Safe Keeping Orders in South Australia

Discussion Paper

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1 Background

1.1 Purpose of the discussion paper
As a result of growing interest and support for introducing safe keeping provisions in South Australia the Guardian for Children and Young People wants to understand better the views, risks and benefits of safe keeping for young people at risk. In addition, the Minister for Families and Communities has recently requested the Guardian provide advice in relation to the recommendation made in the Children in State Care Commission of Inquiry final report that a secure therapeutic facility be established in South Australia. This discussion paper has been prepared to support a roundtable discussion on whether there is a need for safe keeping provisions, the concerns and risks in instituting safe keeping provisions and what can be done to address those risks. The roundtable discussion will inform the policy advice the Guardian provides to the Minister and the Guardian’s position in relation to this matter.1

1.2 Definition
For the purposes of this paper safe keeping is the statutory confinement in a specific location of a child or young person where no offence has been committed. The use of safe keeping orders assumes that a child or young person’s safety or that of others is at immediate and substantial risk and cannot be assured other than through safe keeping. This paper provides a brief overview of the background and context relating to the use of safe keeping, outlines models in use in certain Australian and international jurisdictions and presents specific issues for consideration relating to the use of safe keeping.

1.3 Legislation
South Australia has no current legislative provisions for safe keeping. The Community Welfare Act 1972 provided for safe keeping of children and young people who were under guardianship or custody in secure care facilities, without defined criteria or time limitations. Legislative amendments enacted in 1981 imposed time limits and specified criteria for the use of safe keeping. Safe keeping orders were discontinued and were not included in the replacement legislation in 1993.

1.4 Current context
The issue of how to respond to the complex needs and extreme risk-taking behaviour of some children and young people has gained renewed prominence. A 2002 Department of

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1. In most jurisdictions safe keeping provisions apply to children and young people who are already under guardianship or custody orders, however this is not always the case.
2. Community Welfare Act, 1972, s. 44(1)(c).
3. The time limit was seven days. Conditions were that the child or young person could not be controlled in any other way and was at risk of serious self-injury or injury to others. Community Welfare Amendment Act 1981, s. 6; Community Welfare Act, s. 32(1)(d).
Human Services review of service provision to young people classified as “adolescent at risk” over a one-month period found that most had previous child protection notifications and that one-third were existing clients, which included young people under custody or guardianship orders. The review suggested that young people under guardianship “continue to have needs that are unmet causing them to remain vulnerable,” an outcome that was “serious and requires urgent attention.”\textsuperscript{4} The review by Robyn Layton QC, \textit{Our Best Investment} (2003), recommended therapeutic safe keeping arrangements for some at-risk young people. Layton “acknowledged that safe keeping arrangements are a significant and intensive interaction but, for some young people, there are no other choices.”\textsuperscript{5} The final report of the \textit{Children in State Care Commission of Inquiry} (2008) recommended therapeutic secure care as a last-resort option to protect at-risk children and young people in care.\textsuperscript{6}

1.5 Profile

Research suggests that children and young people with extreme needs and challenging behaviours share certain experiences and characteristics. These include: a history of extreme abuse; difficult relationships or disconnection from family, carers and/or peers; substance abuse; a lack of secure/stable housing; and mental health problems. Children and young people in the out-of-home care system might experience placement instability and a disconnection from carers and family of origin. By mid-adolescence, children and young people might engage in behaviour that poses a significant risk to self (self-harm, substance abuse, sexual victimisation) or others (aggressive/violent behaviour).\textsuperscript{7}

The number of young people who fit this profile in South Australia is difficult to determine. For example, there may be children and young people who are homeless or transient, who engage in prostitution, substance abuse and other activities but who are not under custody or guardianship of the Minister.

It is possible to gain some sense of children and young people who are under custody or guardianship who fall within this profile group. In 2004, of the 70 young people living in Community Residential Care (CRC), 80 per cent (56 young people) absconded one or more times and 40 per cent (28) of the total number were considered to be at ‘high’ or ‘very high’ risk.\textsuperscript{8} In 2006, 47 young people were identified by Families SA as at risk of

\textsuperscript{4} Department of Human Services, \textit{Evaluation Study: Service delivery to adolescents who are the subjects of child protection and “adolescent at risk” notifications in SA}, review prepared by Carmela Bastian, Department of Human Services, South Australia, August 2002, pp. 88, 95.

\textsuperscript{5} Department of Human Services, \textit{Our best investment: a State plan to protect and advance the interests of children}, report prepared by Robyn Layton QC, DHS, Adelaide, 2003, section 13.8, see also recommendation 73.

\textsuperscript{6} Children in State Care Commission of Inquiry, \textit{Allegations of sexual abuse and death from criminal conduct}, Children in State Care Commission of Inquiry, South Australia, March 2008, recommendation 43.


\textsuperscript{8} Department for Families and Communities, Families SA, “Runaway Children and Young People in CRC,” undated.
sexual behaviours of concern. Of these 80 per cent were female and 80 per cent were under guardianship or custody of the Minister.9

In June 2007 Families SA advised the Guardian that at that point in time almost one third of the 55 children and young people living in residential care facilities absconded frequently and were considered to be at risk and in October 2007 Families SA identified nine young people under guardianship who were missing from residential or foster placements. The stated risks to these young people included child prostitution, drug and alcohol abuse, ‘sex for favours’ behaviour, offending and involving others in high-risk behaviours.10

Children and young people considered to be engaging in high risk behaviour in South Australia have tended to be between 12 and 17 years of age. Risk factors include: their whereabouts are unknown or they refuse to return to placements; they frequent locations associated with prostitution or sexual exploitation; they have a reduced capacity to judge consequences; they are targeted by adults in the vicinity of residential care accommodation; they are recruited by other young people to engage in prostitution and other activities. Many young people have become involved in the youth justice system as a result of their behaviour.

There is an established link between absconding from placements and risk-taking behaviours. However, some children and young people in placements may not abscond but have high and complex needs or display challenging behaviours that pose a risk to their safety or others in a placement.

1.6 Development, trauma and behaviour

Many children and young people who fit within the profile group have experienced severe material and social deprivation, which have been linked to risk-taking behaviours.11 The experience of trauma is another common factor, which together with environmental factors has been linked to impaired psychosocial and emotional development.12

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9. Risks included prostitution, recruiting others for prostitution, being involved in the production of pornography and associating with inappropriate adults. Most lived in CRC; those in foster placements often had the placement break down, necessitating a move to CRC.


Adolescence is particularly challenging for young people affected by trauma. During adolescence young people develop self-identity, improved emotional regulation and the skills to live within social and cultural expectations. Young people who have experienced trauma, abuse and neglect might experience altered stress response thresholds, poor impulse control, aggression, anxiety and depression. Abuse and neglect have been linked to cognitive delay, poor self-identity, impaired emotional regulation, limited interpersonal skills, lowered empathy and regard for consequences. Behavioural consequences can include truanting, substance abuse, aggression and violence, self-injury, sexual promiscuity and prostitution.13

1.7 Responses

1.7.1 Policy

The Keeping Them Safe reform agenda states, “where there are immediate, life-threatening circumstances to children, the system must respond with a sense of urgency.”14

Australian and international observers state that responses to at-risk children and young people in care in Australia have occurred within a broader child welfare paradigm that emphasises accommodation, care and protection rather than therapeutic intervention with clear conceptual underpinnings and specific objectives such as conduct or attitudinal change.15 In 2006, the Department for Families and Communities did not advocate safe
keeping “as there is not a body of evidence immediately available that supports it as a constructive intervention in isolation.” At present, children and young people who fit the profile outlined above are provided for within the existing care and accommodation framework, the pillars of which are residential care and family-based foster and relative care.

