Evaluation of the Therapeutic Residential Care Pilot Programs

Final Summary & Technical Report

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Acknowledgements

Verso Consulting would like to acknowledge that this evaluation relates to country for which the members and elders of a number of Indigenous communities and their forebears have been custodians for many centuries, and on which Indigenous people have performed age old ceremonies of celebration, initiation and renewal. We acknowledge their living culture and their unique role in the life of this state.

Verso Consulting would like to acknowledge members of the Therapeutic Residential Care (TRC) Evaluation Project Reference Group and thank them for their time and assistance in this evaluation.

Verso Consulting would also like to thank all the people consulted who gave their time and provided us with information regarding the development, implementation, outcomes and quality improvements within the Therapeutic Residential Care (TRC) Pilots. We would especially like to thank the children and young people living in TRCs who described their unique experiences and shared their feeling with us.

About the contributors

Mollie Sullivan

As project Director Mollie Sullivan provided primary quality control over the project and contributed to discrete portions of the evaluation.

Doug Faircloth

Doug Faircloth, TRC Pilot Evaluation Project Leader. Doug led the evaluation team, coordinating and participating in all phases of the qualitative research. Doug worked with Dr Brann to interpret the quantitative data collected, and to review it in the context of the qualitative information. Doug maintained primary authorship of all sections of the report other than the literature review, cost and benefit analysis and client outcomes where he collaborated.

Jodie McNair

Jodie McNair is the Project Coordinator, and as such has been involved throughout the data collection and analysis, and the interpretation and report writing processes.

Donna Southern

Donna Southern was the primary author of the literature review and prepared the costs, costs avoided and benefit report, while also playing an important role in consultation activities, including the Workforce Survey and Workshops. Donna also contributed to framing the Final Report.

Dr Peter Brann

Dr Brann played a key role in tool identification/development for the Evaluation, as well as training Therapeutic Specialists in the application of the tools, providing ongoing support in the use of the tools, and in the analysis of the data collected.

Dr Brann prepared the figures and tables in this report from a comprehensive data base populated by the data gathering tools completed by the Community Service Organisations conducting the Pilots.

Lis Starbuck

Lis Starbuck has provided expert input in regard to the design of the evaluation methodology both at the project level, and for discrete sections of the project. She has also drawn on her extensive experience to offer sector specific insight.

Sue Faircloth

Sue participated in consultations, workshops and surveys providing written summaries from these evaluation activities.

Laura Ribarow

Laura took primary carriage of the evaluation at the commencement of the project contributing significantly to the ethics approval and the first round of service modelling workshops and subsequent service modelling report.

Report Summary

This summary provides an outline of the TRC Evaluation project and the key findings and recommendations as drawn from the project's substantial research activity that included service modelling workshops, a literature review, comprehensive client outcomes surveys, stakeholder consultations, a workforce survey and interviews with selected young people from therapeutic residential care homes.

Background

Verso Consulting was commissioned to undertake an evaluation of the Therapeutic Residential Care (TRC) pilots, which are a part of Victoria's Out-of-home Care (OoHC) system for children and young people. In June 2007, the Victorian Department of Human Services (DHS) launched the first TRC pilot, referred to as Hurstbridge Farm. Since then, a further 11 pilot sites have been established, each with a specific client focus.

The evaluation commenced in August 2009 and concluded in July 2011, with the aim of providing advice to DHS regarding the effectiveness and efficiency of providing a specialised therapeutic residential setting for children and young people experiencing the aftermath of trauma and neglect.

The technical evaluation report provides detailed information regarding the TRC pilot sites, comprehensive client outcomes data and analysis, detailed exploration of the key essential elements of TRC and the therapeutic approach, an ongoing evaluation framework and knowledge transfer. The quantitative and qualitative data collection tools, methodology and process/basis of analysis are clearly documented.

The Evaluation Project Aim and Hypothesis

The hypothesis that underpins this evaluation work is:

> *"If a particular set of therapeutic resources are applied consistently for children and young people in Therapeutic Residential Care settings it can be expected that outcomes for those clients will be superior in comparison to outcomes experienced by clients in residential care settings where those resources are not applied."*

The overall evaluation project aim is:

> *"To evaluate the effectiveness and efficiency of the Therapeutic Residential Care services that form part of the Out-of-home Care system for children and young people in Victoria".*

Major Conclusions

Therapeutic residential care practice leads to better outcomes for children and young people than standard residential care practice

The children and young people in the TRCs experienced considerable positive progress towards the desired goals as detailed in the Child Protection and Family Services Outcomes Framework over time in the TRC and as a comparison with their experience in general residential care over three time points. Children and young people in the TRC pilots showed significant improvement in a range of outcomes; children and young people in a comparison group did not show this evidence of positive change.

There is one model of therapeutic residential care

The positive outcomes for the children and young people in TRC programs have been achieved by the application of a particular range of program elements that underpin the practice of therapeutic residential care. Whereas there are variations between programs at the operational level and the target groups for each pilot, all of the pilot models consistently used the DHS essential service design elements for therapeutic residential care.

Therapeutic specialists are essential

Therapeutic specialists attached to each TRC pilot unit have significantly impacted client outcomes and are intrinsically linked to each element of the program, thus the impacts are multi dimensional and pervasive. Their importance is not only in relation to their specialist knowledge, assessments and therapeutic planning but equally in terms of the quality of their relationships with staff, clients, families and other Agencies. The Therapeutic specialist primarily works through the staff rather than providing therapy directly to the children or young people.

Ongoing access to the Therapeutic specialist in formal reflective meetings and informally is essential to the success of TRC. Where access was absent, this significantly reduced the impact of therapeutic care on the children and young people in the pilots.

Staff training in the theory and practice of working therapeutically is a program priority

Trained residential care workers who can consistently and skilfully enact the therapeutic approach is essential to the success of TRC. Ninety percent of the staff and management in the TRC Pilots surveyed in 2010 had participated in the core 'With Care' two and five day training programs. This training was a pre-requisite to the implementation of the pilots.

These specifically trained residential care staff are crucial to TRC as they are the ones who build positive relationships with the children and young people and who use every interaction as an opportunity to work through issues, promote healing and achieve emotional and behavioural change. Specialised training assists staff to develop the required skills to work in a therapeutic, often counter-intuitive manner with children and young people in TRC.

Additional staffing

TRC funding provides for increased staffing. This results in more one-to-one time with children and young people (when required), greater program flexibility, and increased opportunities to respond to client needs.

Costs and benefits of therapeutic residential care

Therapeutic residential care is more expensive than general residential care. However, in providing immediate, medium-term and long-term benefits for children and young people, for the community and service system, and for government, net benefits are gained in reduced demand for crisis services and intensive intervention services such as secure welfare, youth justice, police and the courts.

The budget allocation for the TRC pilots on a per annum basis for the extra cost (over the base funding for general residential care) was a total of $2.6 m. This allocation was made to support 40 children and young people; therefore the extra cost per child or young person was calculated as an average of $65,000 per annum.

Table (A): Summary of identified Costs Avoided

Avoided Program & Associated System Costs per Year	$
Reduced broader system costs including secure welfare	$787,147
Placement stability	$164,160
Exit costs avoided	$730,000
Total = financial program benefit	*$1,681,307*
Per person cost avoided (N=38)	*$44,243*

Evaluation Findings

Client outcomes

The client outcomes data reported below covers two time points prior to each young person's entry to the TRC, as well as regular time points post-entry.

Measuring the progress of the children and young people took two perspectives: improvements shown and outcomes achieved over time, and the improvements shown and outcomes achieved relative to a comparison group. Thus there is a longitudinal, time series component, designed to monitor the wellbeing of the TRC residents.

Three quantitative tools have been used in the evaluation. They are:

- Strengths and Difficulties Questionnaire (SDQ)
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
- Brann Likert Scales (developed specifically for this project)

Client outcomes are clearly demonstrated in the following summaries.

Significant improvements in placement stability

Children and young people placed in a TRC have experienced far greater stability compared to their previous experience. Their average length of stay in the TRC is 30 months contrasting to an average of length of stay of seven months in their previous placements prior to TRC.

Significant Improvements to the quality of relationships and contact with family

The children and young people in TRC have experienced and sustained significant improvements to the quality of contact with their family during their period in TRC.

Sustained and significant improvements to the quality of contact with their residential carers overtime in the TRC pilots

Children and young people in the TRC pilots are developing and sustaining secure, nurturing, attachment-promoting relationships with residential carers in the TRC Pilots. These relationships are a necessary element for the development of secure, nurturing and attachment promoting relationships that are a critical element of the therapeutic approach in TRC.

Increased community connection

Children and young people in the TRC Pilots were more likely to engage in community activities or have a part time job than young people in general residential care. Seventy-five percent of TRC residents engage in recreation activities twice per week or more compared 20% in the comparison group of children and young people in general residential care. Prior to TRC, only 28% of the TRC residents engaged in this level of recreation activity showing a significant increase.

Significant improvements in Sense of Self

Children and young people in the TRC have experienced and sustained significant improvements in their sense of self, indicating improved mental health. The measures demonstrates that the young people in TRC sustained considerable improvement with 'poor' to 'very poor' ratings recorded for 81% pre-TRC reducing to 7% at 24-27months post TRC.

Increased healthy lifestyles and reduced risk taking

Children and young people in the TRC experienced a reduction in risk taking which was evident over time in reduced episodes of negative police involvement (although not immediate), police charges and secure welfare admissions. CSOs reported a reduction in risk taking. The rating of "high or very high" risk taking reducing from 68% pre-TRC to 38% at 18 months post entry to TRC. Secure Welfare admissions for the TRC population reduced from a median of 16 at TRC entry to 3 at 18-21 months post-entry and down to 0 at 24-27 months.

Enhanced mental and emotional health

Across the SDQ and HoNOSCA measures, the children and young people in the TRC experienced improvements and significant reductions in the mental health symptom severity. In 13 measures out of 15 the HoNOSCA provides clear results regarding reductions in symptom severity. Across all of the SDQ measures the young people in the TRC experienced improvements.
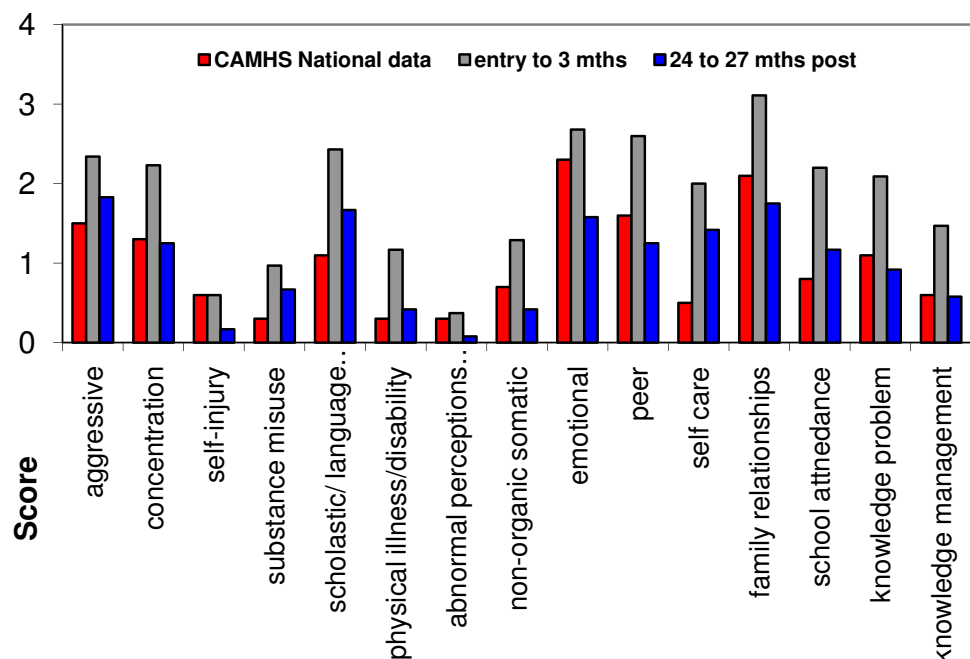
Improved optimal physical health

Over nine measures health status improved and is maintained over time. These included medical, dental, nutritional, sleep and hygiene status, recreational patterns and improved exercise.

Improvements in relationships with school is evident across multiple measures

This included substantial improvements in peer and social functioning at school and improvements (though not as great as peer and social functioning) in academic functioning. The school environment had become more congruent with the therapeutic approach and it would be expected that with further time the quality scales should demonstrate even greater improvements. The HoNOSCA ratings demonstrate a progressive improvement of school attendance.

*Contrast between the comparison group and the TRC*

The comparison between young people in the TRC and young people in the generalist residential population is striking. The young people in the TRC have experienced positive change with significant reductions in 'Poor' to 'Very poor' ratings and even more significant increases in 'High' to 'Very high' ratings. By contrast the young people in the comparison group did not show evidence of change over a twelve month period. (See figure below).

Figure (A): % 'Poor'/'Very poor' and High to Very High Ratings over one year – Comparison Group & TRC

Percentage of Poor/Very Poor or High/Very High ratings for CG and TRC over one year
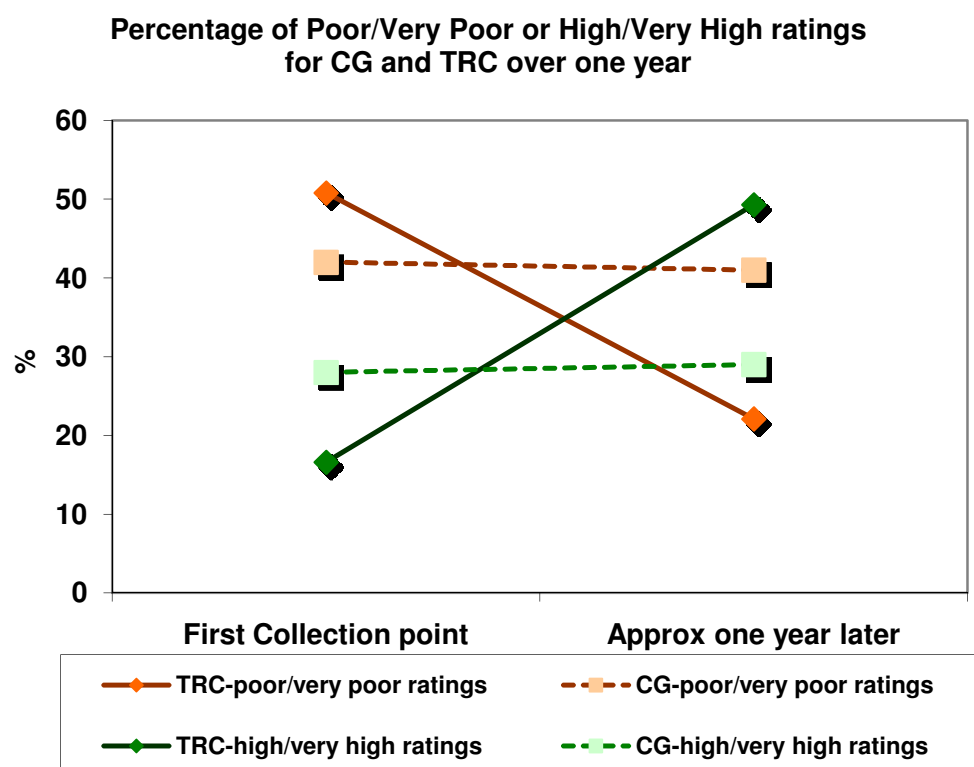
Substantial positive attainments against the Child Protection and Family Services Outcomes Framework are detailed in the following figure.

Figure: (B) Aggregated Percentage Change for Young People in the TRC
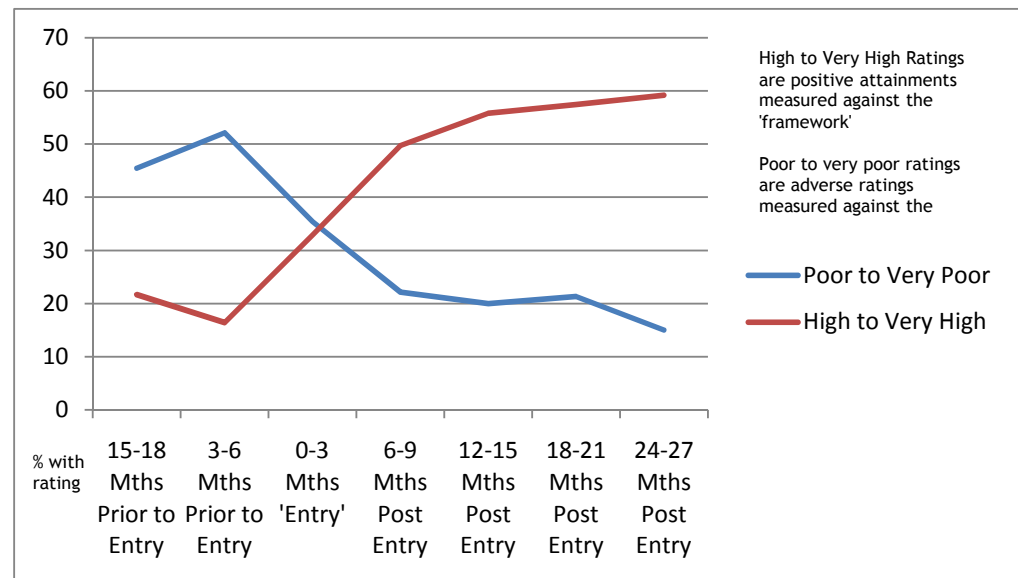
Program Elements

Therapeutic specialist

Refer to therapeutic specialist section above

Trained staff and consistent rostering

The CSOs report that staff turnover is lower in the TRC Pilots than in other residential care units. The increased funding available in the TRC Pilots has resulted in additional staffing, flexible rostering, and more individualised support and supervision of the children and young people.

Having a consistent pattern of staffing and additional staff members is seen as a core feature that provides the predictability and stability that clients require. Most CSOs involved in the pilots have a policy of not using brokered staff and staff absences are covered by extending the hours of existing part time staff or using trained staff from other residential units or a pool of trained casuals who work across residential units

Engagement and participation of the children and young People

In the TRC Pilots the engagement and participation of the children and young people is an important and distinctive element of the program that occurs from prior to their entry to TRC and involves good transition processes and participation in decision making. The relationship dynamic is described by the young people interviewed in the evaluation as being superior to their experience in other Out of Home Care settings.

Client mix

The importance of the overall client mix when assessing the suitability of a potential new client in the TRC unit is a critical program element identified through the evaluation. The objective of client group matching is to create a mix that maximises the opportunities for all children and young people in the TRC Pilots (current residents and the new young person entering the home) to benefit from the therapeutic approach.

Care Team meetings

Regular Care Team meetings are an essential component of TRC practice that supported a consistent approach, problem solving and solution development that would otherwise be unlikely.

Reflective practice

Reflective practice has been uniformly adopted in TRC pilots as a process by which staff develop their skills and practices through being aware of their actions, responses and impacts on the children and young people while they are working (practising). The workers also reflect on the young people's actions, interactions and triggers within a framework that attributes meaning to the young person's behaviour.

Organisational congruence and commitment

Organisational congruence is a dynamic that extends beyond the internal workings of the TRC Pilot and is seen as an important aspect of effective TRC. Organizational congruence involves a whole of organization approach to a framework or organizational culture which goes to all aspects of service provision – in this instance being the approach to therapeutic care. CSOs which had strong organisational congruence displayed consistent characteristics of higher level staff satisfaction, strong relationships with external stakeholders/agencies and positive and collaborative relationships with Regional DHS.

Physical environment

The physical environment, and how the children and young people express their experience of the physical environment, is an essential element of the TRC. Children and young people talked about the TRCs as home and used the word unit to describe their previous experience. The physical environment and the physical arrangements contribute significantly to the creation of a home-like environment that provides a sense of normality and ensures physical and emotional safety.

Exit planning and post exit support

Through workshops and consultations, the critical nature of exiting, exit planning and post exit support was raised by many CSOs as a subject of significant concern. Consistent with literature on this subject, age is not always a good indicator for exit planning as chronological age may not be an indicator of emotional age. CSOs consistently reported concern about mandatory upper age limits as a major determinate for exit from the program.

Recommendations

Verso Consulting has made ten recommendations about further developing and enhancing TRC in Victoria.

Recommendation 1:

That the 'pilot' status of the TRC programs be removed, authorising them as a legitimate and on-going models of residential care.

Recommendation 2:

Utilise the findings of this report to shift from a 'care and accommodation' focus to a 'treatment' focus (therapeutically informed services) across OoHC.

> **Recommendation 3:**
>
> Progressively expand the TRC Pilots to eventually incorporate most Residential Care sites across the State.

> **Recommendation 4:**
>
> Undertake and maintain population based planning to provide accurate predictions of the future demand for residential care.

> **Recommendation 5:**
>
> Develop a minimum data set to measure the effectiveness of the program, the quality of the program, to aid reporting on the program and to support continuous improvement.

> **Recommendation 6:**
>
> Develop an approach to continued resourcing based on the efficacy of the program for the young person and society and giving to due recognition to the capacity to reduce costs occurring in other parts of the system both within DHS and across Government.

> **Recommendation 7:**
>
> Undertake consultations to clarify information exchange and to overcome barriers with regard to facilitating effective therapeutic processes and assessments across TRCs.

> **Recommendation 8:**
>
> Develop a more coherent and effective post exit care response and program.

> **Recommendation 9:**
>
> Support the development of a professional body for Therapeutic Specialists, encompassing accreditation, training, clinical support in order to further develop and maintain this emerging workforce.

> **Recommendation 10:**
>
> Implement 22 service improvements as identified in the main report (built on findings and discussion in sections 3, 4 and 5).

Program Service Improvements

Table:(B) Service Improvements Recommendations

Reference	Improvement
Service Improvement 1: Page 46	Develop an accord
Service Improvement 2: Page 46	Develop a 'Community of Practice'
Service Improvement 3: Page 53	Mandatory training for CSOs
Service Improvement 4: Page 53	Remuneration increases for training attainments
Service Improvement 5: Page 57	Child Protection and DHS Placement Coordination units training
Service Improvement 6: Page 57	Child Protection and Placement Coordination standardised background and referral documentation
Service Improvement 7: Page 59	Ensure that Care Team meetings have the all relevant people in attendance
Service Improvement 8: Page 61	Ensure that Reflective Practice is supported consistently by the Therapeutic Specialist
Service Improvement 9: Page 65	Develop a therapeutic system
Service Improvement 10: Page 65	Improve congruence through training and discourse
Service Improvement 11: Page 65	Cross Agency Training and Briefings (courts and legal)
Service Improvement 12: Page 67	Maintaining the exterior of the TRC Units to match the streetscape
Service Improvement 13: Page 71	Develop the supports required to continue the emotional and mental health improvements
Service Improvement 14: Page 71	Ensure Congruent approaches to maximise outcomes for young people by avoiding premature exits
Service Improvement 15: Page 71	Make better use of all Government funded programs
Service Improvement 16: Page 86	Standardised documentation for filling vacancies
Service Improvement 17: Page 86	With Care Training available to all stakeholders
Service Improvement 18: Page 86	Identify the information sources and information required and where and how to access the information
Service Improvement 19: Page 91	Clearly articulate and manage the Knowledge of the TRC Model
Service Improvement 20: Page 93	All training programs being used in TRCs should be reviewed
Service Improvement 21: Page 93	Review all tools used in the TRCs to support the development of a consistent, effective and sensitive set of tools to be used across TRCs and the OoHC system
Service Improvement 22: Page 93	Develop a practice and policy manual

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1   Introduction

1.1 Background

Verso Consulting was commissioned to undertake an evaluation of the Therapeutic Residential Care (TRC) Pilot programs that are a part of Victoria's Out-of-home Care (OoHC) system for children and young people in Victoria. The evaluation commenced in August 2009 and concluded in July 2011.

The evaluation provides advice to the Department of Human Services (DHS) about the effectiveness and efficiency of a therapeutic intervention for children and young people who are experiencing the aftermath of abuse and neglect, and who have been placed in specialised Therapeutic residential settings.

