Report on Therapeutic Residential Care

Report to the SA Child Protection Systems Royal Commission

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BACKGROUND

The South Australian Child Protection Systems Royal Commission has requested a report on the evidence and practice regarding the therapeutic use of residential care for children within the child protection system. The Royal Commission is particularly interested in establishing the practice parameters under which residential care can deliver therapeutic benefit to children. This report includes an overview of the published research in regard to residential care internationally. It will then provide a summary of emerging models of therapeutic residential care in Australia. The issues of interest to the Royal Commission that will be considered in this report include the following:

- The features of residential care placements for young people with complex needs that make it 'therapeutic' in nature

- The Royal Commission is interested in obtaining a description of 'therapeutic' residential care with particular reference to:

    - Workforce characteristics
    - Physical environment
    - Therapeutic model/framework
    - Specialist/multidisciplinary input
    - Case management
    - Behaviour management approaches.

This report will summarise the international literature and describe how therapeutic residential care is configured within Australia, with reference to the features outlined above.

THE PLACE OF RESIDENTIAL CARE IN AUSTRALIAN OUT OF HOME CARE

The Australian Institute for Health and Welfare (AIHW) distinguishes between home based care and residential care. According to the Australian Institute of Health and Welfare, residential care is defined as:

'Where placement is in a residential building whose purpose is to provide placements for children and where there are paid staff' (Australian Institute of Health and Welfare, 2014, p.46).

While the vast majority of children in out-of-home care are living in home based care (predominantly kinship or foster care), residential care continues to be provided for a minority of children with significant and concerning behavioural and mental health issues and for whom home based care is not deemed suitable (Australian Institute of Health and Welfare, 2014). Nationally, on average around 7.3% of all children in out-of-home care placements are in residential care.

In the last AIHW reporting period, South Australian use of residential care was slightly higher than the national average, with 12.7% of children requiring an out-of-home care placement being placed in residential care. In general, English-speaking countries tend to place only a relatively small proportion of their looked-after children in residential care compared with mainland European countries (e.g., 7% in Australia v. 54% in Germany; Hart et al., 2015).

Views about residential care tend to be highly polarised. According to some, residential care should be viewed as a 'last resort' and temporary service response. This argument is based on its suggested negative impact on children, and the lack of outcome data to demonstrate its effectiveness. Others argue for the potential positive role of well-planned and appropriately timed residential care (see Ainsworth & Hansen, 2015; Mercy Family Services, 2012; Knorth et al., 2008).

Numerous reviews have reported that residential care continues to be viewed as a 'placement of last resort' for difficult to serve children who have experienced multiple foster placement 'failures' and for whom no alternative placement can be found (Bath, 2008; Hillan 2006). This indicates that children in residential care are likely to be those who have the most complex needs. Indeed, several studies have demonstrated that children in residential care have high levels of psychiatric issues including

clinical levels of depression, disorders of conduct, and disordered attention (Meltzer et al., 2004; Ford et al., 2007). Children in Australian residential care have been described as engaging in high levels of violence and aggression (Ainsworth &Hansen, 2009; Bath 2008). It is not really clear, however, how much the behaviour of children in residential care reflects their mental health issues, the impact of removal and numerous placement moves and how much reflects the institutionalisation of their living environment. On the other hand, there can be a tendency to blame the residential care services per se for the difficulties these children present with and for perceived poor outcomes without taking into account the child's placement history and other factors (Bath, 2008). Unfortunately, relatively little evaluation data exists for residential care in all its forms, meaning that these arguments continue to be largely based in ideology rather than evidence (Hart et al., 2015; Knorth et al., 2008).

This report summarises the published research on residential care, and outlines the features of residential care models in Australia and elsewhere that appear important in optimising outcomes for children. The report also summarises the issues that should be considered in further developing Australian residential care services for children under guardianship.

WHAT IS RESIDENTIAL CARE?

Residential care is a broad term that is used internationally to include a range of residentially based treatment and accommodation services that are provided to young people with a range of needs (e.g., mental health, juvenile justice and child welfare needs). Clear distinctions between these services often don't exist, and it can be difficult to tell what proportion of children in these services are placed for reasons of statutory care, as opposed to being at risk, engaging in offending of some description or having serious mental health concerns (James, 2011). This often leads practitioners to talk about residential group care as a whole, as if all services were directly comparable, despite wide variations in the goals of placement, the target population, the length of stay, the level of restrictiveness and the rationale for treatment (Delfabbro et al., 2005; James, 2011).

For example, residential units may vary in size, and in the age and the 'mix' of clinical issues of children in the unit. There are also differences in the goals of the units across different countries and different services: whether

the stated goal is reunification with the biological family, subsequent placement with a foster family, offender rehabilitation, custodial care until independence; short term, emergency or more permanent care. Residential care can be offered by juvenile justice services, mental health or statutory care; each with different treatment models and goals. Similarly, staffing configurations, staff roles, and the professional backgrounds of residential staff can vary widely between services (e.g., whether specialist support is available on-site or is 'wrap-around'; whether staff are viewed as having a treatment or containment role; and the qualifications and number of staff in each unit). Aspects of the physical setting can also vary (e.g., whether the residential placement is in the community or an institution; whether it is offered in single unit or multiple dwellings; and the physical size of the unit). The therapeutic approach and management of the care environment also differs between models (Is behaviour managed through behavioural sanctions? How are safety issues addressed? Is there a 'therapeutic' orientation to care?).

Children placed in residential care facilities in other countries, particularly North America, can be placed for a range of reasons that include the treatment of mental health and offending behaviour. In Australia, the children that tend to be placed in residential facilities are those that already have experience of one or more previous out of home care placements, that may be older, and that cannot or do not wish to be placed in foster care (although children in South Australian residential care facilities are younger than the national average (Australian Institute of Health and Welfare, 2014; Ainsworth & Hansen, 2009; 2015). This distinction is not absolute with a 'considerable proportion' of children in mental health or forensic residential care settings coming from the child welfare system (James, 2011, p.3). Therefore while there is some overlap between the population of children served by residential care here and internationally, there are also some differences that need to be kept in mind when drawing on international literature to inform the development of Australian residential care services. An overview of the major differences in the design and delivery of residential care services between Australian and international residential care models will be provided in the next section.

