



# Support Programs for Young People with Disability and Experiences of Trauma or Abuse

Report prepared for Uniting Care West

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# **Support Programs for Young People with Disability and Experiences of Trauma or Abuse**

## **Executive Summary**

A significant proportion of children and adolescents in out-of-home care have one or more disabilities. Children and young people with disabilities, experience of trauma, challenging behaviours, and other co-morbid conditions may be supported in family-based or foster home care, or in residential units. In addition, families may be supported to keep the child at home.

The overall aim of this scoping review was to identify models of care, interventions and programs for adolescents and young people with disability and experiences with trauma or abuse that:

1. Address behavioural issues that minimise the longer term options of young people to live in the community as adults
2. Support improvements in long term functioning, including daily activities of living and mental health for young people.

There were 24 documents that met the search criteria: 12 research articles, four reviews, and eight reports. Many of the programs identified aimed to improve behaviours, autonomy, self-esteem, natural supports and interpersonal relationships, and mental health through a variety of approaches. Other programs focused on daily functioning, independent living skills, and access to community supports. These factors are all elements of resilience – a concept that recognises multiple elements, individually and in concert, that allow a person to recover, or ‘bounce back’ from an adverse experience or event.

Support organisations and programs should strive to normalise the life course trajectory of every child or young person in contact with the child protection system. It is clear from this review that there is no single intervention or program to suit all young people with disability, exposure to trauma and contact with the child protection system. Similarly, there is no single program that will fit into the working of every support organisation. It is likely that a multi-modal approach will be necessary to suit all parties. In addition, services will need to be able to respond quickly and appropriately to any changes and challenges in the young person’s life. However, there are some commonalities, and some recommendations to be made, based on the literature reviewed.

- Care for children and young people with disability and experience of trauma in the child protection system should be strengths-based, person-centred, flexible and responsive, individualised, and involve family and the community as far as is possible.
- Effective and responsive co-ordination of the various services and agencies involved in care of the child or young person with disability and experience of trauma is vital to the child’s life within and outside the child protection system.

- Trauma-informed programs and therapy should be available to all children from first contact with child protection. The therapy should aim to improve the child's emotional and mental health, and to promote resilience to future trauma.
- Skills training, particularly skills of daily living, self-determination and decision-making, should be an integral part of out-of-home care and throughout the time of contact with child protection. All children and young people need to develop the skills necessary to live outside the family home, and children and young people with disability and experience of trauma are not excepted.
- A major responsibility of care providers should be to help establish and sustain authentic and lasting relationships between the child or young person in care and people who may be expected to support the young person as they transition out of out-of-home care.
- Advocacy support to establish and sustain a suitable living arrangement and support system should be available for all young people ageing out of the child protection system. This may include assisting with NDIS planning, supporting applications for public and/or affordable housing, and assisting with the move to a suitable community-based disability support organisation. Advocacy or mentoring for daily living, employment or further education may also be necessary.

## ***Introduction***

A significant proportion of children and adolescents in out-of-home care have one or more disabilities (Hill, Lightfoot, & Kimball, 2010; Powers et al., 2018, 2012; Schuurmans, Nijhof, Engels, & Granic, 2018). There are three common forms of child out-of-home care used in Australia: foster home; kinship foster home; and supported residential care. All three types of residence may support children and young people with disabilities, experience of trauma, challenging behaviours, and other co-morbid conditions. In addition, families may be supported to keep the child at home. Generally, formal support from child services ceases when the young person turns 18 years old, although the policy of government in Western Australia is for assistance to be available until the individual reaches the age of 25 (Department for Child Protection and Family Support, 2015).

In Australia, family-based and foster home care are the prevalent options for children and adolescents (Mendes, Johnson, & Moslehuddin, 2011; Schmied, Brownhill, & Walsh, 2006). These options provide opportunities for the development of lasting relationships between carer and child, and greater certainty and security for the child in out-of-home care when compared with residential care. In addition, there is some evidence that supportive presence and respect for autonomy from the foster-parent can positively impact child attachment, while foster-parent stress negatively impacts child behaviour (Gabler et al., 2014).