1.7.2 Foster care

By the 1990s, fuelled by concepts such as ‘mainstreaming’ and ‘normalisation,’ there was a systemic shift away from institutional care toward family-based foster care. For most children and young people, the shift toward family-based foster care has been positive. Children can live in the community, engage in mainstream educational processes and have varied social contacts. Ainsworth (1999, 2001) argues that many children and young people with complex needs and extreme behaviours have actively disconnected from mainstream educational processes and struggle in a family-based setting. Foster care was not designed for high-needs children and young people and “evidence shows that this response misses the mark for ‘at risk’ youth.”¹⁷ Barber and Delfabbro (2003) find that foster care in South Australia struggles to provide for the psychosocial functioning of older children with behavioural and emotional problems.¹⁸

1.7.3 Residential care

Residential care settings continue to provide care and protection in small-group community-based placements with attached services. In June 2007 over eight per cent of children and young people in out-of-home care were in residential care, an increase from four per cent since June 2003.¹⁹

The Department for Families and Communities operates six community residential care facilities, which can accommodate about 60 children and young people. In addition, Transitional Accommodation (TA) accommodates about 55 children in ten houses and at Seaford Rise Village.²⁰ Transitional Accommodation (TA) was originally designed to offer transitional accommodation, assessment and therapeutic services. These are non-secure settings.


¹⁹. In this paper residential care is categorised as placement in a residential building whose purpose is to provide placements for children and where there are paid staff. This includes facilities where there are rostered staff (such as supported residence arrangements) or other facility-based arrangements. See Australian Institute of Health and Welfare (AIHW) 2008, Child protection Australia 2006-07, Child welfare series no. 43, cat. no. CWS 31, AIHW, Canberra, pp. 52, 57

²⁰. Seaford Rise Village combines foster care and residential care housing.
Residential care aims to provide a stable place for at-risk children and young people. Families SA’s Psychological Services provides consultancy services and training to staff on responding to high-needs residents and also provides limited therapeutic services directly to residents. Staff can develop valuable, trusting relationships with residents. However, responses to high-needs residents reflect the provision of care and protection rather than stabilisation and treatment services.

The Guardian has reported concerns that the co-location of residents in CRC risks possible ‘contamination’ and that a staff-to-resident ratio of approximately 2:8 impedes effective interactions that might reduce absconding.21 In TA, communications with staff indicated that the complexity of children and young people’s needs as well as the lack of accommodation and service options for transitioning residents have resulted in placements being medium to long-term rather than transitional. TA has had a high staff attrition rate.22 Often, the priority is simply to allocate accommodation. Conversations with staff and information provided to the Guardian indicate that in both settings, staff skills have varied and responses to running away and high-risk behaviours have been inconsistent.23

1.7.4 Temporary placements and associated programs
The government’s reform agenda, Keeping Them Safe, proposed that “alternative care options will be expanded and consolidated, including emergency care for children and young people requiring intensive and specialist help.”24 The principal care settings are intensive foster care, supported accommodation and emergency supported care. A range of services support these placements. The focus is on stabilising clients and building life skills to facilitate community-based placements or independent living, rather than therapy.

Stabilisation Assessment and Transition Services (SATS) is a block-funded program operated by two non-government agencies for placements of up to 12 months. The program provides 24-hour care and services to facilitate the transition to an ongoing placement. Care providers receive training in the care of children and young people with complex needs. Psychological services include the provision of a therapeutic framework to guide carers and assessment of young people’s developmental needs. The provision of direct therapeutic services to children and young people is not part of the program.

Government-coordinated emergency supported accommodation uses commercial care providers in varied care settings for children and young people who cannot be accommodated in the ‘mainstream’ care system. A number of service models exist for children and young people in temporary accommodation, many of which have therapeutic

22. There is a ‘floating’ staff position on AM and PM shift at Seaford Rise. Two Seaford Rise houses are staffed by commercial care providers.
components such as mentoring, counselling and therapy. Numerous Emergency Accommodation Practice Guidelines exist for managing challenging behaviour.\textsuperscript{25}

As with residential settings, these placements and services aim to assist children and young people with complex needs. From conversations with Families SA staff and non-government providers, the importance of workers’ persistence and commitment in fostering trusting relationships with residents is clear. Many programs offered to children and young people help them stabilise. In some cases, children and young people’s needs have been such that ‘transitional’ placements become long-term. However, care can be reactive, unpredictable and non-linear - some clients stabilise, then relapse or transition only to have the placement fail. Care providers are non-specialists in the areas of behavioural management, psychological trauma and behavioural disorders. Care can be disrupted when accommodation falls through, however some services are conditional upon placement stability. Children and young people who do not have a diagnosed disability or psychological disorder can fall through ‘cracks’ in service provision. Ainsworth (1999) contends that “treatment foster care does not have sufficient intensity of service inputs to provide adequately” for the extreme treatment needs of some children and young people and that individualised services successfully maintain ‘at-risk’ young people in placements, but tend to be used as a response to crises rather than within a clear conceptual framework.\textsuperscript{26}

Several Australian and international jurisdictions have employed safe keeping as a response to the behaviours and needs of this core group of children and young people. Orders vary in length, purpose and operation. A synopsis of several models follows.


2. Safe keeping in practice

2.1 Victoria

2.1.1 Legislation

The Children, Youth and Families Act 2005 provides for the Department Secretary to place a child who is under custody or guardianship in a secure welfare service (SWS) for a period of up to 21 days where the Department Secretary is satisfied that there is a substantial and immediate risk of harm to the child. There is provision for one extension of up to 21 days. The Act also provides for court-authorised temporary accommodation of children taken into safe custody who are not under the Secretary’s guardianship in a secure welfare service, for the period before the making of an interim accommodation order if there is a substantial and immediate risk of harm. A lack of accommodation alone is not a sufficient reason for placing a child in a secure welfare service.

2.1.2 Policy and practice

The Department for Human Services (DHS) describes SWS as “a highly structured setting during a significant crisis” for clients “when the broader care and protection network cannot manage or reduce the risks to the child.” SWS is a last resort that “should only be considered where all other placement and support options have been exhausted.”

Child Protection managers authorise SWS placements. A risk assessment can be based on a single incident or accumulated risk. Children aged up to 17 years may be placed in SWS, children aged less than 10 years only in exceptional circumstances. SWS provides stabilisation while plans are made to reduce risk and assist a return to the community. SWS cannot hold children who are on remand or serving a period of detention.

Children and young people must be informed of their rights and, where possible, be able to provide an informed opinion concerning a possible placement. Children and young people, their parents and carers have a right to appeal an administrative decision to place (or not place) in SWS. A child or young person who is incapacitated as a result of mental illness, intellectual impairment or other reason is entitled to have an advocate appointed to assist them in understanding these processes. Regional community care managers are authorised to review placement decisions and must ensure that reviews are prioritised. Reviews must include a meeting or conversation with the child or young person.

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28. Children, Youth and Families Act 2005, ss. 173 (2)(b), 174 (1)(a), (b), (c), (d).
30. If the placement is made after hours, the regional community care manager must approve the placement.
32. Review outcomes must be determined “as soon as possible” from the time of the request for a placement of 24 – 72 hours and within 2 working days for placements over 72 hours.
or young people should be advised that a review of case planning decisions and actions made by departmental staff may be heard in the Victorian Civil and Administrative Tribunal.

2.1.3 Facilities and services
SWS provides two 10-bed gender-specific residential units that are staffed on a 24-hour roster. Clinical and therapeutic services are provided within the Take Two program and include assessment of the child or young person and liaison with medical and mental health services. Traditional therapeutic services such as long-term counselling are not provided.33 Currently, the Victorian government is undertaking a pilot program to convert up to 14 residential care programs to residential care programs with a therapeutic focus.

