will need to be available to participate in;
 - a. Two interviews with your case manager. An initial and closure interview regarding your experience of practice. The interviews will be tape recorded, transcribed and then pooled with the data for reflection and analysis. (and supported by an independent person)
 - b. Your case manager will also need to compile of a description of you, with identifying information changed to conceal your identify.
5. The information gathered from the interviews and profile will be used to explore better ways to work with young people.
6. The interviews & descriptions as mentioned above will be gathered and analysed by a reference and myself group. The Reference group will consist of five people identified from within the field as experienced and able to contribute. At times the guests invited into the group will also be consulted regarding the progress and analysis of the action research.
7. At a later date a book will be published with the findings. This book will in no way identify you or your family. It is designed to create better outcomes for families based on the input gathered during this action research.
8. There will be no adverse consequences from a decision not to participate or to withdraw from the project.

Please note that participation in the research is entirely voluntary and you may withdraw at any time in the research. A reference group has been set up for any problems arising during the course of the Research and can be accessed via the Department of Human Services or the University ethics committee as detailed below.

Please find attached a letter of consent to be signed and returned to your case manager if you decide to take part in the project. If you have any questions please contact your case manager or the senior supervisor David Maunders on 9925 7796

Mirian Martin BA(YA)
Practice Leadership Unit
Head Office Department of Human Services

Any complaints about your participation in this project can be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO 2476V Melbourne 3001. The telephone number is (03) 9925 1745

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

DEPARTMENT OF JUSTICE AND YOUTH STUDIES.....

FACULTY OF EDUCATION, LANGUAGE AND COMMUNITY SERVICES

Name of participant:

Project Title: Unconditional Care: A study of professional practice with high-risk adolescents.

Name(s) of investigator(s): Mirian Martin.....Phone 9616 7532

1. I have received a statement explaining the interviews involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews have been explained to me.
3. I authorise the my case manager to interview me and provide a profile of me.
4. I acknowledge that:
 - a. Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
 - b. I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
 - c. The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
 - d. The anonymity of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
 - e. The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to The Department of Human Services. Any information, which will identify me, will not be used.

Participant's Consent

Signature:Date:.....

(Participant)

Signature: Date:

(Witness to signature)

OR: Where participant is under 18 years of age:

I consent to the participation ofin the above project.

Signature:..... Signature: Date

(Signatures of parents or guardians)

Signature: Date:

Co-researchers should be given a photocopy of this consent form after it has been signed. Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne

Reference Group Members

Plain Language Statement for Reference Group Members

This is a letter of explanation regarding the invitation for you to take part in improving the services for Protective Clients and their families. The current commitment to improving services for adolescent involves a research project in which I will be looking at how the Department of Human Services and contracted agency staff work with adolescents and their families.

My name is Mirian Martin and I am enrolled for the degree of Master of Arts by research at RMIT University in the Department of Justice and Youth Studies. I am undertaking to write thesis titled Unconditional Care: A Study of Professional Practice with High Risk Adolescents. In addition I am employed in the Practice Leadership Unit at Department of Human Services Head Office. In this role am responsible for the research and development of a child protection adolescent practice framework.

Together with the Practice Leadership Unit of Protective Services I am seeking to undertake research and development in the area of professional practice with adolescents. This information invites you to consider taking part in an action research project by sitting on the reference group, which will oversee the work. Due to this group having access to data, the formal consent process needs to be adhered to. This involves reading the following information and making a decision to adhere to the recommended ethical and anonymity guidelines.

Below is the information and guidelines relevant to the reference group members. Both managers and case managers have been requested to be aware of the time commitment involved with the understanding that staff will need to be released from duties to attend focus groups and forums to conduct their role in the project. The attached action plan is a guide to timeliness and information below will explain time commitments needed from practitioners. All case managers and Department of Human Services clients will remain anonymous and client information will be managed in line with DHS ethics committee guidelines. This research is in no way an audit or performance measure. Please note that you will be able to withdraw at any time

It is envisaged that the reference group will meet on a bi monthly basis, commencing in September.

If you would like to contribute to this work you will need to read the following information regarding privacy and consent.

1. All people who agree to take part in the reference group will need to sign a consent form.
2. If you decide to take part in the project, you will:
 - a. Provide an anonymous profile or description of yourself and your background.
 - b. Attend bi-monthly reference groups to analyse reflect and contribute your input to the research.
3. All Case managers (participants), young people and reference group members will **remain anonymous**. All names and some detail ie. The case manager to protect privacy will change location. The case manager will complete the description and interview with details changed prior to handing up to the researcher and reference group. You will be able to withdraw from participation at any time and material relating to them will be removed from the project.
4. There will be approximately five representatives on the reference group. There will be regional representation from the regions involved in the research and one other person identified as an external contributor.