Group homes and other residential care options are generally regarded as less useful types of out-of-home care for children and adolescents than family-based and foster care (Schmied et al., 2006), and as the more expensive option (Child and Family Practice, 2015). Children and adolescents in residential care have been reported to have poor self-esteem, lack feelings of trust and security, and have few interpersonal and life skills. However, some therapeutic approaches within residential care have the potential to address problems experienced by young people in this type of care (Schmied et al., 2006; Schuurmans et al., 2018). A focus on skills development, service coordination, individualised treatment plans, continuity of care, and structured routines and schedules have been found to be beneficial to young people with high support needs in residential care (Schmied et al., 2006).

Young adults with intellectual disability, similarly to most young adults, wish to live independently. Some commentators suggest that it is more accurate to use the term 'interdependent living' rather than 'independent living' (Cocks et al., 2016; Northway, 2015), considering that all individuals are involved in a complex of formal and informal connections and supports throughout their lives. However, the term 'independent living' is almost universally used and will continue to be so. Training in explicit areas, including managing a household budget, shopping, cooking, and going to the doctor's (Pallisera et al., 2018), all help develop feelings of independence and self-confidence for young people with intellectual disability. Emotional support from staff is also important: feeling listened to and understood, and having mutual trust and respect. Person-centred planning and service provision, with an emphasis on the development of decision-making skills and increased self-determination, all support adults with intellectual disability who wish to live independently (Pallisera et al., 2018). However, as is stated in the UN Convention on the Rights of Persons with Disability,

Article 19 (United Nations General Assembly, 2007), there should be a full range of in-home and community supports available to enable people to live independently.

Care-leavers with disability, trauma and/or challenging behaviours are more at risk of homelessness, unemployment, self-harm, mental illness, and contact with the justice system (Herrman et al., 2016). In addition, they often lack many of the skills for daily living, such as money handling, household tasks, self-care, and social interaction skills (Malvaso & Delfabbro, 2016; Snow, Mendes, & O'Donohue, 2014). They may be dependent on Government support funds, such as the Disability Support Pension, or the Newstart Allowance. Many young people leaving care have limited or no contact with their birth family and may have few informal supports. All of these issues negatively impact their ability to live successfully outside the care system, and to successfully engage with support and funding systems, such as the National Disability Insurance Scheme (NDIS).

The overall aim of this scoping review was to identify models of care, interventions and programs for adolescents and young people with disability and experiences with trauma or abuse that:

1. address behavioural issues that minimise their longer term options to live in the community as adults
2. support improvements in long term functioning, including daily activities of living and mental health.

### ***Inclusion Criteria***

Studies were included if they explored support programs for young people with disability and experiences of trauma or abuse.

Inclusion criteria for this review were that participants: 1) were aged 13 – 18 years old; 2) living with disability; 3) had previous experience with child abuse or trauma; 4) exhibited challenging behaviours, with or without mental health issues; 5) were in need of significant and highly individualised interventions; and 6) were unable to live at home or had a limited ability to live independently long term.

Papers were excluded if the all participants were: 1) outside the required age range; 2) without disability; or 3) had not experienced child abuse or trauma.

### ***Documents Identified***

There were 24 documents that met the criteria: 12 research articles, four reviews, and eight reports. Most of the included papers referred to children in out-of-home care, however, children with or without challenging behaviours or disability, and experience of trauma or abuse were rarely differentiated.

All of the papers included young people in out-of-home care, in custody, and/or care leavers. There was considerable information on the outcomes for care leavers, and some data on the factors that affect these outcomes. These are not included in this report.

A number of documents included recommendations for policy and practice for the transition from out-of-home care to adult services. Topics covered include housing, education,

employment, relationships, and involvement with the justice system (Child and Family Practice, 2015; CREATE Foundation, 2012; Johnson et al., 2010; Malvaso & Delfabbro, 2016; Malvaso, Delfabbro, Hackett, & Mills, 2016). Service co-ordination and integration were also considered important factors in child services (Schmied et al., 2006).