2.1.4 Outcomes and trends
Snapshot using 2005/06 data:
- 508 admissions (34 per cent male / 66 per cent female);
- 216 individual clients (86 male / 130 female);
- average readmission rate is 1.6 per male client / 2.2 per female client;
- a minority have multiple readmissions
  - 57 per cent - single admission
  - 27 per cent - 2-3 admissions
  - 9 per cent - 4-6 admissions
  - 7 per cent - more than 7 admissions;34
- 16 per cent of clients were Aboriginal / Torres Strait Islanders (11.6 per cent male / 18.5 per cent female);
- similar readmission rates for Aboriginal / Torres Strait Islanders (1.6 per male client / 2.5 per female client);
- 4315 placement days (1733 males / 2582 females);
- average stay: eight days (males 10 days / females eight days);
- 92 critical incident reports (35 per cent male / 65 per cent female);
- 80 per cent of admissions from metro area;
- average two per cent of clients appeal decision to place (2006/07).

Trends in SWS include more admissions each year (204 admissions in 1993/94 and 504 in 2007/08), more placement days per year (2352 in 1993/94 and 4222 in 2007/08), a consistent, though reducing, gender gap in admissions (65 per cent of admissions in 1993/94 were female; 58 per cent in 2007/08) and a decline in the average stay (12 days in 199/94 to 8 days in 2007/08 for both sexes). Information from the Victorian

34. Gender breakdown not supplied
government suggests that one explanation for the increased trend in admissions is that the non-government sector has struggled to cope with the needs of this profile group and has referred clients on, rather than the profile group itself increasing. The greater number of girls in SWS does not necessarily reflect the gender breakdown of need, but that boys are more likely to run away whereas girls are more ‘visible’ to the protection services.

2.1.5 Critiques
Issues include that the standard of “substantial and immediate risk of harm” has generally been “determined by whether the young person is suicidal” and that “extensive therapeutic services are not provided” as the time in care is limited, which means “Secure Welfare provides little more than temporary relief.” 35 The planning for release has been called inadequate and SWS placements have attracted notoriety, with young people bragging about the number of times they have been admitted.

2.2 New South Wales
2.2.1 Legislation
The *Children and Young Persons (Care and Protection) Act 1998* provides for a court to make a compulsory assistance order that places the child or young person under the responsibility of the Director-General, for intensive care and support for a child or young person to protect him or her from suicide or other life-threatening or serious self-destructive behaviour. 36 A compulsory assistance order is for three months, with provision for three-month extensions. 37 The Children’s Guardian monitors the circumstances of a child or young person who is subject to an order. 38 The sections relevant to compulsory assistance are not yet in force and there appears to be little support to enforce the provisions.

2.3 Australian Capital Territory
2.3.1 Legislation
The *Children and Young People Act 1999* provides for the Children’s Court to make therapeutic protection orders (TPO) for the provision of therapeutic care, defined as “care

37. *Children and Young Persons (Care and Protection) Act 1998* (NSW), ss. 128(1), (2), (3). The Children’s Court, in making an interim compulsory assistance order, must specify its duration, which cannot be more than 21 days. An interim compulsory assistance order cannot be extended. *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 130(1), (2). The Act also provides for the Director-General to place a child or young person under immediate compulsory assistance and specify the place at which the child or young person is to reside before applying to the court for an order. The Director-General must make an application to the Children’s Court for an order person on the next sitting day of the Children’s Court. *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 132(1), (2).
38. *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 133A.
provided by the chief executive for a child or young person, where the child or young person is confined to a place in a way that the chief executive considers appropriate to protect the child or young person from serious harm.” The court cannot make an order unless it is satisfied that it is necessary to prevent the child or young person from behaving in a manner likely to cause physical harm to himself or herself or others, that less intrusive methods have been attempted or would be insufficient for the support of the child or young person, that a planned treatment or therapeutic program is in place (the Chief Executive must provide this to the court) that is likely to lead to a significant improvement in the circumstances of the child or young person and that there are resources and staff to implement the program.

The Chief Executive can confine a child or young person to a place (not used for detention or remand of young offenders) for up to eight weeks, with provisions for eight-week extensions.39 The Chief Executive must cause an application for a TPO to be served on the child or young person, parent and the public advocate within three days.40 The child or young person, parent, a former caregiver or the public advocate can apply to the court for an order to be varied or revoked. The Chief Executive must provide information on the schedule and type of provision of therapeutic protection on request by the public advocate or official visitor.42

2.3.2 Policy and practice

No TPO applications have been made as the ACT does not have a dedicated facility for therapeutic protection.43 Discussions are occurring in the ACT regarding the establishment of an appropriate facility. High-risk young people who would meet the threshold for a TPO and who have been involved in the criminal justice system have been placed at Quamby Youth Detention Centre.44 Others who would meet the threshold for a TPO have been placed at Marlow Cottage, an emergency substitute care shelter accommodating up to eight children and young people.45

39. Children and Young People Act 1999 (ACT), ss. 233, 235 (1)(a)(b)(c), 235 (2)(b), 236 (2)(a) - (e), 242, 244.
41. Children and Young People Act 1999 (ACT), s. 239.
42. Children and Young People Act 1999 (ACT), s. 243.
43. Government of the Australian Capital Territory, Department of Disability, Housing and Community Services, Office for Children, Youth and Family Support, email, 10 May 2008.
45. The Richmond Fellowship, a private provider, manages Marlow Cottage, which is funded by the Office for Child, Youth and Family Support, within DHCS.
2.4 Western Australia

2.4.1 Legislation
The Western Australian government is considering legislation to create a Therapeutic Treatment Order.47

2.4.2 Policy and practice
An assessment centre has operated since 1999 for up to eight young people aged between 10-17 years who have social, emotional or behavioural problems. Placements are for up to six weeks for assessment, which includes support services, mental health and general health needs and treatment needs for drug addiction. The facility has self-contained education and support services and is complemented by dedicated services at three other hostels.48 In 2006 it was noted in Parliament that children had been accommodated at the centre for up to two years. At that time there were five children in residence for periods from six months up to two years.49 Long-term placements remain a trend.

2.4.3 Facilities and services
The Western Australian government is presently reviewing residential care provisions including the policies, procedures and facilities for those who will be subject to a therapeutic treatment order.50 In May 2007 the Western Australian government announced the modification of the assessment centre, for completion in 2009, to create a secure unit to “restrict the movement of children at risk of harming themselves or others.” 51 The secure unit model being considered is similar to that operated by the Victorian government.

2.5 New Zealand

2.5.1 Legislation
Under the Children, Young Persons, and Their Families Act 1989, the Chief Executive may place any child or young person residing in a care and protection residence in a secure section of that residence. This can be done only to prevent the child or young person from behaving in a manner likely to cause physical harm to that child or young person or others,
or to prevent a child or young person from absconding where any two of the three following conditions exist:

- the child or young person has absconded from a residence or from Police custody one or more times within the preceding six months;
- there is a real likelihood that the child or young person will abscond from the residence;
- the physical, mental, or emotional wellbeing of the child or young person is likely to be harmed if the child or young person absconds from the residence.52

Secure care is limited to 72 hours without court approval.53 The court may approve and specify a continued period of detention (being more than 14 days but not more than 28 days).54

The regulations circumscribe the powers of punishment and discipline and requires planned activities to be made available.55 Each case is to be reviewed daily by staff and the child or young person is entitled to be present at this review.56 Residents have recourse to a complaints and grievance process, which include the right to an independent advocate and provision for a grievance panel to investigate complaints.57 There are limitations on continued placement in secure care and any decisions made in respect of continued placements must be recorded.58

2.5.2 Policy and practice

Children and young people can be admitted directly into a secure unit from a community placement if they meet the legal criteria. The Code of Practice for Residential Care Services contains measures that support the humane treatment of children and young people in residences. Professional practice standards are maintained through a 12-week induction programme for new staff and ongoing supervision.59

