RELATIONSHIPS, CONNECTEDNESS AND ENGAGEMENT

A STUDY OF THE MULTIDIMENSIONAL COMPONENTS OF 'GOOD-ENOUGH' COLLABORATIVE APPROACHES FOR YOUNG PEOPLE WITH COMPLEX NEEDS AND THEIR FAMILIES

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ABSTRACT

The focus of this research is an exploration of the use of collaborative intersectoral approaches to service delivery as a means of improving responsiveness to the complex needs and issues presented by vulnerable adolescents and young people.

There are three central domains and contexts that inform this research;
- young people with complex needs,
- their problematic history of access to, and engagement with a particular cohort of service systems and
- the common issues that arise when these service systems interact.

The central research question that this thesis has explored is:
- What are the principles and guidelines that will inform services operating within an integrated collaborative approach for children, adolescents and young people with complex needs?

A multi method design informed by an interpretative research paradigm utilising qualitative research methods was used which consisted of:

(i) An analysis of key policy directions within Australia, United Kingdom and United States relating to young people with complex needs.

(ii) An analysis was undertaken of current local, national and international literature that relates to policy, program and practice for children, adolescents and young people with complex needs.

(iii) In-depth interviews conducted with five stakeholder groups involved with an inter-sectoral service initiative consisting of cross-sector care teams providing a therapeutic service to young people living in residential units.

These research methods provided a respectful means of exploring and conveying the lived experience of at-risk young people, their families, service providers and managers during the development and implementation of an intersectoral service initiative. It provided access to the insights of all the stakeholder groups involved in a collaborative endeavour and
communicated their distinct perspectives. These distinct insights have identified new understandings and knowledge to enhance our understanding of the practice mechanisms required to facilitate collaborative approaches.

These results substantiated and expanded existing Australian and international knowledge about the multiple factors that support collaborative approaches, in particular the central role of trusting and respectful relationships as the foundation to achieve effective inter-sectoral endeavours. What the findings also provided were additional insight and detail about the interactive factors which enable, promote and sustain these relationships.

The research found that strengthened collaborative service responses rely on a cluster of inter-connected theoretical and practice dimensions and stages. These cluster of factors included:

- The critical importance of the particular characteristics of workers and organisations able to embrace collaborative approaches,
- The critical capacity of these workers and organisations to develop trusting and respectful relationships that form the foundation for collaborative approaches,
- The critical policy, organisational, and practice structures that promote collaborative approaches and activities being developed and sustained

This research demonstrated that a matrix of co-existing dimensions, stages and components is required for the development of effective ‘good enough’ collaborative approaches (both between workers and between workers and young people). These dimensions include the dynamic interaction of the temporal, psychological, social, organisational and policy dimensions.

The implications for social work practice are that collaborative approaches require policy, organisational, and practice structures which promote effective and sustained relationships between organisations and engagement with vulnerable young people and their families.
DECLARATION

This is to certify that:

(i) the thesis comprises only my original work towards the PhD

(ii) due acknowledgement has been made in the text to all other material used

(iii) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

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Signed

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In undertaking this research about partnership, collaboration and teamwork, I have been privileged to be supported by a number of my own ‘teams’ who have all contributed to provide the glue that has enabled me to hold this work together. Some have been present throughout the whole process, some have joined the journey at different times and all have offered their particular and highly valuable contribution.

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To the ‘presidents’ of my personal support team, my mother Phyllis Absler and close friend, Yvette Wroby, who provided a wonderful contribution of practical assistance, endless patience, encouragement, support, vision and dedication to this project’s completion. To Jill Byron, who became a later member of the committee and provided me with friendship, assistance, an endless capacity to find new and more creative words of inspiration and was a generous ‘style mistress.’

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I dedicate this PhD to the memory of my grandmothers, Dora Absler and Rebecca Lewis, the courage of their stories always sustained me.
GLOSSARY OF SERVICES AND THEIR ACRONYMS

The Victorian Department of Human Services (DHS). The Department of Human Services is Victoria's largest state government department which takes responsibility for planning, funding and delivering health, community and housing services. Its organizational structure consists of eight divisions. In relation to the focus of this research the relevant divisions include Metropolitan Health and Aged Care Services which has statewide policy, funding and program responsibility for mental health services, Office for Children which includes statutory responsibilities for child protection and juvenile justice and the Rural and Regional Health and Aged Care Services which has state wide policy and program responsibility for drug treatment services.

The Child Protection Program (CP) is a program of the Department of Human Services. It is the statutory Child Protection service system responsible for investigating alleged child abuse and neglect, determining the most appropriate care or support solution for the child and ultimate case management for children on care and protection orders including being placed in residential care.

High Risk Adolescent Program (HRA) is a program developed for a small group of young people identified as having special needs within the broader category of children, adolescents and young people under the statutory care of the Child Protection Program. Inclusion criteria are based on the young people displaying the following persistent high risk indicators: self harming, involvement in crime and frequent placement breakdowns.
Juvenile Justice Program (JJ) is a program area of the Department of Human Services which provides statutory case management of young people on community based orders, provides rehabilitation and support for young people who are incarcerated and post release.

Out of Home Care Services (OHC) is a general term to describe a range of services provided for children and young people not living with their families. It includes residential care, foster care and kinship care. In Victoria these services are provided by Community Support Organisations (CSO’s). The Out of Home Care Program is also a program area of the Department of Human Services responsible for administering these services.

Community Support Organisations (CSO). In Victoria Community Support Organisations deliver the day to day residential (and home based) care for children and young people. Their funding is provided by the Department of Human Services and administered by the Out of Home Care Program area.

Child and Adolescent Mental Health Service (CAMHS) provide services to children and young people aged up to 18 years of age who are experiencing significant psychological distress and/or mental illness. These services are part of the State Government funded specialist mental health system administered by Regional Health Networks (funded through the Metropolitan Health and Aged Care Services division of the DHS).

Drug Treatment Services (DTS) is an umbrella term for a range of services providing treatment for people struggling with issues related to their use of alcohol or drugs. The services run the gamut of inpatient units, community based services and outreach services. DTS are funded through the Rural and Regional Health and Aged Care Services Division of the DHS.
The Department of Employment and Training (DE&T) (formally known as the Department of Education, Employment and Training (DEET) is a department of the Victorian Government which is responsible for the provision of schooling for children from the ages of 5 to 15 years.

Working Together Strategy (WTS) is a Statewide quality improvement initiative of the Department of Human Services (DHS). The WTS was established in 1999 to build capacity and improve services for shared clients of the program areas, Child Protection, Out of Home Care, Mental Health Services, Juvenile Justice, Drug Treatment Services and Education. The focus of this research, The Enhanced Residential Program (ERP) was one of the Working Together Strategys' service initiative activities.

The Enhanced Residential Program (ERP) was one of the Working Together Strategys' (WTS) service initiative activities based in a Metropolitan region of the Victorian Department of Human Services. The Enhanced Residential Program consisted of the establishment of an inter-sectoral care team to provide a service for young people from the ages of 13 living in a residential unit. The Care Team had two components, the provision of direct service to the young people and working as an integrated team to develop individualised case plans for each young person, promote regular discussions about their progress and provide opportunities for staff development and education.
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CHAPTER 1: INTRODUCTION TO THE RESEARCH

You need input from different sectors, no one can help the young people on their own and you need the different strengths and the only way to do that in a coordinated way is through a Care Team (Regional Manager).

1.1 OUTLINE OF CHAPTER

This chapter commences with an overview of the aims of the thesis and the research questions that will guide the research process. The topic at the core of the research is also introduced; an exploration of the use of collaborative intersectoral approaches to service delivery as a means of improving responsiveness to the complex needs and issues presented by troubled adolescents and young people.

The chapter continues with an outline of the critical domains and contexts within which the research is embedded commencing by introducing the young people who stand at the centre of this research.

The multi-faceted components of this vulnerable and challenging cohort are explored. These are young people and families who frequently occupy excluded and marginalised positions within key community structures. The middle sections of the chapter explore how despite the presence of a number of serious co-existing problems such as health, mental health, drug and alcohol, developmental and educational difficulties, these young people have a problematic history of access to, and engagement with service areas.

A number of factors contribute to this unsatisfactory situation. Some are the result of the particular struggles of the young people themselves while
some are due to the mismatch that occurs between the young people and traditional service delivery models. Others arise from the complexities in the working relationships between the services involved with these young people.

The common issues that arise within these interfaces, between the young people and the service systems and between the service systems themselves are described in the concluding section of the chapter.

As a consequence of this situation, state, national and international policy and program development has increasingly supported the need for integrated, co-ordinated and collaborative cross-sectoral practice when working with young people with complex needs. This has proved a challenging policy direction for sectors particularly when accompanied by generalised implementation guidelines.

The policy directions that have occurred within Australia, the United Kingdom, the United States and some other Western countries in relation to promoting collaborative approaches are explored in Chapter Two, The Policy Context.

This research is concerned with strengthening our understanding of the critical components that inform effective cross-sectoral collaborative interactions and linkages between young people, families and practitioners and between the practitioners and services. Attention will be placed on understanding the dynamic nature of these interactions.

The research is interested in exploring the processes involved in the development of a shared orientation which sponsors co-ordinated and collaborative inter-sectoral interventions. The focus is on exploring how
these critical practice principles and components can enhance current forms of service delivery and promote new models.

1.2 THE AIM OF THE RESEARCH

In the past decade multi-agency collaboration has increasingly been viewed as the most efficient way to deliver high quality services and ensure their effectiveness in being responsive to service users' needs (Salmon and Rapport 2005:440).

The topic at the core of this research recognises the importance of using inter-sectoral collaborative approaches when providing a service for children and young people with complex needs as a means of improving responsiveness to this vulnerable and challenging group. As demonstrated by the quotes from British clinicians and researchers, Salmon and Rapport (2005), (above) and Walker (2005), (below), widespread support for this orientation exists within many practice, research, academic and government settings:

this new environment is opening up exciting possibilities for creative joint work where the sharing of skills, knowledge and expertise can enhance the quality of support offered to vulnerable children (2005: 236).

The research embraces the possibilities provided by collaborative intersectoral approaches and plans to build on the recent policy and program directives and the substantial knowledge base that lies behind this emphasis. In the six years since the research commenced this area has expanded enormously. The emphasis on integrated ‘joined-up’ cross-program/sector/departmental practices now occupies a central focus within policy development across multiple government levels. 

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1 Interestingly it has shifted (in some settings) from only applying to marginalised groups (such as young people with complex needs) to being seen as constituting a general principle
The amount of publications and research, establishment of curriculum within tertiary institutions devoted to the topic and the number of service developments being introduced based on this model and philosophy within a number of Western countries, is extensive and far-reaching (Hudson 2002: 16).

Alongside the solid and widespread support for the collaborative approach, a number of writers, researchers and practitioners have also raised concerns that the vigorous and enthusiastic embracing of these concepts at the policy level has been accompanied by:

a) An urgency to ‘...drive developments at a frenetic pace’ (Walker 2005:237; Richardson and Lelliott 2003:253)

b) A tendency to believe in ‘...the deceptively easy rhetoric of collaborative and integrated working’ (Walker 2005:237) rather than acknowledging the complexity of the approach and therefore its implementation. As a consequence, as Hudson (2002) points out, many of the policies appear to be based on the simplistic assumption ‘...that if interagency partnership policies, processes and structures are established, then front line partnerships between a range of traditionally separate professions will fall into place’ (2002:7)

c) The inference that because of its (alleged) simplicity professionals will just know what to do rather than building in the required structures to support it. Robinson and Cottrell (2005) express their concern about the ’...inadequate training or guidance being provided to those required to work within this orientation’ (2005:548)

that will enhance service delivery for all members of the community. This shift is discussed in more detail in Chapter Two, The Policy Context.
d) ‘This major shift in public policy has been subject to very little theorising or research’ (Robinson and Cottrell 2005:548; Salmon and Rapport 2005:441). In relation to relevant areas for this research concern has been expressed about:

- The paucity of research that directly relates to interagency collaboration at the state (government) level’ (United States researchers, Johnson, Zorn, Kai Yung Tam, Lamontagne and Johnson 2003:196)

- The need to ‘....define and operationalise the constructs to capture the phenomenon of interprofessionalism’ in relation to working with children with mental health problems, (the Norwegian researcher, Ødegård 2005:348)

- The lack of research relating to collaborative relationships between the program areas of child protection and mental health (Australian researchers, Darlington, Feeney and Rixon 2005:1087)

- The lack of research related to ‘..factors which underpin effective co-location and interprofessional working relationships’ (Hudson 2002:16) including ‘...how it operates’ on a practice level (Nikander 2005:262)

- The lack of research on program and policy supports and the essential components of effective wrap-around teamwork

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2 ‘Wrap-around’ teamwork is one example of the innovative practice models that has been developed to respond to the needs of young people with complex needs with WORKERS from different organisations ‘wrapping’ (organising) their service around the needs of the young person and their family. It is explored in more detail in 3.7.1.
(Walker and Schutte 2004:189-90; Cashmore and Ainsworth 2004:10-11)

- The lack of research focussing on the emotional demands on practitioners involved in the delivery of collaborative partnerships, (British researchers, Smith and Bryan 2005:203)

- The lack of research focussing on young people with complex needs Mitchell (2000c:22) in general and particularly '...relating to specific mental health problems in 'looked after children'\(^3\) English clinicians Richardson and Lelliott (2003:250). Australian researchers, Mitchell (2000c) and Cashmore and Ainsworth, in their Audit of Australian Out-Of Home Care Research (2004) identified the need for research about effective forms of program development '...to meet the complex and multiple needs of children and young people in care' and for evaluating the impact of policy related to young people in care (2004:10-11)

- The English researchers, Keene (2001) and Robinson and Cottrell (2005) both highlight the '...lack of quality (longitudinal) research in the area’ while Robinson and Cottrell (2005) identify that '...evaluations and critiques of evidence of multi-agency service delivery for children are at formative stages’ (2005:548)

- The lack of inclusion of service users in the research being conducted. Surprisingly this gap was only commented on by a

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\(^3\) 'Looked after children' is an English term that was first introduced by the Department of Health (1989) to describe all children in public care (Richardson and Lelliott 2003:249) but tends to be used more specifically to refer to those who, using Australian terminology are living in 'out of home' care.
few writers. Robinson and Cottrell (2005) acknowledged their 'research had limitations. Ideally, we would have wished to explore the views of service users alongside those of professionals' (2005:559). Garrett (2002) highlights the cost of not including the voices of those affected by the policies in his important question, '..we need to ask whose experiences are being silenced and whose lives are being ignored and whose lives are considered worthy of study?' (2002:841). Moses (2000), also raises that it '....would also be useful to investigate the subjective experiences of youth' living in residential care settings (2000:489).

e) Concern that the research that has been conducted on the outcomes of collaborative approaches has demonstrated varied and in some situations contradictory results. Some suggested that '...many collaborations lack durability and many do not work out in policy or in practice' (Stead, Lloyd and Kendrick 2003:42) or as Leathard (1994) points out, '...there has been little evidence to substantiate the view that collaboration leads to an increase in the quality of care which has furthered the well-being of patients and service users' (1994:7). Alternatively, other researchers have shown that it '...enhances efficiency' (Johnson et al. 2003:196).

In summary, the pace at which the approach has been implemented (particularly without corresponding research to support it), the simplistic assumptions that some of the policy directions have been based on and the contradictory results of its impact are reasons for concern. Stead et al. (2003) describe the juxtaposition of both enthusiasm for and concerns
about the collaborative approach as placing '.those who legislate for them, manage them, work in them and write about them,' in a paradox. Despite these concerns, '...everybody appears to agree they are a good thing (and) the call for joined up services nevertheless continues' (2003:42).

The genesis of this research was in the experiences I and colleagues encountered when faced with such a paradox whilst implementing an innovative inter-sectoral collaborative approach for young people with complex needs. Despite our excitement of being at the forefront of '...opening up exciting possibilities for creative joint work,' we discovered that implementing a policy framework which assumed we knew how to practise collaboratively '..with little training or guidance' made a highly challenging experience even more problematic. It certainly highlighted the gaps previously discussed.

It is therefore the goal of this research to further strengthen the Australian knowledge base that has been developed over recent years regarding effective inter-sectoral collaborative approaches. In particular, to increase our understanding of the principles and working guidelines relevant for working with young people with complex needs and their families, and between practitioners.

The contribution of this thesis will be towards strengthening our understanding of the forms of practice methods required when working collaboratively across sectors, and of the structures that are required and

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6 This innovative approach, The Enhanced Residential Program, is the project that will be studied in detail in this thesis.
the organizational issues that arise and need to be addressed to support and sustain these forms of practice.

1.3 THE RESEARCH QUESTIONS

The research questions have been designed to produce an increased understanding of effective collaborative approaches through analysing the experiences of stakeholders involved in developing and implementing a collaborative inter-sectoral service initiative.7

The inter-sectoral service initiative was called the Enhanced Residential Program (ERP). It was one of the initiatives developed by the Working Together Strategy (WTS) in a metropolitan region of the Victorian Department of Human Services (DHS). The WTS is a Statewide quality improvement initiative of the DHS intended to build capacity and improve services for shared clients of the WTS program partners, Child Protection, Out of Home Care, Mental Health Services, Juvenile Justice, Drug Treatment Services and Education.8

The Enhanced Residential Program consisted of the establishment of a inter-sectoral care team to provide a service for at-risk young people from the ages of 13 living in residential units. The Care Team had two components, the provision of direct service to the young people and working as an integrated team to develop individualised case plans for each young person, promote regular discussions about their progress and provide opportunities for staff development and education.

7 The term inter-sectoral reflects that the participants in the collaborative activity have come together from organisationally distinct and different sectors to work as a team around a particular activity. These concepts will be explored further in 3.4.
8 The WTS will be discussed further in 2.5.4.2 and 4.3. The ERP will be discussed further in 4.3.
The program was piloted in two residential units. The membership of the Care Teams consisted of the residential care staff employed by Community Support Organisations, workers from the statutory programs Child Protection and Juvenile Justice and from the specialist program areas it was hoped to engage them with, Child and Adolescent Mental Health Service (CAMHS), Drug Treatment Service (DTS) and the Department of Education, Employment and Training (DEET).

The stakeholders interviewed for this research included regional managers who were members of the WTS Regional Management Group responsible for developing this initiative, members of the Steering Committees developed to support the Care Teams, and the practitioners involved in the Care Teams. In addition the opinions of the young people and family members living in the residential units during the two year period of the ERP’s operation were also sought.

The aims of the interviews were to access the experiences and opinions of these stakeholders to inform insights into the practice principles and guidelines required to support collaborative practice.

The main research question is:

- What are the principles and guidelines that will inform services operating within an integrated collaborative approach for children, adolescents and young people with complex needs?

The subsidiary research questions are:

- What do current policy documentation, local and international literature indicate are the core components of integrated service
delivery models for children, adolescents and young people with complex needs?

a) Taking inter-sectoral care teams as one example of an innovative service delivery model for children, adolescents and young people with complex needs,

- What do service users, family members, service providers, managers and policy providers involved in the implementation and operation of this model indicate are its core features and key issues?

- What are the strengths and limitations of the model for strengthening the emotional, social, psychological, educational and cultural needs of children, adolescents and young people with complex needs?

b) What are the implications arising from answers to these questions for future policy directions, program development, service delivery and practice models for working with children, adolescents and young people with complex needs?

1.4 THE MULTIPLE FOCUS OF THE RESEARCH: YOUNG PEOPLE WITH COMPLEX NEEDS AND THE SERVICES’ RESPONSE TO THESE YOUNG PEOPLE AND EACH OTHER

Coordination of service delivery systems has a benefit besides economy; that of comprehensively providing child services based on a continuum of child needs across social, psychological, medical, vocational and educational domains (Johnson, Zorn, Kai Yung Tam, Lamontagne and Johnson 2003:196).
The focus of this research is upon a number of intersecting domains. At the centre are children and young people with complex needs and their families. The next focus explores the interaction between these young people and a specific cohort of program areas, followed by attention being placed on the interface between these service sectors in their responses to the young people and each other. Finally the focus moves to the wider policy and service context within which these activities occur. This area will be addressed in the next chapter.

1.5 INTRODUCING THE YOUNG PEOPLE

1.5.1 Exploring the words ‘complex needs’

The words that are used to describe the children, adolescents and young people who are the focus of this research, ‘young people with complex needs,’ inform us that they are a particularly troubled and troubling group of young people with lives characterised by ‘...complex, established persistent and severe co-existing problems’ (Department of Health 2004:4)\(^9\) which span ‘...across the domains of mental and physical health, emotional and behavioural functioning and cognitive and educational achievement’ (Royal Children's Hospital Mental Health Service 2004:7).

When reflecting on the meaning of these two words, ‘complex’ and ‘need,’ it becomes apparent that they are frequently used not only to describe characteristics and attributes of the young people but also how these young people are perceived.

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\(^9\) In Australia, a number of different terms have been used to describe these young people. They include complex clients, (Victorian Government 2000b), multi-service clients, High Risk Adolescents, (Victorian Department of Human Services 1998b) ‘people whose needs require a high level and complexity of service provision’ (Ecumenical Housing Inc and Thomson Goodall Associates 1999), and more recently ‘disengaged youth’ (Victorian Government 2005d). Many of these same terms are used in other countries. Interestingly the descriptive term ‘dual diagnosis’ does not tend to be used when describing this cohort of children and adolescents despite it being widely used when referring to adults.
people impact on others. This latter aspect is critical in understanding the discourse that surrounds this group of young people.

Thus these young people are described as ‘complex’ because of:

- the number of areas in which they experience difficulties
- the severity of these difficulties and
- how their difficulties impact on others, (Thomson Goodall Associates Pty Ltd 2002:4).

Similarly the word ‘need’ has a number of applications when applied to this group of young people. It refers to:

- the need the young person has for a service response that addresses the complexity of their presentation
- the needs placed on services to respond to this group of ‘complex’/‘problematic’ clients and
- the explanation as to why these young people are sometimes excluded from receiving services, that is, that they are seen as not having the right type of presentation (or need) to warrant inclusion in a service.

As Thomson Goodall Associates (2002) state, ‘...people with complex need are often seen as “too hard,” encounter barriers to accessing specialist programs and are shunted between services’ (2002:54). Webb (2006) argues that ‘.....risk and need are often conflated in assessing and determining eligibility criteria for service users’ (2006:32).
Risk regulation comes to dominate and the handling of risk is increasingly displacing need as the focal point and justification for intervention. Risk regulation systems tighten their grip on the construction of policy and front-line practice (Webb 2006:47).

This duality of thinking about these young people’s complexity and needs is aptly demonstrated in the following quotations taken from Victorian Government policy documents. The first, from the Victorian Department of Human Services Responding to People with High and Complex Needs (2002b) outlines how people with complex needs ‘...require a level of support the current design of services does not readily allow. Services are often unable to maintain involvement over time with (these) clients with extremely difficult behaviours’ 10 (2002b:1).

The second quotation is from the High Risk Adolescents Service Quality Improvement Initiative (Victorian Government 1998b), 11 which described this group as:

...highly vulnerable young people (whose) needs are many and complex (and) require a specific, intensive and strategic service response. A high level of collaboration, expertise and immediate access to specialist support services is required to address both risk factors and ongoing developmental needs (Victorian Government 1998b:1).

Thus this group of young people are thought about in relation to their service needs and how their difficulties impact on others. Considerably less emphasis is placed on the internal experiences of their ‘...complex, established, persistent and severe co-existing problems.’ 12 Put another way, these are young people who are more frequently observed from the outside,

10 An initiative established to address the service requirements of people across the lifespan who were defined as having complex needs.
11 This initiative was established in the mid 1990’s. Both these initiatives will be discussed further in 2.5.4.1 and 4.3
through a lens framed in terms of ‘managing’ and ‘controlling’ their complex needs. This is particularly demonstrated in relation to the following sub-group, high risk adolescents.

1.5.2 Exploring the words ‘high risk’

Within the spectrum of young people with complex needs, sub-groups have developed. In Victoria, the sub-group 'high risk adolescents,' has become a critical focus of policy and program development. This is a small group of young people within the broader category of children, adolescents and young people under the statutory care of the Child Protection Program who are identified as having special needs and requiring the additional support and specialised program input provided by the High Risk Adolescent program (HRA). ¹³

Inclusion criteria are based on the young people displaying the following persistent high risk indicators: self harming, involvement in crime and frequent placement breakdowns. ¹⁴ A number of these young people live in residential care.

Morton, Clark and Pead (1999) state that they ‘...constitute a special group in terms of the severity of the harm they have suffered, the high levels of anxiety aroused by their behaviour and the complex issues raised by the

¹³ The program was first established in 1996. At the time in which this research was conducted and in the metropolitan region where the project was implemented, approximately 40 adolescents were identified as high risk adolescents and placed on that regions’ HRA Register.
¹⁴ In relation to the latter criteria a (2001) audit by the Victorian Department of Human Services reviewed the circumstances of children and young people in residential care. It revealed that on average a child or young person in residential care will have experienced 4.2 placements and been in placements for less than 6 months. This average is likely to be higher for at risk young people (Victorian Government 2003:12).
serious risks posed to self and others' (1999:22). Morton et al. (1999) also highlight that

...because of the weighting of the HRA definition of 'high risk' adolescent towards behavioural disturbance, some very emotionally disturbed young people are not eligible for the HRA. They were the 'quietly troubled' young people, severely withdrawn or depressed but not troublesome to staff (1999:25).

As can be seen from Morton et al's. (1999) description, at risk young people comprise a particularly vulnerable group of young people. The form that their underlying difficulties take (which manifest in the high risk behaviours described above) are significant mental health presentations, problematic drug and alcohol use, experiences of abuse and neglect, limited involvement in education or vocational programs and fractured relationships with their families and the wider community which have resulted in their frequent removal from living with their families. Consequently a number of these young people live in residential care.

Sitting alongside their individually oriented difficulties are complex family, social, economic, ethnic and cultural issues that impact on their lives. Thus as Richardson and Lelliott (2003) state, their problems are '..complex, severe and of long duration' (2003:252).

Due to these presentations this cohort of young people have tended to come in contact with a specific combination of program areas. These include the statutory services of Child Protection (CP), including Out of Home Care provided by Community Support Organisations (CSO's) and the Juvenile Justice Program (JJ). 15 They are also likely to have been referred to non-

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15 In Victoria the day to day residential (and home based) care for children and young people is delivered by Community Support Organisations (previously known as non-government organisations) The funding for this aspect of their service provision is provided by the DHS.
statutory services such as Drug Treatment Services (DTS) and Child and Adolescent Mental Health Services (CAMHS).\textsuperscript{16}

The choice of this particular sub-group of young people with complex needs becoming the main focus of policy and program development in Victoria instead of other young people struggling with different clusters of complexity,\textsuperscript{17} reflects a priority being placed on the 'high risk' component of their profile. The question about why this has occurred is worth reflection.

Risk can be thought about and understood from a number of different perspectives and informed by different paradigms. As Australian researchers Thomson Goodall Associates Pty Ltd (2002) confirm:

\begin{quote}
\ldots the issue of complex needs amongst children and adolescents is frequently approached from a 'high risk' perspective where risk amongst young people aged 12-18 is associated with serious personal or community risk, and the young person poses very difficult management problems (2002:15-16).
\end{quote}

The definition of a Victorian State Government committee, The Social Development Committee (1991) highlights the two components of at risk behaviours. They ‘\ldots cause serious physical harm (and) place the physical safety of the person or others in serious jeopardy’ (quoted in Thomson Goodall Associates Pty Ltd 2002:16). This jeopardy can, at its most serious,

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{16}] The terms statutory and non-statutory are used here to differentiate the different legal structures and contexts within which these programs operate and the methods by which referral most frequently occurs. Of course practitioners employed by CAMHS work within the requirements of the Mental Health Act which also has the capacity to place an involuntary status on a service user if this is seen as being required.
\item[\textsuperscript{17}] For example, young people living with a combination of significant developmental and learning disorders, intellectual or physical disabilities, chronic medical conditions. This priority has occurred to such a degree that the term young people with complex needs is anecdotally seen as synonymous with this cohort of high risk adolescents. A related area of colonisation is that it also tends to be used exclusively to describe adolescents and young people rather than children.
\end{itemize}
\end{footnotesize}
require the young person’s incarceration and, at times, result in fatal outcomes.¹⁸ ‘Young people in this high risk group may die as a result of their own inability to keep themselves safe- or cause the injury or death of others’ (Kiraly 2002:16).

This critical aspect of this sub-group of ‘at-risk young people,’ (and unlike many of their complex needs peers), that the outcomes of their distress are extremely serious and tragic for them, and others within the community, is intensified by the likelihood that such dangerous behaviours are often a very public act. Their complex needs get to be ‘played out’ in the public arena, engaging the scrutiny of the media and, at times, resulting in high profile political scandals.¹⁹

As Green (2003) an Australian academic, highlights,

> It is always the more dramatic problems which now preoccupy the media and therefore policy makers for example, chorming teenagers (who) are the concrete manifestations of the challenges confronting community services in the ambiguous political and ethical demands of post-institutional society. And in the absence of the capacity to heal, or even meet the obligation of duty of care, the dominating framework for resolution is usually risk (2003:19).

Frequently this public scrutiny has a critical and blaming quality rather than understanding the complexity and vulnerability of the young people behind the headlines. Walker (2005) believes there is an ‘...historical ambivalence towards troubled children and young people’ which is demonstrated by the focus on young people’s behavioural management ‘...rather than the underlying emotional and psychological causes being acknowledged or addressed’

¹⁸ More commonly for the young person themselves than others.
¹⁹ This is, of course, not to say that the level of distress and trauma experienced by other complex needs children and young people is not serious or tragic. But it does tend to be less extreme and considerably more private.
(2005:236-7). Within such a simplistic and polarised construction, troubled young people are perceived either as victims or villains.

Another explanation for this sub-group's high negative profile, which has a 'blaming' undertone, is the public debate about the 'costs' of 'managing' these young people's 'challenging behaviours.' In particular their contribution to the increasing 'disease burden' imposed on the wider community. Within this framework these young people are rarely perceived as the 'deserving poor.'

A number of studies have quantified the long-term financial costs for the community. Scott, Knapp, Henderson and Maughan (2001), conducted British research which estimated that, by age 28 people who had a diagnosable conduct disorder in childhood\textsuperscript{20} had cost society ten times more than those without and that these costs would most likely occur within the criminal justice, social security, education and respite care sectors, in addition to the health system. Scott et al. (2001) also stressed the significant financial burden of young people with untreated conduct disorder and their families on society (2001:191-194).

Present within this economic rationalist oriented analysis is a perception that this group of young people and often their families are a double burden as they are seen as not financially contributing to the cost they create for the community. What is also present within this frame of reference, as Furedi (1997) points out, '...being at risk becomes a fixed attribute of the individual' (1997:19). Craddock (2001) states this phenomenon even more forcibly.

\textsuperscript{20} A very frequent diagnostic category for high risk adolescents as discussed further in the next section.
The introduction of the concept of 'at-risk' populations has resulted in a kind of linguistic slippage. The risks associated with their population are personalised within each particular participant. They cease to be members of an 'at-risk' population and become instead 'at-risk' people (2001:7-8).

In this discourse it is difficult to hold onto the capacity to think about ‘...the costs in terms of human suffering for the children, their families, their carers and supporting professions’ (Mitchell 2003:6). There is thus a sense of disconnectedness, a distance from these young people that pervades the literature.

A more humane position is represented by United States Social Work clinician and researcher Teather (2001), who identifies the importance of keeping in mind the

.....youngster whose capacity to attach has been profoundly shattered, whose mental model of adult-child relationships is one of repeated hurt, whose behaviors are incredibly provocative, will deal with lifelong challenges which will require resource investments over time (2001:4).

Within perspectives that do focus on the young people’s vulnerability there is also a tendency to take a polarised position, with, in these constructions the young people being perceived as victims. Australian child welfare practitioner, Kiraly (2002) suggests that the service system rather than acting as the young people’s protector, places them at further risk. Kiraly states that ‘..paradoxically the young people at highest risk, are not securely protected’ (2002:18). She believes the theoretical concepts which inform practice towards children and young people in care ‘...are contributing to serious areas of malpractice in child and youth welfare (2002:18).
These concepts include 'adultcentrism,'21 'careism,' a term first coined by Lindsay (1996) '...to describe discrimination on the grounds of care status' (Kiraly 2002:10) and labelling. They result in unsatisfactory and discriminatory practices of discontinuity of care, disruptions to schooling, sibling separation, lack of privacy and confidentiality, the abuse of medication, focus on negative behaviour and the punishing use of 'consequences,' lack of effective constraints to high risk behaviour, neglect of the care of older adolescents and lack of attention to carer selection.

Kiraly (2002) identifies that an additional component to at risk young people being unprotected is the constraint placed on their carers as '...an unexpected consequence of the rights orientation of the Victorian Children and Young Persons Act' (2002:16). A position also expressed by Morton et al. (1999), about '...the uncertainty among staff as to how to impose reasonable limits on young people's behaviour given current interpretations of the Victorian Child and Young Person Act, in balancing the duty of care with civil rights' (1999:32).

The inadequacies of the child welfare system and its role in reinforcing the risk status of young people is also argued by Australian researchers, Ainsworth (1999) and Lonne and Thomson (2005). Ainsworth (1999) proposes that the dominant ideological paradigms informing child welfare policy and planning have not served at-risk adolescents and their families well.

This group of adolescents displays a range of complex needs and age inappropriate behaviours (which) place them in real jeopardy. For many there is a need to go beyond care and support and focus on services that seek to change those behaviours that put them at risk of entering a cycle of disadvantage (1999:17).

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21 '...the tendency of adults to view children and their problems from a biased, adult perspective' (Kiraly 2002:10).
1.5.3 Exploring ‘risk’ and mental health status

As the previous sections highlight, the concept of ‘risk’ applies to the likelihood of severe harm done to self and others, the costs of these risks to the community, the risks the young people are placed under due to inadequate and inappropriate structures and the experiences the young people may be exposed to due to their risk status.

Another perspective and one with particular resonance for me places the emphasis on understanding the meaning behind the young person’s risk factors, exploring what these risk factors reflect about the young person’s broader bio-psycho-social status. As Teather (2001) identifies these young people ‘...have multiple diagnostic labels. What is important is how we choose to understand and act on it’ (2001:3-4).

How these young people are understood and responded to within the dominant mental health paradigm as practitioners from a Victorian Child and Adolescent Mental Health Service (CAMHS) highlight is ‘...a population at risk for ongoing difficulties’ (Royal Children’s Hospital Mental Health Service 2004:7). One common form these difficulties are likely to take, is comorbidity, the co-existence of a number of presenting mental health complaints (UK Government 1999; Department of Health 2004:35).

Young people who are removed from their families and living in residential care are identified as ‘...a group whose mental health needs are known to be greater than those of the general population of the same age’ (Richardson and Lelliott 2003:250; also Morley and Wilson 2001:4; Department of Health

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22 due to my background working within the Child and Adolescent Mental Health service sector (CAMHS).

Dimigen, Del Priore, Butler (1999) found that over one third of children entering care had more than one disorder, particularly conduct disorder and depression (1999:675). McCann et al. found in their 1996 U.K. research that '....the most common diagnosis among adolescents in care was conduct disorder followed by overanxious disorder' (quoted in Richardson and Lelliott 2003:251).

English researchers Collishaw, Maughan, Goodman and Pickles (2004); McCann et al. (1996) and Penzerro and Levin (1995) also identified the high levels of co-morbidity for these young people,

Emotionally disturbed adolescents in out-of-home care are most likely to have histories of placement disruption, particularly those with externalizing disorders such as Attention Deficit Hyperactivity Disorder (ADHD), oppositional-defiant disorder and conduct disorder (Penzerro and Levin 1995:352).

Morton et al. (1999) agree that high risk adolescents '..qualify for many diagnoses' including attachment disorder, which they see as '..arguably the fundamental problem' (1999:46). Moses (2000) states that attachment theory offers a way of understanding the meaning of the behaviour of young people living in residential care particularly those '..abused and neglected children (who) are often found to have insecure internal working models of attachment, understood as adaptive responses to an unreliable or even dangerous interpersonal environment' (2000:476).

There is now a considerable body of research that demonstrates mental health co-morbidity for high-risk adolescents who are also involved with the criminal justice system (Kurtz 1998:543; Morley and Wilson 2001:4; Walker
Young offenders are three times as likely to have a mental health problem as other young people' (Walker 2005:242). 'When compared with the general population, young people within the juvenile justice system are statistically more likely to suffer from both mental health problems and mental disorders' (Victorian Government 2005b:4).

Comorbidity including substance abuse is particularly prevalent with this cohort. 'Research clearly substantiates a high prevalence of concurrent substance use and mental disorders' among at-risk youth, '...with conduct disorder and depression the most frequent mental health disorders identified' (Currie 2001:15).

Another frequent feature of young people with complex needs, particularly those living apart from their families is their low rates of school attendance, poor educational outcomes and a higher incidence of learning and behavioural problems (Department of Education and Training and Department of Human Services 2003:5; Lonne and Thomson 2005:88; Social Exclusion Unit 1998).

A 2001 audit conducted by The Victorian Department of Human Services found that over 70% of young people living in residential care had completed Year 8 or lower and over half of those 13 or older did not attend school at all (Victorian Government 2001a:22). Morton et al. (1999) state that '...it is now well recognised that children and young people in alternative care are at risk educationally' (1999:17).

The 2001 audit also revealed that 62% of clients had a physical or intellectual disability or a formally diagnosed mental health issue (Victorian Government 2003:12). Lonne and Thomson (2005) also highlight that children in State care experience a high rate of developmental

Some authors, while acknowledging the increased psychological vulnerability of young people in care, also express concern that this cohort is at an increased risk of being over diagnosed and over medicated compared to those not in care particularly in relation to the diagnostic category of Attention Deficit Hyperactivity Disorder (ADHD). One Australian study reported the concerning information that at least one in two children/young people in respite care were prescribed Ritalin (one of the main forms of medication used to treat ADHD)\(^\text{23}\) (Mertin 1998:32; Kiraly 2002:14).

The position taken in this research strongly supports attention to this issue and the necessity of particular vigilance being taken to ensure that children and young people in care (like their peers in the general community) are not at risk of being under or over diagnosed or medicated.

1.5.4 Exploring the origins of young people’s and their families’ mental health presentation

Another important component of the debate and discourse that surrounds young people with complex needs is not only how their presentations are understood but also what factors have contributed to their development. The bio-psycho-social model, which is a common framework utilised within

\(^{23}\) It needs to be noted that Mertin’s research (1998) relates to young people in respite care, which includes a range of young people, some of whom go on to require placement in other out of home care programs including residential care; some of whom return to live with their families. However the findings of this research do match the practice experiences I and other CAMHS colleagues have noted, that young people in care do seem to be at a higher risk of being placed on medication and medication for ADHD in particular.
CAMH services operates from the position that frequently an inter-play between characteristics in the child and their environment increases the risks of developing mental health problems (Walker, 2005:241). In fact as Richardson and Lelliott (2003) state,

children in care are much more likely than other children to have experienced risk factors that predispose them to the development of mental disorders. Indeed, these risk factors are often the reasons why they have entered the care system (2003:251).

Walker (2005) states that ‘...the risk factors for 'looked after children' are probably the most extreme of any socially excluded group' (2005:242). Common risk factors that have been identified as impacting on the development of child and adolescent mental health presentations:

...include child characteristics - genetic and biological influences, irritable early temperament, low IQ and academic failure and environmental factors such as poverty, unemployment, parent marital status, marital conflict, parental psychopathology, parental substance abuse, harsh, inconsistent or cold and uncaring parenting styles, exposure to life events and life transitions (Einfeld and Dean 2000:ii).

The English social policy analysts, the Office of Health Economics and The Mental Health Foundation (2004) place a stronger emphasis on the social end of the bio-psycho-social continuum. 'Mental health problems are tied up with issues of risk, deprivation and vulnerability and can be part of a negative life journey resulting in social exclusion, low achievement, adult mental health problems and relationship breakdown' (2004:4).

Mitchell (2003), an Australian child welfare researcher, writes about the families of the children who enter the protective and out-of-home care systems. She quotes Tierney (1976) who conceptualised these families as 'excluded' and describes them as '..typically poor, educationally
disadvantaged, often unemployed or underemployed, and experience housing instability or homelessness. Many have complex family structures and generational contact with the child welfare system (2003:8-18).  

The parents mostly have multiple, chronic, entrenched and serious problems in their own right with many of the families involved, often in an involuntary capacity, with a number of service systems. They '...experience extreme social isolation from normative extended family or social networks, or are involved in networks which are not protective of children or supportive of their normative development' (Mitchell, 2003:16).

Australian mental health clinicians, Einfeld and Dean (2000) also support a more psychosocial orientation in their comment that '..research into adolescents' sense of connectedness to family and to school has found family and school connectedness to be powerful protective factors for both 'acting out' and 'quietly disturbed' behaviour in adolescents' (Einfeld and Dean, 2000:9).

The Australian clinicians and researchers, Morton et al. (1999) provide a psychological and developmental perspective to this discussion which acknowledges the origin of the young people's vulnerability as well as factors that contribute to its maintenance.

This group of young people (have) an extreme level of emotional and behavioural disturbance due to a combination of factors: traumatic early

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24 Morton et al. (1999) report that 9 out of 10 of the cohort of young people from the high risk register that they studied had at least one parent who was suicidal, self-harming, involved in major drug abuse, prostitution or other criminal activities (1999:13).

25 Including some combination of intellectual disability, domestic violence, psychiatric illness, serious physical illness, substance abuse, and/or involvement with the criminal justice system (Mitchell 2003:10, 14-15). Thus the families can be seen as intergenerational cohorts of people struggling with complex needs.
experiences in their families of origin; severe emotional and attachment problems arising from these early experiences; and a course of deteriorating life functioning while in care, associated with a dearth of appropriate service options to meet their needs for treatment, education and care (Morton et al. 1999: viii).

Reflecting on the young people’s internal experience McIntosh (2003), an Australian researcher and clinician describes how ‘..the child in care embarks on multiple journeys simultaneously, travelling away from situations of untold trauma, attempting to re-establish their lives’ in what she calls ‘foreign places’ without any choice in the matter (2003:16). These experiences contribute to the young people’s level of psychological and intrapsychic fragility.

The position taken in this research supports Keene’s (2001) perspective that the challenge for people working with this target group is to make a conceptual shift and embrace that ‘..complex needs cannot be understood as a consequence of individual pathology or individual failing alone, but are part of a range of interacting psychological and social problems’ (2001:118).

1.5.5 The young people’s pathway

An area where there is widespread agreement from those writing about this cohort is in regard to their (often) tragic future trajectory or pathway. Young people who have been in care are likely to ‘....experience high levels of social disadvantage, ill health and risk-taking behaviours after leaving care’ (Richardson and Lelliott 2003:249).

Morley and Wilson’s (2001) statement that ‘...studies consistently show that the greatest impact on a child’s life results from co-morbid conditions’
(2001:10) demonstrates that far from these young people ‘growing out’ of their problems, they tend to be the young people who slowly drift in to adult program areas such as the adult criminal justice system, adult mental health system and become the complex clients of the future. An English report, ‘...the Social Services Inspectorate’s Report (1997) found that 23% of adult prisoners and 38% of young prisoners had been in care’ (Richardson and Lelliott 2003:250).

These outcomes are demonstrated by the two following quotes, the first from the British Office of Health Economics and The Mental Health Foundation (2004),

It seems clear that early vulnerability is predictive not just of mental health problems later in life but also of poor socialisation, criminality, lack of participation, relationship difficulties and so on. This relationship is very complex, and is mediated by biological, psychological and social factors (2004:2).

and the second from Australian social work academic Mendes (2003):

Much local and international research depicts evidence of poor outcomes for care leavers (including) disproportionate levels of homelessness, abuse of drugs and alcohol, poor physical and mental health, poor educational and employment outcomes, inadequate family and social supports, over-representation in crime and prostitution, and high levels of early pregnancy and parenthood (2003:1).

A number of studies have demonstrated a ‘...strong correlation between child and adolescent mental health difficulties and mental health problems in adulthood’ (The Office of Health Economics and The Mental Health Foundation, 2004:6). Australian Child Psychiatrist Birleson, (2005) states that ‘The key factors in the persistence of conduct disorder from childhood are co-morbidity with attention deficit hyperactivity disorder, educational or learning problems, low socio-economic status, poor parental mental health
and punitive parenting’ (2005:4) all factors likely to be present for this cohort.

Considerable research indicates that children and young people who have been in State care generally experience a range of poorer outcomes than their peers including disrupted emotional attachments and relationships and reduced adult and life opportunities (Lonne and Thomson 2005:88). Penzerro and Levin (1995) identified that

...multiple placement is the characteristic most associated with negative outcomes for youths in out-of-home care and is associated with incarceration in young adulthood. A history of placement in out-of-home care is a risk factor for becoming homeless (1995:352).

However it was also pleasing to find some writers that delivered a different perspective from that represented above. Buchanan’s (1999) research demonstrated that although children who had been in care were more at risk of developing psychological problems not all do (1999:35-40) and therefore it was also important to keep in mind the protective factors in care that can support young people’s future pathway. Richardson and Lelliott (2003) report these as consisting of stability and continuity of care and basic requirements such as good physical conditions, and supervision and discipline needs being met (2003:252).

1.5.6 A continuum of need and strengths

One writer who has made an important contribution to the study of people with complex needs is the United Kingdom academic and researcher, Keene (2001). She provides a useful concept to this debate by proposing that a continuum of need exists. At one end of this continuum sits a group of ‘...vulnerable persons who have multiple and usually intractable problems.'
Keene acknowledges that ‘..this minority is seen to preoccupy policy makers, planners and services, are time consuming and resource intensive’ (2001:13) for many of the reasons outlined earlier in this chapter.

However what becomes lost in many of the discourses that surround people with complex needs and particularly at-risk young people is that they can also be thought about other than solely by being 'problematised' and dramatised.\(^{26}\) That part of their complexity also includes co-existing areas of strength and expertise and that being 'at risk' is not a static or chronic state but one that fluctuates in time and intensity.

Biegel and Blum (1999) stress the need to hold on to the possibility that despite this client’s group’s ‘...deficits and constraining circumstances, vulnerable populations have a capacity for resilience, growth and change’ (1999:1). Turner (1999:30) reminds us to remember the diversity that is present in vulnerable populations. Butler and Williamson (1994) state that ‘..young people in the care system often convey a tremendous resilience given the situations they were facing’ (1994:105).

While reflecting on the importance of naming and honouring the resilience and diversity of the young people and their families, as well as their struggles, I would like to take the opportunity at this point, to introduce my own voice and my own engagement with this topic.\(^{27}\) As a social worker who has spent the majority of my career working in child and adolescent mental health services and mental health policy and service development, my decision to undertake a PhD and to select this particular topic for its focus

\(^{26}\) using Green's (2003:9, 19) words.

\(^{27}\) My appreciation to the Australian author Helen Garner for introducing me to this concept at a Melbourne Writers Festival presentation, August 2005.
represented a long standing concern and commitment to exploring service responses for this particularly vulnerable group of young people.  

It was born out of the extraordinary opportunity I have had during the twenty-five years of my practice to have met and known many young people with complex needs, and their families, to have been privileged to hear their stories and gain a glimpse of the courage and creativity present in their lives.  

Such a portrayal, as mentioned previously, is unfortunately absent in much of the research and literature that is written, and was therefore a catalyst to ensure that, in this research the words and expertise of the young people and their families, (and the direct care workers involved with them), are also included.

1.6 THE INTERFACE BETWEEN YOUNG PEOPLE WITH COMPLEX NEEDS AND THE SERVICE SYSTEM

The highly differentiated and complex system of services delivered by mental health, education, juvenile justice, and child welfare to high-risk youth has created conflict in the service system (Okamato 2001:16).

In this section the focus moves to exploring what does occur when young people with complex needs in general, and designated high risk adolescents in particular, interact with the service system. As mentioned previously the key publicly funded program areas that children and young people with complex

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28 This interest has influenced a number of my employment choices and my research and study interests. The topic of my MSW thesis (Absler 1992) was a case study of the use of psychotherapy with an adolescent who was a young person with complex needs (before that term was in fashion).

29 I found this comment by Teather (2001) resonated for me, that these children and families ‘... touch our hearts and souls, and it is our responsibility to advocate for them’ (2001:18).
needs are more likely to be involved with are Child Protection, (CP) Juvenile Justice, (JJ) Out of Home Care Services provided by Community Support Organisations (CSO’s), Child and Adolescent Mental Health Services (CAMHS) and Drug Treatment Services (DTS).

However the means by which the young people come into contact with these program areas differs. The one program area who all the young people are clients of is the Child Protection Program. It is the statutory Child Protection service system that is responsible for investigating alleged child abuse and neglect, determining the most appropriate care or support solution for the child and ultimate case management for children on care and protection orders including being placed in residential care.  

Although some parents do initiate contact with the Child Protection Program to request support, most at-risk adolescents would enter this system as involuntary clients.

When the young people are placed in residential care they then come into contact with another service system, Community Support Organisations (CSO's) as the CSO’s (in Victoria) are funded by the Department of Human

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30 The Children and Young Persons Act 1989 provides the legislative context for the operation of the Victorian child protection and placement system. New legislation was introduced into State Parliament in late 2005 after a review of the problems associated with the current legislation and will become operational from late 2006. Residential Care provides short and long-term out-of-home care in residential facilities for children and young people aged 0-17 years who are unable to be placed elsewhere because of their multiple and complex needs. They tend to be ‘...sibling groups and adolescents with complex needs who have histories of failed home-based care placements and difficult behaviour.’ (DHS 2001a:3).

31 Including some young people involved with the high risk adolescent program.
Services to provide the day to day care for young people in out-of-home care. 32

In addition as many high risk adolescents and the young people involved in this research would also have involvement with the Juvenile Justice Program (JJ) due to their criminal activity. It is the Juvenile Justice Program who provides statutory case management of these young people while they remain on orders.

With the Program areas of CAMHS and DTS while some young people access these services as a result of statutory orders issued by the Children’s Court, the majority are ‘voluntary’ referrals frequently initiated by their case workers from the Child Protection, Juvenile Justice program areas or CSO’s. Both CAMHS and DTS provide a range a services. CAMHS are part of the State Government funded specialist mental health system and their program areas include intake/triage, community based assessment, treatment and liaison services, inpatient facilities and day programs, consultation, education and training, health promotion (Victorian Government 2002h:46).

Drug Treatment Services have as their focus the treatment of clients who are struggling with issues related to their use of alcohol or drugs. The services run the gamut of inpatient units, community based services and outreach services.

The final significant service system for the young people is the Education system. Schooling is compulsory for all Australian children from the ages of 5 to 15 years and the government department responsible for administering

32 It has been estimated that ‘…on any one day across Victoria approx 4000 children and young people live in out of home care’ (Department of Education and Training and Department of Human Services 2003:6).
this universal service is the Department of Employment and Training (DE&T) also funded by the Victorian Government.

1.6.1 Factors that impact on at risk young people’s access to the Child and Adolescent Mental Health Service System

Kylie, a young person’s consumer consultant at a Victorian CAMHS, identified that, ‘...feeling trust and connectedness’ was a key issue for young people being able to experience a quality service (Spink 1998:38).

When reflecting on at risk young people’s access to and involvement with, services, the program area most frequently identified as problematic (by others) is mental health services.33 The literature confirms my own experiences34 and demonstrates the universality of the issue as well as the factors and barriers that contribute to this situation.

One critical factor raised by many writers is the impact of the differential use of language between practitioners. As English writers Morley and Wilson (2001) state,

It is important to define what is meant by mental health (because) there is general confusion about terminology. The terminology used by health professionals to describe children with mental health problems is different from that used in other agencies (2001:4).

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33 The difficulties at risk young people experience accessing CAMH Services was one of the critical factors that contributed to the establishment of the Working Together Strategy, (WTS), the Department of Human Service quality initiative program which sponsored the service development initiative studied in this research. When the WTS was first established in 1998 it was aimed at building capacity and improving services for shared clients of Child Protection and CAMHS. It later extended to include other program areas. The WTS will be discussed further in 2.5.4.2 and 4.3.

34 Working as a mental health practitioner and in service and policy development positions, that CAMH services do struggle with successfully engaging at risk young people and their families.
What also underlies this confusion about terminology are different conceptual understandings of what constitutes a mental health condition. This is demonstrated by the following frequently occurring scenarios. One of the main criteria used by mental health practitioners to determine whether a young person’s presentation constitutes a mental health disorder is based on the ‘...degree of severity and persistence of disturbance along a continuum of mental health’ (Morley and Wilson 2001:3) with public mental health services required to respond to the most severe presentations.

However the frequent focus of disputes relates to debates about whether the young person’s ‘at risk presentation’ is the result of, or certainly indicative of, a mental health problem, whether this presentation constitutes the ‘right’ form of severe and persistent ‘disturbance’ required for access and the quality of the service that is provided. As reflected in research undertaken by the English Mental Health Foundation, the result of these boundary disputes is that other service providers, as well as some young people and parents find CAMHS inaccessible (The Office of Health Economics and Mental Health Foundation 2004:4).

Many writers express concern that

...children, young people and their families who could benefit from mental health services for assessment and treatment are not accessing services. There are a variety of reasons for this: a lack of trust in statutory services, a wish to solve problems themselves; a lack of recognition and agreement that a problem exists, a fear of being teased and stigmatised; a fear of confidentiality being broken, a belief that nothing can be done (Department of Health 2004:15).

Mitchell (2000c) adds ‘...comorbidity, the presence of a range of psychosocial problems, as well as eligibility criteria imposed by mental health
services may work to direct some individuals away from specialist mental health services' (2000c:30).

Tolan (1996) describes the anomaly that '...those children with more severe problems (are) often being the least served, those with the least other resources having the least access to mental health services, and those most in need least likely to access and retain adequate care' (1996:92-3). As a consequence 'it is often the children and young people about whom there is most concern, and who are likely to experience the poorest outcomes, who are most reluctant to seek help' (Department of Health 2004:15) and '...have difficulty developing a connection' (Mitchell 2000b:106).

For young people with complex needs some may not receive a service because they, like all children, rely on their family and care network to initiate or support the referral. Some young people do self refer, but as this requires the young person to posses the confidence, competence and knowhow to negotiate such a process, it is a considerable demand. As Mitchell (2000b) identifies, young people require 'gatekeepers' - 'people in the community who have a role to play in identifying young people at risk and helping them gain access to appropriate support' (2000b:106).

To correctly identify the need for a young person to access a mental health service, their gatekeepers need to possess 'mental health literacy.' 35 In Australia this is an area that needs strengthening and it is a promising

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35 ‘Mental health literacy’ is a term that refers to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking. ’ (Jorm, Korten, Jacomb, Christensen, Rogers and Pollitt 1997:182).
development that it has received increased attention in recent years through health promotion activities.

In previous research I, and a colleague, (O’Neill and Absler 1998, 1999, O’Neill, 1999) tracked the pathway that a cohort of young people in out of home care placements took to receive a CAMHS service compared to young people living with their families of origin. The research was conducted over a two year period and highlighted significant areas of difference between the cohorts. Firstly, the young people in out of home care placements were referred by a different combination of professional groups36 and secondly were referred for different types of problems, than those living with their families of origin.37

1.6.2 Factors that impact on at risk young people’s engagement with the Child and Adolescent Mental Health Service System

Once having negotiated the ‘front end’ of the CAMH service, issues often emerge for at risk young people in relation to their engagement. As the British Sainsbury Centre for Mental Health (2002) articulate in their analysis of care for people with severe mental illness who are hard to engage with services, ‘....unless engagement is achieved and people in the group are provided with safe and effective services, they will continue to face social exclusion’ (2002:1).

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36 Teachers, private health practitioners such as paediatricians and General Practitioners were the most frequent professional referrers for young people living with their families while workers from Child Protection, non government organisations and private health practitioners were the most frequent referrers of young people in out of home care (O’Neill and Absler 1999:22-3).

37 These tended to be for what Australian researchers Sawyer, Sarris, Baghurst, Cornish and Kalucy (1990) described as the ‘externalising’ range of disorders, children whose problems are predominantly those of aggressive, antisocial or under-controlled behaviour such as conduct disorder, ADHD while the other young people were referred predominantly for ‘internalising disorders’ - exhibiting predominantly fearful, inhibited or over-controlled behaviour problems (O’Neill and Absler 1999:23).
At risk young people are a group of young people who mental health services find challenging to engage with, and provide services for. ‘The presence of co-morbidity increases the challenge and complexity of the care and treatment required for children and young people’ (Department of Health 2004:44).

They are challenging for a range of reasons. As established previously, this is a group of young people who have frequently experienced a history of disruption, dislocation and tenuous relationships with their family of origin and significant others. These experiences have certainly contributed to their having a complex cluster of emotional, psychological, educational, developmental and social difficulties impacting on their capacity to trust and form attachments with adults - critical factors in their ability to engage with psychologically based forms of intervention.

As Keene (2001) highlights;

Complex needs clients form a small proportion of most specialist caseloads. For the majority of clients, professional theories and models are clearly of benefit and professionals derive their expertise and effectiveness from specialist knowledge and skills (2001:115).

Keene proceeds to comment that the 'mismatch' that occurs is also often the result of the fact that, '...the majority of the health and psychosocial care system is structured and intended for short specific periods of acute illness or psychological problems that can be treated, cured or changed' (2001:194) while the needs of this cohort of young people are for interventions that acknowledge their complexity and longevity.

Another mismatch that can occur within a CAMHS setting is that, because at-risk young people are involuntary clients, they require a different skill
base and approach than applies with voluntary clients. This does not mean they are not able to be treated. However they require adaptations of traditional forms of service delivery as well as innovative forms of service delivery.\textsuperscript{38} 'A flexible approach to the engagement of young people is often necessary' (Department of Health 2004:16).

Flexibility and openness are also critical in relation to how actions are understood and responded to. 'Failure to attend clinic-based appointments should not be seen as a lack of motivation or act as a trigger to close a case but as an indication of the need to review the nature of the service offered' (Department of Health 2004:15).

For publicly funded CAMH Services required to cater to all children and young people between birth and 18 years, a small group who require different solutions and methods and who have not chosen to access the service generate particular challenges. 'The provision of mental health care for children and young people and their families can be emotionally demanding and stressful, particularly where there are high levels of risk' (Department of Health 2004:34).