### *Interventions*

Many programs aimed to improve behaviours, autonomy, self-esteem, natural supports and interpersonal relationships, and mental health through a variety of approaches. Other programs focused on daily functioning, independent living skills, and access to community supports. These factors are all elements of resilience – a concept that recognises multiple elements, individually and in concert, that allow a person to recover, or ‘bounce back’ from an adverse experience or event.

#### *Multi-systemic Therapy (MST)*

This was the only approach identified for use exclusively with children and adolescents still living in the family home (Schmied et al., 2006), with the aim of preventing admission to care services. This approach encompasses time-limited programs designed to provide children and their families with skills to better function in the community, and to preserve family function. Based upon initial assessments, therapists develop an individualised strategy for each young person and then implement an intensive treatment ‘package’ using a variety of therapeutic techniques, including structural family therapy, strategic family therapy, behavioural parent training, cognitive behaviour therapy and social skills training. However, the programs are intensive and require both commitment and coordination from and between all parties (Schmied et al., 2006). Effectiveness studies of MST rely on strict adherence to its principles, and inclusion and exclusion criteria by both users and therapists. While this allows for more rigorous testing, in countries outside the USA which adopt a less punitive approach to problem behaviours, emphasise positive reinforcement and have fewer restrictions on alcohol consumption, this strict adherence may be less sustainable.

#### *Evolve Therapeutic Services (ETS)*

ETS is a trauma-informed wrap-around model of clinical care developed and tested in Queensland (Eadie, 2017; Martin, Krause, Piccone, Bergh, & Eadie, 2015). Participants in the trial were not differentiated by disability status. The program delivers planned and coordinated therapeutic and behaviour supports to children and young people (1-17 years) in out-of-home care, aimed at improving their emotional wellbeing and the development of skills to enhance participation in school and in the community. The study reported participants had fewer clinically-significant mental health problems, and improved scores on the Strengths and Difficulties Questionnaire after treatment. Carers also reported better outcomes for themselves (Eadie, 2017; Martin et al., 2015). Provision of ETS service is achieved through the flexible use of appropriate evidence-informed individual and systemic therapeutic interventions, and a coordinated and sustainable partnership with key government, non-government and private sector agencies. Clinical mental health interventions include an initial and ongoing comprehensive mental health assessment of the participant and other people of significance in their lives; risk management and safety

planning; attachment and/or trauma focused therapies, which may include dyadic work, individual therapy, family-based intervention or the use of other treatment modalities; and, stakeholder coordination and support. Individual clinicians used a variety of therapeutic approaches and interventions. Some of these interventions included Dyadic Developmental Psychotherapy, Theraplay, Trauma-focussed Cognitive Behaviour Therapy, Narrative and Expressive Therapies, Systemic approaches and Life Story Work (Eadie, 2017).

#### *Treatment (or Therapeutic) Foster Care (TFC)*

There are various models of TFC, with reported results ranging from no improvement to significant improvement in outcomes over time (Biehal et al., 2012; Bishop-Fitzpatrick, Jung, Nam, Trunzo, & Rauktis, 2015; Frederico, Long, McNamara, & McPherson, 2014). Within all models of TFC, foster carers are highly and specifically trained to provide non-restrictive support and care to the child, and to form positive relationships as mentoring adults (Child and Family Practice, 2015). The carer/child relationship is the focal point of the program, and for this reason the program is expected to run for at least one year to allow development of the relationship to be organic and natural (Frederico et al., 2014). The program involves close supervision of the child, with firm rules and boundaries, and a variety of interventions including counselling, skills for independent living and problem-solving training, educational services and support groups. Case managers form a vital part of the program, and are in close contact with the foster parents and the therapy team to ensure consistency and collaboration. The child's birth family are also included in the program and receive therapy, support and education. One study reported that older age at start of treatment predicted greater improvements in mental health and challenging behaviours (Bishop-Fitzpatrick et al., 2015), however, the Circle project in Victoria has worked successfully with children aged from one month to 15 years (Frederico et al., 2012). Significant reductions in 'anti-social' behaviour in young people (10-16 years) were reported after an evaluation of a multidimensional TFC in the UK (Biehal et al., 2012).