55. These include the banning of corporal punishment, of humiliating or degrading discipline and treatment, restrictions on the use of force, the banning of silence as a punishment and restrictions upon confinement to one’s room. Children, Young Persons, and Their Families (Residential Care) Regulations 1996 (NZ) rr. 17-24, 48 (1)(a)(b)(c), 51(1), (2)(a).
56. Children, Young Persons, and Their Families (Residential Care) Regulations 1996 (NZ) r. 47 (1)(2).
57. A grievance panel comprises three persons appointed by the Minister on the nomination of the Director-General. Children, Young Persons, and Their Families (Residential Care) Regulations 1996 (NZ), rr. 15, 16, 19, 29, sch. to r. 15.
58. Approved continued is prohibited for a continuous period of more than 7 days unless the Manager or another senior staff member reviews the case and approves the detention. All residences operate a secure care register, which contains placement and treatment details for each resident. Children, Young Persons, and Their Families (Residential Care) Regulations 1996 (NZ), r. 47 (4)(a)(b), (5), 56.
Managers of each residence monitor compliance with the regulations. The Director-General is responsible for providing facilities and training relating to care and protection residences and for developing a National Code of Practice. Residences are inspected yearly by an individual authorised by the Chief Executive, who furnishes reports to the Chief Executive, the residence Manager and to the Children’s Commissioner. Grievance panels must report quarterly on all reviews of complaints, stating whether there has been compliance with the procedures.

2.5.3 Facilities and services

The Child, Youth and Family, a service within the Ministry of Social Development, operates four care and protection residences throughout New Zealand, which contain open units and ‘secure units,’ or a locked section of a residence.

Residents in secure units receive the same educational and other services as those in the open sections; however there is more intensive monitoring. A Severe Conduct Disorder Programme was launched in 2005. The programme is run in conjunction with private providers from one of the existing care and protection residences and comprises a ten-bed specialist therapeutic unit and a private four-bed (step down) family home. The three stages of the programme are to stabilise young people, to provide methods of coping with emotions, changing behaviours, and relational patterns and to provide assistance to integrate into the community.

2.5.4 Outcomes and trends

Data collection on outcomes has been limited and is not isolated to secure unit placements. Data for care and protection residences generally in 2007 are:

- 114 admissions, equal proportion of males to females;
- almost 50 per cent of admissions are Maori;
- average age 14 years
- 53 extensions to placement in Care and Protection residence
- re-admissions are at 20 per cent

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60. Children, Young Persons, and Their Families (Residential Care) Regulations 1996 (NZ), r. 28.
63. Ombudsmen Act 1975 (NZ), s 13, sch. 1.
64. Government of New Zealand, Department of Child, Youth and Family, information provided via email, 30 May 2008. Whakatakoki (Auckland) 20 beds (five secure); Epuni (Wellington) 10 beds (four secure and an additional 10 that service the severe conduct disorder program); Te Oranga (Christchurch) 10 beds (two secure); Puketai (Dunedin) 8 beds (three secure).
- number of appeals for review of decision not available
- no information is available on use of restraint
- 15 critical incidents across the four residences

2.5.5 Critiques

A number of reports into care and protection residences have highlighted concerns including:

- whether the criteria for holding children in secure care were applied correctly in all residences;\(^{66}\)
- that the internal grievance procedure in care and protection residences generally falls below the rights contemplated in Article 12 of the UN Convention on the Rights of the Child;\(^{67}\)
- that advocacy is not required during grievance procedures and that there is no right of appeal to an independent authority;\(^{68}\)
- significant numbers of outstanding complaints were not addressed adequately;\(^{69}\)
- regulatory requirements for holding children and young people in secure care were not always followed, which raised the issue of staff awareness and training;\(^{70}\)
- the absence of transition planning for children and young people in residences.\(^{71}\)

Child, Youth and Family has advised that a new residential induction training package for all new staff will be introduced and a grievance procedure training package for staff has been developed. Transition planning is under review and a joint program with the Department of Health and Education is underway to facilitate the transition from care.\(^{72}\)

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71. Government of New Zealand, Department of Child, Youth and Family, information provided via email from Senior Advisor Residential Services, 26 May 2008.

72. Government of New Zealand, Department of Child, Youth and Family, information provided via email from Senior Advisor Residential Services, 26 May 2008.
2.6 United Kingdom

2.6.1 Legislation

Section 25 of the Children Act 1989 provides for the “use of accommodation for restricting liberty” where a child or young person in care has a history of absconding, is likely to abscond and is at risk of significant harm from absconding or while placed in any other form of accommodation.73 A child can be kept in secure accommodation without a court authority for 72 hours. Court-authorised secure accommodation is limited to three months and a maximum of six months for each subsequent application.74 No child under the age of 13 can be placed without the Secretary’s approval.75

A three-member panel will review a child or young person’s placement within one month. This panel must satisfy itself that the criteria for secure accommodation remain, that the placement is needed and whether alternative accommodation would be appropriate.76

2.6.2 Policy and practice

In England policies relating to secure children’s homes (SCH) vary according to region.77 Each local authority appoints an Independent Reviewing Officer to participate in statutory care plan meetings for each child in care. This was seen as beneficial to counteract external agencies’ pressure to place children or young people in secure welfare.78

2.6.3 Facilities and services

Secure children’s homes are operated by local social services departments. Young people under youth justice legislation and mental health legislation can also be placed in secure children’s homes - some homes have a mixture of beds while others have ‘welfare beds’ only. Secure children’s homes accommodate between six and 40 residents and are staffed by trained workers with a high worker-resident ratio.79 There were 22 secure children’s homes operating in the United Kingdom as of March 2007. There were

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73. Children Act 1989 (UK), s. 25(1).
74. The Children (Secure Accommodation) Regulations 1991, r. 10, 11, 12.
75. The Children (Secure Accommodation) Regulations 1991, r. 4.
76. The Children (Secure Accommodation) Regulations 1991, r. 15.
approximately 135 beds for children placed on welfare grounds in these homes with ‘welfare’ accounting for 75 placements (being 27 per cent of all children accommodated).\textsuperscript{80}

Secure children’s homes in each region offer a range of education, assessment and therapeutic services to facilitate a child or young person’s return to the community.\textsuperscript{81} In 2007 the Commission for Social Care Inspection regulated 21 services specific to secure units.\textsuperscript{82} The Office for Standards in Education, Children’s Services and Skills (Ofsted) inspects services to children.\textsuperscript{83}

\section*{2.6.4 Outcomes and trends}

Data and records obtained from various sources in different years shows:

- 100 children in welfare placements in January 2007;
- 400 admissions and 409 discharges for year ending October 2006,\textsuperscript{84}
- a majority of children placed are aged between 13 and 16 years,\textsuperscript{85}
- more girls than boys are placed in ‘welfare beds’ and girls tend to be younger than boys when placed;\textsuperscript{86}
- boys were placed due to threatening behaviour, running away and the related threat of criminal activity; concerns for girls were linked to a risk of sexual exploitation;\textsuperscript{87}
- a majority of jurisdictions interpret the legislation to mean that secure placements should be a ‘last resort;’ about one-third have interpreted s. 25 as meaning that secure placements should be used as the most effective intervention, not the last intervention;\textsuperscript{88}


\textsuperscript{84} Department of Health, Promoting Mental Health for Children held in Secure Settings: A Framework for Commissioning Services, Appendix A.

\textsuperscript{85} The use by local authorities of secure children’s homes, p. 11.

\textsuperscript{86} Ibid., p. 11.

\textsuperscript{87} Ibid., p. 15.