Access, location of services and flexible forms of service delivery are critical in relation to this cohort. 'Surveys of users' views consistently point to the fact that young people do not feel able to approach the more traditional type of service and feel it has little to offer them' (Morley and Wilson, 2001:16). As an English user of CAMHS commented; '....we want a choice where we get help in a place that isn't medical' (Department of Health 2004:15).

\textsuperscript{38} Examples of some of the creative forms of service delivery that have been developed for this group of young people will be further explored in 3.7
There are many examples of thoughtful and sensitive work provided by CAMHS practitioners for this client group. These are supported in situations when the young person has links with an adult (a parent, extended family member, carer, worker) who also connects to the service. There are some young people able to engage in their own right.

However the more disconnected the young person is the harder it is for a connection to be made with the service and for the service to connect to the young person and for all the services involved to connect with each other. Similarly the more disconnected the program areas are with each other, the harder it is for them to provide a message to the young people that the service is a helpful and safe place to access.

1.7 THE INTER-ORGANISATIONAL CONTEXT - GRAPPLING WITH THE 'TURBULENT FIELD.'

The needs of children and young people with severe, challenging and complex problems are best met by a network of care; collaborative working of a highly specialised nature (Lindsey 2005:232).

The lives of young people with complex needs are embedded within a number of inter-organisational and cross-program contexts. A key feature of this inter-organisational context is its potential for ‘turbulence’ (Scott 1993:5). As Nikander (2005) highlights ‘...interprofessional encounters represent a potential site for trouble, where conflicting interests and arguments, practical dilemmas and moral issues surface’ (2005:263-4). Unfortunately the interface that occurs between service sectors when working with young people with complex needs has tended to be characterised more by its turbulence than by being a productive space.
Features of the turbulent field these young people, families and service providers occupy include moving between statutory and voluntary program areas governed by different legislative frameworks, philosophies and cultures. As has previously been argued, ‘..services that focus mostly on one area of need find it difficult to provide a comprehensive and holistic service to individual young people’ (Mitchell 2000c:28). Problems are more likely to arise when organisations that operate within different administrative structures and organisational hierarchies attempt to forge partnerships (Mitchell 2000a:119).

As the English Department of Health (2004) states,

- partnership working across agencies working with children and young people with mental health problems can be a challenging task. The lack of understanding of the respective roles, duties, responsibilities and organisation of the different agencies and professionals and of their different language, may lead to poor communication, misunderstandings and frustration (2004:25).

The program areas operating from different cultures is frequently identified as contributing to the turbulence. The struggle for dominance that can occur when professionals with different status, occupational prestige, ascribed and assumed authority and genders across health, welfare and child protection program areas is noted by Hallett (1995:231) and Hudson (2002) who described these interactions as constituting ‘turf wars’ (2002:11).

Keene (2001) describes how ‘...each agency has its own professional perspective, ideology, methods of working, plans and priorities (and that) individual agency agendas and priorities are often in conflict with other agencies’ (2001:6). She has an interesting perspective on what happens when
interactions occur between workers from different systems. She provocatively states that ‘...professionals only want to provide their particular specialist help to clients if this help or the clients themselves are considered 'appropriate'. Appropriate help is seen as that for which they are trained and expert' (2001:84).

A dominant theme present in the literature about this particular inter-organisational context is the portrayal of disparate, disconnected structures that find themselves 'thrown' together because of their shared contact with these young people, not through choice and finding themselves outside their comfort zone. These also tend to be tightly bounded systems that close their boundaries with territorial 'zeal'. Johnson, Wistow, Schulz and Hardy (2003) found in their English study that,

> differences in political views and, therefore in goals, fear of budgetary repercussions, differences in cultures and competing demands on already overworked staff, all worked against the development of the trust and stable working relationships needed to collaborate successfully (2003:80).

Prior to this research I witnessed many examples of these practices, particularly when the practitioners were from program areas which had previously had little or no contact (or the previous contact had been negative), when the programs operated from different orientations, practices and frameworks and involved a mixture of statutory and non-statutory services (Scott 1993:6). 39

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39 In particular the greatest conflict frequently occurred between Child Protection and CAMHS practitioners. This was certainly the situation in the region where this research occurred. I personally experienced an example of this irrational level of hostility when I was accused, by a Mental Health colleague of having 'gone over to the other side' after commencing my position with the Working Together Strategy which involved my being physically located with Child Protection practitioners.
It seemed that in the worst of these situations workers lost their ability to think and reflect about the difficulties they were encountering and the conflict became increasingly entrenched and polarised. One colourful description of this behaviour is from Australian academic Campbell (1999) highlighting that in interdisciplinary collaborative ventures where child protection is involved, there is often ‘...a tendency to ‘play poison ball’ with a case: that is, to attempt to pass the responsibility between agencies as quickly as possible’ (1999:206).

At its most destructive it can manifest in what occurred in the Victoria Climbie case,\(^{40}\) where as Rustin (2004a) described,

> ...it seems that different professionals were relating to one another as virtual strangers, as if they were members of alien organisations, not as members of a multi-disciplinary professional community sharing a common commitment (2004a:13).

From my own practice experience and those of colleagues the type of exchanges that occurred when professionals relate in this way would consist of accusatory statements being made such as,

- ‘...if only CAMHS would not be as precious, rigid and inconsistent with who they accept into their service;
- if only Child Protection would be more consistent in their planning for these young people and provide more structure and containment;
- if only schools would stick with these young people longer and not expel them,
- if only residential placements would be staffed by more experienced workers who could demonstrate an ability to hold onto these children when things got tough.....’

The inference clearly was, if only the others did a better job, we could do ours!

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\(^{40}\) This was a highly publicised case in the UK of a child death which resulted in The Victoria Climbie Inquiry conducted by Lord Laming (The Victoria Climbie Inquiry 2003), an influential review of Child Protection practice which is discussed further in 2.5.1.
It does need to be stated that these are the worst of situations. I have also had the pleasure to work alongside many practitioners from the program areas focused on in this research who shared a strong commitment and passion to find effective ways of engaging and working with, this client group and each other. They would support Scott’s (2000) sentiment that ‘...strong bridges must be built between those working in different sectors’ (2000:6). It was on this goal and belief that this research and thesis was based.

1.8 CONCLUSION

This chapter has introduced the cohort of young people who are the focus of this research, young people struggling with complex needs, and the service providers and program areas they interconnect with and who intersect with each other. The vulnerabilities these young people face and the gaps that exist in the identified service sectors.

These gaps occur both because of the fragmentation of the service system and because interventions are not provided in forms these young people are able to effectively use. The difficulties different program areas have being able to work in a co-ordinated and collaborative way with each other have also been outlined.

The chapter has identified the research questions informing this thesis, questions designed to explore the experience of a range of stakeholders involved in the implementation of a collaborative service initiative to then inform the practice components and guidelines that will guide practitioners in achieving effective integrated collaborative practice.
1.9 OUTLINE OF THESIS

In Chapter Two, the focus shifts to exploring the policy context that sits behind the emphasis on inter-sectoral collaborative practice, the process it has taken within a number of countries, its components and outcomes for these vulnerable young people and the program areas involved with them.

Chapter Three continues to explore and analyse critical components of the literature with the focus on the extensive study that has developed in relation to the research’s dual focus, young people with complex needs and improved collaboration between the service systems involved with them. It also introduces the key theoretical frameworks and concepts that provide a frame for analysis to inform this thesis.

Chapter Four identifies and describes the research design, research methods and the context within which the research occurred. It is followed by Chapters Five to Eight which outline the research’s findings in the following form; Chapter Five consists of the story of the service providers involved in Pilot 1, Chapter Six consists of Pilot 2’s service providers’ story, Chapter Seven is the Regional Managers Story and Chapter Eight the stories of the young people and parents.

In the final two Chapters, Chapter Nine, the analysis and discussion of the findings of the research are presented and in Chapter Ten, the conclusion chapter, an overview of the research is provided including identifying the key principles and guidelines that inform and promote ‘good enough’ collaborative practice are identified.
CHAPTER 2: EXPLORING THE POLICY CONTEXT

The nexus between policy, programs and service delivery is so close, that we need to think holistically about changing all three if we are to have an impact (Scott 2001:2).

2.1 INTRODUCTION

In this chapter, the focus on the context within which the research is embedded, shifts to exploring the wider policy environment. The focus places the micro processes explored in the first chapter relating to young people with complex needs and the service response they receive from the range of sectors they are connected to, into firstly their historical, and secondly, policy context.

Two formative events are noted; the first relates to the impact of deinstitutionalisation policies within the child protection and out of home program area and the service system redevelopments that subsequently occurred. Secondly, it is argued that as these changes were occurring within the broader context of single focused and increasingly specialised large government departments, the consequence was services less able to respond to people living with complex and interrelated difficulties.

An overview is provided of the nature of policy and program responses Western governments have developed to the needs of this cohort, placing an increasing emphasis on services developing co-ordinated collaborative processes and practices inter-sectorally, intra and inter-departmentally. The form these responses have taken has ranged from legislative changes informing broad systemic ‘whole of government’ changes at one end of the continuum, to the development of initiatives and pilot programs placed alongside existing structures at the other end.
The direction taken within English, North American, Australian and Victorian policy and program development are described as examples of this diversity. Within Victoria, the main direction taken has been a 'whole of government' response but without a significant legislative component. While this focus has been successful in contributing to an increased identification and consciousness of the service needs of young people with complex needs, it has also perpetuated the impression that responding to these clients and their issues is additional and therefore peripheral to services 'core business'. An analysis of the critical policy and program responses that have occurred from the core program areas to this cohort is provided.

2.2 THE HISTORICAL ORIGINS OF THE POLICY EMPHASIS ON COLLABORATION FOR YOUNG PEOPLE WITH COMPLEX NEEDS

'Joined-up thinking' and 'whole-of-government' analysis of needs and responsibilities demands a systemic appreciation of essential 'inclusive' and integrated services for vulnerable children and families. If it takes a village to bring up a child, it clearly requires a 'whole of government approach' when the 'government is parent' for that child (Clare 2003:23).

All research needs to be understood as a product of the times and context within which it is situated.

Social work is a profession perhaps more than any other which is shaped by its many contexts - material, social, political, economic and cultural. It is therefore important that we understand in broad terms the main features of the context and what they mean for critical practice (Fook 2002:19).

As outlined in Chapter One this research spans a number of interlocking contexts. In this chapter, the research focus, exploring the importance of services developing co-ordinated collaborative approaches when working with young people with complex needs is placed within its policy context at the
state, national and international levels of government. Policy, as it is used in this research is understood as described by Keene (2001) ‘...as a set of decisions’ (2001:49) and she highlights the requirement to both specify the situations in which the particular policy is set and the outcome of these decisions.

The policy direction that has developed relating to this cohort has been based on the recognition that a group of highly vulnerable young people exists who are marginalised from existing service systems. A starting point for improved and more responsive practice for this group of young people is more likely to develop when partnerships and collaborative practices operate between the services they access. This underlying belief has informed a range of policy directions, program developments and the direction of service delivery inter-sectorally, intra and inter-departmentally.

As Birchall and Hallett (1995) state, ‘....A broad sweep of public policy encourages coordination as a means of improving the effectiveness of many services' (1995:241). The focus in this chapter is on exploring how this 'sweep' has informed the policy directions taken by the key program areas relevant to at risk young people.

To commence, it is necessary to explore the key historical factors that provide the background motif for these developments.

2.2.1 Critical & Co-existing Factors That Have Shaped the Policy Direction - Deinstitutionalisation Policies

A number of co-existing historical factors and events have contributed to shape the policy direction of promoting collaborative practice for 'at risk' adolescents living in residential care. The first critical factor was the impact
of deinstitutionalisation policies that, as Scott (2001) described, resulted in ‘...the most fundamental shift in child welfare policy in the last half century’ (2001:3).

Ainsworth (1999) proposes that deinstitutionalisation was one of six critical concepts that informed the planning of services for children and families in Australia. The others were normalisation, mainstreaming, least restrictive environment, minimal intervention and diversion. Ainsworth proposes that these concepts became ‘...the central ideological tenets of a paradigm used by policy makers and human service planners in Australia’ (1999:14).

The policy and program development direction that accompanied deinstitutionalisation was strongly influenced by a belief that, as much as possible, families should be supported to remain together. As a result of deinstitutionalisation the numbers of young people in State care in Australia declined. Many were maintained within their families. Many of those who needed to be removed, were adequately cared for within community-based (rather than institutional) out-of-home care settings. However some who would become known as 'young people with complex needs,' did not fare as well.

The position raised by a number of authors was that although deinstitutionalisation was generally seen as a progressive development, and a well-intentioned solution to a human rights issue, due to the funding levels that accompanied it and the dominant focus of program development and service delivery that were subsequently introduced, the needs of young people with complex needs were not met (Ainsworth 1999; Scott 2001; Bath 1998; Morton, et al, 1999; Thomson Goodall Associates 2002).
Morton et al (1999) summarises these concerns. They argue that in the form of residential care system that replaced large institutional care, ‘...services were often not equipped to address the level of disturbance of these young people and their level of functioning was said to have worsened in the course of their out-of-home care’ (1999.ix).

Particularly when considering that another change that was occurring during this period was the change in profile of the young people in out of home care. ‘The proportion of older children were increasing, and the children who now reach the out-of-home care system tend to be more damaged and to need more intensive support’ (Morton et al 1999:4; Teather 2001:3).

It was also noted that

The last twenty years has witnessed significant economic and social change including:

- An increasing percentage of children living in poverty
- Changing family and household structures
- The impact of increased substance abuse, problem gambling and family violence (Victorian Government 2003:11)
- Parents of young people removed from their families having ‘...have high levels of chronic substance abuse, psychiatric problems, alcohol abuse and experience of domestic violence and in many cases a number of these characteristics (Victorian Government 2003:12).

A number of writers have expressed the concern that the pendulum swung too far and that there were components that existed within institutional care that served this cohort that were lost.\textsuperscript{41} Many argue that a continuum of service types is required (Thomson Goodall Associates 2002:24)\textsuperscript{42}

\textsuperscript{41} Examples include that there were locked facilities that could be accessed when young people were in danger. Due to the size of the institutions there were on-site psychiatrists and medical staff employed, a school, visiting job placement workers to assist in the transition from the institution to living in the community.

\textsuperscript{42} This position is also explored in 3.7.3
including the incorporation of ‘...residential care for that group of children for whom it is appropriate’ (Scott 2001:4).

This is particularly the view of Ainsworth (1999) who stated that

...unfortunately, the pursuit of the (deinstitutionalisation) paradigm by policy makers and service planners has not led to the same positive outcomes for the more difficult to serve 'at risk' group of adolescents and their families. This group displays a range of complex needs (and) requires services that have sufficient interventive power, are at a higher level of intensity and of longer duration than can be provided by most community-based programs (1999:14-15).

Webb’s (2006) concern, about the regimes that developed in residential settings in Britain with their emphasis on behavioural strategies, are worth bearing in mind when we think about the Australian context. He states that this orientation ‘...eradicated social proximity or “closeness” and closed down trust obtained through proximity and intimacy’ (2006:92-3).

Kiraly (2002) also mirrors this position when she states,

...while much was wrong with the institutions of yesteryear, the better programs at times provided some supports. There is no reason why those positive, therapeutic aspects of congregate care could not be reproduced in today’s smaller, secure units, combined with a contemporary awareness of the rights and developmental needs of the young people, and a much-overdue upgrading of the status, training and remuneration of those who care for them (2002:16).

Ainsworth (1999) acknowledges that

...the dilemma about how to serve this very difficult group of ‘at risk youth’ and their families is an issue across the world. However in the United States, Britain and South Africa policy developments reflect recognition that mature child welfare systems have to contain selective services for the most difficult ‘at risk’ youth and their families (and) that a proportion of these services will be residential programs (1999:15).
One concerning trend that became evident in relation to this group of young people was that as the child welfare institutions disappeared, the young people re-emerged in the institutional settings of other program areas such as the criminal justice and mental health systems or within the homeless sector. The connection between the decrease in young people in residential care (75% fewer children in 1997 than in 1983) and the increase in homeless children and young people has been noted (Thomson Goodall Associates Pty Ltd 2002:17).

2.2.2 Critical & Co-existing Factors That Shaped the Policy Direction - The Impact of Specialised Single Program Areas - 'Silos'

The separate silos such as those of health, mental health, education and welfare must end. Strong bridges must be built between those working in different sectors, at the policy creation, program development and service delivery levels and between each of these levels (Scott 2000:6).

The second critical and co-existing factor that impacts on young people with complex needs living in community based residential care is the broader context of service delivery that operates within the health, education and welfare sectors. These highly specialised single focused government departments house the relevant program areas young people with complex needs and their families are required to access.

They have been described by Scott (2005) as '....single input services based on categorical funding' (2005:133) and 'silos' (Scott 2000:6). Hallett’s (1995) perspective is that these 'mega-government departments' were '...based on the view that services should be organized according to the main skills required to provide them, rather than by any categorization of primary user' (1995:4).
Many authors agree that there are unfortunate consequences of program areas administered under separate structures. The United Kingdom’s Sainsbury Centre For Mental Health (1998) describe a ‘health and social care divide’ (1998:2) while Richards (2001) outlines a process whereby risk is transferred from one public sector organisation to others. With what he describes as ‘silo effects,’ service users typically fall into a limbo between the performance regimes of different agencies (2001:63). They tend to therefore become defined by which service doorway they originally enter.

Australian researchers Thomson Goodall Associates (2002) in their comprehensive literature review conducted to inform the Victorian Department of Human Services Project for their ‘People with High and Complex Needs Project,’ comment on the impact of these interwoven policy and program links.

Deinstitutionalisation policies have been accompanied by fragmentation of the service system, both in terms of geographical separation into community based settings, and separation of responses according to specialization of policy and program areas. Combined with a reduction in funding, they led to less coordination between services, (and) in some cases exclusion of people with high and complex needs (Thomson Goodall Associates Pty Ltd 2002:76).

The fragmentation of services and the ‘...major gap in the service system as far as the needs of (people with complex needs) are concerned’ (Sainsbury Centre For Mental Health 2002:3) has been highlighted as a concern across the United Kingdom, United States and Australia (Hallett 1995:4; The Office of Health Economics and Mental Health Foundation 2004:6; Mitchell 2000c:27).
Two British writers critical of the impact of what one describes as 'functional specialisation' (Webb 2006:193) are Webb and Keene (2001). Keene states:

The combination of fragmented service provision in a range of social, health care and criminal justice agencies together with frequent service usage and non compliance by clients, provide major obstacles to addressing the needs of complex clients...rendering services wasteful and ineffective (2001:28).

Webb (2006) describes another outcome of '...this model of service delivery is that it is prone to fatigue, breakdown or collapse when it comes to dealing with wicked problems' 43(2006:193).

2.2.3 Critical & Co-existing Factors That Shaped the Policy Direction - The impact of fragmentation within the Child Welfare Sector

As highlighted in Chapter One, the focus of this research is on a particular sub-group of young people with complex needs; those who have been identified as at-risk adolescents and living in residential care. For this particular cohort (as is the case for many other young people with complex needs), due to their circumstances of struggling with a number of areas of difficulties in their lives, they come into contact with a large number of service systems each embedded within their own 'separate silos.'

However as well as having to negotiate the fragmentation that exists across sectors in health, education and welfare as described above in 2.2.2; a further complexity the young people face is that within the child welfare system itself, there are also a number of sub-systems. A longstanding

43 'Wicked problems' is a term first used by Rittel and Webber (1973). Wicked problems are often derived from issues of organisational complexity and competing value positions within organisations. Indicators that it is a wicked problem, include when there is confusion and disagreement among stakeholders and the number of organisations defining the definition of the problem (Webb 2006:192).
component of government policy in Victoria relating to the child welfare sector has been the devolution of the care of young people under the State's guardianship to the community sector (Community Support Organisations). In particular whilst their guardianship and case management is the responsibility of the Child Protection Program, their day-to-day care is provided by Community Support Organisations (CSO's). \(^{44}\)

Lyons (2001) argues that non-profit organisations such as CSO's comprise a distinct third sector that sits alongside those of business and government. In Victoria the community sector is a group of agencies with a long standing history, its own reputable and respected peak body, their own governance concerns and quite distinct culture and orientation (2002e:19). \(^{45}\)

Some authors have argued that the presence of these multiple players has resulted in ‘... the fragmentation of service provision across numerous programs for Victoria’s child welfare system’ (Victorian Government 2003:10). Clare, an Australian child welfare researcher (2003), has identified this feature across the Australian child welfare system which he describes as being ‘...unhelpfully fragmentated at legislative, budgetary, standard-setting and audit levels’ (2003:19) and results in ‘... systems deficiency’ (2003:22).

In a 2003 Victorian Government review undertaken to address this fragmentation, the conclusion was that the Government needed to

\(^{44}\) This sector is also known as the community sector and CSO's were previously known as non-government organisations. As outlined in the Glossary, another layer of complexity to the intertwined relationships that exist is that CSO's are funded by the Department of Human Services to provide out of home care services. Some of the tensions that exist between the community sector and the government relate to conflict surrounding funding levels, the range of provisions available and case planning/case management tensions.

\(^{45}\) This body has been known for many years as the Children's Welfare Association of Victoria (CWAV) and more recently the Centre for Excellence In Child and Family Welfare.
strengthen their partnership with the community sector; 'Governments and CSO's need to "shift the paradigm" and recover a common policy framework for child welfare' (Victorian Government 2003:25). Placing their gaze onto a wider horizon, the review also recommended that:

... child welfare goals and strategy need to connect to a higher level, whole of government child and family policy which integrates the responses of various departments (Victorian Government 2003:27).

2.2.4 Unpacking How Policy and Service Development Has Been Constructed For Young People With Complex Needs

Documents might then be interesting for what they leave out, as well as what they contain. They do not simply reflect, but also construct social reality and versions of events. Giddens (1979) argues that a text must be approached in terms of the intentions of its author and the social context in which it was produced (May 1993:138-140).

One of the key methods identified to address the fragmentation described in the previous sections has been through prioritising the need for interagency coordination, collaboration and integration as a policy objective in health, social welfare and related systems.

In the following sections the critical policy and service development responses that have occurred in relation to young people with complex needs are explored. An analysis of the key policy directions taken within Australia, United Kingdom and United States in the program areas of Child and Adolescent Mental Health in particular and Child Protection (and Out-of-Home care) was undertaken utilising a policy analysis frame that posed the following questions:46

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46 This does not imply that the policy directions that have occurred in relation to the program areas, Juvenile Justice, Drug Treatment Services and Education are not also highly relevant however the choice was made to focus primarily on developments that have
a) How was the problem defined?

b) What was proposed as the solution?

c) What were the components of key policy documentation – how were these changes to be achieved?

d) What were the proposed outcomes for young people with complex needs?47

2.3 DEFINING THE PROBLEM

...there has to be serious consideration to how health, welfare, and education deliver services to this at-risk client group. This fragmented silo driven mentality doesn’t work (Pilot 1, Steering Committee member).

As outlined in Chapter One, the identified problem in relation to young people with complex needs is that they experience a diverse and serious range of difficulties that require an increased and different type of support than the current fragmented service system provides. With a particular subgroup of young people with complex needs because these difficulties take the form of severe at-risk behaviours, a sense of urgency surrounds the need to address this ‘problem.’ Therefore the problem is constructed as the fragmentation between key program areas and their consequent lack of responsiveness to the service requirements of young people with complex needs.

47 These questions were adapted from Jupp’s critical analysis approach (Jupp 1996:302-3; Jupp and Norris 1993:50).
2.4 OUTLINING THE SOLUTION

Governments are increasingly embracing 'whole of government' policies in response to complex social problems and the call for services to work together across sectoral, organisational and professional boundaries grows ever louder (Scott 2005:132).

As Scott (2005), an Australian academic indicates in her above quote, what has been consistent across the policy development that attends to young people with complex needs in the Australian, British and United States experience of the past decades, is the belief that increased inter, intra and cross professional coordination, collaboration, partnerships and integration between the program areas involved with young people with complex needs will result in a number of improved outcomes particularly the quality of care at risk young people will receive.

'Multi-agency collaboration appears likely to be particularly beneficial for young people in the "looked after" system, young offenders in custody, those with mental health problems, substance misusers and children with a history of being excluded from schools' (Salmon and Rapport 2005:430). The improved outcomes delivered by timely, integrated, high quality, multi-disciplinary programs arranged around young people's needs '...and not around bureaucratic boundaries and incentives' (The Sainsbury Centre for Mental Health 2000:2) have been identified as:

- the ability to conduct long term planning which will result in improved efficiency,
- overall higher quality service provision including effective assessment, treatment and support, for young people and their families and
- "...preventing social exclusion' (Stead, Lloyd and Kendrick 2003:45; The Department of Health 2004:4-7; The Sainsbury Centre for Mental Health 2000:2).
In a key policy document developed specifically to address the issues experienced by at-risk young people by the Victorian Department of Human Services, The High-Risk Adolescents Service Quality Improvement Initiative (1998a)\(^{48}\) it is stated ‘...a high level of collaboration between program and service areas across the Department, at the individual client level and at the broader service system level, expertise and immediate access to specialist support services' will result in young people with complex needs' risk factors and ongoing developmental needs being responded to’ (Victorian DHS 1998a:1).

What these policy directions share is the strong belief that improved coordination, collaboration and partnership between existing programs will result in young people with complex needs receiving an improved service.

The next sections will focus on the components and methods by which different countries have proposed that these partnerships and collaboration will be achieved.

2.5 COMPONENTS OF POLICY DIRECTIONS

An analysis of the third question, 'what are the components of the policy directions promoting increased collaboration to improve outcomes for young people with complex needs;' demonstrated that similarities and differences were evident between directions taken by the United Kingdom, Australia, the United States and other countries. The main differences have occurred in relation to the methods undertaken to implement cross program approaches, the focus of these changes and their scope. One critical

\(^{48}\) Referred to in Chapter 1.5.
difference is the extent to which governments have used legislation to promote these policy directions and the focus that the legislation has taken.

2.5.1 The United Kingdom Experience

The United Kingdom experience provides a fascinating case study as promoting the use of collaborative approaches has been a constant presence in policy direction over a number of decades and governments. As Cottrell and Kraam (2005) state, '...nearly every document published in the United Kingdom in relation to children's services in the last two decades has highlighted the need for agencies and professionals to work together' (2005:112).

The direction that policy development has taken in relation to inter-sectoral collaboration for the child welfare and mental health sectors in particular, in the United Kingdom has been characterised by four features:

a) The first is the centrality of this direction. As Robinson and Cottrell (2005) state '...the concept of collaboration and partnership working in children's services is central to the government's philosophy' (2005:547).

b) The second is that the initial policy direction focused on single program areas followed by focussing on multiple or cross programs with a particular focus on '....the government’s desire to deliver integrated care across health and social care' (The Sainsbury Centre for Mental Health 2000:1).

c) Thirdly the methods that governments have used to implement this focus have shifted to an increased use of legislation and other mandatory macro system interventions. It is now a legislative
requirement in the United Kingdom to support partnership and multi-agency collaboration' (Salmon and Rapport 2005:429).

d) Finally, within this high profile placed on the collaborative approach, the specific impetus for change to existing policy has frequently occurred as a result of '....scandals concerning the care of children in public care, (which) have fuelled the initiative to reform the ways in which children are treated in health and social care settings' (Lindsey 2005:225).

2.5.1.1 The Impetus for Change

...the tragic death of a child in avoidable circumstances has been a catalyst for change in policy and practice on several occasions over the past 30 years (Hudson 2005:545).

Taking the fourth feature first, Rustin (2004a) an English sociologist, describes the typical process that has accompanied the circumstances outlined by Hudson (above). 'Such cases have on several occasions been investigated by quasi-judicial inquiries, whose published reports have then become central documents in public discussion and in government decision-making' (2004a:9). 49

Rustin (2004a), along with other authors, is highly critical of this phenomenon, querying the value of wide service reforms emanating from circumstances related to what has been a single problematic case. Not withstanding the need to address the '...serious failures in organisational and professional practice' these cases demonstrate (2004a:12). Rustin poses the

49 These include the Victoria Climbié Inquiry (The Victoria Climbie Inquiry 2003) mentioned in Chapter One and the Kennedy Inquiries. One of the earliest that occurred was as a result of 'the death of Maria Colwell in 1973 and the subsequent inquiry (Department of Health and Social Security 1974) (that) is usually seen as marking the emergence of the modern era of working together in British child welfare' (Hudson 2005:537).
critical question ‘...how representative of prevailing practice is the poor standard of practice which was manifested in this one case?’ (2004a:10).

Rustin’s concern is that a predominantly judicial inquiry is unlikely to address problems ‘...generated by a systemic institutional failure, or by a maladaptive culture, or by pervasive anxiety’ (2004a:12). The shortcoming of these methods is also expressed by Ferguson (2005) who states:

   The overwhelming response by welfare states to child deaths and other system failures has been to seek bureaucratic solutions by introducing more and more laws, procedures and guidelines. The more risk and uncertainty has been exposed, the greater the attempts to close up the gaps through administrative changes (2005:782-3).

Ferguson (2005) speaks strongly for the need to enhance the focus of these inquiries to include ‘... a wider analysis of practitioners' lived experiences, the wider meanings of the work being done in these cases’ (2005:789) identifying the lack of attention frequently given to process and feelings, spaces for reflection in the organisational culture, issues of relationships, psycho-social processes and the impact of violence on workers (2005:791-2).

Rustin (2004a) stresses there needs to be greater emphasis on understanding ‘...how good practice is achieved at least as much as anatomies of failure’ (2004a:12). To seriously examine the 'broader preconditions' of practitioner failure such as the quality of professional training and supervision (2004a:13) and the impact of what Ferguson (2005) colourfully describes as the ‘..one-dimensional performance management culture’ (2005:791).
2.5.1.2 The Early Focus on Single Program Areas.

In the earlier periods of policies promoting collaboration that relate to the focus of this research, the main focus was on the program area of child welfare and the need for other programs to work more collaboratively with 'their' clients. As part of this focus '...the requirement for interagency collaboration was embodied in primary legislation in the Children Act 1989' (Hallett 1995:7) and in other pieces of legislation. However, as Hallett, points out, 'earmarked funds were not provided to support' these approaches (1995:7). Thus it appears that the existence of the legislation in its own right was thought to be sufficient to promote collaborative practices.

2.5.1.3 The Shift in Focus and Methods

The shift that subsequently occurred focused on the need for multiple program interventions. Some were the result of reviews and reports (Birchall and Hallett 1995:241). One, the National Health Service Health Advisory Service review of Child and Adolescent Mental Health Services (CAMHS), Together We Stand (1995), '.....had an enormous influence on CAMHS service development 'and introduced the concept of a system of care model' (Cottrell and Kraam 2005:112).

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52 An example was the 1997 House of Commons Select Committee on Health report which encouraged multi agency integration (House of Commons Health Select Committee 1997) and the Mental Health Foundation (1999) which argued for an integrated approach to children's services (Mental Health Foundation 1999).
53 The system of care model is based on the philosophy that children and young people's mental health is cared for by a continuum of services. The four Tier model is a fundamental component of the system of care model. It conceptualises that children's mental health and

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As Johnson, et al (2003) outline, the policy direction was next given a significant injection in the mid-late 1990's with 'partnerships' and 'joined-up government' being

.....leitmotifs running throughout Labour governments' policy proposals. Their lexicon has been of collaboration, co-ordination, partnership and - in respect of health and social care - integrated (seamless) service planning, management and delivery - where the task was to work collaboratively together across organisational and professional boundaries (2003:71).

Webb (2006) takes a critical view of these developments. He states,

New Labour's modernising agenda for the public sector adopts a pragmatic 'what works' approach to joined-up partnerships between health, education and social care. This is regarded as an ambivalent attempt to press ahead with Thatcherite Conservative social policy, on the one hand, whilst furthering some semblance of redistributive justice and democracy, on the other (2006:172).

Hudson (2002), notes

..the early ministerial rhetoric on the need to pull down the 'Berlin Wall' between the two sectors (of health and social care) were followed by a wide array of policy measures to improve interagency working, including statutory obligations, innovative pilot schemes and financial incentives to promote and sustain partnership working (2002:7).

Examples of these policy measures were the 1999 Health Act’s voluntary 'partnership flexibilities' and government-led quality assurance initiatives

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wellbeing is supported by a continuum of service providers. Tier 1 comprises those professionals described as primary care providers; for example, General Practitioners; Community Health workers and those within universal services - teachers, maternal and child health workers. Tier 2 professionals are those with more specific training based in the community and working individually e.g. private practitioners or generalist counsellors. Tier 3 are CAMHS, multi-disciplinary teams working together to provide more complex care and Tier 4 are intensive CAMHS programs such as inpatient units, day programs (Cottrell and Kraam 2005:112).
promoting the integration of research, policy and practice ‘...to maintain ‘joined-up thinking’ across government departments’ (Clare 2003:20).

In 1999, The Audit Commission report referred to health and social services being ‘locked in a vicious circle’ (paragraph 3). Also in 2000 the National Health Service Plan (Department of Health 2000) ‘...the government raised the possibility of structural integration’ (Johnson et al 2003:71) via the implementation of ‘one stop health and social care services’ (Hudson 2002:16).

Charman’s (2004) analysis was that this shift had to occur because ‘...despite all the talk and published guidance about partnership working, little had been achieved at the operational level to integrate services’ (Charman 2004:3). Therefore there was a need for ‘...local strategic partnerships (bringing) together different parts of the public, private, voluntary and community sectors’ (Morley and Wilson 2001:18).

As a result the 1999 Health Act’s ‘partnership flexibilities’ were made mandatory and the 2001 Health and Social Care Act provided a statutory framework for the pooling of budgets and opportunities for integrated service provision’ (Charman 2004:5). Within the 2001 Health and Social Care Act two further organisational structures were created to promote partnerships and improved cross-sectoral practice. The first were Care Trusts which brought ‘...together Health and Social Services components to provide a seamless service to particular care groups’ (Morley and Wilson 2001:17) through joint funding, assessment and provision of services (Department of Health 2004:26).
The second were Child and Adolescent Mental Health Services (CAMHS) Boards, which were "...structures for a "living partnership" approach to the delivery of comprehensive Child and Adolescent Mental Health Services' operating from a shared multi-agency vision" (Morley and Wilson 2001:15). These structures created opportunities for "...better partnership working across agencies with the result that CAMHS were increasingly seen as one component of a wider integrated system supporting children" (Charman 2004:3).

The next significant piece of legislation was The Children Act (2004) which developed as the result of an interesting chain of events. They commenced with the Laming Inquiry into the death of Victoria Climbie. Many of the Inquiry's reforms were incorporated into the Every Child Matters Report (Department for Education and Skills 2003), which 'have subsequently taken shape in the Children Act 2004' (Hudson 2005:538).

The Children Act '...insisted on multi-agency collaboration' (Robinson and Cottrell 2005:548) and continued the trend of introducing mechanisms to enable better 'joint working' for children and young people to occur at the macro level of organisational change (Department for Education and Skills 2005:4:27).

The mechanisms included the establishment of the cross-government Children and Young Persons Unit which reports to Cabinet and the promotion of cross government joint financing arrangements. The Children Act also included the development of national targets related to improving inter-agency communication, shared databases, collaborative working and the

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54 The Laming Report "...repeated the messages of many earlier inquiries about the inadequate nature of communication and information sharing amongst relevant professionals' as having played a critical role in the death of Victoria Climbie (Hudson 2005:538).

In 2004 The Department of Health’s National Service Framework (NSF)\(^{55}\) was released. Standard 9, 'The Mental Health and Psychological Well-being of Children and Young People' recommended that the needs of children and young people with complex, severe and persistent behavioural and mental health needs are best met through multi-agency approaches, and that these approaches need to be strongly promoted by the senior level of Health, Social Services and Education departments.

The Standard also specifically identified the need for adequate services and increased access for those children who have been excluded such as 'looked after children' and other children with complex needs (The Department of Health 2004:4-7; Cottrell and Kraam 2005:113; Charman 2004:6).

Another NSF recommendation consisted of ‘....the “care programme” approach’ which stated that referral and care pathways and interagency collaborations be established’ (Berelowitz 2005:118-119). Stallard (2005) describes the care pathways as providing the mechanism by which ‘...child health care providers work in partnership to provide the most effective package of care to meet the needs of the child’ which will clarify CAMHS and other providers’ roles for ‘...children with complex, multiple and entrenched problems and, as importantly, what they cannot provide’ (Stallard 2005:122).

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\(^{55}\) The formal standard of the NSF is expressed as follows ‘All children and young people, from birth to their 18\(^{th}\) brithday, who have mental health problems and disorders, have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families’ (Department of Health and Education and Skills 2004 NSF:4).
Every Child Matters: The Next Steps (Department of Health 2004) built on the National Service Framework. This document established governance structures called Children’s Trusts which created pooled budgets and integrated ‘joined-up’ commissioning; a ‘mixed economy of providers’ (Cottrell and Kraam 2005:116). The Children’s Trust function was to lead the integrated service delivery, which was expected to result in better outcomes for children and young people (Cottrell and Kraam 2005:116). It was expected that by 2006 Children’s Trusts will have been created to integrate services across social welfare, education and health’ (Walker 2005:237).

In the United Kingdom, projects have also been used to identify innovative ways of engaging and working with young people. The national Innovative CAMHS projects are one example. One of these, the JUST project based in Cheshire, consisted of multi-disciplinary teams working with ‘looked after’ young people. These teams were ‘...based on an underlying philosophy that no one agency has the monopoly in terms of knowledge, skills and resources to meet the needs of the most vulnerable young people in the community’ (Kurtz and James 2004:1).

2.5.2 The United States Experience

In the United States which has a service system spread over public and private service systems, the focus of policy development for some decades has emphasised the need to develop a ‘system of care’ model (Coffey 2004:170; Brown and Hill 1996:4; Sands and Angell 2002:274). The method used to promote the system of care model has frequently included legislative intervention. An early development was The Child and Adolescent Service
System Program (CASSP) (1983) administered by the National Institute of Mental Health (Lourie, Katz-Leavy and Jacobs 1986).

Its primary strategy was to change policies, attitudes and philosophies through the development of coordinated systems of care. One of the CASSP’s guiding principles was that the system of care should consist of ‘...a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents’ (Stroul and Friedman 1986:3).

A further relevant piece of legislation was the Comprehensive Community Mental Health Services for Children and Adolescents with Serious Emotional Disturbances Act (1994) which targeted local cross systems service development (Hanley 1996:285). The Interorganizational Task Force on Model Programs in Service Delivery in Child and Family Mental Health disseminated information on programs of intervention and prevention that modelled best practice and innovations in meeting child and family mental health needs.

Characteristics of model programs included ‘...collaboration with multiple agencies and professionals for a comprehensive yet versatile approach to problems’ (Roberts and Hinton-Nelson 1996:3-9). One model that has been strongly promoted as utilising a system of care approach is the ‘wraparound approach.’ \textsuperscript{56} Wrap-around services are described as

\textquote{...intensive community based (and) seek to prevent more restrictive levels of care. The term wrap-around is a metaphor for enveloping children with whatever services they require. The services are

\textsuperscript{56} This model is explored in more detail in 3.7.1.}
individualised, guided by the specific needs of the children and their families. They provide a comprehensive array of home and/or school based services and work to maximise the strength of families, their natural support systems and their communities (Furman 2001: 82).

Another critical development was the passing of the Individual with Disabilities Education Act 1998 (Implementation Plan 1995) which authorised the inclusion of service coordination across youth-serving agencies requiring that

...interagency collaboration become an essential process for meeting legal mandates as well as clinical expectations. Consent decrees require the state's Child and Adolescent Mental Health Division and the Department of Education to make major systemic changes to address the needs of emotionally and behaviourally disturbed youth. The decree specifies that additional services and programs be developed for these youth and clear practices of case-level coordination within and across state and private agencies be established (Okamato 2001:6-7).

A later National initiative, the Surgeon General's Commission on Mental Health of Children (2000) recommended service delivery innovations based on the systems of care model '....which work to prevent out-of-home placement of children by emphasising the coordination of resources for them and their families' (Coffey 2004:161-2).

2.5.3 Related developments in other countries

The use of collaborative approaches has also been embraced by a number of other countries as the solution to providing more effective services for young people with complex needs. For example in Norway, Ødegård (2005) reports that '....interprofessional collaboration is strongly focused in governmental publications' (2005:347).
In South Africa, the Ministries of Welfare, Justice, Safety and Security, Correctional Services, Education, Health and the National Association of Child Care Workers established an Inter-Ministerial Committee on Young People at Risk, (IMC on Young People at Risk 1996), which '....sponsored a series of innovative residential and community-based programs which were evaluated and transformed into learning sites' (Ainsworth 1999:16).

The needs of at-risk adolescents particularly those in residential care has also been a focus of Israeli policy and service development (Levy 1996; Ainsworth 1999:16).

2.5.4 The Victorian Direction

In Australia, over the last ten to fifteen years, substantial interventions have been undertaken at both Federal and State government levels to address fragmentation of services and respond to the particular service needs of people with complex presentations. One early example was the creation of the Victorian Department of Human Services itself, an amalgamation of two previously separate Departments, the Health Department (where Mental Health Services were located) and the Community Services Victoria Department, which housed Child Protection, and other child welfare services.

However as Wise (2003) highlights,

Despite recent moves toward whole-of-government approaches, Victoria lags far behind the United Kingdom in the development of organisational and bureaucratic arrangements that support joined-up policies and interagency work. Although multidisciplinary and collaborative teams and interagency procedures designed to enhance collaboration currently exist, formal networking and other methods of working as a coordinated system are very new in Australia. There are also many barriers that can inhibit service coordination, for
instance, conflicting state and federal policies, categorical funding in
which agencies receive funding for very specific services and
competition for resources (2003:193).

In the last decade a high priority has been placed on exploring partnership
relationships between different levels of government, within different
program areas within government departments, between government
departments and the community and business sector. This process has
received bipartisan support although the emphasis given to it by
governments has differed.

Some of the initiatives promoting increased partnership and co-ordination
were first introduced in Victoria in the mid to late 1990’s by the then sitting
government which introduced a number of significant changes for the
health, welfare and education sectors. Some promoted this philosophical
direction while others such as ‘...competitive tendering arrangements
damaged inter-agency cooperation and partnership’ (Clare 2003:22).

These developments commenced a process, which continued for the current
State Government (representing a different political party). For the current
State Government the emphasis on partnership has become a core priority
and features strongly in their central policy strategies ‘Growing Victoria
Together 1 & 11’ and ‘A Fairer Victoria.’ It is seen as a major strategy to
progress their social policy vision (Victorian Government 2001b; 2005a).

Growing Victoria Together emphasised policy and program development
incorporating a whole of government approach and the importance of high
quality, accessible health and community services, improved inter-agency and
inter-departmental co-ordination for case management and support services

A significant recent development is the Government’s identification of the cohort of young people aged 12-25 years as requiring a specific policy response (Victorian Government 2002-2004, 2005:d) that has targeted

...ways of addressing disadvantage and social exclusion for youth. The focus is on a strengthened cross-departmental approach to policy and program development for young people (12-25 years) with sectors, communities and schools working together to support pro-social development, increase wellbeing and resilience, and enhance opportunities for learning and work (Victorian Government 2005d:5).

However where the policy orientation promoting collaboration and partnerships in Australia and Victoria has differed from the patterns mentioned in the previous sections relating to the United Kingdom and United States is that it has rarely been embraced in legislative change or included financial and structural mechanisms. When legislation has occurred it has been to support particular initiatives rather than to introduce widespread systemic change.57

The most frequent mechanism used in Victoria, particularly in relation to the program areas relevant to young people with complex needs has been the undertaking of reviews and audits. Many of which have resulted in the implementation of pilots and initiatives which have relied on ‘voluntary’ absorption and integration of these philosophies. This has resulted in a patchy assimilation of these approaches and a tendency for them to remain as peripheral rather than seen as core business.

57 An example is legislation introduced to enable the operation of the Victorian Government Department of Human Services Responding to People with High and Complex Needs Initiative (2002b) which has been discussed previously in Chapter 1.
2.5.4.1 The focus taken within the Victorian Child Protection Program

Within Australia, responsibility for Child Protection and Care is based at the State level. While the State and Territory jurisdictions have very similar Child Protection legislation and management structures there are State based differences (Lonne and Thomson 2005: 88). The focus in this section will be on the critical policy development that has occurred in Victoria during the last fifteen years in particular.

What Victoria does share with other states in Australia and in the United Kingdom, has been the identification of ‘...detailed concerns with the treatment of children in care and their outcomes’ (Victorian Government 2005c:7). Lonne and Thomson (2005) express their opinion very strongly

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58 The Auditor General’s Special Report Number 43: Protecting Victoria’s children: the role of the Department of Human Services, (1996) a performance audit of child protection services concluded that DHS protective services were not ‘...achieving maximum effectiveness in protecting and providing the necessary support for the children of Victoria’ (Parliament of Victoria 2001:7). The Public Accounts and Estimates Committee of the Victorian Parliament (2001) reviewed progress since the 1996 Special Report and described what they found as ‘system abuse:’ when children and adolescents experienced ‘...frequent transfers between placements (which were) described as the most damaging secondary danger for children or young people entering State care’ (Parliament of Victoria 2001:16). Particular concern was made about ‘...the adequacy and appropriateness of placement options and support services for high risk adolescents’ (Parliament of Victoria 2001:16). A further audit of children and young people in residential care, home-based care and kinship care occurred in 2001 (Victorian Government 2001a). This was followed by a 2002 Review, An Integrated Strategy for Child Protection and Placement Services, (Victorian Government 2002d) which identified a series of reforms for the out-of-home program area and in 2003 a review of home-based care was conducted, Victorian Government (2003). In 2003 two further reviews were conducted (Victorian Government 2004b) and (Victorian Government 2004d) which operationalised the 2003 Report.

59 Significant National reviews and those undertaken in other Australian states and territories include the Human Rights & Equal Opportunity Commission Report (1997) of the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families, the Senate Community Affairs Reference Committees (2001 & 2004), reports on Australians who experienced institutional or out-of-home care as children; Western Australia Department of Community Development (July 2003), the Queensland Crime and Misconduct Commission’s (CMC) Inquiry into the abuse of children in foster care Report (2004).
that ‘...there seems to be little dispute that the system of statutory care of children and young people in this country has been in crisis for a considerable period’ (2005:87). With the clear acknowledgement coming from the Department itself responsible for the program area, that ‘...some children and young people placed in out-of-home care do not benefit from that placement’ (DHS 2002d:1) a number of attempts have been made to address the complex issues that surround the care of vulnerable young people.

The method to find these answers, as has occurred in the United Kingdom, has predominantly consisted of conducting reviews which then produce reports consisting of recommendations about required changes in service delivery. Many have been undertaken as a result of trigger events highlighting deficits in the service system. ‘The history of child welfare is littered with inquiries, which have identified failures that have resulted in harm to, or the deaths of children’ (Lonne and Thomson 2005:87).

A critical player contributing to the context that creates the climate for the inquiries and reviews to occur has been the media.

In Victoria, the media has played a key role in shaping the development of child abuse practices and policies for example the 1993 media campaign following the death of Daniel Valero provoked the introduction of mandatory reporting in Victoria. Such campaigns provoked a process of ‘policy development by press release’, rather than policy solutions developed through careful and considered public and expert consultation (Mendes 2001:28).

Morton et al. (1999) report that the Child Protection Adolescent High Risk Program ‘...arose in the context of strong community (and media) concern about wards of the state engaging in behaviour that posed a very significant risk to themselves and/or others.’ In Morton’s 1999 Report they include the
following quote by a judge sentencing a 14 year old boy for a serious violent assault who ‘...told the boy that a particularly troubling aspect of this case is that you have been under the care of the state at all relevant times and that care failed you’ (1999:29).

Some authors are critical of the conservative position that many of these reviews have adopted. Lonne and Thomson (2005) point out ‘...systemic issues have often been ignored or downplayed’ (2005:87). This mirrors Rustin’s (2004a) (and other authors) critical analysis of what has occurred in the United Kingdom citing as an example the heavily influential English Laming Report, that, ‘...the Report is silent on any systemic or holistic dimension in its analysis of the problems’ (2004a:16).

Critical reviews that have directed the policy focus for young people with complex needs in the past thirteen years have included:

a) ‘Protective Services for Children in Victoria: A Report’ (Fogarty 1993) which introduced mandatory reporting of suspected child abuse for particular mandated professional groups in Victoria.


60  This initiative was discussed previously in 1.5.2. Some of the service developments included in the HRA were the establishment of the Intensive Case Management Service, one-to-one care (individualised home-based care) and brokerage funding (Thomson Goodall Associates 2002:29).

c) The Report, ‘When Care Is Not Enough’ (Morton et, al 1999) a case-study of a small number of ‘high risk’ adolescents living in substitute care. This review was highly critical of the existing forms of service...
delivery and identified a number of service gaps.\textsuperscript{61} It recommended that ‘...to meet the needs of the young people with extreme levels of disturbance, an integrated and specialist cross-program response at the regional level, with consistent support from a statewide service is required’ (1999:xii). The Report proposed the development of a range of new residential services under the banner of what was initially called the Intensive Therapeutic Services (ITS) including the establishment of a Statewide Centre of Excellence.

d) The ITS activities eventually became the state wide service, TAKE TWO\textsuperscript{62} which consists of 9 Regional Teams based across Victoria. They provide counselling and therapy for children and young people who have suffered profound abuse or neglect, input to families and carers and support and training for professionals. The service is ‘...based on the recognition that “care is not enough” and that if we can help these children and young people recover from their trauma, then we will be preventing further problems in later years’ (Berry Street Victoria 2003).

e) The 2000 ‘Stronger Citizens, Stronger Families, Stronger Communities’ Report significantly informed the direction of the Community Care service system to ‘...promote social inclusion, strengthen individuals, families, children and young people, and build

\textsuperscript{61} These included the need for early identification, assessment and treatment of children and adolescents entering the care of the Department, multi sectoral, multi disciplinary assessment and case planning, consultation, training and intensive support for carers, intensive specialist therapeutic interventions, therapeutic foster care and therapeutic residential group care, alternative educational programming and mandatory community based intensive therapeutic options.

\textsuperscript{62} Take Two is funded by a partnership between the Department of Human Services, a Community Support Organisation, a regional CAMHS, and a university department.
community capacity through partnership between Government, community service organisations and the community’ (Victorian Government 2000f:7-8).

f) The 2000 Victorian Child Death Review Committee Report highlighted that ‘...many residential placement options appear unable to contain or hold the young person’ (Victorian Government 2000a:31).

g) The 2002 implementation of the United Kingdom initiative, Looking After Children (LAC)⁶³ a case management framework, aimed to improve collaboration for children and young people in out of home care (Victorian Government 2002f).

h) The 2003 Pathways To Partnership Review, was a project designed to ‘....strengthen the partnership between government and the non-government organisations responsible for the majority of Victoria’s residential and home-based care for vulnerable children and young people (Victorian Government 2003:1).

i) The Protecting children: The Child Protection Outcome Project (The Kirby Report) (2004b) recommended:

- A review of the Children and Young Person’s Act
- Improvements to the out-of-home care system,

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⁶³ The implementation of LAC occurred in the months prior to the interviews for this research being conducted. It consists of a framework to ensure the early identification of children and young people with special needs and outlines strategies including regular meetings between service providers, young people and parents which are called care team meetings. In the United Kingdom LAC has been received with a mixed response. Garrett (2002) is critical of ‘...the lack of attention given to considering the social class of "looked after" young people’ (Garrett 2002:834, 841) and the lack of consultation with young people in the development of this and other policy developments.
The continuation of the Take Two program and

The establishment through the new Act of the Office of the Advocate for Children in Care. One of the first functions of this position has been the development of a charter of rights for children in care (Victorian Government 2005c).

j) The Office for Children's Divisional Plan 2005/06 included the funding of the initiative, Family Support and Innovations Projects '....which support early intervention and improved access and co-ordination for at risk families and/or those not currently using services in an endeavour to intervene before crises occur' (Victorian Government 2005e:5).

In Victoria, a number of the reviews and reports that have been undertaken have resulted in specific initiatives being created many of which have replicated model programs from the United States or the United Kingdom. This trend has had mixed results and a number of authors expressed concern about this tendency to '...replicate programs with minimum technical assistance or the ideas or philosophies' without the detail (Ainsworth 2004:34).

Scott (2000) has also expressed strong views about this tendency to rely heavily on the importation of overseas programs. She says that these...

...programs, particularly imported ones, generate their own promotional hype and can come to be seen as a panacea for complex and interrelated social problems. If we have unrealistic expectations we may unfairly come to the conclusion that they are a failure, and they will not survive (2000:9).
Some authors stress that when replicating programs from other countries not enough attention is given to take into account the differences in service systems. Clare (2003) expresses concern about '...attempts at cross-cultural policy and practice activities. Different traditions of social policy and legislative and public policy cultures impact on any international policy transplant' (2003:21).

Another area which has received increased attention in recent years has been the recognition of the poor outcomes of young people after they leave the care of the state.\(^6^4\) In Victoria pressure has been placed on the government from a number of pressure groups to widen their scope of responsibility to preparing and supporting young people through this transition. This has become known as the 'Leaving Care' issue. Unlike some other Western countries and unlike some other states in Australia Victoria, has not had legislative and program supports for care leavers.\(^6^5\)

In recent years The Leaving Care area has received increased attention and funding has been provided to develop pilot programs within Community Support Organisations (CSO's) (London 2004; Mendes and Goddard 2000; Owen, Lunken, Davis, Cooper, Frederico and Keating 2000; Victorian Government 2000g). This issue was relevant to some of the young people interviewed for this research as they 'left care' following their departure from the residential units.

\(^6^4\) As outlined in 1.5.5.
\(^6^5\) In the new Victorian legislation this area is addressed for the first time. In the United Kingdom, the Children (Leaving Care) Act 2000 was passed which includes the maintenance of services for care leavers until the age of 21 yrs (House of Commons 1998; Clare 2003:20).
2.5.4.2 Cross Program Developments

In Victoria initiatives and pilots have been the main mechanism by which the cross program focus has been explored. A number of authors have expressed their concern about this tendency to rely so heavily on pilots.

New programs often only have short term funding due to the insatiable political appetite for new initiatives. Often we see excellent programs destroyed only to be reinvented at a later date. In the process families are hurt by the withdrawal of the service, valuable staff and professional expertise are lost, and inter-agency goodwill is weakened (Scott 2000:9).

Three critical examples of cross program initiatives relating to at risk young people have been:

a) The Working Together Strategy (WTS) which was one of the earliest developments. It was first developed in 1999. When it was introduced it was described as a philosophy and a combination of cross sector approaches to build capacity and improve services for shared clients of the WTS program partners, Child Protection Mental Health Services, Juvenile Justice, Drug Treatment Services and Education (Victorian Government 1999b, 2000b, 2002g). 66

The belief that at risk young people including those in care were not receiving the service access they required from CAMH services was a significant factor in the motivation behind establishing the Working Together Strategy. Although Charman (2004) is discussing the United Kingdom context, her analysis can also be applied to Victoria.

66 The WTS was previously discussed in the Glossary in 1.3 and will be explored further in 4.3.
She states that the motivation for addressing service systems for children and young people at risk was frequently based on

"...concern about the high levels of mental health morbidity among children in care, and frustration that many Child and Adolescent Mental Health Services (CAMHS) were unwilling or unable to meet their needs (Charman 2004:2).

b) The Multi Service Client Project (1999) which similar to the United Kingdom Tracking Project, focussed on '....identifying characteristics of shared clients and the overlap between agencies' (Keene 2001:46-7). The Victorian Project also focussed on identifying the nature and extent of multi service use, multi-service client case management and information management requirements. A cross program coordination framework was developed and piloted in two locations (Victorian Department of Human Services 1999a; Thomson Goodall Associates Pty Ltd 2002:30).

c) In early 2002 The Department of Human Services established a project to develop and implement a framework for management, funding and delivery of service responses for people with unmet complex needs in two or more program areas (Victorian Government 2002b). When the project was first established it included young people however then focused solely on those aged 16 years and above.

Key elements of this model have included the development of a Multiple and Complex Needs Panel, a Specialist Multidisciplinary Assessment Service and Intensive Case Management being provided by specified specialist agencies. For some of these areas to operate legislative change was involved. The initiative is now being implemented in each DHS region across Victoria.
2.5.4.3 Developments within the Mental Health Program Area

Like the previous program areas discussed, mental health policy, program and practice have experienced significant shifts in direction and focus over recent decades. However while public mental health services are also administered by the States and operate under state based legislation, Federal developments within the health and mental health sectors have played a significant role in the direction of Victorian mental health policy and care.


The Plans promoted reforms aimed at improving service accessibility and responsiveness, consolidating the movement of resources from institutions to community-based services, reducing the stigma associated with mental illness, and targeting services to people with the greatest need. The Second National Mental Health Plan (1997/8 - 2002/3) in particular emphasised the importance of strengthening partnerships between services.

The Second National Mental Health Plan (1998) provides a framework for the development of mental health services for younger people. The priority areas it identifies are: mental health promotion and prevention; partnerships in service reform and delivery with other health services and with other organisations both government and non-government and an emphasis on service quality and effectiveness (Einfield and Dean 2000:ii-iii).
The focus of the Second National Mental Health Plan and the National Mental Health Plan have extended the original scope of the National Mental Health strategy ‘….to include an emphasis on prevention and promotion, partnerships among service providers and consumers, and on population health principles’ (Renouf and Bland 2005:420) coordination and integrated care. The National Mental Health Plan Consultation Paper 2003-2008 stated that a fully integrated system of mental health care necessitated

...expanding service frameworks within and beyond the health system, to incorporate mental health and primary care, as well as the disability, accommodation and wider welfare systems, and education, employment and other sectors (Commonwealth Department of Health and Aged Care 2003, quoted in Orygen Youth Health 2004:13).

Both the Federal and State Government policies promoted the concept of a mental health ‘system of care’.

This concept promotes the position that many different primary and secondary services are currently involved in responding to mental health needs in the community and that therefore integration and co-ordination between different services is essential to ensure that children and young people obtain the care they need (Victorian Government 2004c:9-10).