#### *The Ripple project*

This Victorian project tested a complex service system intervention to improve the mental health of young people (12-17 years) in out-of-home care, only 10% of whom were reported to have disability. The final results have not been published, but the intervention shows early signs of being feasible (Herrman et al., 2016). Its features include collaboration between out-of-home care and mental health organisations and tailored delivery of evidence-based mental health support using mental health and alcohol and other drug knowledge and skills. Senior mental health or alcohol and drug practitioners schedule regular visits (2-4 weekly) to program sites. Practitioners are trained and supervised in using community development and adult-learning principles to develop one or more six-session intervention plans collaboratively with organisation workers. All organisations are offered a choice in delivery modes and topics. The tailored approach to planning the mode and content of the intervention is responsive to the learning styles and interests of each organisation, and it allows for changes based on the groups' evolving needs and experience of the intervention (Herrman et al., 2016). Participation of young people with previous experience of out-of-home care and the Ripple program seems to improve the chances of a successful intervention by creating a

positive climate, generating useful ideas and links to decision makers. This is likely to improve the young peoples' engagement, health and social outcomes, and the quality of services and professional work (Herrman et al., 2016).

### *Building Communities of Care (BCC)*

This program was created as a family-involved, strength-based model that is fundamentally trauma-informed, and involves the thoughtful coordination of systems, and procedures to create a restorative community. There is some early empirical support for BCC as a trauma-informed organisational model. It is integrative, individualised, and proactive, and has been associated with reductions in the use of physical restraints, particularly in the cognitive impairment or developmental delay group (Forrest et al., 2018). BCC is broken down into core considerations of trauma-informed care: the environment, clinical treatment, community engagement, and behavioural interventions. These core considerations exist across three ecological systems: individual, community, and external. The individual system consists of personal routines, needs, and habits, while the community system maintains open communication, boundaries, and safety. The external system includes the institutional training of staff members and programmatic policies (Forrest et al., 2018). BCC is grounded in the Attachment, Regulation and Competency (ARC) model (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). The ARC foundation constitutes enhancing children's caregiver-child relationships (attachment), skills to manage internal, and interpersonal experiences (regulation), and key capacities associated with resilience (competency). ARC primarily supports applying skills associated with attachment, regulation, and competency to the processing of traumatic experiences. Evaluations of both BCC and ARC in the USA showed reduced use of physical restraint within care residences, and less harm to clients and staff due to the use of restraints (Forrest et al., 2018; Hodgdon et al., 2013).

### *The Sanctuary/Taking Time*

Sanctuary is a trauma-informed model from the USA for creating or changing an organisational culture to more effectively provide a cohesive context within which healing from psychologically and socially traumatic experience can be addressed (Bloom, 2017; Schmied et al., 2006). A similar trauma-informed framework for people with intellectual disability, Taking Time, has been developed in NSW (Jackson & Waters, 2015). The six foundational values Taking Time are:

- Safety – ensuring physical and emotional safety
- Relationships – maximising trustworthiness through relationships, task clarity, consistency and interpersonal boundaries
- Collaboration – maximising collaboration
- Choice – maximising choice and control
- Voice – prioritising the person's voice being heard and heeded
- Person-centred practice – ensuring the person's needs, goals and wishes guide practice (Jackson & Waters, 2015).

Trauma therapies, including the Sanctuary Model, whether assessed at an organisational or personal level, can improve self-esteem, mental health and behavioural problems, and promote decision-making and problem-solving skills (Rivard, Bloom, McCorkle, & Abramovitz, 2005; Traub & Boynton-Jarrett, 2017). They are another way of building resilience in children and young people who have been exposed to trauma. To the best of our knowledge, neither the Sanctuary or Taking Time models have been tested on children and young people with disability and in out-of-home care.

