Paying attention to the future

Piloting Certificate I in Developing Independence in out-of-home care settings

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Brotherhood
of St Laurence

Working for an Australia free of poverty

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Acknowledgements

Acronyms

BSL   Brotherhood of St Laurence

CAT   Crisis and Assessment and Treatment

CRIL   Certificate of Recognition of Informal Learning

CSO   Community service organisation

DI   Certificate I in Developing Independence

EFYF   Education First Youth Foyers

LLN   Language, literature and numeracy

OOHC   Out-of-home Care

TIP   Trauma-informed practice

Summary

Creating space for a new approach

We need to better support young people leaving care

Out-of-home care (OOHC) is for children and young people for whom the state has determined that it is not in their best interest to live at home due to the risk or likelihood of abuse and neglect (Australian Institute of Health and Welfare 2016). As the name suggests, children and young people in OOHC are housed outside the family home in foster care, kinship care or residential care settings. Residential care is a type of OOHC which houses young people between the ages of 12 and 17 years. Small residential units with up to six young people are supported by rostered 24-hour care staff. In 2013, of the 6,400 children and young people in Victoria's OOHC system around 500 young people were living in residential care (Victorian Auditor-General 2014).

There is widespread recognition that OOHC settings, including residential care, are failing young people in both the short and longer term. Sector stakeholders note that too often these settings fail to equip young people to successfully navigate the transitions to an independent young adulthood (Johnson et al. 2009). This perception is reinforced by young people's low rates of engagement in education while in care and high rates of unemployment, homelessness and disengagement once they exit OOHC at the age of 18 (DET 2016) .

Sector stakeholders have persistently voiced concerns that sustained, deliberative attention is often not paid to assisting young people to remain engaged in education and preparing them for transition out of care. Many have pointed to the failure of OOHC settings to assist young people to grapple with the long-term effects of the trauma arising from abuse and neglect, and to focus on and succeed in education. Instead current residential care priorities and practices are focused on immediate crisis response and risk management. This is partly due to a system whose funding favours 'short-term crisis interventions, rather than long-term wellbeing' (DHHS 2016, p. 9).

Victorian authorities, including the Department of Health and Human Services (DHHS 2016), the Commissioner for Children and Young People (2015) and the Auditor-General (2014), recognise that the OOHC system is in need of reform. In their *Roadmap for reform: strong families, safe children*, DHHS promotes a stronger therapeutic role for the sector based on the principles of trauma-informed practice. The reform also includes greater emphasis on maintaining engagements with education (p. 17) and connection to culture and place (p. 21). The government and the sector are interested in pursuing service and educational responses that will promote positive transitions to young adulthood.

In this context, the foundation level Certificate I in Developing Independence is being piloted in OOHC settings to:

- develop young people's capabilities to engage with mainstream education, and achieve economic independence and social inclusion

- promote a new way of working with young people that moves away from a welfare based approach to one which recognises and builds young people's skills, talents and aspirations, and allows them to independently manage their own futures

- improve housing, education and employment options for young people leaving care.

The scope of this evaluation report is the first stage of the DI pilot, primarily assessing implementation and engagement issues. Subsequent stages of the pilot will address the effectiveness and benefits of DI in OOHC settings in terms of student outcomes.

The Certificate I in Developing Independence

The Certificate I in Developing Independence (DI) is an accredited[1] foundation level course for 16–25 year olds who are service-connected and do not have the necessary personal, family and social networks to engage in formal education and training. The DI course is co-delivered over at least 12 sessions by a qualified educator with links to mainstream education settings (e.g. TAFE, higher education, school) and youth development workers based in service settings. Co-delivery of the course is essential for two reasons. First it aims to connect or reconnect young people to mainstream employment, education and training. Second the course draws upon the complementary expertise of educators and youth development workers.

The course engages service-connected young people in mainstream education by developing their personal vision-planning and goal-setting capabilities and concomitant goals across six life domains: education, employment, health and wellbeing, social connections, housing and living skills and civic participation.

The DI is distinct from case planning as it is an accredited course linked to mainstream education provision. It also operates with a distinct logic centred on young people's existing interests and talents, and the valuable contribution that they can make to their family and community.

Piloting DI in the OOHC sector

The DI was initially developed, trialled and evaluated in Education First Youth Foyers (EFYFs) (Myconos 2014). While it currently forms the backbone of the EFYF approach[2], DI was also developed with the intention that it could be used with service-connected young people in other contexts.

In 2015 community service organisations Berry Street and the Child Protection Society approached the Brotherhood of St Laurence (BSL) to pilot DI with young people in OOHC

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[1] Accredited by the Victorian Registration and Qualifications Authority.

[2] Education First Youth Foyers provide co-located supported accommodation and life-skills education for young people at risk of homelessness. EFYFs are an open talent – oriented model developed and implemented in Victoria by Launch Housing and the Brotherhood of St Laurence (BSL).

in Ballarat and northern Melbourne and through Services Connect in northern Melbourne. The BSL requested funding and as a result the Victorian Department of Health and Human Services (DHHS) and the Victorian Department of Education and Training (DET) commissioned stage 1 of the pilot for the 12 months from July 2015 to July 2016. The DI pilot was delivered with partner agencies Anglicare Victoria and Berry Street in selected OOHC settings in Melbourne's north. Anchor, which provides youth services in a non-OOHC setting in Melbourne's outer east, also participated in the pilot.

Piloting an attempt to shift practice in the OOHC sector

The pilot of the DI course in OOHC settings attempts to shift delivery approaches to service-connected young people from its current focus on individual deficits towards one that enables opportunities aligned with young people's interests.

The DI operationalises the capabilities approach (Nussbaum 2011; Sen 1999, 2002) and an Open Talent framework that is built on advantaged rather than disadvantaged or deficit thinking. It gives a structure and language for care practices that facilitate young people's development of future thinking, positive social status and positive relationships. Its pilot implementation in OOHC settings—particularly in residential care—represents an attempt to better prepare young people leaving care for adult life, and create space to shift practice and institutional priorities.

The pilot and its evaluation are designed to be delivered iteratively over three stages. Stage 1 of the pilot aimed to identify viable strategies for enrolment and completion. Stage 2 will test those strategies, and refine course materials for the cohort. Stage 3 will measure DI's contribution to transition planning and exit readiness.

Building evidence for change in residential care

The developmental evaluation of stage 1 of the pilot is the subject of this report. It aims to identify viable strategies to enhance course enrolment, engagement and completion for the subsequent pilot stages.

This report responds to the following research questions:

- What is helping and hindering the implementation of the DI pilot in OOHC settings?

- What changes at the individual, residential unit and system level would promote student readiness for enrolment, engagement and completion of the DI?

- How could the capabilities approach and the Open Talent framework build the residential care sector's capacity to prepare young people for a successful transition to young adulthood?

The evaluation examined the barriers and enablers for enrolment and engagement at the intersecting levels of the individual student; peer group cultures; care practices; and institutional norms, policies and procedures. It drew data from staff training feedback forms (n=29), field notes from meetings (n=13) and site observations, coursework documents, and interviews with students (n=3), and frontline, management and DI

training staff (n=10). Topics covered in data gathering included student experiences of the DI; the efficacy of DI training provided to care staff; changes made to the course during its implementation; and how well DI fitted into the service environments. We conducted qualitative analysis of interview transcripts, training feedback forms and field notes to identify and categorise themes and utilised descriptive statistics to analyse coursework documents.

Findings

Structure of the DI course helped to engage some students

Feedback data indicated that the DI training provided to care agency staff through the program was well attended and well received. While this did not necessarily translate to recruitment of students into the DI course, most of those recruited had the opportunity to develop future goals and access opportunities that aligned with their aspirations.

For the duration of the evaluation, up to June 2016, 11 of the 15 residential care students recruited into the course remained engaged. Few in this group had made significant progress towards meeting the formal requisites for course completion, but most had engaged in a number of course activities.

For example, young people received assistance to make contact with an external individual or institution that aligned with a personal interest or ambition. These included a visit to an AFL football club, attending work experience at Crown Casino, and contacting Engineers Without Borders, professional make-up and street artists, an Indigenous elder and an academic researcher. In one case, an introduction led to the employment of a young residential care student by a catering company.

Some staff attributed positive engagement to the structure of DI as a certificate course. By providing a pathway that was distinct from crisis-driven service, the DI-trained staff helped students to identify their own aspirations. DI provided a support structure to plan for ways to meet young people's goals. While this data was largely drawn from the non-OOHC setting, it points to the potential contribution of the DI structure and approach to complement traditional casework.

Lack of 'student readiness' hindered implementation

A smaller than anticipated cohort of 15 students from residential care engaged with DI. During the evaluation, no student had completed the certificate. Initial expectations were set at 30 completions in the first year. Staff attributed the lower than expected number of enrolments in residential care settings to a lack of student readiness. They believed that young people's personal histories were marked by prior negative experiences and poor mental health which had a lasting impact on their capacity to take up opportunities. At the individual level, this limited students' engagement with the DI, regardless of how enthusiastic they appeared to be.

Systemic and institutional barriers to implementation

Individual level factors only provide a partial explanation for the slower than anticipated student uptake and progress through the DI course. Workers in care settings face multiple and competing demands. The DI pilot was implemented within an existing hierarchy of practice. Regulations, training and organisational cultures place trauma-informed practice, crisis management and risk management at the top of this hierarchy. At the institutional and systemic level, this ordering of priorities meant that limited attention was directed towards DI activities.

Based on our analysis of the data we contend that *current care practice priorities distract from efforts to build young people's capabilities*. In particular, the narrow interpretation of trauma-informed practice, and preoccupation with crisis management and risk management *inhibits the trustful relationships, space for future thinking and the building of social status required for successful implementation of the DI course.*

The report explores these dynamics and identifies three key barriers to DI implementation:

1   Individual level explanations of poor relationships distract from efforts to build trustful and positive relationships between young people, their workers and their families.
2   A cycle of crisis and response is prevalent and present oriented. It prevents future thinking and inhibits young people's connection to mainstream opportunities.
3   A focus on risk management inhibits building young people's positive social status within mainstream social networks.

These barriers reflected institutional 'deep norms' of trauma-informed practice, crisis management and risk management, which directed attention in particular ways and, ultimately, reinforced the barriers they were attempting to address.

Recommendations

Strategies to improve recruitment and engagement

We recommend two major reforms to DI course structure to address the issue of student readiness.

First, introduce in stage 2 of the pilot a pre-DI preparatory program which is clearly delineated from the accredited course. This would formalise a strategy adopted by DI practitioners in stage 1 to enhance student recruitment. In this adaptation, staff would help students to identify aspirations and would broker some opportunities prior to student completion of paperwork induction requirements. In the proposed pre-DI program, BSL DI staff and residential care workers would broker external opportunities that assist participants to identify future roles that interest them. They would also concentrate on fostering young people's positive relationships, future thinking and building social status, with the aim of progressing them towards formal enrolment in DI.

Second, we recommend that young people formally enrolled in the DI course be housed in a residential unit where everyone is enrolled. All young people in such units would have explicitly committed to a 'deal' brokered through the DI process. Normalising engagement with DI activities in these units would restructure the rules governing young people's internal cultural norms and offer incentives for them to be mutually supportive.

Changes to the DI course in OOHC settings that could support broader systemic change

The evaluation presents a number of strategies to enhance the potential of DI to initiate a shift in residential care practice. In particular, the following recommendations focus on addressing the three institutional and systemic barriers to implementation discussed above. Stronger integration of DI in participating residential settings will indicate the extent to which its use of the capabilities approach and Open Talent framework can promote change within the sector. For stage 2 of the pilot, there are a number of strategies which could facilitate this integration, and potentially shift the broader approach away from deficit models of care.

1   Longer time frames and greater stability are required for young people to develop more trustful relationships with workers; and, where appropriate, more attention, care, expertise and resources need to be directed towards the family-oriented aspirations of young people. Three strategies are suggested:

* In residential care staff training (e.g. Certificate IV in Child, Youth and Family Intervention) and practice models (e.g. Best Interests case practice model) mandatory components should include opportunity brokering and 'coaching' styles of interaction for building positive relationships of mutual care and regard. This should result in greater trust with young people.

* Proactively identify worker – young people pairs with positive relationships of mutual care and regard, and resource these workers to continue a mentoring role beyond staffing or placement changes. Give these workers the role of engaging young people in future-oriented action, such as engaging in education and DI activities.

* Provide workers, young people and their families with practical, professional and emotional support to make family contacts therapeutic. This might involve preparing parents and young people to manage their expectations of contact and providing debriefing afterwards; using culturally sensitive family mediation services; training workers to manage complex situations; and having contacts professionally supervised.

2   The cycle of crisis and crisis management can be disrupted by directing attention towards future thinking. To these ends, three strategies can be suggested:

- Support engagement between young people and institutions that can host mainstream and ongoing connections.

- Recognise young people's progress and maturation with markers and rituals.

- Establish a discrete pre-DI preparatory program with the goal of establishing the preconditions for formal enrolment in the accredited course.