The policy context and vision for Mental Health Services in Victoria is provided by the Victorian Mental Health Service Framework documents (1994, 1996 & 1998a) and the New Directions for Victoria’s Mental Health Services (2002). The latter document identified that ‘...a critical aspect of mental health planning is the need for effective linkages and coordination

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67 As has occurred in the U.K. and U.S. as discussed in 2.5.1 and 2.5.2. See in particular footnote 13 in this chapter. In Victoria the system of care model has been conceptualised slightly differently. It consists of 3 Tiers (compared to 4 in the UK) with the functions provided within Tiers 3 & 4 described as core CAMHS functions.
with services that have similar or overlapping consumer groups' and the requirement to '....better meet the needs of people with more complex needs' (Victorian Government 2002h:3,5).

Reference is made in this document to the increased number of adolescents and young people '...who have severe and complex social, behavioural and emotional problems (which) tend to be difficult to treat and manage in traditional service settings, which often leads to poor clinical and social outcomes' (Victorian Government 2002h:6).

At the time of completing this thesis a new policy document was being finalised to inform the direction of Child and Adolescent Mental Health Services in Victoria. It has embraced the system of care model and acknowledges that with the increasing complexity of presentations of all children, adolescents and young people to public CAMHS a model of care based on partnership, collaboration and integrated services is strongly recommended (Victorian Government 2005e).

CAMHS are one component of a range of services providing mental health care to children and young people. The co-ordination of, and collaboration between, these services is essential to comprehensive quality mental health care. A shared vision, clarity regarding available funding, joint planning, common goals, locally agreed functions, supported by good communication and coordination between services is essential, if mental health outcomes for the community are to be improved (Victorian Government 2005e:7).

Although the Child and Adolescent Mental Health area has not had the volume of reviews and reports as the Child Protection Program area it has also followed the path of introducing pilots and initiatives as methods to address the service needs of multi-sector clients. One important cross-sectoral jointly funded initiative was the establishment of Mental Health
Intensive Youth Support workers; mental health trained workers who were located in Community Support Organisations (CSO’s) and provided mental health assessment, case management, individual and family therapy, consultation, training and education (Hallam, Krupinska, O’Brien, and Woods 1997).

Another key development was the establishment during the mid 1990’s of regional Intensive Mobile Youth Outreach Service teams (IMYOS). These teams provide mobile intensive mental health case management and support to adolescents who displayed substantial and prolonged psychological disturbance, had complex needs and had been difficult to engage utilising less intensive treatment approaches (Victorian Government 2002h:46).\(^{68}\)

A significant recent development includes the establishment of a specific Youth Mental Health Service targeting young people aged 15-24 years within a large metropolitan region of Melbourne and the establishment of regional youth dual diagnosis positions (Victorian Government 2005e:3).

2.5.4.4 Policy Directions within related program areas

The main policy direction for Drug Treatment Services was formulated by the National Drug Strategy, the Victorian Government Strategic Plan (1993) and the 1996 Turning the Tide Initiative. The latter included a strong emphasis on the needs of young people and strengthening community based responses through outreach models (Thomson Goodall Associates Pty Ltd 2002:29).

The 2001 Victorian Government Drug Initiatives included the establishment of specific Youth Residential Withdrawal Units, Youth Alcohol and Drug

\(^{68}\) Workers from both these initiatives were involved in the pilots studied in this research.
Supported Accommodation Services, Youth Alcohol and Drug Outreach Services, Youth Alcohol and Drug Home-Based Withdrawl, Youth Counselling, Consultancy and Continuity of Care and Youth Alcohol and Drug Peer Support services (Victorian Government 2002c).

A number of collaborative and co-operative practices have been developed by the Department of Education & Training (DE&T)\(^6^9\) to address the needs of young people with complex needs enrolled in the educational system. These include the appointment of liaison officers, co-located mental health and educational services in schools and the development of protocols between DE&T, Child Protection and CAMHS services.

The School Focussed Youth Service Initiative was an important state wide initiative developed within Victorian schools that has worked closely in partnership with the Working Together Strategy. CAMHS Mental Health Promotion Officers frequently work within the educational system and a recent CAMHS initiative; the Conduct Disorder pilot is developing programs based within schools.

For young people who have been excluded from the school system in recent years some innovative programs have been developed to try and re-engage these young people into the educational system. An important recent development was the collaborative process undertaken by the Mental Health Branch of the Department of Human Services and the Victorian Student Wellbeing Branch of the Victorian Government Department of Education & Training who developed for the first time a shared policy and program initiative (Victorian Government 2004e).

\(^{69}\) When the thesis first commenced this department was called DEET, Department of Education, Employment and Training.
2.6 OUTCOMES OF POLICY DIRECTIONS

The proposed outcomes that the policy directions described in the previous section of this chapter intended for young people with complex needs were multi-faceted. They included an improvement in young people’s ability to access services and engage with service providers, which would result in improved outcomes for the young people in other areas of their lives. The method that was hoped would achieve these outcomes were services working cross-programmatically in a collaborative and co-ordinated way.

As can be seen from the previous sections a great deal of activity has occurred across a number of countries within a range of program areas endorsing collaborative practice for young people with complex needs. Different methods have been utilised. Within Victoria, despite rhetoric being promoted about the need for creating integrated systems of care, all innovations were undertaken whilst the key program areas retained their discrete responsibilities and functions which does create a somewhat ambiguous position.

Certainly after at least ten years of active attention to this area, anecdotally I am aware there are areas of change, where patches of improved collaborative practice and examples of program initiatives have more successfully engaged young people than previously occurred.  

In the United Kingdom where it appears that the most concerted and comprehensive effort to achieve structural collaborative approaches has been attempted, writers report mixed results. Johnson, et al (2003) state

70 The IMYOS teams are an example. ‘These teams have led to an improved relationship between Child Protection and CAMHS and for a change in culture in some CAMHS settings’ (Morton, et al 1999:36).
there are examples of successful collaborative approaches (2003:198-9). Hudson (2002) presents a more cautious and balanced perspective from his research that ‘...the findings confirm that harmonious interprofessional relationships may be only patchy and partial (but) the fact that they do exist suggests that it is time to move on from an unduly pessimistic view’ (2002:15).

Berelowitz (2005) identifies improvements that have occurred for CAMH services as a result of increased funding (2005:119-120). Charman (2004) also comments on the significant increases in funding71 which accompanied legislative changes and how these represent ‘...a powerful demonstration of the commitment to change at a national level. It also generates a corresponding obligation on the part of services to respond to the challenge and embrace the new vision for CAMHS’ (2004:5).

Many authors also identify a number of teething issues and challenges that have arisen while services grapple with the implementation phase of introducing new approaches. Whilst remembering, ‘...evaluations and critiques of evidence of multi-agency service delivery for children are at formative stages’ (Robinson and Cottrell 2005:548) there are consistent themes. A number of authors have expressed concern about the methods that have been used, the simplistic assumptions underlying the developments, the lack of resources provided and the pressures placed on staff to work within this approach without sufficient training and professional development.

Hudson (2005) is very critical of these processes in relation to the United Kingdoms’ 2004 Children Act, because it had

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71 The Government allocated an increase of 60% growth on current CAMHS spending by 2006 (Charman 2004:5).
many of the hallmarks of a rational ‘top-down’ implementation model - an assumption that political mandates are clear, and that administrators and professionals will simply do what their political masters ask of them. In reality, there are inherent limits to control in complex systems (2005:545).

These include that critical policies such as the National Service Framework (NSF) have been handicapped by not having ‘...the means nor mechanism by which they will be achieved’ (Stallard 2005:121). Particular gaps include the availability of the type of workforce required and the gap in skills and training to achieve the orientation set out in the policy direction (Berelowitz 2005:119-120; Vostanis 2005:131).

Garrett (2002) takes a more systemic analysis in his criticism of the Looking After Children (LAC) policies, describing them as expressing “new paternalism” policies’ (2002:834) and expresses concern about the involvement of Social Work academics in its construction. He believes the role of social work research is to ‘...work creatively at the “edge of the frame” (2002:840) and create an agenda which promotes the inclusion of ‘...the views and perceptions of young people who are “looked after” ’ (2002:841).

Other writers express concerns about the long-term impact of the new structures. In relation to the integrated Children’s Trusts, Cottrell and Kraam (2005) identify the dual dilemma of the risk that CAMH services become ‘lost’ whilst acknowledging that CAMHS retaining its traditional role ‘...runs the risk of CAMHS being isolated from other children’s services’ (2005:116). This is clearly a central dilemma for the ‘joined up’ model, how to balance the maintenance of specialist skills whilst ensuring services work in a co-ordinated and complementary way.
Robinson and Cottrell (2005) report that

themes emerging from research, evaluations and commentaries on issues arising from the implementation of multi-agency team work include dilemmas associated with reconciling different professional beliefs and practices, the complexity of managing workers on different conditions of service and pay scales, problems associated with combining funding streams from distinct service budgets; and the need to invest in joint training and professional development (2005:548).

Johnson, Wistow, Schulz and Hardy (2003) in their study of the experiences of senior health and social service managers responsible for implementing collaborative teams, found the managers questioned the success of policies which relied on mandating collaboration, partnership and integration. They found the most important factors that supported effective integrated teams ‘...depend upon trust’ (2003:82).

Johnson, Wistow et al’s conclusion from their research supported a preference for a ‘...more co-ordinated approach - with budgets coming from a single source and multidisciplinary teams being managed by a single organisational entity’ (2003:80). Johnson, Zorn, et al’s (2003) conclusion from their study was that,

....the findings provide support for a developmental view of collaboration. Collaboration is hard work and understanding how to engage in successful collaboration (will) make the work a bit easier (2003:207).

Okamato (2001), a United States researcher identified from his research that agency fear is

...a neglected construct and that without addressing this fear at the system, agency, and individual level, policy decisions risk becoming undermined during implementation. Addressing this fear concomitant
with system reform and clinical training may result in better outcomes for practitioners and high-risk youth (2001:17).

Darlington et al's (2005) Australian research, also warns that achieving '....effective interagency collaboration is a complex process that needs to be fully supported in policy development and resource allocation' (2005:1095).

Charman's (2004) conclusion captures many of the themes that are emerging as practitioners from across program and sectors in a range of countries are grappling with the realities of implementing collaborative approaches. She highlights that the ability of new partnership structures to be developed and maintained

....will only happen where multi-agency relationships are sufficiently mature, historical rivalries and inter-organisational tensions (don't) persist and block effective partnership development (2004:8).

Charman (2004) highlights that what is emerging from practitioners implementing policy directions promoting collaborative approaches is the need for certain features to be present to enable effective partnerships to develop. What is required is attention to the internal processes that support the external frameworks and structures and that these components are rarely addressed within the policy detail.

It is noticeable that these comments focus on the outcomes for services of these policy directions rather than whether there have been any real or noticeable improvements for the young people. Once again the voice of the young people themselves and their families on the impact of these new approaches are noticeably missing. As Garrett (2002) states, '...there is a need for "looked after" children and young people to have their critical
voices heard in research which examines the wider experience of being "looked after" (2002:842).

If one takes as one measure the number of initiatives and pilots still being developed to 'address the problem' it would appear that the service needs of young people with complex needs remain an area of concern. The question needs to be asked whether pursuing this method without attending to services 'core business' and orientation or confronting the role of the ongoing existence of separate organisational silos, have been a misguided or even incorrect focus and a completely different analysis and framing of 'the problem' and therefore the 'solution' is required?

As Vostanis (2005) forcefully states,

> Health, education and social care are closely interconnected. Any attempt to separate them will lead to fragmentation and poor quality of service provision. This will be particularly evident for children with comorbid conditions and complex needs (2005:131).

### 2.7 CONCLUSION

In this chapter the policy context for this research has been explored. An analysis was undertaken of the critical policy focus that has occurred particularly in relation to the Child Welfare and Child and Adolescent Mental Health sectors within Victoria, the United Kingdom and the United States policy contexts.

The policy analysis undertaken revealed a commonality across these countries and locations in relation to how the nature of the problem has been constructed for at-risk young people, identifying the young people's and their families disenfranchised status and being poorly engaged with service systems.
What the analysis also revealed was that the policy direction identified to respond to 'this problem' is also shared. The solution is universally perceived as the need for fragmented service systems (and the practitioners within them), to develop collaborative and co-ordinated forms of service delivery across micro and macro levels of intervention. This is based on the belief that collaborative approaches will result in young people becoming more engaged with services and also contribute to improved working relationships between sectors.

Where differences have developed is in the means identified to implement this policy direction. Although all the countries and locations studied for this analysis utilised legislative means, some, (the United Kingdom, in particular, and the United States), placed a greater emphasis on this mechanism than has occurred in Victoria. The analysis also revealed that the legislation that has been introduced has included changes at the structural level as well as supporting specific interventions.

Another shared factor particularly between the United Kingdom and Victoria, is a process that has consisted of the use of reviews of the identified 'problem programs' followed by the implementation of time limited pilots and initiatives to address specific areas. This has been particularly prominent in the child welfare program area with the main emphasis being placed on seeking bureaucratic solutions rather than addressing systemic issues, the organisational culture and practice experiences.

Another feature shared by all the countries studied was that there has been an enormous level of activity relating to defining the problem, outlining the solution, developing the components of the solution but minimal attention focused on identifying the outcomes that have occurred as a result of these
interventions. Yet the lack of attention to outcomes has not diminished the enthusiasm for implementing new reviews, pilots and initiatives based on the same problem definition and solution.

In the following chapter the focus will move to exploring and analysing further critical components of the literature in relation to the research’s dual focus, young people with complex needs and improved collaboration between the service systems involved with them - addressing the same analytic questions used in this chapter - identifying how the problems have been defined, what solutions outlined, what the components of the solution have consisted of and what outcomes have emerged.
CHAPTER 3: THE VOICE OF THE LITERATURE

Many minds help (Pilot 2 Service Provider)

3.1 INTRODUCTION

As outlined in the first two chapters, this research is concerned with identifying the practice guidelines that will inform inter-sectoral collaborative approaches as a strengthened form of service delivery for young people with complex needs. The first chapter introduced the three central strands of this research; young people with complex needs, the main sectors with which they have contact and the problematic interface that occurs between the young people and the service systems and the service systems themselves.

The second chapter placed these strands within their historical and policy context. The focus was on highlighting the factors that have contributed to this cohort of young people becoming marginalised from the service system as a result of the process of deinstitutionalisation and the existence of large single focused government departments and program areas.

The Chapter explored the dominant policy directions that have developed to address the service needs of these young people in three countries, Australia, the United Kingdom and the United States. An analysis was undertaken of the way in which the problem has been constructed and responded to.

What emerged were the commonalities and differences between the countries. In common, they shared a commitment to, and emphasis on, policies that embraced collaborative, co-ordinated cross program practice
responses to improve engagement with the young people and between program areas.

The differences lay in the methods and focus the policies adopted. In the United Kingdom and United States policies have been increasingly enshrined in legislation and other mandatory measures and focussed more recently on establishing integrated cross program structures. In contrast, in Australia, where each state manages its own child welfare system, voluntary policy directives, pilots and special initiatives have been the main focus as the example of Victoria has demonstrated.

Relevant literature pertaining to the three strands of the research have been explored throughout the first two chapters. In Chapter One the literature relating to young people with complex needs, in particular at risk adolescents, were addressed. In Chapter Two, the literature relating to policy directions promoting collaborative approaches were outlined.

In this Chapter, the focus on the literature concludes by exploring the research’s third strand, inter-sectoral collaborative approaches. An adaptation of the analytic frame and questions used in Chapter Two have been applied and provide a structure for the organisation of the Chapter. The first sections consist of outlining what the literature has defined as the key problems and solutions in relation to responding to the service needs of young people with complex needs.

Prior to expanding on these solutions, an overview of key concepts from the theoretical frameworks of psychodynamic theory, multidimensional theory, critical theory, structuration theory and the concepts of risk society and social capital are summarised.
The middle sections of the Chapter focus on exploring what the literature have identified as the main features required to achieve effective intersectoral collaboration organised within the levels identified by the multidimensional approach, at the broadest cultural context of the macro system level, the broader structural context of the exosystem, the layer of social networks at the mesosystem level, and the microsystem embracing the individual’s immediate relational context.

The middle section of the chapter also includes an overview of the key ‘best practice’ models identified by the literature as applying to young people with complex needs and raises the critical question of how well these practice domains have engaged the families of these young people.

In the Chapter’s final section, an analysis is presented of what the literature has identified as the outcomes of these solutions for addressing the capacity of young people with complex needs to receive strengthened service responses.

3.2 HOW THE PROBLEM HAS BEEN DEFINED

Collaboration is a difficult enterprise even when people belong to the same profession and have similar perspectives and skills. It is likely to be much more difficult when they have a different professional training and organisational aegis (Patford 2001:73).

As first discussed in Chapters One and Two, the critical ways in which the literature has approached the cohort of young people with complex needs, their interface with sectors and the interface of these sectors with each other have identified a number of ‘problem’ areas. These can be summarised as:

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72 These concepts derive from Harms (2005:10) and will be explored in 3.5.
3.2.1 Factors relating to the young people:

- The complexity of their difficulties; their extent, scope and how these difficulties impact on both the young people and on the community

- Due to the complexity of the young people’s presentation, their need to require treatment from a range of statutory and non-statutory services. Their engagement with non-statutory services in particular is seen as unsatisfactory. As Okamato (2001) states, ‘...treating high-risk youth has become a problem of major scope, magnitude and complexity’ (1991:6).

3.2.2 Features relating to the program areas:

- That they are predominantly organised to provide a service for single diagnoses/presentations which tends to marginalise or exclude young people with complex needs

- Their current practice models are limited in being able to engage this cohort of young people

- The current residential care models do not cater well for young people with complex needs.

3.2.3 Features relating to the inter-organisational context between the sectors:

- That it is a turbulent, conflicted, uncoordinated and fragmented field

- On the whole poor collaboration exists between the sectors involved with young people with complex needs.
3.3 HOW THE SOLUTION HAS BEEN DEFINED

In collaborative practice,

...the parties to this process pool their knowledge, resources and ideas so that they can realize collectively what they cannot achieve individually (Sands and Angell 2002:254).

As detailed in previous chapters, collaborative practice approaches are seen as the means towards addressing the above problem areas. The advantages to be gained from collaboration come from the ‘...blending of ideas and resources, (which) should lead to richer and more sensitive programs’ (Wimpfheimer, Bloom and Kramer 1990:90) and will ‘...bridge service gaps and offer clients a wider range of services’ (Okamoto 1991:6).

Whilst all writers focusing on this area acknowledge the benefits of cross-program collaboration, many also note the ‘...complexity of issues involved in inter-agency working’ (Stead et al. 2003:43). As Johnson, Wistow, et al. (2003) state, it can be ‘...a rather fragile flower to grow and nurture’ (2003:70).

3.4 THE COMPONENTS OF THE SOLUTION

One achievement that has occurred in recent years is the ‘...significant body of research and theory (that) has developed to identify elements important to good collaboration’ (Johnson, Wistow, et al. 2003:70). Central to these elements is the importance of providing clarity about what is meant by collaboration particularly as a feature of the field of study of intersectoral
collaboration has been ‘...a multitude of definitions and models’ (Walker and Petr 2000:494).

3.4.1 Defining collaboration

As Walker and Petr (2000) highlight, collaboration ‘...has been characterized in many ways, as a structure as well as a process, as both process and attitude and as a relationship involving formal and informal components’ (2000:495). The following definition by Abramson and Rosenthal (1995) reflects the position taken in this research. They describe collaboration as:

> a fluid process through which a group of diverse, autonomous actors (organizations or individuals) undertake a joint initiative, solve shared problems, or otherwise achieve common goals. The process is characterised by mutual benefit, interdependence, reciprocity, concerted action and joint production (1995:1479).

thus stressing the process that develops when people work together, the attitude towards this work and the relationships that are formed.

Collaboration, therefore, at its core, consists of ‘shared work’ (Darlington, et al. 2005:1088). The form of shared work that is the interest of this research, is collaboration that occurs between practitioners employed by a number of organisationally distinct programmatic areas.

Collaboration occurs within a number of inter-agency activities and crosses a number of functions. The level of activity differs as Darlington et al (2005)

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73 Most frequently these include the terms cross/inter-sector, multi-disciplinary, inter-agency, cross-agency, partnership, collaborative, joined up, joint working.
74 Walker and Petr 2000, provide the fascinating insight that the Latin roots of 'collaboration translate into working together' (2000:494).
75 As stated in the previous Chapters, the particular cluster of program areas are Child and Adolescent Mental Health, Child Protection (including Out of Home Care provided by Community Support Organisations), Juvenile Justice, Drug Treatment Services and Education.
describe. ‘There are many forms of interagency relationship, ranging from a low level of joint decision making with limited shared resources to multifaceted integrated services’ (2005:1086). The focus of the collaborative activity can differ, from, at the minimum co-ordination, to more shared activities, to integrated teams working as a unit from the same location. Collaborative activity can occur within a range of service delivery forms and utilising a variety of practice methods. It may also occur in relation to non-clinical activities.

This research has particular interest in exploring inter-sectoral collaborative teams working together in the shared care of vulnerable young people. The term inter-sectoral reflects that the participants in the collaborative activity have come together from different sectors to work as a team around the particular activity. Therefore the literature that has been selected reflects this focus.

As mentioned by a number of writers, collaborative approaches to working with young people with complex needs are strengthened when a theoretical framework informs both the ‘problem’ they are addressing and the proposed ‘solution.’

In considering the task I had set myself in this research, how to understand the dynamic interaction of multiple elements in producing outcomes which bettered the lives and experiences of vulnerable young people, it became apparent that I needed to draw on a range of theories and concepts which could (in combination) hold explanatory power.

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76 As has been previously described the location of the cross program initiative studied in this research was based in a residential care setting for at risk young people.
In the next sections the contribution of the theories I selected; psychodynamic theory, multidimensional ecosystems theory, critical theory, structuration theory and the concepts of risk society and social capital, will be explored in identifying what they contribute to an understanding of the components required for collaborative responses for at risk young people.

3.5 'BEST PRACTICE' THEORETICAL FRAMEWORKS

3.5.1 Introduction

As has been raised in previous Chapters, there has been a tendency, within some policy directions, to perceive the development of collaborative approaches required to strengthen service responses for at risk young people, as requiring a simplistic and mechanistic solution. It is the position of many writers working in this field and in this research that, in fact, the opposite is the case.

To assist me in understanding the complexity of what I was exploring in this research, my first decision was to place a boundary around the phenomena to be explored and hence adopted a case study design. I then had to (metaphorically) partialise the elements within the case, considering phenomena occurring at various structural 'levels' within the macro, exo, meso and micro systems.

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77 The term 'best practice' like many of the other terms used in this research has been approached from a number of perspectives and used very widely. Currie's (2001) definition reflects a popular current position. Best practice is defined as 'a consensus of key expert opinion on the approaches and elements of treatment which appear to result in the most successful treatment outcomes for youth' (2002:7). In contrast Barker (2001) suggests the importance of keeping the following questions in mind when identifying best practice elements. 'In what particular way does this or that psychotherapeutic approach, or intervention, work, for whom, to what particular purpose? What are the working processes?' (2001:1).

78 This is explored further in Chapter 4.

79 These concepts derived from the ecosystems model are defined in the following sections.
Looking ‘within’ the case, I wanted to analyse the relationships amongst various key actors in relation to the various ‘levels’, based on assumptions that human actors are influenced both at the intrapsychic and interpersonal ‘levels’ by factors operating structurally and organizationally.

The four theories and concepts that have enabled me to understand these steps were Ecosystems Theory, Psychodynamic Theory, Structuration Theory, Critical Theory, risk society and social capital. They provided a level of theoretical understanding which, like collaborative practice demonstrated that the sum of their whole contribution built on their individual parts.

The following table outlines how these theoretical perspectives and concepts have provided a frame for analysis to inform this thesis. Thus it has been used to analyse the literature relating to collaborative practice approaches and best practice models as outlined in this chapter, it has informed the research methodology used in this research as described in Chapter 4 and provided a framework for the analysis of findings and discussion described in Chapters 9 and 10.

Table 3-1: Multidimensional View of Research Analysis

<table>
<thead>
<tr>
<th>Design</th>
<th>Research Methods</th>
<th>Theory</th>
<th>Concepts</th>
<th>Key Concepts</th>
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<tbody>
<tr>
<td>Case study</td>
<td>Policy Analysis Literature Review Interviews Descriptive profile</td>
<td>Ecosystems (multidimensional) Psychodynamic Critical Structuration</td>
<td>Risk Society Social Capital</td>
<td>Trust Connectedness</td>
</tr>
</tbody>
</table>

In the following sections the four theories and concepts are described in more detail.
3.5.2 Utilising a Multidimensional Systems Framework

In the multidimensional approach (Harms 2005; Hutchison 2003) ‘.....each person is recognised as having unique biopsychosocial and spiritual dimensions as well as structural and cultural dimensions’. Therefore their experiences are ‘.....continuously and simultaneously influenced by individual (biological, psychological and spiritual) and environmental (social) factors’ (Harms 2005:4).

The multidimensional approach incorporates and builds on the earlier work of ecological theorists particularly Bronfenbrenner’s work (1979) based on an ecological understanding of human development. ‘Ecosystems and ecological derivatives make use of some form of systems theory’ (Reid 2002:14). These multi level approaches ‘.....give much needed emphasis to the interactions between people and the multiple social systems in which they live and offer conceptual schemes for making some sense of the intricacies of these interactions’ (Reid 2002:17).

In ecological theory the central focus is placed on the person in their environment (Reid 2002:14). This environment is organised into different concentric circles representing system ‘levels:’ the microsystem, mesosystem, exosystem and macrosystem. As Harms (2005) highlights, no one of these layers can be interpreted without understanding the others as they are embedded within each other (2005:8).

These system levels, the microsystem, mesosystem, exosystem and macrosystem will be used as the organising structure to describe the contribution of a number of key concepts that have informed this thesis.

3.5.3 Identifying the key concepts
3.5.3.1 Concepts deriving from Psychodynamic Theory

Nevin (1996) defines psychodynamic theory as '....an approach which emphasises the emotional content and meaning of all human experience and creates links between the dynamics of individual development and that of family and community life.' She stresses that it '....goes beyond a treatment modality and can be applied in a wide variety of settings' (1996:259). Shuttleworth (1991) states that the analytic approach provides '....access to the lived experience of persons, to allow close attention to be paid to the fine details of particular human situations, a sensitivity to emotional experience' (My italics) (1991:5).

Key concepts that derive from psychodynamic and psychoanalytic theory and are particularly relevant for this thesis are Winnicott's concepts of the 'good-enough' facilitating environment and holding, Bion's concept of containment and Bowlby's concept of attachment. All these concepts have been further developed, enhanced and applied both by other psychodynamically oriented theorists and practitioners including being embraced and assimilated into wider usage.\(^{80}\)

3.5.3.2 Concepts deriving from Critical Theory

The 'critical approach' describes a very broad range of theories that take as their common point a '...critical or radical stance on contemporary society (with a concern about) unequal power relations' (Hough 1999:42). It therefore promotes '....the politics of representation and the politics of diversity' (Camilleri 1999:34-35).

\(^{80}\) The specific references for these concepts are provided in 3.5.4.
3.5.3.3 Concepts deriving from Structuration Theory

Structuration Theory as advanced by the sociologist Anthony Gidden's work is described by Craib (1992) as a work of synthesis' (1992:2). Giddens (1990) has described his work as 'radicalised modern.' His interest is in the interplay that occurs between the person and their environment. Structuration theory tells an integrative story about the connection between individuals and the larger social environment where human actors are seen as coconstructors of, not just interactors within their larger social environments' (Kondrat 2002:444). Key concepts include the individual's capacity to be active agents within their environments, the use of reflexivity and the concept of emotional democracy.

3.5.3.4 The Concept of Risk Society

The idea of the risk society originates from the work of Beck (1992). According to Webb (2006) it describes the society we live in today. 'We live in a world saturated with and preoccupied by risk' (2006:23). 'In risk society we are preoccupied with regulating the future, normalising things and bringing them under our control' (Webb 2006:19-20). Within this framework, critical concepts include risk governance, risk regulation and transfer of risk.

3.5.3.5 The Concept of Social Capital

Within social policy the concept of social capital has been used frequently over the past decade. Social capital refers to 'those stocks of social trust, norms and networks that people can draw upon in local contexts to solve common problems. It is an informal, normative resource that promotes co-operation and reciprocity between two or more individuals' (Webb
2006:20). Useful social capital concepts for this research include Woolcock and Narayan's (2000) synergy model which identifies three dimensions of social capital; bonding capital, bridging capital and linking capital.

3.5.3.6 The Concept of Connectedness

The concept of connectedness does not derive from a specific theory but is a theme that is present within and across many of the frameworks and concepts utilised in this research. The Australian Concise Oxford Dictionary (2004) states that to connect means to join with another, to unite or associate with others in relationships. **Connectedness** is the noun of connected. Like connection, it is 'the state of being connected'. Connection also refers to a link, 'a thing or person that links' people or objects (2004:292-293). (My italics)

As a social worker who came to this research from many years of working within and alongside fragmented service systems, I commenced this process with an awareness that the need for improved and effective '...connections between individuals, groups and organisations within teams and between the team and other service systems'\(^{81}\) (Bland and Renouf 2001:240) was critical for enhanced inter-sectoral collaboration.

This research therefore is based on the belief that connectedness is a core human experience that individuals strive to achieve; the state of being connected, joined and linked to others. There are a number of experiences, states and conditions that are the means to achieve this experience. In relation to the focus of this research, the need for improved service responsiveness for young people with complex needs relies significantly on

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the state of being connected in order to enable effective engagement and collaborative practice to occur.

The young people who are the focus of this research need to experience the state of being connected within their intra psychic, psychological, interpersonal and social dimensions, to enable and promote them to engage with others and therefore use the ‘therapeutic’ experiences being offered to them. Similarly the workers need an environment, which enables them to begin the process of feeling more connected to the young people they work with, to the interventions they provide and to the work they provide together.

When I use the term ‘therapeutic experiences’ I am not referring to a specifically formal or traditional clinical experience of clinical psychotherapy but to a broader environment and atmosphere which enables and promotes healing and engagement and a sense of connectedness.

Central to the condition of achieving a state of connectedness is the provision of a safe place. This can mean a psychological space, a state of mind, an internal space, within one’s own mind or feeling that others have a space in their mind to be thoughtful and hold one’s experience. It can also be a literal physical space, for example, a room or building or a residential unit, or it can refer to an overall atmosphere that is generated within communal space. Clearly this concept is strongly informed by Bowlby’s notion of a ‘secure personal base’ (1988:11).

The need for improved connectedness is a theme that appears prominently in the work of writers working from a psychodynamic and ecological theoretical frame and utilising social capital concepts as are further outlined in the
following sections. What all the theoretical perspectives and concepts described above share is the inclusion of a framework which places the person/environment interface at the centre acknowledging the dynamic nature of the interactions that occur across and between levels.

In the following sections key concepts from the theoretical frameworks and concepts described above are identified organised within the ecosystem levels of the microsystem, mesosystem, exosystem and macrosystem.

3.5.4 The Microsystem

The microsystem is the most immediate level which surrounds the individual. It consists of what Scott (2000) describes as ‘…the face to face interactional sites of our daily life such as family, school, workplace’ (2000:4) which as Harms (2005) outlines, provide the ‘…relational context for our sense of well-being and identity’(2005:10). Therefore for the young people who are the focus of this research the residential unit is an integral part of their microsystem as well as their family, school, friends and community contacts.

Psychodynamic theory has a particular strength in its contribution to understanding the factors that impact on the individual’s development and significant relationships within their Microsystem. In particular the concepts developed by three seminal object relations clinicians and researchers, Bion, Bowlby and Winnicott, provide a framework to understand critical factors that impact on the infant, child and adult’s emotional, psychological and cognitive development, concepts that have particular resonance for this research.
All three developed concepts that highlighted the importance of the earliest caregiving relationships in the infant and child's life. Winnicott stated that '......the "good-enough" environment starts with a high degree of adaptation to individual infant needs' (1986:22). Winnicott developed the concept of holding which he said commences with '......the physical holding of the intra-uterine life and gradually widens in scope to mean the whole of the adaptive care of the infant' (1986:27).

Winnicott explained how the infant or child 'not being held' had significant consequences for their development including experiencing difficulties taking in and holding on to thoughts, feelings, memories and experiences. This placed the child at greater risk of experiencing learning and other developmental difficulties and trusting relationships throughout their life.

Bion (1967), developed the concept of containment, a mental function that enables the infant to feel held and manage other critical psychological processes. Bion outlined the circumstances that promoted the child feeling contained. This occurred when the mother was receptive to the child's anxieties and, by her understanding, reverie and response, her internal processing - taking in, absorbing, feeling, thinking, organising, made the infants' anxieties more bearable.

Bowlby (1988) focused on what was needed in the child's environment to promote the capacity for attachment. This was

......the provision by both parents of a secure personal base from which a child or adolescent can make sorties into the outside world and to which he can return, knowing he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, reassured if frightened (1988:11).
Bowlby proposed that the quality of attachment the child experienced was critical for understanding their future development and functioning.

Winnicott proposed that a safe, therapeutic holding environment provided consistency, continuity, and reliability and had reparative potential. Chescheir (1996) described 'psychological holding' as '...the feeling that one is being held and a safety net is present' (1996:98) and is '....an essential part of the facilitating environment' (1996:121). There are a number of situations where the experience of being supportively 'held' applies, (Applegate 1996:82-3, 85) including clinical work and management. Winnicott (1961) described casework in particular, '.....as a 'holding' of persons and situations, while growth tendencies are given a chance' (1961:107).

An extensive literature exists demonstrating how clinicians and researchers have applied psychodynamic concepts to working with at risk young people including those placed in residential settings. Berlin (2001) describes how '...attachment theory offers a way of understanding the meaning of the behaviour of residential youth'. Interactions within residential services informed by attachment theory have a therapeutic potential to '....provide the young person the opportunities to feel understood, cared about, cared for and safe in this environment, help them to begin to feel cared about, and able to trust staff and thus begin new relationships' (2001:2).

In relation to the microsystem perspective, critical theory places its focus on the '....importance of the social context and its impact on the individual' providing '....a structural analysis of social and personally-experienced problems' (Fook 2002:5). It is concerned about how to produce changes at the micro level. It identifies the importance of ensuring that marginalised voices such as the young people, families and service providers involved in
this research are heard. It involves '...putting people first and developing a genuine partnership' (Camilleri 1999:34-35).

Trainor (2002) demonstrates how what is occurring at the macro level can impact on vulnerable young people's feelings of futility when he describes the '...empty social spaces' that exist in their lives and '..their disenchchantment with a world without a meaning, meta-narratives and grand (truth) theorising' (2002:208).

Structuration theory offers an active and dynamic perspective on the individual's capacity to impact on their environment at all levels as well as the environment impacting on them. It recognises that individuals play an active role '..in the maintenance, stability and transformation of society's institutions' (Kondrat 2002:436) and have the capacity to impact on social reality, thus reducing their passivity. They can be 'active agents capable of self-transformation and involvement in political engagement and social change on a global as well as local level' (Kondrat 2002:436).

Giddens (1984) proposes that social structures and values are enacted at the individual level between people. Therefore when as occurs in this research, the stakeholders include marginalised members of the community interacting with others who are not, there is a risk that beliefs and prejudices which are unconsciously held may interfere with the development of trust which is critical for partnerships to develop.

Mutual trust has been proposed as a hallmark and product of social capital. Webb (2006) identifies that Putnam (1993) conceptualised social capital as referring to the 'connections among individuals,' social networks and the norms of reciprocity and trustworthiness that arise from them' (Webb
Thus social capital includes the glue that creates cohesion between relationships.

As Webb (2006) highlights, marginalised young people and their families are frequently described as having a ‘...deficit of social capital.’ The guiding principle for those working with these families is to ‘...provide ecological frameworks from which to support and facilitate the generation of social capital’ (2006:227).

The risk society’s application at the microsystem level, contributes an analysis of the tendency to perceive marginalised young people from a ‘problem-saturated’ identity where the source of their troubling behaviour is seen as being located within themselves rather than in the relationships and contexts in which the young person belongs or wishes to belong (Gilligan 2005:297).82

3.5.5 The Mesosystem

The next layer within Bronfenbrenner’s model is the mesosystem which considers the ways in which the various relationships within the individual’s microsystem interact with each other. As Harms (2005) outlines ‘...this is a layer of social connectedness, the layer of our social networks. The social network layer is about observing the interconnectedness or linkages between the settings themselves’ (2005:10). Thus it is within the mesosystem that the inter-organisational activity of inter-sectoral collaboration occurs. Hudson and Lowe (2004) argue that the meso level also contains ‘...the core subject matter of the policy process’ (2004:9); that is, how the macro level of policy is transferred or operationalised into practice.

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82 This perspective was explored in Chapter One.
Giddens' structuration theory provides an important perspective and contribution when considering the processes that need to occur for the development of effective collaborative approaches at the mesosystem level. One useful concept outlines that ‘...social structures and systems are constructed, maintained and altered through the social practices of individual members’ (Kondrat 2002:437). Therefore individuals 'carry' aspects of their organisation as well as social practices within them and in their interactions with others.

When there is an awareness that these processes operate, through reflexivity, (a capacity Giddens describes as essential to enable change to occur) they can be considered as a factor that needs to be taken into account to ensure an environment exists that promotes collaboration. If this impact of social structures and individuals remain hidden, they may sabotage the capacity for stakeholders to develop trust and work together as a group.

Giddens' perception that individuals are actors equally impacting on their environment as their environment impacts on them highlights the complex dynamics and energy that will be occurring when stakeholders from very different service systems, with very different access to resources and power attempt to form an effective working relationship (Giddens 1984:25).

Another Giddens' concept relevant to collaborative practice is 'emotional democracy.' Giddens proposes this occurs as a result of repeated interactions which establish mutual reciprocity and respect and promote the durability of the caring relationship. As a consequence 'active trust' develops, a state that has to be energetically developed, handled and sustained (1994:186).
Psychodynamic theory and in particular, attachment theory, has been identified by some writers as the preferred theoretical orientation to inform service models for young people with complex needs living in residential settings (Moses 2000:477; Morton et al 1999:48).

Applegate and Bonowitz (1995) state that:

In situations where conditions require placing children in ongoing care outside their families of origin, reliability and consistency are the mainstays of successful placement. By fostering ego relatedness to (a small number of workers or a team) this approach reduces clients' sense of fragmentation, minimizes delays, duplication of services and bureaucratic mix-ups and in other ways promotes a sense of cohesion and organisation in the service of the holding environment (1995:254).

However particular theoretical orientations can be also incorrectly applied to justify policies and programs. Australian researcher McIntosh (2003) asserts that this has occurred in relation to attachment theory where central concepts have been misunderstood and used to justify ‘…..anomalies in child protection practice and legislation or to lengthen or complicate case practice’ (2003:12).

Core psychodynamic concepts, of having the capacity to attach, feeling held, safe, contained and having a secure base are also applicable across the range of relationships and settings that occur within the mesosystem. The importance of the work setting as being a place able to provide containing, supportive and holding environments is central as the context within which these relationships are expressed.

Winnicott (1965) believed that one of social work's primary roles is to create and sustain holding environments for people whose stability, safety, and continuity has been disrupted or never been firmly established. The holding
function has been described as ‘...the essence of social work’ (Chescheir 1985:220). Winnicott included management as being a potential holding activity. By management he meant creating and sustaining facilitating environments for displaced or troubled people in the community - environments characterized by consistency, reliability and protection from impingements from without and from within.

Menzies Lyth (1991), comments on the need ‘...for the institution to be so organized that it sustains and furthers the development of the capacity for attachment between staff’ (1991:432). This will enable service providers and the service system in which they operate to feel contained, to utilise what Rustin (2004b) described as ‘...spaces for reflection’ where anxieties can be moved ‘...in a more positive direction’ (2004b:21). This may occur within a supervisory or consultative relationship or within a team.

In a comment that has particular resonance for inter-sectoral collaborative practice, Rustin (1991) recommends the importance of:

> the creation of a space in which all aspects of the work could be investigated systematically, (which may have) a particular value (for) a group of colleagues of varying disciplines and seniority (1991:387).

Webb (2006) applies a risk society analytic frame, to the challenges facing social workers working within a ‘complex system.’ Webb describes social work as having a ‘...pivotal role of risk regulation and expert mediation for problematic populations and vulnerable people in risk society’ (2006:5). In their direct practice work this role ‘...can deepen capacity building and mobilise social capital. The ethical in social work emerges as a fragile but necessary response to the politics of neo-liberal risk society’ (2000:8).
Green (2003) utilising a perspective informed by the concept of a risk society expresses a concern about ‘...the risks that arise from the decisions to care for troubled adolescents who live in 'out of home' settings distinguished by high levels of ambiguity about appropriate care and control’ (Green 2003:16).83 He argues therefore that the people affected by these risks are both the young people and the service providers who are placed in the untenable position of providing 'control' rather than 'care.'

Trainor (2002) identifies

...the need in all of us for a sense of social integration in our lives and the need that we all, but most especially young people, need social and political groups and institutions to which we belong to be worthwhile, sound, good and true, to be vital sources of meaning in our lives and to provide cultural pathways to truth (2002:208). (My italics)

Hough (1999) applies a critical theory analysis to organisational functioning and calls for '....an attention to discourse that will allow us to find the absences and silences in the language of organisations' (1999:43). This links to one of the aims of this research, to provide the opportunity for service users (young people and their families) and service providers (those working at the 'coal face' particularly residential care workers) to have their silence broken and enter the discourse on collaborative approaches.

'We can be more alert to the stories about organisations that we tell ourselves and that we tell to others. We can tell localised stories which have some theoretical power' (Hough 1999:51-2). It is the intention of this research to provide the opportunity for the story of an organisational process to be told and heard through all the 'small stories' or 'web of stories' (Bainbridge 1999:180) of those involved. It is hoped as a consequence that

83 A position previously discussed in Chapter One.
participating in this process will contribute to the empowerment of these stakeholders.

In regards to social capital's contribution at the micro and mesosystem level Woolcock and Narayan's (2000) synergy model of social capital is very useful. It identifies three dimensions of social capital. Healy and Hampshire (2002) have applied this model to the service delivery level. The first dimension, 'bonding capital' refers to when workers base their interventions on strengthening social connections that build on similarity, informality and intimacy and '....reinforces the importance of close bonds such as family and friendship connections' (2002:234).

The second, 'bridging capital' refers to strengthening links and networks amongst diverse individuals, characterised by formal and informal relationships, strong and weak ties. It is vital for linking individuals and communities to resources or opportunities outside their personal networks.

These concepts provide another dimension to understanding how collaborative approaches can develop. In this research for the young people and families a hoped-for outcome of their receiving services delivered within collaborative integrated services would be the improved development of all these levels of bonding, bridging and linking capital. As a result of their bridging capital being strengthened they would hopefully be in a stronger position to negotiate and access social networks from which they have been marginalised.

These concepts can also be applied to the experiences of the service providers. It is hoped that as a consequence of the inter-sectoral relationships and connections being formed stronger networks and alliances
are established. And, as a result of these alliances the service sectors can be empowered to act politically and increase their linking capital.

3.5.6 The Exosystem

The mesosystem, in turn, is embedded within the exosystem, which consists of the institutional infrastructure of the labour market, the legal, monetary, health, education and welfare systems. This is a layer in which '...we do not have direct, face-to-face relationships (but) our individual experience and interpersonal and social constructs are all profoundly and indirectly shaped by these factors' (Harms 2005:10).

For this research, the exosystem is the level where the policy and service development activities promoting collaborative approaches at the regional and state wide levels are conducted.\textsuperscript{84} It also encompasses the operations of the key service sectors including their funding models, staffing structures, service models and relationships.

A number of authors have utilised social capital concepts to apply to exosystem components. An Issues Paper commissioned by the Victorian Department of Human Services (2002e) states that '...the interconnectedness of the health of civil society and the health of its community organisations is known as the social capital argument' (2002e:22).

Healy and Hampshire (2002) proposed that the concept of social capital can be used to describe how non-government organisations such as Community Support Organisations (CSO's) have been used to fill gaps previously seen as the responsibility of governments.

\textsuperscript{84} Described in Chapter Two.
Many commentators express concern that social capital concepts are used by governments to hand back responsibilities to communities without the transfer of material and human resources needed to address the problems facing them (Healy and Hampshire 2002:233).

Carter (2000) identifies the constraints placed on CSO’s to fulfil this function:

CSOs which are management dominated and dependent on government do not necessarily contribute to social capital. In the contracted environment of top down, hierarchical management through institutional policy ‘silos,’ social capital formation is distant. Coalition building, which relies on achieving a consensus based on recognising the different values and states of the various participants, allows for social capital building (Carter 2000 quoted in 2002e:23:).

Green (2003) provides an analysis of the risk society orientation at the exosystem level as it applies to the community care and out of home care sector. He outlines that the policy development direction that has occurred in contemporary community care practice as a result of deinstitutionalisation practices have resulted in ‘...fragmentation, dispersal of responsibility and the transfer of risk’ (2003:12).

As a result, ‘...complex protective work that used to be contained and sometimes hidden within the infrastructure of the institution’ (Green 2003:2) is now devolved to community locations where service providers, (such as those involved in this research) are placed in the position of having to operate, in a ‘zone of high risk,’ a term used by Rose (1998: 372).

Webb (2006) identifies the impact of the increased regulation of practice which occurs in ‘the risk society’ as shifting

...the priority from meeting the needs of service users or forming genuine partnerships with stakeholders, other professionals and organisations.’ As a result a ‘blame culture’ develops where ‘....risk
avoidance becomes a key priority, definitions of responsibility (become) specific, narrow and precise, rather than to nourish a sense of shared responsibility. In line with neo-liberal practice the question of responsibility is put into the context of a contest, not the context of common values (2006:70).

In relation to how this orientation impacts on service delivery models practised in care settings, Webb (2006) describes how '...a variety of regulated practices' such as '...the dominant ‘tick-box’ culture\(^5\) have led to‘.. reducing the time spent face-to-face” (2006:93).

The resultant effect is the loss of scope for creativity and innovation, as well as the deskilling of practice and a narrowing of the research agenda. This dulls the possibility of critical reflection and creative professional skills (2006:139).

3.5.7 The Macrosystem

All of the previous levels are ‘....embedded within the macrosystem, that broader cultural blueprint of a society shaped by its core values and characteristics' (Scott 2000:5). Scott (2000) adds that '...in an era of globalisation.....Bronfenbrenner would want to add to the macrosystem, cross-national economic and political factors which also impact on families and communities' (2000:5) including the '....broad environmental - social, economic, technological, demographic - determinants of policy' (Griggs 2005:552).

Harms (2005) utilising the multidimensional frame, describes this level as the ‘...cultural context (which) refers to the norms, principles or mores of a culture’ (2005:11). Kondrat (1999) identifies that the ecological model's

\(^5\) Webb (2006) used the Looking After Care policy development (LAC) (a case management framework for children in Out of Home Care settings previously discussed in 2.5.4.1) as an example of ‘...the use of standardised forms and procedures (which) generates the comfortable illusion of objectivity (2006: 137).
contribution at this level of analysis is ‘...in showing that micro-systems do not exist in a vacuum and that the behaviour of individuals and families must be understood in relation to larger social systems’ (1999:470).

Critical theory acknowledges the impact of developments at the macro level particularly globalisation, the changes in the welfare state and the increasing impact of managerialism and how these factors impact on individuals. It also highlights the dominant discourses that operate in society and how they exclude marginalised groups.

This includes the empowering capacity of naming myths and narratives that have been developed and perpetuated about marginalised people (Hough 1999:43). This focus on the importance of developing partnerships for those that are marginalised is critical for this research.

The emphasis on the place of risk in our society has particular implications for the focus of this research, as (see Chapter One) this is a central motif for how young people with complex needs are perceived and has shaped how programs and services for them are constructed. Beck's (1992) central position is that our current industrial society is being transformed by changes which generate continuing turbulence.

Webb (2006) identifies that this period of time can be understood as one which ‘....includes a social dimension, that of risk society; a political dimension, that of advanced liberalism; and a cultural dimension, that of reflexive or late modernity' (2006:4). The impact of living within a society dominated by these dimensions is that ‘....risk governance increasingly regulates populations and individuals who fall outside the safety net of

86 Some of the 'myths and narratives' about young people with complex needs were explored in Chapter One.
normalised society and this ‘...form of governmentality undermines traditional practices of value and relationship building’ (Webb 2006:47).

The third concept of Woolcock and Narayan’s (2000) dimensions of social capital, ‘linking capital’ applies to the macrosystem as it refers to alliances with sympathetic individuals or groups in positions of power over resources needed for social and economic development (and therefore is also relevant at the exosystem and macrosystem levels) (Healy and Hampshire 2002:229).

Rustin (2004b) reflecting on the impact of these changes from a psychodynamic lens notes that one of the consequences of these changes is that they create a constantly heightened state of anxiety for those living within this environment (2004b:18-19). Freiberg (2002) states that ‘....the identification and management of risk has become one of the structuring principles of contemporary life’ (2002:10).

3.5.8 What these theories and concepts share in common - an overview

The previous sections have demonstrated that the theoretical perspectives and concepts covered in this section despite their diversity, share a number of commonalities. These include an attention to the linkages operating across multidimensional levels.

As Applegate and Bonovitz (1995) identified they also have linkages with each other.

Winnicott’s concepts are epistemologically congruent with systems or ecological theory. While an appreciation of the multiple external systems within which clients transact their lives is crucial, knowledge of the intra and interpsychic systems is also essential (1995:245).
Ritchie (2005) acknowledges the links between social capital and multidimensional theories and their applicability to the young people focussed on in this research in her comment:

Social capital is the result of relationships within families and between family members and the community. It links the micro, meso and exosystemic levels and is invested in children through these relationships. It is also a resource which they can draw for well-being. Where children are removed from their families and social networks, it may be almost axiomatic that significant harm will occur (2005:765).

Another feature that the preceding four theories and two concepts share is the presence in each of their orientations of two key ideas; trust and connectedness. Each brings their own lens to these ideas.

In relation to interconnections all the theories and concepts address the interconnections of systems. Critical Theory's emphasis places a perspective on connectedness and power, and therefore the importance of ensuring that those less privileged in social systems are empowered (by privileging their voice in this research). Connectedness is an embedded implication of all the critical psychodynamic theoretical concepts while connectedness in Structuration theory is an essential component between organizations and actors.

The capacity to develop trust is identified as a central component of development by psychodynamic theories originating at the microsystem level of infant and child development but also critical at meso and macrosystem levels within work places and between structures. Trust is also inherent in the concept of social capital.
Social capital is about building trust at individual levels which lead to building communities and sustaining societies (social systems), so it is a concept derived from systems theory and very useful also in structuration theory. Privileging the voice of the marginalized means building a safe environment where trust and engagement and connection can occur, so it also resonates in Critical Theory.

These theories have therefore provided a useful mechanism to capture the complex phenomena being studied in this research. In the next section the focus moves on to identifying other key factors that have been identified in the literature that are required to support collaborative practice approaches.

3.6 FACTORS THAT SUPPORT COLLABORATIVE PRACTICE APPROACHES

In the previous sections key concepts to be considered when implementing effective collaborative practice for young people with complex needs were identified from the perspective of a number of different theoretical frameworks and concepts. In the following sections further factors that enable the complex but 'creative process' of effective collaboration to be achieved (Wimpfheimer et al 1990:90) are outlined.

The sections have also been organised within their ecosysystemic levels. However as the literature relating to the macrosystem level was described in the policy analysis in Chapter Two, this section will focus on relevant literature applying to the exosystem level, the mesosystem and the microsystemic levels.
3.6.1 Factors to be considered at the exosystem level

A number of writers highlight that for collaboration to be effective there needs to be ‘...a culture of 'commitment' at strategic and operational levels’ which supports the work being undertaken by multi-agency teams (Robinson and Cottrell 2005:558). However for this culture to be achieved it requires ‘sustained preparatory work’ between partner agencies (Robinson and Cottrell 2005:557).

Scott (1993) has identified that what is also needed is for practitioners participating in collaborative work to ‘...recognise that inter-agency conflict is predominantly structural not personal’ (1993:8). She points out that although personalities are important ‘...structural factors such as competition for scarce resources, incongruent roles or overlapping mandates are more significant sources of poor inter-agency relationships.’ Therefore it is important to ‘...avoid making the other agency into the common enemy’ (1993:8).

Hudson (2005) also identifies the importance of being realistic about structural differences, particularly that collaboration ‘...does not take place on a level playing field’ (2005:544). One significant structural issue is whether collaborative practice is being supported by specific funding or additional resources or expected to be absorbed within organisations existing budgets and the tensions this can create (Johnson, Zorn, et al 2003:198-9; Mitchell 2000a:72-3, 74-76).

A number of writers highlight the important role that a key person either within an organisation or at a regional, statewide level can play in promoting the acceptance and integration of collaborative approaches. Morley and Wilson (2001) describe a 'champion', drawing together and building inter-
agency commitment (2001:6). Johnson, Zorn et al (2003) point out the necessity for key person(s) within the agency to be involved as decision makers in the planning and development of the collaboration (2003:206).

In addition, Stead et al (2003) describe the critical role that a 'specialist' inter-agency worker can play in pushing through new and innovative working practices particularly in promoting some of the communication and coordination issues that arise across program areas. Stead et al stress the importance of this person being an 'outsider,' who does not represent any of the agencies involved (2003:44).

As highlighted in Abramson and Rosenthal’s (1995) definition, collaboration is a process. Many writers and researchers have developed models that describe the stages involved in the collaborative process (Okamato 2001:7; Victorian Government 2000c; Hallett and Birchall 1992; Quinn and Cumblad, 1994; Walker and Petr, 2000:495; Stead et al 2003:43).

An interesting model is the one proposed by Wimpfheimer, Bloom and Kramer’s (1990). They break down the process of collaboration into two stages. The first involves achieving the pre-conditions required for collaboration which are identified as mutuality, timing, authority and creativity. Once these are met (and it may take some time for this to occur) the collaborative process is ready to commence. The second stage then consists of the following four conditions being met:

(a) Every party involved in the collaborative activity has to perceive they will gain something from their involvement;

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87 Outlined in 3.4.1
(b) There is ‘….open communication system between or among the partners (which includes) acknowledging one’s contribution to the problem, as well as accepting responsibility for working out solutions.’

(c) There is shared common risk and

(d) There is recognition of the limits for each agency or individual. (Wimpfheimer et al 1990:93-4).

3.6.2. The Pilot Factor

As identified in Chapters One and Two, many of the initiatives utilising collaborative approaches have been developed as ‘pilots’ or special projects. This method appears to be favoured when introducing either a controversial or untested form of service delivery as a means of ‘testing the waters’ before potentially incorporating them into mainstream practice. As mentioned previously a number of writers have expressed concern about this trend.

Mitchell (2000a) states in her evaluation of the (Australian) National Youth Suicide Prevention Strategy that:

special projects’ often do this work well because the ‘special project model’ tends to incorporate some of the factors that have been identified as most critical to effective intersectoral collaboration (e.g. dedication of resources and planning) (2000a:121).

Mitchell reports however that there is generally a lack of evidence about whether special projects are effective in instituting lasting change in

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88 Interestingly, in Victoria, the experience is that many pilots, even when they have successful outcomes have not ended up being replicated or integrated into mainstream practice.
agencies adopting collaborative approaches. ‘This will often depend on whether governments and area and regional service managers maintain a commitment to the area’ (2000a:121).

Other authors also mention concerns about the use of pilots. Hallett (1995) warned that as these innovations are often developed in reaction to a crisis or high-profile case or incident, under these circumstances they are at greater risk of not being integrated into core practice (1995:334). Teather (2001) highlights that as ‘...most change activities take place on top of what people are already doing’ (2001:14) being involved in a pilot can place additional stress on people who are already working under difficult circumstances.

Others point out that certain conditions that are present within pilots, for example having a specific co-ordinator or facilitator for the initiative, are unlikely to be replicated under ordinary circumstances (Rothman and Damron-Rodriguez 1999:46-7). Rothman and Damron-Rodriguez (1999) also raise another critical issue which is how the pilot has been introduced. Has the innovation been wanted by those involved, and seen as introducing advantages or is it something imposed, even a ‘.... “desperation” innovation, which occurs when, due to system failures, the system must do something quickly’ (1999:44).

These circumstances will impact on the adoption rate of the innovation. Other factors that will play a significant role include whether those ultimately involved participate in decision making, the presence of a ‘change agent’ or ‘opinion leader’ who promotes it, whether it has previously been demonstrated as successful in related circumstances and whether it receives peer support (Rothman and Damron-Rodriguez 1999:46-48).
Pilots are often used to test the effectiveness of a particular component of program development before deciding where to replicate it in other settings. As discussed previously Scott (2001) warns that ‘...the uniqueness of the practice context (can) make it hard to transfer best practice from one setting to another’ (2001:6).

Roberts and Hinton-Nelson (1996) argue that attention must be given to local situations while Bachrach (1988) makes the critical point that it is the adoption of the principles upon which model programs are founded that is most helpful, rather than the reproduction of the pilot itself (1988:1258).

3.6.3 The mesosystem level - working as a collaborative team

As stated previously, within the continuum of activities that constitute collaborative approaches, the team approach is one of the mechanisms in which inter-professional and inter-organisational partnerships and collaboration can be achieved. Teams are seen as a method of providing ‘...effective and creative care for vulnerable populations because their needs transcend any one discipline’ and can act as ‘a force for innovation’ (Rothman and Damron-Rodriguez 1999:39-40).

Despite many of the workers involved in this research having worked as members of teams within their own settings, few would have had experiences of inter-sectoral team work. An additional challenge exists when, as Teather (2001), identifies ‘...it is particularly difficult to work collaboratively with agencies where we have had competitive relationships over time’ (2001:11).

As Walker and Schutte 2004, warn, ‘...teams with a diversity of perspectives have the potential to be more creative than more homogenous groups (but)
also are at greater risk of losing effectiveness due to excessive conflict' (2004:187-8). The crucial word here is excessive. Scott (1993) reminds us that '...a certain level of conflict between organisations may be normative and necessary' (1993:4) and therefore the '...diversely constituted team can create a synergy that produces innovative problem solving and facilitate integrated intervention' (Sands and Angell 2002:265).