### *The Stop-Gap model*

Another approach from the USA, the Stop-Gap model of residential care, is designed to interrupt the child or young person's spiral of increasingly disruptive behaviour, and to prepare the environment for a timely reintegration to community-based care (McCurdy & McIntyre, 2004; Schmied et al., 2006). However, there are very limited data on the quality of the model as a way to improve outcomes for young people in residential care (James, 2011), with no differentiation by disability status. Stop-gap involves three levels:

1. Environment-based intervention, which aims to:
  - a) create an environment in which the intensity of behaviour is immediately reduced to a level that facilitates movement of the individual towards community-based treatment
  - b) provide intensive skill teaching, focused on teaching adaptive alternate behaviours, in an attempt to maintain lower levels of problem behaviour over time; strategies used include the token economy, academic intervention and support, social skills training, problem-solving and anger management skills training
2. Intensive interventions when problem behaviours do not improve or intensify. These intensive interventions are more targeted, employing functional behavioural assessment and behaviour support plans.
3. After-care-related interventions on entry to the program which aim to prepare the young person and family for success in a community-based placement and the maintenance and generalisation of acquired skills. After-care-related interventions comprise intensive case management, behaviour parent training and community integration.

### *The Turnaround program*

In Australia, the Turnaround program has been developed to improve services and outcomes for young people with high and complex needs aged between 12 and 18 years (Schmied et al., 2006). The Turnaround team consists of a team leader and case coordinators. Each young person in the program identifies the people and agencies to be part of their 'support team'. This approach actively involves young people and their natural supports in all planning and decision-making. To date, Turnaround has not been evaluated. It does, however, appear to show promise as an effective service which operates from a strengths-based philosophy and a 'no reject, no eject' policy. It may not be effective for many young people with disability and experience of trauma who are known to child protection services, due to their often limited natural supports and impaired decision-making capacity.

### *Take Two*

Another Australian program in development, this program focuses on trauma-informed therapy for children and young people (0-18 years) with high and complex needs and involvement with child protection services (Schmied et al., 2006). In practice, more than half of all referrals in the first five years of operation were aged 12 and over (Frederico, Jackson, & Black, 2010). Fewer than one quarter of children and young people within the Take Charge program were reported to have intellectual disability.

Each referred child is assessed for the trauma they have suffered and their coping capacities. The stresses and resources of their family and others who care for them are also assessed. Treatment planning is collaborative among all parties, and is designed to assist each child directly, as well as many of the adults who care for the child. The two most common goals for program participants are to reduce child behavioural or emotional symptoms, and to enhance emotional, behavioural, social, cultural and physical well-being for the child (Frederico et al., 2010). Take Two provides a safe and therapeutic environment for children and young people. Within the context of secure and attentive relationships with therapists and others who care for these children and young people, complex emotional and behavioural issues are addressed. The program also employs the only Aboriginal psychiatric nurse in Victoria, to ensure its services for Aboriginal children and young people are culturally sensitive and competent. Children, parents, carers and teachers all considered that Take Two was effective in engaging with stakeholders, and led to positive outcomes for the children, including reduced hyperactivity, conduct problems, emotional difficulties, and peer problems (Frederico et al., 2010).

### *My Life*

My life was a transition evaluation of the *TAKE CHARGE* self-determination intervention. Participation in Take Charge improved empowerment, education, employment and independent living skills for young people (16-18 years) in foster care, when compared to those in the standard foster care independent living program (Geenen et al., 2013; Powers et al., 2018, 2012). However, only around one third of participants in either study were reported to have a disability and no distinction was made in the results between those with disability and those without.