3   Breaking the cycle of risk taking and risk management requires an alternative means for young people to develop social status. This might be achieved by:

- developing reciprocal obligations between young people and the broader communities in which they live

- ensuring young people are supportive of each other's efforts towards engagement and opportunity.

Given the limited evaluation data available at this stage, each of these suggestions is necessarily broad and would require further development by practitioners before being operationalised. If the suggestions are implemented, their significance and efficacy can be considered in the evaluation of stage 2 of the DI pilot, thus contributing to the evidence base underpinning practice in the OOHC sector.

1 Piloting the Certificate I in Developing Independence in residential care settings

A new approach to residential care is needed

Out-of-home care (OOHC) is for children and young people for whom the state has determined that it is not in their best interest to live at home due to the risk or likelihood of abuse and neglect (Australian Institute of Health and Welfare 2016). In 2013, there were around 6,400 children and young people in Victoria's OOHC system, 13 per cent of whom were Aboriginal. Residential care is a type of OOHC[3] for young people between the ages of 12 and 17 years[4] in a domestic facility with 24-hour staffing by carers. Four bed, mixed gender units are the norm. Young people are placed in these settings when there are no available options for kinship care, foster care or when these alternatives are deemed unsuitable for them. Around 500 young people are in residential care in Victoria.

There is widespread recognition that young people in OOHC settings too often fail to successfully navigate the transitions to an independent young adulthood (Johnson et al. 2009). In recent years, a range of systemic failures in the residential care system have been acknowledged, to the point that some call for its abolition (Brown 2016). The Victorian Auditor-General produced a report on the sector which states that: 'Regrettably, there has been a fundamental failure to oversee and ensure the safety of children in residential care' (2014, p. vii). Similarly, a report into sexual abuse of children in Victorian residential care, authored by the Victorian Commission for Children and Young People, found that 'It is simply intolerable to continue propping up this flawed model of 'care'' (2015, p. 5). Concerns about the adequacy of residential care have also been expressed at the national level (Council of Australian Governments 2009).

The short, medium and long-term outcomes for young people who experience residential care are also poor. A literature review by Johnson et al. (2010, p. 13) indicated that compared to their peers, Australian care leavers have poorer physical health, have higher rates of substance abuse problems, are more likely to become involved in prostitution and have lower levels of educational attainment. According to a submission by Victoria's largest OOHC provider, Anglicare Victoria, 'Study after study will indicate that 50% of those who leave care will find themselves homeless, in prison, unemployed and or a parent within 12 months of leaving care' (2015, p. 9).

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[3] Other types of OOHC include family group homes, home based-care, independent living and 'other' Australian Institute of Health and Welfare 2016, *Child protection Australia: 2014–2015*, Child Welfare Series no. 63, AIHW, Canberra.

[4] Placements of those who are younger or older do sometimes occur but are not common. Victorian Auditor-General 2014, *Residential care services for children*, Victorian Government Printer, Melbourne.

Various inquiries and reports have recommended reforms, some of them reflected in the Victorian Department of Health and Human Service's 2016 policy document, *Roadmap for reform: strong families, safe children* (DHHS 2016). According to the *Roadmap*, long-term placements of young people in residential care will be phased out and replaced by a program in which residential care takes on an explicitly therapeutic role and becomes 'a program of intensive treatment and stabilisation for young people with complex behaviours so that home-based care is sustainable' (p. 32). The *Roadmap* also forecasts greater emphases on maintaining engagements with education (p. 17) and connection to culture and place (p. 21). Immediate actions in keeping with these commitments include an increase in mandated qualifications for care workers and the establishment of four LOOKOUT centres, which are tasked with monitoring and supporting the educational engagement of young people in OOHC (DET 2016a). However, an ongoing shortage of kinship and foster care placements, particularly for young people with 'complex needs', will mean that many of the young people currently in residential care will most likely move beyond the age of state protection before the therapeutic model is realised.

Care practice in residential settings

In Victoria, the *Children, Youth and Families Act 2005* forms the legal basis for care practice in residential settings. Under the Act, community service organisations (CSOs) providing residential care must be registered and meet quality standards. DHHS funding is also contingent upon the CSO meeting regular performance reporting and monitoring requirements, some of which may be externally reviewed by an independent body. Below, a brief summary of these mechanisms situates this evaluation within the service environment of the pilot.

Looking After Children (LAC) domains

OOHC workers are required to regularly update records of activity across a range of life domains for children in care: health; emotional and behavioural development; education; family and social relationships; identity; social presentation; and self-care skills (Department of Human Services 2012b). While the LAC records have been mandatory in OOHC for some time, training in their implementation only became mandatory in 2016. This leaves questions about the extent to which workers have been applying the LAC framework, their understanding of its components, and its meaningful application in practice.

Certificate IV in Child, Youth and Family Intervention

As part of the *Roadmap to Reform* agenda, this Certificate IV qualification was specified as a mandatory minimum requirement for residential care workers in 2016. Provided by the Centre for Excellence in Child and Family Welfare (2016), it includes units covering developmental theory, trauma-informed practice, crisis management and response, working with intoxicated clients, and suicide intervention counselling techniques. In addition to this training, residential care providers also provide mandatory training for

their staff, on areas including fire safety, occupational health and safety, food handling, effective conflict management, first aid and mental health (Berry Street 2014, p. 12).

Best Interests case practice model

Under the *Children, Youth and Families Act*, s. 10, CSOs must consider the best interests of the child when making a decision. The best interests principles in the Act seek to protect the child from harm, protect their rights and promote their development. DHHS operationalises these principles in its child protection practice manual (Victorian Auditor-General 2014). The Best Interests case practice model prompts a cycle of information gathering, assessment, planning, implementation and review, and is used across the OOHC sector to guide the development of workplace policies and procedures.

The model is 'developmentally and trauma-informed' and includes protocols for working with families, children and young people in the context of concerns about their safety and welfare. It places 'strong emphasis on the need to consider the impact of cumulative harm and to preserve cultural identity' (Victorian Auditor-General 2014).

Transition planning

Victorian legislation requires young people in state care aged older than 16 to be provided with services to support them to make the transition to independent living (Department of Human Services 2012a). This takes the form of the 15+ Care and Transition Plan. It specifies principles, roles and procedures for three stages: preparation, transition and post-care support. The plan intersects with the LAC domains and prescribes priorities for attention: social skills, budgeting and managing money, managing family and other relationships, living with people and resolving conflict, cooking, housekeeping and self-care, and understanding the rights and responsibilities of an adult (Department of Human Services 2012a, p. 13). Upon leaving care, post-care support planning entails providing the young person with the 'necessary appropriate accommodation, employment or study in place and income to live sustainably' (Department of Human Services 2012a, p. 6). The young person is also provided with information on available post-care supports, and how to access them.

While transition plans have been required for some time, investigations have found widespread deficits in preparation for transition (Mendes, Johnson & Moslehuddin 2011 pp. 64-65). A series of publications and advocacy campaigns by the CREATE foundation have drawn attention to the matter: their 2009 *Report Card* found that for Australian young people transitioning care, 28.5 % were unemployed; 35% were homeless in the first year; 45% were involved in the youth justice system; and 63% did not have any plan for their transition from care (McDowall 2009).

Preparing for the future?

Each of the mechanisms detailed above has elements that direct attention towards preparing young people for transition to an independent adulthood. However, these imperatives compete with more immediate concerns around safety, trauma-informed practice, crisis management and protection from further abuse and neglect. This is

compounded by a funding structure that tends towards 'short-term crisis interventions, rather than long-term wellbeing' (DHHS 2016, p. 9). OOHC providers and policy makers alike have persistently voiced concerns that sustained, deliberative attention to preparing for transition is often not achieved. In this context, the pilot of a course focusing on future planning represents a significant opportunity to reflect on the capacity of the residential care sector to apply this dimension of practice.

Piloting a new approach: Developing Independence (DI)

DI course design

The DI is an accredited[5], foundation level course for 16–25 year olds who are service-connected and do not have the necessary personal, family and social networks to engage in formal education and training.

The purpose of the course is to engage these young people in mainstream education by developing their personal vision-planning and goal-setting capabilities and concomitant goals across six life domains: education, employment, health and wellbeing, social connections, housing and living skills, and civic participation. Planning across these domains is commonplace within OOHC; however, it is often carried out through case planning and short-term, in-house courses that are not accredited and not linked to mainstream education.

There is consensus that high rates of disengagement in education, and concomitant low completion rates, play a major role in the system's poor post-care outcomes (DET 2016a; b). Accordingly DI focuses on working with young people to identify their aspirations for the future and the education and training pathways that will be necessary for them to achieve these goals. The previous evaluation found that the 'DI can play a vital role within a foyer context by enhancing a young person's capacity to engage in further education' (Myconos 2014, p. viii).

The DI course is co-delivered by a qualified educator based in mainstream education settings (e.g. TAFE, Higher Education, School) and youth development workers based in service settings. Co-delivery of the course is essential for two reasons. First it aims to connect or reconnect young people to mainstream employment, education and training. Second the course draws upon the complementary expertise of educators and youth development workers.

The DI curriculum (Buick & Stearman 2014) is informed by the capabilities approach articulated by Sen and Nussbaum. The capabilities approach is concerned with increasing the substantive freedom of individuals (Nussbaum 2011; Sen 1999, 2002), which can be achieved by expanding realistic opportunities and individuals' capacity to make the most of these.

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[5] Accredited by the Victorian Registration and Qualifications Authority

Drawing inspiration from the capabilities approach, the certificate was developed using the complementary Open Talent framework. Open Talent was developed within the UK Foyer Federation (Falconer 2009 unpub.) and has been a cornerstone of service development in employment, education and training programs for young people at the Brotherhood of St Laurence, particularly Education First Youth Foyers (EFYFs)[6]. Advantaged thinking is the cornerstone of the Open Talent framework. Open Talent practitioners differentiate themselves from youth workers who foreground crisis response or immediate service needs—in effect, those who practise 'disadvantaged thinking'. Instead, young people are seen as capable, talented and valued members of their communities (Nussbaum 2011; Sen 1999, 2002). With advantaged thinking, practitioners focus on realising the positive potential of young people by developing their future thinking, positive relationships and social capital.

Piloting the DI course in OOHC settings

The DI was originally developed for, and is currently delivered in EFY Foyers, which cater for young people who have experienced or been at risk of homelessness. It was also developed with the intention that it could be delivered to other cohorts and in other contexts.

In 2015 community service organisation Berry Street and the Child Protection Society approached the BSL to pilot DI with young people in OOHC settings in Ballarat and northern Melbourne and through Services Connect in northern Melbourne. Anglicare Victoria also expressed interest in participating in a pilot. Stakeholders widely recognised that OOHC settings were often failing to equip young people to successfully navigate the transitions to a socially included young adulthood. BSL requested funding to deliver this pilot and as a result the Victorian Department of Health and Human Services (DHHS) and the Victorian Department of Education and Training (DET) commissioned the first stage of the pilot for the 12 months from July 2015 to July 2016. The DI pilot was delivered in various OOHC settings in Melbourne's north.

Previous iterations of the course have been evaluated and refined (Myconos 2014). The pilot of the DI course in OOHC settings thus introduces an established, evaluated and operational program to a new service context.

Purpose of the DI pilot

The DI pilot aims to develop the capabilities of young people in OOHC settings to sustain engagement in mainstream education, and ultimately to achieve greater economic independence and social inclusion. The pilot is also designed as a platform to effect cultural change in the care settings in which it is implemented.

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[6] Education First Youth Foyers are an Open Talent oriented model developed and implemented by Launch Housing and BSL. EFYFs provide student accommodation on TAFE campuses and life-skills education for young people experiencing homelessness. Young people who are motivated and committed to engage in accredited education are provided with 24/7 support and accommodation for up to two years. The DI is a mandatory part of the program.

Specific objectives of the pilot stage 1 are to:

- deliver DI to young people living in OOHC settings to assist them to develop core life management skills, to gain a deeper understanding of their goals and aspirations and the further study they need to achieve these and to take independent steps towards sustained engagement in formal education and training in the future

- advocate and promote a new way of working with young people that moves away from a welfare based approach to one which recognises and builds young people's skills, talents and aspirations, and allows them to independently manage their own futures

- facilitate connections between young people, OOHC services and mainstream education providers, so as to promote better pathways for those leaving care

- test the efficacy of DI as a personal planning and educational engagement tool for young people in OOHC settings through trialling and adapting the program and evaluating each stage of the trial.

The DI pilot also promises a new approach to building the connections to kinship, community, economic and civic networks and institutions that young people in residential care will need to transition to independence. Young people leaving care are required to make an accelerated transition, while their peers in the general population often remain in their family home into their early 20s. The latter group typically benefit from their connection to a family and a wider community of supporting adults, who provide social, practical, emotional and often financial support for a gradual transition to independence (Mendes, Snow & Baidawi 2014). To close this gap, DI activities are designed to build young people's networks of contacts with enabling individuals and institutions, while also supporting the young people to develop appropriate interactions with them.