The task is to channel the synergy and conflict creatively, not an easy undertaking and one that relies on the presence of professional good will and respect particularly when the collaboration is occurring between agencies involved in statutory and therapeutic work (Robinson 2004:379). It also relies on what Australian academics and clinicians Bland and Renouf (2001) describe as being '...sufficiently robust to welcome alternative perspectives' (2001:240).

Central to the task of creating a robust intersectoral team is a realistic awareness of what is involved in team building. As Robinson and Cottrell raise (2005) '...team members with different backgrounds cannot be expected to just work together effectively from day one' (2005:557-8). There are a number of factors that can impact on a team’s ability to work collaboratively.

Sands and Angell (2002) believe that '...because professionals are socialized to acquire their own cognitive map, they tend to overestimate the contributions of their own discipline and think that its perception is the perception' (2002:260). As Keene (2001) states:

different professions have differing perspectives, different specialist theories and therefore also different definitions of problems, different assessments, different reasons for starting and stopping help, and different definitions of success and failure (2001:113).
The particular composition of professionals represented in the team and the power differentials between those groups can play a role in the team's capacity to work collaboratively. A number of studies have identified that medical and welfare practitioners often experience challenges when working as a team. 'Different multi-agency teams position individual members differently as specialists or generalists' (Robinson and Cottrell 2005:553) some professions tend to be marginalised, others are more likely to claim the leadership (Birchall and Hallett 1995:249).\(^\text{89}\)

Johnson, Zorn et al (2003) identified from their research that the factors required for partnerships between professional groups to be successfully developed included a willingness to work together, the existence of previous positive collaborative experiences and good communication (2003:198-9). Other authors include the issue of the organisation's attitude or perspective, their capacity to '...be adaptive and innovative' (Rothman and Damron-Rodriguez 1999:33, 43-44) as critical.

In the research Smith and Bryan (2005) conducted, they found collaboration to be '...a complex process and not to be underestimated' (2005:207). The research highlighted the importance of workers' own emotions '....to be recognised and navigated' and for them to learn how to '...manage multiple relationships' (2005:203) and negotiate '...trust, ambiguity and conflict' (2005:196).

As Teather (2001), acknowledges, '....to work collaboratively requires a paradigm shift for most professionals. Collaboration requires power sharing,

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\(^\text{89}\) Of the professional groups involved in this research, the one that previous research has demonstrated to hold a marginalised position are residential care workers and the profession most likely to claim and be seen as leaders are psychiatrists (Barrett 1996; Birchall and Hallett 1995:249).
the careful inclusion of others in decision-making and taking risks based on trust’ (2001:10).

Many writers identify the development of healthy relationships between team members as being the prerequisite for effective partnerships to grow and therefore collaboration to occur. They describe the factors that promote sustained relationships are trust and respect, which require ‘….a process of "getting to know" people and organisations by listening and learning,’ (Mitchell 2000a:104) and sharing knowledge (including personal knowledge of each other (Hallett 1995:315).

As Nikander (2005) identified interprofessional encounters ‘…..take place in various social sites, from informal to formal’ (2005:263) and they all contribute to the development of understanding and building a common view (Campbell 1999:208) which is critical for ‘…..co-operation across professional boundaries’ (Nikander 2005:262).

The areas team members particularly need to share knowledge about are the roles and activities of each others' organisations as well as the principles, practices, conceptual and philosophical frameworks, programs and activities, organisational systems and policy issues that impact on them (Mitchell 2000a:55; Okamoto 2001:11).

A few authors stress the need for there to be ‘….a vital reflective space’, (Smith and Bryan 2005:203), to enable what Walker and Schutte (2004) describe as the promotion of ‘…..team psychological safety, an interpersonal climate characterised by mutual trust and respect’ (2004:185).

Robinson and Cottrell (2005) identify that time is needed for all these processes to occur, to ‘facilitate a shared team climate,’ allowing ‘….the
creation of a shared language in team activities and service delivery, shared protocols and documentation’ (2005:557). Once this occurs ‘...a primary affiliation to the team rather than (to) different agencies’ (2005:553) comes into existence.

These shared visions and values are described ‘...as being crucial to successful collaborative efforts and the glue that holds collaborative efforts together’ (Walker and Petr 2000:495). These processes are also identified as critical to achieve Bion’s concept of a working group which includes a capacity to pursue its recognized task (Rustin 1991:383-4).

However as the contexts in which many workers operate particularly in the sectors focussed on in this research are characterised by a ‘...scarcity of time and resources and conflicting demands’ (Nikander 2005:276) time (or the lack of it) is often identified as the reason why collaborative activity is problematic to achieve. Teather (2001), also highlights how ‘...becoming an effective collaborator means moving to a different way of understanding the worlds in which we live and work in’ (2001:11).

In this shared space it is necessary for the team to develop clear aims and objectives and a shared agreement about what the nature of the problem is, taking into account the capacity to adapt and modify conventional treatment if that is required (Keene 2001:106-113; Mitchell 2000a:106-113; Turner 1999:27, Fonagy 1998:163-4). Keeping the client as the primary focus has been described as essential to enable the joint planning and decision-making that is required (Okamato 2001:11; Hallett 1995:326).

Robinson and Cottrell (2005) acknowledge the critical function of significant time being allocated during the early stages of team development. Others
acknowledge the importance of the team engaging 'in a planning process' (Walker and Schutte 2004:185). Robinson and Cottrell's research (2005) highlighted the need for established teams to

....be supported and encouraged (through) training and development for staff undergoing changes in work practices (2005:558). This requires an emphasis to be given to 'nurturing inter-professional relationships and rituals to sustain professionals' commitment to new ways of working (2005:558).

These qualities are supported by opportunities to practise what is learned, the need for structural supports within the work environment, particularly the support of other staff (Mitchell, 2000a:72-3, 74-76).

Many authors focus on the impact on staff of working with very troubled and challenging young people, and their need for appropriate structures for support and survival including supervision and consultancy (Winnicott 1958; Crago 1996; Fonagy 1998; Mitchell 2000a). 'We argue that workers need proactive support, training and mentoring from their supervisors to conduct this work effectively' (Thomson and Thorpe 2004:54).

Other writers focus on what involvement in teams offers those who participate in them, citing staff satisfaction and learning, reducing individual burden and burnout and breaking down interprofessional boundaries as benefits (Sands and Angell 2002:259). Experiencing success is also identified as being critical for the team's sense of hopefulness about their endeavour (Walker and Schutte 2004:189).

Teather (2001) states that a 'pivotal requirement' (2001:17) in adaptive team functioning is the role of strong leadership and skilled facilitation, particularly during its formation, a point also raised by a number of other

As this role includes the ability to provide ongoing support to the group, (Mitchell 2000a:72-3, 74-76) and to assist in the process of managing '....group emotions particularly in times of ambiguity' (Smith and Bryan 2005:196), '....the person running the task group needs to have the knowledge and skills required' (Teather 2001:15). Roberts and Hinton-Nelson (1996) believe that '....programs succeed because of personnel and leadership' (1996:18) and particularly benefit from '....the enthusiasm of a strong central figure' (1996:17).

Stead et al (2003) in a Scottish study of inter-agency working, highlighted the critical role that team meetings played '....as (a) valuable and necessary forum for sharing opinion, widening understanding and for decision making' (2003:50). Teather (2001), also stresses the importance of meetings needing '...to be run within a framework of agreed upon norms, start and stop on time, have agendas, have source materials prepared and distributed before the meeting' (2001:15).

A critical mass of staff sharing the same knowledge and commitment to working within a collaborative approach is also recommended (Mitchell 2000a:72-3, 74-76). Collaboration between sectors is more likely to be supported by promoting the well-being of the team through the development of a sense of camaderie, stable staffing, a supportive agency environment, building in evaluation and the development of an increased knowledge base about what supports effective collaboration (Mitchell 2000a:106-113; Scott 1993:9; Campbell 1999; Okamato 2001:17; Stead et al 2003:44).
In research Hudson (2002) conducted, co-location was frequently identified as a valuable basis for joint working and where co-location existed, formal procedures were modified by relationships and enabled shifts to take place from hierarchy to network (2002:13).

3.6.4 Qualities required in the microsystem - at the individual worker level

Hudson (2005) highlights that ‘...effective partnership working can rarely be sustained through structural and process changes on their own’ (2005:544) and that, as many other writers stress, the qualities of the workers involved in collaborative approaches is critical. They point out that it is clearly not a form of working that suits everyone. Qualities that are frequently cited include the capacity to demonstrate openness, co-operation, flexibility, problem solving capacity and a commitment to the process (Mitchell 2000c:55; Okamoto 2001:11).

Currie (2001) adds to this list people who demonstrate an ability to show patience, respect and trust (2001:47-8). Mitchell (2000c) stresses the importance of working from a philosophy of self determination and empowerment for the young person and providing a holistic service provision approach (2000c:10-18).

Thus while there appears to be a particular ‘type’ of person best suited for this work, their personal qualities also need to be enhanced by relevant qualifications, knowledge and skills. These are identified as understanding youth developmental issues and operating from a relevant theoretical framework (Currie 2001:47-8).
3.7 'BEST PRACTICE' MODELS

In the previous sections the focus has been on the factors identified in the literature as the components required for effective collaborative approaches with a particular emphasis on factors within inter-sectoral teams. Thus the emphasis has been on what needs to be present between practitioners and their program areas to enable them to work effectively as a unit. In the following sections the gaze moves to what is required in the interactions between these collaborative teams and the young people.

To commence, the key practice models identified by the literature as being indicated for collaborative approaches with young people with complex needs are explored.

3.7.1 Innovative Service Models

A number of innovative cross-sectoral models have been developed in recent years for young people with complex needs. As mentioned in 2.5.4.3 in Victoria, two important developments included the establishment of Mental Health Intensive Youth Support (MHIYS) workers, mental health trained staff located in non-government agencies and the Intensive Mobile Youth Outreach Services teams (IMYOS), CAMHS workers who provide a flexible out-reach based service delivery for young people unable to be engaged by the more traditional office based practice models (Hallam et al 1997).\(^\text{90}\)

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\(^{90}\) Although both these models are important developments there have been limitations to their effectiveness. The MHIYS workers are single positions and the IMYOS Teams are small teams servicing a whole metropolitan or regional region. While both initiatives are included as part of the CAMHS service continuum they have often been positioned as adjunct to the core services offered and therefore perpetuate the marginalised position of this client group (and the workers associated with them).
The Working Together Strategy\textsuperscript{91} has developed a number of service initiatives for this target group. Of particular interest for the program studied in this research, was an earlier initiative based in a different Victorian metropolitan region. This initiative piloted the use of a multi-sector team working with young people living within a few residential units.\textsuperscript{92} Initiatives for young people with complex needs have also been developed within the non-government and government sector, some funded by philanthropic organizations (McDermott and Harms 2002).

The use of collaborative multi-disciplinary teams has been identified as one of the characteristics of exemplary model programs designed to engage at risk children and young people by child and family mental health services in the United States. Other characteristics include the use of a clear theoretical rationale to inform the program, the presence of a strong personal commitment by those involved, creative funding and organizational sponsorships and the use of innovative service support methods.

It is also stressed that these model programs require service providers who work responsively and flexibly with the young person, their family and in all cross agency relationships. A close tie between training, research, evaluation, and service delivery have been identified as critical (Tolan 1996:97-102).

Two highly regarded and high profile service models that originated in the United States but have since been implemented in other countries including

\textsuperscript{91} Described previously in 1.3 and 2.5.4.2

\textsuperscript{92} This initiative was called the Eastern Perspectives Model (Victorian Government 2002a). Although a very different region (smaller, with only one agency providing each of the main program areas and with a history of more positive cross-sectoral relationships) their positive results played an encouraging role in the early planning of the Enhanced Residential Program model studied in this research.
Australia and New Zealand are 'wrap-around services' and multi-systemic therapy.

Some writers identify that '...wraparound is perceived as a philosophy as much as an intervention' (Bruns, Burchard, Suter, Leverentz-Brady and Force 2004:86) and that '...the wraparound model has been described as a primary vehicle for applying the systems of care philosophy'\(^{93}\) (Bruns, et al, 2004:79). The wrap-around philosophy is encapsulated in Walker and Schutte's (2004) description.

Effective intervention requires that representatives of the different systems in a child's environment work together in a collaborative and coordinated fashion to rearrange the environment in ways that promote adaptive functioning (2004:182).

Critical features of the wrap-around model include that they have:

- the objective of providing a network of services for children that include schools, families, counselors and specialized programs as a means of assuring that risks associated with children's development are addressed in a comprehensive fashion (Middlemiss, 2005:92).

In the United States the wrap-around approach has predominantly been applied to young people living with their families. However many of its core principles of providing individualised care from a range of services 'wrapped' around the young person and family and working as a co-ordinated team has been extended to programs in Australia and New Zealand working with young people living away from their families.\(^{94}\)

Writers have expressed both enthusiasm for the strengths of wrap- around models, and reservations. Bruns et al. (2004) state that the wrap-around

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\(^{93}\) Described previously in Chapter Two.

\(^{94}\) One example is a program called 'Wrap Around Kids' established in New South Wales and based in schools.
approach '.....is listed among the handful of promising community treatments for youth (and is) enormously popular' (2004:79). Middlemiss (2005) quotes a number of studies that report the:

.....effectiveness of the different wrap-around approaches suggests that this type of collaboration can positively effect children's behaviour as well as improve children's and families' retention in programming, or their need for service (2005:92).


The multi-systemic therapy (MST) shares many commonalities with the wrap-around approach. MST was developed at the Medical University of South Carolina by Henggeller, Schoenwald, Borduin, Rowland and Cunningham (1998) and is described as a model of treatment for high risk antisocial youth which consists of an intensive training regime that involves close supervision and stringent monitoring of the model (Ainsworth 2004:33).

It is based on providing responsive outreach to young people and their families. Its intervention methods include cross program collaboration assessment, treatment planning and review, family therapy, intervention with community linkages, 24 hour 7 day a week on call support by a multi disciplinary team. The target group is predominantly young people with complex needs living with their families but at risk of removal who have previously experienced periods of out-of-home care.
Where MST differs from other initiatives is that it has been rigorously evaluated (Henggeler, Schoenwald, Rowland and Cunningham 2002; Henggeler et al. 1998). The results indicate that ‘.in relation to outcomes for mental health, family stability, reduced juvenile offending and reduced juvenile substance use, (MST) has been found to be effective on all parameters in controlled trials’ (Victorian Government 2000d).

Taking a more general perspective Australian researchers and practitioners, Flanagan et al. (2001) stress the importance when working with vulnerable young people of using a developmental model that incorporates an understanding of the interaction between the child’s experience of abuse and other developmental processes and provides an understanding of how abuse can lead to risk factors associated with negative adult outcomes. Such an approach needs to:

.....incorporate the opportunity for individual and holistic assessments leading to individualized service delivery plans for each child or young person (and) ensure that responses to children and young people are co-ordinated and integrated across all aspects of the service system (Flanagan et al. 2001:15-16).

3.7.2 The ‘Care Team’ model

As stated previously the use of a cross-sectoral team has gained favour in recent years. Many writers stress the need to draw upon knowledge from a variety of disciplines through interdisciplinary teams. This allows for ‘.the aggregation of the skills and resources from different professions which is seen as vital’ when working with young people with complex needs (Hallett 1995:298).

When the team is multi-disciplinary and intersectoral, it is believed that this can create what Mailick and Ashley (1984) describe as:
a synergy between the relevant parties; a context for cross-fertilisation of ideas to emerge that encourages new perspectives and reformulations of difficult problems and solutions that exceed the boundaries of separate disciplines (1984:542).

Reeder and Cowie (2001) two Victorian practitioners who have promoted the use of multi-sector care teams in the Child Protection and CSO sectors, state that it is the preferred service model for young people with complex needs.

The care team approach emphasizes client work through a team of professionals from a range of service systems involved with a particular young person. It is the care team that collaboratively establishes plans across the service system (including) the family. Assessment and intervention become a function of the group rather than the individual systems. The components of the care team consist of regular meetings, inter-agency planning, clarification of the key workers for the young person and family, secondary consultation and identified agency co-ordinators (2001:1).

The Care Team’s composition is identified as a critical factor. Inclusion of education staff alongside clinical staff was raised by a number of writers as a priority for young people who have had fractured contact with educational facilities. Morton et al. (1999) stress the importance of keeping in mind that ‘..to meet the needs of young people with extreme levels of disturbance, an integrated and specialist cross-program response is required. The recommended service model therefore provides treatment, education and care’ (1999:xi).

Berlin (2001) also focuses on the benefit of including education staff.

Education is a critical part of the total treatment process and demands exceptionally talented, flexible and psychologically minded teachers. The collaboration between (care) workers, teachers and therapists is essential to the effective treatment of seriously attached-disordered clients in residential treatment. Such
collaboration provides the data for each discipline to do their own work more effectively (2001:6-10).

The valuable contribution of the residential care staff to the care of the young person is stressed by a number of writers. Berlin (2001) stresses their role in providing ‘….opportunities for critical, repeated interactions which provide the young person with the opportunities to feel understood, cared about, cared for and safe in this environment’ (2001:2).

However the role of residential care staff is a more contentious issue. Mordock (2002) believes that ‘….the child care worker as therapist approach’ places undue emphasis on staff rather than allowing them to do what they do best which is ‘….creating an environment where behaviour will be less disruptive and less chaotic’ and therefore ‘therapeutic’ (2002:20).

3.7.3 The Residential Care Unit

As outlined in both Chapters One and Two, the direction and predominant models that out-of-home care services have taken in recent decades and their ability to meet the complex needs of at risk young people has been commented on extensively.\(^{95}\) Thomson Goodall Associates Pty Ltd (2002) convey a concern expressed by many that ‘…residential units are in danger of being absorbed by a focus on behaviour control and crisis management to the exclusion of developmental activity’ (2002:17). Thus the overall environment and culture they provide with an emphasis on control rather than care is a critical issue to consider in relation to how they ‘fit’ with more therapeutically oriented collaborative practice models.

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\(^{95}\) As mentioned in Chapters One and Two concerns about the quality of residential care have resulted in a number of government sponsored and independent reviews.
Okamato (2001) stressed the need for balance with highly restrictive programs as well as less-restrictive programs being provided depending on the need of the young person. His research highlighted that more 'high-end' highly restrictive services, such as locked facilities were needed for some high-risk youth in comparison to them being inappropriately placed and treated in 'lower-end' services (2001:16).96

Teather (2001) recommends the need for another form of balance,

given the chronic nature of the young person’s disability, the characteristics of her family, and the experience of ‘connected’ agencies, residential care can only be useful as an integrated component in an enduring family support system, an integrated part of a seamless service system (2001:8).

One factor raised by many authors as being critical to the quality of the service provided by residential care settings was their level of funding and therefore staffing. Many authors concurred with the views expressed by Moses (2000) that

The general lack of financial compensation and professional status accorded to (residential) care work represents an indirect but substantial barrier to practice. Substantial changes in agency structure are called for. (Residential care) positions need to be professionalized and compensated commensurately. Staff should be given further training and provided with professional supervision (2000:488-9).

Much of the literature focuses on the qualities and importance of the role of the residential care worker but also the ambiguities of their position which often results in a climate of demoralization in residential settings (Butler and Williamson 1994:102). Moses (2000) describes the complexity

96 Okamoto (2001) identified these 'lower-end' services as being intensive home based services, multisystemic therapy or wraparound services (2001:16).
and importance of the residential workers role, which integrates parental, therapeutic and social functions ‘...and creates an opportunity for youth to engage in potentially meaningful relationships’ (2000:477).

3.7.4 Engaging young people

When focussing on the opportunity for at risk young people to engage in potentially meaningful relationships, many of the factors raised in the literature resonate with those that were identified as critical between workers themselves. Thus the importance of there being sufficient time and space for the young person and workers to get to know each other is stressed (Mitchell 2000c:11). Butler and Williamson’s (1994) research with young people in care revealed ‘...the most illuminating finding was the caution with which a majority of young people relate to the adult and especially, to the professional world’ (1994:48) a caution that can be understood when we reflect on how the professional world relates to young people.

Therefore the qualities of the workers themselves are critical, particularly the importance of people who are able to build and maintain rapport with young people over the long term, who accept when the young person relapses and do not define it as a failure, who model a positive healthy lifestyle themselves, have the ability to speak with familiarity and experience to the issues of importance to youth (Currie 2001:47-8). But also people who are able to ‘...acknowledge the fluid, unpredictable and changing worlds that the children inhabit’ (Butler and Williamson 1994:36-39).

Other writers also emphasise the interactional factors that occur in the interface between the young people and workers and that with these young people complex dynamics can develop. Moses, (2000), in his study of residential care workers in the United States found:
there were identifiable youth characteristics and behaviour that create more satisfying staff-youth relationships. Those (young people) who are the most emotionally guarded and who have the most difficulty relating i.e. those most in need, are likely to receive the least sensitive caregiving (though not necessarily the least amount of attention) (2000:481).

The importance of program location and physical accessibility when engaging young people in treatment was raised by some authors (Currie 2001:27) particularly that young people are less likely to access services when they are located within formal treatment settings both because they feel uncomfortable within these settings and because they struggle with the organisational and psychological skills required to keep appointment based commitments.

Butler and Williamson (1994) contribute some much needed feedback from young people about what they want from professionals '...striking the balance between professional distance and personal affinity.' They also stress that '.......the starting point for any effective work with young people has to be the construction of a positive personal relationship and the building of trust and credibility' (1994:85).

3.8 FINDING A PLACE FOR FAMILIES

What one would certainly hope would be considered as core to 'good enough' practice with this client group is the involvement of their families in all aspects of service delivery. Yet, the absence of families is noticeable, an area that has been a concern for different writers. Thomson and Thorpe (2004) state,

we find ourselves seriously concerned at the very limited work with parents of children in care (2004:48). If there is hope of restoration of children in care to their families, proactive work that keeps parents involved and keen to work in partnership with workers, is
clearly of value. For many children in care experiencing multiple placements, the family of origin is frequently the most enduring of relationships. Many seek out their families on exiting from care (2004:50).

Morton et al. (1999) also argue strongly for the importance of supporting, promoting and extending existing relationships the young person has, not only with their family of origin, but with their extended family and community (1999:xi).

Kiraly (2002) stresses the importance of recognising ‘…..the benefits of what siblings can offer each other in the way of support, connectedness and identity needs far more recognition’ (2002:13) particularly as ‘…..around 80% of children in care are separated from their siblings over time’ (2002:13).

Another area that receives very little attention in the literature on at risk young people is the role that peer relationships can play in promoting their sense of identity and connectedness despite the fact that forming peer relationships is one of the central and critical components of adolescent development.

This may be because as Gilligan (2005) proposes, acknowledging Unger’s (2004) argument, that ‘…. a young person who is seen as failing in certain “official” domains (e.g. school) may acquire a positive self-identity in what be seen by adults as more subterranean contexts’ (a socially ostracized peer group) (2005:297) and thus is it possible to hold the ambiguity of wanting to promote a critical aspect of development but with who are seen as the wrong people?
3.9 OUTCOMES OF COLLABORATIVE APPROACHES

A feature noted in Chapter Two was that while policy directions continue to strongly promote collaborative approaches there is limited and contradictory evidence of its impact. This ambiguity was also raised in the literature studied for this chapter. Some writers report positive results. Coffey (2004), states that a growing number of demonstration projects offering innovative service delivery based on the systems of care model ‘...have been resoundingly successful’ (2004:170). Brown and Hill (1996) reported that in their evaluation of a wraparound program parents, case managers and children said the program was effective (1996:50).

However there are also concerns that collaborative approaches, although providing coordinated care that addresses many of the problems of traditional models of service delivery, have not developed a clinical theory and model that leads to better clinical and functional outcomes (PulleyBlank Coffey 2004:170). Taking a different position Flanagan et al. (2001) noted, ‘...what is surprising is the extent to which current intervention strategies are based on ideology rather than an understanding of whether or not they are effective’ (2001:22).

Some writers are critical of the popular current solutions being proposed. Green (2003) states,

> significant energy and resources are spent in endless policy discourses about partnerships, continuity of care, ‘seamless services’, ‘wrap around’ services and the companion debates. These are the popular but manifestly inadequate solutions for complexity, fragmentation and under-conceptualised program design (2003:14).

A number of writers highlight that what has been gained is an increased understanding about what needs to be present to achieve effective
collaborative practice. Johnson, Zorn et al. found in their 2003 research, that interagency collaboration is multidimensional, interactional and developmental.

Successful interagency collaborations were developmental, in that they needed time and work to reach a successful outcome (and) preplanning and continued hard work and support were needed for it to continue to be successful. The three major variables for promoting successful collaboration were commitment, communication and strong leadership (2003:205-207).

Johnson et al’s. conclusion suggests that we have gained valuable knowledge about what ‘....deliberate actions could be undertaken by critical stakeholders to contribute to the likelihood that interagency collaborations are successful.’ Collaboration is hard work and understanding how to engage in successful collaboration (will) make the work a bit easier (2003:207).

On a similar note Hudson (2005), highlights the important recognition that

......collaboration does not occur automatically; rather it is an accomplishment, achieved through a series of negotiations or bargains around particular courses of action (2005:544). Critical to achieving effective collaborative practice is .....a climate of interprofessional trust and mutual respect. This will require arrangements to be in place that are currently exceptional, such as interprofessional education and co-location of kindred professionals (2005:546).

These debates are important. The position being proposed in this research is that service initiatives based on intersectoral collaboration and partnerships cannot be seen as the panacea to all that is required for these young people, but as one form of service fitting within an integrated, well developed continuum of service and program delivery that will strengthen service responses for vulnerable children.
3.10 CONCLUSION

In this chapter an analysis of the literature relating to collaborative approaches was presented. The critical ways in which the literature has identified the main problems, solutions, components and outcomes of inter-sectoral collaboration as applied to working with young people with complex needs were explored.

The analysis confirmed many of the issues raised in the analysis of the key policy directions undertaken in Chapter Two. It revealed that a strong preference exists for the use of collaborative approaches as a means of engaging young people with complex needs particularly with non-statutory program areas and to achieve partnerships between the program areas.

Alongside this preference is the awareness of the complexity involved in accomplishing these tasks particularly as there is a need for structures and support at the broader systemic and inter-organisational levels, the intra-organisational and inter-personal level and individual worker level to provide a climate that will promote engagement with the young people and families.

This chapter concludes the overview to the context of this research. It has provided the background to the focus of the research and established the significance of the need to further our understanding of practice guidelines to inform practice when working with young people with complex needs. It has identified the extensive knowledge that exists both within policy development and the general literature in regards to implementing inter-sectoral collaboration, as well as the gaps and areas that need further development.
In the next chapter, the focus shifts to outlining and describing the research that was conducted in order to answer the research question; what are the principles and guidelines that will inform services operating within an integrated collaborative approach for children, adolescents and young people with complex needs?

To identify these principles and guidelines an exploration of the implementation of an inter-sectoral initiative for at-risk young people living in residential settings was conducted. The next chapter identifies and describes the research design, research methods and the context within which the research occurred as well as highlighting the many issues, challenges and opportunities that emerged while pursuing this aspect of the research process.
CHAPTER 4: THE RESEARCH DESIGN - EXPLORING THE LIVED EXPERIENCE.

Qualitative research in particular has given groups of people previously denied a voice the opportunity to be heard for the first time (Darlington and Scott 2002:47).

4.1 INTRODUCTION

In this chapter the research design that was used in the thesis is outlined, including a description of the theoretical paradigm underpinning the design, the methods employed, the context within which the research occurred, the participants involved and the process of data collection and analysis undertaken. The issues that arose during the process of conducting the research are also explored.

4.2 THE RESEARCH APPROACH

A broadened definition of research makes a place for inquiry that includes studies of narrative texts of interventions and looks at case studies as stories whose authenticity or truth speaks for itself. Through these and other qualitative methods of telling social work's stories, we open doors for new research possibilities (Applegate and Bonovitz 1995:250).

The research conducted for this thesis was based on the social constructionist/interpretative research paradigm utilising qualitative research methods. Researchers who work within this paradigm '...are interested in the way people experience their world' (Tesch 1990:68) and in gaining an understanding of those experiences. Thus the interpretative perspective is concerned with exploring social meanings, how these are generated in small-scale interactions (Jupp 1996:304) and how to generate '...accounts of these meanings from the viewpoint of those involved' (Fossey, Harvey, McDermott and Davidson 2002:719).
All qualitative research aims to give privilege to the perspectives of research participants and to ‘...illuminate the subjective meaning, actions and context of those being researched’ (Popay, Rogers and Williams 1998:345). 'Qualitative research views inquiry as an interactive process between the researcher and the participants and relies on people’s words as the primary data’ (Marshall and Rossman 1989:11). 'The heart of a qualitative stance is the desire to make sense of actual lived experience' (Marecek, Fine and Kidder 1997:631).

My focus in this research is in the areas mentioned above, in exploring, unpacking and understanding the actual practice experience and components involved in collaborative multi-sector teamwork as seen through the eyes of all participants. In this respect the research can be described as 'Practice Research,' which Scott (2001) describes as:

‘...a way of investigating the practice context. The defining features of Practice Research include that the questions it explores address the concerns of practitioners and clients, its methods recognize the complexity and uniqueness of the practice situation and it has a feedback loop to practice (2001:2).

The intention in this research was to gain an increased understanding of the processes and experiences involved during the development and implementation of a particular practice context, an inter-sectoral service initiative. The appropriate research design to achieve this was the social constructionist/ interpretive research paradigm using a case study method.

The case study method was selected as it provides the opportunity to study a critical case in depth (Flyvbjerg 2001:74). In this research the critical case was the development of a service initiative for at-risk young people.
with particular attention being given to the experiences of all the stakeholders involved in the development and implementation of the model.

Case studies are particularly well suited to addressing areas such as the one studied '...that are exploratory or descriptive and stress the importance of context, setting and the subjects' frame of reference.' (Marshall and Rossman 1989:46). The case study '...values participants' perspectives on their worlds and seeks to discover those perspectives' (Marshall and Rossman 1989:11). The case study is a method that investigates a contemporary phenomenon within its real-life context and in which multiple sources of evidence are used (Yin 1984:23).

Punch (1998:150) identified that '...the case study aims to understand the case in depth, recognizing its complexity and its context.' He states that 'the case' may be '....a small group, or an organization, a decision, or a policy or a process' (1998:152).

In this research 'the case' being studied consists of a number of the areas Punch (1998) identified. It is a case about a service initiative. It is also a case about a process, the process involved as policy was shaped into a program and implemented into practice. The policy was that collaborative multi-sector teamwork was the preferred form of intervention when working with young people with complex needs.

The program form that was developed was the use of a multi-sector care team operating within a residential care unit. The practice was what actually transpired, the practice experiences and learning that occurred during the implementation of this model in the two year pilot period as perceived by the five stakeholder groups involved; the young people who had been residents in
the units, their parents, the service providers involved in the Care Teams, the managers involved in the Steering Committees/Review Boards and the Regional Managers who developed the initiative from Regional Management Group of the Working Together Strategy (WTS).

To describe phenomena as comprising a case is to establish boundaries (Marshall and Rossman 1989:44) to determine who and what is included in the case and who and what is outside the focus of study. In this case study the boundary was placed around those people who had been directly involved with the initiative; the regional managers who had adapted a state-wide policy for local purposes, the middle managers who assisted in the implementation of the policy at the programatic level, the service providers involved in delivering the program and the young people and family members who were the recipients of the program.

My interest was in exploring and gaining a greater understanding of the implementation process, particularly the working mechanisms of collaborative practice and the practice guidelines that inform it. Thus the focus of study was both the program itself and the people involved in delivering and receiving the program as the development of a program is a dynamic process. I was interested to explore the process of a program evolving towards its final form, acknowledging that a number of factors interact and impact on that process.

Stake (1994) (quoted in Punch 1998) distinguishes three main types of case study:

- The intrinsic case study, where the study is undertaken because the researcher wants a better understanding of this particular case;
The instrumental case study; where a particular case is examined to give insight into an issue, or to refine a theory;

The collective case study, where the instrumental case study is extended to cover several cases, to learn more about the phenomenon, population or general condition (1998:152).

The current research can be seen to relate to all three categories but particularly the second, the instrumental, where this case is examined to give insight into the development of inter-sectoral collaborative practice within a service initiative. English researchers Smith and Bryan (2005) utilised a similar research method ‘...inspired by the case as a method to understand the macro (a national policy which emphasised collaboration and partnerships for services working with young children) through a micro level account of its local implementation and evaluation’ (2005:195).  

Those critical of the case study method identify that its main limitations are that it does not produce generalisable results and that it does not have rigor. Punch (1998) address the first criticism by stating that case studies do produce generalisable results

..by conceptualizing (and) developing propositions. In both instances, the findings from a case study can be put forward as being potentially applicable to other cases. In this view they become the outputs of the research (1998:154).

It is the intention that the findings of this research will assist in the development of guidelines to inform collaborative practice when working with children, adolescents and young people who are multi-service clients in out of home care. In addition the focus and interest of this research extends to

97 Unlike this research Smith and Bryant's (2005) study did not conduct interviews with service users.
the utility of these guidelines being applied for other multi-service clients with complex needs across a range of organisational settings.

Flyvbjerg (2001) and Geertz (1995) address the second criticis. Flyvbjerg counters that the case study demonstrates its capacity for rigor through closing in on real-life situations and testing views directly in relation to phenomena as they unfold in practice (2001:82). Geertz (1995) proposes that the fieldwork involved in in-depth case studies is a ‘.…powerful disciplinary force: assertive, demanding, even coercive. It cannot be evaded’ (1995:119). As will be outlined later in this chapter.98 I discovered the truth of this quote, how the field I studied was a very powerful force that impacted on my research.

Punch (1998) further argues that in

... properly conducted case studies, especially in situations where our knowledge is shallow, fragmentary or incomplete, building an in-depth understanding of the case is valuable. The in-depth case study can provide understanding of the important aspects of a new research area. Discovering the important features, developing an understanding of them, and conceptualizing them for further study, is often best achieved through the case study strategy (1998:154-5).

The case study in this research is an example of discovering the important features of a new research area, the implementation of a collaborative service initiative. The initiative was based in two residential units where an enhanced model of service delivery, the Enhanced Residential Program, was developed and implemented over a two-year pilot period.

4.2.1 Research Methods

A number of qualitative research methods were used in this research:

98 In Section 4.8 The Challenges That Emerged
An analysis of key policy directions within Australia, United Kingdom and United States relating to young people with complex needs was undertaken. A policy analysis frame was developed that posed the following questions:

- How was the problem defined?
- What was proposed as the solution?
- What were the components of key policy documentation - how were these changes to be achieved?
- What were the proposed outcomes of these policy directions for young people with complex needs?\(^99\)

An analysis was undertaken of current local, national and international literature that relates to policy, program and practice for children, adolescents and young people with complex needs. The analysis assisted in informing the boundary of what sat inside and outside the focus of this case study.\(^100\)

Thirdly in-depth interviewing was conducted with five stakeholder groups involved with the Enhanced Residential Program during the two-year pilot period.

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\(^99\) These are my questions adapted from a critical analysis approach from Jupp (1996:302-3) and Jupp and Norris (1993:50). The findings of this analysis are summarised in Chapter Two.

\(^100\) The findings of this analysis are summarised in Chapters One - Three.
A descriptive profile was produced of the young people and service providers based on an analysis of information gathered from the stakeholders.101

4.3 THE RESEARCH SITE

The research site for this thesis was a metropolitan region of the Victorian Department of Human Services (DHS). The focus of the research, The Enhanced Residential Program, (ERP) was one of the Working Together Strategy’s (WTS) service initiative activities.102 As outlined in Chapter Two, The WTS was first developed in 1999 as a Statewide quality improvement initiative of the DHS intended to build capacity and improve services for shared clients of the WTS program partners, Child Protection, Mental Health Services, Out of Home Care, Juvenile Justice, Drug Treatment Services and Education.103

The Statewide WTS Committee recommended that Phase I of the Strategy focused on promoting initiatives that would strengthen service responses for adolescent shared clients before broadening out to include children from 0-18 years. However, in the Region in which this research occurred, the regional management group decided that the focus was placed on a specific cohort of adolescents; those on the Child Protection Adolescent High Risk Register.104

101 The findings of this analysis in relation to the service providers and regional managers are incorporated into Chapters Five to Seven and for the young people in Chapter Eight.
102 The WTS was discussed previously in 1.3 and 2.5.4.2
103 There were variations between regions about which program areas were asked to participate in the WTS. In some, other DHS program areas such as Disability Services and Housing and external program areas such as the police and Koori services were also included.
104 The Child Protection Adolescent High Risk register was previously discussed in 1.5.2 and 2.5.4.1. At the time of the research the Region was one of two in the State with the highest
The Region placed a high priority on the WTS. It appointed a Senior Project Officer to manage and facilitate the Strategy.105 The scope of the WTS service development activities included a number of Reference Groups/Standing Committees,106 Network Groups, Working Parties, Practitioner Forums, projects and a newsletter.

The Enhanced Residential Project (ERPs) was one of the WTS earliest projects. The Senior Management Group established a cross program working party with the brief to develop a model of service delivery that would better meet the needs of what was seen as a very vulnerable subgroup of the adolescents on the High Risk register, those who were placed in residential care. The working party's subsequent document, 'Project Brief Working Together Strategy Enhanced Residential Service Model' (Victorian Government 2000e) outlined the components of the Enhanced Residential Program.107

The Enhanced Residential Program consisted of the establishment of an inter-sectoral care team to provide a service for young people from the ages of 13 living in a residential unit. The Care Team had two components, the provision of direct service to the young people and working as an integrated

representation of young people and with the largest number of young people on the Child Protection High Risk Register.

105 I was the second Senior Project Officer employed within the Region. A specific request had been made to employ someone with either a CAMHS or Drug Treatment Services background as it was seen that these sectors were the least engaged with the WTS. Plus, as there was a long standing history of problematic relationships between CAMHS and Child Protection in this Region engaging these sectors was seen as critical to the WTS success.

106 Examples of the Standing Committees were the Crisis Out of Hours Protocol between CP, CAMHS and Adult Mental Health Services, the Multi-Agency Clinic, the CAMHS-CP Committee, the Statistical Snapshot of Shared Clients Committee and the Development of Vision, Practice Principles and Working Definitions.

107 An unpublished paper produced in November 2000. I was a member of this Working Group and one of the authors of this document.
team to develop individualised case plans for each young person, promote regular discussions about their progress and provide opportunities for staff development and education.

The decision was made to pilot The Enhanced Residential Program in two settings with the expectation that, if successful, the model could be implemented in other residential units and with other age groups. It was also hoped that learnings gained from the concept could be utilised to strengthen service responses for other young people with complex needs.

The program was piloted in two residential units operated by two different Community Service Organisations (CSO's).\(^{108}\) (For the purpose of the research they have been named Pilot 1 and 2). The units had the capacity to house four young people at a time and were staffed by residential care staff employed on 24-hour rosters.

The Care Team membership consisted of representation from the service providers currently involved with the young people; the residential care staff, workers from the statutory programs Child Protection and Juvenile Justice and from the specialist program areas it was hoped to engage them with, Child and Adolescent Mental Health Service (CAMHS), Drug Treatment Service (DTS) and the Department of Education, Employment and Training (DEET).

A planning stage was built into the program's design. A small amount of funding was provided to employ a part-time project officer to facilitate this

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\(^{108}\) The sites were at two very different geographical locations within the large metropolitan region.
process\textsuperscript{109} and to support training and back-fill of residential care staff but otherwise the pilots were expected to be cost neutral. An evaluation process was also built into the program (Victorian Government 2002a).

At the commencement of the planning stage each pilot formed a Steering Committee which consisted of the line managers of those staff involved in the Care Teams. The Steering Committee’s role was to support the development of the care team during the developmental and operational stages. As the WTS Project Officer I took an active role in supporting and facilitating the development and implementation of the initiative.\textsuperscript{110} The Regional Management Committee maintained a role in overseeing this as well as the other WTS initiatives.

The Steering Committees commenced in May 2001 and the Care Teams commenced operating in October and November 2001. Both pilots held launches in early 2002 and the pilot period extended to late 2003. I ceased employment with the WTS in March 2002 and another project officer was appointed three months later.

During the two-year pilot period Pilot 1 retained the original Care Team model. After persisting with the model for twelve months Pilot 2 (with support from the Regional Management Group) replaced it with an adapted model which consisted of separate Care Teams for each young person living in their residential unit. The other main difference in Pilot 2’s model was

\textsuperscript{109} A person was appointed part-time for 6 months during the initial planning period who reported to me. The tasks associated with the ERP’s were distributed between this position and my own during this period.
\textsuperscript{110} I left the position of Senior Project Officer a few months after the Care Teams became operational. It was a few months before the next WTS Project Officer was appointed. This person continued to attend the Steering Committee meetings but took a slightly less ‘hands on’ role in the Pilots activities.
that each Care Team's core membership were CSO staff: the young person's case manager, the unit's residential care worker supervisor, and the young person's residential care key worker. Other practitioners were invited to join the Care Team on the basis of each young person's situation and needs. This model continued for the second half of the pilot. Thus I have used the terms Pilot 1 and Pilot 2 Stages 1 and 2 to reflect these different periods.

The Enhanced Residential Program Pilots (ERP) first captured my attention as a focus of study for a PhD during my employment with the WTS partly because a much higher level of enthusiasm, good will, commitment and passion was evident in this initiative than in the other WTS projects. Also being involved in the development and implementation of this initiative was an extraordinary opportunity to watch and experience an evolving and dynamic process. The opportunity to learn from the participants was a unique experience. The challenges that faced me as I moved from a participant in the process to a researcher are explored in detail later in this chapter.

4.4 RESEARCH PROCESS TIME LINE

Whatever our stages it seems that all of us have chosen to share a way of research life that sweeps us along in continuous circles within circles of action, reflection, feeling and meaning making (Ely, Anzul, Friedman, Garner and McCormack Steinmetz 1991:7).

In the following table the activities that occurred during the research process are outlined.
### Table 4-1: Research Process Time Line:

<table>
<thead>
<tr>
<th></th>
<th>April 2003</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
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<th>November</th>
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<tr>
<td>Stakeholder feedback</td>
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</table>

### 4.5 THE PARTICIPANTS

Children have remained 'voiceless' in the research literature (Darlington and Scott 2002:93).

As outlined in previous chapters I came to this research concerned by the limited presence in the literature on collaborative practice of the voices and active participation of young people and even more so, the families of young people living in residential care. It appeared that when the literature referred to collaboration it focused almost completely on what was occurring between professionals. Therefore I was keen to include the voices of the young people and families in my research.

This position is supported by the social constructionist/ interpretive research paradigm and qualitative research methods and my social work origins, all of which place a strong emphasis on including all relevant voices in
the research process. As Bland and Renouf (2001) state '..social work research includes a concern with the lived experience of consumers and carers' (2001:241). This concern is particularly critical in this research, because as Butler and Williamson (1994) note '...in the field of child protection, the child's view has been significantly absent' (1994:ix-x).

It is critical to access the views of young people and families because as has been demonstrated in research where this has occurred,

Children's perceptions as users and recipients of services are influenced by different considerations to the professionals who provide them, resulting in different conclusions. If we are to serve children effectively, we must be prepared to listen and learn from what children have to say to us (Butler and Williamson 1994: ix-x).

This finding has been raised by a number of authors (Spink 1998:3; Wadsworth and Epstein 1996; Epstein and Shaw 1997) and was also evident in research I conducted with young people and families accessing a specific program in a Child and Adolescent Mental Health Service. It was striking that the areas the young people and families identified as contributing to their satisfaction differed from those the service providers predicted were important\(^{11}\)(Alfred Community Service for Early Psychosis Treatment 2000).

Therefore I was committed to access the views of young people and families involved with this initiative and to ensure that the research methods I utilised, provided '...participation opportunities (that were) flexible in approach and supporting the individuals' (CREATE Foundation 2000:1).

\(^{11}\) The factors identified by the young people and families were valuing prompt access to the service, being 'heard and believed' by service providers, receiving practical help to assist in their current situation and for future issues (Alfred Community Service for Early Psychosis Treatment 2000).
4.5.1 The Stakeholder Groups

Those involved in the implementation of the ERP during its two year pilot period consisted of four distinct stakeholder groups:

(a) The young people who were residents in the units. Nine were interviewed. As mentioned previously they were all adolescents listed on the Region’s Child Protection Adolescent High Risk Register.\textsuperscript{112} This meant they were young people who displayed the following persistent high risk indicators: self harming behaviours, involvement in crime and frequent placement breakdowns.

(b) The parents of young people placed in the units. Eight parents were interviewed. No demographic material was available about the parents however information provided by the case managers indicated that; on the whole, they were parents who struggled with a range of difficulties in their own right and as the Child Protection Program had been involved with their children, had a history of complex and fractured family relationships.

(c) The service providers. Forty-six service providers were interviewed from the two pilots.

(d) Seven regional managers representing the program areas of Child Protection, Juvenile Justice, Child and Adolescent Mental Health and Community Support Organisations. Also interviewed were Managers of three Department of Human Services programs; Community Care,

\textsuperscript{112} The Child Protection Adolescent High Risk Register program was a Register of those young people within the Region who were clients of the Child Protection Program and seen as fitting the criteria of being ‘at high risk.’ The Child Protection Adolescent High Risk register was previously discussed in 1.5.2, 2.5.4.1 and 4.3.
Youth Placement and Support, Placement and Support. The WTS Senior Project Officer was also interviewed (See table 4.2 below).

The following table provides a breakdown of the service providers and managers interviewed based on their program backgrounds.

Table 4-2: Numbers of professionals interviewed from program areas

<table>
<thead>
<tr>
<th>NUMBERS INTERVIEWED:</th>
<th>PILOT ONE</th>
<th>PILOT TWO</th>
<th>REGIONAL REPS</th>
<th>TOTAL</th>
</tr>
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<tr>
<td>CSO 113</td>
<td>11</td>
<td>15</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>CATHS 114</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Drug Treatment</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Child Protection</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Juvenile Justice</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>DHS Program Areas</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22</td>
<td>24</td>
<td>7</td>
<td>53</td>
</tr>
</tbody>
</table>

4.6 THE PROCESS OF DATA COLLECTION

4.6.1 Introduction

To evaluate the adequacy of data collection one should consider whether the chosen data collection methods have enabled the researcher to adequately explore the subjective meaning, actions and social context relevant to the research question (Fossey, Harvey, McDermott and Davidson 2002:729).

'Extensive engagement with participants, data and setting is an essential feature of all qualitative research’ (Fossey, et al 2002:729). Extensive engagement with participants and extensive data collection occurred in this research. Eleven group interviews and forty-three individual interviews were conducted, and two written reports were received. All direct interviews

113 Community Support Organisation
114 Child and Adolescent Mental Health Services
were tape recorded and transcribed. Notes were taken during the telephone interviews.

As part of my preparation for conducting the interviews and to provide information about the research I attended Care Team, Steering Committee and Review Board meetings of both pilots on six occasions. Other sources of data were notes made after interviews and entries into my research journal.

Another major source of data was conducting an extensive literature search.\textsuperscript{115}

Descriptive information about the young people and the service providers was collected through the interviews conducted with the young people and parents and from forms completed by the service providers.

4.6.2 Approval and Recruitment Process

In April 2003 my research proposal was approved by the Department of Human Services Child Protection and Juvenile Justice Research Committee. In July 2003 the Department of Human Services Human Research Ethics Committee, the School of Social Work University of Melbourne Ethics Committee and the University of Melbourne Human Research Ethics Committees granted their approval for the research project to proceed.

These approvals were communicated to the Manager, Community Care, at the Department of Human Services Regional office where the service initiative was located\textsuperscript{116} and to the Directors of the two Community Support Organisations where the pilots were operating. Both provided their strong

\textsuperscript{115} See Chapters One to Three

\textsuperscript{116} I had held a preliminary meeting with the Community Care Manager who had expressed her support for the research to me directly and in written communication. A copy of the correspondence to the Community Care Manager is provided in Appendix One.
support and enthusiasm for the research. The Directors and Senior Managers of all the program areas involved in the two Enhanced Residential Pilots were then contacted by mail. The managers were asked to approve and support the research and the involvement of previous and current members of their staff involved in the Care Teams/Steering Committees. They were also asked to provide permission for those members of their staff who were case managers to assist me in contacting the young people and families.\textsuperscript{117} Assistance in contacting previous members of staff who have been involved in the pilots was also requested.

Letters were then sent to all the service providers, young people and family members inviting their participation in the research. These letters included separate Participant Information and Consent Forms (PICF) for service providers, young people and family members.\textsuperscript{118} The PICFs informed participants that the interviews would be audio taped unless they preferred otherwise (only one young person requested that the interview was not taped). They stated that participating in the interviews was voluntary and that all participants had the option to withdraw from the research at any time if they wished. None chose to.

The PICF's also included the option for the young people, parents or service providers to discuss the research with myself or someone of their choice prior to the interviews being conducted. This option was not requested. This may have been because I was known to many of the staff through previous working relationships and their familiarity with me was communicated to the young people and parents.

\footnote{\textsuperscript{117} A condition of my Ethics approval \textsuperscript{118} Copies appear in Appendix 2}
It was not anticipated that the interview questions would cause distress to the young person, parents or service providers, and thankfully this was the case, however structures were put into place if this occurred.

Case managers or key workers assisted me in contacting and liaising with the young people and family members. They arranged that the young people and family members received their PICF’s thus ensuring that the confidentiality of the young people and their parents was protected. They also acted as negotiators when required in relation to arranging interviews.

In a number of the situations, once the young people and parents gave their permission to the case managers, I contacted them directly to arrange the details of the interviews. To respect confidentiality, the PICF’s outlined that none of the participants would be identifiable in any written reports.

4.6.3 Interviews conducted

The following tables demonstrate the number and type of interviews that were conducted.

Table 4.3: Breakdown of stakeholder interviews

<table>
<thead>
<tr>
<th>NUMBERS INTERVIEWED:</th>
<th>PILOT ONE</th>
<th>PILOT TWO STAGE 2</th>
<th>REGIONAL REPS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people</td>
<td>7 out of 9</td>
<td>2 out of 7</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Parents</td>
<td>4 out of 8</td>
<td>4 out of 7</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Steering Committee &amp; Care Team members</td>
<td>22</td>
<td>24</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Regional Reps</td>
<td></td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>OVERALL TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>70</td>
</tr>
</tbody>
</table>
Table 4.4 Breakdown of types of interviews conducted

<table>
<thead>
<tr>
<th>TYPES OF INTERVIEWS:</th>
<th>PILOT ONE</th>
<th>PILOT TWO</th>
<th>REGIONAL MANAGERS</th>
</tr>
</thead>
</table>
| Young people         | 1 group
                        1 individual
                        4 phone             | 2 phone              |                   |
| Parents              | 3 telephone
                        1 written           | 4 telephone          |                   |
| Steering Committee & Care Team members | 3 group
                                    12 individual
                                    1 written report     | 5 group
                                    11 individual
                                    1 written report     |                   |
| Regional Managers    | 7 individual |          |                   |
| TOTAL - 56           | 26         | 23        | 7                 |

4.6.4 Interviews with young people

Sixteen young people were residents in the two residential units during the two-year pilot period. At the time the data collection phase commenced whereabouts were known for fifteen of the young people (one was interstate and unable to be contacted). Nine out of the fifteen young people were interviewed as part of this research; seven had been residents of Pilot One and two from Pilot Two Stage 2.

Of the nine young people interviewed eight were female and one male. Of the seven young people not interviewed all were male. The imbalance in numbers between the two pilots and imbalance in the gender profile will be discussed in more detail later in this chapter and in Chapter 8.

Of the seven young people who were not interviewed, five were incarcerated, four in detention facilities and one in a detoxification clinic. With the young people incarcerated in detention facilities, two were located in Melbourne and two in regional Victoria. Attempts were made to interview the two young
people in the Melbourne detention facility. Their case managers approved my visit, communicated their support to the institutional staff but the institution prevented the interviews from occurring. ¹¹⁹

In relation to the two young people in regional Victoria, their case managers did not recommend interviews were conducted. With the young person in the detoxification clinic, his case manager informed me that he agreed to be interviewed but the staff at the facility thought it was inadvisable due to his unstable emotional state.

With the remaining young person, he initially agreed to participate in an interview but organising the time and venue proved unsuccessful. His case manager then advised against pursuing further contact due to his renewing significant substance use.

All the young people and parents were given a choice as to the location of the interviews and whether they wished to have another person present. One sibling group requested to be seen together. Three young people were interviewed at their residential unit. One was interviewed at a Juvenile Justice Detention Centre (with his case manager present). Five of the young people were interviewed by telephone due to difficulties arranging face-to-face interviews. ¹²⁰

4.6.5 Interviews with Parents

Eight out of nine parents who were contacted and asked to be involved in the research were interviewed. Four had young people involved in Pilot 1 and four

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¹¹⁹ I was able to visit another young person in the same facility when accompanied by their case manager.

¹²⁰ An amendment to my Ethics approval was sought and granted to enable me to conduct telephone interviews. The factors that contributed to this situation developing are outlined in 4.8.
were from Pilot 2 Stage 2. They included two parental couples. Seven were interviewed by telephone including one who was interstate. One requested and completed a questionnaire by mail. Six out of the eight parents were female and two were male. Seven out of the eight parents were parents of the young people who were also interviewed. The eighth parent was the parent of one of the young people with whom contact was made but an interview did not eventuate. The parent who was not interviewed had given permission to be contacted but did not return calls.

The remaining parents were not contacted, because based on information provided by the case managers, they were incarcerated themselves, their whereabouts were unknown or they had had such minimal contact with their children that the case managers did not think it would be worthwhile contacting them.

4.6.6 Interviews with Service Providers

Forty-six service providers were interviewed, twenty-two involved with Pilot One and twenty-four from Pilot Two. This constituted close to all the service providers who had been involved in the five Care Teams and two Steering Committees/Review Board throughout the two-year pilot period for both pilots. A total of thirty-three interviews were conducted with service providers, eight were group interviews and twenty-five were individual. Thus some service providers were interviewed on more than one occasion, for example they may have been interviewed individually and as a member of a Care Team or Steering Committee.
4.6.7 Reflections on the interviews

When reflecting on the interviews that did take place and those that did not it was evident that some of the case managers had taken a more active screening role than others in deciding whether young people or parents should be contacted. The young people who were screened out were living in more restricted forms of care and the families were those with less connection to the young people and in more chaotic living situations. They were also young people and families with less contact with the case managers.

It was disappointing that more interviews were not able to be conducted particularly as when the young people and parents were asked to be involved they responded with enthusiasm, were co-operative and provided fascinating insights into their experiences.\(^{121}\) The case managers indicated that the number of interviews that did take place exceeded the number anticipated based on their previous research experience. My analysis was that the response rate was influenced by the mixed feelings towards research from some of the case managers, rather than any reluctance on the part of the young people or families, an area explored further later in this chapter.

4.6.8 The Interview Format

The interviews consisted of semi-structured questions. The interview format with the young people and families consisted of questions requesting

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\(^{121}\) When it is considered that out of the eleven young people approached to be involved, nine participated and out of the nine parents approached eight were interviewed these were very high response rates.
information about the young person's circumstances and their opinions about
the Enhanced Residential Model.\textsuperscript{122}

For the young people interviewed in face to face interviews they were
provided with copies of the questions. For the young people and parents
interviewed by telephone I offered to send them a copy of the interview
questions to read prior to the interviews but all were happy to have the
questions read out to them. The one parent who completed a written reply
was sent a copy of the questions. With all the telephone interviews a number
of conversations took place prior to the interviews occurring clarifying the
research process and discussing details related to the interview. These
conversations formed an important part of the engagement process.

The list of questions was the same for all interviews with one exception. In
the first few interviews conducted I became aware that both the young
people and parents were uncomfortable with being asked directly about their
family membership and contact. I decided not to continue to ask this
question. Clearly, for young people and family members where family contact
was a highly emotive area it was important to respect their privacy on this
issue. Interestingly most provided this information during the course of the
interview but in their own time and way.

The semi-structured interviews with the members of the Care Team and
Steering Committees also consisted of questions covering the same areas as
the young people and parent interviews; descriptive information and opinions
about the service model. The descriptive information was collected via a
separate sheet that the service providers completed. None refused to
provide this information.

\textsuperscript{122} Copies of all the questions used in the research are provided in Appendix 3.
In addition questions were asked about their experiences on the Care Team and/or Steering Committee as well as more general questions about collaborative approaches. The questions given to the members of the Steering Committee and Review Board when they were seen as a group and to the senior regional managers focused on general principles and beliefs relating to collaborative practice.

Four questions were asked to all the stakeholder groups. These were:

- What are the core features of the model?
- What are the strengths of the model?
- What are the limitations of the model?
- What should be done differently now as a result of what’s been learned from the Enhanced Residential Model in relation to future policy directions, program development, service delivery and practice models for working with children, adolescents and young people who are multi-service clients and in out of home care?

The language used was adapted for the interviews conducted with the young people and parents to reflect age appropriate language and to address literacy issues. As well as the prepared questions there were a few additional questions asked which arose as a result of the direction some interviews took.

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123 including the young people and parents.
4.6.9 Service Provider Interviews

The interviews with the service providers predominantly occurred at workers' offices across the Region. One was conducted in the car while driving to the detention centre. With two workers no longer employed in the Region or with the same program area, one was conducted at the service provider's home and one at my home.

Two written reports were received from service providers previously involved with the pilots but no longer working within the region. This occurred at their initiative. No service provider who was contacted refused to be interviewed however multiple phone calls, letters and some missed appointments took place before the interviews were completed. Only two service providers previously involved in the pilots did not participate in the interviews because they did not respond to my request. This was a much higher response rate than expected.

4.6.10 Reimbursement

As it is common practice in research conducted with young people in care to provide reimbursement for their participation, I provided a fifteen-dollar gift voucher to each young person interviewed.¹²⁴ The vouchers were included with the thank you letters sent to the young people after the interviews were conducted except for the young person in institutional care whose gift voucher was handed to him directly immediately following his interview. No payment was made to the parents, service providers, managers or regional managers involved in the research.

¹²⁴ This form of reimbursement was selected in preference to cash on the advice of the case managers.
All those interviewed were very enthusiastic and co-operative. Many thanked me for the opportunity. One young person observed that it was the first time she had ever been asked for her opinions about services. Another offered further assistance if this was required.