The Take Charge model is implemented over 9–12 months and features: 1) one-on-one, weekly or bi-weekly youth-directed coaching to support the young person in identifying and pursuing goals they value, and 2) four complementary peer mentoring workshops where young people discuss transition topics, share their knowledge and accomplishments, and receive support from successful slightly older “near-peers” and adults who also have lived experience in foster care (Geenen et al., 2013; Powers et al., 2012). Take Charge coaching focuses on providing youth-directed relationship support to foster communication, trust, and confidence; support to develop skills in achievement, partnership development and self-regulation to achieve their life goals (e.g., problem-solving, negotiating with allies, managing stress); and experiential support to promote successful logistical preparation and engagement in activities to take action toward the young person’s goals, manage challenges and learn about themselves (Geenen et al., 2013). Coaching is flexibly provided and skill introduction

is integrated with the young person's goals and situational opportunities that emerge. The coach also may provide support during the activity (e.g., assist the youth to ask a question), with the intention of encouraging the young person's leadership while at the same time offering support needed to ensure a high likelihood of success. Coaches gradually fade their involvement as the young person demonstrates increasing confidence and skill. Over time, young people experience increasing success in carrying out activities toward their goals, in actively managing barriers that arise, and in increasing their confidence and agency (Powers et al., 2018). Important factors in the Take Charge program are identified as non-judgemental acceptance, trust and respect; consistent and reliable coaching support; transparent and honest communication with coaches; compatible personality and shared experience; reciprocal relationship with coach; practical support; and motivational support. Participants valued the opportunity to develop skills in self-determination, and also to learn by doing – engaging in activities and taking actions towards achieving goals. The mentoring workshops also gave invaluable opportunities for developing relationships with peers (Powers et al., 2018).

### ***Models of care management***

#### *Case management*

Sometimes referred to as intensive case management, this a strategy that actively mobilises, coordinates and maintains a diversity of services for the individual child or young person and their family. Elements include assessment, service planning, implementation and coordination, monitoring, evaluation and advocacy (Schmied et al., 2006). It is an essential component in many services and interventions, including Therapeutic Foster Care and the Stop-gap program (Bishop-Fitzpatrick et al., 2015; Frederico et al., 2012; McCurdy & McIntyre, 2004). Case management assists in providing individualised and tailored services that fit the particular needs of the child or young person in care, and their family.

#### *Wraparound*

Services are 'wrapped around' young people who are considered at risk of out-of-home placement, or who are preparing to leave out-of-home care. Wraparound is a planning process involving the child and family that results in a unique set of community services and natural supports individualised for that child and family. It uses a strengths-based approach, and emphasises the development of natural supports within the family and local community (Eadie, 2017; Martin et al., 2015). Limited or inflexible funding can adversely affect the success of the Wraparound approach. Effective case management is essential to the success of Wraparound (Schmied et al., 2006).

#### *Systems-of-Care*

This is a model from the USA encompassing mechanisms, structures, components and arrangements to ensure that services are provided in an integrated way. It involves a range of service delivery systems, including mental health, juvenile justice, child welfare, substance abuse and special education. The core principles – child centred, family focused, community based and culturally competent – lead to improved interagency working (Schmied et al., 2006). However, there is limited evidence for improved outcomes for children and families.

## *Discussion*

Services are taking a more holistic approach to promoting the overall well-being of children and families in contact with child protection services (Prince-Embury & Saklofske, 2014). A strengths-based and resilience-focused perspective underlies several of the programs included in this review, and individualised, child-centred approaches are becoming common in the area of child welfare. Several Australian jurisdictions are changing their out-of-home care systems through more critical decision-making when children enter care and by increasing the capacity and variety of care arrangements. This includes replacing existing models with new therapeutic and treatment care models and introducing new specialist models of care to accommodate siblings and other client groups (Wise, 2017). There has been a shift from care settings that focus on deficits that predispose, enable and reinforce challenging behaviours (Zolkoski & Bullock, 2012) to settings incorporating a more therapeutic model of care which promotes a safe and supportive environment for children and young people within which to heal psychological and social trauma experiences (Schmied et al., 2006).

In Western Australia, the Department of Child Protection and Family Support has been certified as a Sanctuary organisation and has established enhanced contact centres using the Circle of Security (see [www.circleofsecurityinternational.com](http://www.circleofsecurityinternational.com)) model (Bloom, 2017). Western Australia has also introduced the Circle of Security model for day-to-day therapeutic practice with children in residential care facilities and is proposing further changes to focus on healing from trauma (Wise, 2017).