WHAT DOES THE INTERNATIONAL LITERATURE TELL US?

In Australia, the use of residential care differs from its use internationally in important aspects. Although the majority of research evidence in support of residential care comes from North America, where residential facilities are much more widely utilised, and can involve well developed treatment programs. In North America, in particular, the residential services that have been most evaluated have a mental health or forensic focus (therefore they are referred to as *residential treatment* models). The features of these programs are worth summarising, even though these programs serve a broader population of children, because they do offer some insight into therapeutic approaches for young people with complex needs. Before considering the research in relation to residential treatment programs, it is important to take note of the major differences between Australian residential care and these residential treatment care models on which most research evidence is available.

Residential Treatment Programs: In North America in particular, residential treatment tends to be delivered in larger facilities or clusters of satellite homes, supported by multidisciplinary or 'wrap around' services, and guided by a program of intervention. Generally speaking, the focus is on time limited intervention to address the needs of a reasonably well defined target group of children and aims to support both children and their biological family or wider supports. This contrasts with the majority of traditional and even therapeutic residential care in Australia.

The literature in relation to residential treatment programs is worth summarising as it is feasible that adopting some of the characteristics of residential treatment care models into current practice can considerably improve the potential for residential care to be used therapeutically. More specifically, considering programs that are responsive to children's needs (including not only trauma, but intellectual disability, mental health and offending behaviour); incorporating specialist or multi-disciplinary support; and exploring the potential for larger congregate care models, as opposed to the use of community houses, may help in developing a broader range of models for children in out-of-home care.

Residential Group Care: There is also a smaller body of literature that relates to models of 'group care' that are that are identified by the agencies that run them as being tailored to meeting the needs of children who have experienced trauma, abuse and removal from family of origin. On the whole, the evidence in support of these practice frameworks is relatively underdeveloped compared with youth mental health or forensic residential treatment programs. The literature is relevant to this report, however, since these models have been influential in shaping the nature of therapeutic residential care in this country. Perhaps unsurprisingly, these models all come from English speaking countries. Strictly speaking, the practice frameworks that will be discussed under this section are not really 'models of practice'; they are broad therapeutic frameworks that tend to address organisational culture as well as guiding individual practice. The following section will summarise what has been learned from international research and practice in relation to residential treatment programs and then in relation to residential group care practice frameworks.

RESIDENTIAL TREATMENT PROGRAMS: WHAT CAN THEY TELL US?

As indicated, the bulk of the published research on residential care for young people draws on outcomes research from international residential treatment programs (which tend to be delivered in larger facilities with a clear treatment or forensic focus). Several reviews of international residential care suggest that, on average, children do experience psychosocial gains following a period in residential care (e.g., Curry, 1991; Hart et al., 2015; Knorth et al., 2008).

Collectively, this literature suggests that the success of residential care for children is related to both the characteristics of the child's need and using interventions matched to clearly assessed need; to wider engagement with the child's support network and family; and to the provision of post-care support. An overview of these elements is provided below:

The service directly targets the child's needs:

Young people with externalising behaviour problems (e.g., antisocial behaviours, hyperactivity) appear to make more progress in residential treatment programs than young people with internalising problems (e.g., anxiety, social withdrawal) (Knorth et al., 2008),

suggesting that they might be more suited to the dynamics of residential care intervention. For young people involved in juvenile offending, there is support for providing specific skills training (e.g., empathy and social problem-solving), and for employing social learning/behavioural strategies and techniques in combination with family-focused therapy (Knorth et al., 2008). A child's developmental level, particularly their cognitive development and reflective capacity will determine how responsive they are likely to be to traditional counselling input (Stevens, 2004). Therefore it is important to take into consideration the child's developmental needs (Barth et al., 2009). For children with intellectual delays, for example, a highly structured program and positive behaviour support is likely to be beneficial (Cameron, 2014; McLean et al., 2011). In this case, helping staff to identify the purpose of challenging behaviours and replace these with functionally equivalent behaviours (i.e., positive behaviour support) is likely to be more effective than therapeutic techniques that rely on higher level cognitive skills (see Cameron, 2014). Other factors that influence children's outcomes include the type and severity of difficulties and how longstanding these are (Curry, 1991; Knorth et al., 2008).

In general, however, much more work needs to be done to determine 'what works for whom' in terms of matching need to services in residential care options (McDonald & Millen, 2012). It is unclear the extent to which residential care services in Australia offer programs or group interventions focussed on the kinds of skills described above. It is reasonable to assume that workers could benefit from training in providing structured programs, modelling and instruction in cognitive and social skills.

The service has capacity to work with child's wider network:

The long term effectiveness of residential care placement seems to be related to the service's capacity to engage more widely with the child's support network. From a service perspective, there is clear support for the inclusion of family-focused interventions for young people with severe behavioural problems (Knorth et al., 2008; Leichtman et al., 2001) and for the inclusion of other networks in the assessment, residential care and post-care support phases (Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005). Having residential care workers engage with family and community supports, rather

than having the family work being divorced from the program and left to case managers, is likely to be more effective (Hillan, 2006). Family support appears to be important, even if it is unlikely that the child will ever return to their biological family (Hart et al., 2015). Conceptually, this is often framed as an ecological model, embracing family and community involvement when possible (Bay Consulting, 2006; Hair, 2005). Additionally, the program should have active strategies for engaging with or developing the young person's educational, training and/or work experience network, because academic success and support are also related to positive outcomes (Curtis et al., 2001; Hair, 2005).

In general, more research is needed into the dynamics of family work for children in care. The extent to which family connections are encouraged in Australian residential care is unclear; there are likely to be special challenges in working with abusive or neglectful family members. The parameters and facilitators of family contact for children in care is an area of research that is currently being explored in other jurisdictions by the Institute of Child Protection, at Australian Catholic University. The facilitation of family contact is likely to be an area of professional development that could be of benefit to residential care workers, but which will require clear practice guidance around the conditions for such contact.