4.6.11 Research Journal

Part of the data collection process included entries I made in my research journal. Some consisted of notes after attendance at Care Team, Steering Committee and planning meetings and conducting interviews, after supervision meetings, my PhD study group or presentations required as part of my PhD candidature.

4.7 THE RESEARCHER

In qualitative inquiry the qualitative researcher is inextricably immersed in the research; thus qualitative research requires a high level of 'reflexivity' or self-reflection about one's part in the phenomenon under study (Darlington and Scott 2002:18).

The position of the researcher in qualitative research is frequently an active contributor to the research process. Ely et al. (1991) like Darlington and Scott 2002) above, alerts the qualitative researcher to be reflective particularly when the topic being researched is 'familiar terrain' to them (Ely 1991:16).

A concept from feminist research theory highlights the importance of being aware of the 'position' the researcher takes in relation to the research study: whether they are an 'outsider' or 'insider,' the 'partial insider' (Sherif 2001:446) and/or the 'indigenous or external insider' (Acker 2001:168). All these areas and warnings from the literature were highly relevant for my experience as a researcher conducting this study.
I found the insider/outsider concept enormously helpful in assisting me to understand and process the 'multiple selves' (Sherif 2001:445) I held in relation to this research from having been an 'insider' playing a central role in the development and early implementation of the Enhanced Residential Projects when employed by the WTS to re-entering the field of study as an 'outside' researcher.

As discussed previously, the research process commenced during the period I was employed in the Working Together Strategy (WTS) between October 2000 and March 2002. The Enhanced Residential Pilot Projects were one of the service development initiatives I was responsible for. My duties included the development of the Pilots during their planning and early operational stage.

My enrolment in the PhD and interest in including the pilots as a focus of study of collaborative cross-sectoral practice was known and supported by senior Department of Human Services' staff and members of the participating organisations during my employment and since that time. Following my departure from the WTS position I remained in contact with a number of people involved with the pilots.

In addition to my employment with the WTS I was known to some of the stakeholders due to having worked for many years in the Region as a CAMHS practitioner in one of the services involved with the pilots. I believe this background contributed to my credibility both as a fellow foot soldier in these challenging trenches, someone who understood the service system and had appropriate skills to interview vulnerable young people and families. Another connecting link was that one of the CAMHS practitioners involved in
the pilots was my PhD associate supervisor. This person had a high profile in
the Region and my positioning with him also contributed to my credibility.

However an unfortunate situation occurred that highlighted the complexity
that can arise from juggling multiple roles. At the same time that I received
my ethics approval and was preparing to commence my data collection, the
Regional WTS staff decided to conduct their evaluation of the ERP. I had
not anticipated this occurring as I had expected the ERP evaluation to have
been completed prior to my commencing my interviews but internal Regional
Office factors had caused delays in deciding whether to employ an external
evaluator or ask the WTS Senior Project Officer to conduct the evaluation
as originally envisaged.

Another unexpected development was that I was asked to put in an
expression of interest to tender for the evaluation. I did so but with very
mixed feelings. Regrettably the decision about the outcome of the
evaluation became highly charged. An ‘outside’ evaluator was appointed which
turned out to be preferable to maintain my research’s integrity but caused
considerable practical implications for me that are discussed further in the
Chapter.

Clearly these different roles created ambiguity. I frequently reflected on
Acker’s (2001) provocative question; ‘....how do we even know when we are
inside or outside or somewhere in between?’ (2001:154). She refers to
Collins (1991) who developed the concept of ‘...the outsider within’ a
description I felt aptly captured the complexities of my situation.

Despite these complications I strongly believed that my previous insider
position was critical in securing the high number of interviews I was able to
conduct with the young people, their parents and the service providers. Aker's (2001) quote from her research resonated with my experience.

It appeared that the interviewer's extensive knowledge of the field and the people in it, plus her own experiences, put her in a better position to generate trust, sharing, and emotional expression than was the case for interviews conducted by 'outsiders' (2001:157).

Haynes' (1999) comment was also highly relevant.

I am an outsider with insider knowledge. My informants see me as an insider and I have no doubt that this contributes to their willingness to give up their time and their stories to me (1999:670).

I felt this was also the case for me. When I contacted the service providers and regional managers they all recalled the research and were highly receptive to being involved. They demonstrated generosity in the amount of time they made available for the interviews and in the openness with which they shared their thoughts and opinions with me.

There was a sense that they were willing to 'go the extra mile' because of their commitment to the project and the warm regard with which they held me. This was a result of the (on the whole) positive working relationships that had previously existed but also because they were pleased that the research was being conducted by someone who understood the sector.  \(^{125}\)

It appeared that my previous insider status gave me credibility and therefore a foot in the door which I appreciated. However I was also concerned that it did not impact on the information I received. I did not want the service providers to protect me or for them to censor their answers. To my relief this did not happen. These were people that did not sugar coat or avoid difficult issues. Their honesty and enormous commitment

\(^{125}\) And was not an 'outsider,' a comment that was frequently made.
to this field and this particular cohort of challenging young people meant that they valued the opportunity to share with me their beliefs and perspectives on the needs of these young people.

What I had not anticipated was the intensity of feelings that undertaking the interviews evoked for me. My journal notes from the time reflected a diverse range of responses. As Haynes (1999) captured ‘...I am indulging in reflection in, on and about my research and at the same time, on myself within the research and I am learning as much about myself as I am about the lives and experiences of others’ (1999:670).

Acker (2001) once again helped me with her thoughtful and perceptive words ‘....none of us always and forever are either insiders or outsiders. Our multiple subjectivities allow us to be both insiders and outsiders simultaneously, and to shift back and forth, not quite at will, but with some degree of agency’ (2001:168).

Shaw (2004) relates the experiences of two social work researchers conducting qualitative research who held both insider and outsider roles in relation to their research participants. I strongly related to the experience of one who ‘.....started as an insider yet found herself undergoing a fruitful, if potentially hazardous, process of de-familiarisation through which she became in some degree a marginal “inside out” member’ (2004:13). I wondered if I also had been involved in similar gymnastics.

Part of my reflections on my position included a concern about my capacity to be objective. Did I bring to the research my own agenda to see how processes I put into place as the WTS PO turned out and did I pursue areas of personal interest more strongly than others? Did my previous
involvement influence the questions I asked, how I heard the answers, what I chose to focus on in the analysis, what and how I chose to select back to the stakeholders?

Weil (1995) warns about the dilemmas of being too close to a culture, (1995:6) a point also made by Darlington and Scott (2002). 'There are times when a strong connection can impede the data collection process particularly in 'insider' research' (2002:54).

The process of conducting this research was undoubtedly a journey, a journey that consisted of many challenges and its share of angst and joy. On balance, I felt confident that my awareness of the complexities of my positioning enabled me to achieve and maintain a balanced approach due to my (and my supervisors') constant vigilance.

I felt confident that I had achieved what Ely (et al) (1991) describes:

> We operate from the position that complete objectivity is unattainable, that we strive to become less blinded by our own subjectivities, more self-aware. As researchers we work to present the points of view of our participants to see life through their eyes as well as our own (1991:221).

For me during the process of conducting the interviews, then whilst transcribing and analysing them this helped to differentiate the stakeholders experiences from mine. By writing their story in their words, which are recorded in Chapters 5-8 and my analysis of their story in Chapter 9, I have hopefully achieved the required balance and found '...a way to work creatively within the tensions engendered by the task' (Acker 2001:169).
4.8 CHALLENGES THAT EMERGED

4.8.1 Access Issue 1: The role of the gatekeeper

A ‘gatekeeper’ is that essential person who can provide permission for you to study in a particular setting. Sometimes gatekeepers are not easy to determine. You may believe someone is the gatekeeper only to find it is someone else in the organization, higher or lower in the hierarchy. Often you don’t find out who it is until you find out more about the situation you are studying (Ely, Anzul, Friedman, Garner and McCormack Steinmetz 1991:20).

As has been alerted to previously in this chapter, a number of challenges emerged during the data collection phase. One particular challenge related to difficulties gaining access to the young people and parents. This was undoubtedly the result of a number of factors. It has been noted that ‘...resistance to systemic evaluation and client related research has been reported as characteristic of the child welfare field’ (Mitchell 2003:49).

Vincent (1997) states that ‘... a subtle obstacle may be an organizational culture within child welfare agencies that fears that additional data will fuel attacks from the system’s detractors, who evaluate performance more on the basis of tragedies than successes’ (1997:19). Other contributing factors related to the lifestyles and circumstances of the young people and families and were the result of the requirement of the Ethics Committee that access had to occur through case managers.

It is important to state that the arrangement of working through a third party varied. It worked extremely well with one pilot where the Care Team co-ordinator negotiated all contact between the young people, families and me. Even though two different people undertook this task, both were very helpful, enthusiastic and highly efficient. They had a ‘can do’ attitude, which was communicated to the young people and families.
Unfortunately with the other pilot a different scenario emerged.\textsuperscript{126} Due to the structure of their organisation I worked with a number of case managers. Most were helpful although extremely difficult to contact. However with one case manager who was the contact person for a number of the young people and families, there were difficulties. With some of the young people, the case manager maintained the position that the young people would find the interview experience upsetting and was not prepared to discuss the option of their involvement in the research.

At other times, with young people and family members he thought may be prepared to meet me, the case manager did not follow through on contacting them despite frequent requests for this to happen. As a result I did not interview any of the young people or parents he case managed. This scenario particularly perplexed me as the individual enthusiastically participated in his own interview and provided very thoughtful and useful insights.

4.8.2 Access Issue 2: The Gender/Pilot imbalance

Two imbalances emerged in relation to the cohort of young people who were interviewed. The first related to gender issues. Despite the breakdown of young people placed in the units during the pilot phase being even, (eight males and eight females) those interviewed were predominantly female (eight out of the nine interviews). Therefore of the six young people who were not interviewed all were male.\textsuperscript{127}

\textsuperscript{126} I am outlining the very different processes that occurred and am not presenting this as an example of a good/bad dichotomy between the pilots but a description of what took place.

\textsuperscript{127} As highlighted in 4.6.4 previously two of these had been directly asked to participate in the research, but the interviews had not eventuated, one because the young person's circumstances became unstable and the other because staff in the facility did not support his involvement. The gender/pilot imbalance is also explored in Chapter 8.
This imbalance is worth reflecting on. However as five of the six young men were incarcerated in either a Juvenile Justice or drug treatment facility, the gender bias may be less about gender playing a role in willingness to participate in the research, but a reflection that at risk males were more likely to struggle with externalising behavioural and conduct disorders with significant drug use and criminal activities that resulted in incarceration.

What it does mean for this research is that the voices of the young people represented in this research are predominantly female and that the male voice is silent. It means that if the male experience of involvement with this model was different this information is not accessed. (Although the views of the one male, who was interviewed, did in fact, raise the same issues as the females.) It does raise the question of what was not being said.

The second area of imbalance relates to representation across the pilots. Of the six young people who were not interviewed five were from Pilot 2. Four had been residents during Pilot 2 Stage 1 which as will be outlined in more detail in the following chapters, was a highly problematic period.

To what extent did the difference that occurred between the pilots relate to the process of recruitment that was mentioned in the previous section? Did this reflect differential relationships between me and the pilots, different levels of engagement with the research process, the complication of having to deal with a larger number of case managers in Pilot 2 compared to Pilot 1, different working styles and personalities? All these questions need to be considered.
4.8.3 Access Issue 3: Coping with the unexpected

'Getting in' (to an organisation) is not just a matter of gaining official approval but also of engaging staff at various levels of the organisation. If it is a pilot program which is being evaluated, staff will often feel a heightened performance anxiety, particularly if the program is experiencing the normal teething problems (Darlington and Scott 2002:32).

Another factor that influenced and complicated access to all stakeholders was the impact of the Departmental Evaluation of the pilots being conducted at the same time as my data collection.

Two days before I was due to undertake my second interview the people with whom I was scheduled to meet were directed by staff from the Department of Human Services (DHS) to not meet with me. I was informed that I had to delay all further interviews for a minimum of three months to enable the evaluator to conduct her interviews prior to mine. The repercussions of this situation were profound as I had taken leave from paid employment to undertake the interviews.

A number of complex and protracted negotiations followed involving many phone calls, letters, e-mail messages and meetings. One meeting was convened to discuss my research but neither I, nor anyone else to represent me was invited to attend. Those present from the Pilots refused to discuss the research under these circumstances. They also communicated that they were prepared to participate in both processes (my research and the evaluation) as they acknowledged their different purposes. Unfortunately it was not until a formal letter was sent from my primary PhD supervisor to the Regional DHS Director that a solution was able to be reached.
This solution consisted of a compromise I proposed that immediately after
the evaluator conducted I commenced mine. Unfortunately in some
circumstances this resulted in close to a 3 month delay for some interviews
to occur particularly with the young people and family members.

4.8.4 Access Issues: The impact on the methodology

As well as the delay, disruption and distress this interruption caused, it also
resulted in having to alter my methodology. I held more individual interviews
with service providers than group interviews as these were easier to
organise and had to conduct telephone rather than direct interviews with a
number of the young people and parents. As this required having to
request an amendment from the DHS Ethics Committee, there was a further
delay waiting for this process to be completed.

It also meant that with the increased number of individual interviews it
extended the data collection phase. I was also aware that there was
confusion for some participants about the two processes. On a couple of
occasions service providers were unfortunately required to participate in
interviews one after the other with my interviews being conducted after
work hours. Under these circumstances I was particularly touched by the
enormous support, enthusiasm and generosity I received from participants.

Another change was that I had planned to have one of my PhD supervisors
present at the larger group meetings but as these did not occur, she was
only present at the first interview and all others I conducted by myself.

128 Fortunately research findings from deVaus's (1995) demonstrate that results from
telephone interviews provide the same quality as face-to-face interviews and thus I did not
feel that they influenced the quality of the material I received.
4.8.5 A Reflection on These Challenges

Although causing anxiety these events demonstrated the validity of Marshall and Rossman (1989) words that

A qualitative approach, utilizing various data collection techniques, is intentionally responsive to unexpected data and therefore to adapt procedures if necessitated by changes in the field. The primary strength of the qualitative approach is this flexibility, which allows, even encourages, exploration, discovery and creativity (1989:107-110).

One of the flexibilities I needed to develop was a capacity to respond to multiple gatekeepers. Both those I directly dealt with and those 'hidden behind the scenes' who contributed to the 'challenges' I experienced. It highlighted clearly how, although I received 'formal' approval and support for my research, the informal processes are often far more influential.

As Butler and Williamson (1994) warn, the researcher needs to ‘....understand the unpredictability of the environment - understanding the world of the “gatekeepers”’ (1994:39). Thus, another discovery was that the world that I had known as an insider was quite a different experience to enter as a researcher. During these experiences was the time when I felt most strongly positioned as the outsider.

4.9 DATA ANALYSIS

Listening to understand moves beyond the interview situation and continues throughout the analytical process. Listening to understand leads the (researcher) to look beyond, between, and underneath the participant’s words (Power 2004:860).

4.9.1 Introduction to the Data Analysis process

Qualitative analysis is a process, which involves a number of steps. These include reviewing, synthesizing and interpreting data to describe and explain the phenomena being studied (Fossey et al 2002:728).
As I commenced my data analysis the steps I engaged in included transcribing and analysing the data I had gathered from the written and audio recorded material from the individual and group interviews, notes from my field notes, and journal entries and analysis of the descriptive material.

This process, of analysing data from a number of sources has been called triangulation (Punch 1998:190). Its strength is that ‘...gathering information from multiple sources in multiple ways will illuminate different facets of situations and experiences and help to portray them in their complexity’ (Fossey et al 2002:727).

4.9.2 Data Reduction

As I had conducted fifty-six interviews with seventy participants, there was a large quantity of data to transcribe, process and reduce. I followed the approach outlined by Miles and Huberman (1994:11), which involved three components; data reduction, data displays and drawing and verifying conclusions. These three components involved the operations of coding, memoing and developing propositions.

To begin my analysis, I reviewed and reflected on the interviews I had conducted. As I commenced my data analysis I closely listened for the rhythms, metaphors and meanings of the stories that had been shared with me. I took into account Fossey et al’s (2002) comment that ‘...meaning-focused approaches emphasize understanding the subjective meaning of experiences and situations for the participants’ (2002:729). That ‘....qualitative data analysis is a search for general statements about relationships among categories of data’ (Punch 1998:163).
In qualitative research, coding is ‘...an integral part of the analysis, it involves sifting through the data, making sense of it’ by creating categories and assigning it to selected data (Darlington and Scott 2002:145).

4.9.3 Questions that guided the process

To assist me in commencing my coding task I selected one of the questions I had asked all the stakeholder groups; ‘what are the strengths of the model?’ I read and re-read the answers then organised the data in their stakeholder groups e.g. the strengths identified by the young people, families, Care Team members and looked for emerging patterns.

As I undertook this coding process I was guided by these questions:

- what was the weight of the answers?
- how did they most frequently answer the questions?

Through the use of manual lists and then spreadsheets I identified the most frequent comments for each of the questions I had asked which enabled patterns and themes to emerge. I counted the responses and produced a summary.

This process involved at least three attempts at the spreadsheet, summary, analysis for each question as I refined the process before feeling that I had captured the essence of what the stakeholders were revealing through their answers. I was mindful of my task as Acker (2001) states, of ‘...comprehending a situation and explaining it to others is at the heart of qualitative research’ (2001:154).\(^\text{129}\)

\(^\text{129}\) See Appendix 4 for an example of the spreadsheets and summaries used to analyse one question.
Whilst undertaking this process I was also keeping in mind the following set of questions:

☐ How did they answer the question?

☐ What were the similarities/differences across stakeholder groups within each pilot?

☐ What were the similarities/differences between the pilots?

☐ What were the gaps- what was missing, what are they not saying?

☐ What were the affective themes?

☐ what were the aberrant views if any?

☐ what were important themes but weren’t mentioned often and

☐ what were my questions about their answers? 130

Alongside the benefits of analysing the data in this way I also discovered some concerns and these included that reducing the answers to common themes and codes also reduced the richness of the stakeholders' actual words, metaphors, quaint (but very evocative) sayings. Also moving too quickly into identifying categories risked missing the critical point being communicated. For example, using a category such as 'specialist workers were responsive' lost which of the specialist workers were identified as being responsive and the important detail about that particular worker's contribution.

Darlington and Scott (2002) warn that applying

130 I am indebted to my principal supervisor for these very helpful questions.
...too tight a focus on particular types of data at an early stage of analysis carries the risk that unexpected and unanticipated relationships between the data will be missed. We suggest trying a number of different ways of looking at the data, including looking for differences as well as similarities (2002:146).

Thus I could see that while the process of reducing the data to produce the lists and themes was useful and a necessary step in the process, it was not the final form in which I wished to communicate the depth and breadth of the information I had collected.

4.9.4 Presentation of Material: Capturing the voices

The writing of a qualitative research report demands the creation of a narrative (Ely et al 1991:169).

I reflected on Ely (et al's) (1991) quotes. 'You're ready to tell it. Your job here is to create a text in which the persons you have learned about come to life. What one writes is what happened and what was learned' (1991:167). Being mindful of Ely (et al's) words and those of Darlington and Scott (2002:47) that '...qualitative research is a powerful tool and one to be used with care' my next dilemma was how to present the material in a way that captured its richness while also respecting the confidentiality of the participants. I also felt particular care had to be given to balancing the different voices of the stakeholder groups - not giving too much emphasis to one set of voices compared to others (a concept raised by Spink 1998:11).

I was entering the final stage of analysis, which '....entails bringing identified themes back together into meaningful relation with each other: developing a narrative or structural synthesis of the core elements of the experiences described' (Fossey et al 2002:728).
It was time to pull the voices together. In the process of supervision the idea was formed that I develop my narrative through writing the findings as they had been told to me, as *their* story using the stakeholders' words. To try this idea out I combined the responses from one stakeholder group into a single collective story for example, Pilot 1's service providers' story. Once I commenced writing the story in this way I discovered that it powerfully and accurately captured the 'voices' of the stakeholders.

It also revealed other dimensions. Most stories flowed well using this method. However for Pilot 2, which had gone through two distinct phases and for the Regional Managers, writing their 'stories' in this form did not work. I kept rewriting in order to get it 'right,' until I stopped, reflected on my problem and realised that it wasn't working, not because the form was wrong but because these particular groups were not unified and did not have only one story to tell.

Because of the process Pilot 2 had experienced, they had two quite different stories. Once the story was organised into Pilot 2 Stages 1 and 2, it worked once again. For the Regional Managers a more appropriate format was to write their piece as a summary of the main themes they had identified. Once that had been done their story was also able to be told.

4.9.5 Feedback to participants

I had informed the stakeholders that they would receive interim feedback of the findings. I was particularly interested to receive feedback from them about the method I had chosen to represent their 'stories.' I sent each person a copy of their story with this accompanying note.
I wanted to keep the richness and honesty of how you and others shared your thoughts with me while also respecting and protecting everyone's privacy. I hope I have achieved this balance. It is my plan that aspects of this piece will be included in my final PhD document and that is why it is important to me that it accurately reflects your own and others' opinions. What this story does not include is my opinions or views which is in a separate chapter and will form the basis of the final feedback.  \textsuperscript{131}

This practice is referred to as member checking and is used in qualitative research to enable '...research participants (to) be involved in reviewing the analysis' (Fossey et al 2002:729). I requested feedback from participants about any concerns. None were received although one person expressed surprise to read concerns about aspects of the Care Team's functioning that had not been raised within their Care Team's meetings.

I also received a few positive comments, expressing support and 'delight' for the way in which I had captured their experience. I was particularly touched to hear from one of the young people who told me,

\begin{quote}
I think that what you said in your piece was good, and you said it in a way as if you were living there - you got it!
\end{quote}

I was also able to give one of the Care Teams interim feedback directly when I was asked to attend their end of year function. As well as informing me how rewarding it had been to hear their experiences captured in this form, they also used the opportunity to workshop some of the difficulties that had been raised in their story. I was thus privileged to see an example of what Scott (2001) had referred to as '...the "feedback loop" between research and practice that can occur' (2001:2).

\textsuperscript{131} A copy of this letter is included in Appendix 5
4.10 CONCLUSION

In this chapter the research design has been outlined. A theoretical paradigm, the social constructionist/interpretative model utilizing a case study qualitative research method was selected to enable a critical case to be studied in depth. This method also provided a framework to ensure that all the stakeholders involved in the case under study, the implementation of a cross-sectoral collaborative team to work with at-risk young people, had a voice. The data analysis process also promoted the stakeholders critical messages to be heard.

Throughout this research another voice was also present, my voice, as the researcher who, while not a stakeholder moved between different positions inside and outside the research process. The particular challenges that emerged during this process have been described.

The next four chapters’ consist of the research’s findings. They have been organised under the general title of ‘Stories from the Field.’ Chapter 5 consists of Pilot 1’s service providers’ story, Chapter 6 consists of the stories of Pilot 2 Stage 1 and Pilot 2 Stage 2’s service providers.’ Chapter 7 consists of the Regional Managers Story and Chapter 8 consists of an overview of the descriptive material collected about the young people and parents and young people involved with Pilot 1 and Pilot 2 Stage 2’s stories.
CHAPTER 5: FINDINGS - STORIES FROM THE FIELD.
PILOT ONE’S SERVICE PROVIDERS’ STORY

As a collective we’re stronger than individuals (Pilot 1 Care Team member).

5.1 INTRODUCTION TO CHAPTER

This chapter commences with an overview of the Enhanced Residential Program, its application in relation to Pilot 1 and an outline of Pilot 1’s Care Team and Steering Committee members who were interviewed for the research and whose story is told in the second half of the chapter.

5.2 BACKGROUND CONTEXT TO THE ENHANCED RESIDENTIAL PROGRAM (ERP)

As described previously the Enhanced Residential Program (ERP) was one of the service initiatives developed by the Working Together Strategy (WTS) in a metropolitan region of the Victorian Department of Human Services (DHS). The Enhanced Residential Program consisted of the establishment of an intersectoral Care Team.

The Care Team’s role was to provide an enhanced service for young people living in the residential units. This was to be achieved through two components, the provision of direct service to the young people and working as an integrated team to develop individualised case plans for each young person, promote regular discussions about their progress and provide opportunities for staff development and education.

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132 The phrase 'Stories from the Field' derives from the subtitle of Yvonne Darlington and Dorothy Scott’s (2002) book Qualitative Research In Practice. Stories From The Field.
133 In 1.3 and 4.3. The Working Together Strategy (WTS) is a Statewide quality improvement initiative of the Department of Human Services (DHS) intended to build capacity and improve services for shared clients of the WTS program partners, Child Protection, Out of Home Care, Mental Health Services, Juvenile Justice, Drug Treatment Services and Education.
The young people were all aged between 12 and 16 years and were young people on the Child Protection Adolescent High Risk register, which meant they were young people who displayed the following persistent high risk indicators; self harming behaviours, involvement in crime and frequent placement breakdowns. The residential unit was staffed by residential care staff employed on 24-hour rosters. The unit had the capacity to house four young people at a time and throughout the duration of the Pilot, occupancy was always full.

The WTS Regional Management Group decided to pilot the ERP in two residential units within the metropolitan region. Each pilot consisted of a Steering Committee as well as a Care Team. The membership of the Care Team consisted of representation from the service providers currently involved with the young people; the residential care staff employed within the residential unit, workers from the statutory programs Child Protection and Juvenile Justice and from the specialist program areas it was hoped to engage them with, Child and Adolescent Mental Health Service (CAMHS), Drug Treatment Service (DTS) and the Department of Education, Employment and Training (DEET).

The Steering Committee’s role was to support the development of the Care Team during the developmental and operational stages. The Steering Committee’s membership predominantly consisted of line managers of the staff involved in the Care Team. In addition the Care Team Co-ordinator

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134 A specific profile of the young people is provided in Chapter Eight.
135 As the two pilots were located in two different geographical locations different agencies were involved in Pilot 1 and Pilot 2 (ie two different Community Support Organisations (CSO’s), Child and Adolescent Mental Health Services (CAMHS) and Drug Treatment Services (DTS) agencies, different regional Child Protection (CP) and Juvenile Justice (JJ) program teams and different Department of Education, Employment and Training (DEET) representatives).
(who was the Residential Care Co-ordinator for the unit), the WTS Project Officer and a representative from the DHS program area responsible for Out of Home care were also members of the Steering Committee.

5.3 PILOT 1’S ADAPTATION OF THE ERP CONTEXT

Pilot 1 kept closely to the original ERP parameters throughout its two year pilot phase. It maintained the one Care Team and Steering Committee Structure. The accountability of the Steering Committee was two-fold; as a Committee it was accountable to the Working Together Strategy Regional Management Committee but also each member of the Steering Committee were also accountable to senior managers within their ‘home’ organisation.

Pilot 1’s Steering Committee met approximately monthly with the capacity to meet more frequently if required. As the Care Team settled the frequency of the Steering Committees meetings decreased. The membership of the Steering Committee remained stable throughout the two year period except for the WTS Project Officer position. Two Steering Committee members (the CAMHS and JJ representatives) were also members of the Care Team for the first year of its operation. They remained involved in the Steering Committee after their Care Team position was taken by other representatives from their program area.

The Care Team met three weekly as a combined team. In addition there were a number of other formal and informal contacts between members. Amongst the ‘external’ members of the Care Team; that is, the CAMHS, DTS, DEET, CP and JJ members the DEET representative had the most formal arrangement. She attended the unit on the same day per week when

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she provided educational services for the young people and met with the residential staff.

The other members’ direct contact with the young people varied. Some had weekly or fortnightly contact and more frequently if required. Contact with family members also occurred when required.

The Care Team membership was not as stable as the Steering Committee’s. Only the Drug Treatment Service representative remained involved for the duration of the two year pilot period. In all the other ‘external’ program areas; CAMHS, CP, JJ two representatives were involved and three from DEET over the period. From the CSO, three residential care workers were employed for the duration, two of whom in management positions.

The Care Team members also had a dual accountability, to the Steering Committee and to their own managers from their ‘home’ organisations. Another layer of the accountability structure was that as all the young people were on care and protection orders, the Department of Human Services, Child Protection Program held case management responsibility for them. Within Pilot 1, as part of the ERP this case management responsibility was delegated to the CSO’s Residential Care Co-ordinator.

5.4 OVERVIEW OF SERVICE PROVIDER INTERVIEWS

The Pilot 1 Service Providers’ Story was compiled from material received from 26 interviews conducted with 22 members of the Steering Committee and Care Team:

Steering Committee Members:

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These interviews were previously discussed in 4.5.1
Program Manager Residential Youth Services and Care Team Co-ordinator and Residential Unit Co-ordinator from the CSO

Acting Unit Manager from the Child Protection Program (CP)

Child Psychiatrist from the Child and Adolescent Mental Health Service (CAMHS)

Team Leader from the Juvenile Justice Program (JJ)

Chief Executive Officer from the Drug Treatment Service (DTS)

Principal of the CAMHS Education Unit as the Department of Education Employment and Training (DEET) representative 137

WTS Project Officer

Care Team Members:

8 residential care staff including the Care Team Co-ordinator/Residential Unit Co-ordinator from the Community Support Organisation (CSO)

Senior Protective Workers from the Child Protection Program (CP)

Child Psychiatrist and Psychiatric Nurse from the Child and Adolescent Mental Health Service (CAMHS)

Team Leader and Case Manager from the Juvenile Justice Program (JJ)

137 Both the CAMH services in this region had Education Units attached to their services with trained teachers employed by DEET. When the ERP was first established negotiations initially occurred with the regional DEET to provide school based teachers to be involved with Pilot 1. When this proved problematic the CAMH service agreed to provide staffing from within their small Education Unit.
☐ Youth outreach worker from the Drug Treatment Service (DTS)

☐ Special Education Teacher and two teachers from the CAMHS Education Unit as the Department of Education Employment and Training representatives (DEET)

5.5 PROFILE OF PILOT 1 SERVICE PROVIDERS 138

The information received from Pilot 1's Care Team and Steering Committee members revealed they were a highly experienced and qualified group who had a high level of previous experience with this particular client group, had extended periods of employment within their current agency (and their field of practice) and possessed a range of tertiary qualifications and relevant practice experience.

Twelve had a tertiary qualification with the most common being social work. A number had youth work and child care qualifications. Six had additional post graduate qualifications. A very small number did not have any formal training.

138 This overview is based on the information received from the service providers who completed the service provider profile form previously discussed in 4.2.1. They were asked to identify the position they held in their agency, their qualifications and professional background, their length of employment with their current agency, their previous experience with at-risk young people, the nature of their involvement with the pilots and the length of their involvement.
TABLE 5.1: OVERVIEW OF PREVIOUS INVOLVEMENT WITH TARGET GROUP AND LENGTH OF EMPLOYMENT IN AGENCY.

<table>
<thead>
<tr>
<th>PILOT 1</th>
<th>PREVIOUS INVOLVEMENT WITH MULTI-SERVICE YOUNG PEOPLE</th>
<th>LENGTH OF EMPLOYMENT WITH AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL: 19</td>
<td>YES 18</td>
<td>NO 1</td>
</tr>
<tr>
<td>TOTAL: 19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.6 PILOT 1: THE SERVICE PROVIDERS’ STORY

Deb, you want to hear the story of the pilot, and as the group of service providers involved we are happy to talk about it because it has been a positive and good experience. It has been a positive experience to be involved with and it has been positive that the pilot has been as successful as it has. To be honest, it has surprised some of us how well it has worked.

All of us involved in the pilot agree that this model has resulted in a number of positive outcomes both for the young people and families and for us as workers and that these outcomes were an improvement to what previously existed.

5.6.1 The first goal: creating a client centred model; the impact on the young people

The most important outcome was that this model worked. It worked because it achieved its goal of creating a client centred model with services working around the client as the common focus. In addition, the young people were
more likely to access these services because they were provided at the residential unit, in their home base, their familiar and safe environment.

From the point of view of those of us who are residential care workers, we saw that the young people accessed the services because they were delivered when they were required. The external workers 139 were accessible and responsive to our requests. We had their mobile phone numbers. They replied promptly. They attended when they said they would which was very important for this client group.

We were delighted to see the young people engaging with the external workers. We could see that the young people felt safer, had a chance to get to know the workers before formally engaging with them. We felt more comfortable also and encouraged the young people to get involved with the workers. Nevertheless, the young people were still clearly given a choice about involvement, it was not forced on them, and it was disappointing when some were still not able to engage with the services that were offered.

The form in which the services were delivered, in a relaxed, informal, and creative way contributed to their increased use and acceptance.

A few of us commented on the good range of services involved in this model and having the right agencies involved, which also contributed to the positive outcomes. We had workers from Child and Adolescent Mental Health Services (CAMHS), Drug Treatment Services (DTS), Education, Child Protection (CP), Juvenile Justice (JJ) as well as the Community Support Organisation (CSO).

139 Although a number of different terms were used when referring to the workers from the following non-statutory program areas, Child and Adolescent Mental Health Services, Drug Treatment Services and Education (‘specialist workers’ and ‘the professionals’) the general term ‘external workers’ has been selected to be used throughout this chapter.
In addition, when we required contact with additional services for the young people or parents, the whole referral process became streamlined when those of us with links to those services became involved with the referral or liaison (e.g. CAMHS contacting CAT services, the Education staff contacting schools).

5.6.2 How the client centred model worked: the impact on the residential care workers

As well as the improved services the young people received through their contact with the external workers coming to the unit, another positive outcome was the strengthened service the young people received from the residential care staff. For the residential care staff, we benefited enormously from the input we received from the other members of the Care Team. They provided strategies and ideas, which we valued and found helpful. They communicated clearly. This input was extremely helpful for us including being able to perform our key worker role, which was an initiative of this model.

We found that as the external workers came to know and respect us, they valued our input about the young people, understanding that their interventions were more likely to work when it incorporated our knowledge and perspective of the young people. As one of the external workers said, ‘...you’ve got workers that live with the young people so you’ve got a professional view of the young person.’

Working so closely with the external workers improved the confidence, skills, and knowledge of those of us who were residential care workers. In

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140 The Crisis Assessment and Treatment Team auspiced by Adult Mental Health Services which provides after hours crisis intervention services for all age groups
this model, we took on additional roles in our work with the young people and families, and worked collaboratively with the other workers. All this input resulted in what one of us described as a ‘...changed culture’ in the residential unit.

For those of us workers coming in to the service from the external agencies we learnt that ‘...resi staff are tremendous allies when it comes to delivering care’ including aspects of therapeutic interventions with the young people and incorporating their new understanding into the general care they provided. Some became the front line deliverers of mental health care while we (the mental health workers) took on a consultative role. However, these changes did take some time, for the residential care staff to become familiar with working in this way and to learn how to use what was offered, but once they did, it was wonderful to see how they ‘...blossomed and grew’ in this model.

5.6.3 The demonstrable changes to young people’s lives:

This pilot worked because it brought demonstrable changes to a number of areas of the young people’s lives. We noted the main ones as being:

(a) Increased positive contact between the young people and their families while in the unit and increased numbers of young people who returned to live with family members after they left the unit. One young person, after years of estrangement was reunited with her parent. For some of us we described these improvements in family relationship as ‘...the pilot’s greatest achievement.’

(b) A second area of identifiable change was that many of the young people were ‘...reconnected to the educational experience’ after years
of being disconnected. For some this involved commencing and maintaining attendance at school, TAFE courses, and paid employment while in the unit and after leaving. These interventions were able to occur because of having educational colleagues on the team who provided direct remedial intervention with the young people, developed homework tasks for the young people and residential staff to work on together and promoted linkages between the residential care staff and schools. 'There was very good team work between education and residential workers particularly in school liaison.'

(c) Another important area that changed was general improvements in the young people’s mental health status. Some of the young people became more settled generally and made more balanced and mature decisions in a number of areas of their lives. For others there were reductions in episodes of at-risk behaviour and reduced admissions to emergency departments, psychiatric inpatient units, and secure welfare units.

(d) Because of improvements in all these previous areas, the Child Protection workers amongst us highlighted that another positive change was that some of the young people were discharged earlier from the care of DHS.¹⁴¹

5.6.4 Changes for parents

In relation to the impact of this model on the young people’s family members a number of us identified some positive changes such as increased frequency of contact between the families and the pilot’s workers. There was also a

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¹⁴¹ Department of Human Services.
changed type of contact that took place. For example there were some situations where we, the residential care staff successfully referred parents to appropriate services. There were also some situations when family members came into the unit and had discussions with the residential care staff and the mental health workers.

Although we saw these as important improvements, a number of us were concerned that more of a focus on family involvement was needed, that this area needed further strengthening. The CP workers amongst us raised these concerns in particular.

5.6.5 The second goal: forming a functioning Care team

We all agreed that this pilot worked because it achieved its second main goal of forming a functioning multi-disciplinary cross-sectoral Care Team. The Care Team led to a number of positive outcomes for its members, including improved and expanded skills and knowledge base, improved working relationships and collaborative practice and increased cross program connections.

We saw these as exciting outcomes. We all came out of this experience enriched. We learned a great deal about the highlights, frustrations, and struggles as we moved from being a diverse collection of individuals to forming both a functioning Care Team and Steering Committee.

5.6.6 The process of becoming a team

It certainly took time to develop a Care Team that worked well. We had to learn to trust each other, to be able to work together to develop common goals and provide a more focused vision, and integrated approach. We had to learn how to communicate. We started to think and act differently, not as
individuals or as representatives of our specific programs but as a team with a sense of shared responsibility and joint ownership towards the young people.

There were lots of changes that occurred during the process. For example, some people felt freed up by the opportunities that came with the change of roles, some felt overwhelmed at times by performance anxiety and being outside their comfort zone initially, but became more comfortable as time passed.

For some members of the team being involved in this pilot changed a great deal for us. It challenged our previously held beliefs about how services could be provided for this particular client group. It challenged our beliefs about where services could be delivered and which professionals should deliver them. It confronted our assumptions about the emotional and psychological capacity of at-risk young people and their ability to use therapeutic interventions. It challenged our previous ideas about the form which effective practice could take.

For some of us it even challenged central definitions of what constitutes mental health practice.

(I learnt) that mental health skills need to be delivered in a way where there is an openness, a trust and a shared focus that came from being part of a team. I couldn’t have experienced this if I hadn’t been involved in this model. It’s changed my practice in terms of how psychiatry services can be delivered.
5.6.7 The importance of the Care Team meeting

The place where so much of our learning took place was at the Care Team meeting. Therefore, it is not surprising that the team meetings were one of the areas we mentioned most frequently to you in our interviews.

There were many positives about the meetings. For the external workers it was important to us having the meetings at the residential unit, as it was such a welcoming environment. A couple of us said that a highlight of the experience was that before each Care Team meeting, the residential care staff provided a fabulous lunch. This was important because it gave us time, time to sit, talk, catch up and get to know the other team members’ *I was made to feel welcome.*

What we all valued was that the team meetings provided a structure where we shared ideas, developed, and reviewed the work we were doing with the young people. There were excellent discussions and lively debates, representing the input of people coming from different perspectives.

It became a safe place where issues were discussed openly and conflict resolved and where we learned a lot from each other. We had the opportunity to understand the strengths and limitations of each other’s services.

5.6.8 The role of the co-ordinator

A crucial role in supporting the development and functioning of the Care Team was the co-ordinator and we were very fortunate to have a very competent person. He seemed clear about how the pilot needed to work and was a highly organised person always coming prepared to meetings with agendas, minutes, material to read.
Many of us mentioned the smooth running and organisation of the Care Team and some acknowledged the specific role the co-ordinator played in building and maintaining the team, providing what one of us called, the ‘leadership structure’. One of us talked about the co-ordinator being a conduit, the link, between the different groupings within the team and between the external workers and the young people.

5.6.9 The hiccups and challenges in forming a team

It did take time for the Care Team to form as a team and there were naturally problems and hiccups to deal with on the way. It was a bit of a rollercoaster.’ There were hard parts during this process. For some of us there were feelings of anxiety and uncertainty being placed in unfamiliar roles, having to cope with other team members’ expectations and managing the frustrations that emerged due to internal and external obstacles.

Some of the factors that got in the way ‘.were people’s professional background, the impact of their agency, personality clashes and the blurring of roles.’ Some of us felt that at times the residential care workers’ needs dominated and the meetings became their supervision sessions.

The other issue that annoyed a number of us was irregular attendance from members particularly at meetings but sometimes at other times as well and inflexibility from some about when they could be involved. There were ‘.difficulties with commitment and continuity of staff’ and the turnover of staff involved in the pilot particularly from the CP program area.

The day selected for meetings was an issue for many of us as it was one of the days that those of us who were JJ workers, were required to attend court with clients, which meant we missed more meetings than we would have
liked to and were annoyed this was not changed. In addition, it was also the
day that one of the DTS workers had their rostered day off which meant
they missed a number of meetings. Someone commented that the worker
could have changed his or her day off and it may have reflected a reluctance
to attend meetings. Some of us made sure that if we did miss a meeting we
sent someone else as a proxy because that is what we are required to do
within CP and JJ programs.

Some of us felt pressured by the residential care workers to work with all
the young people whether they really needed to see us and felt that, at
times, the young people were over serviced. Others felt disappointed that
some areas we had discussed being developed did not occur, such as working
in groups or developing leisure type activities. Some felt the orientation of
the Care Team was too clinical. As someone commented, ‘...sometimes it
works well, sometimes it hasn’t and when it hasn’t it’s been possible to
identify why it hasn’t and rectify it.’

5.6.10 The residential unit - its role and changes

A number of us pointed out that a contributing factor to the pilot’s success
was that it was implemented into a residential unit which had many runs on
the board and was respected within the wider service system. It was a unit
which employed and held experienced residential care staff, which placed it
in a strong position to incorporate the changes involved in implementing this
model.

Many of us saw the support and enhancement of skills that occurred for the
residential care workers as one of the key achievements of this model,
demonstrated by it being one of the most frequent areas many of us discussed.

A major shift for the unit was having the case management role transferred from Child Protection staff to the residential unit and specifically to the residential care co-ordinator. This was an enormous change in responsibility and roles and there were many implications of this change.

For the residential care co-ordinator, he saw a number of benefits bringing those tasks and responsibilities within the residential unit, allowing the Care Team to become the place where case planning and case review decisions were made and therefore ‘...different people contributed strategies to the case plan.’ This included ‘...the resi staff (who) are now part of the creation and input into case management plans.’ They were also able to introduce other positive changes such as reducing the number of people present at Case Plan meetings, which was seen as preferable for young people and families.

Those of us who were CP workers saw a number of positives in this transfer. It enabled us to be freed up to relate differently with the young people, families, and it positively changed the quality of our relationships with other staff. We enjoyed the changes it brought us.

_The pilot wanted involvement from CP, for us to see the kids and they involved us with things._

Residential care workers also acknowledged positive changes the new case management structure provided for CP workers such as having more time to spend with families and therefore have more likelihood of engaging with them.
Some of us had concerns about some of the implications of these changes in case management practice. Those of us who were JJ staff were concerned that we were no longer invited to attend the case planning meetings even though we are legally required to do so.

Some of us involved in the Steering Committee raised other concerns about the new case management model. With case management being undertaken by workers located within a residential unit it meant they could only be involved for the period the young person was in the unit and for a short period afterwards. Once the young person left the unit case management had to be transferred outside the agency, which was seen as unsatisfactory and something the agency needed to address.

5.6.11 The reasons for Pilot One's success

A number of us discussed our ideas about why this pilot was successful. We wondered whether it was because of the particular personalities who were involved. The personal attributes that seemed important to be able to work in this way were the capacity for flexibility, creativity, and patience both for our work with the young people and with each other.

It helped that we were experienced workers who had extensive experience both in our current agencies and in previous workplaces. Some of us had been waiting for an initiative like this to come along for a long time. 'I was fortunate enough to be part of a program with very experienced and respected professionals.' A couple of us had specific expertise in research and evaluation and this pilot was an opportunity to explore those interests further and was an additional way in which we could contribute.
A couple of us highlighted the importance therefore of matching staff with the needs of the model, selecting the right people to be involved. Luckily we only had a few examples of people who did not fit into working in this way and boy was that a headache for those of us who had to deal with those situations.

For many of the external workers coming into the unit this way of working was different to what we were used to and therefore took adjusting to. *I feel better now, working as part of the team.*’ For most, we loved the expanded opportunities it provided us and it became a very special experience, even a highlight of our working life. As one of us put it, ‘…..the work has grown on me.’

5.6.12 The importance of the mental health contribution

This question of personal contribution relates to the third of the three most frequently mentioned areas, which was the importance of the mental health contribution generally but particularly that provided by the first mental health worker, a psychiatrist.

We saw that the mental health contribution had a number of helpful components to it. These included the direct work the worker did with the young people, the input h/she provided individually to other staff which enhanced the service they provided, and the contribution to discussions at Care Team meetings.

Some of us felt that this mental health contribution was the strength of this model and the highlight for us individually particularly our interactions with the mental health staff and the gains we made increasing our skill base
and knowledge. In addition, the opportunity to learn how this person conceptualised his work and applied his framework was something we valued.

*I love having CAMHS at the Care Team meetings, being able to bounce ideas off them and consult with,' one person said and another, 'I found it very helpful discussing issues with (the CAMHS person).'

A number of us mentioned this person's passion for the pilot, how accessible and committed he was, his seniority and experience. Some also mentioned the positive spin-offs that occurred from developing a relationship with this person on a personal level and in relation to the development of other projects that have since occurred between some of the program areas.

This area of positive spin-offs came up a few times. Some of us felt that we had made connections, ‘good links,’ personally and professionally between individuals and between agencies that would sustain past the pilot. There have been positive spin-offs in terms of relationships, increased access to services and changes made in other work practices.

5.6.13 The contribution of other specialist workers

Others commented on the particular contribution made by different workers and between workers. As well as the mental health representative a number mentioned the contribution of the Education representative and the DTS representative;

*The Education representative is doing excellent work,

*Education was a key provider

*The Education workers and I (the CAMHS worker) communicate and work well together,*
A core feature of the model is that it has to be CAMHS teachers involved rather than teachers released from schools.

The DTS worker showed creativity in engaging with a young person.

The DTS worker made young people feel safe.

5.6.14 What was needed from our program areas to make the model work

We talked a lot about different program areas involvement and commitment to the model. What we learned through the pilot was that an organisation saying they want to be part of something new and innovative was not enough in itself. Many other things needed to be present alongside verbal commitment. There needed to be genuine support from senior management but even that was not enough on its own. For those of us in the Care Team all our managers authorizing the involvement of staff and supporting the model was crucial.

For some of the agencies even when senior management strongly supported the project it was another matter whether that commitment transferred throughout the whole service. We felt managers needed to model a commitment to collaborative practice.

Middle management, team leaders also needed to be engaged because if we were to be effectively involved in the pilot, our workloads needed to be adapted and for that to happen our involvement needed to be authorised by senior management and practically supported within our team or program setting.

Another area we raised was the processes that occurred about how people became involved in the pilot. One of the Residential care staff raised the issue that those staff employed at the unit when the model was introduced,
were thrown into working within this model. This turned out to be both exciting and stressful as the model placed a lot of demands and expectations for some of us. For other residential care workers employed after the pilot started, it was the reason we chose to work at the agency.

5.6.15 The Steering Committee’s experience

For the Steering Committee some of us talked about how being involved in that Committee was a positive and rewarding experience, particularly the opportunity to get to know people from different programs. We also talked about some frustrations, particularly the infrequency of meetings towards the latter period of the pilot.

Some of us had been involved in the Steering Committee during the initial planning phase. 'The positive outcomes have been a result of the hard and good work that was done in the early planning phases.' It was an important experience to be part of that process, because it gave us a chance to nut out some important issues and get to know each other. Really explore some of the basic principles about how the pilot was going to operate.

Some of us also attended the training provided at the commencement of the pilot and found that a positive and useful experience. There was opportunity for information sharing, building up knowledge about each other’s services, frameworks, and orientations. 'We came out of that training knowing how we were going to facilitate the program.'

5.6.16 The role of external players: the strengths and problems

For some of us in the Steering Committee receiving direction, support and feedback from the Working Together Strategy (WTS) Project Officer (PO) and WTS management was essential for the pilot’s success. At times, we felt
strongly supported by those levels but at other times, that support was missing either because the WTS position was not filled or because (for some of us) the WTS management was acting in a way we found destructive. One comment was that

the PO has been the glue that held the Steering Committee together and some have done this well and some less well.

Some of us had some very strong negative feelings about the wider context within which the pilot operated. The input of senior Departmental staff and their tendency to not consult with us or respect our wishes for example about how the evaluation was to be conducted was raised as a concern. ‘The leadership issue has been a problem. The (Regional) Management Group wasn’t listening at any point to the experience, expertise and professionalism of those involved.’

However, for those of us involved only in the Care Team we rarely mentioned the influence of other structures. Our only reference to the Steering Committee was to say that, ‘...there is no influence from the Steering Committee’and ‘.....in this model the Steering Committee is never mentioned.’

Another issue, which was significant for some of us was the amount and type of orientation we received from our agencies prior to becoming involved differed. Because there was more staff turnover than had been expected it meant that orienting new members happened quite frequently and added another element of pressure for the group to be constantly reforming. Orienting new staff proved to be an added and ongoing task particularly for the co-ordinator.
We all agree this was a successful pilot but it being a pilot also placed stress on us, particularly not knowing when the pilot was going to finish, uncertainty around the evaluation and how it was going to be conducted and being left up in the air about future plans. The issue of involvement in the pilot not being funded became more problematic as time went on and certainly a key issue for some of us when thinking about future involvement.

*There is a lot of potential bitterness from original Steering Committee and Care Team members about the goodwill that was provided to make this work and those resources are not indefinite.*

5.6.17 Future directions

As for future directions, we all felt strongly that it is important that the Enhanced Residential Program model continue as a service delivery option for this client group.

*As a model it's got legs, the legs being that the roles people performed and their personality enabled trusting relationships to develop.*

We raised a number of possibilities of how it could operate. These included:

- continuing in its current form,
- employing specialist staff to be located within a unit,
- the development of a mobile Care Team providing a day program within a cluster of units and
- expanding the model to be used for other populations with complex needs.

We also raised the importance of considering that for a Care Team to function well it needs structures to maintain its functioning and these
include the provision of training that builds up the skills and creativity of the workers.

Promoting such a model also benefits from similar State wide and regional developments being in place and '....the experience that is gained through implementing the model can be taken to a senior level to get structural change that supports that kind of model.' Examples of structural change that are needed were that

"...there has to be serious consideration to how health, welfare, and education deliver services to this at risk client group. This fragmented silo driven mentality doesn't work."

One area that was raised particularly by those involved in the Steering Committee was the importance of positive relationships between those involved in the pilot and with those external committees that sponsor the pilot. Some of us commented that for these types of initiatives to be maintained they need the presence of a position such as the WTS Project Officer to act as the facilitator and driver.

The question of the current nature of mental health services' involvement was raised on a number of occasions. In terms of collaborative practice the WTS has highlighted the problem to bring Mental Health to the table (other than IMYOS),\(^\text{142}\) and although we've got a good understanding of their constraints it's the key that is missing. It is the one weak link in the current Care Team models except for this pilot.' The question was raised as to whether the gains achieved through this pilot will be generalised to other

\(^\text{142}\) IMYOS, is the Intensive Mobile Youth Outreach Service, a team which operates on a regional basis as a CAMHS service and works exclusively with adolescents who have not engaged with CAMHS services. It has been referred to previously in Chapters 1 and 3.
situations within the same mental health service and with other mental health services in the Region.

5.6.18 Thoughtful contributions from one voice amidst the group

As you know Deb, more than one person made most of the comments you have recorded so far, but there were also areas that were raised on one occasion which need to be included because they make important contributions to our story.

One person reflected on the special opportunities that the pilot offered:

_There were fantastic things for example the (pilot's) launch and seeing the kids getting up there and talking, people had never seen the kids in that light before._

A couple of people referred to their experiences entering the pilot once it had commenced. One focussed on the strengths of entering an established 'settled' group that ran smoothly. Another talked about the "complicated experience" of taking over from a colleague who had left particularly someone who had been very valued and '...we all had to find our way through that, which we have.'

There were a number of individual comments made about what components contributed to the strength of the model, '...the holistic nature of the program,' and '...as a collective we're stronger than individuals.' Another person said, '...I believe in the multi-disciplinary approach and the Care Team approach. It fits my philosophy about how to work with young people.' Another person said that they thought

_...a core feature of the model was the philosophy behind it, that care means lots of people caring for the kids._
Other areas mentioned included the importance of ‘...Care Team members needing to feel what they're doing is valued and recognized, supported,’ and having the opportunity to ‘...reflect and evaluate.’

It was commented that this model enabled ‘...workers to feel part of processes and discussions that they weren’t before’ and by another person that ‘...having the Care Team chaired by the resi unit gave the resi unit respect and dignity.’ However, it was also pointed out that for a model like this to work

‘...it takes a level of personal trust and maturity to work through issues and navigate your way through what might work.

There were also reflections about what was needed in the work undertaken with the young people and the importance of ‘...thinking outside the square.’ One of the Education workers described what happened when she was ‘...the person the young person chose to trust, then I got supervision from a clinician, the clinician spends time with (me) and the young person and if they make that link the young person can have individual sessions with the clinician.’

There was also mention of the strategies that were implemented. With one young person ‘...a crisis management plan was developed and used and the young person did not need to be placed in secure welfare.’ In another situation, because the CP worker had

‘...developed strong relationships with the kids. They knew they could trust me. And that meant when we did have to place them in Secure Welfare we could say you're not safe and they said okay and came with me.’

143 Secure Welfare refers to the secure (locked) facility administered by the Child Protection Program where children and young people under the care of CP are placed when they require containment.
One person hypothesised whether what workers were doing in this model was ‘...setting up a good model of parenting (for young people) where normal parenting hasn’t worked.’

The question of whether the Care Teams should have involved the participation of young people and families was raised, with one worker commenting that this should only happen on a secondary basis once the team had developed their therapeutic interventions.

Other comments about structures that were important were ‘...the co-ordinators of the two pilots meeting monthly and it’s been good to share, understanding their philosophy and how they work.’ It was also stated how important it is ‘...to re-visit things in terms of operation. And that’s come out with a couple of issues that have come up with this pilot for example around the funding.’

One member reminded us that, ‘...the learning from the Enhanced Residential Programs is not rocket science to know that people working the way they have will get good outcomes.’ It was also stressed that it can be a ‘time consuming’ way to work although it is ‘...short term loss for long term gain.’ Another person stressed that we need to be aware of how we are ‘...able to replicate (the Care Team model) elsewhere.’ Another perspective was that

144 This contact with Pilot 2 Stage 1's Residential Care Co-ordinator was initiated by Pilot 1's Residential Care Co-ordinator to meet for ongoing peer support something that had never occurred previously (between staff employed by from different CSO's).
‘...it has to be right at the Steering Committee level for the Care Team to work.’

A final comment:

Overall it’s an excellent initiative and I feel very good about being involved with it.
CHAPTER 6: FINDINGS: STORIES FROM THE FIELD - PILOT TWO’S SERVICE PROVIDERS’ STORY

We learnt that more heads are better than one (Pilot 2 Care Team member).

6.1 INTRODUCTION TO CHAPTER

Please refer to the information provided in 5.1, the Background Context to the Enhanced Residential Program as this provides the background for Pilot 2’s development and context. This chapter continues with an overview of the developments that occurred in relation to Pilot 2 throughout the two year pilot period of the Enhanced Residential Program. Following these introductory sections the chapter continues with Pilot 2 service providers stories covering Stage 1 and Stage 2.

6.2 PILOT 2’S ADAPTATION OF THE ENHANCED RESIDENTIAL PROJECT (ERP) CONTEXT

As occurred with Pilot 1, Pilot 2 Stage 1 maintained the original ERP structure as outlined in 5.2 and 5.3 of one Care Team and Steering Committee for approximately a 12 month period. During this time the Care Team met fortnightly although meeting less frequently in latter months. The level of contact that occurred outside these formal meetings was also reported to be intermittent both between the service providers and with the young people. Despite this Pilot 2 Stage 1’s Care Team’s membership remained stable throughout its twelve months of operation.

A significant difference between the two Pilots were the different staffing structures between the two Community Support Organisations (CSO). Pilot 2’S CSO employed a wider range of staff including an Intensive Case
Management Service (ICMS) team funded through the Child Protection Adolescent High Risk Program.\textsuperscript{145} A representative of the ICMS was included in the Care Team which did not occur in Pilot 1 as no such positions existed within Pilot 1’s CSO.

Another critical difference between Pilot 1 and Pilot 2 related to Education’s involvement. Although the CAMH service involved with Pilot 2 also employed DEET staff within their Education Unit they were not made available to be involved with the ERP at either the Care Team or Steering Committee level. Thus Educational representation came from DEET employees from a local school for the Care Team and Steering Committee. Understandably their involvement with the Pilots were extremely limited.\textsuperscript{146}  

The Steering Committee was scheduled to meet monthly but in practice experienced frequent cancellations. Its membership underwent a number of changes from the CAMHS, Juvenile Justice, Child Protection and WTS Project Officer representatives. The dual accountability structures as described for Pilot 1 also applied for Pilot 2.

After what was universally agreed to be an unsuccessful attempt to work within the original ERP structure, at the end of 12 months the CSO management and Steering Committee conducted a review of Pilot 2. The review recommended to the Regional Management Group that the pilot

\textsuperscript{145} The Child Protection Adolescent High Risk Program has been discussed previously in 1.5.2 and 2.5.4.1. The ICMS case managers have case management responsibility for young people on the High Risk Register transferred to them from the Child Protection Program.  
\textsuperscript{146} It was extremely disappointing that I was unable to interview any of the Education representatives involved with Pilot 2 despite making a number of attempts to do so. I did however meet with the Principal from the school established by the CSO in the region which the young people resident in Pilot 2 Stage 2 attended.
should continue but in an adaptation of the ERP. This was approved and Pilot 2 Stage 2 commenced.

Pilot 2 Stage 2 consisted of establishing individual Care Teams for each young person living in the residential unit with their own set of workers. Each Care Team had a core membership from the CSO of an Intensive Case Management Service (ICMS) case manager, the residential care worker supervisor, and the young person’s residential care key worker. The residential care worker supervisor was the only common member across all the Care Teams and this person was also a member of the Review Board. This person was also the only member of Pilot 1 Stage 1 who continued on to become involved with Pilot 2 Stage 2.