Course structure

Certificate I in DI comprises 180 nominal hours and is usually co-delivered over a six-month period of at least 12 sessions by a qualified educator with links to mainstream education (e.g. TAFE, higher education, school) and care workers based in service settings. DI coursework uses the specific expertise of qualified educators and of care workers. While the educator leads the initial sessions, subsequent sessions can be undertaken independently by the student and their worker.

The Certificate I in DI has an emphasis on exploring goals and aspirations, identifying potential barriers, accessing resources, and planning for future learning and workforce engagement. Students are, therefore, not assessed on whether they achieve their goals within the timeframe of the qualification, but rather on their capacity to set small and manageable goals and to develop an awareness of the potential barriers and enablers around them. This relates to the DI's aim of being distinct from a 'welfarised' approach, which views young people as a social problem to be 'activated' through labour market

policies, or 'engaged' through education policies. As such it is not seeking a 'quick fix' or short-term targets of enrolment numbers. Rather, the emphasis is on exploring different areas of vocation and education, and developing a set of core capabilities and an external support network that will enable ongoing, independent management of a young person's own trajectory.

Completion of the course requires participation in a range of skills building, goal setting and planning and individually tailored opportunities. These can include work experience, sporting or cultural activities or lessons with specialist tutors. The DI educator conducts specific assessments throughout the course and assesses the evidence submitted across each unit of competency. The formal accreditation marks a period of progress and maturation and may promote a more positive outloook towards future education and training opportunities.

A progress report for this study from March 2016 (Hart, Mallett & Cull 2016) argued that DI had value as an effective vehicle for culture change within care settings. This was argued with reference to the pilot's effects: drawing attention to systemic deficits; engaging students with civic, cultural and economic activities; providing a forum for discussing care practices; providing well-received training to partner agency staff; and learning about institutional dynamics and their effects on practice.

Partner agencies

Three partner agencies from the residential care sector commenced the DI pilot: Anglicare Victoria, Berry Street and Services Connect[7] (a state government initiative). However, as no students were recruited from Services Connect, their role in the pilot ceased. After the pilot had been in operation for several months, a youth homelessness service, Anchor, expressed interest in DI and joined the pilot. In addition, BSL DI staff brokered a relationship between Brophy which operates a youth foyer – style service in Warrnambool in south-west Victoria and a local TAFE college so that their students could complete the DI course without reliance upon a BSL DI educator. Two students enrolled through this program, but distance prevented the collection of data from Brophy for the pilot evaluation.

The three agencies participating in the pilot are briefly introduced below.

Berry Street

Berry Street[8] is a large welfare organisation specialising in services for families and children, and a major provider of residential and other forms of OOHC in Victoria. Two separate regions of Berry Street participated in the trial: one in the regional city of Ballarat; and the other in the northern metropolitan region, encompassing the municipalities of Banyule, Hume, Nillumbik, Whittlesea, Darebin, Moreland and Yarra. In

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[7] A small-scale initiative of the Victorian government for integrated human services in Victoria
[8] For more information see https://www.berrystreet.org.au/

both regions, Berry Street appointed a dedicated worker to implement DI across a small cluster of residential units.

Anglicare Victoria

Anglicare Victoria[9] is the largest provider of OOHC in Victoria, with109 residential care placements in 2014–2015 (Anglicare Victoria 2015). Young people they referred to the program resided in Melbourne's north (n=1) and Melbourne's west (n=1). While Anglicare Victoria staff took part in many of the preparatory DI training sessions, their recruitment of students was lower than expected. This was partly attributable to changes in residential care personnel during the trial.

Anchor

Anchor—the only non-OOHC partner agency—provides a foyer-style model of support and accommodation to young people who have experienced or been at risk of homelessness. Based in the Lilydale area of Melbourne's outer east, they provide four co-located, three-bedroom townhouses, a lead-tenant house, and outreach to other young people living independently. Their clients are older than their counterparts in residential care (16–22 years compared with 15–17 years), but younger than the EFYF cohort. From their initial exposure to the EFYFs and involvement in the DI pilot, the Anchor service was able to adopt Open Talent and advantaged thinking. Staff are well linked with local service providers and more broadly with the local community. Where data gathered from the Anchor service are presented in this report, they are generally presented as a counterpoint to shed light on the residential care data.

Student recruitment

Twenty-five students were referred to the course over 12 months. Fifteen residential care students were recruited from Berry Street (n=13) and Anglicare Victoria (n=2). A further 10 students were enrolled through the Anchor service. Across all settings, 10 students were male and 15 were female; and 5 identified as Aboriginal. Anglicare Victoria and Berry Street students were aged between 15 and 17 years, and Anchor students were aged between 16 and 22 years (see Figure 1).

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[9] For more information see https://www.anglicarevic.org.au/

Figure 1 DI student age by setting
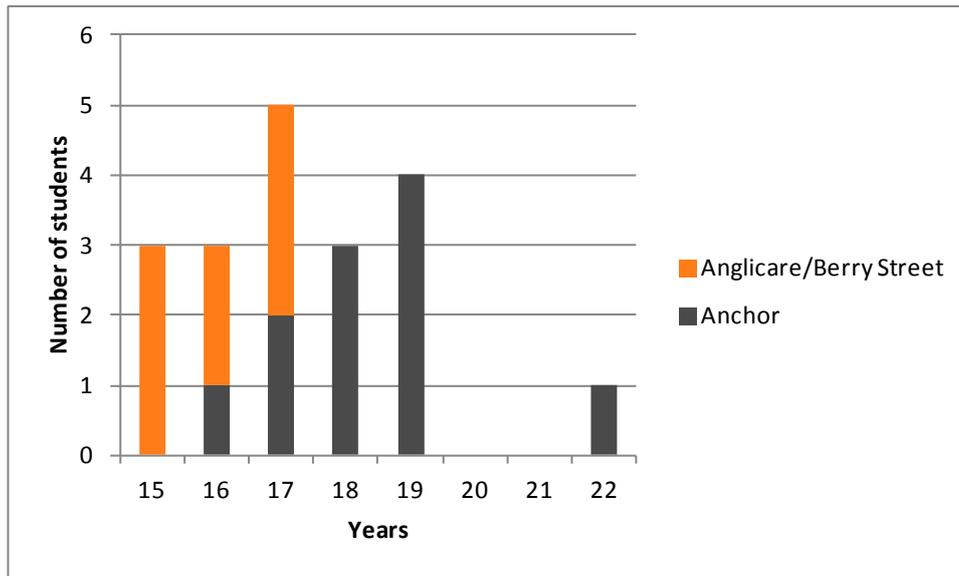
The recruitment of students occurred in roughly three waves. The first wave of six students was recruited from Berry Street (n=4) and Anglicare Victoria (n=2) between August and October 2015. A second wave of students (n=10) was recruited from Anchor between December 2015 and May 2016. The third wave of students (n=9) was recruited from Berry Street between May and June 2015.

Once the students were recruited, early coursework activities often involved student, workers and educators collaborating on the completion of four coursework instruments: a language, literature and numeracy (LLN) assessment; a readiness form; a Certificate of Recognition of Informal Learning (CRIL); and the Developing Independence Map. At a meeting of the steering committee in February 2016, it was noted that some students recruited in the first wave felt less motivated to pursue the course after having completed the LLN assessment and readiness form since they were disinclined to do paperwork. Other students who might have been interested in engaging in the course were discouraged for the same reason. In contrast, in the Anchor service (wave 2), DI staff were able to administer the full set of instrumentation with the majority of students. These students were older and living in a much less crisis-prone and more flexible service delivery setting. The Anchor service was more able to implement the Open Talent approach across their sites. We might speculate that these circumstances enabled Anchor students to complete the paperwork with less difficulty. In the third wave, paperwork requirements for recruitment were waived and students were considered to have been recruited when they had verbally agreed to engage with program activities. Table 1 shows the frequency of instrument completion at the end of June 2016 by recruitment wave.

Table 1 Instrument completion by recruitment wave

Data source	Wave 1	Wave 2	Wave 3	Total

Data source	Wave 1	Wave 2	Wave 3	Total
Total in wave	6	10	9	25
Readiness form	3	10	3	16
DI map	2	7	2	11
CRIL	4	8	2	14
LLN	2	8	0	10

It should be noted that, despite relaxing the paperwork requirements, no student could formally complete the accredited course without having completed these components.

Stage 1 pilot operations

The pilot and its evaluation are designed to be delivered iteratively over three stages. These stages and their evaluation are designed to assist adaptations and ensure maximum enrolments and completions. The first stage, which is the concern of this evaluation, aimed to identify viable strategies for enrolment and completion. Stage 2 aims to test those strategies, and to refine course materials for the cohort. Stage 3 will aim to measure DI's contribution to transition planning and exit readiness.

Day-to-day management of the pilot was undertaken by the BSL Project Manager. The DI trainers were employed by BSL and worked directly with students and partner agency care staff. A relationships broker was also employed by BSL to work with care staff and students to source opportunities matching student skills and aspirations: work experience, community groups, arts projects, family counselling, etc. Interagency liaison and advocacy for the program was undertaken by BSL's Youth Transitions Principal Adviser and the Project Manager.

Governance

Stage 1 of the pilot was commissioned for 12 months between July 2015 to July 2016 by the Victorian Department of Health and Human Services and the Victorian Department of Education and Training. The funding supported DI trainers, a relationships broker and management for the pilot.

A steering committee compromising BSL, care agency partners and government funder representatives oversaw the pilot. The committee met four times between November 2015 and March 2016. It reflected on pilot activities and care practices in residential settings, and considered strategies to engage partner agency staff and students, and broader structural challenges facing the sector. Contributors to the DI pilot are presented in Figure 1 below.

Figure 2 Contributors to DI Pilot in OOHC settings 2015–2016

		Data source	Audience	DRC
Intervention targets	Residential care staff	x	x	
	Students	x		
Partner agencies	Berry Street sites	x	x	x
	Anglicare Victoria sites	x	x	x
	Brophy Foyer	x	x	x
	Anchor Foyer	x	x	x
Vic. Govt funders	Dept of Health and Human Services		x	x
	Dept of Education and Training		x	x

Steering committee members (row label spanning Partner agencies and Vic. Govt funders)

*DRC = developmental research collaborator. See 'Research design' section below

Staff training

Training for staff was conducted by BSL DI and EFYF Foyer staff. Initial training sessions were delivered over two days and later sessions were delivered in one day. While the design and content of sessions has been adapted over time to better suit the needs of trainees, each training session included introductions to:

- the Open Talent approach employed in EFYFs
- DI course activities
- tools and instruments provided for workers and students.

Earlier training sessions were delivered mostly to frontline care staff, while later sessions were delivered to supervisors and managers.

Pilot stage 1 evaluation

Research design

The research design followed the conventions of a developmental evaluation (Patton 2010). The evaluation was developmental insofar as it attended to the adaptation of the course as it was being piloted; and insofar as the evaluator (AH) played an active role in the BSL DI team and the steering committee. The developmental design also enabled these groups to actively shape the research process by supporting the evaluator's data gathering activities, and by suggesting analyses of prevailing issues.

The iterative and inductive process of data gathering, analysis, identification of issues, discussion, and reframing of research direction differentiates this evaluation from more deductive studies that seek to measure program value in predetermined ways.

Many of the arguments presented in this report reflect the practice experiences of BSL DI and care agency staff as they grappled with the circumstances of the young people they were working with and the broader residential care system.

The DI pilot in OOHC settings seeks to assess how the certificate can be most effectively delivered to this cohort. This includes recommending and implementing the adaptations needed. The evaluation of stage 1 of the pilot supports these aims by identifying strategies for strengthening future implementation of the DI, with a focus on optimising course enrolment, engagement and completion. In particular, the evaluation examined the barriers and enablers for enrolment and engagement at the intersecting levels of the individual student; peer group cultures; care practices; and institutional norms, policies and procedures.

Evaluation questions

- What is helping and hindering the implementation of the DI pilot in OOHC settings?

- What changes at the individual, residential unit and system level would promote student readiness for enrolment, engagement and completion of the DI?

- How could the capabilities approach and the Open Talent framework build the residential care sector's capacity to prepare young people for a successful transition to young adulthood?

Method

Research design was mixed methods and primarily qualitative. Data were gathered through interviews with frontline and management staff, a few interviews with students, document analysis and participant observation.

The data gathered from the staff sample for this evaluation came from:

- eight interviews with individual (n=6), and multiple (1x2 staff and 1x3 staff) staff members in frontline (n=6) and management (n=5) roles in participating agencies (3x BSL, 3x Anchor, 2x Anglicare Victoria, 2x Berry Street). One staff member (management, Anchor) was interviewed twice. In addition, field notes were collected from 13 meetings with staff.

- completed feedback forms from staff attending DI training sessions (n=29).

Data gathered from the student sample for this evaluation came from:

- three interviews with students (3x Anchor)

- analysis of coursework instruments from 25 students as detailed in Table 1

Sample recruitment

Staff sample
The evaluator's (AH) recruitment of staff interviewees was targeted to represent each participating agency and a mix of frontline and management staff. BSL staff often introduced AH to potential recruits at steering committee meetings, or suggested partner agency staff members who were playing important roles in the pilot. After introductions and suggestions, times were scheduled and AH travelled to care agency settings to conduct the semistructured interviews.