The evaluation incorporates twelve TRC Program sites across Victoria. The Community Service Organisations (CSOs) conducting the Pilots are:

- Berry Street, Gippsland Region

- Berry Street, Hume Region

- Berry Street, Southern Metropolitan Region

- Glastonbury, Barwon South West Region

- Hurstbridge Farm, DHS Eastern Metropolitan Region & North and West Metropolitan Region

- Menzies Inc, Southern Metropolitan Region

- Mildura Aboriginal Corporation (MAC), Loddon Mallee Region

- Salvation Army Eastcare, Eastern Metropolitan Region

- Salvation Army Westcare, North and West Metropolitan Region

- St Lukes Anglicare, Loddon Mallee Region

- Victorian Aboriginal Child Care Agency (VACCA), Statewide service

- Wimmera Uniting Care, Grampians Region

Each TRC site has a specific clientele focus (such as gender, age, and statutory orders) and housing capacity. The maximum capacity of most of the TRC residences is usually 4 children/young people, however Hurstbridge Farm has the capacity to accommodate up to 8 young people (2 x 4 bed houses) and Glastonbury has a sibling group of 5. Berry Street Southern has 2 x 2 bed houses.

DHS launched the first TRC program Pilot, Hurstbridge Farm, in June 2007. Since that time the DHS adopted a staged funding of TRC pilot programs across the State, with the above CSO's commencing TRC operation upon completion of 'With Care' therapeutic training (which was pre-requisite to implementation).

The timeframe for the establishment of the MAC TRC was later than the TRC Pilots that were reviewed in this evaluation. However DHS considered that there was considerable value in incorporating MAC's input and pertinent observations regarding the development of a TRC at MAC as part of this study.

1.2 The Evaluation Project Aim and Hypothesis

The hypothesis that underpins this evaluation work is:

> *"If a particular set of therapeutic resources are applied consistently for children and young people in Therapeutic Residential Care settings it can be expected that outcomes for those clients will be superior in comparison to outcomes experienced by clients in residential care settings where those resources are not applied."*

The overall evaluation project aim is:

> *"To evaluate the effectiveness and efficiency of the Therapeutic Residential Care services that form part of the Out-of-home Care system for children and young people in Victoria".*

1.3 The Evaluation Objectives

The evaluation design is best understood as multi-layered, with specific evaluation objectives that correspond with each component of the review process. The evaluation design is consistent with a program logic framework, comprising both qualitative and quantitative components.

The qualitative components provide a formative evaluation focus on the TRC programs, as many were still becoming established at the inception of the evaluation project.

The quantitative component of the evaluation has been constructed using a longitudinal, time-series design, to track the wellbeing of the young people in the TRC, prior to their entry (i.e. retrospective) and post-entry.

This component of the evaluation specifically focuses on outcomes for the children and young people, such as the impact of Therapeutic intervention, through pre-defined outcomes. TRC program elements that contribute to outcomes, and the pertinent client and service relationships with the OoHC community are explored within the quantitative component.

The overall evaluation objectives are listed below:

- Identification of best practice approaches for the planning, development and implementation of TRC programs

- An understanding of the effectiveness and efficiency of each element of the Hurstbridge Farm Pilot site as the original and longest running pilot

- Clarification of the specific client outcomes that should be measured

- Confirmation that the client measurement tools currently in use are the best possible tools to contribute to understanding of the clients' progress.

- An appreciation of how well each TRC has performed against stated objectives

- An appreciation of the applicability of the key lessons from the TRCs to generalist residential settings

- Design of a continuous quality improvement system for the TRC suite of initiatives

- Development of an evaluation framework for the TRC suite of initiatives

1.4 Overview of the Report

The application of therapeutic residential care in the pilots is influenced by both contemporary theories into trauma and disrupted attachment and successful practice examples such as the Sanctuary Model. Therapeutic Residential Care (TRC) was first trialled in the Victorian Out of Home Care System (OoHC) at the Hurstbridge Farm. Based on growing International evidence of therapeutic care model's impact in relation to children and young people affected by trauma and the early encouraging outcomes at Hurstbridge Farm, the Department the of Human Services Victoria (DHS), through its partnerships with Community Service Organisations (CSO's) commenced multi site TRC pilot programs. The practices relate to the application of a consistent and particular set of therapeutic resources working with the children and young people at the nominated sites (TRC Pilots).

Evidence supporting various aspects of the science underpinning therapeutic approaches to care has culminated over the past thirty years (Moran 2007; van der Kolk et al. 2005; Perry & Hambrick 2008). However, the accumulated research evidence has only relatively recently become more integrated (Moran 2007). Whilst getting evidence in to practice is a broad challenge known to take at least a decade before becoming integrated (Silagy & Haines 2001) this evaluation represents a major milestone to the Australian OoHC system as it details the challenges of incorporating the evidence in to practice in a programatised manner.

This report details the model and its underpinning theories (particularly within Attachment 1 Literature Review) and provides a brief history of the development of the model at Hurstbridge Farm and a description of the model as delivered in the pilots.

Insight into the efficiency and effectiveness of the TRC pilots and their care services are provided through addressing: the conditions under which therapeutic resources are applied and the degree to which they are consistent; the essential elements that make up the therapeutic approach; the stakeholder and community interface and its impact; the costs, costs avoided and benefits of the program; and by reporting on quantitative measures that demonstrate outcomes for the young people. There are dedicated sections of the report addressing these issues.

Other issues addressed in the report are an ongoing evaluation framework and knowledge transfer.

At the beginning of each section a brief overview of the section will support the reader to appreciate how the section relates to the overall goals of the report. Throughout the report, where relevant, the methods used to gather evidence have been described.

1.5 Evaluation Methodology

1.5.1 Key Project Activities

This Final Report draws on the findings of the Evaluation Project research activities in order to respond to the research questions posed by DHS.

This Report is the culmination of a range of activities as depicted in Figure 1.

Figure 1: Components of the TRC Pilot Project Evaluation
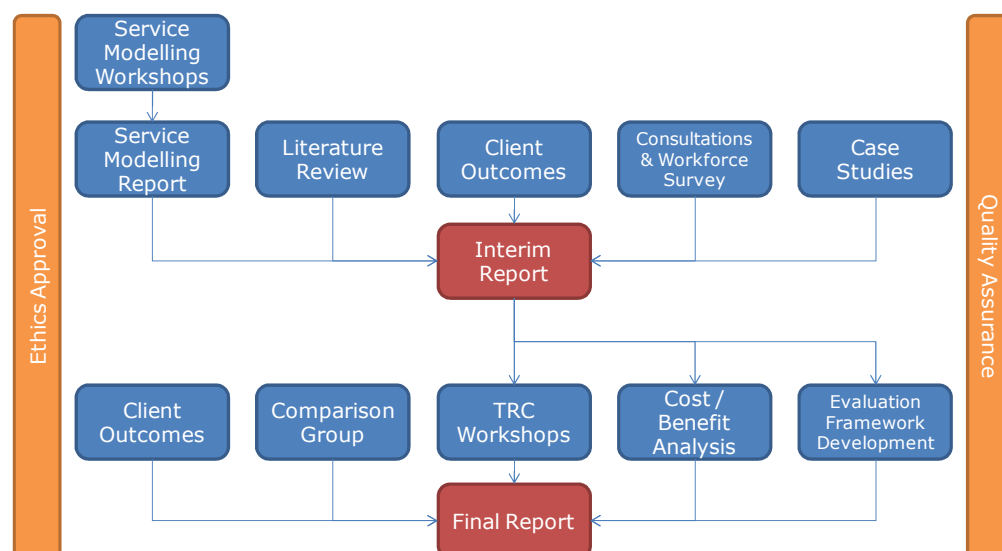
1.5.2 Project Timeframes

The following table lists the key project activities and the associated timelines.

Table 1: Key project activities

Activity	Timeframe
Project commencement	August 2009
Ethics application & approval	November 2009-February 2010
Service modelling workshops	November 2009-March 2010
Service modelling report	April 2010
Client outcomes initial data collection	April 2010
Consultations	May-August 2010
Literature review	May-August 2010
Workforce Surveys	May-August 2010
Case interviews	August 2010
Interim project report	September 2010
Ongoing client outcomes data collection	July 2010-May 2011
Comparison group initial data collection	November 2010
TRC CSO workshops	January-February 2011
Comparison group final data collection	March 2011
Cost and benefit analysis	March-May 2011
Develop ongoing evaluation framework	May 2011
Final project report	July 2011

1.6 Structure of the Evaluation

The structure of the evaluation is detailed in Figure 1. Of particular note, there are distinct qualitative and quantitative components to the data which enable triangulation of the final results.

There are also two distinct foci of the evaluation design. The first relates to assessing the efficiency and effectiveness of the TRCs from an organisational and operational

perspective, and the second relates to assessing improvement in the subjects, or clients of the TRCs.

The client outcomes data collection covers two time points prior to each young person's entry to the TRC, as well as regular time points post-entry (see Figure 2: Pilot Group Data Collection Points). In the case of one young person, data relating to the time periods 30-33 months and 36-39 months post-entry was also available and therefore collected.

Figure 2: Pilot Group Data Collection Points

15-18 mths pre-entry	3-6 mths pre-entry	TRC entry (0-3 mths)	6-9 mths post-entry	12-15 mths post-entry	18-21 mths post-entry	24-27 mths post-entry

Measuring Progress

Measuring the progress of the children and young people also takes two perspectives: improvements shown and outcomes achieved over time, and the improvements shown and outcomes achieved relative to a comparison group. Thus there is a longitudinal, time series component, designed to monitor the wellbeing of the TRC residents. In addition, the wellbeing of the children and young people will also be compared with those of a comparison group who have not received an equivalent Therapeutic component of care.

The comparison group data collection involved 16 young people from four CSOs (Westcare, Berry Street Hume, Menzies and Berry Street Southern) and relates to the following time points:

Figure 3: Comparison Group Data Collection Time Points

January-March 2010	July-September 2010	January-March 2011

1.7 Ethics

Approval for this evaluation was obtained from the DHS Human Research Ethics Committee, and project conduct has been consistent with the approved processes.

1.8   Structure of this Report

The research questions addressed in this report have been structured into themes to minimise duplication and to optimise contextual discussion of the issues raised. Each theme forms a chapter, and can be quickly located through the table of contents.

The original Project Brief had an emphasis on specifically evaluating the Hurstbridge Farm Therapeutic Residential Care program; however post-project commencement, DHS advised that Hurstbridge Farm (HBF) should be treated in a consistent manner with the other Pilots being evaluated. Hence the intent of some evaluation questions has been broadened (such as questions 5 and 6) to include all Pilots, while others have been consolidated (such as questions 2, 3 & 7; and 4 & 12).

Table 2: Correlation of themes and research questions

	Research Questions	Theme	Chapter
1	What is the background to the development of Hurstbridge Farm? How was it implemented and what can be learned from the process?	Development and Implementation	2
2	What is the Hurstbridge Farm model, its key and distinctive elements, and the underpinning theory that supports the model?	Defining the Model	2
3	How and to what extent do these various program elements that together comprise the Hurstbridge Farm model contribute to the outcomes achieved by clients? (Elements would include the DHS/Take Two partnership, the relationship with Baltara school/DEECD, and the program environment.) How can these elements be further improved?	Program Elements	3.1
7	For each Therapeutic Residential Care pilot, what is the model, its key and distinctive elements, and the underpinning theory that supports such a model? To what extent are the models achieving their stated objectives/goals?	TRC Models and Individual Sites	3.2
4	What are the detailed arrangements (eg processes, protocols, guidelines and reporting arrangements) that describe the relationships between Hurstbridge Farm and the service system and how can these be further improved?	Service System	4.1
12	To what extent have better links with other parts of the service system (e.g. with schools, mental health, disability services) been forged as a result of these models?	Service System	4
	Are therapeutic 'partnerships' the way forward OR is it best for an OoHC provide to sub-contract the therapeutic work to a specialist?		
5	What are the relationships between Hurstbridge Farm and the community within which it is located, both at a client and service level, and how can these relationships be further improved?	Client Outcomes	6
6	How have staffing processes for Hurstbridge Farm, including recruitment, training and support, contributed to staff satisfaction and client outcomes, how can these processes be further improved?	Program Elements	3.1
8	What elements and learnings from Hurstbridge Farm and each of the TRC pilots can be applied to other pilots and to other aspects of the out-of-home care service system?	Knowledge Transfer	5
9	In what other ways can Therapeutic Resi Care be improved?	Recommendations	9.2
10	What has been the impact of Therapeutic Residential Care (including Hurstbridge Farm) on individual TRC clients? What improvements have been made for clients against the defined prescribed outcomes areas defined? How do client outcomes from the TRC programs compare with outcomes for children and young people in generalist residential care services? What are the circumstances for young people leaving a Therapeutic Residential Care facility (eg new care arrangements, schooling, employment, links to community etc. Why do young people exit from Therapeutic Residential care?)	Client Outcomes	6
11	Which elements from the pilot TRCs have contributed most strongly to client outcomes?	Program Elements	3.1
13	What are the unit costs of providing Therapeutic Residential Care (HBF and TRC pilots) as compared to general residential care and how does this compare with the benefits and outcomes achieved?	Costs and Benefits	7
14	What is an appropriate evaluation framework and related survey instruments that can be applied to all residential care services within the out-of-home care sector?	Ongoing Evaluation Framework	8

2 Development and Implementation

In response to the evaluation questions the underpinning theory is described and a brief description regarding how the Hurstbridge Farm was implemented and what can be learned from the process is outlined. The section, 'conceptual underpinnings' was drawn from a comprehensive literature review focused on the need for the evaluation. The literature review provides details of the underpinning theories a small section of the literature review has been included in this section.

Summary of Findings

- Alternate approaches to OoHC were sought by the Victorian Government in an effort to better meet the needs of children and young people and better meet the increasing demands on the service system.

- The Principal Child Protection Practitioner (DHS) investigated alternate approaches to OoHC eventually recommending that the Sanctuary Model best informed the framework of organisational change required to support therapeutic approaches to care. As a result in 2008 Sanctuary training was provided to CSOs that deliver residential care.

- The conceptual underpinning of the Victorian Therapeutic Residential Care models is influenced by the Sanctuary Model. The Sanctuary Model represents a theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organisational culture.

- Theories of attachment; trauma; neurobiology of brain development and resilience underpin the development and practice evident in the TRCs.

- The theories were tested in the program development and practices at Hurstbridge Farm.

- The early positive results for young people at Hurstbridge farm encouraged DHS and the sector to develop, pilot and evaluate TRC programs across the State

2.1 The Need for a New Response

The impetus for a "new approach" to Out-of-Home Care (OoHC) arose from a number of quarters, including the previous Secretary of Premier and Cabinet and the 1999 report "When Care is Not Enough" (Morton et al. 1999). Concerns were raised as to the increasing demand on the system, poor outcomes for young people, the increasing length of stay in OoHC, the increasingly complex profile of young people in OoHC and the increasing financial and economic cost to the community.

A significant investment was made into researching an appropriate alternative model for the Victorian OoHC system. The DHS Principal Child Protection Practitioner recommended that the Sanctuary Model a trauma-informed residential treatment model developed by Dr Sandra Bloom, provided a practice framework that could guide the development of therapeutic residential care practices in Victoria. (Morton et al. 1999).

James Anglin's work was also a strong influence on the original model developed, as it was acknowledged as "the best form of care for young people in residential care" (Morton et al. 1999). Organisational change in the context of a Therapeutic Model

was examined, and the value of adopting an approach that "builds an environment of safety for a wide range of young people" (Morton et al. 1999) (young people with a disability, different age groups, Indigenous and other specific target groups) was endorsed.

A fuller discussion of the Victorian, national and international research and application of Trauma and Attachment Theories is covered in the TRC Evaluation Project Literature Review (Attachment 1).

2.2 Conceptual Underpinnings

It is generally well understood that all children and young people who find their way into the OoHC system have experienced some degree of significant trauma, abuse or neglect (Wise & Egger 2007). Research evidence from Australia, the United Kingdom, Canada and the United States indicates that outcomes are not always good for children taken into OoHC (Wise & Egger 2007). Overwhelmingly, the research provides clear evidence that children and young people across the whole OoHC system have a greater struggle in achieving many of the educational, social and other developmental milestones compared with children in the general community (Wise & Egger 2007; Wise et al. 2010; Barber & Delfabbro 2004; Sawyer et al. 2007).

Thus it is acknowledged that the vast majority of children and young people in the OoHC system would benefit from therapeutic treatment that would reduce and redress the impact that their previous experiences of abuse and neglect have had on their development.

The key theories underpinning approaches to therapeutic practice

A central tenet of therapeutic practice frameworks is the need to stabilize the living environment for those troubled children and youth who enter the OoHC system. The theoretical framework that informs this central tenet relates to attachment, trauma and the neurobiological development of maltreated children. This theoretical framework also has some consistency with resilience theory.

Attachment Theory

The reasons why multiple disruptions to placements are so serious are best understood in terms of how young brains develop, and the requirement for a stable, secure attachment figure.

Attachment theories in childhood development vary in detail (e.g. Bowlby; Rutter) however; they all fundamentally support the premise of the importance of stability in the young person's environment.

The founder of attachment theory John Bowlby, described 'attachment' as an in-built human drive toward forming and maintaining attachments with others (Bowlby 1969; Bowlby 1973; Bowlby 1980; Bowlby 1988). Whilst attachment theory is proposed to be universal in its application, it is acknowledged that there are culture-specific aspects of attachment (Colin 1996).

Essentially, attachment refers to the 'enduring affectionate ties that children form with their primary caregivers.' (Bowlby 1969; Ainsworth et al. 1978).The quality of early attachments is necessary for children to develop a sense of security, confidence and acceptance (Bowlby, 1969). Bowlby asserted that children form only one strong attachment, usually to the mother and that the strength of this attachment lays the foundation for later psychosocial and cognitive development. Serious developmental impairment may result from being separated from the mother in infancy (Bowlby, 1969). Later work by (Rutter 1987) supports the contention that children are capable of forming multiple attachments, and that it is the quality of the care, rather than

just the continuity with a single attachment figure that is most important (Rutter 1987).

Particular patterns of attachment are formed in early childhood however; these remain influential across the entire lifespan (Bowlby 1969). The first three years of life are the most crucial in terms of influencing how later attachments will be formed in adulthood.

A key concept in attachment theory is the internal working model. Fundamentally, a person's internal working model generates and carries a mental representation of the self, other people and the world in general (Fairchild-Kienlen 2007). Within these representations of self are "expectations and beliefs about one's own and other people's behaviour; the lovability, worthiness and acceptability of the self; and the emotional availability and interests of others, and their ability to provide protection" (Howe et al. 1999).

Patterns of attachment behaviour among very young children (under the age of 2 years) have been researched and documented under experimental conditions (Morton et al. 1999; Osborn 2006). The later consequences of disrupted early attachments have been inferred through case studies and correlation studies. Disrupted early attachments are consistently associated with severe personality disturbance, poor mental health, a range of anti-social behaviour and later parenting difficulties (Morton et al. 1997; Osborn 2006).

Trauma Theory

Trauma is generally defined as '…psychological injury caused by some extreme emotional assault' (Reber 1995). The core experiences of psychological trauma are disempowerment and disconnection from others (Herman 1997).

A traumatic experience may involve the experiencing or witnessing an event involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Herman 1997). Typically, the person's response will be intense fear, helplessness, or horror of an overwhelming nature. Due to trauma experiences being so overwhelming, often they are not fully integrated into memory (Herman 1997).

Typically, experiences that may represent the traumatic experience even in part, may act as 'triggers' (i.e. internal or external cues) that reactivate the person's experience of the traumatic event. The re-living of the traumatic event includes acting or feeling as if the traumatic event were actually happening, with intense physiological reactivity and arousal (Herman 1997).

The experience of trauma may be a discrete and isolated event, or it may be ongoing and more complex such as that experienced by people subject to prolonged, repeated trauma. Approaches to understanding and treating trauma tend to draw on the American Psychiatric Association description of isolated or discrete traumatic events that are associated with the description of Post-Traumatic Stress Disorder (PTSD) (van der Kolk et al. 2005).

However, trauma experts (e.g. van der Kolk; Ford; Marans; Herman) emphasise the need to distinguish the nature of discrete trauma from the more pervasive and complex forms. This difference between the two types is summed up by Herman:

'People subject to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is "not herself", the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all' (Herman 1997, p.86).

The experience of complex trauma for children and young people is extremely pervasive as it occurs within the daily context of primary care giving relationships

therefore, the potential 'triggers' are very diverse and constant (van der Kolk et al. 2005). They may include seemingly benign, normal sensory experiences such as a particular smell, taste, sight, sound, tactile experience, and relational interactions such as for example facial expressions, tone of voice, and physical contact (van der Kolk et al. 2005).

Herman states that in order for children and young people to survive and negotiate chronically traumatic events, they tend to develop maladaptive coping styles resulting in '…an immature system of psychological defences' (Herman 1997, p96).

Trauma is understood to be just as much a neurobiological and psychophysical experience as it is psychological and emotional (van der Kolk 2006). Importantly, the physical dimension to the trauma has implications for therapy because people experiencing the trauma have limited conscious control over their actions and emotions (van der Kolk 2006). The profound and pervasive effects of neurobiology on behaviour are highlighted by van der Kolk:

'The fact that reminders of the past automatically activate certain neurobiological responses explains why trauma survivors are vulnerable to react with irrational, sub-cortically initiated responses that are irrelevant and even harmful in the present. Traumatised individuals may blow up in response to minor provocations; freeze when frustrated, or become helpless in the face of trivial challenges'(van der Kolk 2006).

This leads now into discussion about the application of neurobiology to interpersonal human behaviour underpinning some aspects of therapeutic practice.

Neurobiology of Attachment and Trauma

'For centuries scholars have known to some degree that the capacity to express full human potential is related to the balance of developmental opportunities and challenges. In extreme cases of developmental challenge such as maltreatment – threat, neglect, humiliation, degradation, deprivation, chaos, and violence – children express a range of serious emotional, behavioural, cognitive, and physiological problems' (Perry & Hambrick 2008, p.38).

How a person's interpersonal or relationship experiences, particularly in the first five years of life, impact the development of the neural pathways involved in attachment and self-regulation is important to understand for success of therapeutic interventions (Perry & Hambrick 2008; Siegel 2003). This area of study that explores how neurobiology relates to human behaviour is defined as interpersonal neurobiology (INB) (Schore 2003; Soloman & Siegel 2003).

Research evidence supports the contention that the development of healthy brain structure, anatomy, function, synaptic networks and neurons are to a significant extent experience dependent (Perry & Hambrick 2008; Siegel 2003).

Human brain development has been characterised in detail and the following summary has been taken from Perry (2009). It is known that brain development occurs sequentially, in a hierarchical fashion. There are four main anatomically distinct regions of the brain:

- Brainstem
- Diencephalon
- Limbic system
- Cortex

During development, the brain organizes itself from the bottom up, from the least complex (brainstem) to the most complex (limbic and cortical) areas. Each of these main regions develops and becomes fully functional at different times during

childhood. For example, at birth, the brainstem is responsible for regulating cardiovascular and respiratory function and is mostly organized in utero. The cortical areas responsible for abstract cognition have years before they will become fully organized and functional. Each brain area has its own timetable for development, with micro-neurodevelopment (synaptogenesis) being most active in different brain areas at different times and as such, more sensitive to disruptive experiences during these times. Thus the very same traumatic experience will impact an 18-month old child differently to a 5-year old child.

The brain also organizes in a use-dependent fashion. Undifferentiated neural systems are critically dependent on sets of environmental stimuli and micro-environmental cues (e.g. neurotransmitters, cellular adhesion molecules, neurohormones, amino acids, ions) in order for them to develop properly. Stressors, particularly prolonged or repetitive, impact the development of neural networks, altering their future use and function.

Thus, when infancy and childhood is characterized by ongoing relational trauma, a variety of brain insults occur that cause serious, long-term and relatively intractable neurobiological, psychological, emotional and behavioural impairments.