The service offers continuing post-care support for the young person:

The available evidence seems to suggest that the impact of any residential program may be time limited unless appropriate ongoing support is provided. The evidence suggests that the short-term gains that children make during residential care may be greater than long-term gains (Knorth et al, 2008; Leichtman et al., 2001). Although most young people improve during their stay in residential care, this improvement does not appear to be a good predictor of long-term outcomes when they return to the community (Leichtman et al., 2001). It seems that purposeful and ongoing post-care support is essential (Curry, 1991; Knorth et al., 2008). Facilitating post-care support will require designing creative ways that children and families keeping in contact with unit staff in order to continue to benefit from professional and informal supports.

This is likely to be a significant practice challenge for the residential care workforce. The extent to which relationships with young people are maintained post care in Australian residential care is unclear and it is likely that workers will benefit from organisational support and practice guidance around the conditions under which ongoing support is offered. Post-care support is a key element of the next three year action plan for the National Framework for Protecting Australia's Children. It is hoped that this policy reform will support a national focus on this important area.

In summary, the body of literature on residential treatment care programs appears to support a range of interventions and program elements that can be effective, provided they are aligned to the child's need. These include behaviour modification, family focused interventions, and specific skills training tailored to the child's developmental level (e.g., social skills, assertiveness training, self-control/self-instruction training, anger management) (Knorth et al., 2008; McLean et al., 2011; Stevens, 2004).

RESIDENTIAL GROUP CARE MODELS: WHAT CAN THEY TELL US?

In addition to the much larger body of evidence derived from residential treatment models there is also a small body of international literature on residential group homes and the frameworks for guiding practice that have been adopted in these group homes for children in out-of-home care.

The principal models used internationally include the CARE model (Holden et al., 2010) and the Sanctuary® model (Bloom, 2003). These models in particular have also been influential in shaping the practice and policy landscape in relation to therapeutic residential care in Australia. They are summarised below:

Children and Residential Experiences (CARE) model:

The CARE model was devised over 10 years ago in a collaboration between researchers at Cornell University and a large US child welfare organisation, with a view to developing a competency-based curriculum for residential care workers. The competencies that were identified and that form the basis of the model were derived from consultation with a large group of residential care staff. The CARE

practice framework focuses on both organisational competencies and on developing consistency within and between team members in the way that they understand and respond to children (Holden et al., 2010; McDonald & Millen, 2012). Ideologically, the model aims to strengthen children's attachments, build competencies, involve families in children's care, enrich children's environments and enable staff to adjust their expectations of children to take into account children's developmental stage and their experience of trauma (McDonald & Millen, 2012). Accordingly, the model has six guiding principles (Holden et al., 2010):

1 It is developmentally focused. The training curriculum supports workers in choosing activities that can facilitate children's normal development; development that may be delayed as a result of traumatic experiences. The model teaches staff to appropriately select tasks that are difficult, but achievable with assistance; thereby constantly extending the child's development. Staff teach children skills that they may be missing, and adapt the environment so that children can experience success.

2 The child's family is involved. The model views children's identity as inextricably tied to their family; the model advocates that the involvement of a parent or other significant adult is critical to planning for the child's life after care (Holden et al., 2010; Mc Donald & Millen, 2012).

3. The model is relationship based. The model maintains that nurturing care experiences are necessary for children to be able to form meaningful relationships. Positive relationships between children and staff are encouraged as they enable children to feel safe, to learn to trust, and learn interpersonal skills and problem solving skills from staff.

4. The model is competency centred. Staff are encouraged to help children to learn skills, and develop the knowledge and positive attitude needed to master the challenges of everyday life. Their role is to help children to become more competent at managing both their environment and in learning new skills.

5. The model is trauma informed. One of the main foci of the CARE model is a focus on the creation of a safe, non-violent culture that supports children to overcome the effect of trauma. Emphasis is

placed on staff learning about the pervasive impact of trauma on all aspects of children's social relations, activities and expectations.

6. The model is ecologically oriented. The model places emphasis on the broader environment: provision of a caring and nurturing environment can provide children opportunities to participate in the range of activities and relationships that are on offer (Holden et al., 2010; McDonald & Millen, 2012).

By engaging staff at all levels of the agency in intensive training around the above six principles, all of which are based on child development research, the authors suggest that services can consistently create the conditions for improving children's social and emotional wellbeing. (Holden et al, 2010).

Much of the support for the CARE model is embedded in grey literature where the 'evidence' cannot be critically evaluated (e.g., Cameron, 2014). The only published research that appears to exist in relation to the CARE model comes from a survey that was completed at the time that the CARE model was implemented in one jurisdiction in the US (Holden et al., 2010). The author's evaluation of the program indicated that staff training resulted in improved knowledge and that they found the training useful and motivating. Workers' intentions to modify their practice as a result of training was also assessed using Likert survey items (behavioural response before training was compared with intended response post-training). Training resulted in significant changes in the way staff intended to respond to behavioural incidences in the future. The strengths of the CARE model are that it provides an evidence-based theory of change and a manualised training program. The limitations are that there is only limited evaluation evidence, that has been conducted by the research group that designed the program, and that relies on staff reports of their intentions, rather than actual observations of the way that staff react to children's behaviour.

The Sanctuary Model®:

The Sanctuary® model, originating from the Andrus Children's Centre in New York, is a systems-level approach that targets staff in the entire organisation (in this way it is similar to the CARE model). The Sanctuary® model was originally developed in an acute inpatient adult psychiatric setting for adults who had been traumatised as children (Abramowitz & Bloom, 2003; Bloom, 1997,

2000, 2003; McDonald & Millen, 2012). It has since been adapted for a wide variety of settings such as youth justice, domestic violence shelters, substance-abuse treatment centres and schools, as well as residential treatment settings for children (Bloom, 2005). It is included in this report because it has been extremely influential in shaping the emerging model of therapeutic residential care here in Australia.