The United Nations SOS Children's Villages International recommends that all young people in care should be assisted to develop social and life skills that will help prepare them to become self-reliant. This should include opportunities for formal and vocational education, a discrete support worker, and specialised services for children with special needs. Preparations for leaving care should begin well before the child leaves the setting (SOS Children's Villages, 2010; United Nations General Assembly, 2010). Current practice in out-of-home care in Western Australia sets age 15 years as the time to commence planning for leaving care (Department for Child Protection and Family Support, 2015). Some of the interventions in this review are more effective when started at younger ages, particularly those that address trauma recovery, behavioural issues, and self-determination and decision-making skills.

Resilience is the ability to bounce back from adversity and is closely linked to trauma therapy. Resilience has been identified as a mediator of post-traumatic stress disorder for young people with experiences of sexual assault and abuse (Hébert, Lavoie, & Blais, 2014) and other types of childhood abuse (Hong et al., 2018). The process of resilience involves a complex interplay between individual skills and characteristics, interpersonal relationships, and social environment (Sulimani-Aidan, 2018). The various programs in this review all contribute in some way to building resilience in young people with disability in contact with the child welfare system.

Among the personal characteristics recognised as contributing to resilience are self-belief and self-esteem, positive outlook, and future focus (Aranda & Hart, 2015). Individual therapy from a consistent source enhances self-belief and shows someone else believes in the young person's ability to cope with trauma (Sulimani-Aidan, 2018). These personal characteristics

can be strengthened within many of the interventions: Take Two, Building Communities of Care, Take Charge, Sanctuary, Evolve Therapy, Ripple, and Taking Time.

Child protection staff can help with the establishment and maintenance of a range of supportive relationships, including with family members, mentors, and peers, which promote resilience (Aranda & Hart, 2015). These relationships, particularly with peers and mothers, can reduce the likelihood of post-traumatic stress disorder in young people with experience of sexual abuse (Hébert et al., 2014), and may also help with other types of trauma experiences. Supportive relationships, both formal and informal, can be nurtured by the ability of young people to ask for help or to form a connection with others. Programs that help to develop strong relationships for young people with disability include Take Care, Building Communities of Care, and Take Two. Resilience is further supported by paid staff taking a strengths-based approach that reduces the effects of trauma on the child or young person with disability in out-of-home care.

A number of the programs reviewed aim to support better community and social connections for young people with disability in care, and their families. These include Evolve Therapy, Therapeutic Foster Care, Stop-Gap, Building Communities of Care, Take Two, and Take Charge. Care-leaving planning, in conjunction with National Disability Insurance Scheme (NDIS) planning, can guide the development and maintenance of supports in the community. Effective case management supports the development of coordinated and tailored service provision for the young person before and after leaving care.

A common problem faced by young people with and without disability leaving care is their lack of skills for independent living, particularly those involving financial matters and decision-making. Many of the programs in this review include skills training for the participants (e.g., Evolve Therapy, Therapeutic Foster Care, Building Communities of Care, Take Charge). Due to some of the limitations experienced by young people with disability in care, starting the training at younger ages could prove beneficial. However, many people with disability, especially intellectual disability, will need support in some areas throughout their lives.

The services and programs outlined in this review often rely on external, natural and community-based services and supports for children, young people and families with high needs (e.g., Therapeutic Foster Care, Building Communities of Care, Take Two). Establishing positive relationships between the child or young person in care and residential staff, foster carer, therapist, and case manager appears to be a key program element of many of these interventions. However, a focus on individualised care may be compromised when existing external services do not match the young person's and family's needs, or, more problematically, if the services do not exist at all. This may be especially evident in regional and remote settings.

In Australia, the NDIS roll-out is expected to lead to not only a greater demand for non-professional disability support workers, but also a change to their traditional roles to include planning, advocacy and brokerage roles (Judd, Dorozenko, & Breen, 2017). These issues may also have an effect on the availability of suitable child protection staff, whether in foster or residential carer roles. However, in Australia there are a number of measures to better

resource and support the child protection workforce, including the Signs of Safety Reloaded Project and improved preparation training for foster carers in Western Australia (Wise, 2017).