Briefly, assaults on the developing brain result in the following physiological changes:

- Prolonged, excessive secretion of the stress hormone cortisol, causing:

  - over-pruning of synapses related to cortex development (involved in the modulating and regulation of emotion and response to stress)

  - damage to limbic system inhibiting soothing functions at a physiological level

  - reduction in brain size

  - impaired development of the corpus callosum resulting in impaired creativity and problem solving skills

  - reduction of the hippocampus, the part of the brain concerned with memory and development of a sense of self in the world.

- Over use and over development of the primitive portions of the brain

  - predisposition to significant and chronic levels of impulsivity, reactivity, dysregulation, aggression, hyper-vigilance, hyper-arousal, hypersensitivity, bias towards perceiving threat and hostility and a persistent state of stress response

- Under development of the midbrain area and under development of the higher brain areas (prefrontal and orbitofrontal cortex)

  - lack of empathy, violence, poor executive planning and control of inhibitions and inability to process, contextualize, and understand life experiences. Predisposition to a host of neuro-psychiatric problems.

However, neurobiological research has shown that the development of brain structure, circuitry, and biochemistry is use dependent (Perry 2009; Soloman & Siegel 2003). To varying degrees, aspects of the brain possess plasticity. This means that the harmful effects of trauma and attachment disruption on brain development may be positively altered in the context of a highly intentional, therapeutic environment (Perry 2009).

Importantly, in order for therapeutic interventions to succeed, they must be in tune with the neurobiological profile of the brain and be developmentally appropriate (Perry 2009).

The Neurosequential Model of Therapeutics (NMT) is a recent approach to qualitatively mapping brain function in order to guide the therapeutic process (Perry

2009). Whilst this approach is in its very early stages, it has shown some promising results and its evaluation continues (Perry 2009).

Attachment, Trauma and Resilience

As a broad concept, resilience has been studied over several decades and encompasses a number of foci including for example, individuals, families, communities and culture (VanBreda 2001; Rutter 1987; Resnick et al. 2003).

Generally, resilience is understood as the capacity to 'bounce back' from adversities (Newman 2002). The concept of resilience is important to children in care because it has been argued that children are less able to cope with stressors compared to our forefathers, partly due to being sheltered from challenging opportunities and learning how to manage risk within increasingly risk averse society (Newman 2002).

Historically, research has tended to focus on pathology and problems rather than strategies of coping, elevating pathology into the scientific realm and coping into 'folklore' (VanBreda 2001). A dominant focus on psychopathology has tended to obscure the focus on positives, strengths, and as described by Robbie Gilligan the 'ordinary plenty of life' (Gilligan 2001).

A focus on attachment theory, trauma and neurobiology may be viewed by some as being too medicalised, or psychopathological in focus eg (Lemay 2006). However, whilst much is known about how resilience emerges (Newman 2002; Rutter 1987; Resnick et al. 2003) little is known about the ways in which these processes can be influenced and the application of resilience theory in practice is relatively recent (Rayner & Montague 2000).

However, a focus on attachment theory (i.e. emphasis on building capacity for secure, nurturing, attachment-promoting relationships with older, capable adults) is understood to underpin the building of resilience (Rutter 1987; Resnick et al. 2003) and may act as a "buffer to mitigate the impact of overwhelming stressors, and to support recovering and healing" (Blaustein & Kinniburgh 2005).

Thus rather than presenting opposing approaches, resilience theory and an attachment and trauma focus may offer a consistent, complimentary approach.

2.3 Hurstbridge Farm

2.3.1 How was the Therapeutic Approach implemented?

The Hurstbridge Farm (the Farm) pilot gave particular impetus to the development of therapeutic residential care practice in Victoria. Opened in May 2007, the Farm was a test bed for an alternate model of residential care. The Farm is located on 13.4 hectares in Hurstbridge (an outer Northern suburb of Melbourne). The farm has two residential houses, a school in a converted farm shed, administrative offices, farm equipment sheds and an independent living unit. A farm manager is employed to manage the agricultural activities and to support young people's involvement in those activities. The houses can accommodate four young people. The program originally targeted young people between twelve and fifteen years of age. As stated in the first round workshop with HBF; "In an attempt to select children who are at a developmental stage where they are likely to be able to reap the most benefit from the program, many programs have dropped the age range of eligible clients. The eligible age range for program entry is now (at HBF) from 11 years to 13 years and 11 months".

Observations from Hurstbridge Farm

Key observations from the implementation were obtained from interviews with policy makers, workshops (2010 and 2011) with current Hurstbridge Farm staff and management and a site visit and accompanying consultations. Respondents were asked to reflect on early planning and primarily the first two years of operation (2007-2009) as detailed in this section.

Hurstbridge Farm provided the opportunity to learn about and develop the TRC model. The approach was pioneering with a pure ethos in the delivery of a therapeutic model being a primary focus. The 'farm' helped DHS to see how residential care could be different and the results provided momentum to help roll out the TRC model. The farm assisted CSOs and DHS to see how the theory could be realised in practice.

The experiences of the implementation of the 'farm' (positive and negative) reinforced the value of strong residential service structures. Issues such the importance of good management and organisational structure and the interaction with therapeutic specialists were cited as essential elements.

Hurstbridge was an important first step that gave the young people, staff and DHS insight into the challenges and benefits of working in a trauma informed environment.

2.3.2   What can be learned from the process?

Learnings from the Farm are summarised below. They are wide-reaching, having impact at a policy level, on service management, system interface, research and on research and education.

Policy

• The importance of developing a good residential framework as well as the therapeutic model

• The importance of organisational congruence

• Ensuring funding levels are appropriate to realise the model

Service management

• Good management structures

• Staffing models with a particular emphasis on shifts (length) and to the self care of staff

• Attention to managing the cohort or mix of residents

• The importance of reflective practice and ensuring that it is embedded in practice

System interface

• Building the whole system to support young people in a congruent manner

• Case management needed to be congruent and consistent e.g. It was noted that a "Critical flaw of the initial Hurstbridge Farm model was that staff had to liaise with six different case managers which over-complicated everything." This led to "changes in the policy and they organised for one case planner per region and a case manager was based at the Farm."

- Congruent and well coordinated approaches with education providers – this has been an effective and highly integrated element of 'the farm'

Research and education

- Research helped inform new services and put a framework around the implementation of the new legislation

- The evaluation of 'the Farm' and other programs helps inform what 'not to do'" and 'what works best'.

- The results from 'the Farm' generally helped offer enthusiasm and motivation for staff at the other sites.

2.4 Essential Service Design Elements - TRC

Prior to requesting proposals for organisations to pilot TRCs, a guide to Essential Service Design Elements – Therapeutic Residential Care was developed. Compliance with this guide was a key evaluation criterion for applicants seeking funding to pilot the TRCs.

The Essential Service Design Elements are summarised below (see Attachment 2 for full text of the Essential Service Design Element Paper).

Table 3: Essential Service Design Elements Summary

Essential Service Design Element	Brief Description
Project Management	The organisation's senior management is to provide a clear commitment to project management of the development, establishment and on-going management of the TRC
Organisational Values and Culture	The organisation has a clearly documented statement of its values and culture consistent with its aspiration and capacity to provider a therapeutic care environment
Therapeutic Model	Organisations are to have a clearly documented and theoretically based model
Program Design	Program documentation is to include consideration of the following aspects of the program's design: Project vision; Target group; Service/Model operation; Defined goals and outcomes
Budget and Funding Availability	Documentation of the proposed service model is to include a detailed budget, including funding sources other than DHS
Staffing	The organisation has clearly documented statements in relation to the following dimensions of program staffing: Staff model; Qualifications; Salary levels; Recruitment, selection and interview processes; Relief staff; Staff training
Client Referral, Assessments, Selection and Admission	A range of specific program documentation requirements overseen by a Referral and Assessment System/Panel
Case Planning and Case Management Model	A holistic "care plan" is to be developed which ensures that the client is at the centre of the planning process in relation to the therapeutic residential care placement and includes all aspects of the client's individual circumstances, and is consistent with the Looking After Children (LAC) and Best Interests Case Planning frameworks
Specialist Services	The program arrangements are to ensure access to the following specialist services unless identified as not appropriate to the characteristics of the client group: Mental health; Drug and alcohol; Education and training; Secure Welfare Services; Regional and State-wide Child Protection Services; Youth Services and Youth Justice
Service System Links	Program documentation is to identify how effective links with relevant services will support effective operation of the service
Participation of Young People	Program documentation is to identify how it will provide for involvement of young people and a commitment to respond to the

Essential Service Design Element	Brief Description
	wishes of the young people in their care
Family Links	Program documentation will outline the organisation's capacity to involve specialist and skilled therapeutic interventions with known family, assisting young people to identify their family of origin, and assist Aboriginal children and young people to re-connect or maintain contact with their extended family and Aboriginal community
Post Placement Support and Leaving Care	Program documentation is to outline ongoing extensive post-placement support for young people transitioning from the residential placement
Community links, sport, cultural, social and recreational activities and opportunities	Program documentation is to outline the service model approach to providing for a high level of links suited to individual interests and skills of children/young people
Quality of Care (ongoing monitoring and measurement)	Daily operations are marked by a high quality of care and responses to Incident Reporting are thorough and of a high level
Physical Facilities	Program documentation is to outline the suitability of the physical facilities and their capacity to support the therapeutic intent of the pilot project
Service Quality	The program documentation is to outline mechanisms to ensure that the level of service quality matches the aspirations of the mission/intent of the service, use of processes to support continuous service quality improvement, and staff support
Evaluation Framework and Methods	Program documentation is to confirm a commitment to participation in the evaluation of the service model, and development and participation in an agreed joint evaluation approach of the pilot projects

2.5 Defining the Model

The evaluators were required to answer the question; "What is the Hurstbridge Farm (TRC) model, its key and distinctive elements, and the underpinning theory that supports the model?" To respond to this question the evaluators approached the task of defining the TRC Program Model without any pre-conceptions of what the constituent elements may be, preferring instead to be led by the field to define the elements inductively.

2.5.1 Developing a TRC Program Model

Drawing on a range of information sources including the literature review, targeted consultations and the Round 1 (Service Modelling) Workshops, the consultants developed an overarching model to convey the TRC Approach. The framework offers a means of representing the various understandings and experiences of participating stakeholders about the TRC program. The framework can be used for further study of the TRC system and as a means to draw together the practice elements of individual TRC Service Models into a cohesive program-wide representation.

Figure 4: Framework for the Therapeutic Residential Care program
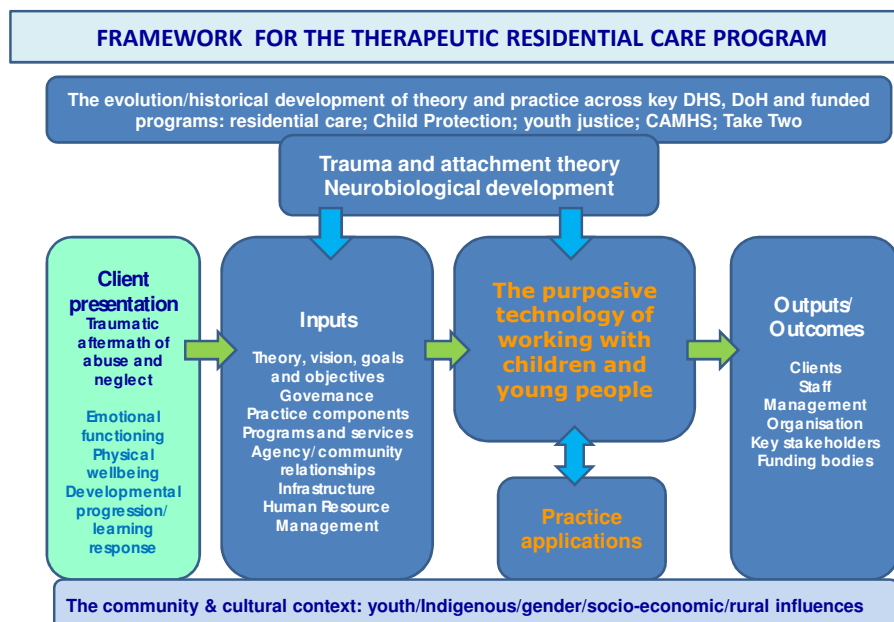
Resourcing/budget

A detailed budget, clearly identifying funding expenditure requirements of the model including all costs involved in liaison with Take Two, specialists and other services was provided by CSOs to DHS prior to the commencement of the TRC Pilots.

As detailed in 3.2 TRC Models at Individual Sites a number of changes have occurred to the targeting (age, complexity of need, reunification goals/capacity) that have necessitated renegotiation of the original agreements. Other one off arrangements have been negotiated as required.

Base funding

The table 4 contains information extracted from the 2009-12 Children, Youth and Families Policy & Funding plan, which is subject to an annual price indexation of 3.14%.[1]

Table 4: Base funding structure

Funding Component	Description	Base Funding	Case Management
Intermediate (RP2)	Residential care intermediate is for young people who display a significant level of challenging behaviour or because they are a part of a large sibling group.	$147,995	$10,301
Complex (RP3)	Residential care complex is for young people who display a significant level of complex behaviours, have multiple or complex needs and engage in high risk behaviours.	$211,832	$13,733

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[1] DHS Child Youth and Families North and West Metropolitan Region, Invited Call for Residential Care Service Submissions (CY&F/N&WMR/2011), June 2011

CSOs providing residential care services receive funding according to the complexity of the child/young person. The majority of targets in the TRC Pilots are designated as "Complex" (formerly RP3).

Extra funding

TRC pilot programs all receive funding to employ a therapeutic specialist (most of these specialists are .5 EFT per TRC home). Many of the TRC pilots have also been supported to maintain improved staff rosters and to access key services and/or resources as prescribed in their TRC service design.

DHS has estimated that the annual cost of a TRC placement is approximately $2.6m per annum to support 40 young people.

3 Therapeutic Residential Care Models

This section of the report details the program elements and describes the TRC model as operationalised at each site. The practices that have supported positive outcomes for young people, the staff and the efficiency of the program have been discussed in this section. The practices and one-off incidents that have detracted from these positive outcomes have also been identified to amplify what works and the essential nature of the element. The information in this section is critical to the evaluation as it provides evidence regarding the conditions under which therapeutic resources were applied and the degree of consistent application. This section also describes the interplay between the elements and how this impacts on outcomes. An understanding can be drawn from the findings of what works and why it works.

The section also supports a range of service improvement recommendations aimed at increasing both the efficiency and effectiveness of the program in the future.

The particular evaluation questions answered in this section are:

- How and to what extent do these various program elements that together comprise the Hurstbridge Farm (TRC) model contribute to the outcomes achieved by clients?
- How can these elements be further improved?
- Are therapeutic 'partnerships' the way forward OR is it best for an OoHC provider to sub-contract the therapeutic work to a specialist?
- How have staffing processes for TRC's, including recruitment, training and support, contributed to staff satisfaction and client outcomes,
- How can these processes be further improved?
- For each Therapeutic Residential Care pilot, what is the model, its key and distinctive elements, and the underpinning theory that supports such a model?
- To what extent are the models achieving their stated objectives/goals?
- Which elements from the pilot TRCs have contributed most strongly to client outcomes?
- What are the circumstances for young people leaving a Therapeutic Residential Care facility e.g. new care arrangements, schooling, employment, links to community etc. Why do young people exit from Therapeutic Residential Care?

Summary of Findings

The TRC model program elements were found to be: Therapeutic Specialist, Trained Staff and Consistent Rostering, Engagement and Participation of the Young People, Client Mix, Care Team Meetings, Reflective Practice, Organisational Congruence and Commitment, Physical Environment and Exit Planning and Post Exit support. This supports the contention that there is one model for the TRCs.

These elements were present in all the pilots however the lack of consistency or gaps in replacing therapeutic specialists in two of the pilots amplified the critical nature of this element. Differences at individual sites were related to the young people and their unique needs arising out of their circumstances, as targeted by the TRCs. Family reunification and a lowering of the entry age are the most common changes being considered or that have changed over the course of the evaluation when considering TRCs at individual sites.

3.1 Program Elements

3.1.1 Introduction

In the course of the evaluation, the vast majority of those interviewed (including young people in the TRC Pilots) were confident that "TRC works". The task of the consultants, however, went a step further in terms of unpacking and describing the how and why of this observation, and identifying the program elements that comprise the "black box"[2] which is the Therapeutic Approach, as well as confirming this hypothesis through quantitative data.

In the course of conducting the evaluation, the consultants were continually seeking to identify what it was that set the TRC Pilots apart from general Residential Care. In some cases, these distinguishing factors were readily apparent by virtue of the premise of Therapeutic Residential Care (e.g. Therapeutic Specialist, Reflective Practice, Training), whereas other distinguishing factors emerged in the course of the evaluation.

The evaluators used multiple qualitative methods to ascertain what the key elements were, and the methods included:

- Conducting two rounds of workshops with each CSO (aggregated total participants N=158); the written report on each workshop was reviewed by the CSOs and where necessary edited to accurately reflect the outcomes of the workshop

- Conducting multiple focus groups and forums; with CSOs in a State-wide forum, Therapeutic Specialists at Take Two, with Regional DHS Managers at Verso (aggregated number of participants N=95)

- Reviewing each CSO's original tender bid

- Obtaining from the CSOs written responses using a standard proforma about the 'critical path' of a young person into the TRC, within the TRC and exit planning or actual exits and the activities and resources utilised by the agencies

- Undertaking Workforce surveys that included opportunity for individual and confidential feedback from staff and Managers N=73

- Regular telephone contact between the CSO's and the Therapeutic Specialists and the Evaluators

- Interviews with nine of the young people in the TRCs (including three site visits and discussion with staff)

- A site visit to Hurstbridge Farm and subsequent interviews N=5

- Regular discussions and feedback with the evaluation management team

- Stakeholder Consultations N=26

- Consultation with Crime Prevention Officer, Yarra Ranges Police Service Area (with reference to a project for the Police Divisions of Yarra Ranges, Knox and Maroondah, to track 49 young people in the residential homes and their contact with Victoria Police. Project summary is provided as Attachment 6)

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[2] A device, process, or system, whose inputs and outputs (and the relationships between them) are known, but whose internal structure or working is not well, or at all, understood; not necessary to be understood for the job or purpose at hand; or not supposed to be known because of its confidential nature. http://www.businessdictionary.com/definition/black-box.html

As a result of the qualitative methods the evaluators identified the following key program elements which distinguish the TRC Pilots. They are discussed in this Section are as follows:

- Therapeutic Specialist - 3.1.2

- Trained Staff and Consistent Rostering - 3.1.3

- Engagement and Participation of the Young People - 3.1.4

- Client Mix - 3.1.5

- Care Team Meetings - 3.1.6

- Reflective Practice - 3.1.7

- Organisational Congruence and Commitment - 3.1.8

- Physical Environment - 3.1.9

- Exit Planning and Post Exit Support - 3.1.10

The identification of the key elements using the methods detailed identified a close alignment between the Table 3 Essential Service Design Elements and the findings from the evaluation. Therefore the program design elements were being realised in practice and found to be effective in contributing to the planned outcomes for young people.

3.1.2 Therapeutic Specialist

The impact of the Therapeutic Specialist on client outcomes is summarised in the key points in this section, however it should be noted that the role of the Therapeutic Specialist is intrinsically linked to each element of the program thus the impacts are multi dimensional and pervasive. For example, the Therapeutic Specialist has been labelled as the custodian of the 'Therapeutic Approach', and "they make sure that the values and approach is maintained across all the stakeholders".

The role of the Therapeutic Specialist

The Therapeutic Specialist role was an essential, funded element of all TRC pilots. It is significant that their importance is described not only in relation to their specialist knowledge, but equally in terms of the quality of their relationships with staff, clients, families and other Agencies.

The following summarises the role of the Therapeutic Specialist:

- In collaboration with the residential care staff[3] they identify the best matched young person to enter the Unit and develop strategies to ensure that the young person is successfully integrated and to ensure that the integration of the young person is positive for the young people who are the existing residents of the Unit

- Using background information, feedback through the Reflective sessions with staff, the application of assessment tools and the observations of staff, they collaboratively develop strategies and approaches that promote healing and progress towards the desired outcomes

- Develop a therapeutic plan for each young person that is regularly reviewed and updated (informed by the actions in the preceding point)

- They support staff to develop and consistently provide practice responses that have been developed to bring healing or to mitigate behaviours that are damaging to the young person and/or others

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3 Staff are defined in 3.1.3

- They support staff to problem solve through Reflective practice enabling alternate approaches to be developed in response to approaches that are not achieving the desired outcomes

- They support staff to reflect on the progress the young person is making and the need for new approaches to be adopted and the development of agreed practices

- They support staff to self manage (including the tendency to respond in a punitive manner under pressure, vicarious trauma and/or become reactive to their own history) so they can remain consistent in their application of responses that have been developed to bring healing or to mitigate behaviours that are damaging to the young person and/or others

- They support staff to respond to crisis situations (incidents) in relation to the young person and to reflect on the triggers and other dynamics associated with the incident

- They support the Agency and stakeholders (including DHS) to remain congruent in their Therapeutic Approach and in the maintenance and development of practices. The congruence promotes a pervasive culture of thinking and acting that in-turn affects all interactions with the young person – note that this is the goal, but success has varied across the Pilot sites in their engagement with interfacing Agencies

Developing a Therapeutic Specialist workforce

The development of a new workforce of suitably qualified and experienced persons to enact the role of Therapeutic Specialist is a notable achievement. This achievement includes the capacity to quickly establish a workforce and retain professionals who are in high demand. Interviews with Therapeutic Specialists confirm that this group is professionally fulfilled in being able to affect significant behavioural and emotional change and in some instances support family reunification and/or independent living.

Within all TRC Pilots, the Therapeutic Specialist is integrated into the team. Therapeutic Specialists working in the Pilots include persons who are psychologists, neuropsychologists, social workers and psychiatric nurses. They require a sophisticated understanding of child and adolescent mental health assessment and treatment.

The Therapeutic Specialists are working in a field that is still developing in terms of role, function and effect.

It is important that practices in the program remain malleable as the science relating to brain development and associated behavioural sciences continues to develop. To ensure that this continues to occur, the Therapeutic Specialist will be required to work under the supervision of appropriately qualified and experienced people. It should be expected that supervision will relate to the individuals practice and will also support the continuing development of practices that are responsive to evolving clinical developments.

In the course of the evaluation additional practice questions were identified that require further exploration e.g. 'what is the long term affect of the Therapeutic Approach?' and 'should there be a post exit Therapeutic Approach?' It could be concluded that program development will be shaped by the evolving science and by a mix of shared learning from within the TRC Pilots and from International experience. In this environment DHS's TRC management will have to maintain a high level of engagement with the professional body(s) and contribute to and facilitate forums for ongoing discussion with the Therapeutic Specialists and their supervisors. This is an evolving program.

Take Two is a consortium led by Berry Street in partnership with the Austin Child and Youth Mental Health Service, La Trobe University, Mindful (Centre for Training and Research in Developmental Health) and the Victorian Aboriginal Child Care Agency. Take Two provides a range of therapeutic services and clinical advice and practice to Victoria's OoHC system.

In the context of the TRCs Take Two Therapeutic Specialists work with the staff and young people in many of Victoria's TRC pilot programs. The Take Two therapeutic specialists have been able to work within this evolving and developing program effectively.

The effectiveness and contribution has found to be:

- DHS and Take Two have maintained effective communication at a senior level prior to and throughout the evaluation that has facilitated congruent practice and thinking – the relationship could be described as a partnership

- Take Two Therapists have skilfully integrated themselves into the Agency teams as a fully functional and valued team member

- Take Two Therapists have maintained high levels of professionalism while developing egalitarian environments to facilitate the Therapeutic Approach and the key program element of Reflective learning within individual Pilots

- Take Two has continued focus on the development of professional practice and the development of their Therapeutic Specialist; including exposure to International developments in the field e.g. Bruce Perry's visit in late 2010 and the related lectures and workshops (facilitated by Take Two)

- Take Two continues to proactively expand the workforce through engagement with Universities thus piquing interest for future Therapists

- Take Two have been able to manage vacancies and staff turnover with minimal disruption to program outcomes

The subcontract arrangements with Take Two have been more effective than alternate arrangements in the TRC Pilots. The alternate arrangements are described in the following subsection 'employment arrangements'.