The principal goal of the Sanctuary® model is to create a trauma-informed and sensitive organisational environment within which specific trauma-focused interventions can be carried out. The creation of a trauma-informed work environment supports staff to process and address children's needs that are seen as arising out of a traumatic background. Within this trauma-informed culture, the model uses a 12-week recurring program of weekly psycho-education and skills development. Recovery from trauma is conceptualised as occurring in four stages that focus on Safety, Emotional Management, Loss, and Future (SELF). Using this trauma recovery framework together with teaching cognitive behavioural skills, helps young people develop more adaptive coping and self-regulation strategies. A core assumption underpinning the model is that young people have experienced trauma of some form (broadly defined – including maltreatment, attachment disruption and abuse). The program also engages family members wherever possible. It is important to note that although Sanctuary® explicitly teaches coping skills; is not a model of therapeutic intervention *per se,* but rather a systemic approach to creating a consistent organisation climate that supports recovery from trauma.

The core elements of the model include the development of a culture of: non-violence (achieved by staff teaching and modelling safety skills); emotional intelligence (achieved by staff teaching and modelling affect regulation/management skills); inquiry and social learning; shared governance (achieved by staff teaching and modelling self-discipline and appropriate use of authority); open communication (achieved by staff teaching and modelling healthy interactions and boundaries); social responsibility (achieved by fostering social connections and healthy attachments); and growth and change (achieved by maintaining focus on hope, meaning and purpose). The culture is supported by all staff members (including administrative staff) being trained and working with the understanding of this model. Like the CARE model, the implementation of the Sanctuary® model requires a commitment

from managers and senior staff. Staff meet twice daily to provide structure to their therapeutic community in the home and to reinforce desired social norms in the residential facility. Collaborative problem solving and learning is encouraged between staff: the shared 'trauma-informed' framework and common language that both staff and children are taught facilitates this.

Despite the influence of the Sanctuary® model on group care, it has only been subject to extremely limited evaluation. Indeed, program reports and other grey literature suggest it has been widely adopted in a range of client populations (Cameron, 2014; Department for Child Protection, 2011, 2012). In one quasi-experimental study young people who had undertaken programs based on the Sanctuary® model were compared with a non-randomised control group (residential treatment as usual). In this study, young people who undertook programs based on the Sanctuary® model demonstrated improvements in the areas of interpersonal conflict, personal control, verbal aggression and problem-solving skills, when compared with the control group (Rivard et al., 2005). Measures of 'therapeutic culture' at six-month follow-up also picked up changes on dimensions of the organisational environment that are considered essential to a trauma-sensitive culture (see also James, 2011; McLean et al., 2011; McDonald & Millen, 2012 for reviews of this model).

At this stage, therefore, there is little evidence to support either the CARE or the Sanctuary® model, or to distinguish between the relative effectiveness of these models. In the absence of clear evidence, it is feasible that having a clear model of practice is as important as the type of model that is adopted by a service (McDonald & Millen, 2012; McLean et al., 2011), but more research is needed to answer this question The evaluations that have been conducted have lacked client input, important contextual information (about clients, staffing etc), adequate control groups, and longer term outcome data, and have been driven by the model's developers. In order to get a clearer idea of 'what works for whom' (Hart et al., 2015; McDonald & Millen, 2012), any commissioning of these models could be accompanied by independent evaluation, given the expense involved and the vulnerability of the young people in question (Hillan, 2006).

Whether formally adopted or not, both the CARE model and the Sanctuary® Model have been influential in shaping emerging models of

therapeutic care in Australia. Strictly speaking, organisations wishing to formally adopt these models must commit to training and an implementation period that can take several years (McDonald & Millen, 2012). Perhaps because of this, many services appear to adopt the ethos of the models, but not necessarily the full implementation and associated training. The common features of these models are summarised as follows:

- Both models address organisational culture and advocate agency wide changes in knowledge, attitudes and behaviour towards children. Both CARE and Sanctuary® models have in common a focus on all staff developing the same understanding about children's development.
- In both models there is recognition that children in residential facilities have suffered a wide range of traumatic experiences and disadvantage. There is emphasis on staff understanding and responding to the reasons behind behaviour, rather than simply responding to behaviour (Holden et al., 2010; McDonald & Millen, 2012).
- Both models focus on the development of appropriate competencies (e.g., coping skills, emotional regulation, psycho-education about trauma) that are delivered at a level that is appropriate for children's current development. There is a recognition that staff and children need techniques for being aware of, and regulating, their responses to stressful situations and reminders of trauma (Holden et al., 2010; McDonald & Millen, 2012).
- While neither model specifies the qualifications of the staff administering the program; both models offer extensive staff training in order to develop a common and agency-wide language for understanding children's difficulties. Both models support a case management model that requires staff to work with the child's wider environment (schools, family, community) (McDonald &Millen, 2012; McLean et al., 2011).
- Neither model specifies the characteristics or structure of the physical environment, although the Sanctuary® model places emphasis on regular group meetings and has been most commonly administered in larger facilities. There is an emphasis on therapeutic culture and relationships, rather than the physical environment *per se*.

In the following section, the emerging Australian practice of delivering purposeful and therapeutic residential care will be described. Most (if not all) Australian therapeutic residential care service providers appear to

draw on therapeutic frameworks described in the previous section (i.e., most services appear to draw on CARE or Sanctuary®), or some derivation of these models. The remainder of this report will describe relevant parameters of therapeutic residential care in Australia, including the context for its development, the policy that supports its use, relevant practice and staffing guidelines, and other features that characterise current practice in therapeutic residential care. The evidence in support of the emerging therapeutic care model and the limitations to knowledge about this form of care will also be outlined.

THERAPEUTIC RESIDENTIAL CARE: WHAT IT IS AND HOW IT IS USED

While therapeutic residential care has not been uniformly adopted as standard practice for children in residential placements in Australia, there is information to suggest that it is rapidly becoming a popular model of service delivery. Exactly how many of the services ensure the delivery of therapeutic care remains unclear. In one jurisdiction in which the use of therapeutic residential care has been evaluated, however, it has been judged as a viable and cost effective alternative to standard residential care for troubled children (Verso Consulting, 2011; Victorian Auditor-General, 2014).