Student sample
AH's introduction to student interviewees was dependent on BSL and partner agency staff. The three students interviewed were all from the Anchor service, where care staff issued a general invitation to all DI-enrolled students. Two students were interviewed individually in the Anchor setting and one in a local cafe. Residential care staff reported that students regularly had (unwelcome) visiting adults from the child protection and welfare sector in their domestic space, so the opportunity to participate in a DI-related interview was unlikely to gain much interest. For this reason, direct observations from young people in residential care were not available for this study.

Students who completed induction instruments (as detailed in Table 1 in the Student recruitment section above) and provided informed consent (all but one) were included in the document analysis sample.

Staff interview method
Staff interviews were semistructured and lasted about one hour. All interviews were conducted by AH, audio-recorded and professionally transcribed. Although each interview differed from the last as the inductive process developed, interviews covered some common topics. Staff participants were asked about their general duties and their specific role within the pilot; student recruitment process and its suitability; their reflections on the cohort's motivation and engagement with the course; interagency and intraorganisational dimensions of the course; the opportunities and limitations of working in a multistakeholder pilot; and, finally, barriers or opportunities they had noticed for the specific students or residential settings they had worked with.

Student interview method
Each of the three student interviews was semistructured and lasted about half an hour. Each was audio-recorded and professionally transcribed. Interviews began with questions about students' initial enrolment and engagement in DI. Details were sought about experiences of course activities and the course structure. These questions touched on schedule and place; tools, curriculum and resources; and relationships with DI staff and care agency workers delivering the course. Students were asked about external opportunities made available through the course, their value, and what might have enabled or prevented them from taking advantage of these. Finally, questions

turned to relationships with other students in the course and overall reflections about experiences in the course and their value. One interview was conducted solely by AH, and in the other two interviews, AH was joined by BSL DI project manager, who was not known to the students. After their interview, each student was presented with a $25 supermarket voucher to compensate them for their time.

Document analysis

Early coursework activities often involved the completion of four coursework instruments: a language, literature and numeracy (LLN) assessment; a readiness form; a Certificate of Recognition of Informal Learning (CRIL); and the Developing Independence Map. These data were collated for quantitative and qualitative analysis.

Fieldwork

Field observations were conducted in steering committee meetings, meetings between BSL and partner agency staff, and one-on-one meetings between staff and AH. Basic notes were taken during the event and details were added when they were typed up soon afterwards.

Staff training evaluation

Staff attending DI training sessions were provided with feedback forms asking seven questions. Three questions ('content of day', 'clarity of communication', 'your ability to participate and connect with others') used Likert scale (using a scale from '1', 'poor' to '5', 'excellent') and open responses; and four further questions had open response only ('Which part of the training was useful and why?'; 'Are there any areas of training that you think could be excluded?', 'Are there any areas of training that you think could be included?', 'Please give any general feedback, comments or ideas?'). The feedback form and process were designed and implemented by BSL staff, not the evaluator. However, 29 completed forms were accessed by the evaluator and qualitative data and quantitative data were transcribed into a spreadsheet.

Analysis

With the exception of descriptive statistics developed from the coursework instruments, all analysis was qualitative. Qualitative analyses involved the thematic categorisation of data from interview transcripts, training feedback forms and field notes. While some substantive course outcomes were documented, coding focused on barriers to specific DI activities and tenets of Open Talent.

Field notes and interview transcripts were imported into qualitative analysis software (NVivo) and all were coded into an initial thematic scheme. The early coding process developed thematic nodes of barriers to course implementation:

- time rhythms and temporal orientation

- civic, economic and institutional participation

- relationships between workers and students

- internal relationships between young people living in care

- relationships with family and kinship networks

- crisis and escalation.

The next stage of analysis focused on the disjuncture between existing care practices and the tenets of Open Talent, and used the previous coding scheme to analyse specific tensions. These tensions are reflected in the structure of findings presented in this report and are interpreted with relevant sociological literature to develop a range of suggestions for reform and adaptation.

Quantitative analysis involved development of student cohort demographics from coursework instruments, and descriptive statistics from training feedback forms.

All data were gathered in accordance with the procedures outlined in the research proposal approved by BSL's Human Research Ethics Committee. In this report pseudonyms are used to protect the identity of individuals and locations.

Limitations

No interviews were undertaken with students in residential care. This limits the scope of this study's findings.

2 Staff enthusiasm did not translate into student recruitment

Staff training

To prepare them for their role in delivering the DI, around fifty staff from Anglicare Victoria, Berry Street, Brophy, Anchor and Services Connect attended seven training sessions between August 2015 and May 2016. Training sessions were conducted by BSL DI and EFYF Foyer staff. Staff training evolved iteratively in response to feedback, and was delivered initially to frontline staff and later to managers. Feedback from 29 participants indicates that the training sessions were well received. In selecting responses to questions about satisfaction with the training, using a scale from '1' ('poor') to '5' ('excellent'), all responses were '3' or greater and the median response to each question was '4'. In their qualitative feedback, trainees wrote positively about the opportunity. Some illustrative quotes from four participants are:

> Great project and a great opportunity to support young people in residential care that are not provided with the tools to be prepared for independent living.

> I have been re-inspired with my practice with YP [young people] and feel so very grateful to be given the opportunity. I am hoping our CSO [community service organisation] will be flexible enough to facilitate this program fully.

> This course is very simple and achievable as we do this with YP regularly[,] only through this they're able to receive a Cert [I] and further encourage education.

> What an amazing opportunity for us, thank you. It is so exciting to be involved in something that is actually going to happen for our kids. And such an innovative way to look at education. The kids wouldn't see it as education as it's about them, by them, for a change. And to have such inspiring people supporting them us amazing.

These quotes illustrate that host agency staff were enthusiastic about the prospect of delivering the course, and about using the Open Talent approach generally, in their respective care settings. They also recognise the need for this approach, and its departure from existing practice.

Reflecting on the contrast between staff enthusiasm and the low number of student recruits, the BSL DI staff hypothesised that trained staff lacked an authorising environment in which to administer the program, a concern that was flagged in the quote above expressing 'hope' that the agency would be 'flexible enough to facilitate this program fully'. In response, BSL DI staff shifted their training focus from frontline care staff to site coordinators and managerial staff. In addition, they mounted advocacy about the program with participating agency managers and leaders. While these interventions had some success in bolstering participation, recruitment and engagement remained slower than anticipated.

Course recruitment and student engagement

All 15 Anchor students were close to course completion, and 11 of the 15 residential care students recruited into the course were still engaged, when data gathering for this study finished at the end of June 2016. While few of the latter group had made significant progress with the requisites for completion, most had engaged in a number of course activities. Four of the 15 residential care students had discontinued their engagement: two aged out of care and did not take up the opportunity to continue DI, and two were transferred to another region where DI was not offered.

This section of the report begins to unpack aspects of DI that facilitated and hindered engagement. While the available data come largely from staff and students in Anchor's non-OOHC setting, these are included here to highlight the potential contribution of the DI structure and approach to traditional casework, and to provide examples of the possibilities of the course in environments where care practices are more attuned to the tenets of Open Talent.

Identifying goals and accessing opportunities

Most recruited young people had the opportunity to develop future goals and access opportunities that fostered their aspirations. For example, young people received assistance to make contact with an external individual or institution that aligned with a personal interest or ambition. These included a visit to an AFL football club, attending work experience at Crown Casino, and making contact with Engineers Without Borders, professional make-up and street artists, an Indigenous elder, and an academic researcher. In one case, an introduction led to the employment of a young residential care student by a catering company. Some young people expressed goals of improving family relationships. Making contact with country and culture was a priority for a few Aboriginal students. Through the DI, young people were given contacts and practical and emotional support to pursue their kinship goals.

DI students and staff in the Anchor service reported that the DI course provided a more structured approach to casework; extra focus on future housing, employment and education aspirations; and support for education. For example, Anchor staff reported that DI workshops attracted higher attendance than their usual events. Students also discussed 'enjoying' DI workshops that were relevant and that aligned with their interests. These included workshops covering legal rights in police interactions, and personal safety. One student suggested that her enjoyment was due to bringing in external experts rather than relying on internal workers. Another student referred to an extrinsic reward of participation, in helping her apply for lead tenancy. Unlike their counterparts in residential care, students in Anchor settings tended to maintain a consistent engagement in the course.

Anchor staff and trainers attributed this higher level of engagement to the structure of DI as a certificate. An Anchor staff member believed that this structure facilitated engagement in a couple of ways. First, it elicited a sense of shared purpose among the young people constituting a positive form of peer influence that reinforced participation. Second, this staff member felt that the structure of the certificate helped keep the young people 'on track' on a 'pathway (for them) to navigate'. The DI trainers echoed these sentiments. One also referred to the importance of the course structure as helping to maintain focus:

> Quite often a lot of services get really caught up in the everyday crisis of the young people, and it's really easy to kind of get trapped into the story and go down that path with the young person instead of essentially coaching them forward in their lives in another direction at the same time. So with the DI, it kind of is a constant reminder and a bit of structure to keep bringing it back on to that side that you want to be. So when you sort of get pulled off in their direction you can also bring them back.

Another DI trainer also spoke to the importance of structure, adding that the DI's value was in intentionally supporting students to identify their aspirations:

> The thing I think is the value in the certificate that I see is that it is student-directed mostly as far as their aspirations. It sets up a framework to ensure opportunities for

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> those six service offer areas so it highlights to them and their workers that we need to make sure we're providing opportunities in these areas.

Student aspirations therefore contribute to the structure of the course, shaping the kinds of opportunities offered to them. An important aspect of this structure is that the worker closely supports student to identify their own aspirations. For one Anchor student, the encouraging support of her worker taking her through the structured workbook helped her to gain confidence to engage in the goal-setting aspects of the DI course.

> With this course it makes you think a lot about what do you actually want to do? What are your actual goals? My worker, she was going through those things in the booklet with me and it was very difficult for me to answer those questions, but then she just explained that you need to have goals and you need to be looking forward to something further on in life and … so, I did start off with very little goals, like, passing Year 10. For most people that would be a little goal. For me that was a massive goal because no-one in my family has done that. It took my brother three times to pass Year 10. I did it first time … I think it's easier to make goals and to think about your future when it's something that you want and you've got people there for you [saying] 'you can do it', and you start to think to yourself, 'yes I can do it'. So it's a good feeling when you pass that goal. Like, 'I can do things', 'I can do anything'.

The momentum of attaining those aspirations led this student to set further educational goals.

In residential care settings, however, many students struggled to maintain their engagement. The reasons given for this by staff and students are discussed below.

Lack of 'student readiness'

Several barriers hindered students' recruitment into, and engagement with, the DI course in residential care settings. At the individual level, a number of agency staff and DI trainers felt that many young people, in spite of their enthusiasm, were not ready to take up opportunities.

> Sometimes one of the issues here is that everything sounds good for the young people, but then when push comes to shove they're not really ready for it. But they haven't said so, so often they just won't turn up. (Anchor staff)

Several of the care agency staff attributed this to a history of previous opportunities being blocked:

> You can get excitement from them but you can get resistance because in their life they haven't had things that have gone well. (Anglicare Victoria staff member)

For example, particular questions in the intake and assessment forms required for DI, such as questions about alcohol and other drug use, were considered by some partner agency staff to be 'triggering' for the young person because of their 'trauma histories'.

Within the steering committee meetings, this was discussed as a potential reason for student resistance to engaging with DI.

DI trainers also spoke about young people's fear of failure and the unfamiliar, which led some to 'back away' when opportunities were presented. One Anchor student referred to her anxiety issues as inhibiting the take-up of DI activities:

> A lot of the time I do say no to things because of my anxiety. My anxiety does stop me from going out and actually doing things, being bold. I actually think that was one of the main reasons why I didn't go to the catering thing. Because there wasn't going to be anyone there that I knew, I wasn't sure what I was supposed to do. I had to take public transport there. I haven't taken public transport any further than Riverside.

At the same time, these individual and biographical explanations for a lack of 'readiness' can obscure the role of institutions and systems. The shift in focus from individual deficits to enabling structures is a principle of the DI program, as demonstrated by one DI staff member:

> You're always ready for an opportunity. Just get the right one. But that has come up a lot, is he or is she quite ready yet? Well, I just sort of scratch my head. Of course they are.

Here, care staff assumptions about readiness form a structural barrier to young people's participation. These assumptions are challenged by the DI staff member. To overcome these barriers and build young people's interest in the program, BSL DI staff provided significant engagement support, which included spending extra time with students to discuss options and possibilities for the future. More time was also spent in brokering opportunities for the young people to engage with potential employers and community groups, which achieved moderate success in maintaining engagement.

To inform the stage 2 of the DI pilot, we need to look beyond the individual and biographical reasons given for a lack of engagement with the course. Barriers to engagement at the residential setting and systemic levels are discussed in the following sections.