Employment Arrangements

All but two of the Pilots began with a therapeutic specialist employed by Take Two. One of the CSO's had a partnership with CYMHS/CAMHS to provide the therapeutic specialist. The other CSO had initially employed their own therapeutic specialist and when that person resigned the CSO requested that Take Two take on the Therapeutic Specialists role.

Of those pilots that involved Take Two from the outset (nine pilots) there was a turnover of staff four Therapeutic Specialists; all but one of these positions being filled within 3 months or less. In the Agency where the Therapeutic Specialist was not filled Take Two's Eastern Regional Manager filled the role with less day to day availability.

Dynamics of the Therapeutic Specialist's input

The Therapeutic Specialist is pivotal for the TRC in achieving quality outcomes for young people in the program. At this stage in the program's (TRC Pilots) development it is difficult to quantify the impact of any single dynamic of the Therapeutic Specialist's inputs (related to client outcomes). It appears that a fine balance of all the dynamics may be producing the optimum outcome. It is possible to identify that as young people reach milestones and move towards exiting the TRC Pilot, the focus

of the Therapeutic Specialists inputs does shift with a greater emphasis being required on a particular dynamic as detailed in the stages outlined below.

The desktop review and critical path analysis identified a series of progressive stages. There may be significant overlap between some stages and setbacks may require multiple iterations of some stages; however the following serves as a useful guide to the way the focus may shift as the young person progresses through the Pilot:

- Stage 1: Intensive information gathering and initial assessment

- Stage 2: Monitoring transition into the Unit including impacts on the young person, staff matching, and impacts on other residents

- Stage 3: Intensive observation and validation of initial assessments

- Stage 4: Trials of interventions to move towards understanding behaviours, triggers and responses that reduce hyper arousal

- Stage 5: Moving toward age appropriate milestones and supporting young people to develop and move towards goals

- Stage 6: Exit planning

- Stage 7: Post exit support

Over the period of the Pilot speculation regarding opportunities to develop varying levels of therapeutic input has been proposed by DHS and CSO management. There is no evidence at this juncture to support changes to the intensity of Therapeutic Specialist input. As the TRC program matures, it is possible that some inputs that are currently tailored for each young person may be able to be systemised through the development of a refined quality system and operational practice guidelines.

Access to and continuity of the Therapeutic Specialist

Access and continuity in this context picks up on two key dimensions of the quality of engagement between the residential care staff and the Therapeutic Specialist. Staff and Therapeutic Specialists observed that when an environment is created where learning and reflection is reciprocal, the optimum quality of engagement and teamwork is achieved. Outcomes achieved when this environment is established include:

- Building and consolidating staff confidence

- Developing an open, honest, transparent and supportive environment

- Team building as well as informal peer support opportunities

- Debriefing specific to staff experiences

These practices lead to a more egalitarian approach while diminishing professional stratification and distance.

Overwhelmingly, staff considered that ongoing access to the Therapeutic Specialist in formal Reflective meetings and on an ad hoc basis was essential to achieving effective outcomes. They observed that program effectiveness was affected both by the Therapeutic Specialist's input into how residential care staff worked with the young person and in some cases their family members and in managing staff's own emotional and professional behaviour within the context of their work in the Pilots.

Staff from a Pilot that had experienced a considerable time without a Therapeutic Specialist provided the following insights, "Regular meetings with the Therapeutic Specialist are very valuable, but since the Therapist left (6 months ago) "we are

floundering" – a Therapeutic Specialist [a casual stand-in arrangement] attends meetings but does not seem to have the confidence of the workers".

Supporting staff to achieve client outcomes

Within this section, the Therapeutic Specialist's role in achieving outcomes through the staff is discussed.

The capacity to self-manage responses impacts on the degree to which staff in the TRC remain consistent in their approach to the young people. This capacity is significantly impacted by the access to the Therapeutic Specialist, particularly the day to day interactions. Consistent responses contribute to the effectiveness of Therapeutic processes.

The vacancies and alternate arrangements for Therapeutic Specialist input provided the evaluation with invaluable insights. One of the Pilots received ongoing support from a Take Two Clinical Team Leader during the vacancy over eight months. The Take Two Manager attended all the required meetings and developed a strong relationship with staff. The staff were nevertheless of one accord; outcomes for the young people were slowed due to reduced access to the Therapeutic Specialist. This example reinforces the critical importance of consistent access to the Therapeutic Specialist outside the formal Reflective Practice meetings relative to client outcomes.

Family support

Although only one pilot has a family therapist as a member of the program staff; working with families has been a consistent element across the pilots. Usually the Therapeutic Specialist took a lead role and quantitative data (see 6.5.2) indicates family connections have improved for most young people in the TRC pilots. However actual reunifications home for the young people were limited. Therapeutically informed interaction with families has resulted in:

- Reduced agitation and disruption from a parent/parents

- Supporting families to understand the support and care being provided to the young person by the TRC

- Supporting improved family relationships

- Supporting families to understand behaviours of young people and to reduce triggers that may prompt further emotional and behavioural problems

- Developing pathways for reunification (five instances – three unsuccessful)

- Assessing the impact and dynamics of families to promote enhanced therapeutic responses for the young person

Support for families is facilitated through staff and through direct contact including visits to the parent/parents and family home in some cases. Family contacts and connections are not exclusive to TRC Pilots, but are less consistent in the general residential setting. Staff member's involvement is commonly dictated by the quality of relationship an individual staff member (primarily the manager, supervisor or care staff) has developed with the family.

Tools

Therapeutic Specialists identified a number of tools that they used to support the assessment, monitoring and development of care plans for the young people. These tools include:

- Intervention Plan

- Trauma Symptom Checklist for Children (Briere, 1996)

- Social Network Map (Tracy and Whittaker, 1990)

- Harm Consequences Assessment (Take Two instrument)

It should be noted that the tools listed above were not employed in all TRC Pilot settings. Heart Rate Monitoring was used in one of the pilots as part of a process of measuring anxiety and progress for the young people.

In addition, the Pilot Evaluation required application of a range of tools in order to report on quantitative client outcomes:

- Strengths and Difficulties Questionnaire (SDQ)

- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

- Brann Likert Scales – a tool specifically developed for the evaluation to produce outcomes data that aligns with the Child Protection, Placement and Family Services Outcomes Framework (DHS Victoria)

The application of these tools supported Reflective Practice within each Unit relating to the young people's progress and their background. The input of residential carers and management supported high quality observations regarding each young person in the Pilot evaluation. A fuller discussion regarding the selection and application of these tools is provided in Section 6.2.

Identified areas for improvement

Service Improvement 1: Develop an accord

It will be essential that a sophisticated understanding and acceptance of the active dynamics of the Therapeutic Specialist input (supporting high quality outcomes) and the critical path of the young person through the Pilot is developed by the Agencies, Take Two, CYMHS/CAMHS, DHS and the individual Therapeutic Specialists. It would be beneficial to the program if this understanding and acceptance supports the development of an accord regarding those elements of the Therapeutic Specialists work that cannot be compromised if ongoing high quality outcomes are to be achieved. The accord should also be extended to a clear description of the Model and the identification of the active elements of a TRC Model that cannot be compromised if consistent high quality outcomes are to be achieved.

Service Improvement 2: Develop community of practice

The Therapeutic Specialists would benefit from developing and maintaining a 'community of practice'. A community of practice could facilitate the exploration the evolving development of Therapeutic Approaches with regard to program implementation and clinical care. This includes the evaluation and appreciation of International developments in the field. The 'community of practice' could emerge as a National body with International links.

3.1.3   Trained Staff and Consistent Rostering

Staff definition

This section details HR practices that are considered to contribute to the satisfaction of staff and the outcomes for young people. This section also details recommendations on how these processes can be improved.

Staff in this context are:

- Residential Care Program Manager – with multi site or multi program responsibility

- Unit Manager (Management, Team Leader)

- House Supervisor (Unit Supervisor, Supervisor)

- Residential Carer (also called: Care Workers, Therapeutic Workers, Therapeutic Youth Workers)

Individual pilots may have other roles and definitions that differ; in one of the Pilots the Case Manager is also Assistant Unit Manager. Pilots may have other persons who are not thought of as external stakeholders but as extended members of the team, they include; cultural support worker, educational support worker/ teacher/ teacher's aide, family therapist and Case Manager. These persons may be internal CSO employees or employed externally; what distinguishes them as extended team members is the way they operate in concert with the unit staff.

In Section 3.1.2 there is a discussion on the role and function of the Therapeutic Specialist who has a pivotal role in the Care Team, but is not part of the Unit staff group.

The workforce across the TRC Pilots can be broken down as illustrated in Figure 5. Staff as defined above and discussed in this Section make up 92% of the overall workforce who responded to the Workforce Survey.

Figure 5: Roles of Workforce Survey respondents
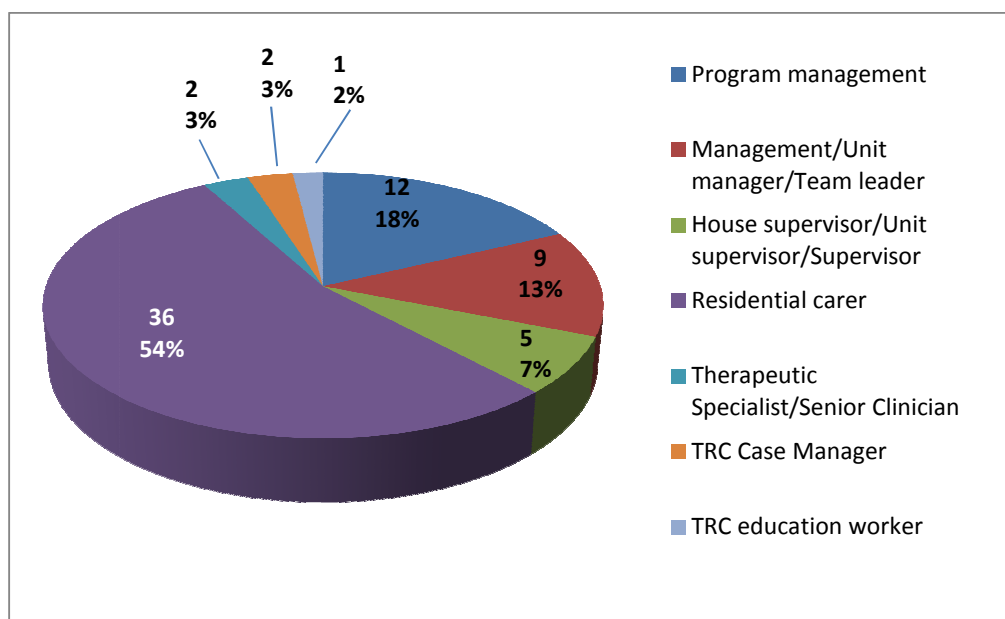
Staff turnover

The CSOs report that staff turnover is lower in the Pilots than in other Residential Units.

In the early development of the Pilots there was a settling down period with staff turnover typically being linked to:

- Not agreeing with and/or adhering to the practices required in the TRC Pilot

- Not fitting in with the team members

- Not having shifts that suited the team member

- Early occurrences of staff misunderstanding how to apply non-punitive approaches to behaviours of concern

Difficulties arising from staff turnover and subsequent problems in recruitment and training, particularly in rural regions, were expressed in a number of ways, including:

- Inconsistency of staffing and stress burnout arising from compromised rosters

- A tendency of some staff to default to traditional care approaches when under stress

- Unsupported residential carers focusing on house routines to the exclusion of therapeutic practices

- The use of agency staff (some Pilots) and untrained staff from the wider pool of CSO staff

- Reflective meetings and thinking being undermined by time pressures

As the Pilots have progressed, the factors contributing to staff turnover have significantly reduced (as measured by the change to responses gained from workshops in 2010 and 2011, staff and management surveys and other interaction with CSOs). A positive factor noted by a number of CSOs is the promotion of staff and staff pursuing higher education. This is contributing to a low level of staff turnover, provided sufficient challenge and variety is maintained in the workplace.

The maintenance of a stable team is an important element in supporting the therapeutic approach as young people need to be able to build trust and require a consistent approach from team members and stability in staff and roster arrangements supports this process. CSO staff observed "If staff members are inconsistent, behaviours deteriorate significantly" and "Consistency of staff – is foundational to the Therapeutic Approach".

Satisfaction measures

As a measure of satisfaction, staff in the TRC Pilots (n=87) compared their experience in other 'Residential Care' settings and universally responded: "I would not go back to a normal resi unit". There was only one exception whose response was "I would return, as long as I can take the therapeutic approach with me". Management responses were particularly poignant as Managers were regularly engaged with both therapeutic and non-therapeutic residential units. A sentiment expressed by one Manager provides a perspective on the impact of the Therapeutic Approach, "After a long-time in the sector you become cynical and worn down, seeing what is possible in the Therapeutic Unit gives you hope again and reminds you of why you wanted to work in the sector". Most of the staff in the Pilots were working in non-therapeutic residential care prior to taking up roles in the TRC Pilots.

The evidence shows that working in a program that makes a difference in the life of young people is rewarding and satisfying for TRC staff. Residential cares and Managers consistently expressed their commitment to facilitating change for the young people as a pivotal reason as to why they work in the sector. This issue is underscored by the following feedback, "The rewards of the role are that you feel like you are doing something for the kids rather than just chaperoning". This finding is consistent with literature on the subject; Dr Sandra Bloom has found that an outcome of trauma sensitive culture is better staff morale and lower turnover (Bloom 2005).

Sub-Section 3.1.8 reports on congruency; in that sub-section some instances of incongruent practices between DHS Regional Offices and CSOs are detailed. Where this existed TRC staff reported that it was demoralising and discouraging. The evaluators found that the following dynamics mitigated the impact:

- CSOs with a strong stable management and leadership culture managed the practices that were incongruent the best

- Good communication between the regional DHS office and the CSO

The absence of, or lack of access to, a Therapeutic Specialist was also found to negatively affect satisfaction levels. Staff reported that impacts on their capacity to self manage and the capacity to quickly respond and problem solve.

Staff recruitment

Regardless of the staffing model adopted, an essential element of an effective TRC has been consistently identified as being the passion, commitment and skills of all staff.

Particular attributes for appropriate staff have been described as:

- Understanding therapeutic processes and how to apply them

- Understanding their own triggers and responses

- Being responsive rather than reactive

- Considering and discussing their own impact on clients and other staff

- Working with known risks

Many of the interface Agencies consulted pointed out that the success of the TRC Pilots was attributable to passionate staff members who were committed to both the children and the therapeutic model of care.

Remuneration

It should be noted that while increased remuneration figured as an issue in discussions with staff, it was not raised as an overall driving dynamic in the choice to work in the sector or in fact seek other work. Remuneration was seen to be about the value that was put on the work and the added training. Worthwhile insights regarding remuneration can be understood through the following lens:

- Remuneration as a tool that reflects genuine reward and valuing of staff who have gained additional qualifications; this is about reinforcing the importance of the attainment and its impact on improved outcomes for young people and the degree to which the CSO genuinely supports their value statements

- Remuneration is not the main motivation for staff working in the Pilots: affecting change in the lives of young people is

- Constraints within 'the Award' impose problems with rostering. Some staff opt to forego pay to be at meetings. The new Award imposes 'breaks' – it will quickly become expensive to attend Care Team meetings

Staff Training and Development

The core training program for the staff of TRC Pilots is the 'With Care' two and five day training. This program is funded by DHS under the Residential Care Learning & Development Strategy (RCLDS) and delivered by Take Two in partnership with the Salvation Army Westcare. The two day 'With Care' training is provided to residential care workers in Victoria (general and therapeutic), and was continuously conducted throughout the evaluation. The subsequent five day training was specific to the TRC pilots.

The "With Care" (Stages 1 and 2) training draws significantly from:

- Sanctuary Model – Dr Sandra Bloom

- Attachment – Dan Hughes, Circle of Security, Mary Dozier,

- Resilience - incorporated in many perspectives, particularly Van Der Kolk and Bruce Perry

- Trauma – Van Der Kolk, Bruce Perry/Child Trauma Academy, Judith Herman

- Child development and brain development – Bruce Perry

- Organisational/learning culture – Peter Senge

- Congruence - James Anglin

Table 5: "With Care" training overview

	Stage 1: Two day "With Care"	Stage 2: Five day "With Care"
Topics covered:	• Understanding child & adolescent behaviour & development and how abuse and neglect affects functioning, developmental pathways, intellectual and emotional functioning, attachment capacity and ability to understand and form trusting relationships • Related theories: trauma, attachment, resilience, systems, organisational and learning theory • Understanding the traumatic impact of abuse and neglect on children • How theory translates into practice • Developmentally appropriate balance between empowerment & limit setting • Brain development • Basic building blocks of residential care • Triggers & vicarious trauma • Aboriginal children, young people, families and communities • Practice challenges and implications • Impact across LAC dimensions	• In-depth reinforcement and further detail of Stage 1 topics (over three days) • Community meetings • Action Learning and research • Congruence • Sanctuary Model • Working in a culturally informed way with Aboriginal children and young people • Working with families • Care Teams • How will Therapeutic Care look across your organisation • What do you need to make it work
Comments:	Stage 1 has been provided for over 800 residential care workers in Victoria over the period 2008-2011.	Stage 2 is targeted to staff working in the TRC Pilots, and includes time spent undertaking case studies and using Reflective discussion.

The Stage 2 'With Care' training was conducted with each TRC Pilot CSO and sought to include all program staff, organisational management, some interface agency staff and relevant DHS staff. The training was customised for each CSO in order to reflect the particular approach and target group.

The Stage 2 'With Care' training was repeated in April-May 2011, the first time this training has been offered since the roll out of the TRC Pilots. This was for new TRC pilot staff who had joined since the original training.

Additional training units (Stage 3 – "Advanced Trauma Training" for residential workers in all units across Victoria, Stage 4 – "Digging Deeper" for TRC Pilot staff) have been developed, and a training schedule is being planned with The Centre for

Excellence in Child and Family Welfare in order to roll these additional sessions out across the state through 2011-12.

Ninety percent of the staff and management in the TRC Pilots surveyed in 2010 had participated in the 'With Care' two and/or five day training. As there has been staff turnover since that period, the percentage of staff and Managers who have completed the 'With Care' training will have reduced (at the time of writing this report, June 2011).

Other notable training undertaken by staff and management as identified in the Workforce Survey includes:

• Bruce Perry/PACE/Sanctuary Model (28% of respondents)

• Strength-based approach (6% of respondents)

• Other trauma & attachment training (9% of respondents)

• DHS training: LAC/Best Interest/CRIS/CRISSP[4] (9% of respondents)

• Behaviour management/Restraint training/Suicide prevention/Therapeutic conflict management (7% of respondents)

The 'With Care' training is the central training required for care workers in the TRC Pilots. Over the period of the evaluation the call for refresher training and training for new staff members has increased in volume and urgency as noted in recent feedback from CSOs. The urgency and frequency of the calls have been measured through two rounds of CSO workshops (October 2009 to February 2010 and January to March 2011) and through management and staff surveys completed in April 2010.

CSOs have demonstrated a strong commitment to ensuring that the "right" staff are working in the TRC Pilots, and that the staff are provided with support to assist them in their role, in the absence of Stage 2 "With Care" training when they joined the TRC Pilots. The mechanisms being used by CSOs to support these staff include:

• Shadow shifts as part of induction process

• In-house training: one CSO provides training that includes; Therapeutic Crisis Intervention, Punishment versus Discipline by Prime Focus, Self Care

• Reflective Meetings with the Therapeutic Specialists

• Staff to staff, Manager to staff and Therapeutic Specialist to staff mentoring

• Recruiting from existing residential care staff pool and seeing if they can work therapeutically; one CSO reported; "Often 'try before you buy' – you recognise qualities in a person and try to help them move towards the Therapeutic Model. "It is obvious very quickly if they have the way of thinking" and "Some staff in the house have not had training, but already work in the Therapeutic way"

Through the workforce survey, staff identified ongoing training in the therapeutic approach and practice as their number one recommendation to improve or strengthen teamwork. Staff also identified that adopting team building exercises as a method of enhancing the consistency of approach. They consider this highly beneficial to the staff of the Pilots and to the outcomes for young people in the Pilots.

Rostering & consistency

Consistency and cohesion are among the primary drivers for positive outcomes for clients in the TRC Units. Cooperation and coordination between team members as

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[4] LAC - Looking After Children; CRIS – Client Relationship Information System; CRISSP – Client Relationship Information System/Service Provider

well as the client and their family also influence client behaviours and responses. The TRC staff recognise that when they are working well together with a positive, stable and enthusiastic team, they have a far greater impact on the young person. The development of consistent boundaries for both the young person and the care workers is a vital element of the Therapeutic Model.

CSOs report that the increased funding available in the TRC Pilots results in flexible rostering with more individualised support of the young people.

Having a consistent pattern of staffing and staff members is seen as a core feature that provides the predictability and stability that clients require. CSOs maintain a number of measures through the rostering to provide the predictability required to achieve the desired client outcomes such as rostering for both part-time and full-time offers consistency with some cross filling from other Units. The way handovers are managed is an important consideration in the rostering arrangements. Two issues have to be considered in the rostering arrangement. They include managing handovers in a manner that increases communication and reduces stress associated with the handover thus reducing the potential for the young people to 'act out'. It also provides time to document reflections from the shift and facilitates the documentation of more complete information about each young person. The roster elements or policies that are more common include:

- Most CSOs involved in the pilots have a policy of not using brokered staff

- Vacancies, sickness and holidays are covered by extending the hours of existing part time staff or using trained staff from other residential units or a pool of trained casuals who work across residential units; one CSO provided this insight, "Extra hours offered to part-timers as first call. We re-jig the roster where possible rather than get a new person in"

- Ensuring that staff that are there when the young person goes to bed are the same as those who are there when they wake up

- Allowing appropriate overlap time for handing over to another person when there are shift changes e.g. at the end of each shift a worksheet is filled out with any important information; verbal communication; phone updates to 'on-call' and Case Manager; completion of communication book/daily notes; and monthly case book with documented strategies may be updated

How staff, staff training and staffing arrangements contribute to client outcomes

- Having a consistent pattern of staffing and staff members is seen as a core feature that provides the predictability and stability that clients require

- Rostering that supports sufficient time for handovers which increases communication and so in turn reduces the likelihood of young people 'acting out' (during the handover)

- Trained staff consistently and skilfully enact the Therapeutic Approach:

  - providing an environment and strategies that produce healing

  - supporting young people to understand their own trauma history and learn that they are empowered to make their own choices

  - avoiding secondary trauma

  - mitigating opportunity for risk taking behaviour both as a consequence of the additional numbers of staff members in the Unit and them being attuned to the young people and their triggers

- Trained staff that are able to recognise and manage their own triggers thus:

- maintaining a consistent therapeutic approach in their dealings with the young person

- reducing staff turnover and therefore supporting consistency of people and approach (maintenance of known and trusted staff)

- providing emotional support

Suggested improvements

Service Improvement 3: Mandatory training for CSOs

- Require all staff working in the TRCs to undertake all Stages of the Therapeutic training (see above), with Stage 1 specifically included as part of their orientation prior to commencing work in the TRC

- Require CSO Management to undertake the 'With Care' two day training as part of their orientation prior to commencing work with the TRC or for those in CSO Management who have not yet undertaken the two day 'With Care' training

- Maintain a consistent regime of Stage 1-4 training with scope for additional sessions in response to CSO requests

- Promote regular TRC CSO days as a platform (among other things) to share approaches to rostering, training and Reflective learning

(A number of initiatives have already been implemented or are in planning to support these recommendations)

Service Improvement 4: Remuneration increases for training attainments

Additional remuneration for staff who complete approved training programs associated with the Therapeutic Residential Care should be available. This would serve to:

- Underscore the value placed on the training by the CSOs and DHS

- Reinforce DHS's commitment to the program and its underpinning theories into the long-term

- To telegraph to staff an appreciation of their attainments and their commitment to the model and its impact on the young people

3.1.4   Engagement & Participation of Young People

In the TRC Pilots the engagement and participation of the young people is an important and distinctive element of the program; this element is facilitated by the program and manifest in a two way relationship between the staff and the young people. The TRC Pilots draw heavily from the Sanctuary Model which is a trauma informed model of residential treatment developed by Dr Sandra Bloom. The various components that inform the Sanctuary Model framework for practice are also evident in the TRC Pilots. Specific components relevant to engagement and participation are:

- Community meetings

- Concrete behavioural goals within SAGE/SELF framework[5]

- A trauma sensitive culture that includes:

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[5] Dr Sandra Bloom developed SAGE/SELF, a framework for trauma-informed treatment that increases awareness of the impact of trauma and how individuals can overcome these challenges. http://www.fssinc.org/dhs_parenting_collaborative.html (accessed 5/7/11)

- Higher expectations and greater sense of responsibility (for both staff and young people)

- An emphasis on real and perceived safety for young people

- Improved ability to articulate goals and create strategies for change

- Better understanding of re-enactment behaviours – staff and young people

- More democratic at all levels

- Values clarification process/commitment to non violence and democratic process

Within the program, the engagement and participation in decision making and goal setting occurs in the following broad categories:

- When the young people are initially engaged about the possibility of participating in the TRC Unit

- During the period of time the young person is being prepared to enter the Unit

- During the young person's time in the TRC Unit

- In development and execution of exit plans and post exit support

The relationship dynamic is described by the young people interviewed in the evaluation as being superior to their experience in other Out of Home Care settings:

- "They respect my opinions and my need to feel safe at night - I read to the carers in my room until I go to sleep."