Therapeutic residential care is not offered across all jurisdictions, nor has it been routinely adopted in South Australian residential care (McLean, et al., 2011). Although information is limited, it appears that the majority of residential care in South Australia and in other jurisdictions, is still 'standard' in nature, that is, delivered without additional or specialist support or exceptional staffing configurations.

DEFINITION OF THERAPEUTIC RESIDENTIAL CARE

The publication of the first Australian research paper on therapeutic residential care, entitled *'Therapeutic Residential Care: Taking Stock and Looking Forward',* was a significant development in this emerging field of practice. This paper, published by the Australian Institute of Family Studies, was based on the proceedings of the inaugural Therapeutic Residential Care Forum, held in 2010 (see McLean et al., 2011). It appears that the use of therapeutic residential care has grown considerably since this publication, which contained a 'snapshot' of practice at that time. This paper also contained a definition of therapeutic residential care, that continues to inform practice, and which states that it is:

> *'... intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and developmental needs.'*

(National Therapeutic Residential Care Working Group; in McLean, et al., 2011).

This definition, created by practitioners, contains important components that have been influential in shaping practice ideology in therapeutic residential care. This definition placed emphasis on several aspects of care, most notably the importance of: 1) safe relationship as central to healing; 2) employing a trauma-informed framework, and 3) offering a time-limited service that works towards a less intensive placement.

First, this definition places healing and safe relationships with workers at the centre of therapeutic residential care practice. This reflects an ideology that preferences relationship, life space work and intentional therapeutic conversations *with* young people over 'interventions' that are done *to* young people. Life space work and daily care (care work) are seen as naturally occurring opportunities for young people to experience healing relationships. How to practice 'therapeutically' in relationship with young people, however, has not been well articulated, leaving much to be interpreted by those who are in direct daily contact with the young people in care (Verso Consulting, 2011).

Second, the definition specifies that knowledge of trauma and attachment should inform the service's therapeutic framework. There appears to be a universal recognition amongst services offering therapeutic residential care of the importance of using trauma and attachment based approaches and of developing practice frameworks that support these approaches.

Finally, this definition highlights the time limited nature of residential care; reflecting an ideology that residential care should be a short term step towards placement in a less restrictive setting. This aspect of the definition has been questioned by some (e.g., Ainsworth & Hansen, 2015) because in reality the period spent by most children in therapeutic residential care in Australia appears to be quite lengthy (e.g., reported average stay of between 18-30 months in two Victorian services; Ainsworth & Hansen, 2015).

This paper also proposed the 'core components' of what was at that time an emerging model of service delivery. These included, amongst others, ensuring that any service provided to young people in residential settings:

- has a clearly articulated model of practice
- prioritises the placement of children and young people with complex needs who are able to benefit from the trauma-informed therapeutic approach
- has a child-focused program structure
- provides a therapeutic environment
- has a trauma-based orientation to program design
- administers individualised therapeutic plans based on best available evidence
- involves participation of young people in shaping their care
- engages with young person's family, community and culture
- supports young people to exit care and plans for post-care support
- employs an evaluation and feedback framework to support the delivery of high quality and evidence based practice.

(Source: adapted from McLean et al., 2011).

The authors also included examples of how each of these core components could be enacted in practice. The authors did not suggest which of these elements were more important, due to the lack of available evidence. The need to design programs in response to a clear assessment of children's needs, to engage with the child's wider family, social and community supports, and to ensure adequate post-care support was emphasised throughout the body of the paper (McLean, et al., 2011). Although the

development of a means of evaluating residential care was recommended by these authors, this has yet to be been achieved by the sector. Purposeful partnering with independent or university-based researchers and evaluators could improve the ability of out-of-home care services to determine what works in residential care.

This paper also summarised the results of a 'snapshot' survey of care providers in several jurisdictions, conducted by the Australian Institute of Family Studies, to establish the types of therapeutic approaches that were being used and the population of children being cared for in these therapeutic placements (McLean, et al., 2011). Responses from different jurisdictions were collated and summarised so that individual jurisdictions were not identified. In this survey, children and young people in therapeutic residential care were consistently described as having a history of abuse and neglect, and trauma caused by these events; this history was viewed as a pervasive backdrop to current behavioural challenges. Services offering therapeutic residential care described the children they cared for as experiencing a significant history of:

- recurring and often severe self-harming behaviours, including suicide attempts;
- a history of running away and prolonged absences;
- multiple placement disruptions due to behaviour;
- sexually inappropriate behaviours;
- mental health problems;
- antisocial behaviours, including violence and aggression towards others;
- alcohol and substance abuse;
- cruelty to animals; and
- developmental delays or disabilities.

(Source: McLean et al., 2011).

Service providers indicated that what differentiates young people in therapeutic residential care from other forms of care is that problems normally occur with significant frequency and affect day-to-day functioning in a highly adverse manner. Services described a history of unsuccessful attempts to manage difficulties and behaviours, which points to the need for a more holistic, structured therapeutic approach to children's needs.

Some therapeutic residential care services achieved specialist input by having clinical specialists working full or part time alongside other trained staff. Others defined therapeutic input in terms of having all staff trained in

trauma-informed care (McLean et al., 2011). Some jurisdictions at that time reported providing staff induction training in trauma-informed care and offering access to ongoing training in areas such as child development, brain development and the effects of trauma, and therapeutic crisis intervention. The training requirements of other jurisdictions were slightly more extensive, with workers in therapeutic residential care homes being required to participate in an initial two-day introductory training, followed by a five-day training program that is specific to the facility in which they work. This therapeutically oriented training was additional to standard employment pre-requisites in that jurisdiction. Services indicated that offering training to staff had led to positive behavioural changes in children and young people. Well-articulated case plans were identified as one of the most promising practice elements.

Some of the challenges noted by service agencies in this paper were the difficulty in obtaining consistency across multiple government and non-government agencies involved in the provision of therapeutic residential care. Some noted that difficulties in recruiting and retaining staff and in setting realistic expectations for staff regarding what could be achieved by using a therapeutic approach (see McLean et al., 2011).