Any additional membership of the Care Teams was determined by these core members. Additional members were invited to join the Care Team based on the young person’s situation and needs. At the time the interviews were conducted for the research there were three active Care Teams.\footnote{As at this time there were only three young people placed in the unit.} In one Care Team the additional member was the mental health worker employed conjointly by the CSO and the local CAMHS service in the Mental Health Intensive Youth Support position described previously.

In the second Care Team a private counsellor was included as a member although the person did not attend meetings and the main contact occurred through telephone contact. Previously the Principal from the school run by the CSO had attended this Care Team while the young person was being reintroduced to school.\footnote{During the period of the research being conducted the CSO established a school for the young people under its care. Although the school was staffed by trained teachers it was funded by the CSO, some government funding and support from a philanthropic organisation.} With the third Care Team membership also included
a Juvenile Justice representative, Drug Treatment Service worker and workers from the young person's treatment team at the Juvenile Justice facility where the young person was currently incarcerated.\(^{149}\) All Care Teams met on a fortnightly basis.

Another change that happened with Pilot 2 Stage 2, was replacing the Steering Committee with a Review Board. However the membership of the Review Board included the same programs that had been involved in Pilot 2 Stage 1’s Steering Committee; ie, a representative from the Child and Adolescent Mental Health Service, Drug Treatment Service, Child Protection Program, Juvenile Justice Program, DEET (Education) and the CSO’s Regional Manager and Residential Manager.

An additional member also joined the Review Board; the Manager of the CSO’s Intensive Case Management Service (ICMS). The frequency of these meetings were extremely inconsistent and the membership also underwent a number of changes during their twelve month operation.

6.3 OVERVIEW OF SERVICE PROVIDER INTERVIEWS \(^{150}\)

The Pilot 2 Service Providers’ Story was compiled from material provided in 23 interviews conducted with 24 members of Pilot 2 Stage 1’s Care Team and Steering Committee and Pilot 2 Stage 2’s Care Teams and Review Board.

Pilot 2 Stage 1 Steering Committee Interviews:

- Manager from DHS Placement and Support Services

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\(^{149}\) Unfortunately I was unable to interview the non CSO members of this Care Team due to the lack of co-operation of the CSO case manager, the same person discussed in 4.8.1.

\(^{150}\) These interviews were previously discussed in 4.5.1

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- CSO Care Team Leader/ Residential Unit Supervisor
- CSO Residential Manager
- CSO Regional Manager

Pilot 2 Stage 1 Care Team:

- CSO Care Team Leader/ Residential Unit Supervisor
- CSO Residential Care Workers
- CSO’s Intensive Case Management Service (ICMS) Case manager
- Case Manager from the Juvenile Justice Program (JJ)
- Protective Worker from the Child Protection Program (CP)
- Case manager/clinician (Social Worker) from the Child and Adolescent Mental Health Service (CAMHS)

Pilot 2 Stage 2 Review Board:

- CSO Regional Area Manager
- CSO Regional Residential Manager
- CSO Manager, Intensive Case Management Service
- CSO Residential Unit Supervisor
- Co-ordinator from the Drug Treatment Service
- Regional Manager from Juvenile Justice Program
- Unit Manager from Child Protection Program
- Acting Manager from DHS Youth Placement and Support
- Manager from CAMHS - Psychiatric Nurse
- Working Together Strategy (WTS) Senior Project Officer

Pilot 2 Stage 2 Care Teams

- CSO Residential Unit Supervisor
- Residential care workers from the CSO
- Mental Health Intensive Youth Support worker (joint position between CAMHS & CSO)
- ICMS Case managers from the CSO

6.4 PROFILE OF PILOT 2 SERVICE PROVIDERS

The information received from Pilot 2 Stage 1 and 2’s Care Teams and Steering Committee/Review Board members revealed they were predominantly an experienced and qualified workforce with a high level of previous experience with this client group, extended period of employment within their current agency (and their field of practice), a range of tertiary qualifications and relevant practice experience. Eleven had a tertiary qualification with the most common being social work. Some had youth work and child care qualifications. Two had additional post graduate qualifications.

There were two exceptions to this profile. Within the CSO only one of the six residential care workers involved with the pilot had previous experience working with this client group and all the CSO’s five case management staff
had been employed for less than eighteen months indicating higher staff turnover and less experience than in other program areas.

**TABLE 6.1: OVERVIEW OF PREVIOUS INVOLVEMENT WITH TARGET GROUP AND LENGTH OF EMPLOYMENT IN AGENCY.**

<table>
<thead>
<tr>
<th>PILOT 2</th>
<th>PREVIOUS INVOLVEMENT WITH MULTI-SERVICE YOUNG PEOPLE</th>
<th>LENGTH OF EMPLOYMENT WITH AGENCY</th>
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<td></td>
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<td>NO 6</td>
</tr>
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<td>TOTAL: 22</td>
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6.5 **PILOT 2: THE SERVICE PROVIDERS’ STORY**

Deb, you want to hear the story of Pilot 2 from the point of view of us, the service providers. We are pleased to talk to you about our involvement in this initiative because, as all of us said, it was an ‘interesting’ experience. Now, of course, interesting is one of those words that can describe an incredibly wide range of experiences, so to elaborate further we thought we would tell you our story in the following way.

The first group to tell our story will be those of us who were involved in the first stage of Pilot 2. Then it is over to our colleagues who became involved in Pilot 2, Stage 2 which commenced following the review of Pilot 2, Stage 1. Finally, those of us who travelled with Pilot 2 throughout the entire pilot, which is actually a very small group of people, will come in at the end to give our perspective of the whole picture. We thought it might be easier to organise things in this way because the group of people involved in each of the phases is quite a distinct group and therefore the best ones to capture their specific experience during their period of involvement.
6.5.1 Pilot 2 Stage 1 service providers’ story

As you know, Pilot 2 Stage 1 commenced with the original ERP model of one Care Team servicing all the young people in the unit. This model operated for approximately the first year of the pilot.

What was Pilot 2, Stage 1 like? Some of us talked about it having been an exciting time, a good learning opportunity, and talked about particular aspects that worked well, such as the initial training and learning about different agencies. But for most of us, the most frequent word we used about this experience was frustrating.

Other words were ‘...difficult, hard, haphazard, disheartening, demoralizing, feeling as if we were failures’ and ‘...we felt we failed the kids.’ They certainly reveal the strong feelings that were present. For some of us, the intensity of feeling and distress brought to mind recalling that time surprised us and the relief talking about those feelings was significant. A number of us realised when we spoke to you it was the first time we had talked about our experience and thanked you, for that opportunity.

You see we started out as a group of service providers enthusiastic about becoming involved in this new initiative. We knew we were participating in something new for the region and there was a lot of interest in it. Some of us said we felt proud to be the representatives of our program area in the pilot and that we were 150% behind the initiative.

But, unfortunately, from very early on the pilot ‘...lost its way,’ ‘...things (went) horribly wrong’ and ‘...the original idea of people working directly with the young people from the unit, the Care Team working together as a team did not happen.’
6.5.2 The nature of the difficulties

Problems emerged during the planning phase prior to the pilot commencing. For some of us from the CSO we were concerned that we were not involved with the decision making and planning when we thought we should have been and then found ourselves having to work in a model we didn’t support.

For the residential care workers from the CSO it was frustrating because there were constant delays waiting for the pilot to commence and then everything had to be done in a rush including getting the team ready and completing the renovations on the unit.

One of us from the CSO said,

*The pilot happening was bad timing for the agency because they had lots of other things happening. In hindsight we should have said, let’s slow everything down, do the proper training, get the paper work done, develop clear processes. It was all over the shop. We didn’t do enough homework, enough planning at the beginning.*

For some of us from the external agencies, we were affected during the planning phase by turnover of key management staff that had played a formative role in the early discussions and design of the model at the Steering Committee level. Therefore, by the time the Care Team had to begin operating, there were management representatives who were unfamiliar with the key decisions and understandings that had been reached.

Therefore, many of us on the Care Team felt uncertain about how this new model was to function in practice and felt we were receiving mixed messages. On one hand, there was an expectation by external bodies that we were meant to work out the practical details ourselves without any basic
guidelines to direct us. But on the other we were continually being told what we wanted to do was wrong.

6.5.3 The role of the co-ordinator

Many of us raised the co-ordination of the Care Team as a problematic area. Within the CSO, there was confusion for some of us about whether the ICMS case manager should have been the co-ordinator rather than the residential care co-ordinator. There was also confusion about the co-ordinator’s areas of responsibility.

For many, including the co-ordinator, this person’s availability for the Pilot was a problem as he was required to maintain his supervisory responsibilities at other units, at the same time as running the Care Team (unlike what was happening in Pilot 1).\footnote{What is being referred to here was a significant difference between the two pilots. Pilot 1’s Care Team Co-ordinator was the Residential Care Co-ordinator for the residential unit where Pilot 1 was based. This was a full-time position whereas Pilot 2 Stage 1’s Care Team Co-ordinator was the Residential Care Co-ordinator across a number of residential units. This situation changed with Pilot 2 Stage 2.}

There was confusion about who should chair the meeting, how to chair the meeting and lots of us talked about these endless unstructured meetings where we were trying to be ‘collaborative’, but it turned out pretty chaotic and terribly time consuming.

Some others felt that one of the external workers acted as if they were in charge and influenced who was allowed to attend Care Team meetings, even who was allowed to be included in the group photo taken at the launch which caused ill-feeling and hurt. It was said by someone outside the Care Team that it felt like a ‘closed shop.’ It took ages for basic principles to be
clarified even though many of us thought these general principles were supposed to have been previously worked out.

6.5.4 Issues around the external workers' involvement

Problems developed around each of the external workers' involvement but the CAMHS' worker's involvement was seen as a key issue. This was due to the particular worker turning out to be available for fewer hours than had been expected. The time she was available was used up on attendance at Care Team meetings and secondary consultation. This left little or no time for direct work with the young people at the residential unit, or a capacity to visit the young people when incarcerated or to respond to crisis situations or to negotiate for others from mental health services to provide a service. There was even a different understanding between the CAMHS worker and others about whether the direct clinical service would be delivered at the residential unit or the CAMHS service.

There were a number of issues in relation to the DTS agency's involvement. There were different understandings between the DTS agency's Steering Committee representative and Care Team representative about the nature of the work the Care Team representative should be involved with. There was also a different understanding between the DTS representative and other Steering Committee representatives about what was required of him.

When it came to Education's involvement, we even had difficulties securing a regular representative. A couple of different people came in and out for short periods, which is probably why you weren't successful in managing to speak to any of them. It became an ongoing battle to find someone available
and for the person to be in a position to attend meetings on a regular basis let alone become involved with the young people.

It was a great disappointment to us all that this happened as we saw the involvement of Education as crucial to try to engage the young people in some sort of day activity or to be re-connected into the educational system. We can only imagine that it must have been a very confusing experience for the teachers when they came to meetings because they seemed completely unprepared and overwhelmed by the nature of the task. One of the teachers did not even feel safe to drive to the unit for the meetings and had to be chaperoned by a CSO staff member.

One of the external workers described the difficulties he experienced coming in to join the Care Team which already felt like a group, most of whom appeared to know each other, and this made him feel like an outsider. He expressed concern about the lack of attention given to team building for the Care Team. All these issues contributed to feelings of confusion and ill will.

Even for those of us from the program areas of CP and JJ, who were familiar with the client group and had multiple previous connections with staff from the CSO, many issues arose around clarifying roles and tasks. As one of the CP workers said,

*I didn’t have a hands on role with the kids and I would have liked to because that was a limited role and I felt out of place. In the end I thought my role was useless because I wasn’t doing anything.*

For many of us the issue of balancing our existing commitments and workloads, with our involvement with the pilot caused a lot of stress. This issue was a major problem and impediment to the Pilot’s success. Although
most of us in the Care Team felt that management supported the general
principle of our involvement, at the worker level we were not in the position
to do the work because our existing workloads were not reduced.

6.5.5 Issues for the CSO staff

Those of us from the CSO had a number of internal issues to sort out with
each other. Although Care Teams had previously operated within our agency,
they had not included residential care workers and therefore roles and tasks
needed clarification between the residential care staff and the case
managers.

Some of the residential care workers thought that we should take on case
management functions, (as they did in Pilot 1) rather than involving the
additional layer of the case management staff. For the case management
staff we found it challenging having responsibility for all the young people in
the unit, and preferred the single Care Team model we were used to.

6.5.6 The factors that contributed to our difficulties

To be honest, many of us also felt that there were individuals involved in the
Pilot who were the wrong personalities to do collaborative work and to work
with the type of challenging young people placed in the unit. It felt that we
were stuck with people who either could not, or did not want to be involved.
In addition, there were huge gaps between some of us in relation to the way
we were used to work, even standards of professional behaviour.152

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152 One very colourful example of these differences was a team meeting when a residential
care worker arrived bare footed and wearing a torn t-shirt with what was described by one
of the female (external) members of the Care Team as an offensive misogynist statement
written on it. The worker strongly expressed her disapproval and that she would not remain
in the meeting with the person dressed in this manner. The residential care worker
Some of us felt that a factor that played a significant role in the difficulties the Care Team experienced forming as a group, was the clash between cultures that developed particularly between some of the residential care workers and other Care Team members. The concern about suitability of staff was raised by some of us within the CSO in relation to the residential care staff. We wondered whether it would have been preferable to ask for expressions of interest to be involved in the pilot rather than using, overall, those staff who happened to be allocated to that unit.153

Some external workers felt that the expectations were very high on us, that some team members did not understand the situations we were in within our own agencies, or respect our competing demands. There were also different views about the form of work that should be undertaken with young people as troubled as these were.

As the CAMHS worker, I felt pressure from fellow Care Team members to see the young people for individual therapy because it was seen as the only intervention that was valued and accepted. They did not see any benefit from me providing or organising other forms of intervention such as secondary consultation, professional development activities or training workers to work directly with the young people.

Some of us agreed that individual therapy was not always indicated for these young people but thought some form of direct outreach work was but that would have required people to ‘...step outside their comfort zone’ eventually left the meeting complaining bitterly about his colleague’s lack of a sense of humour.

153 These concerns were in relation to the person mentioned above and another residential care worker who it was felt acted inappropriately towards the young people. Both people were asked to leave the agency before Pilot 2 Stage 2 commenced.
something we all struggled with. We all needed to be more creative, innovative and take risks.

6.5.7 The issue of the young people

One area we did all agree on and mentioned frequently, was our concern about the particular group of young people resident in the unit. We all felt strongly that the particular client mix proved a major limitation to the model’s effectiveness. As one of us said,

*The main reason Pilot 2 Stage 1 fell over was that there were 4 clients all highly active in the criminal sphere within the same activity, so they just fed off each other, it just didn’t work. It came back to the selection of the clients in the first place.*

This group of young people was re-offending continually and therefore in and out of custodial care. Some of us described them as young people with conduct disorders who were not able to use the type of services provided by the Pilot and because of their presentation and continual re-offending there was no time to engage therapeutically with them. It was only crisis work that was able to be undertaken.

*The model needs to be matched appropriately with young people who are at the developmental level where they can engage with services.*

Some of us were critical that the four young people were placed in the unit at the same time rather than staggering their placements, as is common residential care practice. Some of us felt so strongly that we said ‘*Having the four of those clients together in the one unit sabotaged it from the beginning.*’ ‘*It was destined to fail.*’

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154 Examples of the frequency of the young people’s re-offending were that for 6 months during the Pilot’s operation one or other of the residents were incarcerated with one period when all 4 were incarcerated at the same time.
The issue of the selection of the clients was a particularly charged issue. Many of us involved in the Care Team and Steering Committee strongly voiced our concerns about this combination of young people being placed in the unit at the time but felt our opinion was disregarded. We felt ‘...not listened to,’ ‘...we didn’t have a say in the kids we took in (while) Pilot 1 had the opportunity to vet their referrals.’

One of us saw the issue of the placement of these young people in Pilot 2 as reflecting the reality of the pressure that CSO’s are placed in. ‘Young people were placed in Pilot 2 because the system didn’t have anywhere else to put them.’ This was a theme a few of us raised, that this CSO was often given the most difficult young people in the Region to care for, something which was seen as a compliment to the skills of the staff and their commitment, but was also experienced as being "dumped" in difficult (and unreasonable) situations and expected to cope.

6.5.8 What about the families?

A number of us said it was a real problem that there had been a lack of engagement with families.

We hadn’t connected with families. It’s one of the things that made us wake up that it wasn’t working. We’re still a bit stuck on a professionals’ model as opposed to how we engage young people and families in the process.

6.5.9 Feeling unsupported

Many of us identified that a common feature of the experience of being involved in Pilot 2 Stage 1 was feeling under pressure and unsupported within a number of relationships. Some Care Team members felt pressured and unsupported by each other. As a group the Care Team felt pressured and
unsupported by the Steering Committee, which resulted in a strained relationship developing.

In the Care Team we felt strongly that the Steering Committee did not listen to our concerns and did not provide the leadership and support we required.

_We felt pressure from the Steering Committee, to come up with solutions. Everything had to be run down by them. The Steering Committee were getting the minutes of the Care Team meetings. / The Steering Committee were of the opinion that we were making a mountain out of a molehill, the pressure was there, that we had to make it happen._

Some individuals within the Care Team did not feel supported by their particular managers. Some of us on the Steering Committee felt pressured by our seniors and from other external groups. One person described feeling ‘...my loyalty was continually questioned and I felt torn between all the groups.’

6.5.10 The Steering Committee experience

For those of us on the Steering Committee there was a range of reactions to the experience. Early on there was a positive energy and commitment to the pilot but as time moved on we felt increasingly frustrated by cancelled meetings, emerging conflict, and, at times, confused and frustrated by the Care Team’s inability to work more autonomously and it’s need for direction.

One thing all of us (in the Steering Committee and Care Team) raised with considerable feeling was the performance pressure, the constant feeling of having to ‘...get it right.’ ‘We all felt watched,’ ‘...all eyes are on you,’ and ‘...one pressure corrupted the other.’ Many of us felt there was an overall lack of commitment to the pilot.
6.5.11 Being compared to Pilot 1:

Part of the pressure was the constant negative comparisons made between ourselves and Pilot 1. ‘There was Pilot 1 who were going great guns, they were faultless.’ ‘We felt like the "poor cousins."’ ‘There were constant reminders about how different their experiences were. ‘One was seen as being on track and the other as not which was too simplistic because they were completely different.’ This made our situation even more difficult.

6.5.12 At the end of Pilot 2 Stage 1: reflections on the experience

A number of us spoke about how badly things deteriorated towards the end of Pilot 2 Stage 1. ‘There was a lot of cynicism, conflict, there wasn't even a group meeting. In the end it got pretty shitty.’ One of us who joined at the time commented on how ‘...there was a lack of commitment, they were beating their heads against the wall with the kids there and had lost heart.’

Reflecting back on the experience we had different opinions about whether there were any positive gains from this experience. Some of the residential care workers felt that ‘...Pilot 2 Stage 1 although with lots of problems was still better than what previously existed’ that ‘....there were components of the model that did work’ 155 Others felt that the clients were getting less service and not as good quality service than they would have prior to the pilot.’

155 Examples provided by the service providers about how Pilot 2 Stage 1 was better than what existed before predominantly related to improvements for the service providers. These included undertaking the specific training provided, gaining an increased understanding about each others’ agencies, examples of working well together within the Care Team, residential care workers contribution being acknowledged and becoming more empowered. In relation to direct improvements for the young people only one service provider mentioned a positive achievement which was engaging the family of a young person which had not occurred previously.
All of us agreed that the model that had operated in Pilot 2 Stage 1 had been beset with many difficulties. Some of us wondered whether if these problematic areas had been addressed, could Pilot 2 Stage 1 have worked?

6.5.13 Pilot 2 Stage 2: a new model

It's time now to handover to our colleagues who became involved with Pilot 2 Stage 2 and let them have their say.

So, what was Pilot 2 Stage 2 like? All of us felt that the Care Team model that operated during Pilot 2 Stage 2 was a very good model. We thought that

...the lessons of Pilot 2 Stage 1 have been learnt. In Pilot 2 Stage 2, It's getting there. It is working well, it's a dedicated committed team. / Pilot 2 Stage 2 is terrific; I am enjoying it, we've got it right this time.

6.5.14 Characteristics of an effective Care Team

What we saw as working best about Pilot 2 Stage 2 was that it was effective. It was co-ordinated and provided a focussed better service. The Care Team meetings played an important role in achieving these outcomes, particularly their being held fortnightly, having a structure and not being too large. They provided us a place where strong relationships were built and sustained.

We developed common and clear goals and objectives in our work with young people and we became more informed about the different service systems, frameworks, personal styles and cultures that we came from. It was a place where we could ensure that the specialist services young people needed were accessed for the period required.
We found a good Care Team model promotes increased clarity about roles and responsibilities and opportunities for offering and receiving support. Workers are able to develop a sense of joint ownership and shared responsibility for the young people. We worked from a common plan and therefore felt we were more accountable for our practice.

We learnt that more heads are better than one. We learnt a particular strength of Pilot 2 Stage 2 was having a residential care key worker who comes to meetings, because of their knowledge and involvement with the young people. We found that working in this model results in improved and clear communication between workers and with young people and families, which is extremely important with this client group. In Pilot 2 Stage 2 we feel that the communication and contact with families has improved and there has been an increased ability to engage with families and address issues with them.

We also saw improved outcomes occurring with the young people involved in Pilot 2 Stage 2. They are receiving an individualised service, are engaged with services and accessed services. They have become more mature. Some have returned to attending school\footnote{All to the school which had been recently established by the CSO.} and were making other positive changes in their lives.

As some of us from the CSO pointed out, Care Teams were not a new concept for our agency, and we had a preference for the Care Team model
that preceded the ERP, which was more fluid regarding membership and frequency of meetings.\textsuperscript{157}

Others saw Pilot 2 Stage 2’s Care Team model as an improvement because they automatically included residential care workers, introduced the key worker system, were more structured with regular meetings and paper work. We also saw there were still further areas that could be strengthened.

6.5.15 The Review Board

A number of us raised concerns about the operation of Pilot 2 Stage 2’s Review Board. Some questioned the purpose and need for the group at all, expressed concern about the frequency of cancelled meetings and poor attendance. One of us did not know that there were CAMHS and D&A program representatives because they had rarely attended. Some felt the Review Board needed to take more of a role as the driver.

6.5.16 The perspective from those who travelled the whole distance

What is there left to say from those of us who travelled with Pilot 2 through all its journeys? We agree with all our colleagues’ comments. But from our perspectives there are some areas that we would like to comment on.

We agree that for a Care Team to be effective it needs to have the active involvement of mental health and education services.

\textit{You can’t underestimate the importance of the mental health clinician’s role within the Care Team. It is crucial and the importance of someone like (the

\textsuperscript{157} Examples provided were that in some situations a Care Team consisted of the case manager and one other person. In other examples meetings were called only when necessary therefore had the flexibility to meet a number of times a week or not at all.}
CAMHS member in Pilot 1) who spanned management and clinical work being in that position.

It is particularly critical for education to be involved with this group of young people and to have the correct education staff involved.

Education is an area that continues to need more work. Keeping the ball rolling with education about how it can happen that more kids are involved in alternative educational experiences.

We believe there needs to be further clarity around what constitutes a Care Team model. One of us commented that:

..while Pilot 1's model has worked I don't believe that's a model that should be adhered to. If you call it something else, a development and support mechanism but for the young people I don't see it as a Care Team. It's a really good structure for secondary consultation for a set group of staff. When I talk about a Care Team I mean individual constructions for young people.

Another of us felt that:

The core feature was about getting services to work well together and not training resi staff as being therapeutic mental health workers or hands on drug and alcohol workers but training them, educating them as to what these services do, better ways of managing clients.

A few of us also spoke about regretting not having spoken up earlier and with more force about the problems Pilot 2 Stage 1 faced. We felt regret about what the workers went through and almost surprised at how restrained we had felt to say something at the time. 'I suppose as a manager I should have pushed it because the buck stops with me.'

6.5.17 Future recommendations

Looking to the future, we all recommend that at the minimum the Care Team model should continue and operate within all residential units. We also raised
other options such as the model being expanded to include a day program, the membership widened to include other professionals or used to provide services for other children and young people who ‘...don’t fit the mould.’

In terms of a wider vision other reflections included:

...I have a view that you don’t develop models, you employ an agency and you say here are the clients, here is the money. Once you design models the really hard kids are going to get kicked out. The funding providers need to show faith in the providers to design and provide models that are going to be best for those young people.

And another,

In terms of policy direction there needs to be some commitment to the Care Team approach or whatever it’s called that comes out of these pilots, that it does indicate that collaborative form of case management is a practice standard and what will flow from that is the legitimization, the training and it becomes second nature for people.

And some final thoughts about the impact of the ERP;

Things are better than they were 12 months ago and they were better than they were 2 years ago and it can get better if we keep working together.

Being involved on a Care Team ‘...makes people think about good practice because people come from their own perspective of what is effective and in that diversity being close to others’ expertise and bouncing around, sharing ideas it’s a very positive thing and you can think outside your own box and experiences.’
CHAPTER 7: FINDINGS: STORIES FROM THE FIELD - THE REGIONAL MANAGERS' STORY

The good and respectful relationship is the key, developing relationships and looking after them (Regional Manager).

7.1 INTRODUCTION TO CHAPTER

This chapter consists of the findings gained from the interviews with representatives involved with the Working Together Strategy's (WTS) Regional Management Group. This was a committee that held overall governance for the operation of the WTS in the Region.\textsuperscript{158} The Regional Management Group was chaired by the DHS Regional Director. Its membership consisted of representation from all the WTS partner programs, Child and Adolescent Mental Health Services, Drug Treatment Services, Education, the Department of Human Services program areas, Child Protection, Juvenile Justice and the representative of the Community Support Organisations operating in the Region.

In addition there was representation on the Regional Management Group from key programs within the DHS Regional Office, Community Care and Youth Placement and Support. The Regional Management Group met monthly. The membership of the group was fairly stable throughout the ERP's two year pilot period with the change of personnel occurring within the Juvenile Justice Program representative and the representatives from Community Care and Youth Placement and Support.

In relation to accountability structures, the members of this Committee also occupied and participated in a number of different structures. Although a

\textsuperscript{158} As described in 4.3 there were approximately 15 WTS activities operating however the ERP pilots were the most ambitious and successful.
number shared the same line management (the DHS Regional Director) the non DHS partners had their own structures. However what these members all shared was that they were the line managers for the middle managers and service providers involved in the Steering Committees and Care Teams for the ERP Pilots.

7.2 OVERVIEW: THE REGIONAL MANAGERS’ STORY

The Regional Managers’ Story was compiled from the material raised in the seven individual interviews undertaken with regional managers and the Working Together Strategy (WTS) Project Officer. Those interviewed consisted of representatives from the following program areas involved in the WTS Regional Management Group:

- A Regional Director from one of the Community Support Organisations (CSO) who was the CSO representative on the Regional Management Group (this person was the Director of Pilot 1’s CSO)
- A Senior Manager from the Child Protection Program (CP)
- Child Psychiatrist - one of the two Child and Adolescent Mental Health Services representatives (CAMHS) on the regional management group (this person was the Director of the CAMHS involved in Pilot 1)

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159 The WTS PO was included as although she was not a member of the RMG she attended the RMG meetings and was a member of both the Steering Committee of Pilot 1 and the Review Board of Pilot 2.
160 The only Regional Manager representing a WTS program area who was not interviewed was the Drug Treatment Service representative due to the individual’s unavailability during the time of the interviews.
161 This person was not the Regional CP Manager but a Senior Manager nominated because of her links to the Adolescent Teams involved with the ERP.
- The Juvenile Justice Regional Program Manager (JJ) (also on Pilot 2’s Review Board)

- The Department of Education Employment and Training Regional Director (DEET)

- Two from the Department of Human Services - Community Care Manager and the Acting Manager Youth Placement and Support - the latter on Pilot 2’s Review Board

- The Senior Project Officer of the Working Together Strategy - also a member of Pilot 1’s Steering Committee and Pilot 2’s Review Board.

7.3 REGIONAL MANAGERS PROFILE

The information received from the Regional Managers revealed they were a highly experienced and qualified group who had a high level of previous experience with this particular client group, had extended periods of employment within their current agency (and their field of practice) and possessed a range of tertiary qualifications and relevant practice experience. Interestingly only one had a higher degree qualification.

TABLE 7.3: OVERVIEW OF PREVIOUS INVOLVEMENT WITH TARGET GROUP AND LENGTH OF EMPLOYMENT IN AGENCY.

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7.4 THE REGIONAL MANAGERS’ STORY

We are pleased to talk to you about the Enhanced Residential Program because it is an initiative that we have been particularly interested in. Some of us were present at the first discussions to establish a Working Group to address this issue. All of us are interested to hear how the pilots have worked, the results of the formal evaluation and your research and what we will learn for future planning.

We have been pleased and enthusiastic with the developments to date. One of us described it as a ‘...fantastic initiative because it fosters working together practically rather than just talking about it.’ Some of us said that ‘...both the Pilots are exciting, going well, been run well’ and providing ‘...holistic service stuff (which) is a gem.’

7.4.1 The Core Feature of Inter-sectoral Collaborative Practice

The area we raised most frequently in the interviews with you was what we see as the core feature of inter-sectoral collaborative practice; the development of a sense of shared responsibility and joint ownership towards the young person. This is a crucial shift to what has previously existed. For those of us who felt that we could comment, we were aware that this feature had developed within the ERP pilots.

7.4.2 Core Features of Successful Care Teams

We also identified the core features of successful Care Teams:

- They provide a place where members share information, perspectives and beliefs,
They provide a place where members inform each other about interventions, conceptual frameworks and service delivery models utilised within their home program.

They provide a place where the process of sharing enables an increased understanding about the needs and issues of the young person they are working with.

When working well, they provide a more focussed and integrated, joint problem solving approach.

They provide a place where a shared appreciation of outcomes is developed and a shift occurs as members move to ‘...see yourself as part of a group working together, making decisions.’

The Care Team develops a group identity.

Successful Care Teams have a co-ordinator who, amongst other tasks, takes responsibility for integrating the various groups involved. It was felt that Pilot 1 was a good example of how this can be achieved.

They provide a place where members develop strong team relationships. They develop trust and respect and the maturity to work through issues, manage, and deal with conflict. ‘The good and respectful relationship is the key, developing relationships and looking after them.’ However for this to be able to occur, ‘...consistency and continuity of staff are important.’

Once again, those of us who felt we knew about the functioning of the pilots believed that they had successfully developed some of these characteristics.
7.4.3 What Care Teams Offer - the impact on service delivery for young people and families

As for the impact of the ERP model on service delivery, this was not an area we discussed as much as other areas. However, those who did comment saw a number of positive features have occurred:

*These young people are being worked with, with more engagement,*

*These placements aren’t breaking down*

*Because workers feel more supported (in this model), they work more effectively and therefore interact better with the young people and the young people would feel that.*

*You need input from different sectors, no one can help them on their own and you need the different strengths and the only way to do that in a coordinated way is through a Care Team.*

Some of us were not sure whether this approach has improved services for the families of the young people although we hoped they had received benefit from being involved with the Care Teams.

7.4.4 What Care Teams Offer - the impact on workers

In relation to the impact of this model on workers it was commented that Care Teams provide:

- Support

- An opportunity to develop an understanding about other team members’ services, the services' strengths, weaknesses and limitations

- Promote clarity about roles and other issues.

- 'Care Teams pull professional responsibility into them'
For the residential care staff it provides useful learning. The residential care staff have been given strategies to work with the young people which were particularly important as the main service delivery occurs through them.

We thought these changes had happened with the ERP pilots.

7.4.5 The Contribution of Different Program Areas

One issue we saw as central to the success of Care Teams was the involvement of Education and Mental Health. Education providers play a crucial role with this group of young people and it was positive that Education had begun to come on board with the pilots.

The mental health contribution needs to consist of the mental health worker’s direct involvement with the young people as this ensures a respectful relationship developing with the other team members. This also means that a secondary consultation relationship is more likely to work. Others commented that the mental health contribution that occurred in Pilot 1 was: ‘...excellent, (the worker) has been very involved, committed, passionate and promoted the ERP.’

It was questioned, ‘...whether Pilot 1’s mental health worker's interest would be transferred to others from within Mental Health services’ particularly as ‘...Mental health has always been the area that has been less inclined to accept the assessments of others particularly residential care workers.’
Others felt that positive 'spin-offs' had already occurred particularly between CAMHS and CP.\textsuperscript{162}

7.4.6 Management’s Contribution

From the management level:

- Managers need to demonstrate leadership, modelling and prioritising working collaboratively to enable the individual practitioner to have the space and freedom to work in this way. Particularly as Care Teams are more work and time consuming. Management ‘...needs to demonstrate commitment to the model to the people delivering the model.’ There was also an acknowledgement that management representatives themselves need to work on their collaborative relationships with each other.

- Some of us pointed out that it was critical that middle management (team leader) level also demonstrated leadership in the principles of collaborative work practices.

- There needs to be ownership and support ‘...throughout the food chain' for collaborative practice.

\[\text{At all levels people need to be willing to take risks and give things a try.}\]

Some of us also commented that increased commitment needs to filter down from the Regional Management Group (RMG) to others in the Region for this

\textsuperscript{162} As an example the CP Regional Manager and one of the CAMHS Directors have commenced regular meetings to discuss issues, shared cases and model to their staff their commitment to collaborative approaches.
way of working and the role of the RMG was to establish a level of trust in relation to the initiative.

Another participant expressed the view that collaborative practice is developed at the practitioner level but need credibility and a mandate through their agency up to the regional and state wide programs to ministerial accountability.

7.4.7 The Region’s Contribution

We thought pilots like the ERP's gained support from other regional initiatives. These were now occurring in our Region replicating the Care Team principles of people willing to come together and jointly plan and care for young people. We all thought further progress was still needed in this area.

7.4.8 The Importance of an External Driver

A number of us discussed how these initiatives need a driver, a facilitator to become successful and keep them operating. The Working Together Strategy Project Officer had performed this role for these pilots.

Yet the person in the PO position said the role had been a complex one. Some people have commented to her about the centrality of this role, while at other times members of the pilots have said she had no role to play in them at all. An issue for the PO was that

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163 Examples provided were the Southern Consultancy Panel and Looking After Children initiative.
...at no stage have I got to the service delivery stuff. I have never seen the
resi units, never been invited and if I had that may have made the work a bit
different and more meaningful.\textsuperscript{164}

7.4.9 Outcomes of the initiative

Some of us commented that as a result of this initiative a number of
program areas have embraced the use of Care Teams including other
residential care services. They are \textit{'now seen as the way to work with young
person with multiple issues, a more developmental way and the way we should
work with every young person.'} It was raised that multidisciplinary teams
may be the future direction needed for residential care services.

7.4.10 Future Directions

In relation to future directions some of us expressed the view that for
collaborative practice to become part of core practice, the Region has to
decide whether this is a way of working they support. Some felt we need
\textit{'...collaborative energy in the Region'} and a structure to keep it alive so that
it becomes systemic. If it is not \textit{'...it will be tagged onto our jobs and will fall
over.'}

One of us expressed concern about the gaps that exist in relation to our
general understanding about the practice of collaboration.

\textit{We've got people who can articulate the broad policy but we're bereft of
ideas about how we can do it and what works. We know what doesn't work
but can we actually say what are emerging models of good practice in
Australia, in other countries, a research base that comes up with
alternatives. How do we disseminate that information?}

\textsuperscript{164} This comment surprised me as it reflected a different type of involvement than mine had
been when employed in this position.
Another person identified that;

Long-term it’s about incorporating (collaborative practice) into training for all professions to support the attitudinal shift that is required within systems.

7.4.11 Thoughtful contributions from different voices amidst the group

Most of the comments you have recorded so far were expressed by more than one member of the group. However there were also comments raised by one person which make an important contribution.

One member spoke in depth and with passion about the wider shifts the education system needs to make for this group of young people. These include the need for schools to take on the role of being collectively responsible for education being provided to all young people in the community including those not currently involved in school. This would involve the need to deliver educational services differently, to make the shift to thinking an educational service can be provided anywhere and anywhere. There are examples within the Region where resources have been used differently and creatively to achieve this aim.165

Which DEET staff should be accessed to become involved in pilots such as the ERPs was important. Those involved in the two pilots had come from two different sources; Pilot 1’s staff were attached to a CAMHS and worked across schools while Pilot 2’s staff were teachers based within a school with teaching duties. The first model was seen as preferable.

165 For example some DEET staff have been based at an outreach location while retaining access to professional development, support and other DEET structures. This model is seen as an exciting model of partnerships developed between DEET, funding from a philanthropic organisation and DHS and was seen to be preferable to other models where alternative schools are established outside DEET’s auspice.
Another person reflected on the strength of the ERP was that it allows workers to start where the young person is functioning, acknowledge their developmental needs and promotes maximizing all the influences in their lives such as their peer group and significant adults.

Another area discussed by one member was that the experience from the pilots raised the importance of initiatives needing to fit in with what is already operating within an agency rather than imposing a very different structure. It was felt that this was what had occurred in Pilot 2 Stage 1 when a completely different way of operating a Care Team was imposed on an agency that was comfortable with their existing model. It was felt to be particularly problematic for the case management staff from the CSO to manage this new model.

Another member commented on the difficulties that can impact on Care Teams being able to do their work when their members come from complex work environments, particularly those that have difficulties making people available. For teams to work effectively they require team building activities before they commence, regular meetings where progress can be discussed and reflection occurs. What also strengthens teams is having members who can be flexible, demonstrate good will and perseverance.

The question of the membership of Care Team was also discussed; whether they should consist of professionals only. One person expressed concern about parents being excluded and stressed that without the young person and parents present Care Team meetings can only have an advisory not a decision making component.
It was also raised by a member that what needs to be present for collaborative practice to be achieved is that at all levels people need to be willing to take risks and give things a try, that there needs to be formal structures, formal mechanisms and formal ownership to support the contribution in a practical, policy and philosophical sense.

One person also raised the warning about pilot initiatives, stating that planning how it will keep going long-term needs to be thought about before it begins because ‘...if you start something good then stop it, it can cause disenchantment and angst.’

Some final words;

There have been changes and shifts but there needs to be more. The role of the WTS in this region has been important and has begun to change things across the region.’ What is also required is ‘...being able to keep the gains that have been achieved because of the WTS going - shared case management, shared responsibility for the young people, the strength to think outside the square, take risks, give things a shot.'
CHAPTER 8: FINDINGS: STORIES FROM THE FIELD - THE YOUNG PEOPLE AND PARENTS’ STORIES

When you needed someone to talk to they were there (Young person Pilot 1).

8.1 INTRODUCTION

This Chapter is organised into two sections. In the first a summary of the profile of the young people is presented. The profile information was collected from two sources. For those young people interviewed the information was provided by them and their parents. The detail provided about the young people who were not interviewed was provided predominantly by their case managers.

In the second section the young people and parents involved with the Enhanced Residential Program tell their stories commencing with the story of the parents and young people involved with Pilot 1 followed by the parents and young people involved in Pilot 2 Stage 2.

8.2 PROFILE OF YOUNG PEOPLE INTERVIEWED

As stated previously nine young people were interviewed:166

☐ Seven out of the nine young people were involved with Pilot 1;

☐ Two of the four young people were involved with Pilot 2 Stage 2. 167

The following table provides information regarding the nine young people who were interviewed regarding their age, resident status, length of stay in unit,

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166 Previously outlined in 4.5 and 4.6.3
167 As stated in 4.6.4, 4.8.1 & 4.8.2 unfortunately none of the four young people involved in Pilot 2 Stage 1 were interviewed.
number of previous placements and location following their exit from the units involved with the Enhanced Residential Program (ERP) pilots:

TABLE 8.1: PROFILE OF THE NINE YOUNG PEOPLE INTERVIEWED.

<table>
<thead>
<tr>
<th>AGE AT TIME OF INTERVIEW</th>
<th>18</th>
<th>17</th>
<th>16</th>
<th>15</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENT STATUS</th>
<th>Current residents</th>
<th>Previous residents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LENGTH OF STAY IN UNIT</th>
<th>0-12mths</th>
<th>1 yr - 2yrs</th>
<th>2yrs +</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF PREVIOUS PLACEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>lived in one previous placement</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBER OF PREVIOUS PLACEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>lived in 5-20 placements</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION FOLLOWING ERP UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>with family</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION FOLLOWING ERP UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>with partner</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION FOLLOWING ERP UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>in custodial care</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

8.2.1 Age:

The young people were aged between thirteen and seventeen years when they lived in the residential units. This is a common profile.

8.2.2 Resident Status:

Four were current residents (three from Pilot 1 and I from Pilot 2 Stage 2) and five were previous residents (four from Pilot 1 and I from Pilot 2 Stage 2). The four current residents had been living in the units between five and twelve months. The previous residents had lived at the units for periods
between four months and in excess of 2 years. My understanding is that this is a longer period than usually has been the case with this client group.

8.2.3 Number of placements in residential units:

All the young people had previous placements in residential units. Five had lived in between five to twenty residential units throughout their lives and four had lived previously in one unit. This is a common profile.

8.2.4 Living circumstances for the five that had left the residential units:

One young person was completing a custodial sentence before being placed in an adolescent community placement. His case manager described this as a promising development for a 16 year old with a long history of placement difficulties. The remaining four had left the units to live with family members, or were living independently with a partner. (This number increases to seven when including the outcomes in this area for three of the young people who were not interviewed.)

All the workers commented on how unusual and exciting this aspect of the profile was. Most young people placed on the high-risk adolescent register and placed in these units do not leave the units to return to reside with their families or successfully manage a transition to independent living.

This outcome was appropriately seen as one of the most exciting and important outcomes for the pilots. Particularly as many of the young people were estranged from their families prior to their placements and therefore two important and complex steps had been achieved, firstly resuming contact and then re-building the relationships to the point where reunification was possible.
The following table provides information about the outcomes for the young people regarding their involvement in school or work and with specialist services.

**TABLE 8.2: OUTCOMES FOR THE 9 YOUNG PEOPLE.**

<table>
<thead>
<tr>
<th></th>
<th>INVOLVEMENT WITH SCHOOL/WORK</th>
<th>INVOLVEMENT WITH SPECIALIST SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIOR TO UNIT</td>
<td>YES 2</td>
<td>NO 7</td>
</tr>
<tr>
<td></td>
<td>YES 5</td>
<td>NO 3</td>
</tr>
<tr>
<td>DURING PLACEMENT IN UNIT</td>
<td>YES 9</td>
<td>NO 0</td>
</tr>
<tr>
<td></td>
<td>YES 9</td>
<td>NO 0</td>
</tr>
<tr>
<td>AFTER LEAVING UNIT (5)</td>
<td>YES 5</td>
<td>NO 0</td>
</tr>
<tr>
<td></td>
<td>YES 3</td>
<td>NO 2</td>
</tr>
</tbody>
</table>

8.2.5 Educational and vocational outcomes.

This was also an area where considerable gains had been achieved by this group of young people. At the time they entered the units seven out of the nine were not attending school which considering that six out of the seven were well under the school leaving age (and had not been attending school for some time), although common to this client group, is highly concerning. During their placements at the units, the two attending school were maintained at school and the other seven were re-enrolled either in school, other forms of day programs, other forms of training such as TAFE courses[^168] and commencing employment.

[^168]: TAFE are educational institutions offering a range of further education courses.
In Pilot 1 the young people attended the program set up at the unit by the Education staff as either a preliminary to the process of re-engaging with school or following unsuccessful attempts. In Pilot 2 the young people attended the CSO’s school.

For the five young people interviewed who have left the ERP units, one continued her employment, completing an apprenticeship and moving into a more secure employment situation and four were attending courses at TAFE some of which had been arranged while they were living in the units. (This number increases to six attending a TAFE course when including two of the young people who were not interviewed).

Once again these were different and important achievements to the usual profile both in relation to what occurred while the young people were placed at the units and following their departure. It is particularly commendable that the gains the young people achieved at the unit in relation to their education and employment were able to be maintained since leaving when the young people were relying predominantly on their own (and their family’s) resources. It indicates that the changes that had been achieved had been able to be sustained and generalised which is an important indicator for longer term outcomes.

8.2.6 Involvement with specialist services.

At the time the young people entered the units five out of the nine stated they were involved with the following specialist services, Mental Health, Drug and Alcohol Services and Education/employment services. Three said they were not involved and one could not remember. The service providers pointed out that as some of these contacts were inactive, they would have
put the number at less than five. During their placements all nine had contact with workers either those involved with the model or continued contact with existing workers.

Since leaving the units three of the five young people continued their contact with these program areas but not with the same agencies that had been involved with the ERP. The explanations given for this were that the young people had moved out of the agencies' catchment areas. It would seem from this outcome that increased access to specialist services had been achieved whilst in the unit which was a successful outcome. In relation to the contact that had occurred after leaving there were some improvements in this area which the young people and parents felt were based on the positive experiences they had with these workers when living in the units.

As this was one of the central goals of the pilots it was an accomplishment that this result was achieved and it is hoped that the young people continue to feel that contacting professionals is a viable option for them. However it is a concern that none of the contacts established during the placement in the unit were continued and while there may be a number of factors that contributed to this result it is an outcome that needs to be noted.

8.3 PROFILE OF YOUNG PEOPLE INVOLVED IN PILOTS BUT NOT INTERVIEWED

Although over 50% of the young people involved in the pilots had been interviewed, I could not presume that the circumstances of these young were representative of all the young people involved with the ERP. I was therefore keen to gather whatever information I could about the other young people's circumstances from the service providers, one of the family members I interviewed and the evaluation document of the ERP produced by
the Department of Human Services (Victorian Government 2004a) Although
not a primary source of information the details I gathered provided an
important contribution to understanding the outcome of the ERP model for
all those involved and therefore are included in the following section.

8.3.1 Gender balance:
As mentioned in Chapter Four, although the gender distribution of the young
people involved with the ERPs was close to even, with eight males and eight
females, my interview group was highly skewed. Eight of the nine young
people I interviewed were female; the eight I did not interview were all
male. Another imbalance was that although three of the eight young people
I did not interview were seen by the service providers and a family member
as having made some positive gains in their lives, those who agreed to speak
to me were seen as having experienced the most positive outcomes from
their involvement with the Pilots.

It is interesting to reflect on why the interview group I ended up with were
predominantly females or more specifically why the females within the pilots
had more positive outcomes than the males. One factor why this particular
group spoke with me may have been that they were currently living in more
settled circumstances that enabled contact to occur.

The fact that they were all involved in some sort of educational or vocational
activity may have contributed to their confidence and social skills to feel
comfortable to talk to a stranger. The fact that they had had predominantly
positive experiences from their involvement in the pilots may have made
them more willing to speak to me and contributed to wanting to have their
stories told.
Certainly when I explained that I had hoped to find out from my discussions with them an increased understanding about the experiences of young people in residential care, they expressed enthusiasm to participate and acknowledge the positives they had received, point out the areas that still needed attention and give back something to both the people that had cared for them and for other young people who may be travelling a similar road.

As stated previously in Chapter 4, it is important to state that out of the eight young people not interviewed it was not the young people themselves who refused to be involved. Four were not approached, one because he was interstate and his current location unknown and three because their case managers did not think their circumstances were suitable for their involvement. The other four agreed but with three access was denied by the gate keeping staff at the custodial and treatment centres they were incarcerated in at the time and one became too unstable for contact to occur. Thus the barriers were as much a result of their circumstances and the increased obstacles that needed to be manoeuvred.

8.3.2 Lack of input to research from Pilot 2 Stage 1’s young people:

A particularly unfortunate imbalance was that I did not have the opportunity to interview any of the four young people involved in Pilot 2 Stage 1. From the reports received it was this group that the ERP had the least impact on. All four had not been attending school prior to entering this unit and had limited or no contact with specialist services during their placements. In fact their profiles remained the same (none engaged in school or any structured day activity, none engaged in any meaningful way with the specialist workers and their legal circumstances continued with repeated periods of incarceration).
In the time that had passed since Pilot 2 Stage 1's operation the profiles of the young people have unfortunately followed the common trajectory expected for this client group with all four currently incarcerated at the time of interviews with some having 'graduated' to adult facilities and more serious offences.

8.3.3 Profiles of the four young people not interviewed:

With the other four young people who were not interviewed, three were seen to have made positive changes in their lives. One was living interstate and although little information was known about his circumstances it was understood that he was not currently incarcerated and living independently. Another young person had left the unit to live with his family and despite concerns about whether this situation would be able to be maintained had remained there for some period and been attending a day program. At the time of the interviews he had voluntarily arranged an inpatient admission at a substance abuse facility but was expected to return to his family afterwards.

Another young person was living independently with a partner and child and had recently commenced a TAFE course. At the time of the interviews he was experiencing some resurgence of his substance abuse habit, which his case managers were providing support for.169 The final young person was a current resident in one of the ERPs and had not been interviewed as he was placed in a youth training facility at the time and was seen by his case manager to be too unsettled to manage the interview.

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169 Both these young people had agreed to be interviewed but due to their instability at this particular time the interviews were not able to be arranged. However the way in which they both had handled their current 'hiccups' were to be commended as they had sought treatment and support.
It is disappointing that the part of the ERP story that remains untold is from those young people who did not have as demonstrably positive outcomes as their peers. That, of course, may not mean that they still did not find the experience useful in some way, or not. Unfortunately I do not have the benefit of their words to assist me in understanding this aspect.

8.4 INFORMATION ABOUT FAMILY MEMBERS

No demographic material was collected from the family members interviewed as that was not the focus of this research. Of the eight parents interviewed all were parents of the young people interviewed except for one. Thus they were representative of those of the young people who had experienced positive outcomes as a result of being involved in the program. As the eight included two parental couples they covered six of the young people who had been involved in the pilots.

Therefore parents of eleven young people were not accessed and the parents who I interviewed were, not surprisingly those with whom the service providers were most engaged. However, as the parents, young people and service providers all confirmed, that had not been the case with some of them when the young people were first placed in the units and thus their willingness to be interviewed was an indication of the relationships that had developed.

8.5 OVERVIEW: PILOT 1: THE PARENTS' STORY

The Pilot 1's Parents Story was compiled from the material raised in the four interviews (2 individuals and one couple) undertaken with the Pilot 1 parents.
8.6 PILOT 1: THE PARENTS’ STORY

What was our view of this new model; well, overall we thought it was better than what operates in other residential units. We saw a number of positive factors about the model.

As for this name (the acronym that the pilot was known by), some of us had heard of the name but no one was sure what it meant.

8.6.1 Things that were good about the model:

The three areas we talked about were that:

1. The young people did well in this model. They were more settled, mature, and became more patient. They got into less trouble and stayed longer than they did at other units. They were more willing to be involved with services and became more aware of the services that exist.

2. We found the workers helpful, caring, involved, understanding, and constant. We liked them. They taught us strategies that we could then use. The co-ordinator was excellent. For some of us an open trusting relationship developed with the residential care workers.

3. We thought it was better having the services going to the unit to see the young people because we know how difficult it is to get young people to see workers at agencies. In this model, the young people got to know the workers, became familiar with them before seeing them. They had a good range of services there and good access to services. They did things like set up a plan, which was put into place if the young person started to hurt herself. Two of us mentioned the Mental Health worker. One because we
thought he was very good and the other because we were not impressed with him.

One of us felt extremely positively about the model. *I only have praise for (the resi unit). I was so stoked by them.*’ Two of us felt that it was because of the work they did with our children that they were then able to return home.

We all commented on how this unit ran differently to others. They were firmer and had consequences for behaviours. We felt the young people were safe there which was very important.

In the area of communication, we had opposite experiences. Two of us felt they kept in closer contact with us than other units had while for two others, the lack of communication was our main area of concern. We felt frustrated that we did not hear information about events relating to our child until after events occurred.

8.6.2 Areas of concern

Although we had more positive comments than negative ones, there were also a number of areas of concern.

1. One major concern was about the types of young people who were placed in the unit. We think young people who are chroming, and those who are heroin addicts should not be placed in the same unit with young people who are not involved in these activities. We know that it’s not the workers from the unit who decides who gets placed in the units.

2. Some of us did not like the system they had there. There were stupid rules. The atmosphere needed to be more like a family. We also did not
like that the young people received incentives for doing their chores which we saw as bribery.

3. We also thought there needed to be more contact between the workers and young people once they returned home.

4. Some of us were critical of the high caseload of the Child Protection workers.

5. Some of us were critical of the overall system of care. One said, 'I would not have put my child into DHS care if I had known. I would have put her straight into (the resi unit).'

8.7 OVERVIEW: PILOT 1: THE YOUNG PEOPLE’S STORY

It was a good place to be, more settled and safe (Pilot 1 young person).

The Pilot 1 Young People’s Story was compiled from the material raised in seven interviews (6 individual and two young people seen together).

8.8 THE YOUNG PEOPLE’S STORY

The Pilot 1 model, what was it like you ask? Well, we thought it was really good. It was definitely different to what happens in other resi units and better than what we have experienced before.

8.8.1 What was good about this model

The main thing we thought was better was having the workers coming to the unit rather than us having to go out to see them in other places, because that doesn’t work. With them coming to the unit we were more likely to see the workers, we got one on one help and we still had the choice whether to see them, which was good. We knew when they were coming. When we
needed someone to talk to, they were there. As one of us said, '....I used to
drink a lot but since I've seen the D&A worker I haven't.'

Most of us felt so strongly that this model should be introduced into other
units because of how well it worked that it was the second most frequent
area we raised with you.

The other things that we talked about were the other areas we found better
in this model. We found this model more helpful. The workers did more with
us, there was more offered and they did things that were helpful like
teaching us how to save, manage money and other skills. It worked well, it
was run better, was more organized and a good environment. It was a good
place to be, more settled and safe. The workers were nicer; they
communicated more with us, were more caring and understanding.

Yes, we have all heard of (the acronym that the pilot was known by) although
some of us forgot what it meant. Three of us knew that it means the way
things work at this resi unit, with workers from five services who came to
the unit to see us and who meet together as a team.

8.8.2 What was not good about this model

Now, although we all agree strongly, that this model was good and better
than other units, a number of us thought there were also lots of things that
were not good. Most of us thought there were really stupid rules in the unit.
They were far too strict and some didn't make sense, like young people
having to be out of the unit during the day whether we are involved in a
program or not. As one of us put it, '...so if you weren't going to school or
some other activity you weren't allowed in which encouraged some kids to go
off and do things that got them in trouble.'
Other areas that two of us who have left the unit felt strongly about, was that we did not receive adequate preparation for living independently and did not receive enough support after we left the unit. As one of us said, ‘it was a big issue for me because of my experience and how hard it was.’ Another said, ‘...I needed help for longer.’

8.8.3 Other thoughts

Some of the other areas we thought were important for you to know were, that some of us thought there was a need for a day program in the unit for those young people who weren’t going to school. Some of us were not happy with some of the decisions workers made, that they made promises they didn’t keep and couldn’t manage some of the young people. Some of us knew that the local neighbours hated the unit, which wasn’t good.

When you asked what we would say to another person who was going to be placed at this unit, two of us said that if the young person doesn’t have to move out of home we wouldn’t recommend it because you go downhill living in resi units. There are other kids there who are using more serious drugs and you have to stay in other places that are worse before you even get to a place like this. But, if you have to go somewhere, then it’s an okay place to be.

A final word: one of us commented that she had never been asked her opinions before and thought it was good to be asked and it should happen more often.

8.9 OVERVIEW: PILOT 2: THE PARENTS STORY

Pilot 2’s Parents Story was compiled from the material raised in the four interviews (3 individuals and one couple) undertaken.
8.10 PILOT 2: THE PARENTS STORY

You are interested to hear our experiences of this new model. Well, three of
us felt there were good and helpful aspects of this experience. We thought
this unit was different in a positive way to other units our children had lived
in. One of us felt very dissatisfied and thought there was nothing helpful or
good about the experience of our child living in this unit or our contact with
it.

8.10.1 Areas we saw as strengths:

When we think about the areas we saw as strengths, the three we talked
about most frequently were:

1. The young people got better in this model. Examples included:

   - The young people becoming involved and enjoying school.

   - For two of us our child has recommenced contact with us after
     previously not wanting any and having told people we were dead. We
     are feeling our way with this relationship but we are getting on better
     than we have.

   - Other improvements we noted include the young people settling and
     maturing, opening up more, developing routines, and wanting to help
     other young people in the unit.

   - For two of us we see now that our child has potential and we see
     certain possibilities we did not before.

2. Three of us were happy with what the service offers, that it was good
   and relevant. We saw it as a place where young people get opportunities.
All of us think the unit is being run as well as they can and were very aware of the constraints the workers were under. We saw that the workers in this system are ‘up against it’ because it would not be easy working with the young people they are dealing with.

3. We thought the workers were good, concerned about the young people and us, they communicated well and were good to us. We felt we could talk to them.

When thinking about what we would say to other parents in our situation, our advice would be that if they were in as desperate a situation as we felt we were, then they do not have much choice but to have their child placed in a residential unit. They should give it a go but do not expect things to change too quickly and be very understanding. If their child is in those circumstances, where there is no one to look after them it is best that they are with people who know what they are doing.

8.10.2 Areas we saw as concerns

All four of us had concerns. The areas we raised most frequently were:

1. Concerns with the residential care system:

Some of us saw the unit as being cold, not a home or family environment. We were concerned about the ‘...powerlessness of the workers.’ As one of us said, ‘I was surprised because I’d thought the people working there had options I didn’t have.’ ‘We were all concerned that the workers were not able to stop the young people from being in at risk serious situations.’ We were also concerned that within the one unit were young people who had a drug problem living with others that did not.
2. Concerns with the way the unit operated in relation to the young people:

The workers did not seem to have high enough expectations of the young people. There did not seem to be any consequences for the young people of their behaviours. There needed to be a roster and clear living arrangements for the young people, boundaries rather than them just being able to walk in and out. The workers did not give the young people guidance or direction. We thought the workers allowed the young people to make decisions they were too immature to make on important areas.

3. Concerns about the quality of the workers:

The workers were not efficient. They were not effective. One of us particularly was dissatisfied that the workers did not provide reports. There were no records.