- "The carers listen to my feelings and respect them and help me work out stuff. They understand what I want to do with my life."

- "It is good. You are able to talk to the workers. They listen to you. They will take you out and talk. You can come home and there is someone you can talk to."

The testimony of the young people is supported by the quantitative research which details the best quality of individual relationships the young person has with a residential carer prior, on entry and during their time in the TRC. Figure 6 shows that the "poor" and "very poor" quality of engagement with residential carers consistently decreases over time, while the "high" and "very high" reports increase. Section 6.2 (Gathering Quantitative Data) details the sample sizes and data tools used to present the following figure.

Figure 6: Best quality of contact between young person and residential carers
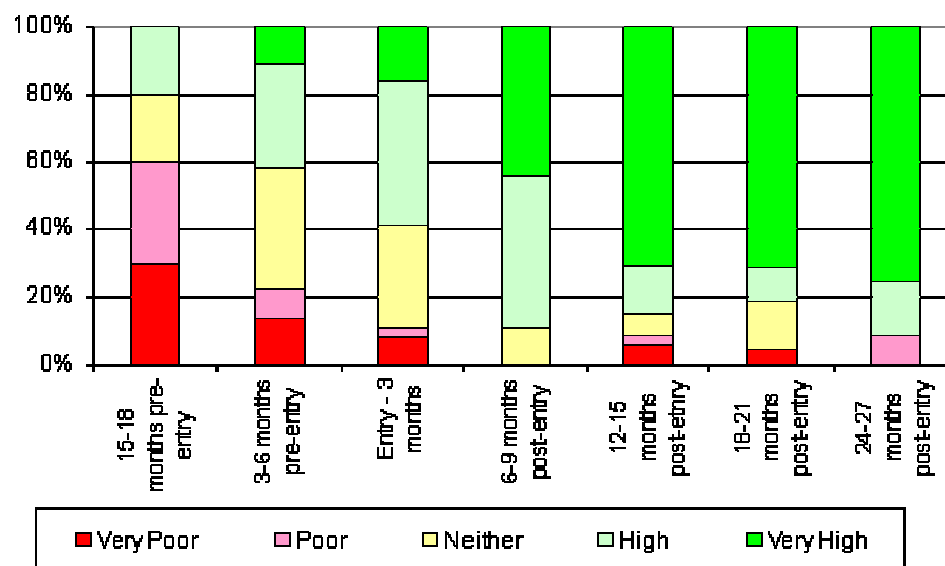
Initial engagement

Having identified a young person who could possibly participate in a TRC, staff approach the young person (after reviewing a variety of records that illuminate the young person's history) to explore with the young person the option of participation. The discussion may reflect on the young person's goals and how they may benefit from being in the Unit. The discussion may include supporting the young person to imagine what it would be like to live in the TRC.

This process focuses on ensuring that the young person has the opportunity to participate in the placement decision. This participation includes:

- Opportunities to identify processes that may help them make a decision e.g. meeting multiple staff members from the Unit on a one-to-one basis

- Having reasonable time to consider the choice to participate in the TRC Pilot

- Feeling that they can ask the questions that they would like to ask

Preparation for entry

The preparation for entry is built on the relationship that is established in the 'initial engagement' phase. The engagement and participation in this phase may include:

- Visiting the Unit

- Meeting the teachers in the Education Unit/Education Support Workers (as relevant in each CSO)

- Meeting the other young people in non-threatening environments, such as a social event

Ideally the literature suggests that four months be allowed for the 'initial engagement' and 'preparation' phase, however the reality of external constraints and demands most often see these stages take considerably less time, frequently as little as six weeks.

Dynamics in the TRC

The young people in the TRC Units are consistently engaged in democratic processes regarding 'their home' (the Therapeutic Unit); Dr Sandra Bloom states that an underpinning practice of the Sanctuary Model is a commitment to non-violence and democratic processes (Bloom 2005).

The community meeting is one of the instruments used in the TRC Pilot. These meetings assist in developing pro-social behaviours and it also provides a forum to develop and maintain consistent boundaries, to help name feelings and to underline the availability of help and support.

The engagement and participation is a product of the culture of the TRC Unit which is supported by:

- Sufficient staff resources to support staff to engage in discussions, 'to be there'

- Staff who are trained to engage with young people and who have the capacity to build trust; trust is supported by the application of consistent practice

- Responses from staff, other young people in the Unit and the individual young person that is 'Less victim blaming and judgemental'

- Responses from staff and from interfacing services that are therapeutically intentional and trauma informed (not punitive)

Exiting the TRC

The engagement of young people in relationships and their participation in decision making is an element that supports better outcomes for the young people including an enhanced capacity to articulate their post placement goals.

CSOs consistently identified that the resources available to facilitate post placements were inadequate and uncertain. As eleven young people in the evaluation have left, at the time of this evaluation, the full effects and issues of exit planning are yet to be fully assessed.

Post exit

CSOs identified that the young people sought to maintain connections with the TRC staff after they exited the Unit. This is an indicator of the strength of relationship or engagement with the young people and the significance of these relationships.

Further comment regarding the current availability and nature of Post Exit support is discussed in Section 3.1.10

3.1.5   Client Mix

The importance of the overall client mix when assessing the suitability of a potential new client in the TRC Unit is another program element identified through the evaluation. The objective of client group matching is to create a mix that maximises the opportunities for all young people in the TRC Pilots (current residents and the new young person entering the Unit) to benefit from the Therapeutic Approach. Consideration for compatibility may include:

- Clients already in residence (progress, background, trigger points, age, gender)

- Age and gender of the young person being considered for entry

- Particular care needs

- Willingness of the young person to participate in the therapeutic approach

- The CSOs' TRC designated targets

- Scope to apply therapeutic approaches within a longer-term framework (typically 24 months)

- The nature of externalised behaviours and the potential impact on others

Externalising behaviours

It is critical that in the identification and assessment process the additional range of supports and safeguards needed for clients with high levels of externalising behaviours are taken into account. These need to be viewed in the context of other clients who present a different range of needs and behaviours who are already residents.

Although a statement of eligibility was developed prior to CSOs receiving funding for their TRC Pilot services, workshop participants in 2010 and 2011 identified a range of additional influences on the selection of clients to fill vacancies. Influences include:

- Negotiating across varying operational interpretations of the stated eligibility criteria

- Managing differing priorities of stakeholders (including TRC services, regional DHS programs and other CSOs) such as pressure to accept short term emergency placements

Where the identification and selection process has not operated at an optimal level, contradistinctive views and priorities are evidenced such as unsuitable referrals or labelling of the TRC as being "overly-selective" or "elitist". The CSO's and Therapeutic Specialists indicated that this circumstance is often a consequence of referring Case Managers being unfamiliar with or having limited appreciation of the TRC approach and therefore making inappropriate referrals. Cases were cited where unreliable or incomplete referral information was provided to improve the likelihood of the young person being accepted for a TRC placement.

How this element contributes to client outcomes

The careful management of the mix of clients has the following impacts on the young people and their outcomes:

- Promotes and ensures feelings of, as well as actual, safety

- Facilitates relationships and dynamics that promote progress towards desired outcomes for each young person in the unit (alternatively does not negatively impact progress or foster relationships that are likely to increase risk)

Quantitative outcomes are specifically discussed in Section 6 of this report.

Suggested Improvements

Service Improvement 5 Child Protection and DHS Placement Coordination units training

- (Building on Service Improvement 3), Child Protection and DHS Placement Coordination units should be required to participate the Take Two trauma and attachment 2 day training . The recommended participation will support an understanding of the underpinning theories and practices of the TRC such as client mix and how it impacts on their role in referral and placement

Service Improvement 6 Develop standard documentation to support TRC Vacancies

- Develop standard documentation regarding the profile of young people being targeted to fill a current vacancy. The documentation should collect the extensive information required in a treatment focused system compared to the current arrangements focused on care and accommodation

3.1.6 Care Team Meetings

Care Team Meetings are facilitated by CSOs on a regular basis (one to four weeks) with contributions being made to the individual cases of young people by relevant stakeholders. The review process for each young person may take between half an hour and an hour depending on the young person, the complexity of their background and current issues. Stakeholders involved in these meetings include:

- The Therapeutic Specialist

- The Unit Manager

- Case Manager / Intensive Case Management Service (ICMS)

- Child Protection Case Manager (if relevant)

- Teacher/education support (depending on the circumstances)

- Parent/Family (in a few cases)

- Drug and Alcohol worker (if relevant)

- Mental Health Support Worker (if relevant)

- Police (if relevant)

- Young Person (in a few cases)

Care Team Meetings have been identified as having the following impacts:

- Enhanced communication supporting congruence and consistent approaches and measures

- Ongoing education and learning regarding therapeutic practice across multiple Agencies

- The identification of alternate strategies to support the young person's progress towards the identified goals and outcomes

- Problem solving regarding externalised behaviours (understanding the need/s which underlie the behaviours)

- Discussions regarding other young people who may be suitable for the TRC program (matched to the existing client group, within the targets for the individual TRC Pilots)

Client-focused practices are central in these meetings, the practices encompass:

- Focus on clients as individuals, not as collective groups

- Appropriate referrals and information sharing

- Proactive planning for each client

- Transition planning for entry and exit of clients

- Ensuring safety of clients and staff via safety plans and other strategies

- Culturally appropriate responses

- Measurement of client progress

- Clear and appropriate communication – amongst staff and between TRC and external Agencies such as DHS, schools and Regional Reference Groups

- Partnerships with schools to assist/encourage adoption of therapeutic practice

How this element contributes to client outcomes

Care Team meetings contribute to the goal of providing unconditional high quality therapeutically focused care and a disposition to 'never give up'. Through the meetings there are multiple inputs and in particular they support collaboration and up-to-date information about the young person. This supports a consistent approach and facilitates problem solving and solution development that would otherwise be unlikely. This results in an approach that reinforces/supports the therapeutic impact on the young person and supports problem solving when the approach is not producing positive outcomes for the young person.

Suggested Improvements

Service Improvement 7: Ensure that Care Team meetings have the all relevant people in attendance

- Ensure that all TRCs have a Therapeutic Specialist available to attend regular Care Teams and have a contingency arrangement to cover absences and vacancies. This is aimed at ensuring that the Care Team meeting regularly occur and that the pivotal role of the Therapeutic Specialist is a constant in those meetings.

- Care Teams have all relevant people attend including police where appropriate

- Supporting the participation of young people and families where appropriate

3.1.7 Reflective Practice

Reflective Practice was not identified as an essential service design element by DHS in the original brief defining the elements that were required in the TRC pilots. It is a finding of the evaluation that Reflective Practice is a program element of the TRCs. Reflective Practice is consistently employed across the TRC Pilots. The following section details the central role of this practice in defining the model.

The Australian Childhood Foundation makes this comment regarding Reflective Practice: "Reflective Practice is seen to be at the heart of effective therapeutic programs and the development of professional competence"[6]. It is a process by which staff in the TRC Pilots develop their skills and practices by being aware of their actions, responses and their impacts on the young people while they are working (practicing). The staff also reflect on the young people's actions, interactions and triggers within a framework that attributes meaning to the young person's behaviour. Within this practice framework, staff take dedicated time to evaluate their observations/learnings by talking and asking their colleagues and the Therapeutic Specialist to contribute to their observations and reflections.

TRC staff are coached and supported to develop this approach as a consistent practice and way of thinking; participating in team meetings is central to this process. Other team members participate in these meetings through Reflective Practice thus creating an environment where the practice thrives. The Therapeutic Specialist uses their expertise to create an egalitarian and an informed learning environment that reinforces the value of each team member's reflections and contribution. In this way what is learnt through practice is strengthened and reinforced and new ideas can be proposed for the benefit of the individual staff member, the team as a whole, the young person and the TRC Pilot. It is important to note that reflective practice should be given its own regular planned time and be differentiated from other meetings that staff attend.

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[6] Presentation from the Australian Childhood Foundation Community & Disability Services Ministers' Advisory Council National Therapeutic Residential Care Workshop 9-10 September 2010

The following benefits underscore the value of Reflective Practice in the TRC setting:

- Opportunity to increase knowledge and skills, including improved understanding of therapeutic strategies and application

- Improved outcomes for the young people

- Team development

- Personal support (self care)

- Understanding of sub-conscious contributions to re-enactments

There are differing responses that aid or restrict staff's participation in Reflective Practice; (1) initial reluctance to speak up or offer a solution due to being uncertain in group settings, their oral skills or status of the Therapeutic Specialist (2) being put at ease by the Therapeutic Specialist so it was never an issue to speak up (3) Not feeling valued or being left to feel unqualified to comment.

The application of regular Reflective Practice in the Units underpins an effective collaborative Therapeutic Specialist impacting on a range of outcomes and decision making processes as detailed:

- Ongoing assessment of the young person's progress with significant input from the staff

- Intensive responses to immediate individual client needs

- The development of alternate approaches to responding to needs of young people when other strategies and approaches have not succeeded

- Strategies and guidance regarding engagement with families of the young person

- Reflection on effective outcomes for the young people

- Support in the development of exit and post exit strategies and activities

Feedback from staff provides further insight into Reflective Practice:

- "Failure is OK. We use Reflective Practice space to help learning."

- "Quite a distillation of information occurs; it is a collaborative process."

- "At first I thought that I would have nothing to contribute."

How this element contributes to client outcomes

Reflective Practice is multi-faceted, with a range of discreet, obvious and subtle impacts on the outcomes for young people. The following highlights several of the areas where more comprehensive and multi-faceted insights are gained and shared:

- Triggers that prompt the young people to 'act out'

- Underlying factors (self revealing) from trauma history

- Responses and impacts of specific strategies that mitigate behaviours and/or promote progress toward goals for the young people

- Emotional impact on young people of their trauma history

- Staff gaining an understanding of their own history and its impact on how they practice

Reflective Practice assists staff to hone their skills in and capacity for interaction with young people in a intentionally therapeutic manner, which in turn has positive impacts for the young people

Suggested Improvements

Service Improvement 8: Ensure that Reflective Practice is supported consistently by the Therapeutic Specialist

- Ensure that all CSOs have a Therapeutic Specialist available to attend regular reflective practice meetings and have a contingency arrangement to cover absences and vacancies. This is aimed at ensuring that not only do reflective practice meetings occur regularly, but also that the pivotal role of the Therapeutic Specialist is a constant in reflective practice

3.1.8   Organisational Congruence and Commitment

Congruence DHS and the TRC Pilots

A fundamental principle in the Sanctuary Model and broader trauma theory is to acknowledge that residential care and the broader child protection and care system works in trauma context dealing with high service demand, traumatised clients and sometimes traumatised staff. This can include all the elements of the system not just TRC staff. As such a number of CSO's perceived that some DHS Regional Office practices (including Placement Coordination Units and Child Protection) were not always consistent with trauma and attachment theory. They stated that such instances were demoralising and discouraging for TRC staff.

CSO staff and DHS Regional management identified that there is varying pressure on CSOs depending on the region to fill unit vacancies. The range of requests or demands cited included; emergency placements, young people who were not matched to the young people in the unit, young people outside the Pilot target group and pressure to compromise the intake processes. The following statements are typical of widespread feedback received on this issue:

- "There is pressure to place kids in any vacant beds, but [our Manager] is adamant about who goes in"

- "We get a very good understanding of the chaos that is Child Protection. There is often desperation to get the child into a bed"

- "They deliberately withheld information that would have influenced the matching process and suitability of the young person for the program"

Where the DHS Regional Office staff understood and supported the Pilot (target young people, theoretical approach, entry and exit processes and matching) staff satisfaction levels were enhanced as were benefits for young people[7].

It should be noted that the TRC has a treatment focus which represents a significant shift from the care and accommodation focus of generalist residential care. DHS Regional staff were required to develop new and customised approaches to support:

- The identification of suitable young people

- The gathering of (or access to) comprehensive information to support more extensive and holistic assessments

- CSO vacancy selection processes

- Extended timeframes related to pre-entry interaction between the young person and the CSO

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[7] This observation is based on anecdotal evidence from a range of sources, as quantitative outcomes were not analysed at this level.

The positive impact of the flexibility and willingness of the DHS regional staff to develop and manage these customised approaches should not be underestimated. Although there are examples of incongruent practice effectiveness of the pilots was enhanced when CSOs and DHS maintained:

- Good two-way communication (written material from the CSOs outlining process and targets were cited by both CSOs and other consultees as significant contributors to quality communication)

- Regular care team meetings

- Regional Reference Group meetings

The evaluators also noted that CSOs with a strong stable management and leadership culture managed the identified pressures from DHS best. Good communication with the regional DHS office was evident in these instances.

Congruence TRC Pilot Organisations

The following circumstances and issues negatively impact on outcomes and general satisfaction:

- CSOs used personnel (brokered staff or staff from non therapeutic units) to cover staff shortages; these persons were not trained in the therapeutic approach [three known examples]

- A young person entered a TRC as an emergency placement [one known example]

- The Pilot, staff arrangements and model were not understood and/or not accepted by the wider CSO [two known examples]

As indicated above, the instances of these issues were limited however the occurrences provide insight into the way guardianship of the integrity of the model impacts staff. One of the stakeholders made the point; "If the staff perceive that the management are not sympathetic to the therapeutic approach they will quickly revert to old patterns of responding."

CSOs which had strong organisational congruence displayed the following consistent characteristics:

- A higher level of staff satisfaction – staff felt empowered to operate in a therapeutic mode and knew that they had the support of management

- Strong relationships with external stakeholders/agencies – fostered through deliberate and constructive engagement at all levels (management, Therapeutic Specialist, staff)

- Positive and collaborative relationships with Regional DHS (Placement & Support, and Child Protection)

There has been a maturation of the TRC Pilot in the last 12 months in relation to organisational congruence. In the first round of workshops TRC staff identified issues such as: jealousy from staff in non-therapeutic units, different expectations as to what a "Therapeutic Unit" meant and the CSO's organisational culture as the issues that impacted their satisfaction. The evaluators found that the concerns commonly expressed regarding organisational congruence when workshops were conducted in early 2010 and the mid 2010 Workforce Survey had to a large extent been resolved by the time workshops were conducted in February and March 2011.

Congruence with interfacing Agencies

Interviews with 26 interfacing Agencies and feedback from workshops with CSOs provided the following insights.

The TRC Pilot CSOs identified the following Agencies and key people as those with whom it is important to have a good relationship to ensure a consistent approach in the support of the young person:

- Student Wellbeing Coordinator (or similar role)

- Principal and Vice Principal of Schools attended by young people in the program

- School Year Level Coordinator

- Police Youth Liaison Officer/ Police Officers (where the young person has had ongoing contact with police)

- Youth Justice Worker (if relevant)

- DHS Case Contacting Team Leader

- Team Leader of programs such as 'Leaps and Bounds' and Education Support Program

The following were nominated less frequently, but reflect particular TRC client groups:

- DHS Refugee Minor Program - Case Manager

- Youth alcohol and other drug consultant

Some interfacing Agencies cited multiple points of contact with either the child or the TRC Unit (staff members, Therapeutic Specialist, TRC management) while others had minimal contact. As the regularity of contact with the young person and/or the TRC Pilot CSO diminishes so too does the interfacing CSO's capacity to provide proactive support of the overall direction of the TRC Model.

Most of the interfacing Agencies could identify the underpinning theory of the TRC Pilots as a program that uses stable relationships with the children along with a family style environment to bring about healing and change in the child's life through a sense of normality, responsibility and accountability. They identified that it uses a nurturing approach (looking beyond the behaviour to the need presenting) rather than punitive when the child 'acts out' or misbehaves. Twelve of 26 interfacing Agency representatives (46%) interviewed were aware of the needs of children in relation to their history of trauma and attachment type and the Therapeutic Approach to practice.

One of the key elements of the Therapeutic program is regular 'Care Team Meetings' and these should produce optimal service integration and coordination, continuity of care for clients and timely and appropriate information exchange. Most of those surveyed attended one or more Care Team or Case Management meetings per month and most have a vibrant working relationship with the TRC Unit and care workers with 'lots of informal contact by phone or email' as well as other more formal/structured meetings.

The regular meetings (including staff, parents, teachers and other interface Agencies) are recognised as a Key Element of the program and serve to maintain a consistent approach. Consistency was cited as a mainstay of the Therapeutic Approach and with that in mind a schedule of regular meetings with clients, teachers, care workers, Case Managers, staff and interface Agencies was seen as critical to the child's emotional, physical and mental wellbeing.

However, five interfacing Agencies (20%) (mostly schools and police representatives) indicated that they had 'no idea' of the underpinning theories or key elements of the TRC program and some said that they had little or no contact with the Residential Team and not much more than an occasional phone call or email. Police considered

that they could have a more positive role in supporting the outcomes for young people, however from their perspective this was not welcomed or sought.

Improvements identified by interface Agencies as a result of their positive relationship and participation with the TRC Pilots include:

- There is an atmosphere of collaboration and mutual support between many services that was not there previously. The regular Care Team meetings and case management meetings are providing a platform for Reflective care of the child while allowing for information to be shared in a systematic and professional manner

- With an increase in understanding the overarching theory and training in strategies and responses, many of the interfacing Agencies have found that they have a much better working relationship with the residential unit than previously

- Of the schools spoken to, many have greatly appreciated the "Calmer Classrooms" program and training[8], and have implemented the program throughout the whole school with positive results

Table 6: Calmer Classrooms: A guide to working with traumatised children

> "Both research and wisdom show us that regardless of the adversity they face, if a child can develop and maintain a positive attachment to school, and gain an enthusiasm for learning, they will do so much better in their lives. The role of teachers in the lives of traumatised children cannot be underestimated.
>
> "This booklet encourages teachers and other school personnel to forge those attachments through two key mechanisms: understanding traumatised children and developing relationship based skills to help them.
>
> "Teachers who understand the effects of trauma on children's education, who are able to develop teaching practices to help them, and who are able to participate actively and collaboratively in the systems designed to support traumatised children will not only improve their educational outcomes but will assist in their healing and recovery." (p iv)

Where it is problematic maintaining congruence with interfacing Agencies, the following issues and dynamics were identified by the evaluators:

- Those who believed that there had been no change in the way services worked together also felt they had no voice regarding the care of the child and were unsure of both their role and the role of other interfacing Agencies with regard to the child in question. These interfacing Agencies believed clearer definition of roles would facilitate a smoother, timelier exchange of information and client history which would in turn maintain consistency of care and response to incidents.

- The interfacing Agency was unsure of the theory and practices of the Therapeutic Care Model.