\textsuperscript{88} Ibid., p. 7.
• jurisdictions using the ‘last resort’ interpretation use secure welfare placements more often than those who use it in a proactive manner; 89
• about half of secure welfare placements achieve stabilisation and helped ameliorate risk-taking behaviours, but some children have multiple readmissions to secure welfare; 90
• most jurisdictions have appropriate processes for considering placements; 91
• secure children’s homes invite participation and encourage contact between children and parents or carers; 92
• secure children’s homes have complaints procedures and independent advocacy services visit homes; 93

Data on the use of restraint in secure children’s homes is expected in June 2008. 94

2.6.5 Critiques
A number of criticisms have been raised including:

• the co-location of young offenders with children and young people in ‘welfare’ placements violates Rule 17 of the UN Rules for Juveniles Deprived of Their Liberty; 95
• differing interpretations of legislative purpose meant that orders were used both as a positive intervention and as a last resort; 96
• some local authorities had no policy relating to the legislation and policies varied in scope and quality. 97

89. Ibid., p. 8.
90. Ibid., p. 13.
96. The use by local authorities of secure children’s homes, p. 11.
97. Most were found to reflect the legislation appropriately. Government of the UK, Department for Education and Skills (UK), Research Report No. 749, Qualitative Study: The use by local authorities of secure children’s homes, report prepared by Jane Held Consulting Ltd, Department for Education and Skills, London, 2006, p. 12.
varying use of orders reflected senior decision makers’ practice culture and opinions;98
orders could be obtained but there was no available bed;99
SCHs refuse placements to maintain a specific gender or age mix;100
gendered interpretations of ‘risk’ (that is, male sexual activity not seen as a risk factor but the same behaviour in females is);101
capacity (there are unused placements) but limited availability of placements to meet specific needs;102
unregistered single child units were created or commissioned to meet need;103
some homes not approved as secure homes offered "semi-secure" accommodation, using locked doors or physical restraint to stop children from leaving. Some local authorities sought placements in these homes;104
SCHs often simply contained residents and staff were seen as needing more qualifications and skills;
SCH did not facilitate effective transitions to an open setting;
better service provision would increase confidence in using SCHs as positive interventions;105
inconsistent use of physical control, strip-searching and single separation.106

2.7 Ireland

2.7.1 Legislation

Under the Children Act, 2001, on an application by the Health Service Executive (HSE), a court makes special care orders that commit a child aged 12 years or older who is in its care or who resides or is found within its area who “requires special care or protection” where the “behaviour of the child is such that it poses a real and substantial risk to his or her health, safety, development or welfare” to the Health Service Executive’s care, which is authorised to detain a child or young person in a ‘special care unit’ for the purpose of providing “care, education and treatment.” Special care orders are between three and six months and may be extended.107 A court application is preceded by a family welfare

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98. The use by local authorities of secure children’s homes, p. 11.
100. Ibid., p. 7.
101. Ibid., pp. 4, 15.
102. Ibid., p. 5.
103. Ibid., p. 17
105. The use by local authorities of secure children’s homes, pp. 5, 8, 12, 16-17, 19.
106. HMICA, Safeguarding Children: The second joint Chief Inspectors’ Report Safeguard Children, pp. 8, 42-43, 56
107. Children Act 2001 (Ire.), s. 23B (4)(a), (b). Interim special care orders require that a child be detained in a special care unit for a period not exceeding 28 days. Children Act 2001, s. 23C.
conference and review by the Children Acts Advisory Board (CAAB), which advises on the application.\(^{108}\)

Government regulations on the use of special care require (among other things) that: staff have appropriate qualifications and receive training; all staff are vetted and have criminal record checks; health and education services are provided; children and young people have access to relatives, guardians and legal representatives; a care plan for each child is completed prior to placement; corporal punishment, cruel and degrading treatment are prohibited; critical incidents are reported to the HSE; restraint is not used except in specific circumstances; single separation is limited; a complaints procedure is in place, which includes reporting all complaints to the HSE; the HSE monitor the units to ensure compliance with standards.\(^{109}\)

### 2.7.2 Policy and practice

The criteria for admission to special care units (SCU) include that all other non-special care options have been considered. Children or young people with learning disabilities, with acute psychiatric or medical illness, who require medically supervised detoxification for drug misuse or who have been convicted of an offence should not be admitted to SCU.\(^{110}\) Applications are reviewed by the National Special Care Admission and Discharge Committee (NSCADC) of the HSE as well as by the CAAB. Ultimately, the NSCADC makes a decision on the acceptance or not of an application made by a social worker.\(^{111}\) Special care unit Admissions Panels establish whether the admissions criteria are met, match the child’s needs to placement availability and ensure procedural regularity in applications.\(^{112}\)

The CAAB advises on “policy relating to the remand and detention of children” and issues admission and discharge criteria. The CAAB is currently reviewing admission criteria and will establish discharge criteria during 2008.\(^{113}\) The Department for Health and Children

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109. Child Care (Special Care) Regulations, (Ire.), rr. 512, 1315, 16, 17, 18, 19, 22, \ldots, 26


112. Special Residential Services Board and the Health Service Executive, Criteria for Appropriate Use of Special Care Units, p. 14.


issues *National Standards for Special Care Units*. The Social Service Inspectorate, a statutory body within the Health Information and Quality Authority, monitors the quality of care.\(^{114}\)

2.7.3 Facilities and services
The SCU is a facility to stabilise a young person in order to return him or her to less secure care as soon as possible. SCUs are provided and maintained either by the government or by a voluntary body in arrangement with government. The Minister (Health and Children), approves units and issues operational regulations.\(^{115}\) There are three units housing between five and 15 young people.\(^{116}\)

Special care units provide an allocated social worker with frequent contact for each young person, educational services, speech and language therapy, accessible psychological and psychiatric services, medical service and a support for social and family reintegration programme.\(^{117}\)

2.7.4 Outcomes and trends
Research on the 36 special care applications made between January and June 2007 is underway and a report on the level and nature of residential accommodation and support services to children detained in special care units is due for release in 2008.

Available information is that:

- there is an average of 100 applications per annum;
- there are 36 beds in total;
- on average 16-18 beds used on any one night;
- girls tend to go into special care and boys into the juvenile justice system.\(^{118}\)
- in 2004 there were 79 applications for admission split almost evenly along gender lines;
- an average of 53 per cent of applications were admitted;

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114. The SSI was administered by the Department of Health and Children (DoHC) from 1999 until May 2007, when it was established on a statutory basis. Social Service Inspectorate, Health Information and Quality Authority. <http://www.hiqa.ie/functions_ssi_bg.asp> Viewed 2 May 2008.

115. These include the care and welfare of children while detained in the units, unit staffing, reviews of children’s cases, inspections and records. Children Act 2001, ss. 23k.


• an average of 30 per cent of applications were turned down (reasons not clear);
• an average of 17 per cent were withdrawn / awaiting information / successful but placement did not proceed (reasons not clear);
• almost 2:1 ratio of females to males admitted (24 females and 14 males);
• girls older (15-17) than boys (13-14) at admittance;¹¹⁹
• it was unclear whether re-applications were for people who had actually been placed previously and whether any previous admissions were successful;
• some young people appeared not to have been re-admitted to SCUs based on their previous good behaviour but young people were ‘models of behaviour’ to ‘run down the clock’.¹²⁰

A two-year study of the impact of special care units reported improvements in socialisation, medical care, educational attainment, peer, family and professional relationships. The study found that special care units offered a focussed intensive therapeutic intervention, offered respite to young people, education, coping strategies and containment from harm.¹²¹

2.7.5 Critiques
Reports and reviews raise several issues:

• residents have been placed in SCU to meet accommodation need;¹²²
• s. 16 of the Children’s Act 2001 does not define the boundaries under which an order can be granted and that there is no definition of the health, safety, development or welfare of the child;¹²³
• the application process was slow and it was not always possible to provide the required information (eg where a psychiatric report was required but a young person had never attended a psychiatrist, refused to attend a psychiatric assessment or whose circumstances made attendance difficult, such as being missing / homeless);
• the purpose for the placement was not always clear in applications, reflecting poor understanding of criteria;
• need for access to information about people subject to applications;¹²⁴