Most services stated that their practice was informed by attachment theory, trauma theory, the neurobiology of attachment and trauma, and the concept of resilience. Many of the jurisdictions explicitly noted that their programs were underpinned by these theories and concepts. The concept of organisational congruence (consistency in approach) was seen as important (Anglin, 2002). Some jurisdictions reported adopting the Sanctuary® model of care (Bloom, 2005).

Since that time, there appears to have been an increase in the use of therapeutic residential care service provision across Australian jurisdictions. Recent information suggests that the Sanctuary model continues to be influential, particularly in Western Australia and New South Wales (Urquhart, R., & Foote,W. (2015). It appears that only one significant evaluation of therapeutic residential care has been published, which was commissioned by the Victorian Government and compared a range of Victorian therapeutic and standard residential care services (Verso Consulting, 2011). This will be described in detail below. In general, however, research and evaluation on this form of service provision has largely been ignored, despite recommendations to prioritise the evaluation of this model (McLean et al., 2011).

Since the inaugural Therapeutic Residential Care Forum in 2010, interest in therapeutic residential care has continued to grow and the number of services offering therapeutic care across Australia appears to have expanded (National Therapeutic Residential Care (NTRC) Forum, personal communication). As a result of this, some jurisdictions have developed policy or practice documents that outline the requirements and practices in relation to therapeutic residential care. Publically available information is limited to that published on the websites of service providers or statutory agencies, rather than in peer reviewed journals.

The most notable developments have been made in Victoria, which has clearly specified and described the training, and the configuration of service elements required by agencies that wish to be commissioned to provide therapeutic care. Policy or practice documents related to therapeutic residential care have been produced by the Governments of Western Australia, Queensland, and Victoria. It appears that some non-government organisations in other jurisdictions also employ 'therapeutic workers' (e.g., South Australia, Northern Territory, Tasmania), but no publically available information was found on the respective government websites that indicated whether or not therapeutic residential care was mandatory in those jurisdictions. The documentation and policy in relation to therapeutic residential care from Western Australia, Queensland and Victoria is summarised below:

Western Australia: The Department for Child Protection and Family Support (DCPFS) in Western Australia now stipulates that all residential care services must offer a '…coherent therapeutic approach to care and more importantly … a model for organisational change within the facilities' (Department for Child Protection, 2012, p2.). According to the Department's 'Sanctuary Framework' document (Department for Child Protection, 2012), the Department's decision to mandate a therapeutic approach to residential care has been accompanied by a devolving of larger hostel accommodation into smaller (four bedroom) houses, located throughout the metropolitan area and major country areas (with some 6-8 bed houses in rural areas). The Department has also outsourced some provision to the non-government sector. The Department's practice manual

for residential care states that all services and family group homes should practice in a manner consistent with the Sanctuary® model of care (Department for Child Protection, 2012, p.3-5). It further specifies a referral and exit pathway that articulates that placement in residential care is considered when no other option can be determined for the child (Department for Child Protection, 2009, 2012, p.25). The practice manual describes the role of specialist input. A residential facility must have a psychologist and education officer who will contribute their respective expertise to the therapeutic milieu and the child's psychological and educational needs. The psychologist is placed at the residential facility and adopts a 'hands on' approach (Department for Child Protection, 2011, p. 33). This document also specifies the allocation of a key worker for each child in residential care. The key worker is required to liaise with the child's case manager, and other unit staff to ensure that children's needs are addressed. Unit managers are required to report monthly to the Director of Residential care. The document also emphasises regular meetings of the residents, regular supervision of staff, and active case planning processes. It also articulates practices in relation to the therapeutic use of physical restraint and crisis intervention. No information was available in these documents on the criteria for employment or the staffing ratios in residential care homes.

Further Information:

Department for Child Protection (2009). *Department for Child Protection Residential Care Conceptual and Operational Framework.* Perth: Government of Western Australia.

Department for Child Protection (2011). *Residential Care Practice Manual: Residential Group Homes, Family Group Homes.* Perth: Government of Western Australia.

Department for Child Protection (2012). *Residential Care (Sanctuary) Framework.* Perth: Government of Western Australia.

Queensland: Queensland also appears to have several non-government service providers that are offering therapeutic residential care services across the state. In 2010/2011 the statutory child welfare department (Department of Communities; Child Safety and Disability Services) collaborated with the peak advocacy body for non-government community organisations (PeakCare Queensland) to develop guidelines for the delivery of therapeutic residential services in that state. A lengthy consultation process was held in conjunction with a literature review, which has led to the development of Queensland's 'Contemporary Model of Residential Care' (Department of Communities, 2010).

A set of core elements emerged from this process. The consultation process identified that the implementation of these core elements was central to making a significant difference to the quality of lives for children and young people in residential care in Queensland. These core elements were adopted as the foundations of Queensland's contemporary Model of Residential Care, and were published to provide direction to service providers.

The core elements of Queensland's Model of Residential Care were listed as:

- a clear child-focused system with a focus on creating nurturing and healing care for traumatised young people, responsive to the assessed needs of children
- ensuring participation of young people in shaping their care and futures
- comprehensive assessment and clear transition planning, informing placement and interventions
- prioritising of family connection, engagement and healing, and sustained meaningful relationships
- participation by young people in normal ways, in their communities
- skilled, trained and supported care staff including supervision and sound agency governance
- support for kinship, cultural and community connections and placements — for children and young and children who are Indigenous and from culturally and linguistically diverse backgrounds — including trained and skilled staff

- access to required therapeutic supports for all children and young people
- education considered for each young person to ensure adequate levels of literacy and numeracy and an improvement in successful learning
- support extending to post-care lives of young people
- improved relationships across the sector, including mechanisms to enhance understanding and coordination
- an evaluation framework to support the development of understanding of how best to make a difference for young people moving through residential care.