3 Regulations and practice norms direct attention away from DI

While staff viewed the DI training positively, the low numbers of young people recruited from OOHC into the DI course and their slow progress through the course prompts us to identify the barriers to DI implementation and uptake. Barriers operate at multiple levels, including the residential unit level and the systemic level. Within residential care units, relationship dynamics between young people and staff, and among the young people, can hinder the implementation of DI. At the broader level, system regulations and requirements shift attention to practice priorities that either leave little room for DI practice or may be at odds with the principles with the DI course.

In this section, we contend that current practice in DI pilot settings that emphasises trauma-informed practice, crisis management and risk management inhibits the delivery of DI in four ways:

1   Heavy emphasis on regulatory compliance prioritises activities other than DI.
2   Individual level explanations of poor relationships distract from efforts to build trustful and positive relationships between young people, their workers and their families.
3   A cycle of crisis and response is prevalent and present-oriented. It prevents future thinking and inhibits young people's connection to mainstream opportunities.
4   A focus on risk management inhibits building young people's positive social status within mainstream social networks.

These are discussed in the following sections. Alongside these findings, we draw from examples of positive student engagement with DI to propose strategies for enhancing enrolment and engagement in subsequent DI stages.

Hierarchy of care-giving practice in a regulated environment

Workers in care settings are subject to numerous layers of regulatory requirements, practice guidelines and organisational norms that direct how good care is practised. While staff were typically supportive of DI in their positive response to the training, their subsequent lack of referrals of students to the program point to systemic patterns that undermine the implementation of DI. In other words, shifting attitudes through the DI training does not translate to shifting the practice norms embedded in residential care settings.

From interviews with care agency staff it is clear that the delivery of DI is subordinate to DHHS regulations and requirements:

> My priorities are the young people in the house and looking after the staffing and making sure that all our policies and procedures are in place. And that's mandatory so I'm under program guidelines. At the end of the day rightly or wrongly [the DI] was not mandatory for me.

The distinction made between the non-mandatory DI and existing mandatory program guidelines reflects a hierarchy of care giving in these residential care settings. In the same interview, care agency staff clearly distinguished standards of care practice from DI. Staff confirmed that these standards fall within DHHS frameworks, which in their view had 'nothing to do' with DI.

Atop the hierarchy of care sit compliance, monitoring and reporting mechanisms that direct the attention of workers. A further quote from care agency staff highlights how government oversees these priorities:

… in terms of those spot check audits they come unannounced, whenever. And our staff are drilled basically on making sure they know their policies, that they certainly know that there's documentation that's required, that [the auditors] need to have a look at.

Initiatives such as DI fall outside of these mandatory frameworks, placing DI lower in the hierarchy of residential care activities. The hierarchy was, at times, frustrating for the BSL DI trainers to navigate. As one trainer mentioned in an interview:

Some of the staff on the ground think, 'Great, let's do that'. But then there's this fear of what happens up the line … The case manager might not even sign off on it because 'Well, the department would hate that. That's not allowed, that's not child protection. How does that affect the order?' And again, the reality is there are child protection orders—there are some things you can't get around.

However, this does not necessarily mean that the DI practice is incompatible with meeting DHHS requirements. As the trainer pointed out in the same interview:

I can't see anything where [child protection orders] says that you can't do this sort of stuff, the opportunity side of this certificate, or the community connections.

Nevertheless, the persistence of enrolment challenges and engagement in stage 1 of the DI pilot suggest that systemic priorities did not include implementing DI. The following sections make sense of the hierarchy of practice and how it hinders implementation of DI.

Existing care practice is trauma-informed

Before examining how the current hierarchy of practice hinders the implementation of the DI, we will briefly show how trauma-informed practice (TIP) underpins care-giving practice in residential care settings.

Staff at Berry Street and Anglicare Victoria described aspects of their care practice as 'trauma-informed'. During an interview, an Anglicare Victoria staff member said:

We are a trauma-informed practice and … we look at most of our clients through a trauma lens, around their behaviour and what to do … particularly over the last couple of years.

Similarly, a Berry Street staff member spoke at length in an interview about young people in their care who had 'trauma histories' and 'trauma symptoms'. When asked to describe the assumptions underpinning TIP, the staff member explained that:

the young people that we work with, there's often significant attachment issues that have impacted on their internal working models and that can be about their sense of safety relative to certain interactions with adults.

This description of TIP aligns with the views of care staff who often attributed their poor relationships with young people to the biological and psychological legacies of traumas experienced by the young people. The theoretical core of TIP proposes a causal link between individuals' experiences of attachment and trauma during childhood and their

later interpersonal styles and responses to stress (Atkinson 2013; Ford & Blaustein 2013; Frederico, Jackson & Black 2010; Jackson et al. 2013; Rothschild 2000). Some of these causal attributions and their effects are explored in the remainder of this section.

The workers' repeated references to trauma are indicative of the emergence of the therapeutic TIP approach in OOHC settings. Discourses of trauma and TIP are widespread and officially embraced in the OOHC sector (Commissioner for Children and Young People 2015; DHHS 2016; Victorian Auditor-General 2014). Trauma-informed philosophy underpins program design, individual planning, and engagement with family, community and culture. Training in TIP has been widely accessed by OOHC workers in recent years, and is included in the Certificate IV in Child, Youth and Family Intervention and the Best Interest Case Planning model. The *Yarning Up on Trauma* series of workshops, which was auspiced by Berry Street, was provided to 170 Victorian OOHC staff in 2006–2007 (Frederico, Jackson & Black 2010, p. 71). A range of other trauma-informed staff training programs and policy initiatives are being evaluated in other OOHC settings (Zelechoski et al. 2013). In this context, TIP has attained the status of a 'deep norm'.

To explain the relative importance of competing priorities in the data from our staff interviews, we draw upon a moral framework that categorises how attention is directed in care settings (Heimer 2008). Priorities can be directed along a spectrum of attention. At one end, 'deep norms' represent the ultimate ends or purpose of service provision, such as de-escalation of a crisis or engaging in future planning. At the other end, 'shallow rules' prioritise organisational rigmarole such as the filling out of a form.

As part of the emerging therapeutic model, TIP has an important role in safe and effective residential care by managing crisis and risk. However, the longer term risk of young people's limited opportunities to attain their aspirations and establish independent livelihoods remains. The three sections below explore how deep norms in current residential care are not directed towards building young people's capabilities. As such, they can act as barriers to young people's positive relationships, future thinking and positive social status, thus limiting the effective implementation of DI and the Open Talent framework.

At a practical level, the prioritisation of risk and crisis management and TIP minimises the attention available for the delivery of DI. At a deeper level, these approaches shift attention to immediate issues, and to the lasting impact of past trauma on the present. As a type of deficit logic, this approach to young people sits at odds with the advantaged thinking and future orientation of DI. The Open Talent framework underpins DI and distinguishes it from current care practices that foreground crisis response and immediate needs. DI requires a shift in attention towards realising young people's positive potential by developing their future thinking, positive relationships and social capital. These issues are discussed in the following section.

Trauma-informed practice approaches distract from efforts to build positive relationships

Within the DI pilot, trustful relationships between workers and students, and the young person's connections to family and kinship networks are critical to student engagement in the course. However, the dominant understanding of a TIP approach in residential care means that young people's complex and problematic relationships with workers and family members distracted from building more positive relationships. This is partly due to the way that 'trauma histories' are invoked to individualise young people's inability to form positive relationships.

Trauma-informed practice is used to explain poor relationships

Many comments made by partner agency staff referenced TIP and its impact on young people's relationships. Field notes show that Berry Street staff discussed how the trauma lens is used to filter understandings of interactions with young people in daily care practice:

> Some [young people] can't think in a structured way—they're very primal. The attachment issues that these girls have. They have no script. No language to name their emotion. No regulation. They need to co-regulate. We're looking at what we role model. There's all this heightened [emotion] and then de-escalation. They size us up by testing us out. Then they co-regulate, then they can trust. There's nothing you can do when they're heightened.

Similarly, another care agency partner remarked in an interview that:

> Young people require a very attuned approach from the person with them and that the relationship is the critical cornerstone of their ability to learn. If the young person experiences moments of dysregulation, they have built up a period of trust with that person to assist them to co-regulate.

In these examples, young people's inability to regulate their emotions is attributed to maladaptive interpersonal styles and responses to stress. Grounded in attachment theory, the TIP approach regards co-regulation as a way for young people to regulate their (disordered) emotional lives through their relationship with their carers (Cameron & McDermott 2007 pp. 143-144; Jackson et al. 2013, p. 24). In attachment theory literature, the ability to regulate one's emotions has a biological basis:

> The quality, quantity and timing of early attachment relationships shape certain neural networks in the brain such as those responsible for empathy, reward, social interaction and communication. Many of these neural systems are also involved in our stress response. Attachment theory explains how we come to rely on attachment figures to reduce our stress reactions when under threat. (Jackson et al. 2013, p. 31)

Staff drew on this biological and psychological framework to explain the challenges they have in building trust with young people who have experienced trauma.

Trauma-informed explanations of poor relationships are embedded within practice and are not inherently problematic. However, overt focus on the lasting negative impact of trauma on young people's ability to regulate their emotions hindered the implementation of the DI course in a couple of ways. First, this understanding of the effects of trauma tends to emphasise individual level factors at the expense of structural reasons that also engender poor relationships. If the institutional context diminishes relationships, but diminished relationships are attributed to trauma, then poor relationships will persist. Second, TIP's preoccupation with the inability of these young people to form positive relationships, or deficit logic, is at odds with the DI course and its explicit aim to expand capabilities. This is particularly relevant in activities that seek to improve familial and kinship connections. The following sections deal with these respective barriers in turn.

Institutional structures can enable or inhibit the trustful relationships required to implement the DI

In residential care settings, a range of institutional dynamics can foster or diminish the opportunities to develop relationships sufficient for delivering DI. In particular, the high turnover of staff and students undermined opportunities to build relationships of trust.

Unfortunately, relationships between young people and workers in the DI pilot often lacked the qualities required to effectively deliver the course and to confer trust in the broader OOHC system. For example, field notes record a worker's comment during a DI training session:

> [trust] seems to get lost with the amount of people in and out of their lives. Other clients, workers. You get brought down to common denominator. The rules, the paperwork.

According to this worker, trust was elusive for two reasons: high turnover of staff and students, and 'the rules, the paperwork'. When questioned about the link between compliance and effective practice, care agency staff stressed that regulations and administrative measures were no substitute for quality relationships between staff and young people:

> In order to actually pass as an agency you have to have that checklist there. We talk about this quite a bit … we become so fixated in ticking boxes that sometimes we forget engagement is much more important than any of those tick boxes I can assure you. You can have the world's best safety plan put in place, that's not going to work if that kid doesn't have a connection with you.

The connection between staff and young people in residential care settings is predicated upon trust. Unfortunately, the conditions for trustful relationships are often foreclosed by institutional settings prone to high turnover of staff and young people. As the Victorian Auditor-General (2014) stated: 'More than one-third of children and young people in residential care have experienced over 10 OOHC placements'; and casual staff make up '55 percent of the residential care workforce' (p. xii). A high turnover of staff

and placements was noted in a number of residential settings involved in the pilot, pointing towards a systemic problem, rather than an institutional problem. For example, an interview with an Anglicare Victoria staff member referred to 'a group of staff that all left' during the DI trial. The short duration of many residential placements was an ongoing difficulty, not only because there was not enough time to build substantive relationships, but also because it altered the house dynamics. One interviewed worker observed that:

> It's not impossible [to develop a trustful relationship] it just takes a long period of time to get kids [to trust you], and just when you've got them there, remember that as one kid leaves another kid will enter, so that unsettles the whole environment.

The interplay between systemic movements of staff and young people and the dynamics within institutional settings reveals the complexity of implementing a course such as DI that requires the building of trust over time.

On rare occasions, longstanding relationships enabled students' engagement with DI. For example, the relationship between Berry Street worker 'Anastasia' and student 'Jess' highlights some of the qualities necessary for implementing the DI: sustained across placements, a track record of advocacy and genuine mutual care and regard.

Field notes from a meeting with a BSL DI worker indicate that Jess, who had rejected previous opportunities to do DI activities, was motivated to engage with the course because of her relationship with Anastasia. Anastasia and Jess had stayed in touch for six years across different placements, and Anastasia had supported Jess to connect with family and kinship networks, and advocated for her within the residential care agency and with other organisations. On this basis, we might infer that Jess had a sense of Anastasia's genuine interest and commitment to her wellbeing. Anastasia had similar relationships with other DI students within her agency. These long standing substantive relationships between workers and young people are vital resources for DI implementation.

These observations can be used to craft practice recommendations for future stages of the DI pilot, a matter considered at the conclusion of this section. For now, our attention turns to how family and kinship relations affect DI activities.