¹²⁰ SRSB, Review of Admission Criteria and Processes for Special Care, p. 7.
¹²² Social Services Inspectorate, Glenn Alainn Special Care Unit Inspection Report, p. 3.
¹²⁴ SRSB, Review of Admission Criteria and Processes for Special Care, pp. 11-13.
- children were held in reformatory schools prior to admission to special care, highlighting the need to monitor the use of interim orders;¹²⁵
- need for links between special care and ‘step down’ facilities¹²⁶
- more interaction with families of those in SCUs was needed¹²⁷
- need for after-care planning and a continuum of services and supports¹²⁸

¹²⁵ SRSB, Review of Admission Criteria and Processes for Special Care, pp. 14, 18-19.
¹²⁶ SRSB, Review of Admission Criteria and Processes for Special Care, p. 11.
¹²⁸ SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, p. 8.
3 Discussion

3.1 Necessity

The central question is whether it is necessary to detain a child or young person to respond effectively to immediate and substantial risk. It can be assumed that optimal interactions with young people are based on active engagement that promotes empowerment and responsibility for life choices. Responses to children and young people that involve compulsion “are not necessarily those that will best ensure safety,” note Morton et al in a review for the Victorian Government (1999).129

The decision to use safe keeping orders is complex. For example, there might be circumstances when engagement techniques do not ensure a child or young person’s safety. A child or young person’s mental or emotional capacity might impede judgement about the consequences of his or her decisions, resulting in substantial risk as a result of those decisions. A child or young person may benefit from safe keeping when community service providers will not work with him or her.130 Conversely, a child or young person may not engage professional help unless he or she is detained.131

Question 1:

Do we have within our existing range of service responses the potential to provide for the needs of children and young people who put themselves at high risk?

Question 2:

Is containing a child or young person essential to respond effectively to immediate and substantial risk or harm?

Question 3:

Has the ‘risk of absconding’ become the defining risk on which the decision to intervene is made? If so, is this appropriate?

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129 Government of Victoria, Department of Human Services, When care is not enough: A review of intensive therapeutic and residential service options for young people in out-of-home care who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood, report prepared by J Morton, T Clark and J Pead, DHS, Melbourne, 1999, p.95

130 Government of Victoria, Department of Human Services (DHS), When care is not enough: A review of intensive therapeutic and residential service options for young people in out-of-home care who manifest severe emotional and behavioural disturbance and have suffered serious abuse or neglect in early childhood, report prepared by J Morton, R Clark and J Pead, Department of Human Services, Melbourne, 1999, p. 95.

131 DHS, When Care is Not Enough, pp. 93-94; SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, p. 34.
3.2 Philosophy

The clear conceptualisation of the confinement of children and young people who are not in conflict with the law is critical, given that confinement has historically been used to respond to offending. How safe keeping is viewed will affect its use, and hence its outcomes for children and young people. It is also important because orders can become more open to interpretation if their underlying concept is not clear. For example orders may be seen as rehabilitative and protective or as punitive and regulatory.\(^{132}\) They might be seen as a positive intervention or, as Anglicare SA has argued, an intervention that carries a social and psychological stigma.\(^{133}\) In Ireland, there has been some concern that admission to special care attaches stigma to a child or young person in part because of societal conceptions of special care as the final stop for young people who are considered ‘out of control.’\(^{134}\) The impact of philosophy as a determinant on the design and use of safe keeping orders should not be overlooked.

Cultural, moral and practice justifications and assumptions can be embedded into the application of orders. There are differing interpretations of risk, for example. Gendered interpretations can influence use – a 1983 Department for Community Welfare report on safe keeping in South Australia observed that orders were used differently for girls than for boys and that status offences “often serve as buffer charges for monitoring and punishing suspected female sexuality.”\(^{135}\) The UK and Victorian experiences confirm this risk and correlates with research indicating that girls are disproportionately incarcerated for minor offences.\(^{136}\)

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Question 4:

What are our cultural assumptions if we support the use of safe keeping?

Question 5:

What social attitudes and views does the use of confinement for safe keeping reinforce?

Question 6:

Whose interests are safe keeping orders designed to serve?

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135. Difficult adolescent girls and safekeeping, p. 6.

3.3 Protecting children’s rights while protecting children

Article 19 of the 1989 UN Convention on the Rights of the Child (‘the Convention’) states that nations “shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation.” Article 37 of the Convention states, “no child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.” The state has both the duty to protect children’s liberty and the duty to provide for children’s well-being. For example, the state may act to restrict some rights in order to meet the child’s needs, because the child is incapable of meeting their own needs.\(^{137}\)

There is a potential conflict between the state’s responsibility to protect a child or young person and the child or young person’s right to self-determination, which detention arguably infringes.\(^{138}\) The deprivation of liberty, argue Brennan and Noggle (1997), requires that a clear benefit to a child or young person result from this infringement of rights.\(^{139}\)

It is accepted that interventions to protect children and young people should proceed with their ‘best interests’ in mind. Article 3 of the Convention states that, “in all actions concerning children … the best interests of the child shall be a primary consideration.” It has been argued that the concept of ‘best interest’ is potentially problematic. What is in a child or young person’s best interest is open to interpretation, cannot always be known incontrovertibly and can be influenced by cultural frameworks or differing views of child welfare practice.\(^{140}\) Thus, it is not clear that the notion of ‘best interest’ itself guarantees that children’s rights will be recognised. To mitigate any uncertainty, it has been argued that the principle of ‘best interest’ should be constructed through the use of administrative and legal rules of dispensation.\(^{141}\)

It has also been suggested that children and young people should have a means of influencing the decision, with competence and emotional maturity taken into account.\(^{142}\) Article 12 of the Convention holds that “the child who is capable of forming his or her own views [has] the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” This asks us to “consider [children and young people] agents of their own lives.”\(^{143}\) The centrality of children’s rights in decision-making might impose restrictions on the rights of those responsible for their care.\(^{144}\)

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140. Thomas and O’Kane, “When children’s wishes and feelings clash with their ‘best interests,’” p.139.
142. Thomas and O’Kane, “When children’s wishes and feelings clash with their ‘best interests,’” p.139
Anglicare SA’s presentation to the Children in State Care Commission of Inquiry (CISC) noted a general objection to the idea that it is acceptable for the state to forcibly detain young people against their wishes who have broken no law and who present no immediate risk to their own lives or the lives of others. Anglicare SA stated that forcible detention was “unacceptable” because of “the breach of the principles and values of fairness” and the “breach of the United Nations Convention on the Rights of the Child.”  

Another perspective is that the emphasis on rights limits intervention unduly. Bath (2002) suggests that a libertarian perspective creates a perception that “we would rather let some young people make destructive choices that place themselves at extreme risk, than intervene in any way that might involve a restriction of choice.” A children’s court lawyer in Victoria argues that rights and freedoms are given to at-risk young people in care by people “who would never give those rights to their own children.” Professor Dorothy Scott argues that authorities must explore “how the needs and interests of children need to be put ahead of … rights of freedom, of movement and freedom of association with a group of such damaged young people.”

Brennan and Noggle (1997) argue that children should receive the same moral status consideration as adults. However, such a libertarian view is not at odds with the view that children can be treated differently from adults. Indeed, recognising children’s equal moral status does not suggest that children have the same duties and rights as adults, nor that it precludes differential treatment. Brennan and Noggle see that the denial of rights to children may occur not because they are children, but because they lack the relevant abilities or maturity to exercise their rights. The goal is to treat children in a manner that is consistent with equal moral consideration. This includes respecting the child’s rights and infringing them only when necessary and only to the degree necessary to meet the child’s needs.

Question 7:

Can safe keeping provisions ever be applied without violating a child’s rights? Under what circumstances?

Question 8:

Why are we now entertaining the notion of detaining young people for their own protection when in South Australia we have opposed it since the 1980s?