This document in turn led to the publication of the Department's policy in relation to the use of therapeutic residential care. The Department's policy document on therapeutic residential care specifies that therapeutic residential care be provided by non-government organisations, and be

> *'… a placement and support model in which children and young people with complex and extreme support needs are provided with intensive therapeutic care, in a therapeutic living environment, to facilitate recovery from the impacts of physical, psychological and emotional trauma resulting from their experiences of harm or risk of harm.' (Department of Communities, Child Safety and Disability Services, 2013 p.1).*

The Department's policy document further specifies that placement decisions will be made by the Department, in close collaboration with non-government service providers; and that placement in therapeutic residential care can be made for up to 18 months and should occur as a result of consideration of children's needs and wishes. The Department retains responsibility for placement decisions and ongoing case-management, although the policy document emphasises partnership between the Department, the therapeutic residential care service providers, and health and education departments. Therapeutic plans are required to draw on specialist clinical oversight and support from Evolve Interagency services. Evolve provides training for therapeutic residential care staff, represents young people in clinical discussions and directs the behaviour support services to therapeutic residential care houses. The policy document further specifies that actions must be undertaken to

maintain positive family relationships, individual rights, and cultural and ethnic values.

Further Information:

Department of Communities (2010): Queensland's Model of Residential Care: State-wide Consultation and Literature Review. Brisbane: Department of Communities and PeakCare Queensland.

Department of Communities, Child Safety and Disability Services (2013). Policy: Therapeutic Residential Care(Policy CPD577-3). Brisbane: Department of Communities, Child Safety and Disability Services.

Victoria: The role and nature of therapeutic residential care is most well elaborated in Victorian policy and practice documents (see Department of Health and Human Services, 2015). Victoria has a well-developed and specialised non-government sector that has long standing working relationships with the Victorian statutory welfare authority (Department of Human Services). This long standing working relationship has resulted in a productive collaboration of Government and non-government sectors in the development and commissioning of services for children in care.

The Victorian Government has also taking the step of commissioning an evaluation of the effectiveness and cost-effectiveness of their residential care services for young people in out-of-home care (Verso Consulting, 2011; Victorian Auditor-General, 2014). Both of these evaluations have supported the cost-effectiveness of therapeutic placements, and as a result the Victorian Government has invested in therapeutic residential care as a viable option for children with high and complex needs (see Victorian Auditor-General's Office, 2014, for details of these costings).

Therapeutic residential care has been in place in Victoria since 2008 and can be provided for children with intermediate or complex needs (Department of Health and Human Services, 2015). The majority of residential care placements in Victoria are managed by the larger non-

government agencies; these agencies also provide case-management for young people who access their services. The Department's documents specify that therapeutic residential care placements will attract an additional funding component of $71,500 in order to comply with the Department's requirements for therapeutic care service providers. These requirements include: 1) the employment of one 0.5 therapeutic specialist per unit; 2) the employment of two additional residential staff, and 3) the provision of a stand up night staff member.

The Victorian Government has published comprehensive guidelines that clearly articulate practice expectations for those services offering therapeutic care in Victoria (see Department of Health and Human Services, 2015). This document details the service providers' obligations regarding provision of therapeutic care, organisational support, the nature of the casework model and staffing requirements.

The physical environment must be 'home-like' and personalised, with colour schemes that 'maximise peace and safety', and contain reflective spaces. The physical environment of the house cannot have a staff office or partitioned observation area (Department of Health and Human Services, 2015, p.23). Organisational commitments include an agency-wide commitment to training and working in a trauma-informed model of practice; and the adoption of a mechanism of accountability for the progress of young people. Staff are required to have, or be willing to undertake, minimum qualifications in Cert IV in Child Youth and Family Intervention (Residential and Out-of-Home Care) training; or have social work, youth work, or alcohol/other drugs training. In addition, all residential care staff working in therapeutic residential care houses must undertake the mandatory 'with care' training in trauma-informed work. The 'with care' training is funded by the Department under the Government's Residential Care Learning and Development Strategy and delivered by key non-government service providers, in collaboration with senior advisors from the Department of Human Services. The core training for workers in therapeutic care takes between 2-5 days, depending on previous experience with the delivery of therapeutic care. See http://www.cfecfw.asn.au/learn/residential-care-learning-and-development-strategy for more detail.

The Department of Human Service's documents also clearly specify the role of the therapeutic specialist. The therapeutic specialist provides assessments and therapeutic plans for children in addition to providing support for staff in relation to maintaining therapeutic responses to children during their stay in the residential facility. In Victoria, therapeutic specialists are sub-contracted positions; this is a funding arrangement that allows experienced and specialised support staff to be 'purchased' from agencies that have expertise in the provision of therapeutic care (in Victoria therapeutic specialists generally belong to one of two major non-government organisations with acknowledged expertise in out-of-home care service provision). Each child's therapeutic plan outlines the nature of partnership arrangements between the therapeutic service provider and other services (mental health and drug and alcohol services, health and education, training and employment services). Strong links are required to be maintained between Department caseworkers and non-government agency caseworkers. Referral to a therapeutic placement is initiated through a panel process, involving a non–government agency manager, therapeutic specialists, Department placement coordinators, department child protection manager and representatives from Aboriginal Community Service organisations as relevant.

Further Information:

Commission for Children and Young People (2013). *Residential Care Matters: A Resource for Residential Care Workers.* Melbourne: Victorian Government and Commission for Children and Young People.

Department of Health and Human Services (2015). *Program Requirements for the delivery of therapeutic residential care in Victoria*. Melbourne: State Government of Victoria.

The Residential Care Learning and Development Strategy (n.d.) See: http://www.cfecfw.asn.au/learn/residential-care-learning-and-development-strategy

HOW EFFECTIVE IS THERAPEUTIC RESIDENTIAL CARE?

The Victorian Government commissioned an independent consultant to conduct a review of therapeutic care pilot sites in Victoria (Verso Consulting, 2011). A strength of this evaluation is that it appears to be the only evaluation of therapeutic residential care that has attempted to establish whether or not investment in therapeutic, as opposed to traditional, residential care is warranted. The aim of this evaluation was to provide 'proof of concept' and explore the evidence in favour of therapeutic residential care over traditional residential placement.