Family and kinship networks distract from engagement in the DI

Young people in the DI course were often distracted and preoccupied with their family and kinship relationships. BSL DI staff found that engaging young people in DI activities was often more difficult when family matters arose. While young people wanted to reconnect with family, such attempts often resulted in disappointment. These disruptions commanded attention as immediate and pressing concerns, leaving little room for DI.

For example, a BSL DI educator attended an appointment in a residential unit in the days leading up to Christmas 2015. Field notes record that it was not possible to meet with

the young person. The educator reflected that, 'Christmas time is difficult with family'. Field notes record a partner agency worker reflecting: 'some of these [family] relationships are so toxic. We can see they're being used and abused, but they can't [see it]. [They feel that] "This person loves me, no-one else does"'. This dearth of love and entanglement in 'toxic' family relationships imposed a heavy emotional burden on young people and diminished their sense of hope for the future, and their willingness to invest in it.

In more encouraging instances, some young people accessed specialist mediation services and improved their family relationships.

At a systemic level, however, efforts to improve family relationships do not receive much attention. In their submission to a Senate inquiry, Anglicare Victoria argued that while programs 'providing a reunification-focussed intervention to the birth families of children in OOHC' exist, they were 'very limited in their intensity due to the high workloads' and a 'natural tendency to focus on urgent unsolved placement issues'. They also argued that care providers 'are not funded, regulated or supported to work with birth families' once a placement has been made (Anglicare Victoria 2015, p. 8).

The lack of care, attention and resources directed towards family relationships negatively impacted on the implementation of the DI course. On the other hand, data suggest that improvements in family relationships can be associated with increased capacity to engage with the DI course. The inverse of this was also apparent. For example, field notes from a meeting with a BSL DI worker record that one student had identified reconciling with a family member as a specific goal she wished to pursue. The DI worker organised for family mediation provided by an Indigenous cultural expert and this resulted in reconciliation with a family member. The DI worker noticed an associated increase in engagement with the course. Although a subsequent breakdown in the relationship resulted in reduced engagement, the student requested further access to the mediation service. Within the capabilities approach, this improvement in family relationships might be theorised as 'fertile functioning' (Nussbaum 2011, pp. 21–22, 34), insofar as it had a compounding effect of capability expansion. In contrast, interpreting distress about family relationships as evidence of biological and psychological dysfunction risks missing this opportunity for capability expansion.

Learning about maintaining healthy relationships, including relationships with family, is part of the 'Social connections' component of the DI service offer, and several young people pursued greater connection with Aboriginal communities and heritage as part of their course activities. If more attention, care, expertise and resources were directed towards the family-oriented aspirations of young people, then this would assist effective delivery of DI in the future. A literature review (Bullen et al. 2015) has identified a number of strategies to assist family contact to be 'therapeutic'. For example, preparatory work with parents and young people to manage their expectations of contact, and debriefing afterwards; culturally sensitive family mediation services;

training for workers to manage complex situations; and having contacts professionally supervised can all yield positive results.

Strategies for directing attention towards positive relationships

Relationships with workers and family are critical to the effective delivery of DI and to the expansion of young people's capabilities. TIP offers a powerful explanatory framework for these dynamics, but it can be used to label young people with dysfunctional psychological and biological traits. Other explanations can be mounted in which problematic relationships are the result of systemic dynamics. In light of these dynamics and the need for more attention to family relationships discussed in this section, three strategies are suggested for the development of more positive relationships:

- In residential care staff training (e.g. Certificate IV in Child, Youth and Family Intervention) and practice models (e.g. Best Interests case practice model) mandatory components should include opportunity brokering and 'coaching' styles of interaction for building positive relationships of mutual care and regard. This should result in greater trust between workers and young people.

- Proactively identify worker – young person pairs with positive relationships of mutual care and regard, and resource these workers to continue a mentoring role beyond staffing or placement changes. Give these workers the role of engaging young people in future oriented action, such as engaging in education and DI activities.

- Provide workers, young people and their families with practical, professional and emotional support to make family contacts therapeutic. This might involve preparing parents and young people to manage their expectations of contact and providing debriefing afterwards; using culturally sensitive family mediation services; training workers to manage complex situations; and having contacts professionally supervised.

Crisis management prevents future thinking

While staff viewed the DI training positively and were receptive to the underpinning ideas of the DI, once they were back in the OOHC setting, standard practice (i.e., deep norms centred on safety and risk) remained centred on immediate crisis responses. The impact of the care-giving hierarchy in subsuming other needs was articulated by a partner agency staff member:

> the issue of safety creates a pretty clear priority and the challenge in the space of multiple needs is how to align those others relative to safety. I don't see it just as a whole bunch of things on an equal footing, it is the safety as the critical bottom line and I'm not saying that that gets off the table ever, but that can create in our sector a crisis-

driven way of thinking, it can be about the safety planning overriding the choice of the
young people.

Assumptions of young people's developmental challenges resulting from trauma shape
the focus and prioritisation of practice. These form barriers to alternative care-giving
approaches such as DI that aim to engage young people with long-term planning.

In residential care settings where DI was piloted, incidents of crisis varied in severity,
from the extreme end such when a Crisis Assessment and Treatment (CAT) team and
police were called, self-harm or violence occurred, or household items and property
were damaged; to less extreme incidents, such as when a plan for a worker to assist a
young person with DI activities was foregone because the young person was distressed
and preoccupied with family concerns.

Frequent crises and carers' focus on crisis management are mutually reinforcing because
they create a dynamic in which little attention is paid to the future thinking that could
reduce the frequency and severity of crises. Breaking this cycle is a significant priority for
the residential care sector.

This section examines the tensions between care practices that focus on crisis
management and practices that focus on planning for the future, such as DI. We suggest
a number of practice reforms for breaking the cycle of crisis and response, and
prioritising future thinking. With the aim of better implementing DI in future stages of
the pilot, we suggest broad and specific actions to help shift crisis management from a
deep norm to a background logic that prescribes specific care practices without
dominating attention, and would enable the elevation of future thinking to the status of
a deep norm.

Crisis sets the agenda

Our claim that crises sometimes set the agenda and displaced future-oriented DI
activities is supported by a case study. The example concerns individuals introduced
above, care worker Anastasia and student Jess. The case is drawn from field notes in
which Anastasia described a DI activity.

The first DI interaction had begun well, with a meeting in a cafe between Jess, Anastasia
and a DI educator. Together they completed some DI workbook activities and identified
Jess's aspiration to re-establish connection with an older sister. Afterwards they moved
outside to spend some time in a park, where Jess received a phone call from her
boyfriend. Jess's conversation with her boyfriend escalated into an argument, which
involved shouting and swearing. They moved towards the car park, where the episode
escalated further to the point where Jess was rocking, screaming and crying in the car.
After the DI educator left, and Jess had some time to calm down, Anastasia sat with her
outside. They talked for a while and Jess decided that she ought to go to school.
Anastasia drove Jess to school and Jess went to class.

In this example, DI sessions were marred by an escalation into crisis which detracted from the focus and energy Jess had available for her proactive plans and engagement in course activities. While it is not evident from this incident alone, there is reason to believe that the frequency and severity of crises can be reinforced by staff preoccupation with crisis management. According to a care agency staff member in an interview:

> It's normally the kid that screams the loudest that gets the most attention.

Later in the interview, this worker went on point out how these dynamics displaced DI activities:

> As much as we want to do this [DI related activities] and we always say we just want to make time, we don't have that time, we don't have that spare 10 minutes where we can actually sit and reflect because we have to deal with the crises, they're constant.

A BSL DI educator made a similar point about who sets the agenda in residential settings:

> The [educator] is very concerned that the most disruptive, violent, aggressive and destructive practices tend to get the most attention in resi[dential] care settings. Flipping this around would seem to be a priority. (Field notes)

Crises demand deliberative, controlled, mindful and intelligent worker engagement and, to this extent, crisis management operates as a deep norm within residential care settings. In contrast, future thinking is relegated to the status of a shallow procedure. As the staff member noted above, precious little time is available for reflection beyond immediate crises. Some of the effects of this ordering of attention are discussed in the following section.

Crisis management is present-oriented

One of the effects of the deep norm of crisis management is the short-term focus on immediate concerns. This compounded the difficulties of implementing the future-oriented activities required by the DI course.

A BSL DI educator offered another observation about short-term vision typical in care practice:

> With resi[dential] care, they look to the end of the [protection] order. Their job is just to get them to the next stage. They're just in survival mode—the workers and the young people. (Field notes)

Here, the critical time frame of care practice is limited to the 'end of the protection order', rather than the longer process of transition towards independent young adulthood. A further quote from a BSL DI educator suggests that, in the context of crisis management and changing shifts, the horizons of care practice can be even shorter:

> ... it's almost like an unspoken rule of working in resi[dential care]. It's how they go 'They're [the young person is] going to escalate it so this is what we do to just contain it

and get through another shift'. It seems to me that the attitude is 'We just need to get through this shift', and not 'There are certain things we want to assist a young person in doing'. It's a totally different approach ... with handover it's all about, right, 'How are we going to control this situation?' Dealing with the spot fire as opposed to the broader issue, which doesn't make sense to me. (Interview)

When the shift is the most important unit of time, 'spot fires' take precedence over longer term planning. The source of this orientation to the present requires some reflection if we are to understand the challenge of implementing DI.

Future thinking is also restricted by trauma-informed practice

Workers spoke of the lasting impact of trauma, and how a focus on the past and present restricts the kind of future thinking that DI seeks to promote. A Berry Street staff member linked the lasting impact of trauma (i.e. 'regulation issues') with the young person's inability to engage with future thinking:

> the experience of time seems to be about being very much in the present, about having very little sense of future thinking or planning. That can be very influenced by the regulation issues that the young people have relative to how they react to the very present challenges of their life. And that can be from a text coming in or somebody turning up at their house or simply being at home preoccupied with something. So it's about young people finding restraints around thinking about the future, and often being very preoccupied with the past too.

Similarly, field notes from a meeting with a care agency staff member explain why young people may value the present above the future:

> If [young people are] not seeing an immediate value in it, forget it ... some young people aren't planning to be alive very long. They don't think they need to plan for it ... Some kids can look down the track. Others can't see a week ahead.

This quote shows that young people, like their workers, tend to concentrate on activities that have 'immediate value', rather than activities which might, if persisted with, bear fruit in the future. The limited data from young people in this study suggests that the young people themselves also hold this view. For a couple of students, instability in their lives made questions about the future very difficult to answer:

> I don't know, a lot of the questions, they might ask what do you want to do in the future and stuff like that. I always find them questions the hardest to answer because I don't even know what my life's going to be like in the future. I'm not in a stable condition really, so it could go whatever way. So I hate questions like that.

However, the link between trauma and lack of capacity for future thinking is assumed. The DI educator quoted earlier above, went on to challenge the belief that TIP necessarily precludes future thinking:

> [short-term focus] doesn't align with this trauma-informed practice that I keep reading about … that to me would [be having] a trauma-informed eye over everything. But … I

can't see it anywhere in anything I've read or heard that says we must contain, control, and really place restrictions around a young person.

For one student, the goal-setting processes encouraged by staff in the DI course were initially challenging. However, she described how goal setting ultimately shifted her preoccupation with immediate and pressing concerns:

> Those questions, they were quite difficult about a month or so ago, they were quite difficult because I didn't have any goals or anything. I didn't want to have goals. I struggled with that quite a lot and I've been thinking what I want to do after school, what I want to do in school, do I want to get a part-time job now. Those questions were very helpful because they made me think about it. Whereas I didn't really think about it before … but it kind of made me think about that. It was quite easy to do once I started to think about what I want to do with my life, it was a lot easier to answer those questions.

While this example is from one student in the non-OOHC setting, similar progress with goal-setting capability was evident for numerous students. Analysis of completed CRILs suggests that many students had enjoyed only limited previous opportunity to develop and demonstrate skills and interests, but during DI they were prompted to articulate their skills and interests and provided with resources and opportunities to pursue them. Analysis of course paperwork completed by students and DI educators suggests that, at the beginning of the course, none of the participants had a clear sense of where they would live next, or what their tenure there might be. During the course, students were able to articulate plans and were supported to take steps towards these outcomes.

In these brief examples, DI presented opportunities to shift thinking towards a longer term vision for young people. The following section outlines strategies that may help facilitate future thinking in the DI pilot.

Building connections to mainstream opportunities

Many young people in residential care settings appear to have little hope for the future, and few institutional connections for structuring future thinking. Their orientation to the present is an understandable response. Carers' preoccupation with crisis management reinforces an orientation to immediate concerns. Breaking this cycle is a complex task, but a necessary one for future implementation of the DI, and for improving the outcomes of residential care more broadly.

The DI prioritises future thinking and connection to mainstream institutions as separate but mutually reinforcing activities. The underlying assumption is that engagement with mainstream external actors can add structure to future thinking.

Generally, young people in the DI pilot were not successfully connected to mainstream opportunities. Field notes from a training session with workers note that, when workers were asked to list the links between the residential care settings where they worked and local civic, sporting or commercial operations, the workers could only nominate social

services. There was a consensus among the 17 workers in the room that implementing DI would require new contacts with local clubs, businesses and institutions. However, few such links were established by the workers during the course, partly because of the ongoing burden of crises.