145. Anglicare SA, “Notes for presentation to the Mulligan Inquiry.”
148. Professor D Scott, quoted in “High Risk Kids,” Background Briefing, Radio National.
3.4 Risk of inaction

An identified yet unmet need poses risks to children and young people. In Ireland, for example, a perceived increase in complex needs and behaviours coupled with a lack of specialised care options resulted in young people being channelled inappropriately into the criminal justice system.150

Children and young people might themselves seek safe keeping. Victorian private therapeutic provider Berry Street states, “There are times when young people seek out a form of containment themselves and the system needs to respond to this.”151

Public consultation about Keeping Them Safe elicited views that an order would allow for case assessment and management to occur.152 The Victorian Commissioner for Child Safety notes that safe keeping orders stimulate coordinated, timely case planning for children and young people.153 The manager of the Victorian Secure Welfare Service concurs, noting that a placement in SWS prompts a range of service providers and practitioners to meet, to identify gaps in service provision and institute integrated care arrangements.

It may be asked whether the decision not to use containment in circumstances where a child or young person has a demonstrated lack of capacity to make informed decisions and is at risk of substantial or immediate harm breaches the state’s duty of care to a child or young person.154 In the immediate context this relates to survival and safety. In the broader context, as Ainsworth (1999) notes, children and young people with complex needs are at greater risk of adult unemployment, social dislocation, crime, poverty and homelessness without intervention. Ainsworth contends, “if this is the freedom that must be protected then it is an unjust freedom.”155 He argues that to deny at risk children and young people a range of intensive services on the basis of cost or limited knowledge of how to design such services is “to abandon those ‘at risk’ youth who might benefit from them,” which is a form of social injustice.156 Professor Dorothy Scott argues that this group’s level of vulnerability requires the community to “own the title ‘paternalism’ and to be a parent that both cares and controls. Otherwise it has become a laissez-faire permissive parent,” whose neglect damages children and young people.157

150. SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, p. 16.
154. DHS, When Care is Not Enough, p. 93.
Prior to the *Children Act 2001*, Ireland’s failure to provide secure accommodation for at-risk children (in some instances placing them in detention centres) sparked a series of legal cases around the issue of whether the state had breached its duty of care. Breen (2004) argues that Ireland’s failure to provide accommodation and care that was appropriate to need breached international conventions and its own constitutional obligations.¹⁵⁸ Several young adults with behavioural problems who argued they did not receive appropriate accommodation later sued for damages.¹⁵⁹

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**Question 9:**

*Is the state breaching its duty of care in not imposing restrictions on young people who put themselves at high risk?*

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### 3.5 Purpose

The purpose of safe keeping varies across Australian and international jurisdictions. In Victoria, safe keeping is not seen as a placement but as a service. It incorporates therapeutic services but these serve the primary purpose of stabilisation. In the ACT, the primary purpose of orders is placement-oriented therapeutic protection. This approach also underpins orders in Ireland and the UK.

Barber and Delfabbro (2004) conclude that residential care will continue to be a necessary option for children in out-of-home care who have multiple and complex needs, given the high coincidence of placement instability and the experience of early trauma and abuse. They argue, “therapeutic interventions involving the treatment of trauma, the establishment of better attachments and social functioning must therefore be emphasised in addition to interventions that seek to stabilise and control the behaviours leading to placement breakdown.”¹⁶⁰ A 1999 review of services in Victoria found that consistent and high quality care offers continuity of positive relationships for children and adolescents who suffered traumatic early environments but that “*care is not enough* to effectively address the aftermath” of early abuse (italics in original).¹⁶¹

Safe keeping can be viewed as a proactive or last resort service intervention. In the UK, both interpretations were evident in practice, with some orders sought in a proactive manner and others only after children and young people were cycled through other inappropriate placements. Often, ‘last resort’ is interpreted as an ‘end of the line’ or least appealing

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¹⁶¹. Government of Victoria, *When Care is Not Enough*.
service option rather than the best response to a presenting problem. This thinking was evident in the UK and also in Ireland. Ainsworth (2003) argues that the trend toward least intrusive responses has prejudiced thinking about therapeutic interventions in secure settings. He contrasts the situation in child welfare with that in the health and education sectors, noting that health and education offer services solely to provide care in as intensive and immediate a manner as client need and severity require. Society does not expect that children exhibiting complex, severe medical symptoms will receive specialist attention only as a ‘last resort,’ or that children with identified learning difficulties should receive generalist education services. In welfare practice, however, there is an entrenched aversion to proactive, intensive interventions. He argues that intensive interventions such as safe keeping should be seen as a viable, legitimate ‘first resort’ in some cases.162

Question 10:
If the legislation provides for safe keeping specifically as a ‘last resort’ what does this mean? What implications does this hold?

Question 11:
Should the purpose in South Australia be for therapeutic intervention in placement or stabilisation to commence therapeutic intervention?

3.6 Abuse of purpose
A relevant concern is whether orders will be used for their intended purpose.

Anglicare SA contends that it would be almost impossible to guard against “the future abuse of such legislation.”163 A 1983 Department for Community Welfare (SA) report found that safe keeping orders were used for matters of little threat to the community. Orders were used to punish so-called status offences, which were defined only vaguely and used disproportionately against females.164 In Ireland, mental health legislation defined the child or young person up to the age of 16 years – the absence of psychiatric placements and services for people aged between 16 and 18 years meant that some were placed inappropriately in special care units.165

The review by Robyn Layton QC acknowledged concerns that facilities could become ‘dumping grounds’ for young people, be used to solve housing needs or for mentally ill

163. Anglicare SA, “Notes for presentation to the Mulligan Inquiry.”
164. DCW, Difficult adolescent girls and safekeeping, p. 6.
165. SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, pp. 34-35.
young people when insufficient mental health services have been available. Layton acknowledged too that children might seek to be admitted and act out for that purpose, a concern highlighted in Victoria.166

Question 12:

What safeguards would be required to ensure safe keeping provisions were applied only for strictly defined purposes?

3.7 Eligibility

Which children and young people will be the subject of orders requires clarification. In some jurisdictions, such as Victoria and Ireland, legislation provides for children who are not already in state care to be placed into safe keeping. For example, the Irish legislation allows for a parent or guardian of a young person to request the HSE to make an application for a court order for special care. In Victoria about 25 per cent of admissions to SWS are of children and young people who are not under a custody or guardianship order.

Question 13:

What should the eligibility criteria be? At what age? And what circumstances, including whether safe keeping should apply to all children in South Australia who fit the profile or only to those already in care?

3.8 Legislation

Legislation establishes the rationale and function of safe keeping. It spells out the rights of the child or young person and the appropriate safeguards to protect those rights. Rule 12 of the UN Rules for the Protection of Juveniles Deprived of their Liberty (1990) states, “the deprivation of liberty should be effected in conditions and circumstances which ensure respect for the human rights of juveniles.”168 Article 25 of the UN Convention on the Rights of the Child (the Convention) states, “a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health” has the right of review of the treatment “and all other circumstances relevant to his or her placement.” Article 37 states that children deprived of liberty have the right to maintain contact with family, the right to gain access to legal assistance and the right to challenge the legality of the deprivation of liberty.

166. Layton, Our Best Investment, 13.8
167. Children Act, 2001 (Ire.), s. 23A(3).
Experience suggests that legislation must provide clear direction as to how orders are used. Considerations include:

- the authority to place (court or administrative);
- who can be placed (that is, all children who meet legislative criteria or limited to clients already under guardianship or custody orders);
- limitations on placement (for example, not for accommodation, limits on co-location with young offenders or mental health clients);
- criteria for placement (definition of need, requirement for use of alternatives);
- purpose of orders (protection, stabilisation, assessment, therapeutic care);
- length of orders and provision for extension / revocation;
- child / young person’s participation in decision to place;
- rights of review and complaint;
- Contact with family / others;
- monitoring of placement;
- service provision;
- monitoring / inspection of facilities.