In this evaluation, the progress of young people placed in any of the state's 12 therapeutic homes was assessed in comparison to those placed in comparable, but traditional, residential units. The evaluation team used brief, well-known measures of mental health to track young people's progress over a period of approximately 30 months. Overall, the study compared the pooled data from both therapeutic and standard residential care units, all run by a range of non-government providers.

Although there were operational differences in the therapeutic residential care homes that were evaluated, they were all required to conform to the Department's guidelines regarding therapeutic residential care provision. The evaluation also included interviews with workers and children aimed at capturing important information about what appeared effective and about the experience of care. This evaluation suggested that the presence of a therapeutic specialist and increased staffing associated with therapeutic houses were important factors in enabling quality relationship with young people. They also noted the significance of the training received by staff at therapeutic units, as opposed to traditional residential units. Ninety percent of the staff and management in the therapeutic houses had participated in specially designed training programs delivered by a large non-government organisation. This training was a pre-requisite to the employment at a therapeutic house.

The Verso report concluded that placement in a therapeutic care house was associated with improved placement stability within the residential home (average length of stay of 30 months compared with average of 7 months in

previous placement). In addition, children in therapeutic placements seemed to experience improved engagement with community compared to traditional residential care. Seventy-five percent of children placed in therapeutic residential care engaged in community recreation compared with 20% in the comparison group. Both risk taking and secure care admissions had gradually reduced over the time period of the evaluation for children in therapeutic placements. The children and young people in the therapeutic placements experienced considerable positive progress towards goals identified in case planning, when compared with traditional residential care clients (see Verso Consulting, 2011).

The cost analysis that formed part of this evaluation indicated that therapeutic residential placement costs an additional $65,000 per year than a traditional placement, but that this additional cost was likely to be justified when longer term outcomes were considered (Verso Consulting, 2011). Similarly, the Victorian Auditor-General (2014) report also concluded that therapeutic placements were cost effective and resulted in better outcomes, although it remained unclear what aspect of therapeutic homes contributed to improved outcomes (e.g., increased training or increased staffing levels, or other factors).

SUMMARY: THERAPEUTIC RESIDENTIAL CARE

This review has identified several models of therapeutic residential care operating in Australia and comparable countries overseas. There is some variability in staffing and practice supporting the operation of therapeutic residential care in different jurisdictions across Australia. The remainder of this document will summarise the key features that both current practice, and the available literature, suggest should be considered in implementing therapeutic residential care in South Australia.

Clear recruitment criteria, mandatory training requirements, and clear operating standards can create an environment which facilitates a common understanding of children's behaviour. In Victoria, the therapeutic residential care sector has been established for longer and the Department has well-developed criteria for the operation of therapeutic homes and for

the recruitment and training of staff. It is significant that the Department, as the commissioning organisation, has specified what training is required and has devolved case management and training responsibility to the non-government sector. It is significant that the non-government sector has been well-established in Victoria for a relatively long time (in comparison with other jurisdictions). Victoria is also supported by legislation that enables non-government workers to take on a casework role. This staffing model can offer the advantage of better aligning decision making and case planning responsibility with those agency workers that have the daily care of children. The Victorian government's recognition of the specialist skills of the non-government sector may also assist with the retention of residential care workforce. Previous reports have highlighted lack of opportunity to develop knowledge and skills; and a professional identity as contributors to poor staff retention (White et al., 2015). In other jurisdictions, the case management role appears to be retained by the relevant statutory Department.

The provision of therapeutic care in small houses has both potential benefits and disadvantages. To date, there has been a focus in offering therapeutic care in small houses and an emphasis on creating a 'normal' feel to homes, ensuring access to community and educational facilities, and basing facilities in the community. Currently, most therapeutic residential care is delivered in small houses which home between 2-6 young people, depending on the service. This is driven by an ideology that emphasises providing children with 'normal' living environments that do not look like institutional residences. This differs significantly from the larger forensic or mental health focused service models found elsewhere. While this kind of setting fosters a 'home like' environment, it has drawbacks in that may be more difficult to achieve the kind of staff oversight/monitoring that ensures high quality service provision and guards against adverse interactions between isolated staff and high needs children. Nonetheless, most, if not all, services that offer therapeutic residential care do so in small houses of up to 6 young people. There may be a role for larger facilities that can support multidisciplinary service delivery to special groups of children, such as those with intellectual disability, sexualised behaviour, problematic sexual behaviour, complex and aggressive behaviour, or large sibling groups. These groups appear to be disproportionately represented in

residential care, and there may be arguments against the use of smaller houses for these groups.

Therapeutic residential care services draw heavily on conceptual approaches such as the provision of 'trauma-informed care', and organisational congruence in care, but have not gone as far as operationalising these concepts to allow for oversight and quality assurance regarding the delivery of these aspects of care (i.e., How does one know that 'trauma-informed' care is being delivered? What does it look like and how is it measured? What staff attributes ensure it is used with integrity?). To date, the emphasis has been on understanding trauma and on the therapeutic nature of worker–child relationships, rather than developing additional program content that is tailored to this population of children. Increasing the specialist mental health input, whether by use of the therapeutic specialist, or other consultation models may be a cost effective means for further developing the therapeutic residential care model and broadening the range of services that can be provided to children within therapeutic residential care. While adopting a trauma informed approach may ensure that the needs of many children are addressed, other issues relevant to children in care (e.g., intellectual disability, sexual offending) may be better addressed by adopting some of the features of residential treatment models (such as structured behavioural analysis, skills training and empathy training programs).

In summary, across Australia, therapeutic residential care is informed by a recognition of trauma, addressed children's attachment relationships (e.g., see Department for Child Protection, 2012). The limited evaluations that have been completed to date indicate that although therapeutic care is more costly, it is potentially more cost effective when longer term outcomes are considered (see Verso Consulting, 2011; Victorian Auditor-General, 2014). Therapeutic residential care is a relatively new model of care, and there is scope to draw on the research implications of residential treatment models and to further develop and tailor this model to cater for the needs of specific groups that are over-represented in care, such as children with disability, children displaying problem sexualised behaviour, and larger sibling groups.

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