On the occasions where engagements with mainstream settings were offered through DI staff, those staff reported that students sometimes did not attend scheduled appointments. For example, one young person had not attended scheduled driving lessons because they had 'slept all weekend'. Such instances further diminish future prospects as they limit interaction with enabling social networks and institutions. The lack of engagement is not surprising given that studies of the daily rhythms of people who are institutionalised (Calkins 1970), homeless (Van Doorn 2010) or habitual drug users (Järvinen & Ravn 2015) show that their social and material environments fall out of step with the 'normal' temporal cycles of work and social life.

Feelings of 'future-orientedness' are achievable for young people experiencing disadvantage if they add 'more social roles' and achieve greater 'social integration' (Järvinen & Ravn 2015, p. 17). Lewis and Weigert (1981) argue that institutions can mark, ritualise and structure progress, maturation and development. Apart from a possible transition into a lead-tenant setting, the most significant temporal marker offered by residential care settings is the exit on reaching the age of legal adulthood.

Strategies for enhancing future thinking and planning

Our observations of the institutional aspects inhibiting future thinking in the DI pilot lead us to suggest two strategies. First, increasing engagement with mainstream settings can add structure to future thinking; and second, social services might also offer rituals and markers of progress. The DI appears to offer a contribution to both these strategies: first, through its emphasis on developing engagement with enabling actors and institutions; and second, through its modules contributing to an accredited outcome. In addition to implementing the DI, the residential care system might introduce further markers of progress and maturation. For example, given the high proportion of Aboriginal young people in residential care, Aboriginal culture might provide a cultural framework for rites of passage.

One of the clear implications of the sociological analysis is harnessing institutions' role in providing markers of maturation and progress. To this end, future implementation of DI might include a preparatory stage which is clearly delineated from the course and provides young people with supports and opportunities which develop their readiness for formal engagement. This strategy would also reflect the reality that, in the pilot, students sometimes found completing the paperwork intake requirements a disincentive. Rather than waiving these requirements for assessment and enrolment, as was the case for students recruited in wave 3, interested students might be initially recruited into the preparatory stage with minimal formal requirements, and then complete the full suite of documents upon formal enrolment. This would structure the

DI pilot in two stages: preparatory and enrolled. Alongside the DI, a broader process of transition planning might make parallel steps. Each stage can mark a stage of progress and maturation, and contribute to the development of future thinking.

In addition to this suggestion, our analysis identifies the social networks and mainstream institutions that could promote future thinking. This might have the positive effect of reducing escalation and crisis—and crisis management—which would, in turn, create more room for work towards outward and future-oriented connections.

To summarise, three reforms can be suggested:

- Support engagement with mainstream institutions that can host young people now and into the future

- Recognise young people's progress and maturation with markers and rituals.

- Establish a discrete pre-DI preparatory program with the goal of the preconditions for formal enrolment in the accredited course.

While the practical expressions of these reforms require further development, they offer an opportunity to move crisis response into the background as a set of ready-to-execute steps, while the task of assisting young people to construct a future of opportunity and engagement is given the most thoughtful attention.

Risk management inhibits building young people's positive social status within mainstream social networks

Risk-taking practices are common among young people in the residential care sector (Jackson et al. 2013 pp. 16-17). In our data, this led to carers' attention being directed by risk management, sometimes diminishing young people's external opportunities to connect to mainstream social networks. Various parties described young people's risk-taking behaviours. For example, an Anglicare Victoria manager described the motivation of one young person in a residential setting where DI was being implemented: 'All he wanted to do was to continue to use drugs and have lots of other people around his house to use drugs'. In her DI recruitment documentation, a young person mentioned self-harm as an ongoing concern. In a training session for care staff, a worker alluded to some young people in his unit stealing cars. With reference to sociological literature, we argue that risk taking can be understood as arising from young people's need to achieve social status within their disadvantaged milieu. Providing an alternative source of social status by developing mainstream social capital may help to break the cycle of risk taking and risk management. This section investigates these dynamics and proposes some strategies for replacing the deep norm of risk management with the development of positive social status.

Risk practices are supported by peer groups

The internal culture of young people in residential care drives risk taking. In an interview, a care agency worker described how this occurs within its own informally regulated space:

> Kids in care have their own culture. It's their own tribe, it's very private. It's a whole world. They have their rules and hierarchies within the care world, adults only have a certain amount of access to it.

Evidence of this culture, with its own rules, norms and hierarchies—and its link with risk-taking practices—can be found in field notes taken from a meeting with a DI educator.

> The educator noticed fluctuations in a student's attitude while they worked through the CRIL. The educator described one of the attitudes as 'gangsta', and another as 'engaged'. During the session, the student's brother and another young person were in and out, and it seemed that their proximity corresponded with the 'gangsta', and their absence corresponded with 'engaged'. I asked the educator to speculate about this correlation. The educator thought it had to do with the student not wanting to be seen to want something different or better for her life while her peers were not expressing similar desires. This difference would put her at risk of being 'put down' by her peers.

This observation led to the DI educator scheduling further sessions with this young person outside of the residential setting. However, that strategy did not always protect young people from the internal culture, as one young woman reported to DI staff that she felt victimised by other residents for participating in DI-brokered work experience. Making a related observation, another DI educator reflected: 'It's almost as if the young person views them [the worker], or anyone who's in any way shape or form connected to the system, as the enemy'. By extension, this was problematic for DI, as the stigma of connecting with education was prevalent. For example, an interview with a care agency staff member demonstrates the tension experienced by some of the young people who recognised the importance of education, but were held back by the norms of their peer group:

> I was talking to a young man who doesn't reside with us anymore, he was a tough young man, a very complex young man who was quite intelligent and wanted to go to school but just went 'I can't'. And when I sat with him and spoke to him about it he was basically saying that 'I get called a nerd and then I don't get accepted, I don't have any friends'.

The staff member added that the young person was adamant that in spite of staff encouragement he would not enter into education, and that the pull of their peer group was too strong. She recalled the young person saying to her:

> I trust you … I can talk to you but it doesn't matter what you say, it doesn't matter what lead staff are saying, I need to feel connected to my peers and the only way I feel connected is if I go and rob a liquor store or I go and assault someone. I know it's wrong but my life is in more jeopardy if I don't do that.

Of value to the young person in this situation is the recognition and status conferred upon them by their peers. The concept of 'negative social capital' offers a well-fitting theoretical framework for these data. Negative social capital is a 'unique type of cultural capital' (Barker 2013, p. 361) affording symbolic, economic and material benefits within the social field of those who are recognised within culturally hegemonic settings as a 'stigmatised pariah' (Barker 2013, p. 361; Bourdieu 2000). Negative social capital is accrued by visibly challenging the central normative values of broader society and is inimical to social capital in mainstream cultural fields. The risky practices of young people in residential care can be viewed as examples of acting to cultivate their negative social capital.

According to Barker (2013), the accumulation of negative social capital tends to be pursued by young people who have few options to develop other types of social capital. In the previous section, we presented evidence from the study that opportunities for young people in residential care to develop social capital in mainstream settings are very limited, and connections with local civic and economic actors are weak or non-existent. This observation was also repeated in a number of staff interviews.

Lack of social capital also shapes young people's experiences outside the confines of their residential home. For example, the quote above about the young man not attending school suggests that, in addition to avoiding victimisation from the residential care cohort, he felt disinclined to go to school because he had found it difficult to make friends there. For these reasons, for young people in residential care to develop social capital would require increased opportunities for them to engage with settings that not only confer social status, but are welcoming and friendly for young people who are stigmatised. The next section discusses a strategy for achieving these changes.

Building social status through 'the deal'

Young people's risk taking points towards a deeper lack of reciprocity between young people and the wider world they live in. Rehabilitating these connections appears to be a priority for future DI implementation, and for care practices more broadly. Open Talent's construct of 'the deal' might be a suitable mechanism for this task.

The deal seeks to replace negative social capital with mainstream social capital, and facilitate a process in which young people are included in community activity, while agreeing to be bound by social norms such as educational attainment, economic participation and respectful interaction. It is a process of forging reciprocal bonds of obligation between young people, social services and the broader community. Brokering the deal involves a social service provider arranging for a business, cultural, civic or sporting group or other collective project to include a young person who has expressed an interest in its activities. The social services provider undertakes to provide the practical, emotional or other supports necessary to make this realistic for the young person and the opportunity provider. The continuing support of the social services provider is contingent on the young person upholding their end of the deal—remaining

engaged and conducting themselves appropriately. The deal aims to create a compounding cycle of mutual recognition, trust, benefit, inclusion and shared values. This gradually builds the young person's status as an equal member of society. The strategy fits with research findings that young people who are engaged with mainstream or open access activities and opportunities are more likely to make a successful transition from OOHC than those engaged only with 'specialist' services (Department of Families Housing Community Services & Indigenous Affairs 2011, p. 23).

While the deal entails expectations and responsibilities for the young person and the social services provider, it also entails mutual accountabilities and responsibilities with the community. Socioeconomically disadvantaged young people, such as those in residential care, are more likely to experience harsh treatment from their peers (Due et al. 2009) and the role of stigma in entrenching socioeconomic disadvantage is well established. Within the deal, young people are invited to challenge these social dynamics, and advocate for a more just and inclusive culture. As legitimate and enfranchised citizens, they are also invited to use appropriate forums to voice their opinions or advocate for their own interests. This is operationalised in DI through a service offer supporting young people to 'engage in activities in that community that benefit others', including 'campaigning around an issue of interest' (Buick & Stearman 2014, p. 29).

During the pilot, DI educators implemented 'the deal' by putting young people in touch with mainstream organisations and opportunities that were directly relevant to their interests and aspirations. DI educators provided significant practical support and encouragement, since negotiating opportunities was sometimes unfamiliar and anxiety-inducing for the young people. DI educators provided introductions and supports on the proviso that young people remained engaged with the course.

However, data indicate that instituting the deal in residential settings was not always successful or fully understood. For example, field notes from a DI training session with residential workers records a participant responding to the lesson on the deal by explaining that reciprocal deal making was already common practice: 'If you clean your room, I'll get you a slurpie'. This transactional strategy is not the kind of reciprocity called for, as it does not enlist the community in a process of developing the young person's social status, or entail mutual accountability and responsibility. It may be that the training package requires further development to improve workers' conceptual grasp of the purpose of 'the deal', its scope and how it differs from limited short-term incentives.

A further difficulty was presented by an inability to put more at stake within the framework of the deal. In the Anchor settings and in EFYFs, participation in DI is associated with ongoing tenancy, meaning that all young people residing there are pursuing opportunities across the six domains of DI service offers. This protects against peers discouraging each other from engaging in DI, and instead builds cultural norms where students work towards future-oriented opportunities. Making tenancy contingent

on engaging with DI also led to a number of students in the Anchor setting finding work, re-engaging in education and becoming more involved in civic activities during their DI course.[10] In residential care settings, the deal had less reciprocal depth, because the young people could not be ejected for failure to comply with their deal. Placing DI students in specific houses might strengthen reciprocal arrangements and guard against the normative order of negative social capital. These proposals are discussed in the following section.

Strategies for directing attention towards social status

Risk-taking practices among young people in residential care settings are supported in peer groups as a way to attain status and recognition. In response, carers direct their attention to institutionalised risk management strategies and procedures, which diminishes the attention available for developing social capital. The existence of negative social capital norms within DI pilot settings hampered course implementation. Future DI implementation ought to include strategies for instilling norms associated with mainstream social capital. As a mechanism for building reciprocal obligations between young people and their broader communities, the deal represents a possible strategy for overcoming the dynamics of risk taking and risk management. In future stages, delivery of DI might be targeted towards young people who live in designated units in which all young people have explicitly agreed to a deal brokered through the DI process. This deal would entail individual agreements through which staff enable:

- external civic, economic and cultural actors to provide opportunities for including and enfranchising stigmatised young people

- young people to take advantage of these opportunities, and provide the practical and emotional support they need to do so

- young people to challenge the social norms that have excluded them, and to hold others accountable to standards of social justice and inclusion

- young people to be willingly bound by social norms such as educational attainment, economic participation and respectful interaction. Periodic 'performance review' style appraisals may also be useful.

Continued residency within the units set aside for DI participation would be conditional upon young people abiding by this agreement. Similarly, young people would need to have avenues of recourse to hold carers and DI staff accountable for facilitating the opportunities and providing access to the necessary resources to achieve their aspirations. Of course, for such an arrangement to be just, there would have to be no disadvantage for other young people in participating agencies, who might be given the option to participate in a pre-DI preparatory program if they wish, and to ultimately gain access to a DI-participating unit themselves. We might expect that, in DI-participating

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[10] Expanding external educational, civic and economic engagement could not be attributed solely to participation in the DI, since this was an existing component of the Anchor model.

units, such an arrangement would displace the normative regime of negative social capital and would instead provide an environment where young people could support one another's efforts towards engagement. We can speculate that this would allow young people to engage without fear of alienation from their peers and would enable carers to shift their best attention from risk management to social status oriented activities.