Question 14:

If safe keeping orders are introduced, what should be legislated for to protect the rights of children? What is the minimum? What can be left for policy decisions?

3.9 Facilities and services

Design and location of facilities can affect the likelihood of absconding, therapeutic engagement and benefit, dignity and respect. Fulcher (2001) argues that the ways in which architectural design and the allocation of public and private living spaces in a facility contribute to the achievement of care outcomes is relevant in assessing quality of care.  

Issues to be considered include:

- level of security;
- the number of residents to be accommodated;
- co-location of young offenders, mental health and complex needs clients;
- composition of residents in terms of age, gender and needs;

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• provision of supervision and isolation;
• service proximity / availability;
• accommodation of residents who cannot engage with others, who have negative associations triggered by family-style settings, or who might reject an overtly “secure” setting;
• the need for respite and privacy as well as interaction.

A 1997 review of the Victorian model found, “there is little doubt that the management of up to 10 young people with a range of sometimes severe behaviours is highly problematic and limits the utility of placement for some young people.”170 In Ireland one review noted that units’ physical environment reinforced that young people were detained, which contributed to their sense of being punished though no offence had been committed.171 SWS units in Victoria were architecturally re-designed to enhance residents’ privacy and sense of well-being as well as their safety. This includes security that deters running away, but does not completely prevent it, so that residents do not escalate violent or self-harming behaviour to instigate their removal.

The deprivation of liberty for the purposes of addressing at-risk or high needs behaviour obliges the state to provide appropriate services.172 The UN Rules for the Protection of Juveniles Deprived of their Liberty (1990) argues for “the benefit of meaningful activities and programmes which would serve to promote and sustain their health and self-respect, to foster their sense of responsibility and encourage those attitudes and skills that will assist them in developing their potential as members of society.”173 A 1983 Department for Community Welfare (SA) report on safe keeping orders found that no therapeutic treatment was provided to children and young people on safe keeping.174 In England, Ireland and Victoria, service availability and quality emerged as inhibitors on orders’ usefulness. A review from Ireland highlighted the negative impact on children and young people who believe they are being detained to receive assistance only to find that assistance is not forthcoming.175

The type and duration of services that are attached to safe keeping orders should reflect legislative intent. Services are likely to address not only immediate need, but also the transition from the intensive secure environment. The Association of Children’s Welfare Agencies argues that programs must be well-managed and provide appropriate inputs.

SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, p. 50.
SRSB, Review of Admission Criteria and Processes for Special Care, p. 55.
Programs can be complex and expensive – “if they don’t work effectively, they can be quite damaging” to children and young people. A review of programs in secure care in South Australia linked effectiveness to: programs’ cultural, gender and age appropriateness; residents’ willingness to engage; trained and skilled staff; length of time (substance abuse programmes over 90 days’ duration and violence-related programmes longer one year).  

The importance of qualified, trained specialist staff to care for children and young people with complex needs is evident. Morton et al (1999) argue, “there is a high level of risk that treatment that is sub-optimal will have serious consequences for young people.” Along with skill, a clear philosophy and rationale to frame decision-making in safe keeping is needed, to minimise practice inconsistencies that result from workers’ differing perspectives or preferences. Fulcher (2001) observes that even in general residential care, “the value and knowledge base that informs practice … is dependent upon a particular carer or carers, and little is written down.” The needs of the profile group argue for staff-resident

Question 15:

What are ‘bottom-line’ features of a secure therapeutic facility?

Question 16:

How can we ensure or protect the right to good quality individualised services to young people while in secure care and on release?

3.10 Cost

Residential care generally costs more than foster placements and children with complex needs spend more time in residential care. In the UK, one study found that children with multiple, complex needs cost about three times more to look after than children who did not display high needs. However, one of the biggest contributors to the greater cost of care for children with multiple complex needs was moving children through a number of placements, with secure units used as the last resort. There was a strong ‘gate-keeping’ function for residential care and workers were required to explore all other placements. Another 2006 study of UK secure children’s homes found that alternative services to secure placements are often more expensive than secure placements.

177. DHS (Vic), When Care is Not Enough, p. 99.
180. Ward and Holmes, “Calculating the costs of local authority care for children with contrasting needs,” pp. 84, 86.
181. Department for Education and Skills (UK), The use by local authorities of secure children’s homes, p. 7.
Bath (2003) has noted that the current high cost of responding to a small number of high-needs young people has arisen partly because there is no programmatic response, but reactive “jerry rigged” arrangements.\textsuperscript{182} Ainsworth (2003) notes that the public accepts the high cost of intensive specialist medical and educational services but that there is not the same acceptance of specialist services for at risk young people.\textsuperscript{183}

Question 17:

What have we learnt about the financial costs of alternative care which provide us with lessons in establishing safe keeping services?

3.11 Effectiveness

The markers of a ‘successful’ intervention need to be identified and defined. In Ireland, for example, criteria include attachment formation, stabilising adverse behavioural patterns, instilling greater levels of emotional control, developing personal identity and social adjustment.\textsuperscript{184} In Victoria, it has been practice to use the client’s needs and presentation at admission as a baseline for measuring outcomes. In Victoria and Ireland, multiple re-admissions are accepted as appropriate if community services cannot meet a child or young person’s needs rather than being seen as proof of previous admissions having ‘failed.’

Outcomes research into treatment programs in residential settings have produced mixed findings, due largely to poor conceptual definition of what constitutes a ‘positive’ outcome as well as methodological problems (small samples and program variation)\textsuperscript{185}. Ainsworth’s survey (2001) of studies of residential treatment programs finds that studies have limitations, but indicate that residents achieve positive educational and relationship outcomes, could progress to less restrictive placements, report positive self-identification and engagement with treatment.\textsuperscript{186} Positive outcomes correlate to a standardised treatment regime, positive interactions with caregivers, individualised treatment plans, enforcement of a strict code of discipline, academic support and sound after care planning and service provision.\textsuperscript{187} Ainsworth concludes that “carefully planned and professionally managed” residential programs “have a place in the continuum of child and family services.”\textsuperscript{188}

\textsuperscript{182} Radio National, “High Risk Kids,” Background Briefing.
\textsuperscript{183} Ainsworth, “Social injustices for ‘at risk’ youth and their families,” p. 27.
\textsuperscript{184} SRSB, The Impact of Placement in Special Care Unit Settings on the Wellbeing of Young People and Their Families, pp. 76-80.
\textsuperscript{186} Ainsworth, “After Ideology: The effectiveness of residential programs for ‘at risk’ adolescents,” p. 17.
\textsuperscript{188} Ainsworth, “After Ideology: The effectiveness of residential programs for ‘at risk’ adolescents,” p. 17.
3.12 Monitoring

The need for robust, independent and rigorous monitoring of the circumstances of children emerges as an important theme in practice and theory. It has been argued that articulating children’s rights helps to “move children into the public realm … so that they are not at the mercy” of family carers. A similar sentiment can be applied to monitoring, which can ensure that those rights guaranteed by laws relating to safe keeping are enforced. Key areas include ensuring that orders are used according to legislative intent, that systems abuse does not occur, that rights to review and complaint are enforced and that facilities and services meet the needs of children and young people. In the UK, for example, the dearth of information about the use of restraint complicates systemic review. Systemic monitoring of agreed-upon outcomes allows for evaluation of policy.

Question 19:

What would a sound monitoring system look like?

Question 20:

What are the priorities for monitoring?

3.13 Review of decisions

Existing safe keeping models have mechanisms by which the decisions related to orders can be reviewed. Key issues include:

- which decisions are subject to review (decision / refusal to place, extension of order);
- who can initiate a review;
- who should review decisions (individual / panel);
- the independence of the reviewer (internal review / external body);
- levels of review available (internal and external);
- timeliness of the review process and outcomes;
- what actions should arise from reviews.

Question 21:

What are the ‘bottom-line’ elements for sound review of decisions?

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