4. Concerns about our relationship with the workers:

There was inadequate communication. Three of us would have liked more communication and contact and for the workers to return calls more than they did. Some of us also wanted family meetings to work towards reunification and saw that as an area that was lacking. One of us said, ‘...I was horrified that they didn’t.’

A very sad but powerful final comment from one of us was;

I wouldn’t wish this experience of having a child in a residential unit on anyone. It was heartbreaking to go through this.

8.11 OVERVIEW: PILOT 2: THE YOUNG PEOPLE’S STORY

The services they give you there were good (Pilot 2 young person).
Pilot 2’s Young People’s Story was compiled from material raised in the interviews undertaken with two young people.

8.12 PILOT 2: THE YOUNG PEOPLE’S STORY

What was this model like; well we both agreed it was different to other units. One of us thought it was good and better than other units. The other one thought it was all right but preferred another unit I had been in. We both thought there were good things about this model and these were that:

- They treated us better there
- The staff were good and went out of their way to help
- The services they give you there were good and
- They had good stuff there.

We have both heard of the words Care Team. One of us was not sure what they mean and one of us thinks that it means a house in a resi unit.

One of us thought that everything about this model was good while the other:

- Thought they should provide more activities during the day.
- ‘I got bored and so I got into drugs.’
- They should focus more on young people’s needs.
- One of us commented that there was more chroming going on there than at other units.
In relation to contact with our families, neither of us was seeing our families while we lived at the unit. The workers did have contact with one of our families, which was okay. With the other young person, the workers did not get involved with my family and that was okay.

We both talked about the experience of living in a residential unit. One of us thought that any resi unit could not be that good because you are only there because you have problems and you don't have your family but considering that, this one is one of the best.

The other young person commented,

\[ I \text{ would change the system altogether. They can't do much more than they do if the kids don't want to be helped and don't follow the rules, there's nothing they can do. They can't physically stop the kids from going out at any time. They are doing their best, but it's not good enough. It's not their fault. } \]

One of us said I would be happy to talk more at another time if you want me to.

A final word from one of us;

\[ \text{If you don't have a family you need support and you look at the workers as the closest to family.} \]

8.13 CONCLUSION

In this chapter an overview was provided of the circumstances of the young people interviewed for this research. It demonstrated that whilst their circumstances when they entered the residential units where the Enhanced Residential Program were piloted were characteristic of at-risk young people, the outcomes that occurred resulted in significant improvements in a number of areas of their lives. Thus the young people who were interviewed
as part of this research and some of the others who were not able to be interviewed became more engaged with their families, with school and vocational activities and with service providers and that these areas were maintained following their departure from the units.

The chapter concluded with the stories of the parents and young people who were interviewed sharing their perspectives of the strengths and challenges of the Enhanced Residential Program from the perspective of those who received the service.

In the next chapter my voice, the voice of the researcher returns, to explore my analysis and overview of all the 'stories from the field' alongside the other findings undertaken in this research and integrate the learnings and insights that this research contributes to our understanding of effective collaborative approaches.
CHAPTER 9: ANALYSIS OF FINDINGS - MAKING SENSE OF THE LIVED EXPERIENCE

The heart of a qualitative stance is the desire to make sense of actual lived experience (Marecek, Fine and Kidder 1997:631).

9.1 INTRODUCTION

The excitement (in qualitative research) resides not so much in reaching the destination, for we can never completely enter the world of the other, but in the voyage and what might be found on the way (Darlington and Scott 2002:20).

The focus of this research is an exploration of the use of collaborative intersectoral approaches to service delivery as a means of improving responsiveness to the complex needs and issues presented by troubled adolescents and young people.

There are three central domains and contexts that have informed this research:

- young people with complex needs,
- their problematic history of access to, and engagement with a particular cohort of service systems and
- the common issues that arise when these service systems interact.

The central research question that this thesis has explored is:

- What are the principles and guidelines that will inform services operating within an integrated collaborative approach for children, adolescents and young people with complex needs?

The research methods designed to explore this question consisted of:
1. An analysis of key policy directions within Australia, United Kingdom and United States relating to young people with complex needs. The findings of this analysis were described in Chapter Two.

2. An analysis was undertaken of current local, national and international literature that relates to policy, program and practice for children, adolescents and young people with complex needs. These findings were described in Chapter Three.

3. In-depth interviews were conducted with five stakeholder groups involved with the inter-sectoral service initiative, the Enhanced Residential Program. The thematic findings from these interviews were outlined in Chapters Five to Eight, Stories From The Field.

4. A descriptive profile of the young people, service providers and managers was undertaken. The findings were incorporated into Chapters Five to Eight; Stories From The Field.

As described in Chapter Four, the research methods utilised for this thesis were selected because they provided a respectful means of exploring and conveying the lived experience of at-risk young people, their families, service providers and managers during the development and implementation of an intersectoral service initiative.

In this Chapter an analysis and overview is provided of their 'stories from the field' alongside the other findings undertaken in this research. It is intended that the product of this analysis will be '....a creation that speaks to the heart of what was learned' (Ely 1991:140).
The chapter describes how the findings substantiated and confirmed critical areas from the literature, in particular the central role of engagement and relationship building to achieve effective inter-sectoral approaches. What the findings also provided were additional insight and detail about the interactive factors which enable, promote and sustain these relationships.

These cluster of factors included:

- The critical importance of the particular characteristics of workers and organisations able to embrace collaborative approaches,
- The critical capacity of these workers and organisations to develop trusting and respectful relationships that form the foundation for collaborative approaches,
- The critical policy, organisational, and practice structures that promote collaborative approaches and activities being developed and sustained.

In this Chapter, this cluster of areas are explored and outlined in more detail. They are presented by focussing on how they develop within the multidimensional levels of the microsystem, mesosystem, exososystem and macrosystem.\(^{170}\)

9.2 MICROSYSTEM LEVEL

If you don’t have a family you need support and you look at the workers as the closest to family (Pilot 2, young person).

The microsystem is the most immediate level which surrounds the individual. It consists of ‘...the face to face interactional sites of daily life such as

\(^{170}\) described in Chapter Three
family, school, workplace' (Scott 2000:4). The situational profile of the young people involved in this research\footnote{171 prior to the introduction of the Enhanced Residential Program (ERP).} confirmed the perspective presented in earlier chapters of this thesis, that their microsystems were characterised by a ' . . . deficit of social capital' \footnote{172 (Webb 2006:227). One could argue that particularly the young people placed in Pilot 2 Stage 1 who were heavily involved in a offending culture were members of what Unger (2004) described as subterranean contexts, a world which provided them with social capital and a sense of belonging albeit by a socially ostracized peer group,} of the kind that would foster their successful participation in the mainstream community.

Thus the young people had either been estranged from their families or had limited (and frequently) conflicted contact with them. They had a history of out-of-care placements and most were not attending school or a vocational activity. Despite having significant mental health and drug and alcohol difficulties, few were effectively engaged with workers from those program areas.

Information gained during the research process indicated that at the completion of the ERP's Pilot phase, these young people had achieved significant positive changes both in the above interactional sites,\footnote{173 See Chapter Eight for detail about these changes. These improvements relate to the young people involved in Pilot 1 and Pilot 2 Stage 2. As the outcomes for Pilot 2 Stage 1's young people were different they will be addressed separately.} and in their 'bonding capital.' \footnote{174 'Bonding capital' as discussed in Chapter Three, is a social capital concept developed by Woolcock and Narayan (2000) which occurs when ' . . . close bonds such as family and friendship connections' are strengthened (Healy and Hampshire 2002:234).} It was particularly significant that a number of the young people continued to consolidate their gains following their departure from the units through continuing to strengthen the relationships with their families, remain out of institutional care, maintain their participation in educational and work activities and negotiate new supportive relationships with professionals.
As social exclusion and isolation were identified by a number of writers as one of the key risk factors for young people in care\textsuperscript{175} and consequently family and school connectedness to be ‘…powerful protective factors,’\textsuperscript{174} these changes were critical to the young people having a strengthened capacity to avert those poor outcomes and negotiate a different ‘negative life journey’.\textsuperscript{177} Ritchie (2005) quotes research undertaken by Prilleltensky and Nelson (2000) that identifies the ‘..importance of the ecological framework within which the child is placed and on its protective factors: the importance to the child of home, school, community and social networks’ (2005:765).

The research findings demonstrated that the important improvements that occurred for some of the young people were the result of a cluster of factors and stages impacting at a number of different multidimensional levels. Some occurred simultaneously and some incrementally. None was easy to achieve and there were no shortcuts involved. Although some were more critical there were none that could have, on their own, produced the changes that occurred. They were interdependent.

In the following sections these interlocking and interacting ingredients and stages are outlined. The first section will focus on those that apply within the young person’s microsystem.

\textsuperscript{175} Walker (2005:42); The Office of Health Economics and The Mental Health Foundation (2004:4); Mitchell (2003:8-18).
\textsuperscript{176} Einfeld and Dean (2000:9)
9.2.1 Transforming the Residential Unit into a ‘good-enough environment’\(^{178}\)

*We saw it as a place where young people got opportunities (Pilot 2 parents).*

The research findings demonstrated that as a consequence of the introduction of the ERP pilots, improvements occurred for the young people across the developmental ‘.domains of mental and physical health, emotional and behavioural functioning, cognitive and educational achievement’ and general well-being.\(^{179}\) It is my analysis that these changes occurred as the ERP provided the young people with a ‘good-enough environment’ particularly within the residential units, their key interactional site, but also in other dimensions of their life.

As outlined in earlier chapters, writers including Green (2002), Kiraly (2002:16), Thomson Goodall Associates Pty Ltd (2002:17) and Ainsworth (1999:14) identified that current service delivery practices in residential care were the result of dominant ideological paradigms that prioritised ‘risk’ control over care resulting in an atmosphere that placed a low priority on reparative ‘.... proximity and intimacy’ (Webb 2006:92-3).

Consequently the capacity to provide a response based on the developmental needs of vulnerable young people was significantly limited. It was in recognition of the limitations and outcomes of these philosophies, working practices and conditions that the ERP was developed.

\(^{178}\) The use of the term ‘good enough’ derives from the work of British psychoanalyst and paediatrician, D.W. Winnicott. He originally used it in relation to the ‘good enough’ mother ‘...to enable parents to set themselves realistic goals rather than to be perfect parents’ (Schmidt Nevin 1996:260). It has since been used as a general concept to refer to situations being ‘good enough’ rather than aspiring to unrealistic expectations.

\(^{179}\) All these domains were identified as areas of vulnerability for young people with complex needs (Royal Children’s Hospital Mental Health Service 2004:7).
It is not surprising then that the words used by service providers to describe what occurred within the residential units during the pilot period, were a 'cultural change.' The research findings confirmed that a significant shift had occurred, allowing environments which previously had struggled '....to address the level of disturbance of these young people' (Morton, et al 1999:ix) to establish a qualitatively different psychological, social and developmental experience.

The young people (who between them had previously experienced approximately forty residential units) were very clear about the difference. They, (and their parents), described these units as 'good,' 'settled' and 'safe' places to live, which provided more 'activity' and 'opportunities, structure and organisation.'

Using a psychodynamic theoretical lens, what had been achieved was enabling the young people to feel more contained\(^{180}\) and held\(^{181}\) because these units had become secure personal bases.\(^{182}\) Together, these components contributed to '... a sense of cohesion and organisation in the holding environment' (Applegate and Bonovitz 1995:254).

As Winnicott (1973) described, a holding environment was one which provided consistency, continuity, and reliability. Bion (1967) stated that individuals felt contained when their significant carer was able to hear their distress, tolerate, understand and respond to it in a way that makes the experience bearable. Bowlby (1988) described parents who, because of their understanding of the push and pull of development, provided a secure base,
an emotional structure that promoted and sustained attachment through their consistent, nurturing, reassuring presence (1988:11).

It is argued that these research findings demonstrated that through the introduction of the ERP, the service delivery model provided by the residential units was enhanced and became a holding environment. Critical to that being achieved was the holding, containment and secure base provided by the residential care workers for the young people and their families.

9.2.2 Enhancing and Liberating the Residential Care Workers' role

_The staff were good and went out of their way to help (Young person, Pilot 2)._ 

_We felt we could talk to the workers (Pilot 2 Stage 2 Parents)._ 

The introduction of the ERP resulted in major structural changes for the residential care staff. Although the actual forms this change process took differed between Pilot 1 and Pilot 2,\textsuperscript{183} what was common across the models was the empowerment of the residential staff through their elevation into decision making position and functions.

This change can be understood using different theoretical frameworks. From a family systems orientation it can be hypothesised that the residential care staff shifted from single parent status to acquiring co-parents in the parental sub-system. A change had also occurred at the

\textsuperscript{183} For Pilot 1 it was the establishment of the Care Team which included residential care workers as equal members and the residential care co-ordinator becoming the Care Team co-ordinator and the transfer of case management to this position which were significant. For Pilot 2 Stages 1 and 2 it was the inclusion of residential care workers when they had previously been excluded from the version of ‘Care Teams’ that had previously operated within the agency. Consequently they now worked alongside Case Managers as the ongoing core members of the Care Team.
instrumental psychological level for the residential care workers - their role had expanded to include more 'parental' functions.

Organisationally the residential staff had moved from occupying a marginalised, and, at times, invisible and informal position placed outside of existing decision making structures, into a formal and sanctioned role.\textsuperscript{184} Applying one of Giddens concepts they had become 'active agents' impacting on their environment (Giddens 1987).

This change in positioning was most clearly demonstrated by three critical structural changes:

(i) The Residential Unit Co-ordinators taking on the role of Care Team Co-ordinators for both pilots,

(ii) The altered case management practices which for Pilot 1 involved the transfer of case management responsibility from Child Protection to the CSO’s Residential Unit Co-ordinator.

(iii) The establishment of 'key worker' positions held by the residential care workers.\textsuperscript{185}

A residential care worker from Pilot 1 aptly described the impact of these changes as giving the residential workers ‘.....respect and dignity.’ Thus the residential care workers moved from a position of exclusion to one of increased visibility and status. There was a sense that for many of the external workers they were able to 'see' the highly complex and skilled

\textsuperscript{184} In some ways the residential care workers and the young people’s parents had previously held similar positions - 'excluded' and silenced from where the real power was held and decisions were made.

\textsuperscript{185} Each young person was allocated a 'key worker' who was the main contact person for all matters relating to this young person.
contributions of the residential care workers for the first time. As one residential care worker stated; ‘.....we found that as the external workers came to know and respect us, they valued our input.’

Thus a sequence of events had been put into place. On a psychological level the young people felt safer, held and contained in the units which enabled them to interact and engage more meaningfully in other domains of their life. This occurred because the residential care workers, as the young people’s primary carers, were able to promote these intrapsychic, psychological, social and developmental processes because of the changes they had experienced. On a psychological level the residential care workers also felt more held and contained by the Care Team structure and the input from the external workers.

Organisationally the residential care workers felt less isolated because they had moved from a marginalised devalued position to one of valued members of the Care Team. The ‘internal’ residential care staff had been given the sanction and tools they required to do their job assisted by the ‘external workers’ joining them inside.

The care of the young people was now shared by all members of the Care Team and the wider ERP structure. A shared ownership of the care provision and connection to the young people had developed. A containment process had been put into place and a new order and balance had been established. All these aspects were essential for effective and sustained change to take place.
9.2.3 The process of engagement with the young people

As engaging at-risk young people was identified in the literature and practice as being particularly challenging and the findings of this research demonstrated improved engagement occurred between many of the young people and their families and with workers, it is important to reflect on the components that enabled this to occur.

Certainly the experience of both pilots reinforced the learning from the literature of the importance of sufficient time and space for the young person and workers to become familiar with each other to promote engagement and trusting relationships to develop (Mitchell 2000:11) and that these same principles also apply as workers negotiated new forms of relationship with each other. This research’s findings further elaborated the subtle details about the intricacies involved in enabling such relationships to form. They demonstrated how a number of incremental and interrelated steps are required to create trust and safety.

These findings captured the minutiae of those steps. They demonstrated how rituals of entry and engagement were very different under these circumstances to what occurs within formal service locations. This was a service which was being provided in a location which was the young people’s home and the residential care workers primary base. Therefore the need for the external workers to become familiar to residential care workers before the residential care workers felt safe to make links with them was a slow and steady process achieved through the external workers actions, particularly their reliability, consistency, accessibility and non-intrusive presence.
Only *then* could the residential care workers communicate the message to
the young people that the external workers were *okay* to be initially
checked out and then commence their own process of forming a relationship
with them. Thus the residential workers were operating as emotional
'gatekeepers' deciding who to let into their space and how this could happen.
And, for these young people in particular, the sanction of their most
'significant other' plus the element of choice being given about whether to
engage with the external workers, proved critical to sealing the process.

In turn the tentative trust that formed between the young people and
external workers further confirmed the respect of the residential workers
that these people were *okay.* The interdependence of these parallel
processes was vital. The findings therefore reinforced the reciprocity
involved in forming the foundation of relationships. For the external workers
to feel safe they needed to feel welcomed into the young people's home and
the residential care workers' work base. Therefore as the 'outsiders'
entering others' space they needed to be attuned to the sensitive cues that
govern *'....spatial relations such as insideness and outsideness, disjunction

As Currie (2001:47-8) highlighted, the qualities of the workers themselves
were critical in understanding how to negotiate these transitions. As the
residential care workers involved in Pilot 1 outlined, the personal attributes
that seemed important to be able to work in this way were *'....the capacity
for flexibility, creativity, and patience both for our work with the young
people and with each other.'*

As a member of Pilot 1's Care Team described,
You have to engage with the young people first, have a laugh, what you've got to offer them has to be relevant, walk alongside them to achieve their aims, celebrate their successes, don't take things personally, it's a learning together process.

It was these qualities that were critical in the promotion of a feeling of safety and confidence in what was being offered. But it was not these qualities alone. When they were complemented by people who were ‘responsive, committed, experienced’ it was a combination that provided the ingredients for a firm foundation for effective trust, relationships and engagement to occur.

When considering that social capital was described by Webb (2006) as consisting of ‘....those stocks of social trust, norms and networks that people can draw upon in local contexts to solve common problems, that promote co-operation and reciprocity’ (Webb 2000:20) it is apparent that what occurred within the two pilots (with the exception of Pilot 2 Stage 1) was generation of social capital. Through the mutual exchange that occurred between the residential workers offering a genuine welcome and sanction, and the external workers’ contribution of their knowledge and wisdom, ‘bridging capital’ 186 was also achieved.

It could be said that these processes applied more strongly to Pilot 1 where ‘external workers’ who were clearly outsiders had to negotiate the transition to ‘insideness’ in order to be able to develop relationships with the residential care workers and young people. However they appeared to have

186 Woolcock and Narayan’s (2000) concept further developed by Healy and Hampshire (2002:234) was previously described in Chapter 3. It occurs when links and networks between diverse individuals and organisations are strengthened which is vital for linking marginalised individuals and communities to resources or opportunities outside their personal networks. See also Footnote 5 in this Chapter.
equally applied to Pilot 2 (in both Stages 1 and 2) where workers employed within the same organisation but in program areas that had previously remained very separate (particularly the residential care workers and case managers) had to learn how to work as partners within a collaborative team.

With Pilot 2 Stage 1 however, it was evident that a minimal generation of any social capital or bridging capital occurred. In that situation the boundaries remained firmly in place.

9.2.4 The Residential Unit: A home, house or therapeutic facility

The result of all these changes was a changed culture and environment. The question of what it had changed into is an important one. The young people and parents offered a useful perspective on this issue. Although there was a clear communication from them that the ERP had created tangible improvements, there was still a strong message that there was further distance to travel before the units offered all that was required to comprehensively meet these young people’s needs.

Two comments are particularly insightful. One from a parent who suggested that the units were too ‘...cold, not a home or family environment’ and the other from one of the young people, who described a Care Team as ‘...a house in a resi unit.’ It would seem that this young person was communicating that this living experience was less institutional than others she had lived in. However her use of words is noteworthy. She has clearly differentiated that even though there was a shift, it was to a house rather than to a home, the place where families live.

And she was correct. The ERP’s introduction had not transformed residential units into a home. This was partly because the adults who lived there were
there because it was their work place, they were paid to care for the young people and partly because it had not become 'homely' enough. As Fischer and Kargel (1997) state '....spatial arrangements matter' (1997:15). They matter because '...the essence of "being at home" is based on its sense of orientation and emotional belonging' (Webb 2006:87).

They matter because, as the findings from the research demonstrated, young people who are not living with their families are still looking for a 'family-type' experience. While not wanting workers to replace their parents they seek a form of relating that provides the demonstration of warmth, feeling cared for, being thought about. And parents who have had the experience of having their children removed from their care either by choice or otherwise, also want this environment to be able to offer what they were not able to. As one parent stated,

*I'd thought the people working there had options I didn't have.*

Therefore although the spatial dimension of the residential units could (and should) not be transformed into a 'family home,' the research demonstrated they were able to incorporate some 'homelike,' 'parental', caring aspects that, as a result provided a more emotionally restorative experience for the young people and their parents. These changes were an indication of the beginning of a process for the units to provide an increased depth and diversity of experiences for the young people.

It was an important beginning because even with this minimal level of intervention, on a psychological and intrapsychic level, the unit had become a space where the young people engaged more meaningfully and effectively with the workers as well as in other aspects of their lives. As described earlier, it had become a space they felt more connected to. Through their
psychological and emotional dimension being strengthened it enabled them to interact with and occupy other parts of their world differently.

The interventions that achieved this shift occurred within the climate and structure of the unit. On a functional level, the young people were provided with more input and activities; on an organisational level they were provided with more structure; on the 'care' level the residential and statutory staff were both more available and there was a different quality to how they worked with the young people and families; and the young people were provided with additional services through their access to the specialist/external staff.

However whether these changes meant it had become a ‘therapeutic unit’ and consequently whether another way in which the changes in the residential care workers’ role could be described as incorporating a ‘pseudo therapeutic’ function, is worth considering. Two influential service providers from both Pilots expressed opposite views on whether this should be the outcome of such models.

One (from Pilot 1), strongly supported this shift and described the residential care workers as having become members of the therapeutic team, in fact ‘...the front line deliverers of mental health care’. The second, (from Pilot 2) strongly opposed the residential care worker being used as ‘...therapeutic mental health workers or hands on drug and alcohol workers’ but believed the focus needed to be on ‘...training them, educating them as to what these services do, better ways of managing clients.’

These comments reflect the different tensions also present in the literature about preferred service options for this group of young people as
demonstrated by Mordock (2002) who stated that ‘...the care worker as therapist approach places undue emphasis on staff’ rather than allowing them to do what they do best which is ‘...creating an environment where behaviour will be less disruptive and less chaotic’ and therefore ‘...therapeutic’ (2002:19-20).

This is an important debate. What was apparent from the research findings was that, as a result of the introduction of the ERP, the residential units had successfully expanded and enhanced their service. They now provided the benefits of a secure base, through integrated ‘...parental, therapeutic and social functions’ (Moses 2000:477). These structures created an increased opportunity for the young people to have the necessary foundation to create sustained engagements with other members of their microsystem ‘...to engage in meaningful relationships’ (Moses 2000:447).187

How well this secure base was able to embrace and engage with the young people’s families is explored in the next section.

9.2.5 Finding a place for families

As Thomson and Thorpe (2004) and other writers highlighted, a concerning gap in existing practice is the ‘...limited work (undertaken) with parents of children in care’ (2004:48) thus perpetuating their exclusion and marginalisation particularly when as Thomson and Thorpe (2004) identified,

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187 It is noteworthy that another achievement of the ERP was that the young people involved in the Pilots were able to remain for longer periods of time within these residential units than was the norm. This confirms there was something within the experience provided by these environments that ‘held’ and ‘contained’ them. Anecdotally some of the residential care staff also reported that the units operating from the ERP model had played a role in their interest in working in these units and their decision to remain in the job longer than other positions.

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and this research demonstrated, '....many young people seek out their families on exiting from care' (2004:48, 50).

It is challenging for workers to be placed in a position to engage with parents who have had their children involuntarily removed from their care, and who, as Mitchell (2003) have described, are likely to be struggling with their own multiple, chronic, entrenched and serious problems (2003:8-18). It requires a professional maturity, the necessary skills and capacity to work from an orientation committed to enabling 'capacity building' (Webb 2006:8).

Considering these multiple barriers, the evidence in this research suggests that the service provided to the parents within these pilots was one of their most important achievements. The findings indicated that a more helpful connection was established between many of the young people and their families and between workers and the parents. Having said that, it was apparent, and not surprising, that this engagement with families was in very early stages and was the most fragile and developing practice area.

From the parents' point of view, they identified a number of changes. There was a sense, from some, that the distance from professionals that Thomson and Thorpe (2004) referred to, had begun to break down. With closer communication, 'open trusting relationships' (Pilot 1 Parent) had been able to develop. Within that new space they could look at each other in a less polarised way. A humanising that had not previously been present in their interactions developed. 'We felt we could talk to the workers' (Pilot 2 Parents).

For some of the workers there was an identification of the need for more attention and focus to be given to engaging families; which was to be
commended. However it can be conceptualised that increased involvement with parents was a second-order change and that the priority for a new model in its early development was in building the primary foundations of the structure before more advanced work could commence.

9.2.6 Examining the demonstrable achievements.

The range of positive outcomes that were achieved for the young people as a result of the ERP’s introduction included reduced at-risk presentations, placement turnover, statutory involvement and increased engagement with education, vocational activities, services, their families (including reunification) and an ability to maintain these improvements after leaving the units.

As a result of these changes some of the parents felt more hopeful for the young people’s future and the beginning of hope for improved relationships with them as demonstrated by this moving comment, ‘…… our child has recommenced contact with us after previously not wanting any and having told people we were dead. We are feeling our way with this relationship.’

Many of the parents and young people saw direct links with what was offered by the ERP and the changes that had occurred. As this young person from Pilot 1 stated, ‘….I used to drink a lot but since I’ve seen the Drug & Alcohol worker I haven’t.’ Whilst two parents said, ‘…… it was because of the work they did with our children that they were then able to return home.’

As well as the direct services that were provided by the external workers and the enhancement of the care provided by the residential care staff, many of these achievements were supported as a result of other changes that occurred within this model. These consisted of the improved linkages
provided by the external workers to other parts of their networks. These interventions streamlined processes and also enabled bridging capital to occur.

9.2.7 Examining the demonstrable challenges and deficits

A significant factor that impacted on service delivery for the Pilots was the changed case management structures. For Pilot 1 this involved residential care staff having case management responsibility transferred from Child Protection. For Pilot 2 Stage 1 it meant the one Case Manager held case management responsibility for all the young people in the residential unit and for Pilot 2 Stage 2 residential care staff being more actively included in those decisions.

These changes also involved the Care Teams’ more active involvement in case planning and case review decisions. On the plus side most of the service providers and managers interviewed expressed the opinion that a more streamlined service delivery was achieved with all people involved with the young people contributing to the planning, delivery and management of their care.

However, alongside these benefits there were also some unforseen and unfortunate consequences of introducing case management responsibility into the residential unit’s domain particularly in relation to continuity of care. This was particularly the case for Pilot 1 as when the young people left the residential unit, their case management was transferred to external
agencies, which was described as unsatisfactory by some young people, families and service providers.  

Thus, although the ERP’s achieved improved outcomes in relation to the number of young people who successfully negotiated the transition to live with their families and into independent living, the young people and families involved indicated that there were inadequate support to manage these transitions. This may have been because the staff were not familiar with dealing these situations and roles.

As two young people from Pilot 1 stated,

\[...we did not receive adequate preparation for living independently and did not receive enough support after we left the unit. ..It was a big issue because of my experience and how hard it was. ...I needed help for longer.\]

This stressed the importance of preparing and supporting young people and their families for their transition from leaving care whether it was to independent living or returning to families and for that to be undertaken by workers with whom the young people have an existing relationship - all factors raised within the 'Leaving Care' literature.  

Another example of an area that was perceived as highly problematic and a significant deficit in how the residential units operated related to some of the care practices utilised by both units. Whilst the young people and parents were generally satisfied with the care provided a number raised concerns about some practices. With Pilot 1 the criticism related to the harshness and rigidity of some of the rules that operated, particularly the

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188 Although interestingly not mentioned by any of Pilot 1’s Care Team. The reason for this was that Pilot 1’s CSO did not employ staff who could take over the case management role and that the residential care staff’s role did not include follow up with the young people once they left the units.

189 referred to in 1.5.5 and 2.5.4.1
practice that young people were not allowed to remain in the unit during school hours.

Whereas with Pilot 2 Stage 2, the focus of concerns were the laissez-faire practices that operated; giving the young people too much freedom and not providing appropriate limits. Both extremes were examples of what Kiraly (2002) has described as the punishing use of 'consequences' at one end of the continuum and the lack of effective constraints to high risk behaviour which operate in Australian care settings. Kiraly says that both have the same result, the young people not feeling 'securely protected,' (2002:18) a sentiment clearly expressed by the young people and parents involved in this research.

These service delivery deficits and those that Pilot 2 Stage 1 experienced were examples of the types of difficulties that arise for Pilots as they struggle to operationalise broad general guidelines. They highlighted the impact that local conditions and resource factors can have or when insufficient thought and attention is given to local situations (Roberts and Hinton-Nelson 1996:16).

They also demonstrated how exosystem policies and directions impact and are enacted at the meso and microsystem levels. They are a demonstration of how a fragmented service system compartmentalises situations as problems that needed to be solved by different sets of people. Therefore the 'problem' of how to manage and control at-risk young people while they are in care is thought about only in relation to this particular episode of care rather than thinking about where the young people are located in their life course and what they need to support that development.
They demonstrated in particular, the importance and necessity of Teather’s (2001) comment that residential care needs to be thought about as one part of an ‘...integrated component of a seamless service system’ (2001:8). Therefore any intervention that occurs within one aspect of that system cannot be considered in isolation.

9.3 PILOT 2 STAGE 1’S EXPERIENCE

As Pilot 1 Stage 1’s experiences and outcomes were significantly different from those that occurred for Pilot 1 and Pilot 2 Stage 2 they are explored separately in the following sections. The first section focuses on the issue that the service providers involved with Pilot 2 Stage 1 (and many others) considered as playing a critical role in the unfortunate demise of Pilot 2 Stage 1; the type of young people who were placed in the residential unit during the Pilot or what I prefer to describe as;

9.3.1 The ‘type of young people’ debate

Once you design models the really hard kids are going to get kicked out. The funding providers need to show faith in the providers to design and provide models that are going to be best for those young people (Service Provider, Pilot 2).

One factor raised by a number of the stakeholders was the model’s effectiveness being ‘spoiled’ by the wrong young people being placed in the pilots. For the young people and parents they focused on the risk of ‘contamination’ they believed that the young people with serious substance abuse habits posed for those with less entrenched conditions.

In many ways those involved with Pilot 2 Stage 1 had a similar analysis of the ‘contamination factor’ but placed their concerns on a different emphasis. They believed that the cohort of young people who had been placed in their
unit had ‘more serious’ problems because of a juxtaposition of a number of characteristics particularly compared to the young people involved in Pilot 1 and in Pilot 2 Stage 2.

These characteristics were that the young people:

- Were males with conduct disorders, significant substance abuse, criminal histories and current offending behaviour
- Were too similar to each other
- Were introduced into the unit as a group.

As a consequence, who the young people were ‘...was the main reason Pilot 2 Stage 1 fell over’ (Pilot 2 Stage 1 Service Provider).

In comparison, the young people in Pilot 1 and Pilot 2 Stage 2 were male and female, had a mix of internalising and externalising presentations and levels and type of criminal activities and had been introduced into the units in the usual practice, one at a time.\(^{190}\)

This debate about which ‘types’ of young people could utilise a Care Team model was somewhat puzzling. The ERP was specifically developed\(^{191}\) for exactly the group that the service providers were complaining about - at-risk young people unable to be engaged by existing forms of service delivery. Certainly the service providers’ concerns raised important practice issues, about the care and thought that does need to be taken about matching the

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\(^{190}\) As described previously in Ch 1 these are terminologies used to refer to different forms of mental health presentations. Young people with ‘internalizing’ presentations are those struggling with depression and anxiety issues and those with ‘externalizing’ presentations are those with behavioural symptoms such as conduct disorder and oppositional/defiant behaviours.

\(^{191}\) with the strong support of all sectors in the Region
young people and how they can most effectively be integrated into the residential unit.

However there was a sense that something else was also going on to explain passionate comments such as these:

...having the four of those clients together in the one unit sabotaged it from the beginning. It was destined to fail (Pilot 2 Stage 1 Service Providers).

This became a highly charged issue for many people. However I wondered whether it could be best understood as capturing intense feelings that, in fact, related to other factors altogether. In particular it could refer to a pervasive sense of unfairness and disappointment the service providers felt about other broken agreements.\(^{192}\)

What was also important about this debate was that it reflected an uncomfortable demonstration of the discourse that frequently surrounds these young people that has previously been discussed in Chapters One and Three. Could these attitudes be understood as a demonstration of what Walker (2005) described as the historical ambivalence that exists towards troubled children and young people (2005:236-7) and an example of the human cost of the risk society perspective?

Thus as Craddock (2001) states, within the concept of 'at-risk' populations '.....the risks associated with their population are personalised within each

\(^{192}\) In particular a feeling that the CEO who auspiced Pilot 2 Stage 1's residential unit often felt 'dumped' in difficult (and unreasonable) situations and expected to cope - particularly by being asked to take on young people that no other services would. Secondly, that this situation contradicted the understanding that the Pilots would decide which young people would be placed in them (which did in fact occur for Pilot 1).
particular participant. They cease to be members of an "at-risk" population and become instead "at-risk" people' (2001:7-8).

Where conflict and dissonance exists it seems to become displaced too easily onto a polarised adversarial debate where someone or something is blamed. In this space the capacity to hold and reflect thoughtfully on the enormous complexities and issues Pilot 2 Stage 1 faced, became lost. The tragedy was that very committed dedicated workers found themselves also focusing on the young people as 'the problem.'

It may be the case that the words the workers identified were accurate but their focus was mistaken. There was, without doubt, the wrong mix of ingredients in Pilot 2 Stage 1 but not in relation to the young people. They were exactly who should have been placed together for this initiative. It was not the four of them who were the problem, but a number of other factors that caused this Pilot to 'lose its way.'

Included in this equation were the four mismatched external agencies who also found themselves 'together in the one unit and a Steering Committee that also '...lost its way' by becoming too involved in its own internal conflicts to provide the support, guidance, containment and authorisation the Care Team required. There was no doubt that as a consequence what proved highly problematic was the combination of a homogeneous group of acting out adolescents with a disparate group of professionals who lacked the support, structures and resources they required to provide the service needed by the young people.

Unfortunately for the young people one can only hypothesise that living and working within the highly conflicted environment that developed must have
been demoralising and de-stabilising. The parallel of highly troubled young people coming from families where conflict and tension were frequently present, living in an environment where these experiences were also occurring between their professional carers, was extremely unfortunate.

It is interesting to reflect on how, although the service providers spoke at length about the impact on them of this troubled time, the impact on the young people of living amidst this chaotic, conflicted environment was only obliquely alluded to. This ‘toxic environment’ had unfortunately fulfilled Nikander’s (2005) prophecy of ‘...a potential site for trouble’ (2005:263-4)\(^{193}\) where these marginalised young people had become even more difficult to be kept in mind.

9.3.2 How Pilot 2 Stage 1 impacted on the young people

As stated in Chapter 8 it was very unfortunate that none of the young people or parents involved during Pilot 2 Stage 1 were interviewed as part of this research. The information provided by the service providers indicated that as the Care Team involved in Pilot 2 Stage 1 never sufficiently ‘got off the ground,’ the impact the model made on the young people resulted paradoxically in a minimised level of service delivery.\(^{194}\)

One person involved at the time voiced the contrary opinion that, despite its enormous difficulties Pilot 2 Stage 1 was an improvement because it had introduced the significant shift of including residential care workers into the membership of Care Teams, a highly significant and important shift for

\(^{193}\) Nikander’s full quote is worth repeating ‘...interprofessional encounters represent a potential site for trouble, where conflicting interests and arguments, practical dilemmas and moral issues surface’ (2005:263-4).

\(^{194}\) The reason for this was that as there was an expectation that all specialist services would now be provided by those agencies involved with the Pilot, even though this was not occurring the workers could not access those workers they had previously referred to.
this agency which hopefully had positive spin-offs not for these but for other young people, in future Care Teams.

9.4. A FINAL REFLECTION ON THE MICROSYSTEM CHANGES.

The stakeholders interviewed for this research identified that the face to face site of daily life for the young people living in the ERP residential units improved across a number of domains in relation to their sense of mental health and well-being, their involvement with their parents, their connections to school and work. They perceived that these improvements were the result of the impact of:

- The direct interventions that occurred between the young people and the external workers resulting in increased engagement and positive use of these relationships,

- The strengthened, enhanced level of care they received from the residential care and statutory workers who themselves felt more supported and skilled,

- The enhanced collaborative relationships that developed between the workers which resulted in an increased sense of shared responsibility for the young people and promoted a more settled environment where improved relationships were generated.

It is my analysis that it was the synthesis of these individual components that resulted in a highly valuable form of ‘therapeutic’ care. This care derived from the enhanced psychological, emotional, social and developmental opportunities that developed within and across the residential units and the Care Teams. As a result something new came from these
separate parts that matched the young people’s needs and emotional and psychological capacity.

9.5 MESOSYSTEM LEVEL

The good and respectful relationship is the key, developing relationships and looking after them (Regional Manager).

9.5.1 Transforming the Turbulent Field

The mesosystem, as outlined in Chapter 3, embraces the inter-organisational context and therefore how the various relationships and interactional sites within the individual’s microsystem interrelate with each other. Thus in relation to this research it includes the space in which the Care Teams operated.

Prior to the introduction of the ERP the inter-organisational context of the program areas studied in this research could only be described as ‘turbulent.’ It was characterised by poor communication, misunderstandings, frustrations and was guilty of conducting and (in some situations) promoting ‘turf wars’ (Hudson 2002:11). It was an environment characterised by significant social capital deficits.

Although these characteristics mirrored those operating state wide, nationally and in the international context,\textsuperscript{195} they were particularly problematic within this Region. As such they had contributed to the Working Together Strategy’s Regional Management Group’s decision to address what was seen as ‘...a system failure’ (Rothman and Damron-Rodriguez 1999:44) the service needs of at-risk young people living in residential care through the development of the ERP.

\textsuperscript{195} As outlined in Chapter 2
Considering therefore the challenging position facing the agencies who commenced the initiative, it was not surprising that some of the service providers involved in Pilot 1 commented ‘...it surprised us how well it has worked.’ From the position of one who was both inside and outside this initiative, the positive outcomes that the Pilots achieved in relation to the young people and the development of improved inter-sectoral collaboration and the valuable lessons from Pilot 2 Stage 1's struggles, were all important achievements.

They provided critical insights about the development of inter-sectoral collaboration and how it is both ‘...a complex process not to be underestimated’ (Smith and Bryan 2005:196-207) and ‘...a rather fragile flower to grow and nurture’ (Johnson, Wistow et al 2003:70).

The findings of this research confirmed many of the key areas discussed in Chapter Three's literature review that are required to achieve effective inter-sectoral collaboration and those that interfere with the process. One way of understanding the different outcomes that did occur is from Gidden’s (1994) concept of 'emotional democracy' which describes a process that occurs when repeated interactions establish mutual reciprocity and promote the durability of the caring relationship. As a result ‘active trust’ is achieved (1994:186). It can be argued that ‘emotional democracy’ was able to be developed for Pilot 1 and Pilot 2 Stage 2 but not for Pilot 2 Stage 1.

The findings clearly demonstrated that a number of co-existing factors are required for collaborative teams to form, develop and sustain, many of which were similar to the processes described in the first sections of this chapters. Thus for trusting relationships to develop and engagement to occur there were a number of steps and stages that needed to be passed
through. Thus many of the words the workers used to describe what occurred in the formation of the Care Teams mirrored those they used when discussing the engagement that was achieved between workers, young people and families.

The workers also needed to feel safe and settled. They needed to feel contained. They needed a holding environment providing structure and containment. In particular they needed the time, space and opportunity to learn how to let go firmly held preconceptions and commence the tentative process of getting to know, and trust, their inter-sectoral colleagues. However this does not imply that the form of the relationships that were established were exactly the same as those which developed between the young people, families and workers, but that many of the critical ingredients were the same.

In the following sections the factors that promoted the development of an environment of emotional democracy and active trust will be explored in more detail.

9.5.2 The ‘Right’ Agencies

_They had a good range of services there and good access to services (Pilot 1 Parent)._

_Morton et al (1999) stated that ‘..to meet the needs of young people with extreme levels of disturbance, an integrated and specialist cross-program response is required. The recommended service model therefore provides_
treatment, education and care' (1999:xi). This balance was achieved to different degrees in all three pilots.\footnote{In this respect I am counting Pilot 1, Pilot 2 Stage 1 and 2 as three distinct case examples of the ERP model.}

As clearly highlighted in the discussions in the Microsystems section earlier in this Chapter and particularly in 9.2.2, the 'right' agencies and 'right' people needed for an integrated and specialist cross-program response involved the inclusion of the previously excluded and devalued professional group of residential care workers as well as finding a way of engaging the valued but disengaged program areas - mental health, drug treatment services and education.

What the findings of this research further highlighted is the careful thought and matching that needs to be applied in determining what the 'right' cluster of services and the correct representatives from those program areas needs to be for the collaborative approach being undertaken. The experiences of the ERP pilots confirmed Berlin's (2001) comments that the 'right' cluster of services includes the involvement of residential care workers, teachers and therapists as this cluster '....is essential to the effective treatment of seriously attached-disordered clients in residential treatment' (2001:6-10)

In relation to educational practitioners as Berlin (2001) identified, '...education is a critical part of the total treatment process' (2001:6-10) However Education is in a different situation to the other program areas as it is a universal service providing care to all children within the community. Therefore to expect someone from a mainstream school to contribute to this specialist area of work and manage such a commitment alongside their
general duties was a ‘tall order’ as demonstrated in the unsuccessful integration of the teachers in Pilot 2 Stage 1.

As these research findings demonstrated ‘... a core feature of the model is that it has to be CAMHS teachers involved rather than teachers released from schools’ as those involved in Pilot 1 were or, as occurred in Pilot 2 Stage 2, someone from a specialist facility trained to work with young people with complex needs and a fractured educational history.

The contribution of Education is critical for young people excluded from the school system and the achievement in Pilot 1 and Pilot 2 Stage 2 of successfully ‘reconnecting the young people to the education experience’, (Pilot 1 Service Provider) was invaluable and critical to the Pilot’s success.

In addition the contribution of these ‘non-welfare’ practitioners was particularly useful for the Care Teams themselves, providing a grounded contribution that demonstrated that a ‘...diversely constituted team can create a synergy that produces innovative problem solving and facilitate integrated intervention’ (Sands and Angell 2002:265).

The research findings also confirmed what was identified in Chapter One, that the engagement of mental health services was a critical component to the success (or struggle) of the ERP. A Manager involved with Pilot 2 identified that;

>You can’t underestimate the importance of the mental health clinician’s role within the Care Team. It is crucial and the importance of someone who spanned management and clinical work being in that position (Manager Pilot 2).

Thus it is both the ‘right’ agencies but also the ‘right’ people from those agencies that holds the key.
9.5.3 The 'Right' People

The literature identified that working from a collaborative approach does not suit all workers. There are particular characteristics required. These were identified as '....the ability to be adaptive and innovative' (Rothman and Damron-Rodriguez 1999:33, 43-44), people who could '...manage multiple relationships' and '....group emotions particularly in times of ambiguity' (Smith and Bryan 2005:196-207).

The findings of the research confirmed the need for a blend of ingredients; someone coming from the required background and having the relevant qualifications, knowledge, skills and appropriate theoretical framework (Currie 2001:47-8) but also having personal qualities that inspire and promote positive team functioning. Someone with credibility, whose skills matched what was required working from a collaborative approach and acting as a mentor to others.

In relation to educational practitioners, Berlin (2001) identified that collaborative approaches require '....exceptionally talented, flexible and psychologically minded teachers' (2001:6-10). One could argue that these same characteristics applied equally to all program representatives. The contribution of the first CAMHS representative from Pilot 1 was identified as an example of the 'right' person to be involved in such an initiative. The qualities and characteristics cited were '.... involved, committed, passionate and promoted (the initiative)’(Regional Manager).

Included in these skills to work collaboratively is the capacity to reflect on the learning and experience of being involved in such a challenging process and the openness to embrace what Teather (2001) described as 'a paradigm
shift' (2001:10). These comments from Pilot 1's mental health worker demonstrate this process,

   I learnt that mental health skills need to be delivered in a way where there is an openness, a trust and a shared focus that came from being part of a team. I couldn't have experienced this if I hadn't been involved in this model. It's changed my practice in terms of how psychiatry services can be delivered.

The transition to being able to shift to this shared focus was identified by a number of authors as being critical to teams being able to provide '...effective and creative care' (Rothman and Damron-Rodriguez 1999:39-40). What these findings demonstrated was that this transition has to occur at a dual level; for the team but also for the individuals and the capacity to achieve this shift in focus requires individuals able to demonstrate flexibility and adaptability.

Johnson et al (2003:206) talked about the importance of 'champions.' They focused on those who promote the 'cause' of collaborative practice within and across agencies or regions and the need for this individual to be a key person within the agency. This concept will be discussed further in the next section in relation to how it applies at the exosystem level.

However it is my analysis that for effective collaboration to develop, champions are needed across all levels including within the team itself and that it was this function that the Pilot 1 mental health representative provided and was unfortunately lacking for Pilot 2 Stage 1. The strength of this person's contribution was that he was a psychiatrist, coming from a highly respected profession and held a senior management position within his agency. These qualities were particularly important for the context that existed within the Region at this time.
It was also the case that Pilot 2 Stage 2 had champions most of whom sat outside the Care Team structures. They were individuals within strategic management positions within the agency whose support and opposition played key roles in Pilot 2 Stages 1 and 2’s outcome. Thus both examples highlight the strategic role played by ‘...a "change agent" or "opinion leader" who promotes’ and therefore authorises the initiative (Rothman and Damron-Rodriguez 1999:46-48).

The qualities identified as critical for enabling engagement to occur between the young people and external workers equally applied to establishing trusting working relationships between the workers themselves. The words the stakeholders used;

...reliability, consistency, accessibility, flexibility, creativity, and patience, responsive, committed, experienced, willing to take risks give things a try and the strength to think outside the square.

resonate with the qualities identified earlier by Winnicott (1973), Bion (1967) and Bowlby (1988) describing what is required to hold, contain and provide a secure base. In addition these qualities are also required to negotiate the challenge of working as an inter-sectoral collaborative team.

The findings of this research demonstrated the importance of workers who as Bland and Renouf (2001) described were ‘...sufficiently robust to welcome alternative perspectives' (2001:240) and weather the ‘...rollercoaster ‘ the service providers described. They needed to be able to negotiate ‘...trust, ambiguity and conflict’ (Smith and Bryan 2005:196-207).

This research was not intended to compare or ‘play favourites’ between the pilots that were studied. What this research demonstrated was how when workers with many of the 'right' characteristics (described above) are
placed together there is an increased opportunity for effective inter-sectoral teams to develop (as occurred in Pilot 1 and Pilot 2 Stage 2) compared to what occurs when they do not (Pilot 2 Stage 1). What it also revealed was that even when the 'right' agencies and 'right' people are involved it is a complex road that needs to be travelled before effective partnerships are achieved.

9.5.4 Processes that Promote Partnership Building

The experiences of the Pilots’ strongly supported Robinson and Cottrell’s (2005) statement that

...team members with different backgrounds cannot be expected to just work together effectively from day one (Robinson and Cottrell 2005:557-8).

As these research findings highlighted, the workers had to learn how to become a team. A number of factors contributed to this process of team building. In particular these were:


- the time to develop a sense of connection,

- structures such as regular meetings,

- the support of a leader/facilitator,

- team members who were interested and able to participate both personally and
team members who were supported by their home organisation to do so.

Time is crucial and yet is often the ingredient missing in our 'short-termism' culture. It is particularly needed to redress and address toxic inter-organisational cultures that have taken many years to establish. Time in this situation relates to time within and across contact, that is, sufficient time when meeting, and sufficient meetings across time. These pilots demonstrated the importance of regular committed time that was used well and the stress when it is not. Thus how time is structured remains critical.

These pilots also demonstrated the importance of the team engaging 'in a planning process' (Walker and Schutte, 2004:185) but one which involved those who needed to be involved. They also confirmed the findings of Robinson and Cottrell's (2005) research which highlighted the need for established teams to also '...be supported and encouraged (through) training and development,' supervision and consultancy as staff undergo '...changes in work practices.' This requires an emphasis to be given to 'nurturing inter-professional relationships and rituals to sustain professionals' commitment to new ways of working (2005:558).

Working from practice frameworks that match the needs of vulnerable young people is also essential for the practice models operating within a collaborative approach. The goal of these models as Webb (2006) states is for an intervention that

.....can act as a safety net of security for vulnerable people and those in need of social protection from risk or harm, a concern for the well-being of the client, the establishment of trusting relationships and a

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sense of belonging through feeling secure sit at the heart of much of front-line practice (Webb 2006:231).

It is interesting that the actual theoretical and practice frameworks that the workers involved in these pilots used were not identified. However the fact that service providers involved in Pilot 1 commented that ‘the opportunity to learn how the mental health worker conceptualised his work and applied his framework was something we valued’ implies that it was discussed within the team context.

9.5.5 The Glue That Held Them Together

The findings of this research confirmed Teather’s (2001) statement that a ‘pivotal requirement’ (2001:17) in adaptive team functioning is the role of strong leadership and skilled facilitation. As the literature has also highlighted, some professions tend to be marginalised, while others are more likely to claim the leadership within collaborative ventures (Birchall and Hallett 1995:249).

One of the most fascinating factors in this initiative was that those roles were turned on their heads with the position of the co-ordinator of the teams taken on by residential care unit managers, the previously most marginalised excluded group.198 In this respect these were very different teams. It placed enormous pressure on the people who held that role, something which the individual in Pilot 1 was able to achieve because of their outstanding personal skills but which proved problematic for the person in Pilot 2 Stage 1 with the unfortunate combination of difficulties operating within that context. It also required team members who demonstrated the

198 Particularly, when there were other members of the team, mental health representatives and child protection workers, who would usually have assumed these roles.
capacity to tolerate a very different leadership structure to what they were used to.

9.5.6 Where To From Here?

Alongside the unanimous agreement from the stakeholders that the ERP had achieved improved conditions and outcomes for the young people, was universal support for the continuation of the Care Team model within all residential units. A number of the stakeholders also supported variations of the model such as expanding to include a day program, or the membership of the model being expanded to include other professionals and to provide services for other children and young people who ‘...don’t fit the mould.’

There seemed universal agreement from those interviewed that this was a ‘...model with legs.’ However there was agreement that despite its enhancement to prevailing models of residential care, an initiative such as the ERP was not a panacea for all ills and could and should not make up for broader structural deficits in out of home care particularly in relation to improved staffing models, training requirements and funding levels particularly for the CSO sector. Thus they supported Moses’ (2000), position that ‘...substantial changes in structure are called for’ (2000:488-9).

9.6 EXOSYSTEM LEVEL

The exosystem consists of the institutional infrastructure of the labour market, the legal, monetary, health, education and welfare systems. This is the layer in which the individual does ‘...not have direct, face-to-face relationships’ but which profoundly and indirectly shapes their individual experience and interpersonal and social constructs (Harms 2005:10). As
outlined in Chapter 3, the exosystem is the level where the policy and service development activities promoting collaborative approaches at the regional and state wide levels are conducted.

It also encompasses the operations of the key service sectors including their funding models, staffing structures and relationships. Within this research, the structures that are located within the exosystem consist of the regional structures of the Regional DHS Office, the WTS Management Group and WTS staff and to some extent the ERP Steering Committees.

9.6.1 ‘Cultures of Commitment’ for collaborative practice

The findings of this research substantiated many of the critical areas that have previously been identified by writers as needing to be present at the exosystem level. Robinson and Cottrell’s (2005) comment that multi-agency teams need to be supported by a ‘...“culture of commitment” at strategic and operational macrosystemic levels,’ was certainly demonstrated (2005:556).

The success of the ERP with both Pilots 1 and Pilot 2 Stage 2 achieving their key goals of improved outcomes for the young people and the development of functioning inter-sectoral Care Teams was the result of a number of cultures of commitment. These ranged from the authority hierarchies within the program areas of the service providers’ home organisations, to support from regional structures.

A theme which strongly permeated the Regional Managers’ comments was the proud ownership they felt for the initiative and their delight in what had been achieved through its implementation. They strongly acknowledged the gains that had been achieved through the ERP playing a central role in other
achievements occurring in implementing and sponsoring a changed culture across the Region.

What was striking however, was that those directly involved in the pilots both in the Care Teams and Steering Committees did not appear to know this was how the Regional Managers thought. Their experiences of the Regional Management level were of faceless bureaucrats who they felt isolated from, criticised, controlled and dismissed by. Communication and feedback loops were strangely and unfortunately missing.

A surprising result from the findings was the relatively minimal comments made by some of the stakeholders in relation to these structures despite their pivotal role in promoting a culture of commitment for the ERP. The further away from these structures the less comment was made. There did not seem to be an awareness that many of the positive experiences that had been achieved had been supported through the actions of these levels having done a ‘good job’ of the planning, preparing, supporting and acting as a buffer between the Care Team and external bodies.

There was also no reference at the Care Team level in particular to the contribution of the wider WTS structures (which organised many of the areas identified as useful, for example, training), or the Regional Management Group. The Care Team saw itself as a self-enclosed entity responsible for the positive experiences that were occurring.

Although there were very few references made about the contribution of the external system to the strengths of the model this differed when discussing the limitations. This indicated that service providers did not see
the role that the external system played in contributing to the strengths of the model but did see the impact they played on the deficits.

The Steering Committee members had more to say about the negative impact of some of the external bodies they related to, particularly the WTS management structure and the regional management group who were seen, at times, as interfering and undermining and not listening to what they wanted. It was also surprising how few opinions were expressed by the service providers towards senior DHS management,\textsuperscript{199} although when the tape was turned off that was a different story again. It was not surprising that those who did speak openly on this topic were not employed in program areas which had direct line responsibility to or were directly funded by the Regional DHS Office.

When discussing the 'culture of commitment' it is necessary to address what occurred for those involved in Pilot 2 Stage 1 which was a clear demonstration of what occurs when that culture was patchy at best and missing at worst. Certainly the description of feeling 'unsupported' that existed at both the Care Team and Steering Committee level highlighted how without those organisational supports and structures, it is very difficult for direct care workers to successfully achieve the development of a collaborative team.

\textsuperscript{199} However there were a number of comments made on this topic that occurred 'after the tape recorder was turned off' thus were unable to be included in the findings. It may not be surprising that these comments were critical comments made about individuals within the WTS and DHS Management structure. The reluctance to include these comments 'on the record' seemed to be influenced by a concern about the potential negative consequences of making these comments. Clearly this indicates that for individuals who feel disempowered within an organizational structure, it is difficult for them to step outside their real life situations despite the 'protection' and anonymity offered by the research context.
Whether it was the changeover of staff at crucial times in the planning process, the mixed messages being given about expectations, the reneging of agreements related to the time devoted to the task, all resulted in an environment that actively interfered with trust being developed and the work being able to be achieved.

9.6.2 'Champions'

The literature also states that the 'culture of commitment' is reliant on what Morley and Wilson (2001:6) describe as a 'champion,' who Johnson et al (2003:206) identified, as discussed in the previous section, needed to be a key person within the agency. As one of the Steering Committee members identified, support for an initiative such as the ERP needs to also exist at all levels within the organisation, from the Director to the team leader or program manager.

Pilot 2 Stage 1’s experience demonstrated the fragility of the culture of commitment. How it could be dependent on one key person who, in an environment of high staff turnover can then place the initiative and individuals in a precarious position. Thus, as this research demonstrated, there needs to be a number of champions both within and across organisations and relevant structures.

Pilot 2 Stage 1 also demonstrated the importance of the inclusion of all key players and that there may be hidden key players who need to be engaged in a process for it to succeed. It also demonstrated the critical need to
recognise key existing philosophies and programs already operating within
the organisation as well as individuals.200

9.6.3 The Specialist 'Outsider'

Equally critical was Stead et al's 'specialist inter-agency worker' (2003:44),
the 'outsider' who was skilled in pushing through new and innovative working
practices. In this research that role was taken by the WTS Project Officer
position. However it was notable that there were no references made by the
Care Team members about this position, with some comments from the
Steering Committee members but the main people who acknowledged it were
the Regional Managers.

Most comments were positive, acknowledging the contribution made by the
WTS Project Officer to the early development of the Pilots and the impact
noted when the position was not filled. 'The PO has been the glue that held
the Steering Committee together and some have done this well and some
less well.' However it seemed there was a highly ambiguous relationship
towards the WTS Project Officers from the Steering Committees who
described the position both as a champion and facilitator of the initiative,
but at other times a mouthpiece of management.

I wondered whether more was not said because of my having held this role
previous role, whether they were protecting me from feelings related to this
time or when others had held the position. I also wondered whether much of
the impact of such a position is in fact, invisible. Many of the activities that
were referred to occurred because of the work the project officer had

200 This seemed to be a particularly sensitive point for some representatives from the CEO
involved with Pilot 2 who felt that there was no recognition that they had been working
from what they called a Care Team model (and a superior version to the ERP) for some time.
directly undertaken with the support of Senior Management, but were not acknowledged.

Was a feature of these facilitative championing positions that they contribute to the foundation and structures that enable such an initiative to operate but this work is rarely seen until it is taken away?

The research highlights that whilst supporting strongly the need for a specialist inter-agency worker it also identifies the complexities involved in holding the ambiguities of such a position.

9.6.4 What the Research Demonstrated about implementing policy into program and practice - assessing the pilot factor

The experience of this research highlighted many of the themes raised in the literature about the challenges of translating broad policy directions into program descriptions and then negotiating these parameters into direct practice particularly when the mechanism used was a 'pilot.' This research demonstrated that there were a number of strengths in taking this course of action particularly that the pilots' 'special status' provided resources that would not otherwise be present.