- Schools and Police identified difficulties regarding sharing information with relevant parties; they found privacy requirements were often stated as the reason for lack of information but found this to be inconsistent as the therapeutic approach is based on knowledge and understanding of the child's history. This issue persisted as a theme in workshops with the CSOs and with DHS Managers

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[8] "Calmer Classrooms: A Guide to Working with Traumatised Children", Office of the Child Safety Commissioner, 2007.

- Youth Justice stated that they considered engagement with the evaluators as a possible breach of privacy. CSOs were unanimous that engagement with, and obtaining information from Youth Justice was generally problematic

- A lack of regular and informative meetings to the extent needed by the interfacing Agencies in order for them to feel that they have an integral role in the care of the child/young person.

- Two CSOs raised concerns regarding congruence with the courts typified by the following remark, "Children's Court needs to be well educated in the process used in the therapeutic setting." Consultations indicated that the legal profession is interested in the advances being made and would welcome briefings.

Suggested Improvements

Service Improvement 9: Develop a therapeutic system

Develop a 'therapeutic system' to facilitate the shift from systems and procedures that support accommodation and care to a therapeutic system that facilitates and supports a treatment focus. Elements include:

- The development of a quality system for the TRCs that includes practices for CSOs and all of the DHS personnel involved in the TRCs. The quality system would serve to provide a framework to measure the application of agreed practices for all parts of the system outside the Pilots and to facilitate improvements to cross department practices such as the interaction between Youth Justice, Child Protection and the CSOs.

- Develop better and a more consistent approach to accessing and sharing records across Departments and jurisdictions

Service Improvement 10: Improve congruence through training and discourse

- Make the 2 day 'With Care' Training available for all Regional DHS staff regularly interacting with the TRC or the individual young people in the TRC

- Begin organisation to organisation discourse to identify barriers to communication and engagement and develop a joint action plan to resolve blockages

Service Improvement 11: Cross Agency Training and Briefings (courts and legal)

- Magistrates and judges in the Children's Court and other associated legal professionals should be provided with briefings regarding the outcome of this evaluation and the underpinning theories

3.1.9   Physical Environment

The physical environment

The essential service design element identified by DHS in the original design brief for the TRC pilots identified the element of the 'physical facilities'. The evaluators found the physical environment that makes up an essential element goes beyond the limitations of the facility, for instance, relating to how the young people express their experience of the physical environment:

Several CSOs explicitly identified the value of having:

- Purpose built/adapted premises that allow for private spaces

- Indoor recreation activities

- Design that assist in development of personal responsibility and hygiene

- The opportunity for young people to personalise their room

A number of CSO's provided no or little detail in their initial proposal to DHS regarding the physical environment however common elements have emerged across all TRC pilots that include:

- "space for a client to safely withdraw"

- "a place where staff can observe without intruding"

- "somewhere (safe) to use up energy (in bad weather)"

Three of the TRC Pilots have direct access to farms or farm like environments as part of their approach.

Homes visited in the course of the evaluation displayed several important features including:

- Minor maintenance was attended to

- None of the units had obvious damage

- Furnishings were home-like and coordinated

- The homes were spacious

- The young people spoke positively about the arrangements

Young people's perspective

In the interviews conducted with the young people they consistently called the TRC home and described other Residential Units they have lived as a 'unit'. When they were asked to explain this distinction, the young people talked about issues such as "it doesn't have that little window that they look through" and "you can have your own stuff". One of the young people talked about how they "acted out" and "wrecked some of their stuff in their bedroom (including a TV)". The young person stoically described how they needed to take responsibility for their action and how they would have to save money to replace what they wrecked.

The young people would appreciate the houses being consistent from the street with the other houses a remark that typifies the young people's perspective is; "you can tell a resi unit from the street, they are too plain".

There is a therapeutic intent

Prior to the young people entering a TRC Pilot their preferences for personalising their rooms in the TRC Pilot are discussed. Arrangements are made to respond to requests and preferences within reasonable limits and implemented prior to entering the TRC Pilot; this is part of the transition planning and process.

The private spaces, personal items and preferred furnishings contribute to the home-like environment and they have therapeutic intent particularly creating 'a safe place'. Anglin's research demonstrates the importance of 'offering a safer environment while they (the young people) work out their problems.' (Anglin 2002).

How this element contributes to client outcomes

The physical environment and the physical arrangements contribute significantly to the creation of a home-like environment that provides a sense of normality and ensures physical and emotional safety which is a key concept in Anglin's work.

Suggested Improvements

Service Improvement 12: Maintaining the exterior of the Unit

Ongoing attention need to be paid to the exterior of the TRC homes so they are consistent with similar houses in street; to reinforce normalisation.

3.1.10 Exit Planning and Post Exit Support

Essential Service Design Element – post placement support and leaving care was a required element for TRC Pilots. Through workshops and consultations, the critical nature of exiting, exit planning and post exit support has been raised by many CSOs as a subject of significant concern. The following section details the concerns, the effectiveness of current arrangements and recommendations.

Exit planning approaches

Exit planning approaches were articulated by those CSOs (Eastcare, St Lukes, Hurstbridge Farm, Westcare, Berry Street Southern, Menzies) who had young people leave the program; this relates to a total of ten young people across all the Pilots. Other CSOs were able to outline the approach they described in their original proposals.

There are different approaches and circumstances that drive the timeframe for an exit plan. A key determinate is the age of the young person on entry to the TRC Pilot as evidenced by CSO comments: "We think about the plan from the start. A 15 year entry age drives this approach as compared to 13 year olds" and "Exit is presently at 18, and over the two years work is done with the young person to ensure they are in a good space to go into Home Based Care or kinship placement."

Consistent with literature on this subject, some CSOs are acutely aware that age is not always a good indicator for exit planning as "chronological age may not be an indicator of emotional age" and "If you were basing the exit on developmental milestones, some kids may not reach that level for years."

CSOs consistently reported concern about mandatory upper age limits as a major determinate for exit from the program. These concerns stem from the CSOs' perspective on the way underlying theories of trauma and attachment support the development of strong relationships with residential carers. While these relationships are not familial, for many of the young people they are the only stable and trusting relationship that they have ever had with an adult. The impact on exiting into an environment without supports and the absence of these relationships causes staff in the TRC Pilots to have significant concerns. Comments that exemplify their concerns include:

- "are we setting them up, telling them that they can be open and afford the risk of trusting others and then abandoning them?"

- "The exit options are not there. We have developed a relationship to the extent that the child is calling the unit home. If it is home then parents don't just throw out their child when they reach 17."

- "17 year olds [still] need to be at home...there are no formal exit points [for young people this age and] kids often exit into homelessness."

One of the TRC Pilot CSOs develops exit plans based around any of the following:

- When the young person turns 16

- When reunification with family is a possibility

- When the young person has developed the skills to live independently

Another CSO defers developing an exit timeframe and plan until staff at the unit have had opportunity to get to know the young person. Some CSOs plan exits based on progress made towards skill attainments that support independent living. "The exit is usually planned for two years from date of entry, and the next step of the plan is for the young person to have gained emotional awareness and worked/planned for a new future, e.g. study, career, own house." Another perspective is that "the children usually know themselves when they are ready to exit", in that they have developed the necessary skills and support networks.

Exit planning has other layers of complexity as the TRC Pilots do not have uniform entry age and therefore differing perspectives as to when exit planning should ideally commence such as, "The main focus is to work with an end point in mind" and "the length of stay is anticipated to be 24 months".

High Needs

CSOs identified the high levels of need that still exist for the young people leaving the TRC Pilots: "We need to be mindful that they are high risk adolescents - services will not take them on". The Client Outcomes Data (Section 6) identifies the following characteristics regarding the young people that should influence when exit plans and post exit support are considered:

- Young people in the TRCs are experiencing significant reductions in behaviours of concern

- Young people in the TRC's experience significant improvements in positive and healthy behaviours

- While experiencing significant improvements in mental health and emotional health for young people in the TRCs these improvements do not occur as rapidly as the changes to their behaviours

- The measures of the young people's mental and emotional health remain at high levels at 24 to 27 months post entry to the TRCs when compared to CYMHS and normative population data indicating that whilst significant improvements have been achieved, there is still considerable work to be done and high degrees of vulnerability to be taken into account in future planning

- Trend data for the young people in the TRC suggests with ongoing and longer term support they may experience continuing reductions in mental health and emotional health symptoms and chronicity

Exit destinations

Locating exit destinations and managing the transition process for clients is a matter of concern for all TRC CSOs, and heavily relies on their capacity to work with the wider service system to identify a destination and appropriate exit process.

Where appropriate, families are involved in the exit discussions, but the young person and/or the families are not always interested in reunification even though the relationships may be better or have increased contact. It is also necessary to bear in mind that families have not benefited from the intensive therapeutic support which has been provided to the young people.

As the variety of responses and differing applications suggests this aspect of the TRC Pilots is still being 'bedded down', the most significant findings in relation to this matter are that:

- exits should be planned, with a consistent orientation toward skill development and readiness

- appropriate exit destinations must exist

The lack of support options particularly accommodation impinges on effective exit planning with CSOs consistently reporting: "There is a lack of opportunities for accommodation for these kids post placement. There are no guarantees." This perspective is echoed in a press release issued by Hon Julie Collins MP Parliamentary Secretary for Community Services (29/04/2011); "We know that children and young people leaving out-of-home care face many challenges and often do not have the support of their families as they move into adulthood. Young people leaving care have lower education levels, are more likely to be on income support and experience high levels of homelessness."[9]

Young people leaving State care are often required to live alone or with other young people in their mid to late teens, and lack an ongoing supportive base to continue and complete their education or go on to further training. Unlike their peers "leaving home", young people "leaving care" are deprived of the opportunity to return to their former accommodation if and when they need to. When young people who have been in care leave care, they are more likely to experience homelessness, unemployment, early parenthood, loneliness and despair[10].

The Department of Education, Employment and Workplace Relations has a range of programs that provide considerable assistance to young people with the profile of those in the TRC. The evaluators found no evidence of knowledge of these programs or of them being accessed and incorporated into exit planning.

Post Exit

Post exit practices and program responses described here are related to the maintenance of relationship with the young people. There is ongoing discussion (CSO staff and therapeutic specialists) regarding the quality and importance of the relationship the young person has with staff and how the relationship will outwork post exit. Attachment theory (i.e. emphasis on building capacity for secure, nurturing, attachment-promoting relationships with older, capable adults) is understood to underpin the building of resilience (Rutter 1987; Resnick et al. 2003) and may act as a "buffer to mitigate the impact of overwhelming stressors, and to support recovering and healing" (Blaustein & Kinniburgh 2005).

The evaluators observed in two settings where young people exited the TRC that the relationship remained strong and connected with regular contact and support.

As exiting and exit planning processes have a variety of responses and differing applications so too does post exit support. Representative comments include:

- Post exit – "staff keep in touch, e.g. visit young person in new house"

- "There is ongoing contact with the child: phone calls, visits, support with legal information"

- "The Post exit plan is prepared by the Case Manager and Clinician"

- "The young person visits the unit regularly and has a cuppa and chat with the staff"

- After care – "unit staff keep in contact for at least three months they make phone calls, the contact is ad hoc. If relationship is not well formed staff take turns managed through a roster to find out how kids are going"

9
http://www.juliecollins.fahcsia.gov.au/mediareleases/2011/Pages/jointrelease__outofhomecare_29april2011-of-homecare.aspx
10 Youth Affairs Research Scheme by David Maunders, Max Liddell, Margaret Liddell and Sue Green

TRC exits to date

Exits and exit planning is not fully developed as the numbers of planned exits have been limited. The following table identifies the exit history for the TRC pilots. The table identifies six planned and five unplanned exits. Deliberate ongoing post exit connections exist for 6 of the young people. One of the placements broke down due to a DHS emergency placement, one was court ordered and another was made against the recommendations of the staff in the TRC Pilot.

The exit history suggests that there is significant variation in the young people's journey. There is evidence of very good outcomes such as family reunification, however given that it may take more than 18 months to support and to embed behaviour change exits that occurred before this date may have reduced what placement in the TRC could have offered these young people (the average detailed in Table 7 is 1.4 years). The client outcomes data suggests that a placement of at least 24 months would be more likely to embed change. There is evidence that it may take longer than 18 months for the desired mental and emotional health changes to occur as detailed in the Client Outcomes section of this report. Three of the eleven exits (27%) may have been avoided with more congruent system wide arrangements with much better outcomes for the young people.

Table 7: Exits from the TRC

Young Person	Exit Option	Length of Stay in TRC (Year Fraction)	Planned or Unplanned
1	Disability supported accommodation and study (left due to age)	1.6	Planned
2	Living independently, working and studying	1.4	Planned
3	Reunited with permanent foster parents	0.9	Planned
4	Ran away to escape police, now in remand on a custodial sentence	1.4	Unplanned
5	Court ordered reunification which broke down after 3 months; Young Person is now living in General Residential Care	0.4	Unplanned by TRC
6	Ran away but is employed, living in stable accommodation, and is in regular and ongoing positive contact with care manager	0.9	Unplanned
7	Breakdown of placement, and transferred to alternative Residential Care	1.8	Unplanned
8	Living independently	1.4	Planned
9	Breakdown of placement	3.0	Unplanned
10	Family reunification, which broke down. YP returned to Residential Care	1.8	Unplanned by TRC
11	Kinship Care	1.4	Planned

Further Consideration for exit planning and Post Exit Support

CSOs identified the following issues that need to be considered when undertaking exit planning:

- The extent to which the unstable placement history[11] of the young people and its affect should be taken into account when developing the type of post exit planning and the supports that may be required

- The impact of secondary trauma that can be the result of the young person's unstable placement history and their experience of the OoHC system[12] and the potential that as exit age is reached that they may be triggered into episodes of anxiety and associated behaviours (this is an issue raised by a number CSOs)

- The opportunity to support further improvements to the young people's mental and emotional health with additional time in the TRC or a specifically designed post exit program

- The degree to which the stable attachments formed in the TRC may be required to facilitate stable mental and emotional health which will in-turn facilitate greater opportunities in life

Suggested Improvements

Service Improvement 13: Develop the supports required to continue the emotional and mental health improvements

Develop a more coherent and effective post exit care response that supports the time and resources required to continue the emotional and mental health improvements experienced by the young people.

Service Improvement 14: Ensure congruent approaches to maximise outcomes for young people by avoiding premature exits

Build on service improvements 11 and 9 to ensure that young people can maximise the benefits of the TRC by remaining in the TRC for the length of time that will support behavioural change. This can be achieved through congruent arrangements internally within DHS and externally e.g. the courts

Service Improvement 15: Make better use of all Government funded programs
Greater use could be made of all Government initiatives targeted to support young people at high risk such as vocational training options, employment services. TRC Pilot staff should be provided with comprehensive information regarding, housing, employment, vocational training, mentoring supports to assist them in exit planning and in the one-on-one discussion they have with the young people

3.2 TRC Models at Individual Sites

3.2.1 Introduction

The following Section discusses the application of Program Elements (3.1 above) by each Pilot, specifically targeting exceptions or deviations from the "majority" approach. The discussion and information presented in the section responds to the question: For each Therapeutic Residential Care pilot, what is the model, its key and distinctive elements, and the underpinning theory that supports such a model? To what extent are the models achieving their stated objectives/goals?

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11 The young people in the TRCs have experienced an average of 10.5 placements over a 6 year period spent in the OoHC system, before entering Therapeutic Residential Care; 1 placement change every 6.9 months (CRIS data file audit)
12 Anglin identifies the ongoing challenge in dealing with this pain and pain-based behaviour in residential care is not to unnecessarily inflict secondary pain experiences on residents though punitive or controlling reactions from staff (Anglin 2002).

This information in this section is drawn from a range of sources: original funding proposals, Workshop 1 (Service Modelling Workshop), Workshop 2 (Critical Path Analysis), Workforce Survey and broad discussions with CSO staff and management. In some cases information relating to a specific Pilot is not available; no comment is offered on these occasions.

3.2.2 Program Element 1: Therapeutic Specialist

Engagement arrangements

Take Two provides Therapeutic Specialists through sub-contracting arrangements with 11 of the 12 TRC Pilot CSOs. The exception is St Lukes; the St Lukes employed a Therapeutic Specialist though CYMHS/CAMHS. The Therapeutic Specialist role at St Lukes is currently vacant, and (at the time of the Final Report) has been so for over 12 months.

Eastcare also initially employed their own Therapeutic Specialist who was actively involved in developing the Pilot Model and funding proposal. However, prior to commencement of the Pilot, the Therapeutic Specialist resigned from the CSO. In this case there was a significant gap (12 months) before Take Two were contracted to provide a Therapeutic Specialist. Staff had undertaken Stages 1 and 2 of the "With Care" training, but did not have the support of a Therapeutic Specialist during this period.

Role in assessing referrals

The Pilots take a panel approach to assessing and accepting/declining referrals. The Panels typically include stakeholders such as Therapeutic Specialist, CSO Program Manager, CSO Unit Supervisor, Child Protection, Placement & Support). In some cases (Eastcare, Berry Street Gippsland) the Take Two Regional Manager also participates in this process.

Due to the characteristics of the Glastonbury Pilot, no referral or assessment process has been undertaken: the Pilot was built around existing clients, a group of young siblings who have remained in the unit.

The Berry Street Hume Therapeutic Specialist made the final decision regarding one referral (accept), but regardless of who makes the final call, the Therapeutic Specialist has significant input into the decision-making process.

Managing Therapeutic Specialist vacancies

During the evaluation five TRC Pilots have had the same Therapeutic Specialist (Berry Street Southern, Berry Street Hume, Glastonbury, Menzies, Wimmera Uniting Care) while the Therapeutic Specialists of five Pilots left the role (and the Pilot) during the course of the evaluation (Berry Street Gippsland, Westcare, St Lukes, Hurstbridge Farm, VACCA); Eastcare did not have a Therapeutic Specialist at the commencement of their Pilot, MAC did not commence their TRC until the latter stages of the evaluation.

Four of the Pilots experienced a lengthy gap (from 3 months to 12+ months) without a Therapeutic Specialist (Berry Street Gippsland, Hurstbridge Farm, VACCA, Eastcare). Interim support arrangements during the vacancies varied:

- Berry Street Gippsland and VACCA received ongoing input from Take Two Clinical Team Leader

- Hurstbridge Farm received support from Take Two

St Lukes has been without a Therapeutic Specialist for over 12 months. Occasional support is provided by Child and Youth Mental Health Services (CYMHS) – CYMHS would provide supervision for an internally employed Therapeutic Specialist

The absence of a Therapeutic Specialist for an extended period, without an effective interim support arrangement, was seen to negatively impact on the effectiveness of Pilots, in particular maintaining strong orientation of staff to the principles of therapeutic care.

Issues that contributed to turnover in the Therapeutic Specialist role included:

• Bypassing the agreed referral and assessment processes and thereby compromising the therapeutic congruence of the pilot

• Incapacity of a Therapeutic Specialist to establish effective relationships with the care staff and to foster a Reflective environment

• Promotion to another role within Take Two

Therapeutic Specialists working across two Pilots

At commencement of the Pilots, two (Menzies and Berry Street Southern) shared a Therapeutic Specialist. During 2010, another Therapeutic Specialist was appointed to work with both VACCA and Westcare. This scenario has been observed to provide a number of benefits such as cross-learning and observation of different group/staff dynamics, and reinforces the Therapeutic Specialist's capacity to support staff and equip them to respond to a wider range of situation within a shorter period.

3.2.3   Program Element 2: Trained Staff and Consistent Rostering

Limitations to training staff

Some CSOs (Wimmera Uniting Care, St Lukes, Berry Street Hume) indicated that their budget did not extend to cover the travel and accommodation costs associated with staff undertaking training at a central location. DHS Central Office has advised that training will be conducted in regional locations in order to address this issue; however the timing of this arrangement may not necessarily coincide with the need for staff from these CSOs to attend the relevant modules.

All Pilots made comment regarding the difficulty in backfilling shifts with appropriately trained and skilled staff while team members attended training: "who will look after the kids?"

Use of brokered workers / Backfill strategies

The majority of CSOs specifically stated that they did not use brokered staff at all in their TRC Pilots (Westcare, Menzies, Berry Street Gippsland, VACCA, St Lukes, Berry Street Southern, Wimmera Uniting Care, Hurstbridge Farm, Berry Street Hume). These CSOs achieved this through cultivation and maintenance of a core casual pool and/or drawing on therapeutically trained staff from other units.

Glastonbury stated their preferred approach was to maintain a pool of casual staff, trained in the therapeutic approach and known to the children in the unit. This strategy, however, did not prove to be effective in that Glastonbury could not offer the casual staff a sufficient number of shifts; the result was regular turnover of casual staff. The alternative approach currently in practice is a collaborative arrangement with a brokerage service: individuals identified as being sympathetic to working therapeutically are provided with the appropriate training, and engaged through the brokerage service. These staff are then able to work across other services if not required at the TRC Pilot.

Where possible, Eastcare utilise a pool of therapeutically trained casuals. Eastcare has, however, built a strong relationship with a brokerage service and is able to call on a select group of staff known to the young people and staff in the TRC. Hurstbridge Farm described a similar arrangement with a brokerage service, used in similar circumstances.

Rostering

Rostering approaches are unique to each Pilot, crafted around the particular developmental needs of the young people they are supporting. It is also worth noting that at least five CSOs (Westcare, Glastonbury, St Lukes, Eastcare, Wimmera Uniting Care) have reviewed or are in the process of reviewing their roster structure. While it is recognised that such reviews often emerge from a range of circumstances, stated reasons are as follows:

- Westcare: budget constraints necessitated a change from overnight stand-up and sleepover rostering to stand-up only

- Glastonbury: the changing routines of the children in the unit have necessitated adjustment of the weekday roster to provide the necessary support

- Eastcare: currently a staggered shift model, but contemplating a "team on, team off" approach to minimise handovers as the young people tend to escalate during handover

Overnight rostering is a particular example of variation across the Pilots. The following CSOs operate a "sleepover" model: Glastonbury, Berry Street Gippsland, Berry Street Hume (two staff on sleepover), Wimmera Uniting Care.

Westcare has one staff member on "stand-up" (active overnight), while Hurstbridge Farm has two staff on sleepover, and a third on stand-up. Westcare particularly commented on the therapeutic value of overnight stand-up rostering "there are a lot of disclosures late at night."

Particular value was placed on having the same staff member rostered for "bed and breakfast", which was seen to contribute to the young people's sense of safety and security, as well as normalising the residential care experience to be more similar to a "home" experience.

"Family Business"

VACCA particularly commented on the staffing challenges they face in relation to extended absences or resignation due to "family business" commitments. Connection to culture has a particular emphasis in VACCA's TRC Pilot, and while this provides young people in the TRC opportunity to observe what genuine connection to culture involves, it remains a challenge to ensure that appropriately skilled and trained carers are available.

In addition, the extended concept of family in Indigenous culture has resulted in staff finding they are related to young people in their care (VACCA, MAC). While there is potential for this to cause difficulties, VACCA has reported that, to date, this dynamic has been beneficial to the relevant staff member and young person building their own relational connection.

3.2.4   Program Element 3: Engagement & Participation of Young People

All CSOs endeavour to take an individualised approach to engagement and participation of young people; it is therefore difficult to identify CSO specific variations in this Program Element.

3.2.5   Program Element 4: Client Mix

Target group

Each of the TRC Pilots put forward their preferred target group in their proposal to run a TRC Pilot:

Table 8: TRC Pilot target groups

CSO	Initial Target Group	Comment
Glastonbury	Sibling group	The sibling group were existing residential care clients
Westcare	High risk, high needs adolescents	Originally the TRC had a focus on family reunification; while work continues with families to improve relationships and connection to family, less emphasis is placed on family reunification as a primary goal. A Family Therapist is part of this TRC program
Eastcare	Females 12-14.25	A primary goal is to skill the young people for independent living
Menzies	Young people aged 12-17 with diagnosed intellectual disabilities	Due to the ID criteria, emphasis is placed on equipping the young people for a successful transition to adult accommodation
Berry Street Gippsland	Age 11-14, high support needs (RP2)	The target group has been revised in negotiation with DHS to target more complex young people at higher risk (RP3)
Berry Street Hume	Age 15-17	Target group age has been revised to 12-14 years, considering gender specific focus
Berry Street Southern	Age 13+, on High Risk Adolescent Register	Considering a focus on younger age group; continuing emphasis on restoring family connections where possible
Wimmera Uniting Care	Age 12-14	Focus on improving young people's connection to family and community
St Lukes	Age 13-15	Focus on developing community and education linkages and supports
VACCA	Age 9-12 years, ATSI	Currently a state-wide service; focused on transition to kinship/home-based care
Hurstbridge Farm	Age 11-14, trauma related presentations	Considering a focus on younger age group; priority goals of re-establishing family connections, and developing pro-social functioning
MAC	Age 0-14, ATSI	Focused on Indigenous young people coordinates with MAC internal education program

In the course of operating the Pilots, however, some CSOs have seen value in revising the characteristics of their target group. Formalising such a review involves the endorsement of the Regional Reference Group to ensure compatibility with the characteristics of the young people in the Region in need of residential care.