5. The purpose of this group will be to:
 - a. Contribute to the analysis of the data as it is gathered.
 - b. Assist the case managers in their self analysis of their data
 - c. Assist in the development of the unconditional care practice notions
 - d. To help the researcher to deal with conflictual or difficult issues arising out of the research To bring an objective point of view to the research process
 - e. To contribute practice knowledge.
6. You will not have access to formal case notes, or client information and files. These are protected by current legislation. The case managers will provide the data.
7. The data (interviews, profiles and self-analysis) as mentioned above will be gathered and analysed by the reference group and myself. At times the guests invited into the group will also be consulted regarding the progress and analysis of the action research. These two parties will also be signing consent forms protecting anonymity.
8. On completion of the research a thesis will be published, a framework developed from the findings and I will publish a book. In these materials all practitioners, young people and identifying information will be protected as discussed by anonymity.
9. Please note that participation in the research is entirely voluntary and people may withdraw at any time in the research. A reference group has been set up for any problems arising during the course of the Research and can be accessed via the Department of Human Services or the University ethics committee as detailed below.

Please find attached a letter of consent to be signed and returned. Please contact me with any questions on 9616 7532 or alternatively my senior supervisor David Maunders 9925 7796

Mirian Martin BA(YA)
Practice Leadership Unit
Head Office Department of Human Services

Any complaints about your participation in this project can be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO 2476V Melbourne 3001. The telephone number is (03) 9925 1745

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

DEPARTMENT OF JUSTICE AND YOUTH STUDIES.....
FACULTY OF EDUCATION, LANGUAGE AND COMMUNITY SERVICES

Name _____ of _____ participant:
.....

Project Title: Unconditional Care: A study of professional practice with high risk adolescents.

Name(s) of investigator(s): Mirian Martin.....Phone 9616 7532

1. I have received a statement explaining the participation involved in this project.
2. I consent to participate in the above project, the particulars of which, have been explained to me.
3. I authorise the investigator or his or her assistant to include my contributions
4. I acknowledge that:
 - I. Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
 - II. I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
 - III. The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
 - IV. The anonymity of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
 - V. The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to The Department of Human Services. Any information, which will identify me, will not be used.

Participant's Consent

Signature:Date:.....
(Participant)

Signature: Date:
(Witness to signature)

OR: Where participant is under 18 years of age:

I consent to the participation ofin the above project.

Signature:..... Signature: Date
(Signatures of parents or guardians)

Signature: Date:
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed. Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.

Appendix Ten:
High Risk Adolescent (HRA) Examples

10. HRA PROFILE EXAMPLES

The HRA client who was identified for this study was located when a warrant was executed. She had been being missing for 5 months. When located she spent a week in Secure Welfare and had her health checked. I utilised this time to re-engage her and to try to find out where she had been and what had happened to her during the time she had been missing. She was healthy, clean, well dressed and was able to express herself quite well. This was different to how she had been 5 months earlier. All of the medical information came back clear, including an AMHS (Adolescent Mental Health) psychological assessment. With the assistance of Secure Welfare staff, she was encouraged to appeal her stay in Secure Welfare. Her appeal was accepted.

She was then placed in a caravan park with staffing 24 hours a day which was arranged with another service. She had spoken with a legal representative about appealing her Guardianship Order. They advised her to wait for the case plan in a months time. This meant that if she could demonstrate an ability to make safe decisions for herself, a recommendation not extend the order would be made.

She stayed in the accommodation for two weeks before absconding again. The last known contact indicated that she was in Queensland. Her case plan recommended that her protective order be removed (for a variety of reasons) however, it was rejected. A six-month extension of the order (Guardianship) occurred. I've since heard that her HRA status has continued with a warrant. I've had contact from her, as she wanted to find out the outcome of her case plan. She claims to be fruit picking in Darwin. Case management was returned to the Department .¹⁰⁵

(Young Persons Profile, Completed by a Case manager)

This young woman is 16 years old with five siblings, two who are deceased. She has interests which includes; modelling, music, fashion and makeup, magazines. She is on a 12 month Custody to the Secretary Order and has experienced two Case managers. She has been Case Managed for six

¹⁰⁵ The researcher had slightly edited the profile for readability.

months by the Case manager completing the research. Her strengths include; being highly intelligent, socially appropriate, well-educated, attractive, personable and persuasive. The current risk factors include; a violent relationship with boyfriend, suicidal ideations, post traumatic stress symptomology, self-harming, substance use, including daily heroin use, absconding and eating disorder anorexia/bulimia. She also sexually active, vulnerable to sexual exploitation due to nature of relationship with boyfriend, has a previous history of prostitution history of sexual assault.

(Young Persons Profile)

Last sighted 30 October currently missing. Suspected the be with a 37 year old male. Warrant in place and Secure welfare placement application approved.

(Young Persons Profile)

Chronic depression and post traumatic stress disorder, fixated on death, darkness and abuse, inability to adopt self protective behaviours. Client has been a victim of sexual abuse since the age of 4. Number of case managers at least 14. Total number of placements at least 8. DHS has a role in monitoring that family to ensure compliance through using power of removal of child and encouragement and reinforcement of need to maintain distance between the client and the offenders.

(Young Persons Profile)

The risks for this young person include domestic violence, chroming, associations with sex workers, transience, psychiatric issues, can't sustain relationships. There have been ten placements in the last 13 months.

(Young Persons Profile)