These strengths included the support of the WTS Project Officer and the presence of the Steering Committees which provided another layer of authorisation and legitimacy and governance to the work of the Care Teams. However on the deficit side, the experience of the ERP demonstrated how being involved in a pilot can place additional stress on people already working under difficult circumstances (Teather 2001:14).

This was particularly the situation for Pilot 2 Stage 1's Care Team members whose descriptions of being unfavourably compared to their colleagues
involved in Pilot 1 and living in this fishbowl of scrutiny, highlighted the stress that can come from this experience.

As Mitchell (2000) identified, a crucial issue is what comes after the pilots, ‘...whether governments and area and regional service managers maintain a commitment to the area’ (2000:121). The Regional Managers believed that a number of positive achievements had occurred as a result of the ERP including the use of Care Teams which were ‘...now seen as the way to work with a young person with multiple issues, a more developmental way and the way we should work with every young person.’

It was also felt that the ERP had initiated a number of spin-offs for this region but the challenge was

...to keep the gains that have been achieved because of the WTS going - shared case management, shared responsibility for the young people, the strength to think outside the square, take risks, give things a shot (Regional Manager).

However the outcomes that have occurred to the Care Teams since the Pilot phase ended demonstrate the mixed outcomes that specific initiatives do face. On the negative side they demonstrate a number of the concerns

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201 The fragility of the Pilot status was clearly demonstrated by what happened to both Pilot 1 and Pilot 2 Stage 2 soon after the Pilot phase ended when both the residential units were moved to other locations within the region. For Pilot 1 this meant the composition of their Care Team could not continue as the agencies involved in that pilot did not service the part of the region that the unit moved to. Since relocating the Residential Care Supervisor has worked tirelessly towards creating a new Care Team with mixed results (he has set up a new Care Team but not with the program representation he wanted). Pilot 2’s CSO retains the use of Care Teams working from the model established in Pilot 2 Stage 2. On a positive note the role of pilots in ‘piloting’ new service models that are then transferred and integrated more widely has been demonstrated by a number of new initiatives being developed in the region. These include discussions between some of the agencies that had been involved in both Pilots to develop new Care Teams to service other residential units across the Region. Care Teams have also been established by Child Protection for a number of at-risk adolescents in their care. The WTS continues in this region and has established a number of other excellent initiatives.
raised by a number of authors (Scott 2000:9)\textsuperscript{202} in relation to the sustainability and transferability of using time-limited pilots particularly when strategies to support their integration into core practice were not factored in from the beginning. However they also demonstrate how Pilots can be used successfully as a means to ‘test’ new service models that are then transferred and integrated more widely into new initiatives (see footnote 32).

9.7 THE MACROSYSTEM LEVEL

The macrosystem encompasses the broader cultural blueprint of a society, the cross-national economic, social and political factors (Scott 2000:5) and the dominant discourses that operate in society. As discussed in previous Chapters, when a risk society and critical theory analysis is applied to this research context, the dominant discourses of advanced liberalism (Webb 2006:4) and the fragmented service systems that operate within the field of child welfare and ‘community services in the ambiguous political and ethical demands of post-institutional society’ (Green 2003:19), the result has been over-regulation of marginalised groups such as at-risk young people and their families. Central to the values that underly these beliefs is the promotion of problem-saturated myths and narratives about the young people and their families.

Operating within the constraints of this broad context, the service initiative studied in this research aimed to develop an inter-sectoral collaborative

\textsuperscript{202} Scott’s (2000) words speak very strongly about these negative costs. ‘New programs often only have short term funding due to the insatiable political appetite for new initiatives. Often we see excellent programs destroyed only to be reinvented at a later date. In the process families are hurt by the withdrawal of the service, valuable staff and professional expertise are lost, and inter-agency goodwill is weakened’ (2000:9).
team which offered an alternative to the prevailing 'one-dimensional performance management culture' (Ferguson 2005:791). On the whole they did succeed in enabling service providers and their agencies to form connections and find a shared common concern and methods to engage with each other and the young people in ways that promoted creativity and improved outcomes for the young people.

However some of the obstacles they encountered on their journey and the outcomes that followed the lifetime of this pilot demonstrated the multiple ways in which the macrosystem's values, priorities and structures can and do impact and are expressed in micro-practices.203

However despite the macrosystem’s blueprint, values and priorities permeating the worlds both the service providers and the young people and families occupied throughout all the ecosystem levels, the material raised in the research was predominantly silent on the macrosystem level. Those who mentioned macro influences were mainly the Regional Managers and a few middle managers.

What was noticeable in the Regional Managers' comments was that, despite presenting as quite distanced from many of the face-to-face impacts of the ERP model, they preferred a feedback loop which did not rely solely on a top-down model of policy implementation:

203 Examples included the poor communication and fragmentation that was mirrored between the regional management, middle management and direct practice level, the impact of staff turnover and inflexibility of some work practices, the dichotomy between the overzealousness of some of Pilot 1's practices and Pilot 2's laissez faire philosophy and the use of case management practices which unfortunately demonstrated Kiraly's (2002) description of "...unsatisfactory and discriminatory practices of discontinuity of care" (2002:10) and, as identified in 9.3.1 the attitudes expressed towards Pilot 2 Stage 1's young people.
...the experience that is gained through implementing the model can be taken to a senior level to get structural change that supports that kind of model (Pilot 1 Service Provider).

9.8 CONCLUSION

In this chapter the critical findings of this research were explored. It was demonstrated that the research provided confirmation within the Australian context of the critical existing knowledge about collaborative approaches and provided further expansion and extension to this knowledge through an application of this approach for at risk young people. This consisted of further detail and insight into the dimensions required for the development of effective collaborative approaches (both between workers and between workers and young people).

The research demonstrated that a multi-dimensional matrix of elements, stages and factors is required for the development of effective collaborative approaches (both between workers and between workers and young people). These dimensions include attention to the temporal, physical and psychological, social, organisational and policy dimensions. The findings demonstrated therefore that for professionals to engage effectively with at-risk young people and their families, engagement needs to exist within and between all the relationships, levels and domains that impact on the young person.

This multidimensional engagement creates the foundation required to develop and sustain inter-sectoral collaboration. The findings demonstrated that an interlocking and interacting cluster of areas need to be present to strengthen all levels of collaborative activity and intervention and that these occur through progressive stages.
In the following chapter these dimensions will be explored in more detail and it will be outlined what they have contributed to an understanding of the principles and guidelines that inform 'good enough' collaborative practice.
CHAPTER 10: CONCLUSION

At the end of the day without each other it’s not going to work (Pilot 1 service provider).

10.1 INTRODUCTION

As identified in Chapter One, this research was generated through recurring experiences that presented themselves across a number of work places which shared an interest in, and commitment to improving service responsiveness for young people with complex needs and their families.\(^{204}\)

Despite the frequent presence of commitment, good will, extensive practice experience, and even when operating from a policy framework that promoted the use of inter-sectoral collaborative approaches, when the time came to ‘just do it’ - work collaboratively - something inevitably seemed to go wrong. In this particular terrain we needed additional maps and guides to complement those we usually relied upon.

Thus the journey of undertaking this research commenced with the goal to further strengthen the existing and valuable Australian and international knowledge base regarding inter-sectoral collaborative approaches. In particular, my aim was to expand our understanding of the practice principles and guidelines for working with young people with complex needs and their families. The research methods, and specifically the research questions, were designed to provide an increased understanding of effective collaborative approaches.

\(^{204}\) As a CAMHS social work practitioner working directly with young people with complex needs and their families, and in a service development position specifically established to facilitate strengthened inter-sectoral collaborative responses for these at-risk young people.
This chapter commences with an overview of the strengths and limitations of the methodology selected to inform this thesis beginning with how successfully the research that was undertaken answered the main and subsidiary research questions.

10.2 METHODOLOGY AND METHODOLOGICAL CHALLENGES

Research is an essential tool in improving services and making them more accountable. Qualitative research in particular has given groups of people previously denied a voice the opportunity to be heard for the first time. It is a powerful tool and one to be used with care (Darlington and Scott 2002:47).

10.2.1 The Strength of the Methodology

*It's never happened before that I've been asked what I think of the services and it should happen, it's good* (Young person, Pilot One).

The design of this research was informed by an interpretative research paradigm utilising qualitative research methods. It utilised research methods that effectively provided the means to answer the following research questions.

1. What are the principles and guidelines to inform services operating within an integrated collaborative approach for children, adolescents and young people with complex needs?

2. What do current policy documentation and local and international literature indicate are the core components of integrated service delivery models for adolescents and young people with complex needs?

3. Taking cross-sectoral care teams as one example of an innovative service delivery model for children, adolescents and young people with complex needs,
3.1 What do service users, family members, service providers, managers and policy providers involved in the implementation and operation of this model indicate are its core features and key issues?

3.2 What are the strengths and limitations of the model for strengthening the emotional, social, psychological, educational and cultural needs of children, adolescents and young people with complex needs?

4. What are the implications arising from answers to these questions for future policy directions, program development, service delivery and practice models for working with children, adolescents and young people with complex needs?

5. What are the implications arising from answers to these questions for future policy directions, program development, service delivery and practice models for working with children, adolescents and young people with complex needs?

10.2.2 The young people’s and parents contribution

A qualitative stance invites broad-based inquiry into spaces that are undocumented in other studies (Marecek, Fine and Kidder 1997:632).

One of the strengths of the research methodology utilised was that it provided a respectful and effective means of exploring and conveying the lived experience of at-risk young people, their families, service providers and managers during the development and implementation of the intersectoral service initiative, the Enhanced Residential Program. It provided an opportunity for the young people and their families, who have previously tended to be excluded or silent within research, to contribute their stories and perspective about collaborative practice.
In addition, the experiences of this research demonstrated that, despite the quite strong misgivings expressed by some service providers about the willingness of the young people and families to participate and the anticipated negative impact of their involvement, the contrary proved to be true. All those interviewed participated enthusiastically, expressed that they appreciated the opportunity to contribute their perspective and demonstrated the ability to provide thoughtful, insightful and helpful comments.

The findings demonstrated that the young people and parents were very astute observers and interpreters of their environment. From the young people's location of experiencing the initiative from 'inside' the experience and the parents' lens being singly focused on the impact of the model on the young people and themselves, their comments demonstrated the ability to 'see' and name critical issues including some not raised by the service providers. They demonstrated '....an attention to discourse that (allowed) us to find the absences and silences in the language of organisations' and to '....tell localised stories which had theoretical power' (Hough 1999:43, 51-2).

When we reflect that within the risk society frame of reference as Furedi (1997) identified '...being at risk becomes a fixed attribute of the individual' (1997:19), the findings of this research also highlighted the narrowness and shortcomings of this discourse that surrounds the young people and their families.

Far from being passive objects of control whose level of risk needs to be monitored, they demonstrated as Gidden's (1984:25) has identified, the capacity to be 'active agents' impacting on their environment. This interactive capacity was demonstrated by the young people and families'
capacity to name some of the fundamental deficits that existed within the Care Team’s functioning as well as the enthusiasm within which they embraced the opportunities made available to them in these environments.

Thus, when provided with the opportunity to have their voices heard, the young people and their families who were interviewed demonstrated that far from being abstract ‘high-risk adolescents’ they, like all adolescents and young people were articulate, thoughtful, compassionate, multi dimensional human beings with common as well as uncommon human needs.

As one of the important contributions of this research was the opportunity to hear this contribution of the young people and their families’ perspective, the thoughtfulness and wisdom of their responses reinforced the importance and necessity to ensure their continued involvement in future research and evaluation.

10.2.3 The Challenges of the Methodology

There is a tension between, on the one hand, the desire of and need for marginalized groups to come to voice, and, on the other, the inevitable role of the researcher in co-constructing such accounts (Acker 2001:158).

The most significant challenge of the methodology proved to be the requirement to work through a third party to access the young people and families. Thus a process that was introduced to protect vulnerable young people, the gatekeeper role, paradoxically in some circumstances, inappropriately resulted in denying a number of the young people and families the opportunity to tell their stories.

Consequently I encountered the truth of Ely’s (1991) warning that,
Sometimes gatekeepers are not easy to determine. You may believe someone is the gatekeeper only to find it is someone else in the organization (Ely 1991:20).

In this research another challenge was the discovery that there were more gatekeepers than I initially anticipated. These consisted of different gatekeepers appearing at different stages in the research, including ‘hidden’ gatekeepers as Ely (1991) identified, ‘...Often you don’t find out who it is until you find out more about the situation you are studying’ (1991:20).

In hindsight with the awareness of these additional gatekeepers the process of conducting this research may have been simplified by employing different strategies in relation to engaging each of these gatekeepers. In particular despite receiving formal approval to conduct the research from senior managers and meeting with them it may also have been useful to meet with those in strategic middle management positions to ensure their active support for the research which would have then filtered down to the case managers I so heavily relied upon.

10.2.4 What I Would Have Liked To Learn More About

Being able to see the ‘maze of many’ truths requires an openness of mind, a willingness to confront one’s own beliefs directly, and the strength of character and intellectual honesty to let go of cherished assumptions (Ely 1991:127).

Although the questions used in the interviews satisfactorily answered the research questions, it was only after a number of interviews had been conducted that I realised that I would have liked to learn more about the theoretical and practice frameworks the service providers utilised when engaging with the young people.
Due to my own increasing engagement with the issue of which theoretical and practice frameworks did provide 'best practice' for vulnerable young people and their families, it would have been interesting to explore with the service providers their perspectives.

Another area that did not emerge as much as I had thought it would, was learning about how the service providers understood the young people's needs and cultures, how they perceived these young people. Did they share the wider social constructions of 'at risk' young people or did they have a more holistic perspective? Although my reading of their general responses to how they perceived the young people indicated the latter (other than those involved in Pilot 2 Stage 1) I would have been interested to address this area more directly.

In retrospect both these areas required specific questions in their own right and are certainly worthy of further research attention.

10.2.5 Reflections on being a 'border-dweller' 205

There were many learnings throughout this research process about the challenges of conducting practice based research. Many were alluded to in Chapter 4. In this research my positioning of being '...both an insider and outsider in the world that I am researching' (Haynes 1999:663) no doubt enabled me to gain access and insight into the complexity of the issues the stakeholders faced and therefore to '...work creatively at the 'edge of the frame' (Garrett 2002:840).

As I reflect on the journey and outcome of the research I am struck by the recurring motif of 'spatial positioning' and boundaries for this research. 206

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205 Acker (2001:166).
This initiative was established to find a way to effectively link marginalized young people and the residential staff who care for them, (both of whom are marginalised within their respective communities) with workers who, because of their dominant form of service delivery, have been 'outsiders' to this client group. It may be the case that many of the contributors to this research, (including myself) could be seen therefore as being faced with matters related to being inside and outside, included, excluded and straddling 'borders.'

From the point of view of being the researcher who had previously been located inside the area of practice this research was exploring, I became acutely aware of Bland and Renouf’s (2001) conceptualisation that social workers frequently find themselves '...working on the edge (which) can be difficult and uncomfortable, and brings with it some ambiguity of role' (2001:240).

It is my hope that whilst conducting this research I was successfully able to balance working on 'the edge' and through the frame I brought to the research to achieve Garrett’s (2002) recommendation that '....because of social work’s proximity to oppressed and exploited people and because of its attentiveness to the processes of micro-interactions, it perhaps has some opportunity to forge a different type of research agenda' (2002:840).

The following sections of the chapter continue my reflection and appraisal about the contribution of this study to social work practice.

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206 The concept of boundaries relates to the psychological and physical spaces that people occupy. They refer to the living experience that occurs within each of these spaces.
10.3 THE CONTRIBUTION OF THE THEORETICAL FRAMEWORKS AND CONCEPTS

As outlined in Chapter Three the task at the core of this research, to understand the dynamic interaction of multiple elements in producing outcomes which bettered the lives and experiences of vulnerable young people, required the application of a range of theories and concepts which in combination held explanatory power. The theories I selected; psychodynamic theory, multidimensional ecosystems theory, critical theory, structuration theory and the concepts of risk society and social capital, provided a useful mechanism in achieving this task.

They informed the research design of a case study, the methodologies used when conducting the policy analysis and literature review, the in-depth interviews and descriptive profile of the stakeholders involved in a collaborative service initiative. They also provided a frame to analyse the policy and literature and a framework for the analysis of findings.

In particular the key ideas of connectedness and trust that emerged as integral to the frameworks and concepts proved to have strong resonance for the findings of this research and as core components of the principles and guidelines that inform collaborative approaches.

Most importantly these theories and concepts enabled me to capture the complex phenomena being studied in this research, to take a multidimensional lens and achieve a comprehensive account of the phenomena being studied. They provided an in depth and detailed account of the ingredients of the “glue” that hold collaborative approaches together.
10.4 CONTRIBUTION OF THIS RESEARCH TO SOCIAL WORK PRACTICE - PROMOTING 'GOOD ENOUGH' COLLABORATIVE APPROACHES

Trainor (2002) identifies that ... young people need social and political groups and institutions to be worthwhile, sound, good and true, to be vital sources of meaning and to provide cultural pathways to truth (2002:208).

This research demonstrated that a matrix of co-existing dimensions, stages and components is required for the development of effective 'good enough' collaborative approaches (both between workers and between workers and young people). These dimensions include the dynamic interaction of the temporal, psychological, social, organisational and policy dimensions.

The psychological dimension - encompasses the creation of a 'safe place' that is containing, a holding environment. This applies to what inter-agency workers require so that they can learn how to become an effective working team and what young people require to be able to effectively engage with workers.

The personal dimension - effective inter-sectoral collaboration has more chance of being achieved when those participating in it possess a 'good-enough' cluster of particular characteristics.

The temporal dimension - incorporates a 'good enough' (realistic) and regular amount of time for the work of collaborative practice to be achieved.

The organisational dimension - This research has demonstrated that workers are more likely to achieve effective inter-sectoral collaboration and engage effectively with young people when they are realistically and genuinely supported by their home organisations, by the presence of multiple key
players, champions within and across organisational settings and when their home organisations demonstrated specific qualities and characteristics.

The policy dimension - effective inter-sectoral collaboration is strengthened by the existence of policies that support these approaches and also provide the structures that enable them to be achieved.

When these dimensions are attended to, those involved in effective collaborative practices are in a strengthened position to ‘...create a synergy that produces innovative problem solving and facilitates integrated intervention’ (Sands and Angell 2002:265) for service responses to vulnerable young people and their families.

As a result of the findings that emerged in this research the following practice principles and guidelines have been identified to inform the facilitation of collaboration practice approaches.

10.5 PRINCIPLES FOR INFORMING COLLABORATIVE APPROACHES

Feedback loops from the research to policy and practice will often be central to the research (Darlington and Scott 2002:34).

This research has demonstrated that collaborative activity and intervention are strengthened by the presence of an interlocking and interacting cluster of areas. The research has confirmed that collaborative activity and intervention occurs through progressive developmental stages.

Achieving effective inter-sectoral collaboration is strengthened by the following principles:

- Vulnerable young people and their families require service responses tailored to their needs and capacities
Program areas involved with vulnerable young people and their families need to achieve effective and sustained collaborative approaches as a component of ‘good enough’ service delivery.

Effective collaborative approaches are based on values of respect and ethical practice that promote the development of ‘...meaningful ethical relationships’ (Webb 2006:232).

10.6 GUIDELINES FOR INFORMING COLLABORATIVE APPROACHES FOR VULNERABLE ADOLESCENTS AND YOUNG PEOPLE AND THEIR FAMILIES

The findings of this research demonstrated that when it comes to achieving effective collaborative practice, one size does not fit all nor do short cuts work. Achieving effective and sustainable collaborative practice requires a multi-dimensional developmental process that needs the time and conditions for sustained change to occur.

10.6.1 Guidelines for policy design (macro level)

Collaborative practice is strengthened when an active commitment for this approach is demonstrated at all organisational levels; statewide, regional, intra and inter-organisational, inter-departmental committees; structures which seriously tackle the ‘silo’ structures - not to dismantle them but address how they can operate in a more integrated way and address the current anomalies.

The presence of strategic and numerous champions at the regional and statewide levels will also support these approaches.
Effective inter-sectoral collaboration is strengthened by the existence of policies that support it but also provide the structures that enable it to be achieved including:

- flexible funding and staffing models
- provision of resources
- provision of training opportunities

10.6.2 Guidelines for program design: (exosystem and meso system levels)

- Young people with complex needs are not a homogenous group. Within this category there are a number of different sub-groups with different needs and requirements. Therefore the selection of young people for involvement in collaborative programs needs to be based on the young person’s developmental and psycho-social needs and circumstances and the most comprehensive knowledge base available

- Program designs require sufficient flexibility to respond to the specific needs and individual differences within the target group they are catering for

- This may include the introduction of pilots to ‘test’ the effectiveness of a new initiative but built into the planning process is how the pilot will then be integrated into core business and the resources and structures to support that occurring

- Collaborative practice needs to embrace local agency conditions while also maintaining a commitment to general principles
Effective collaborative practice requires good will and commitment from all levels within the practitioners’ home organisations particularly from key management representatives who themselves champion collaborative practice.

10.6.3 Guidelines for engagement with young people: (mesosystem and microsystem levels)

Engaging young people with complex needs requires a capacity to build a respectful ongoing relationship delivered in safe, containing environments which are adaptive to the young person’s circumstances.

Engaging young people with complex needs requires the involvement and engagement of their significant others, particularly family members with any interventions undertaken.

Collaborative practice requires the active participation of all relevant practitioners involved with the young person.

Any interventions undertaken with young people requires active contribution to service plans from young people, their family members and all relevant practitioners involved with the young person.

Service plans for young people, particularly those living apart from their families, need to be developmentally based and incorporate a focus which is wider than that based on their current episode of care.

10.6.4 Guidelines for team operation: (Mesosystem level)

The general principles for promoting collaborative practice approaches include:
• holding regular and consistent meetings, consistency of membership, the appointment of a designated co-ordinator from within the group, promoting ongoing team development, the provision of a ‘safe place’ that is containing, a holding environment

• Ensuring that a ‘good enough’ amount of time is scheduled and provided for the planning, development and maintenance of effective relationships that form the foundation of effective inter-sectoral collaboration and promote the establishment of a shared and common goal between the practitioners

10.6.5 Guidelines for individual practice (mesosystem and microsystem levels)

• Participation in collaborative practice approaches requires practitioners learning ‘how’ to work collaboratively and thus being provided with appropriate and ongoing training, supervision and guidance

• Effective inter-sectoral collaboration has more chance of being achieved when those involved possess a cluster of characteristics. For example workers who are open, flexible, creative, knowledgeable, experienced, mature, patient, have a capacity to ‘stick with it,’ manage and embrace change and uncertainty, possess good will and a commitment to the process

• These qualities enable workers to demonstrate reliability, accessibility, responsibility, responsiveness, be well organised, be clear and respectful in their communication with and understanding of others.
Workers can only achieve effective inter-sectoral collaboration and engage effectively with young people when they are realistically and genuinely supported by their home organisations.

10.7 CONCLUSION

The focus of this research has been both on a cohort of vulnerable adolescents and young people who have often experienced significant disruption and fragmentation in their psychological, social and economic development and on the service sectors with which their lives are intertwined.

It has been argued throughout this thesis that the range of services that relate to these young people and their families are currently organised in a fragmented way. Different organisations take responsibility for different aspects of the human condition and respond to them using their own frameworks and orientations. This research has explored what occurs when representatives of these varying perspectives come together to work as an intersectoral Care Team for vulnerable young people living in a residential unit.

Many previous studies have explored similar territory and identified important understandings of the processes and components that contribute to effective collaborative approaches. A strength of this research's contribution is that its findings have confirmed these existing understandings and previous research about service system development and delivery to young people with complex needs.

In addition a particular contribution of this research has been that it has provided access to the insights of all the stakeholder groups who were
involved in this collaborative endeavour. The research has communicated the distinct perspectives of those who directly delivered and received the service as well as those who developed the policy and facilitated the program implementation of the initiative. These distinct insights have identified new understandings and knowledge to enhance our understanding of the practice mechanisms required to facilitate collaborative approaches.

This research has demonstrated that ‘good enough’ collaborative practice is an important component of the continuum of service responses required to address the complex needs of young people and their families. It has demonstrated that a central component of collaborative practice is the development of sustained meaningful relationships and that these relationships are more likely to occur when certain conditions exist.

This research has demonstrated that when vulnerable young people feel more connected within themselves, with others in their lives and to their community, this becomes an opportunity for significant changes to occur in their lives. The research findings have provided the evidence of the strengthened service that workers provide when they feel more connected to the young people and their families and to other workers also involved with these young people.

This research demonstrated that a matrix of co-existing dimensions, stages and components is required for the development of effective ‘good enough’ collaborative approaches (both between workers and between workers and young people). These dimensions include the dynamic interaction of the temporal, psychological, social, organisational and policy dimensions.
The research findings demonstrated that the multiple services involved with young people with complex needs can together provide an effective, co-ordinated, developmentally enhancing service delivery to children, young people and their families which does contribute to an improvement in their life chances. It has provided an example of policy, program development and implementation occurring in a more co-ordinated form across sectors.
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APPENDIX ONE

EXAMPLE OF CORRESPONDENCE SENT TO MANAGER, COMMUNITY CARE, AT THE DEPARTMENT OF HUMAN SERVICES REGIONAL OFFICE

Ms,
Manager Community Care,
Department of Human Services
Metropolitan Region

July 22nd 2003

Dear,

I am writing to inform you (confirming my earlier e-mail messages) that my research project, *Developing guidelines for services with an integrated approach for children, adolescents and young people who are multi-service clients: policy, program and practice* has been approved by the Department of Human Services Human Ethics Research Committee. Could you please note that this is an amended title to the previous one that was used.

The University of Melbourne Human Ethics Research Committee and the School Of Social Work Ethics Committee accepts the decision of the Department of Human Services Human Ethics Research Committee and has registered this approval on their records. I have also advised ........ from the Department of Human Services Child Protection and Juvenile Justice Branch Research Coordinating Committee that the research has been approved.

Having received these approvals I am very excited to report that I will now be commencing the data collection phase of my research over the coming months. The two Community Support Organisations involved with the Enhanced Residential Model Pilots will facilitate my contact with current and previous participants. I appreciate and will certainly utilise your previous generous offer to be able to contact yourself or ........ should I require advice or have any issues that need to be explored in the conducting of my research.

Ongoing progress reports will be provided to the Region and to the Child Protection and Juvenile Justice Branch Research Coordinating Committee.
Please feel free to contact myself on 9578 6602 or my principal supervisor Dr Fiona McDermott on 8344 9416 if you have any areas to discuss in relation to my research,

Thank you again for your support throughout this process,

Yours Sincerely,

Deborah Absler  
PhD Student  
School of Social Work  
University of Melbourne
APPENDIX TWO - COPIES OF PARTICIPANT INFORMATION AND CONSENT FORMS

COPY SENT TO YOUNG PEOPLE

Dear

Not another research project......

Now, I imagine that the last thing you want to read about is yet another request to be involved in a research project but if you wouldn't mind hearing me out I would appreciate it. And I know this letter is pretty long so maybe if there is someone who could read it with you, that would be great.....

Anyway, my name is Deborah Absler and I am a social worker who is doing further studies at the School of Social Work, University of Melbourne. These studies are called a PhD and as part of that I have to do a research project. Mine is about finding the best ways to work with young people who have a whole range of things they're struggling with and are living out of home. The official title is (wait for it): “Developing guidelines for services with an integrated approach for children, adolescents and young people who are multi-service clients: policy, programs and practice.” My supervisor for the PhD is Dr. Fiona McDermott.

I am writing to ask you to be part of this research project. For this research project I want to talk to young people who have spent time at Pilot 1 and their families. Because the names of young people who have spent time at Pilot 1 are kept private I have asked the staff to send this letter to you.

In the rest of this letter I would like to tell you about the research project and ask you to decide whether you would like to take part in the project. As part of making your decision to be involved in the research I hope that you
will get a chance to discuss your thoughts with your key worker, friends or if you like, members of your family.

If you do agree to take part, I need you to sign some forms at the back of this letter called Consent Forms. You will be given a copy of this Participant Information letter and the Consent Forms to keep as a record.

**What is this research project about?**

I am a social worker who has worked for many years with young people and their families. I’m very interested in finding out what is the best way of helping young people who are struggling with lots of different worries and problems in their lives and are living away from home.

I am doing this research because I think that the way services are organized now for young people who have lots of different problems have not always worked as well as they could and that a new way of doing things is needed. I am interested to find out whether the way the Pilot 1 services are organised, where the different workers come and meet with you at the resi unit, might be a better way to help young people.

As you are one of the young people who have been involved in Pilot 1 I’m really interested in hearing your ideas about what’s worked well and what hasn’t worked as well with Pilot 1.

A number of different committees have said that it’s okay for me to do this research project. They are the Department of Human Services Ethics Committee, the Human Research Ethics Committee, University of Melbourne and the Department of Human Services Child Protection and Juvenile Justice Research Committee.

**What Am I Asking You To Do?**

What I am asking is whether you would agree to meet with me to talk. I’ll ask you some quick questions about yourself and then some questions about Pilot 1. I don't expect the meetings to go longer than an hour at the most. You can choose who will be at the interview, whether you're okay about meeting with me alone or whether you would like someone else there, like
your key worker. You can also choose where the interview takes place, say at
the resi unit or maybe at a service you know. If you would like to meet with
me before the interview, that’s also fine.

It will really help me if we can tape record the interview so that I make sure
I get all the details of what you’ve told me right (my memory is not too good
on its own). But if you really don’t want me to tape the interview then that is
okay. After the meeting once I’ve written out what you said I will send you a
copy to have a look at to make sure it’s right.

Why Should You Do This?

You’re probably wondering why you should do this. Well, I think your views
about what services work best for young people are really important and
your opinions will help people to plan new services in the future.

I have made sure that the questions I ask you will not be difficult or
upsetting. But, if for some reason you do become upset during our meeting
we’ll stop straight away. If you become upset after the meeting I will make
sure that one of the workers you feel good about will be available to talk to
you as soon as possible. I’m also someone who has worked for lots of years
with young people, so I think I’m pretty good about knowing how to ask
people questions that won’t upset them and what to do if people do get
upset.

What happens next

- If you want to know more about the research before you decide to go
  ahead, or have questions at any time, then let your worker know and
  they will arrange a meeting for us to talk together.

- I would also like to talk to your parents or family member about their
  thoughts about Pilot 1 and other ideas about what is helpful. This
  would happen after our meeting but only if you agree.

- If you are happy to be part of the research program then please sign
  the form and give it to your worker and they will make sure it gets to
  me.
• When it is time for the interview your worker will arrange a time for us to meet.

How Private Is All This?

That’s a really important question. The answers that you will give me will be kept completely private. Only my supervisor and I will see the answers. No one will know that you said these things because I won’t use your real name. Either a pretend name will be used or your answers will be mixed up with all the other answers. Being part of the project or any comments you make, will not effect your involvement with Pilot 1 or any other services you’re involved with.

During the project all the information I have including the tapes will be locked away safely in a cupboard at the School of Social Work. After 5 years the tapes and all other notes will be destroyed by my supervisor. This will be done because it is a University rule.

After the project is finished if you want to hear about the things I learnt from talking to you and the other young people, talk to your key worker and we can arrange a meeting to discuss them.

It’s important that you remember that you don’t have to take part in this research project unless you want to. If you change your mind about being involved that’s also fine.

If you have any questions about the project please feel free to talk to your parent, one of your workers or me, or my supervisors, or the Research Ethics Office at the University.

If you want to contact any of these people here are our numbers: myself, Deborah Absler, Ph: 8344 9416, Dr Fiona McDermott (my main supervisor), Ph: 8344 9416, Dr Lynda Campbell (my other supervisor), Ph: 8344 9418 and Dr Alasdair Vance (another supervisor), Ph: 8552 0555.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, the person to contact is:

Name: Ms Kate Murphy
Position: Executive Officer, Human Research Ethics, the University of Melbourne, Vic
3010, ph: (03) 8344 7507;
Telephone: ph: (03) 8344 7507

Because I appreciate the time you will be making available to be involved in the research you will receive a gift voucher after our interviews are completed.

If you are happy to be part of my project, please sign your name on the next page.

Thank you

Yours Sincerely

Deborah Absler
PhD Student

School of Social Work
The University of Melbourne Victoria 3010 Australia
Telephone: +61 3 8344 9400/9401 Fax: +61 3 9347 4375
Dear

Can I have a minute of your time to discuss something?

Now, I now the last thing you want to hear about is yet another request to be involved in a research project but if you wouldn't mind hearing me out I would appreciate it.... My name is Deborah Absler and I am a social worker doing further studies at the School of Social Work, University of Melbourne. These studies are called a PhD and as part of the PhD I am conducting a research project. The title of my research project is: “Developing guidelines for services with an integrated approach for children, adolescents and young people who are multi-service clients: policy, programs and practice.” My supervisor for my PhD is Dr. Fiona McDermott.

I am writing to ask you to be part of this research project and to ask your approval for your son/daughter to also participate in the project.

For this research project I want to talk to young people who have spent time at Pilot 2 and their families. Because the names of young people who have spent time at Pilot 2 are kept private I have asked the staff to send this letter to you.

In the rest of this letter I would like to tell you about the research project and ask you to decide whether you would like to take part in the project and whether you are happy for your son/daughter to take part. As part of making your decision to be involved in the research I hope that you will get a chance to discuss your thoughts with your son/daughter and any workers or friends.
If you do agree to take part, I need you to sign some forms at the back of this letter called Consent Forms. You will be given a copy of this Participant Information letter and the Consent Forms to keep as a record.

What is this research project about?

I am a social worker who has worked for many years with young people and their families. I’m very interested in finding out what is the best way of helping young people who are struggling with lots of different worries and problems in their lives and are living away from home.

I am doing this research because I think that the way services are organized now for young people who have lots of different problems have not always worked as well as they could and that a new way of doing things is needed. I am interested to find out whether the way the Pilot 2 services are organised, where the different workers come and meet with the young people at the resi unit, might be a better way to help young people.

Therefore I am interested in meeting with the young people who have been living at the resi units where the Pilot 2 projects are being run, family members such as yourself and the workers who have been involved with Pilot 2 to hear your ideas about what’s worked well and what hasn’t worked well with Pilot 2.

A number of different committees have said that it’s okay for me to do this research project. They are the Department of Human Services Ethics Committee, the Human Research Ethics Committee, University of Melbourne and the Department of Human Services Child Protection and Juvenile Justice Research Committee.

What is involved?

What I am asking is to meet with you and to meet with your son/daughter. The interviews with yourself and your son/daughter will happen at different times. At these meetings I’ll ask some very quick questions about you and
then ask some questions about Pilot 2. I don’t expect the meetings to go longer than an hour at the most.

You can choose who will be at these interviews, whether you’re okay about meeting just with me or whether you would like someone else there. You will also have a choice about where the interview takes place. If you would like to meet with me before the interview to discuss what’s involved, that’s also fine.

It will really help me if we can tape record these interviews so that I make sure I get all the details of what’s been said. But if you really don’t want me to tape the interview then that is okay. After the meeting once I’ve written out what you said I will send you a copy to have a look at to make sure it’s right.

Why should I do this?

I’m hoping you will consider being involved and allowing your son/daughter to be involved because I think that the views you have about what services work best for young people are really important and will add a valuable perspective to help influence future ideas about how services should be set up.

I have made sure that the questions I ask you and your son/daughter will not be difficult or upsetting. But, if for some reason you (or they) do become upset during our meetings we’ll stop straight away. If you (or they) become upset after the meeting I will make sure there is someone available to talk to you as soon as possible. I’m also someone who has worked for lots of years with young people and parents, so I have experience in knowing how to ask people questions that won’t upset them and how to cope if they do become upset.

What happens next

○ If you want to know more about the research before you decide to go ahead, then let your child’s worker know and they will arrange a meeting for us to talk together about this.
o If you are happy to be part of the research program then please sign the form and give it to your child’s worker and they will make sure it gets to me.

o When it is time for the interview your child’s worker will arrange a time for us to meet.

**How private is all this?**

That’s a really important question. The answers that you and your son/daughter will give me will be kept completely private. Only my supervisor and I will see the answers. No one will know what you said because I won’t use your (or your son/daughters) real name. Either a pretend name will be used or your answers will be mixed up with all the other answers. Being part of this project will have nothing to do with your son/daughter’s involvement with Pilot 2 or any other services they’re involved with.

During the project all the information I have including the tapes will be locked away safely in a cupboard at the School of Social Work. After 5 years the tapes and all other notes will be destroyed by my supervisor. This will be done because it is a University rule.

After the interviews are completed if you are interested in hearing about the research please mention this to your son/daughter’s key worker or case manager and we can arrange a time to discuss the findings.

It’s important that you remember that you and your son/daughter don’t have to take part in this research project unless you both want to. If you change your mind about being involved that’s also fine.

If you have any questions about the project please feel free to talk to me, or my supervisors, or the Research Ethics Office at the University.

If you want to contact any of these people here are our numbers: myself - Deborah Absler, Ph: 8344 9416, Dr Fiona McDermott (my main supervisor), Ph: 8344 9416, Dr Lynda Campbell (my other supervisor), Ph: 8344 9418 and Dr Alasdair Vance, (another supervisor) Ph: 8552 0555.
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your or your son/daughter's rights as a research participant, the person to contact is:

Name: Ms Kate Murphy

Position: Executive Officer, Human Research Ethics, the University of Melbourne, Vic 3010, ph: (03) 8344 7507;

Telephone: ph: (03) 8344 7507

I also wanted to inform you that consistent with common research practice your son/daughter will receive a gift voucher for their involvement in the research after our interviews are completed.

If you are happy to be part of the project, and for your son/daughter to be involved I need you to sign your name on two pages, on the form giving permission for you to be involved and on the form giving permission for your son/daughter to be involved.

Thank you for taking the time to read this letter. If you are happy to be part of my project, please sign your name on the next page.

Yours Sincerely

Deborah Absler
PhD Student
Dear

May I have a few moments of your time?

I would like to introduce myself to you and thank you for taking the time to read this letter. My name is Deborah Absler and I am a social worker enrolled in a PhD at the School of Social Work, University of Melbourne. As part of the PhD I am conducting a research project. The title of my research project is: “Developing guidelines for services with an integrated approach for children, adolescents and young people who are multi-service clients: policy, programs and practice.” My supervisor for my PhD is Dr. Fiona McDermott.

I am writing to invite you to participate in this research project.

This Participant Information Form contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it. Please feel free to ask questions about any information in the document and feel free to discuss the project with a person of your choice.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.
You will be given a copy of the Participant Information and Consent Form to keep as a record.

**What is this research about?**

I am a social worker who has worked for many years with young people and their families. I am doing this research because I think that the way services are organized now for young people who have lots of different problems have not always worked as well as they could. I am interested to find out whether the way the Pilot 2 services are organised, where the different workers come and meet with the young people at the resi unit, might be a better way to help young people.

You will participate in this project alongside a number of other participants. These will include other service providers who have been involved in Pilot 2 as well as the young people and their family members and some regional stakeholders.

You are invited to participate in this research project because as one of the service providers who have been involved in the development and implementation of Pilot 2 your opinion will provide a valuable perspective of the strengths and challenges of this model.

A number of different committees have given their approval for me to do this research project. They are the Department of Human Services Ethics Committee, the Human Research Ethics Committee, University of Melbourne and the Department of Human Services Child Protection and Juvenile Justice Research Committee.

**What am I being asked to do?**

Your participation in this project will involve attendance at group interviews.

If you were a member of a Care Team and/or Steering Committee/Review Board during the pilot phase but are no longer currently involved with the project, you are invited to participate in one group interview with other
service providers who were also previously involved. However if you are interested in being involved in the research but are unable to attend an interview, I will arrange for a telephone or written interview to be conducted.

If you are a service provider currently involved in one of the Pilot 2 Care Teams you are invited to participate in one group interview with other members of your Care Team (and a second if required).

If you are a residential care staff member you will be asked to attend an additional meeting with the other Residential Care Staff involved in the Care Teams (and a second if required).

If you are a member of the Pilot 2 Review Board you will be asked to participate in one group interview with other members of the Review Board (and a second if required).

It is anticipated that these meetings will run for a minimum of one hour and a maximum of one and a half hours duration.

If you are one of the four senior regional staff that have been invited to participate in this research you will be asked to participate in an individual interview which will be of one hour duration.

All service providers being interviewed will also be asked to fill in a brief questionnaire asking for demographic information. The focus of the questions raised in the interview will be to explore as a group what you saw as the strengths and challenges involved in this new form of service delivery.

I will be facilitating the group interviews with Dr Fiona McDermott acting as a co-facilitator. It will really help me if we can tape record these interviews so that I make sure we make an accurate record of what you say. When the tape has been transcribed, you will be provided with a copy of the transcript, so that you can verify the information is correct and/or request deletions.

If you are a service provider currently involved in the pilots a letter and copy of this participant information form will also be sent to the Senior Manager/Director within your organisation to inform them about the research project and to request their support of your involvement.
Why should I do this?

Possible benefits for you as a participant in this research is the opportunity to contribute to one of the first pieces of Australian research about this innovative form of service delivery. It is also hoped that the opportunity to meet and discuss your experiences in developing and implementing this new form of service delivery will be beneficial to your professional development. It is hoped that the benefits to the service sectors working with this vulnerable client group will be extensive.

It is not anticipated that any possible risk or discomfort will occur from participating in this research. As I have had previous collegial experiences with many of the service providers involved in this initiative and extensive experience as a clinical social worker I am hoping this will place me in a strong position to conduct the interviews with sensitivity and the capacity to deal appropriately with any issues that arise.

However in the event of any practice issues or service related problems being raised during the interviews that will need to be explored further these will be directed to the appropriate person in the relevant organisation using existing structures. If other forms of support will be required as a result of your involvement in this process these will be negotiated through consultation with Dr Mc Dermott and an appropriate referral will be made.

How private is all this?

We intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. Your privacy will be respected through the use of de-identified data. You will not be identifiable in any written reports and pseudonyms will be adopted in all raw data. No personal and identifying information will be included in the thesis or other reports. Pseudonyms will be used in data collection and in report writing. Your name and contact details will be kept in a separate, password-protected computer file from any data that you supply.
During the project all the information I have including the tapes will be locked away safely in a cupboard at the School of Social Work. After 5 years the tapes and all other notes will be destroyed by my supervisor. This will be done because it is a University rule.

After the interviews are completed you will be invited to attend presentations of the major findings during the process of the research and to an interim and final information session.

It's important that you remember that you don't have to take part in this research project unless you give consent. If you change your mind about being involved at any time that's also fine, you can withdraw at any time without prejudice.

If you have any questions about the project please feel free to talk to me, my supervisors, or the Research Ethics Office at the University.

If you want to contact any of these people here are our numbers: myself - Deborah Absler, Ph: 9578 6602/ 8344 9416, Dr Fiona McDermott (my main supervisor), Ph: 8344 9416, Dr Lynda Campbell (my other supervisor), Ph: 8344 9418 and Dr Alasdair Vance, (another supervisor) Ph: 8552 0555.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, please contact:

Name: Ms Kate Murphy
Position: Executive Officer, Human Research Ethics, the University of Melbourne, Vic
3010, ph: (03) 8344 7507;
Telephone: ph: (03) 8344 7507

As this is unfunded research you will not be paid for your participation in this project. However if a situation arises where you incur costs as part of participating in this research please contact me to discuss mechanisms to reimburse you for those costs.
If you are happy to be part of the project please sign your name on the following form.

Thank you for taking the time to read this letter.

Yours Sincerely,

Deborah Absler
PhD Student

School of Social Work
The University of Melbourne Victoria 3010 Australia
Telephone: +61 3 8344 9400/9401 Fax: +61 3 9347 4375
Consent Form Version 2 Dated 9/7/03

Full Project Title: “DEVELOPING GUIDELINES FOR SERVICES WITH AN INTEGRATED APPROACH FOR CHILDREN, ADOLESCENTS AND YOUNG PEOPLE WHO ARE MULTI-SERVICE CLIENTS: POLICY, PROGRAMS AND PRACTICE.”

Student Researcher: Ms Deborah Absler
Principal Researcher: Dr Fiona McDermott
Associate Researcher(s): Dr. Lynda Campbell, Dr. Alasdair Vance.

I have read, or have had read to me, and I understand the Participant Information version 2 dated 9/7/03.

I freely agree to participate in this project according to the conditions in the Participant Information and I agree to the following.

- I agree to have the interview taped Yes ☐ No ☐
- I understand that I can stop being involved in the research at any time Yes ☐ No ☐

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant’s Name (printed) .................................................................

Signature .................................................................................. Date

Name of Witness to Participant’s Signature (printed)
.................................................................................................

Signature Date

Researcher’s Name (printed) .................................................................

Signature Date

Note: All parties signing the Consent Form must date their own signature.
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Full Project Title: "DEVELOPING GUIDELINES FOR SERVICES WITH AN INTEGRATED APPROACH FOR CHILDREN, ADOLESCENTS AND YOUNG PEOPLE WHO ARE MULTI-SERVICE CLIENTS: POLICY, PROGRAMS AND PRACTICE."

Student Researcher: Ms Deborah Absler

Principal Researcher: Dr Fiona McDermott

Associate Researcher(s): Dr. Lynda Campbell, Dr. Alasdair Vance.

I have read, or have had read to me, and I understand the Participant Information version 2 dated 9/7/03.

I give my permission for.......................I to participate in this project according to the conditions in the Participant Information.

I will be given a copy of Participant Information and Consent Form to keep.

The researcher has agreed not to reveal the participant's identity and personal details if information about this project is published or presented in any public form.

Participant’s Name (printed) .................................................................

Name of Person giving Consent (printed) ..................................................

Relationship to Participant: .................................................................

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Name of Witness to Parent/Guardian Signature (printed) ....................

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Researcher's Name (printed) ............................................................

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Note: All parties signing the Consent Form must date must date their own signature.
Revocation of Consent Form
Version 2 Dated 9/7/03

Full Project Title: “DEVELOPING GUIDELINES FOR SERVICES WITH AN INTEGRATED APPROACH FOR CHILDREN, ADOLESCENTS AND YOUNG PEOPLE WHO ARE MULTI-SERVICE CLIENTS: POLICY, PROGRAMS AND PRACTICE.”

Student Researcher: Ms Deborah Absler
Principal Researcher: Dr Fiona McDermott
Associate Researcher(s): Dr. Lynda Campbell, Dr. Alasdair Vance.

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Pilot 2.

Participant’s Name (printed) ...................................................

Signature Date
APPENDIX THREE - COPY OF INTERVIEW QUESTIONS:

1. QUESTIONS FOR YOUNG PEOPLE:

- What has the experience been like for you being involved with Pilot 1? What have you learned?
- What do you see as the core components/features of the Enhanced Residential Model? How does it differ to other models provided in residential care for young people who are multi-sector clients?
- What do you see as the strengths of this model for the young people and families? What difference has it made?
- What is it about working as part of a care team model that was useful for your work with the young people and families and for you as a worker?
- What are the limitations of this model for the young people and their families and/or for you as a worker?
- What would you say to a new worker who was becoming involved in the Enhanced Residential Model?
- What should be done differently now as a result of what's been learned from the Enhanced Residential Model in relation to future policy directions, program development, service delivery and practice models for working with children, adolescents and young people who are multi-service clients and in out of home care?
- What do you think your service specifically should do differently when working with children, adolescents and young people who are multi-service clients?
- Is there anything else that you think that’s important for me to know about being involved with Pilot 1?
2. **QUESTIONS FOR FAMILIES**:

Thank you for agreeing to participate in this interview. I would like to ask you the following questions about the services provided for young people and families living at the residential unit .......... If there are any questions you don't want to answer please leave them blank.

- I would like to talk about the service that was provided when your son/ daughter lived in .......... by a program called Pilot 1. Have you heard of this term and do you know what Pilot 1 means?

- How old is your son/ daughter now?

- How old was your son/daughter when they lived at ..........?

- How long did they live at ..........?

- Was that the first time that they had lived in a residential unit?

- If they had lived in other units how many had they lived in?

- When they first came to live at .......... were they attending school or involved in some other sort of day activity?

- During the time they lived at .......... did they attend school or another sort of day activity?

- Since they left .......... have they attended school, another type of program or been employed?

- When they first came to live at .......... were they involved with seeing workers from any services? If yes what services were they?

- While they lived at .......... did they become involved with any of the services provided through Pilot 1? If yes which ones?

- Since they left .......... have they been involved with these or any other services?
1. **What did you think of the service provided by Pilot 1? What was it like for your son/daughter? Was it different to how things have been run before at other residential units?**

2. **What are the good things about Pilot 1 for your son/daughter?**

3. **Did the staff from .......... or Pilot 1 have any contact with you while your son/daughter was at ..........? Were you satisfied with the service provided?**

4. **Were there things about how .......... was run that wasn’t good for you and/or your son/daughter? What were they?**

5. **If you knew someone whose child was coming to live at .......... what would you tell them about it?**

6. **Do you have any general thoughts about the way services should work for young people living in residential units and their families?**

7. **Is there anything else that you think that’s important for me to know about your and your son/daughter’s experiences?**

3. **QUESTIONS FOR SERVICE PROVIDERS**

1. **What has the experience been like for you being involved with the Enhanced Residential Model (ERP) Pilots? What have you learned?**

2. **What do you see as the core components/features of the Enhanced Residential Model? How does it differ to other models provided in residential care for young people who are multi-sector clients?**

3. **What do you see as the strengths of this model for the young people and families? What difference has it made?**

4. **What is it about working as part of a care team model that was useful for your work with the young people and families and for you as a worker?**

5. **What are the limitations of this model for the young people and their families and/or for you as a worker?**

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What would you say to a new worker who was becoming involved in the Enhanced Residential Model?

What should be done differently now as a result of what’s been learned from the Enhanced Residential Model in relation to future policy directions, program development, service delivery and practice models for working with children, adolescents and young people who are multi-service clients and in out of home care?

What do you think your service specifically should do differently when working with children, adolescents and young people who are multi-service clients?

Is there anything else that you think that’s important for me to know about being involved with the ERP?

3. QUESTIONS FOR STEERING COMMITTEES & REGIONAL MANAGERS

What are best practice principles and guidelines for services who are working from an integrated approach with children, adolescents and young people who are multi-service clients?

In order to promote and sustain inter-sectoral collaborative practice, what needs to exist/be present at the:

- Individual practitioner level,
- Care team level,
- Within their home agency at the program/team level
- At the agency level
- Within regional and statewide program structures and policy levels?

What are the core features and key issues involved in the implementation and operation of cross-sectoral care teams such as Pilot 1 & 2 as an example of an innovative service delivery model for children, adolescents and young people who are multi-service clients?

What are the strengths and limitations of the care team model for strengthening the emotional, social, psychological, educational and cultural needs of children, adolescents and young people who are multi-service clients?
Based on what has been learned from the development and implementation of Pilot 1 & 2 what are the implications for future policy directions, program development, service delivery and practice models for working with children, adolescents and young people who are multi-service clients?

5. **SERVICE PROVIDERS PROFILE QUESTIONS**

- What is your current employment? (position held in agency)
- What is your professional background?
- How long have you been employed with your current agency?
- Have you had previous experiences working with young people who are multi-service clients and if so what were they?
- What is the nature of your involvement with Pilot 1 & 2? (ie member of Care Team/ Steering Committee/Review Board/Member of Regional Management Group)
- How long have you been involved with Pilot 1 & 2?
APPENDIX FOUR – SPREADSHEETS AND SUMMARIES:

THE QUESTION WHAT ARE THE STRENGTHS OF THE MODEL HAS BEEN SELECTED AS IT WAS ASKED TO ALL STAKEHOLDER GROUPS

PILOT 1: SUMMARY OF QUESTION TO SERVICE PROVIDERS:
WHAT ARE THE STRENGTHS OF THE MODEL?

(6)
A strength of this model were the regular Care Team meetings which provided a structure for workers debriefing, sharing ideas, openly and transparently discussing issues and resolving conflict.

A strength of this model was the contribution of the CAMHS worker - coming to the unit to directly work with the young people, working with residential and other staff which enhanced the service they provided and the CAMHS contribution at Care Team meetings.

A strength of this model was that it enhanced and supported residential worker’s skills and knowledge, they learned new techniques, strategies and were more involved in service delivery

(4)
A strength of this model was that it was client centred, with the services working around the client as the common focus.
A strength of this model was that it had good client outcomes e.g young people reduced their severe self-harming behaviour, returned to live with their families.
A strength of this model was the development of relationships and mutual respect.

(3)
A strength of this model was that young people accessed services in their familiar environment
A strength of this model was that young people received a quality service
A strength of this model was that residential staff felt acknowledged, respected and affirmed by the other workers.
A strength of this model was the flexibility it provided workers for example the Child Protection worker.
Communication has been a key aspect of this model
A strength of this model was the role of the Working Together Strategy
Project Officer (& WTS management) being central to the success of WTS initiatives, providing direction, support & feedback.

A strength of this model was that it worked well
A strength of this model was that it demonstrated how a Care Team model needs to continue and be introduced into other units.

PILOT 2: SUMMARY OF QUESTION TO SERVICE PROVIDERS: WHAT ARE THE STRENGTHS OF MODEL?

(7)
A strength of this model was that workers shared common goals

(6)
A strength of this model was that systems were brought together

(5)
A strength of this model was that it promoted maturity in young people
A strength of this model was that workers contacted parents
A strength of this model was that the service system is around the young people
A strength of model it that it is a better model
A strength of this model is that it improved communication
A strength of this model was that all stakeholders became more informed about different service systems
A strength of this model was that strong relationships were built

(4)
A strength of this model was that young people have their own set of workers
A strength of this model was that services were accessed for how long they were needed
A strength of this model was it engaged families
A strength of this model was that there is an individualised service
A strength of this model was that young people received an improved service
A strength of this model was that secondary consultation was used
A strength of In this model was that workers were co-ordinated
A strength of this model is that a co-ordinated Care Team is the best way to work with this client group

(3)
A strength of this model was that young people engaged with services
A strength of this model was that we addressed issues with families
A strength of this model was that it provides a better service
A strength of this model was that workers were accessible
A strength of this model was that workers supported each other
In this model the Care Team was focused
A strength of this model was holding regular meetings
This model makes sense
In this model workers exchanged information about each other’s frameworks

SUMMARY OF QUESTION TO REGIONAL MANAGERS: WHAT ARE THE STRENGTHS OF THE MODEL?

(8)

The critical factor is that people develop a shared responsibility, joint ownership towards the young person

(6)

Care Teams share information, perspectives, interventions, conceptual frameworks, models of service delivery, beliefs and understanding about the young person

Care Teams provide a more focussed and integrated, joint problem solving approach based on the needs of the young person

These sorts of initiatives need to have a driver, facilitator to keep them happening otherwise they drop off, the role of the WTS PO was central to the ERPs which was highlighted in the period when there wasn’t one

(5)

In Care Teams you see yourself as part of a group working together, making decisions

Central to Care Teams are the development of trust, respect and maturity to work through issues and manage and deal with conflict

What we need is schools to take on the role of being an education service provider to collectively be responsible for all the young people in the community including those who are not involved in schools and find a way to
deliver an educational service for these young people. DEET have to shift to thinking we can provide a service anywhere, anywhere.

(4)

Care Teams provide support

Workers in Care teams develop an understanding about each other’s services, their strengths, weaknesses and limitations

Management needs to demonstrate leadership, modelling and prioritising working collaboratively for the individual practitioner to have the space and freedom to also work in this way

Other regional initiatives replicate the Care Team as examples of people willing to come together and jointly plan and care for young people

(3)

The ERPs are exciting, going well, been run well

Care Teams will be the way we go in the future to have the model operationalised across resi services

A strength of this model is having a case manager who takes responsibility for integrating the various groups involved is a core component of Care Teams

Care Teams promote clarity about roles and other issues

Care Teams are now seen as the way to work with young people with multiple issues, a more developmental way and the way we should work with every young person,

Care Teams need to develop a shared appreciation of outcomes

Consistency and continuity are important

The good and respectful relationship is the key, developing relationships and looking after them
Care Team's are more work and time consuming,

Middle management (team leader) is critical to show leadership to the same principles of collaborative work

There needs to be ownership and support throughout the food chain for collaborative practice

The region has to think whether this way of working is something that we're going to support. There needs to be a structure to keep it alive so that it becomes systemic, the way we work. If it isn't it will be tagged onto our jobs and it will fall over
APPENDIX FIVE -
COPY OF LETTER TO PARTICIPANTS RE STORIES

July 28th 2004

Dear

I hope that this letter finds you and your family well. Last year (earlier this year) you were very generous to speak to me about the experiences you had when your daughter/son was living in a residential unit, for research I was undertaking as part of my PhD. The interviews I conducted with yourself(ves) and other parents provided me with extremely thoughtful, helpful, and moving information.

Over recent months, I have been busy sorting through this material (as well as other interviews, I conducted with the young people and workers involved with the pilots). After a lot of thinking, I have decided that the best way to present the information I received, was not to produce lists or tables of the answers but to write it up in a way that respects the way it was told to me as a story combining the views of all the parents who spoke to me. I wanted to keep the richness and honesty of how you and others shared your thoughts with me while also respecting everyone’s privacy. I hope I have achieved this balance.

I have enclosed a copy of the summary I have written which I have called, the Pilot 1 & 2 Parents Story. I hope that you will read it and keep it as a record of our contact. I would also appreciate hearing any feedback that you have about the piece, particularly if you are unhappy with it and feel that it does not represent your opinions or does not respect your privacy or even misses out something that needs to be said.

It is my plan at this time that this piece, along with the other pieces I have written will be included in my final PhD document and that is why it is important to me that it accurately reflects your and others opinions.

If you would like to give me any feedback about this piece please contact me by phoning me on this number; 8344 9430 or, if you prefer sending me e-mail to my e-mail address: d.absler@pgrad.unimelb.edu.au. If you would prefer to speak to someone else please contact my PhD supervisor, Dr Lynda Campbell
on 8344 9418 or otherwise one of the workers you had contact with through Pilot 1 & 2 and they can pass the message on to me.

Thank you for taking the time to read this letter and the following piece. Once again thank you for your generosity in sharing with me your very personal thoughts and feelings, which provided an important contribution to the research. I felt honoured to receive them.

Yours Sincerely

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