Particular reasons cited for reviewing the target groups were:

• Establish a viable funding base for the Pilot

• Limited numbers of young people in the region who meet the target group criteria

• Growing recognition that in practice, the effectiveness of the therapeutic approach is increased with younger age at entry, 11 years of age being regularly suggested

Family reunification objective

While a common theme in the original proposals (Glastonbury, Westcare, Berry Street Gippsland, St Lukes, VACCA, MAC) there has been a shift toward "re-building family connections" rather than specifically family reunification. This is largely due to the

range of factors which are outside the remit of the TRC Pilots which obstruct achievement of such a goal. There have, however, been a small number of successful family reunifications (Westcare, Hurstbridge Farm).

3.2.6   Program Element 5: Care Team Meetings

Care Team members

Care Teams for young people in the TRC Pilots have a similar composition, typically including stakeholders such as: Child Protection worker (DHS), Placement & Support (DHS), Therapeutic Specialist, Program Manager, Case Manager, TRC staff (key worker/team leader/all unit staff), education representative (teacher/ worker/specialist), other professionals as relevant (mental health, Youth Justice, Victoria Police, drug & alcohol worker).

Particular variations include: Family Therapist (Westcare), parent/family members (depending on the relationship). Some CSOs allocate a "Key Worker" for each young person (Berry Street Hume, Hurstbridge Farm). In these cases the Key Worker plays a critical role in the Care Teams; other unit staff are unlikely to specifically be involved in Care Team meetings where there is a key worker.

Meeting frequency

Care Team meetings focus on one young person at a time, and consider the specific needs and progress of each individual. Meetings typically take 1-1.5 hours per young person.

Glastonbury, Berry Street Gippsland, Eastcare, Berry Street Hume and Hurstbridge Farm conduct Care Team meetings on fortnight-monthly basis; Menzies and Berry Street Southern have Care Team meetings 6-8 weekly; while Wimmera Uniting Care has Care Team meetings weekly.

3.2.7   Program Element 6: Reflective Practice

The majority of TRC Pilots conduct focused Reflective Practice meetings on a fortnightly basis, ranging from 90 minutes (Menzies, Berry Street Southern, Hurstbridge Farm) to 4 hours (St Lukes).

Eastcare has weekly Reflective Practice meetings with a typical duration of 4 hours.

Berry Street Hume takes a different approach with 3 hour Reflective Practice meetings held monthly, supported by half hour catch ups each morning which have a reflective bent.

3.2.8   Program Element 7: Organisational Congruence and Commitment

In general, CSOs have shown an evolving sophistication in their understanding and practice of congruence and commitment to therapeutic care.

Two standout examples of organisations which have successfully engaged with the wider sector and DHS touch-points are Menzies and Glastonbury. Both CSOs have built strong relationships with interfacing Agencies and Regional DHS oriented to meet the specific needs of their client groups. In particular, Menzies has a particularly strong relationship with Disability Services, while Glastonbury has a comprehensive network of support across Geelong for the young sibling group in their care.

In contrast, St Lukes provides an example of a lack of congruence, and the consequences of this dynamic. In particular, incongruence between the CSO and Regional DHS came to a head when the agreed referral and assessment process was bypassed. The CSO and the Regional DHS staff recognise in hindsight that the

resulting emergency placement was a key factor in the eventual breakdown of placement of one of the young people who had benefited significantly from their longstanding placement in the TRC Pilot, with other residents also affected to a lesser extent. The emergency placement was also the major reason cited by the Therapeutic Specialist for resigning and was a significant factor in the Unit Manager's resignation. The turnover of staff resulted in uncertainty and dissatisfaction and has taken over 12 months to resolve.

3.2.9   Program Element 8: Physical Environment

Hurstbridge Farm

A major thrust of Hurstbridge Farm is its rural setting and farm activities. Another unique attribute of the Farm is that it comprises two 4-bed homes, rather than one large residence and has a school on site. The school is run by the Department of Education and is an extension of Baltara School. It was envisaged that involvement and responsibilities for activities related to running a "real farm" would form a key element of the therapeutic environment, while the 2 x 4 units would ensure a small group dynamic.

St Lukes, Berry Street Hume, Berry Street Gippsland

These TRC Pilots are located in rural locations (not working farms). Particular benefits observed include extended space for outdoor recreation activities (basketball court, riding bikes), and large indoor areas (workshop, education rooms, craft/art rooms) and the distance from urban centres.

Berry Street Southern

Unlike the other TRCs, Berry Street Southern operates 2 x bed units, located in St Kilda and Bentleigh (Hurstbridge Farm has 2 units on the one site). This structure enables a highly customised approach, given that staff are considering the needs of just two young people; although this model does not provide economies of scale in terms of the staffing structure.

3.2.10 Program Element 9: Exit Planning and Post Exit Support

Exit destinations

All CSOs endeavour to draw on the "leaving care" resources and programs available in their Region. As noted elsewhere in this report, these options are often limited and may not be suitable for young people leaving TRC care.

Two standout approaches are detailed below:

- In addition to the two homes on site, Hurstbridge Farm has a single bedroom unit with a kitchenette and living area that has been used to trial independent living arrangements for one of the young people. This arrangement was part of an effective and comprehensive strategy supporting exit arrangements for a young person

- Eastcare has a "step-down" unit attached to the TRC which has been utilised by one young person while transitioning to another accommodation arrangement

Exit experiences

With regard to the eleven young people who have left the TRCs who were part of the evaluation study group, exit experiences included:

- Planned exits consistent with the preferred approach (Menzies, Westcare, Berry Street Hume, Hurstbridge Farm)

- Unplanned exits ordered by the Court and contrary to what the CSO thought was in the best interest of the young person; young person is currently back in general residential care (Berry Street Southern)

- Unplanned exit due to young person running away; one young person is currently on a custodial sentence, another is living independently (Berry Street Southern)

- Unplanned exit due to the young person's lack of engagement with the program (Eastcare, Hurstbridge Farm)

- Unplanned exit precipitated by inappropriate client mix due to incongruent practice (St Lukes)

Of the exits to family/foster care, two have been successful, while four have broken down.

Post exit support

Westcare has developed a comprehensive Post-care Support arrangement which involves TRC staff, the relevant Case Manager and the Family Therapist. A schedule of regular contact by means of visits or phone calls with the young person and family (either separately or together) is in place, and has proven beneficial in this case of family reunification.

Menzies provides extensive post exit support for three months including case management, outreach support and planned respite. One of the young people who exited was supported by Menzies to finish her schooling (Year 12). A variation specific to Menzies is support provided to ensure the exiting young person is registered as a client with Disability Services, which includes access to supported accommodation.

The young person who exited the Berry Street Hume TRC is a particular success story. Over time she built a strong relationship with the family of a school friend, which led to her transitioning from the TRC to living with the family. The young person has ongoing case management support, which has been valuable in assisting her to settle into a new family situation.

Berry Street Southern endeavours to provide appropriate supports for young people who have exited, however the circumstances of the three exits to date (court ordered family reunification) have limited their capacity to respond to the particular needs of the young people. At the time of the second workshop (Critical Path Analysis), it was reported that one of the young people was homeless (sleeping rough), the family reunification effort having failed.

St Lukes and Eastcare have provided a range of supports for the young people who have left their TRC Pilots, including phone calls, visits, access to legal assistance/information, access to a step down unit and welcoming visits by the young person at the unit (where appropriate).

Issues related to building staff capacity

Berry Street Hume has been confronted with a situation where the capacity of some workers has developed (through training, experience and formal education) to the extent that they are seeking further challenges and are seeking to extend their opportunities. If the TRCs cannot offer opportunities for these workers to advance their professional skills and standing, it is likely that they will seek other employment. Feedback from the Pilots is that staff in TRC Pilots are seeking educational advancement at a higher rate than their counterparts in non-therapeutic

care. Although this dynamic should be seen as a positive it does impact on the capacity to provide long-term stable staff to deliver a model based on Trauma and Attachment theory.

Case Management

A number of different approaches to case management have been adopted by the Pilots. Most are case contracted, while DHS case management is in place for young people at Wimmera Uniting Care.

Of those which are case contracted, most Case Managers are part of the CSO's specialist case management team (in some cases ICMS): Westcare, Eastcare, Menzies, Berry Street Hume, St Lukes and VACCA.

Glastonbury, Berry Street Gippsland and Berry Street Southern however have case managers specifically attached to the TRC Pilot. In the case of Glastonbury, the Assistant Unit Manager is also the Case Manager for all the children in the Pilot.

Some CSOs specifically allocate different Case Managers for each of the young people in the TRC (Berry Street Hume, Berry Street Gippsland) in order to reinforce a one on one focus; other CSOs may allocate multiple young people in the TRC to a single Case Manager.

Interaction with Therapeutic Specialist

Positive interaction between TRC staff and the Therapeutic Specialist has been described as essential. In the early stages of their Pilot, however, Berry Street Gippsland experienced a situation where the Therapeutic Specialist and staff were unable to cultivate a reflective environment; this in turn affected the implementation of therapeutic care. After a number of months, the Take Two Clinical Team Leader stepped in to pick up primary support of the TRC staff; several months further on a new Therapeutic Specialist was appointed, who has been able to build on the strong foundation laid by the Clinical Team Leader.

4 Service System

Within this section the conditions under which the therapeutic practices have been applied and the resultant positive outcomes for young people have been reviewed with specific reference to the service system. The evaluators recognise that the TRC Pilots do not operate in a vacuum and their efficiency and effectiveness are impacted by the service system they sit within.

The evaluation questions answered in this section are:

- What are the detailed arrangements (e.g. processes, protocols, guidelines and reporting arrangements) that describe the relationships between the TRCs and the service system and how can these be further improved?

- To what extent have better links with other parts of the service system (e.g. with schools, mental health, disability services) been forged as a result of these models?

Summary of Findings

Building and maintaining strong relationships between the TRC Pilots and interfacing Agencies needs to be a priority.

- Engaging with other Agencies, including education about the Therapeutic Approach, should be a focus of both TRC staff and management

- These relationships require all parties to take the time to understand the extent to which they can support each others' role in enhancing the wellbeing of the young people

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4.1 The Dynamics of Service System Relationship

Where possible, the consultants engaged directly with "interfacing Agencies", those organisations which have a specific role in ensuring the wellbeing of the young people involved in the TRC Pilots such as; education, police, youth justice and mental health services. There was some representation of these organisations in the Round 1 & 2 workshops. Targeted telephone and face-to-face interviews were also conducted in mid 2010 with these service system representatives and some additional face to face interviews have been conducted subsequent to these dates to seek clarification and to pursue new lines of enquiry in response to learnings from the evaluation. An additional workshop was conducted with DHS Regional Managers and staff in April 2011 in response to issues raised by CSOs during the course of the evaluation. The various impacts of the issues and concerns were explored with DHS staff in this workshop.

The insight and observations of key sector voices (The Centre for Excellence in Child and Family Welfare, DHS Placement and Support and Children Youth and Families Division, Berry Street/Take Two, The Office of the Child Safety Commissioner, and CREATE) were also sought in regard to the relationship between the TRC Pilots and interfacing Agencies.

4.1.1 Key Relationships

Key relationships include the following:

- DHS: PASAs[13], Case Contracting Team Leader, Refugee Minor Program Case Manager, Child Protection Worker/Case Manager, Placement Coordination Worker

- Education providers: Principal/Vice Principal, Student Wellbeing Coordinator, School Year Level Coordinator

- Police: Youth Liaison Officer, local police officers, community policing

- Specialist Support Services: Youth Drug and Alcohol Worker, Take Two Therapeutic Specialists, CYMHS Clinicians

- Youth Justice worker

- Health Professionals: Local GPs, Chemist, Dentist, Mental Health Services

- Case Managers – (DHS and CSOs)

4.1.2   Developing and Maintaining Key Relationships

Key relationships are maintained through:

- Regular interaction (not necessarily in meetings) in relation to supports and services accessed by the young person (weekly or more often)

- Care Team Meetings (weekly to monthly depending on the CSO and the particular needs of the young person)

- Reference Groups (three to six monthly; initially focused on implementation of Pilots, now focus on operational issues)

Other important relationships are established through occasional interactions, these include:

- Case Managers advocating for the young person they are supporting to be placed in a TRC Pilot or presenting to intake panel; may also be working with the young person and their family

- Local Police (normally infrequent except for several young people who have very regular contact) usually with the Unit Manager

- Health Professionals usually with the Unit Manager, residential staff and ICMS

- Secure Welfare workers

Regular informal interactions

Training or schooling is a key focus of ongoing contacts requiring in some cases daily interactions and therefore this discussion is framed around these relationships. This discussion illustrates the underlying principles and dynamics of the informal regular service system relationships. The education and vocational arrangement across TRC Pilots and for individual young people varies including:

- Internal schooling within the CSO

- Education at an onsite school (on the property) in the case of Hurstbridge Farm that includes farming/ animal husbandry activities

- 'Special school' for some young people with particular special education support needs

- A private school arrangement that was calculated to have a particular therapeutic benefit

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[13] Program and Service Advisor

- Regular mainstream schooling, additional coaching arrangements as required

- Assistance to develop apprenticeships and have vocational training and their work arrangements that prompt regular interaction

The variety and occasion of the interactions lend themselves to the primary relationships being established and maintained by staff in the Unit. A Case Manager commented "The TRCs are different as there are things that I would expect to do as a Case Manager that the staff attend to". In one of the CSOs the Case Manager is also the Assistant Unit Manager; this TRC supports a sibling group. The stable placement experienced by young people in the TRC Pilots – see 6.5.3 which demonstrates an improved outcome for the young people with regard to their relationship with their residential carers - also supports the development of a broad range of relationships that are strengthened over time.

Staff are constantly mediating issues and relationships between the young people in the Pilots and the external Agencies and their staff. These interactions and the way they support the young people in the Pilots is part of the Therapeutic process which embraces a constant and consistent approach to learning, growing and reflecting.

The daily problem solving and communication affords staff the opportunity to educate Services/and their staff in the therapeutic approach. This has led to increased congruency as stakeholders have identified how to realise the theory in practice.

Care Team

Care Team meetings have been discussed extensively in Section 3.1.6 as a key element of the TRC Pilots. DHS Regional Managers identified that while care team meetings occurred in general residential settings, "they were less likely to include Child Protection" and "the frequency and time given was less intense [in general residential settings]".

Regional Reference Groups

Regional Reference Groups were established as a mechanism to bring together the CSO operating the TRC Pilots and the wider service system. The Reference Group had a significant role in the pre and early stages of the Pilot to ensure that the Pilots were implemented in a manner reflecting the underpinning theories of Therapeutic Care.

The Reference Group's raison d'être was in some cases viewed to have been satisfied when the implementation phase was over. As issues emerged and new young people entered the TRC Pilots, the Reference Groups have positively reoriented to a new role. The DHS Regional Managers identified the Regional Reference Groups as "a key way of staying in touch". Reference Groups generally meet bi-monthly. The focus of a number of Reference Groups has been to review (and in some cases redefine) the TRC Pilot target group. The two changes that have been identified (see Section 3.2.5) are:

- Relaxing the strict focus on family reunification for two of the Pilots

- Shifting the target age group downwards

Every Pilot has a Regional Reference Group. Members of Reference Groups are typically:

- CSO Management

- Therapeutic Specialist

- Unit Manager

- DHS Regional Offices - Placement & Support

- DHS Regional Offices - Child Protection

- DHS Regional Offices - Disability Services

- DHS Central Office – Placement and Support

- Other providers of residential care services in the region

- Department of Education and Early Childhood Development (DEECD)

Infrequent contacts

The managing of the infrequent contacts is the most challenging aspect of developing congruent practice in the TRC Pilots. Typically infrequent but important service system contacts are with:

- Youth Justice

- Some team members of Placement & Support and Child Protection

- Individual Police members (usually)

- Health Professionals

Challenges to optimal service system relationships

In the process of the evaluation information exchange was consistently raised as being problematic. Significant resources are unnecessarily absorbed by staff who have to spend time navigating their way around individual blockers and system blockers. Broad consultation identified that challenges often arise from several underlying themes:

- Managers in DHS Regional Offices and across the CSOs observed that the current OoHC system is designed to provide safety, and basic care and accommodation, with an emphasis on risk management. They have commented that TRC Pilots seek to create holistic goals and use clinical approaches that bring about healing which is a significantly different goal. They are of the view that systems, information, data sets and methods all have to be redeveloped or built from scratch to support achievement of therapeutic goals through a therapeutic approach which also manages risk

Example

The following example was provided in the course of the evaluation and serves to illustrate the way that the broader system design impacts on the TRC Pilot program.

"At the time Child Protection removed the subject child from the family home they found that the child was wearing shoes that were far too small and causing the child severe pain. It was not in Child Protection's remit to pass on this information as they were not operating within a therapeutic framework.

"It was later found that the shoes were a significant symbol to the child of their trauma history and the requirement to wear shoes was a trigger for escalated behaviour.

"A person with a therapeutically informed approach would identify the potential for information regarding the shoes to be significant in developing strategies to bring healing to the child in the context of their traumatic past."

- The underpinning theories relating to Therapeutic care are not understood or accepted by all of the CSOs and personnel across the service system that TRC Pilots are relating to

- The administration and emphasis on non punitive approaches has been highlighted by detractors of the TRC Pilots as an imponderable response to young people's 'bad behaviour'

- Relevant and vital information is restricted or hard to access, Agencies holding the information cite privacy laws or internal protocols as the reason for restricting or denying access to information considered essential to the Therapeutic Specialist and CSO's in a TRC

In summarising these themes one participant commented; "they either don't get it, they don't agree with it, or they can't make it work in the current system".

4.1.3   Optimal Relationships

CSOs and Service System representatives have commented that where communication has been improved so has the quality of the working relationship e.g. relationships and outcomes have been improved when CSOs have provided written briefs to Case Managers and placement and support regarding the young people they are targeting with particular reference to client mix. Written briefs are not uniformly used by CSOs when seeking to fill vacancies in the TRCs.

Optimal Service System relationships are achieved when:

- Regular contact and communication occurs

- The underpinning theories and practices of the TRC Pilots understood and accepted

- Service System staff understand why particular strategies are used in response to individual young people in the TRC Pilots and more generally why the program practices are employed

- Service System staff appreciate the distinction between the Therapeutic Approach as practiced in the TRC Pilots and therapy

- The positive outcomes for young people in the Pilots becomes evident

- Systems and people in Juvenile Justice, Placement and Support and Child Protection act in a manner that is congruent with the TRC Model

- Care Team Meetings and Reference Groups are regularly held with broad and appropriate membership

4.1.4   Effective Service System Relationships Outcomes and Improvements

When the optimum conditions and accompanying practices are present in the individual and organisational relationships across the TRC Pilots, their auspice CSOs, Government programs and instruments (including education) and other service system professionals and CSOs there are improved outcomes for young people. The outcomes may be direct or indirect. These outcomes are broadly identified under three themes in this section; service integration and communication, continuity of care for the young people and information exchange. The section summarises the main elements as there is significantly more detail regarding some of these dynamics in other sections of the report as referenced.

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Service integration and communication

Good communication and cooperation supports the integration of services. The outcomes are:

- Improved morale for all staff involved

- Reductions in frustration and tensions

- Congruent practice impacting on the young people and accelerating healing processes

- Practices that align with and support the TRC Pilots including those practices that impact on: identification, transitions into the TRC Pilot, initial assessment, care planning and activities (e.g. dental and health care), education and vocational training, exit planning and exiting, post exit support

Continuity of care for the young people

Literature supports the contention that a consistent approach from all service providers working with/supporting the young people is essential to achieve outcomes proffered by the therapeutic approach (Anglin 2002; Bloom 2005; Ward et al. 2003).

The therapeutic milieu facilitates the approach within the unit. The tendency for agencies without an understanding and acceptance of the therapeutic approach to revert to punitive measures to mitigate behaviours of concern can reduce the impact of therapeutically informed approaches.

Where there is regular interaction (planned and ad hoc), staff have effectively facilitated continuity for young people in collaboration with other service providers. Typically school, vocational training and case management have been impacted by discourse regarding therapeutic processes and responses. Staff, in particular, have been able to explain "why" a particular response should be applied and have provided ongoing insight into the impact of that response. Where the relationships are irregular, surveys and consultations demonstrate that there is less consistency of care.

Information exchange

The timely exchange of appropriate/relevant information assists with:

- The identification of a young person to fill a vacancy and the way they may impact on the mix of young people in the Unit and the way existing young people may impact on them

- Transitions into the TRC Pilot including the length of time and preparations that may be required to achieve optimal outcomes for the young person

- Entry and initial assessment with the associated development of care plans, support for improved health such as dental, mental health and medical and participation in education and vocational training

- Identification of triggers and strategies that support the de-escalation of hyper arousal and associated behaviours

- Exit planning, exiting and post exit support

The HoNOSCA scores (6.5.11 Client Outcomes) measures the knowledge the CSOs have regarding the young people's symptom severity over 14 measures. Although there was considerable improvement in the knowledge of the young people's symptom severity over the 12 to 15 month period within the TRC Program, the knowledge only reached a level that was equivalent to CYMHS for their young people at entry. The Brann Likert Scales (Section 6 Client Outcomes) also measure the quality of information as

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referenced in the 'quality of documentation'. Using these measures it is after entry to the TRCs that these measures show consistent improvement. This suggests that this information was not uniformly available for young people entering the TRC and the full extent of their symptom severity is not known until the Therapeutic Specialist and the TRC staff have been able to get to know the young people.

Incomplete and inaccurate records may be another issue impacting on the timeliness of responses and a full understanding of issues affecting young people. The CSOs have reported that the maximum number of placement changes experienced by any young person in the TRC is 22; the CRIS data reports the maximum as 45.

It is reasonable to surmise that ignorance of issues that are impacting the young people's health, mental health, emotional health and issues affecting behaviours are delaying the effectiveness of the TRC. It is also reasonable to surmise that greater efficiencies could be realised with better and timelier information exchange.

The benefits of better information relating to the young people can be measured in flow on effect of receiving more timely responses, more accurately targeted strategies to de-escalate behaviours leading to reductions in harmful behaviour (self and others) and to a greater quality of participation in education, community, and important relationships. There are long-term benefits associated with these outcomes that impact on the quality of life the young person may be able to enjoy and their opportunities in life.

Effective service system relationships outcomes and improvements

Training in TRC theories and application models for interfacing Agencies involved with the young people, including orientation to the range of triggers and possible responses, will provide a platform for improved service system relationships.

Inconsistencies in delivery and interpretation of the underpinning theory may lead to avoidable incidents. For example, not all teachers at the schools attended by the children are aware of the needs of the child which can result in inappropriate responses to the child when incidents do occur. Unless everyone is 'on the same page' there can be difficulty in maintaining the continuity necessary for the implementation of the Therapeutic Approach in different settings. The Calmer Classrooms material (see Table 6: Calmer Classrooms: A guide to working with traumatised children) is consistent with the "With Care" training, and provides a good base for teachers to gain an understanding of a therapeutic approach. Support and reinforcement by Therapeutic Specialists will enable teachers and school to maximise the benefit from this existing resource.