4 Fitting DI within existing practice

In summarising the key arguments in this report, this section briefly reflects on the tensions between DI and current practice oriented around TIP, crisis management and risk management.

Competing logics?

In this report, we have argued that current practice in the residential care sector is regulated and mandated to take a TIP approach in which the management of crisis and risk is paramount. Staff operate according to a hierarchy of care practice that marginalises alternative approaches. The DI is an example of an approach that seeks to work within this current hierarchy and to enable young residents to develop plans for a successful transition to adulthood. However, attention and resources paid to DI are reduced in indirect ways, such as when trauma-informed explanations obscure the inhibiting role of institutional and system dynamics. Implementation is also hindered directly when practice is oriented towards immediate demands of crisis and risk management. Such priorities leave little space to build the connections to mainstream opportunities and social networks that would facilitate deeper integration of the DI program. This raises the question of whether DI can fit with the widespread assumptions and logics in the residential care sector.

The DI program aims to be flexible enough to work within diverse delivery settings. Piloting DI in residential care is an initial attempt to assess this adaptation. Partner agency staff recognised some aspects of the DI program that were commonplace in their service delivery. For example, Anglicare Victoria staff considered goal setting and discussions about aspirations as part of the 'bread and butter' that they practised prior to involvement with DI. However, while there is some overlap, it is clear is that DI and current residential care practice diverge in some key respects. A care agency partner made this distinction by first discussing how practice priorities are unlikely to be upended:

> A lot of the issue of safety creates a pretty clear priority … I don't see it just as a whole bunch of things on an equal footing, it is the safety as the critical bottom line.

Notwithstanding the importance of attending to safety, he went on to argue that finding a space for DI within residential care is worthwhile as it promotes longer term thinking that ultimately benefits the young person:

> It's about building longer term planning into the young person's development of goodness, and again we get back to power—are they capable of keeping themselves safe? For a good deal of the time with lots of our young people they're actually not, but we've still got to find a way to help them to build that capacity for their choice within something that's quite limiting and constraining.

The staff member here illustrates the tension in translating DI into a different setting and for a different cohort. The aspirations and mechanisms for educational engagement and goal setting in DI enter an existing hierarchy of practice organised around notions of safety. Further complicating the next stage of this pilot will be a refined approach to safety in 2017, with the embedding of DHHS' therapeutic model. For partner agencies already practising aspects of the therapeutic model, DI could present some integration challenges:

> I suppose a therapeutic overview would be an attempt [by] our education team to build a bit of a hybrid understanding of where education and a therapeutic approach might be in the best interests of that young person. So that's often a challenging space for all practitioners because it's across different bodies of knowledge I suppose.

In terms of TIP, the challenges of implementing DI included attending to the diverse interpretations of TIP at different settings. One DI trainer acknowledged that generally speaking DI and TIP are well aligned. However, the trainer also said that further work on integrating DI into TIP was required in settings where TIP led to overtly risk-averse practice. Several trainers and partner staff cited the example of a partner agency's reluctance to use DI course materials as they might trigger young people's previously poor experiences with education. The trainer characterised this view as an interpretation of TIP that diverges from the DI:

> I think where our philosophies sort of diverge is that we see it as really important to have high expectations and provide opportunities that engage a young person in their aspirations and hopes for the future, whereas I think they're a lot more concerned about taking a young person out of their comfort zone and maybe re-traumatising them by putting them in a vulnerable space. So I think they're very cautious about that occurring and we're not so cautious, and want to provide opportunity for [the young person].

On the surface, DI and TIP may appear to uphold competing logics that clash at the point of practice implementation. However, the same DI trainer also recognised the importance of TIP to the OOHC sector, and observed it was the organisation's *interpretation* of TIP as a guiding framework that created the divergence from DI. On the one hand, this example highlights that more work is required to bring DI and TIP together. On the other, it encourages us to consider the scope for interpreting TIP in ways that open up space for and complement the DI approach.

What is helping and hindering the implementation of the DI pilot in OOHC settings?

Structure of the DI course helped to engage some students

Notwithstanding some divergences between TIP and the DI, there were encouraging signs of young people's engagement and progress within DI. For instance, most of the students who engaged in the course identified future goals and accessed opportunities that aligned with their aspirations. The structure of the DI course enabled a student-

directed approach and helped provide a pathway along which young people were able to gain a sense of progress. Workers' capacity to support students to identify their own aspirations also facilitated this level of engagement.

Some young people accessed specialist mediation services and improved family relationships. Some students and workers enjoyed trustful relationships with one another. These experiences represent clear alignments between what students themselves prioritised and valued and what the course was designed to achieve, and might in future come to be understood as moments of capability expansion. Care workers and DI educators associated with stages 2, 3 and beyond can feel confident that, whatever the implementation difficulties might be, some positive outcomes from course participation are likely.

Lack of 'student readiness' hindered implementation

A smaller than anticipated cohort of 15 young people in residential care engaged with DI, and for the duration of the evaluation, no student had completed the certificate. Initial expectations were set at 30 completions in the first year. Staff and trainers attributed the lower than expected number of enrolments in residential care settings to a lack of student readiness. Staff believed that young people's personal histories were marked by prior negative experiences and poor mental health which had a lasting impact on the young people's capacity to take up opportunities. At the individual level, this limited student engagement with the DI, regardless of how enthusiastic they appeared to be.

Systemic and institutional barriers to implementation

Individual level factors only provide a partial explanation for the slower than anticipated student uptake and progress through the DI course. Workers in care settings face multiple and competing demands. The DI pilot was implemented within an existing hierarchy of practice. Regulations, training and organisational cultures place trauma-informed practice, crisis management and risk management at the top of this hierarchy.. At the institutional and systemic level, this ordering of priorities meant that limited attention was directed towards DI activities.

Based on our analysis of the data we contend that the ***current care practice priorities distract from efforts to build young people's capabilities***. In particular, a preoccupation with trauma-informed practice, crisis management and risk management ***inhibits the trustful relationships, space for future thinking and the building of social status required for successful implementation of the DI course.*** Barriers to implementation led to lower than expected number of enrolments in residential care settings, and diminished the level of engagement students were able to achieve.

These key barriers to DI implementation are:

- **lack of trust between staff and students**
  Systemic patterns of high turnover of staff and students undermined opportunities

to build relationships of trust. While TIP offers an explanatory framework for relationship difficulties, it also obscured the importance of these institutional dynamics

- **distraction of tenuous and shifting family relationships**
  Troubled relationships with family and kinship networks left some students distracted and preoccupied.

- **focus on immediate crisis response to the exclusion of future thinking**
  An orientation to immediate concerns diminished engagement with future-oriented DI activities.
  Present orientation meant that education and civic, economic and institutional participation were not a priority for some students

- **focus on risk management that precludes connection to mainstream social networks**
  Students' risky behaviours sometimes diminished young people's external opportunities for connecting to mainstream social networks prioritised by the DI

- **peer group norms that stigmatise DI participation**
  Some young people living in care did not participate in DI because it was stigmatised among their peer group. Recognition and social status are attained in these settings by challenging broader social norms, including the kind of mainstream engagements promoted by DI.

Workers' responses to these barriers were institutionalised as deep norms, directing attention in particular ways and, ultimately, reinforcing the barriers they were responding to. Future stages of the DI pilot will need to address these issues if they are to achieve higher degrees of enrolment and engagement. The recommendations below are designed to respond to these barriers. Achieving such changes is complex work that requires ongoing collaboration between researchers, practitioners, young people, policy makers and other stakeholders. Future implementation will require ongoing development.

What changes at the individual, residential unit and system level would promote student readiness for enrolment, engagement and completion of DI?

The management of crises and risks and the use of TIP clearly have a role to play in safe and effective residential care. However, this study notes instances where risk and crisis management and TIP have been applied in ways that are not conducive to the expansion of young people's capabilities. There is a need to balance an understanding of the lasting impact of trauma with a focus on present capabilities, social status, trustful relationships and future thinking.

DI seeks to promote systemic change by displacing deficit models of young people with enabling structures that provide them with mainstream opportunities. The suggested

strategies are not designed to disregard current practice, but to enable BSL DI practitioners and residential care workers to direct attention towards activities that will expand young people's options after they leave care.

A multilevel approach to systemic change is required. Some changes will need to be enacted at the level of departmental auditing and accountability procedures; some will need to be reflected in practice changes within residential care units implementing the course; and some will need to be enacted within specific relationships between workers and young people, and in the internal culture of young people living in the system. Finally, some changes will need to be reflected in the structure and delivery of the course. This section deals with this last level of change.

Strategies to improve recruitment and engagement

In light of the evaluation findings, two major reforms to course structure are recommended to address the issue of student readiness. First, given the challenges of formally recruiting students into the course, it is suggested that stage 2 of the pilot introduce a pre-DI preparatory program which is clearly delineated from the accredited course. This adaptation would formalise the strategy used for recruiting students in wave 3, when students were supported to identify aspirations and were provided with opportunity brokerage prior to their completion of paperwork induction requirements. In the proposed pre-DI program, BSL DI staff and residential care workers would broker external opportunities that assist participants to identify future roles that interest them. They would also concentrate on fostering young people's positive relationships, future thinking and building social status, with the aim of progressing towards formal enrolment in the accredited course.

Second, it is recommended that young people formally enrolled in the DI course be housed in a residential unit where everyone is enrolled. All young people in such units would have explicitly committed to a 'deal' brokered through the DI process. This provides a mechanism for residential care staff and DI practitioners to enable:

- external civic, economic and cultural actors to provide opportunities for including and enfranchising stigmatised young people

- young people to take advantage of these opportunities, and provide the practical and emotional support they need to do so

- young people to develop appropriate methods of challenging social norms which have excluded them, and to hold themselves and others accountable to standards of social justice and inclusion

- young people to commit willingly to educational attainment, economic participation and respectful interaction. Periodic 'performance reviews' might also be useful.

Continued residence within the units set aside for DI participation would be conditional upon young people abiding by their deal. Similarly, the young people would need to have avenues to hold carers and DI staff accountable for providing access to the

opportunities and necessary resources to achieve their aspirations. We can speculate that the normalisation of engagement with DI activities in these units would restructure the rules governing young people's internal cultural norms and offer incentives for young people to be mutually supportive.

The operationalisation of these strategies would need to be developed further by residential care agencies, with the support of BSL DI staff and Open Talent experts. The efficacy of each strategy would need to be tested in the evaluation of stage 2 of DI.

How could the capabilities approach and the Open Talent framework build the residential care sector's capacity to prepare young people for a successful transition to young adulthood?

Piloting a capabilities approach and Open Talent framework in the residential care system has identified a number of opportunities for developing care practice. While the practice suggestions are relevant for the future implementation of the DI course, they are also designed to contribute to systemic reforms. The following strategies focus on addressing the institutional and systemic barriers to implementation discussed above.

Poor relationships between workers and young people, and between young people and their families, can be understood to result from specific institutional dynamics and care practices. Longer time frames and greater stability are required for young people to develop more trustful relationships with workers; and, where appropriate, more attention, care, expertise and resources need to be directed towards the family-oriented aspirations of young people. Three strategies are suggested for the development of more positive relationships:

- In residential care staff training (e.g. Certificate IV in Child, Youth and Family Intervention) and practice models (e.g. Best Interests case practice model) mandatory components should include opportunity brokering and 'coaching' styles of interaction for building positive relationships of mutual care and regard. This should result in greater trust with young people.

- Proactively identify worker – young person pairs with positive relationships of mutual care and regard, and resource these workers to continue a mentoring role beyond staffing or placement changes. Give these workers the role of engaging young people in future-oriented action, such as engaging in education and DI activities.

- Provide workers, young people, and their families with practical, professional and emotional support to make family contacts therapeutic. This might involve preparing parents and young people to manage their expectations of contact and providing debriefing afterwards; using culturally sensitive family mediation services; training workers to manage complex situations; and having contacts professionally supervised.

The cycle of crisis and crisis management can be disrupted by directing attention towards future thinking. To these ends, three strategies can be suggested:

- Support engagement between young people and institutions that can host mainstream, and ongoing connections.

- Recognise young people's progress and maturation with markers and rituals.

- Establish a discrete pre-DI preparatory program with the goal of establishing the preconditions for formal enrolment in the accredited course.

Breaking the cycle of risk taking and risk management requires an alternative means for young people to develop social status. This might be achieved by:

- developing reciprocal obligations between young people and the broader communities in which they live

- ensuring young people are of supportive each other's efforts towards engagement and opportunity.

Given the limited evaluation data available at this stage, each of these suggestions is necessarily broad and would require further development by practitioners before being operationalised. If the suggestions are implemented, their significance and efficacy can be considered in the evaluation of stage 2 of the DI pilot, thus contributing to the evidence base underpinning practice in the OOHC sector.

Ultimately, the development of any intervention ought to be guided by an overarching commitment to increasing young people's capabilities—that is, their external opportunities and the internal skills and resources they have for making the most of these.

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