There is a shortage of suitable homes for adults with disability, whether leaving care or the family home. Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD: 2006) outlines the rights of all persons with disabilities to live in a home of their choosing, with whom they choose, and with the necessary supports to do so (United Nations General Assembly, 2007). In Australia, affordable housing is scarce, and young people with disability leaving care may not have sufficient funds or knowledge to access such housing. They are likely to need considerable amounts of support and advocacy to attain a suitable home, particularly if there is limited support from their family. Australian studies have noted that personalised approaches for people with significant support needs improve outcomes without affecting support costs when compared with congregate options (Fisher & Purcal, 2010), although the actual housing costs may be greater in individualised arrangements.

A set of case studies in Australia identified several organisational models of care that aimed to support people with disability in personalised living arrangements (Fisher & Purcal, 2010). People with high support needs and/or mental health problems were included in these studies. The studied models tended to be flexible and responsive to change, while delivering strong and enduring partnerships with government and community organisations, families, and social networks. In addition, all of the models cost less than group home living, regardless of client support need profile. Clients of the organisations reported better social networks, self-determination, community participation, involvement in domestic tasks, and personal wellbeing than before they accessed these supports (Fisher & Purcal, 2010).

Similar results have come from a study of individual supported living arrangements in Western Australia, New South Wales and Victoria (Cocks, Thoresen, McVilly, & O'Brien, 2017). In Western Australia the organisations whose models of care have been evaluated are My Place, Community Living Association, Cam Can, Enable South-West, and Avivo (Cocks et al., 2017; Fisher & Purcal, 2010). Cocks et al. (2016) described four different types of living arrangement that fit within the individual supported living model: living alone, living with a co-resident, living with a host family, and living in a relationship. People living alone had support ranging from less than one hour per week to in excess of 350 hours per week to enable them to live in a home of their own. Co-resident arrangements often meant that a person was offered free or reduced rent to live with the person with disability and provide some care when paid supports were not available. Host families basically provided adult foster care for an individual with disability. The types of relationships between people living together ranged from married/intimate to friendship. These living arrangements were sustained over time, with the longest identified being more than 30 years (Cocks et al., 2017).

### ***Recommendations***

Support organisations and programs should strive to normalise the life course trajectory of every child or young person in contact with the child protection system. It is clear from this review that there is no single intervention or program to suit all young people with disability, exposure to trauma and contact with the child protection system. Similarly, there is no single

program that will fit into the working of every support organisation. It is likely that a multi-modal approach will be necessary to suit all parties. In addition, services will need to be able to respond quickly and appropriately to any changes and challenges in the young person's life. However, there are some commonalities, and some recommendations to be made, based on the literature reviewed.

- Care for children and young people with disability and experience of trauma in the child protection system should be strengths-based, person-centred, flexible and responsive, individualised, and involve family and the community as far as is possible.
- Effective and responsive co-ordination of the various services and agencies involved in care of the child or young person with disability and experience of trauma is vital to the child's life within and outside the child protection system.
- Trauma-informed programs and therapy should be available to all children from first contact with child protection. The therapy should aim to improve the child's emotional and mental health, and to promote resilience to future trauma.
- Skills training, particularly skills of daily living, self-determination and decision-making, should be an integral part of out-of-home care and throughout the time of contact with child protection. All children and young people need to develop the skills necessary to live outside the family home, and children and young people with disability and experience of trauma are not excepted.
- A major responsibility of care providers should be to help establish and sustain authentic and lasting relationships between the child or young person in care and people who may be expected to support the young person as they transition out of out-of-home care.
- Advocacy support to establish and sustain a suitable living arrangement and support system should be available for all young people ageing out of the child protection system. This may include assisting with NDIS planning, supporting applications for public and/or affordable housing, and assisting with the move to a suitable community-based disability support organisation. Advocacy or mentoring for daily living, employment or further education may also be necessary.

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