Recommendations

Service Improvement 16: Standardised documentation for filling vacancies

Establish a uniform approach for documenting and describing the client mix at the time of a vacancy arising and the characteristics and restrictions regarding the young person the CSO considers appropriate to fill the vacancy

Service Improvement 17: With Care Training available to all stakeholders

Offer the 2 day 'With Care' training to all stakeholders

Service Improvement 18: Identify the information sources and information required and where and how to access the information

Identify the information consistently required by CSO's to enable a comprehensive background to be developed of the young person to facilitate therapeutic processes in the TRC; identify where that information is held; identify the protocols and clearances required to access the information – develop a system wide approach to

overcoming the issues related to accessing this information. Information should include documentation such as; full placement history; full history of police history; family history including the circumstances that have led to trauma; family structures; family interaction; academic performance; likes/wants/wishes/preferences; behaviours and adverse reactions; secure welfare; hospital/detox/mental health (accompanying records); medical records; medications and details of medication reviews. Identify blockers and problem-solve to overcome these issues (perceived or actual).

5 Knowledge Transfer

Understanding how knowledge about the TRC is transferred, who the custodians of knowledge are and how this will impact on future service development will aid DHS to manage the significant cultural shifts required if the TRCs are to be extended more widely across the system. This knowledge will also enable DHS to retain leading practice as advances in the field continue to be made. The evaluation comprehensively deals with the circumstances under which the therapeutic model and its elements are applied. Within the evaluation report there is ample opportunity for all stakeholders to benefit from particular elements and learnings to enhance the efficiency and effectiveness of current and future pilots.

This section responds to the evaluation question: What elements and learnings from Hurstbridge Farm and each of the TRC Pilots can be applied to other Pilots and to other aspects of the out-of-home care service system?

Summary of Findings

The TRC Pilots have produced positive outcomes for clients. These positive outcomes have been achieved with the application of a particular range of program elements and model. The models as practiced across the Pilot sites have replicated DHS's essential service design elements. The Pilots have been consistent; the evaluation has demonstrated there is one model with a consistent set of elements.

Therapeutic models are not consistent across Australia underscoring the need to define and document the TRC model and to manage the definition (knowledge management). There is a potential for some TRC Pilots to drift from the essential service design elements resulting in a need to establish and maintain a quality framework for ongoing operations.

The Therapeutic Specialist, Take Two and DHS Child Protection, Placement and Family Services have acted as custodians of the TRC Model and will enact the role as the pilots continue to develop and as the underpinning science continues to develop.

The transfer of knowledge from pilot to pilot has been a dynamic and constant element of the TRC pilots. This transfer of knowledge and learnings has supported the development of effective outcomes for young people and improvements to organisational and administrative arrangements required to support the operation of the pilots. This includes individual arrangements developed between DHS regional offices and CSOs.

Practices that could particularly support learning across OoHC include:

- Core Training Programs and alternate training options

- The knowledge acquired by the therapeutic specialists and the TRC staff from practice

- Practices developed to facilitate therapeutic care between the CSOs and the DHS Regional offices

- The tools and outcomes of the tools used in the TRCs

5.1 Knowledge Transfer Dynamics

Knowledge transfer in the Therapeutic Pilots and in the wider system relative to trauma and attachment theories is multifaceted in the way knowledge is transferred and as to who is transferring the knowledge. The table below seeks to provide insight into the pathway of knowledge transfer, who is involved and methods of knowledge transfer within the TRC Pilots.

There are several key insights that are not explicit in the information in the table that have been identified in the evaluation pertaining to knowledge transfer in the TRC Pilots; they are:

- The Therapeutic Specialist consistently acts as a custodian of the Therapeutic Approach and supports many of the key Agencies and the interfacing staff to maintain a commitment to practices that are supported by the underpinning theories

- Take Two has taken a key role in being a knowledge and learning bank and providing impetus to ongoing learning and access to the developing science

- DHS Child Protection, Placement and Family Services have partnered the sector in the ongoing knowledge transfer, financing of the Pilots and in providing the leadership and management momentum necessary to facilitate broad knowledge transfer and learning. The evaluation of the Pilots is also a significant and positive leadership initiative of DHS supporting knowledge transfer

- Individual Managers and CSO's are strongly committed to the TRC Models

Table 9: Knowledge Transfer dynamics

What Knowledge	Prime Knowledge Holder	Prime Knowledge Transfer	How is Knowledge Transferred
Brain Change The effect of trauma Attachment Theory	An International body of psychologists, psychiatrists and child protection practitioners	Take Two Child Protection, Placement and Family Services CSOs providing OoHC Peak Body Individual Therapeutic Specialists	Literature Conferences Practitioner to Practitioner Course work in tertiary institutions
Theories regarding the application of the science relating to brain change, trauma impact and attachment theory for children in State care	An International body of psychologists, psychiatrists and child protection practitioners	Take Two Management of Child Protection, Placement and Family Services (DHS) Management of CSOs providing OoHC Peak Body Individual Therapeutic Specialist	Literature Conferences Practitioner to Practitioner
The development of a trauma informed Therapeutic Approach in OoHC	An International body of psychologists, psychiatrists and child protection practitioners Management of Child Protection, Placement and Family Services (DHS) Take Two	Management of CSOs providing OoHC Peak Body Individual Therapeutic Specialist	Literature Conferences Personal influence Training
The development of a trauma informed	Management of Child Protection, Placement	Management of CSOs providing OoHC	Literature Conferences

What Knowledge	Prime Knowledge Holder	Prime Knowledge Transfer	How is Knowledge Transferred
Therapeutic Approach in residential OoHC in DHS funded programs	and Family Services (DHS) Take Two	Peak Body Individual Therapeutic Specialist	Personal influence Training Early TRC Pilot trail
The development and trail of a program of trauma informed Therapeutic Approaches in residential care as a DHS funded program	Management of Child Protection, Placement and Family Services (DHS) Management and staff of the early TRC trial Therapeutic Specialist in the trial Take Two	Management of CSOs providing OoHC Individual Therapeutic Specialists DHS Regional management DHS regional practitioners Staff in individual Units Staff in other services	Literature Conferences Personal influence Training The development of TRC Pilots Reference Groups State-wide Meetings Service provision interaction
The effect and function of a program of trauma informed Therapeutic Approaches in residential OoHC in 12 Pilots across Victoria	Management and staff of CSOs providing OoHC Individual Therapeutic Specialists DHS Regional management DHS regional practitioners Staff in the Pilot programs Service System Agencies Young People Families Management of Child Protection, Placement and Family Services (DHS) Take Two CYMHS Health Professionals Community services	Management and staff of CSOs providing OoHC Individual Therapeutic Specialists DHS Regional management DHS regional practitioners Staff in the Pilot programs Service System Agencies Young People Families Management of Child Protection, Placement and Family Services (DHS) Take Two CYMHS Health Professionals Community Services	Observation Discourse – between persons Problem solving Cross functional teams Unlearning Developing information – recombining or developing new or different information as a result of melding information and learnings Reference Groups Intensive Care Team Meetings Team Meetings Unit meetings State-wide Meetings Training Conferences Workshops
The efficacy of a trauma informed Therapeutic Approach in residential care in 12 Pilots across Victoria	Management of CSOs providing OoHC Individual Therapeutic Specialists DHS Regional management DHS regional practitioners Staff in the Pilot programs Service System Agencies Young People Management of Child Protection, Placement and Family Services (DHS)	Management of Child Protection, Placement and Family Services (DHS) The OoHC sector (CSOs, staff, management) Government The Senior Management of DHS Juvenile Justice Peak Body and opinion makers	Reports Presentations Discourse – between persons

Consultations with AIFS, participation in a National focus group with peak body representatives and through participation in the Community & Disability Services Ministers' Advisory Council National Therapeutic Residential Care Workshop the issue

of multi-faceted interpretations of what constitutes a Therapeutic Model and approach was raised. There are differing interpretations and programs across Australia that ostensibly have the same title. The outcomes achieved for young people in the Victorian TRC's are based on the consistent application of program elements (detailed in this report). Some 'drift' may already have already begun to occur with unique training programs emerging and long periods where two pilots operated without Therapeutic Specialists. Protecting the brand, 'TRC Model", will be particularly important, as alternate approaches may be delivered across Australia with less rigour. These models may fall out of favour if they are unable to produce the positive client outcomes detailed in this evaluation within costs and benefits framework delivered through the model as piloted.

Service Improvement 19: Clearly articulate and manage the Knowledge of the TRC Model

Foster leading and evolving practice in the TRCs though knowledge management including; what is the knowledge, who holds the knowledge, the prime knowledge transfer and identify how the knowledge is transferred.

To facilitate knowledge management an action plan should be developed and monitored

5.2 Elements and Learnings

Applicable elements and learnings for other Pilots

Within individual pilots and their related agency relationships there have been unique responses developed that may be beneficial to all pilots. The following discussion details opportunities for that knowledge to be transferred.

Wider OoHC system

Therapeutic responses across the OoHC system are being developed in a number of frameworks such as therapeutic foster care and partially funded Therapeutic Specialist in other Residential settings. Within the following section each identified area of learning has a section that addresses elements and learnings that could be beneficial and applicable to the wider OoHC system.

5.2.1 Progressive and Dynamic Knowledge Transfer

The transfer of knowledge from pilot to pilot has been a dynamic and constant element of the TRC pilots. This transfer has supported the development of effective outcomes for young people and improvements to organisational and administrative arrangements required to support the operation of the pilots.

The following dynamics have aided this transfer:

- Two of the Therapeutic Specialists work across two pilots facilitating the learning from both pilots across the sites

- Take Two currently provides Therapeutic Specialists to all but one of the CSOs enabling learnings from each CSO to be regularly discussed and shared promoting further cross CSO communication

- Take Two management have played an active role in providing supervision and support so the evaluators thus have gained insight to broad learnings from CSOs and their TRC pilot, from the community connections, from other stakeholders, from the service system and from how the program impacts on the clients. Take Two have also played a primary role in collecting comparison data to support the

evaluation. Take Two have held monthly meetings for its Therapeutic Specialist that have supporting ongoing learning. These learnings have been able to be tested through internal person to person discourse and through person to person discourse with the Management of Child Protection, Placement and Family Services. These learning have filtered through the Therapeutic Specialist to CSOs and individual pilot sites

- The Community and Disability Services Ministers' Advisory Council (CDSMAC) National Therapeutic Residential Care Workshop (Melbourne 2010) added significant impetus to knowledge transfer across CSOs and pilots

- The role the managers in the Child Protection, Placement and Family Services Branch have played in problem solving and disseminating learnings and information. The managers from this section have used the following methods and forums:

  - Participation in all regional reference groups

  - Regular one on one contact and discussion with CSOs running the Pilots

  - Focused support when a pilot needed additional assistance including marshalling additional professional inputs to support problem solving or the allocation of additional financial resources etc.

5.2.2 Regional DHS Service Integration

During the evaluation some of the TRC Pilots and Regional DHS offices negotiated and/or developed arrangements to create consistent practice supporting the Therapeutic approach. As previously highlighted the TRC Pilots require comprehensive background information regarding the young people who may enter and those entering the TRC's, they also require different approaches to placement of a young person, transitions into the pilots, client mix and Care Team meetings. These requirements have required the development of alternate arrangements to standard practice for OoHC at a regional level. In some regions and in circumstances these arrangements have worked very well in other cases the arrangements have been inadequate and detrimental to relationships and the pilots.

The learnings from these experiences need to be passed on to examine how system integration could be consistent across the regions and pilots.

5.2.3 Tools

Pilots and therapists have utilised a variety of tools such as daily notes. A therapeutic Specialist is developing an electronic version of the daily notes to support more efficiency and effective processes for gathering this invaluable information. One therapist has used the clinical evaluation tools (SDQ) as a way of analysing the impact of individual changes and cited new rostering arrangement as an example. Tools being used vary from one pilot to another and one therapist to another. However three tools were used by all Therapeutic Specialists as means of collecting data required for the evaluation. The three tools are; the Brann Likert Scales, SDQs and HoNOSCA. Other tools used in individual TRC Pilots include:

- Intervention plan

- Trauma Symptom Checklist

- Social Network Map

- Heart rate monitoring

- Harm consequences assessment (Take Two instrument)

5.2.4 Alternate Training programs

TRC Pilots have developed or implemented a number of other training programs other than the 'With Care' training that forms a core component of the TRC Pilots. The following training programs have been completed by between seven and twenty eight percent of staff surveyed in the evaluation. The staff described the training as:

- Bruce Perry/PACE/Sanctuary Model

- Strength-based approach

- Other trauma & attachment training

- DHS training: LAC/Best Interest/CRISSP/CRISS)

- Behaviour management/Restraint training/Suicide prevention /Therapeutic conflict management

TRC CSOs would benefit from sharing the relevant value and outcomes of these additional programs including the impact on the wider service system. A number of the CSOs have adopted Calmer Classrooms training in association with their TRC Pilots and the example provided demonstrates the impact of knowledge transfer on the pilots, the wider OoHC and on other agencies.

The evaluators identified the risk that proprietary training programs may have a different emphasis that over time results practice that is inconstant with mandated TRC practice in Victoria.

Example

A teacher interviewed in the evaluation said "It had changed the way I work with at risk young people". Other teachers remarked that, "Knowledge of the child's back ground and history were invaluable in shaping their attitude to all young people they worked with not just those from the TRC Units". The "Calmer Classrooms" training has been adopted by many of the schools spoken to in the course of the evaluation, the teachers identified "the learnings from these have been invaluable". Another response was, "It's been fairly impactful for me and other teachers at the school."

Service Improvement 20: All training programs being used in TRCs managed and authorised

Undertake a review of all training in the TRC. This process should support the maintenance of clarity regarding the essential elements of Therapeutic Residential Care and seek to cement these elements through training.

Service Improvement 21: Review all tools used in the TRCs to support the development of a consistent, effective and sensitive set of tools to be used across TRCs and the OoHC system

Peer review and discussion regarding the usefulness and the application of tools should be undertaken to develop therapeutic practice in the TRCs. This type of review should result in recommendations regarding a range of standard tools for assessment of the young person and to measure the progress they are making.

Service Improvement 22: Develop a practice and policy manual

The practices employed in the TRC Pilots should be developed into a policy and practice manual to be used as part of a continuous quality improvement process and to orientate new staff to TRC Pilots. This initiative could be invaluable in supporting the development of new pilots

5.3 Knowledge Management

As alluded to in other parts of the report it is important to acknowledge that the TRC Pilots have taken a set of theories and applied them in a program and applied them over time. The sample of 38 young people being measured in the pilot (detailed in this report) is a large sample compared to other program evaluations of therapeutic approaches in residential settings. The evaluation and the TRC Pilots will contribute to knowledge that will be shared across Australia and Internationally.

The underlying theories are continuing to be developed as is the application 'in program'. The dynamic nature of the therapeutic approach requires knowledge management that can respond to the changes that will inevitably occur as the underlying science continues to advance. Knowledge management will also support the application of this knowledge 'in program'.

Knowledge management requires somebody to maintain a custodian role. The 'somebody' identified in the initial phase of the development of a program trial of the TRC was shared between the Management of Child Protection, Placement and Family Services (DHS) and senior team members of Take Two. If the knowledge is maintained and constantly developed by new inputs from the International experience and 'in program' learnings, the TRC approach will enjoy the possibility of increasing effectiveness.

Risks to knowledge management include gaps and or misuse of technical tools and the loss of key personnel. The evaluators have recommended that the 'custodians' review of training and tools used in the TRCs Pilots and play an active role in the ongoing management of these elements. It is suggested that this custodian role will reduce the likelihood of the misuse of technical tools and will facilitate processes that are likely to support the identification of gaps and options for responding to them.

Service Improvement 24: Formalise the knowledge custodian roles and develop a platform to foster effectiveness of the role into the future

It is recommended that:

• the importance and power of the custodian role is acknowledged by DHS

• the custodian role continues to be shared by the Management of Child Protection, Placement and Family Services (DHS) and senior team members of Take Two

• a process and platform for reflective learning is maintained by DHS and Take Two to facilitate this 'custodian' role.

Knowledge Management shared in the manner described will enable the individual Therapeutic Specialist to continue to act as custodians in each pilot and amongst interfacing agencies.

6 Client Outcomes

Within this section the outcomes for the young people are explored with reference to the Child Protection, Placement and Family Services Outcomes Framework. Using a comprehensive set of measures change for the young people has been explored. The pre entry ratings are compared to young people in generalist residential care services. The pre entry scores for the young people in TRC reflects the differences in their experiences in general residential care and in the TRC. This section responds to the questions:

- What has been the impact of Therapeutic Residential Care (including Hurstbridge Farm) on individual TRC clients?

- What improvements have been made for clients against the defined prescribed outcomes areas defined?

- How do client outcomes from the TRC programs compare with outcomes for children and young people in generalist residential care services?

- What are the relationships between Hurstbridge Farm and the community within which it is located, both at a client and service level, and how can these relationships be further improved?

A comprehensive summary is provided at the conclusion of this section.

6.1.1   Defining Positive Client Outcomes

The Child Protection, Placement and Family Services Outcomes Framework (CPPFS Outcomes Framework, the Framework – Attachment 3) is the key reference in terms of defining positive client outcomes for the purpose of this evaluation.   The Framework describes "child safety, stability and development" as the core objectives of the service system, and indicators and measures associated with each of the Outcome are included in the Framework.

The components of the Framework are outlined below:

Table 10: Child Protection, Placement and Family Services Outcomes Framework Components

Outcomes	- Safe from injury and harm - Connected to family and carers - Connected to school and community - Connected to their culture - Achieving optimal physical health - Achieving optimal education and learning - Achieving optimal social and emotional development - Achieving positive sense of self - Achieving positive behaviour and mental health - Healthy lifestyle

The 'Framework' defines 'outcomes', 'indicators' and 'measures'. The indicators and measures were designed for a very broad application in child protection, child placement and family services. A more finally tuned set of indicators and measures were required for the TRC evaluation than those developed in the 'framework'. The more finely tuned outcomes and measures have ensured that data; gathered, analysed and reported against the outcomes in the framework did so within the context of the TRC program and its remit.

The consultants have utilised this Framework in order to present client outcomes in a manner consistent with an agreed set of standards. The Brann Likert Scales, for example, have been developed specifically to support measuring client outcomes against the CPPFS Outcomes Framework.

6.1.2 Qualitative Data Collection Methods

A range of qualitative data collection methods were utilised in the course of the evaluation in order to assess the client outcomes resulting from the Therapeutic Approach to residential care.

These methods included:

- Interviews with TRC staff and management
- Interviews with Therapeutic Specialists
- Interviews with a sample of young people living in TRCs
- Interviews with representatives from interfacing Agencies working directly with young people

Interviews with the Young People

Nine young people who are (or were) residents of TRCs were interviewed in five different settings. The young people had been in TRCs for at least 15 months at the time of the interview. Their perspectives will be incorporated into commentary and analysis on the data tables to support an understanding of the data or to provide context.

6.2 Gathering Quantitative Data

6.2.1 Quantitative Data Collection Tools

The following quantitative survey tools formed the basis of client outcomes data collection for the evaluation.

The Health of the Nation Outcomes Scale (HoNOSCA)

The HoNOSCA is a comprehensive outcome measurement system that is gaining use internationally (Brann 2010; Gowers, Harrington, Whitton, Beevor, et al. 1999; Gowers, Harrington, Whitton, Lelliott, et al. 1999; Hanssen-Bauer et al. 2010; Brann et al. 2001) and has been validated for use in child and adolescent mental health service (Bilenberg 2003; Brann et al. 2001). It comprises thirteen core scales (rated between 'No Problem' to 'Severe Problem' over a 5 point scale) which address behaviours, symptomatology, disability, and social functioning (Gowers, Harrington, Whitton, Beevor, et al. 1999; Gowers, Harrington, Whitton, Lelliott, et al. 1999). The scales address the following areas:

- Disruptive/aggressive/antisocial behaviours
- Over-activity/concentration
- Non Accidental Self-injury
- Substance misuse
- Scholastic/language skills
- Non-organic somatic symptoms
- Emotional symptoms
- Peer relationships
- Self-care
- Family relationships
- School attendance

- Physical Illness/disability
- Hallucinations/delusions/Abnormal Perceptions

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a widely used measure of a young persons' (aged between 3 – 16 years) functioning from different perspectives. The SDQ asks about 5 areas of functioning as well as impact chronicity and burden of problem area attributes, some positive and others negative (R. Goodman 1999; R. Goodman 2001). The 5 area are listed below:

- Emotional symptoms
- Conduct problems
- Hyperactivity/inattention
- Peer relationship problems
- Pro-social behaviour

Brann Likert Scales

The TRC evaluation tool (the Brann Likert Scales) includes a number of scales and questions designed to allow the extraction of relevant information by TRC staff from the young person's file. Reflecting the Child Protection, Placement and Family Services Outcomes Framework, the material from files sought includes information about:

- Injury and harm including details of lodged incident reports
- Connectedness to family and carers
- Connectedness to school and community,
- Residential stability of placements
- Connection to culture
- Physical health
- Education and learning
- Social and emotional development
- Positive sense of self
- Healthy lifestyle and risk taking

The scales were administered within the TRCs in the following manner:

- The Therapeutic Specialist attached to the TRC was responsible for coordinating the data collection pertaining to the young people at that TRC
- All young people in the TRC at the time this evaluation commenced were included
- For each young person, there were two data records for their time pre TRC, one at entry, and up to four after entry
- At each collection period Sections 1, 2 and 3 were completed that consisted of:
  - Section 1 is comprised of a number of Likert scales, and associated information. To complete the scales, the person(s) rating was asked to circle one number on each scale that represented their view. Some scales have descriptions for some but not all numbers. This allowed the person(s) rating

to circle an intermediate number if their view is somewhere between the text for the adjoining numbers. Completion of this section was informed by their experience of the young person, reading of files, discussion with others and any other relevant documentation

- **Section 2** is comprised of the HoNOSCA instrument. This scale is used to measure the views of the person rating with reference to the young person's mental health symptoms and functioning. Completion of this scale is informed by the person rating's experience of the young person, reading of files, discussion with others and any other relevant documentation. Unlike section 1, HoNOSCA asks person rating to focus on the two weeks prior to complete this data collection. The glossary at the end of the instrument assisted with completing the scale

- **Section 3** is comprised of the Strength and Difficulties Questionnaire. The SDQ is a widely used measure of a young person's functioning from different perspectives. Notes on the application of the scales, including the time frames to be considered, were included to aid the completion of the SDQ

- Unless a question nominates a specific time frame, all information available at the relevant collection period was used to answer the questions. For example, if the data collection period of interest is the 6-9 months after entry to the TRC, all information in that period was considered

- For the data collection periods prior to TRC entry, data is probably being collected retrospectively. The person(s) rating were asked to consider whatever information was available and to answer the questions with regard to information relating to that collection period.

Where there is a referral or assessment information relating to the entry to the TRC, which would be expected to be accessed regularly for that young person, the person(s) rating were asked to include this in each collection period occurring after that document was written. For example, cultural background may be included in the initial assessment documentation on arrival to the TRC and would not be expected to be rewritten every few months. This type of documentation can be included in each collection period as relevant.

6.2.2   Data Gathering Time Points

The following diagram illustrates the data collection points along the timeline of each young person's participation, based on their date of entry to the relevant TRC Pilot.

Figure 7: Pilot Group Data Collection Points

Data collection at each TRC site was coordinated by the Therapeutic Specialist attached to that Unit. To ensure consistency in the tool application, Verso conducted a group training session with Therapeutic Specialists in use of the tools as they apply to this evaluation. The training session was led by Dr Peter Brann, who has also provided ongoing practical support to the Therapeutic Specialists if/when the need arose.

6.2.3   Sample Size

The progress of 38 young people is being tracked in the course of this evaluation. It should be noted that additional young people have entered the Pilots since the reporting commenced.

To date, ten of the 38 young people participating in the evaluation have exited the Pilots: data relating to these young people has been included in the analysis of the relevant data collection points.

Table 11: Sample size and collection dates

Collection period	15-18 mths pre-entry	3-6 mths pre-entry	Entry - 3 mths	6-9 mths post-entry	12-15 mths post-entry	18 -21 mths post-entry	24-27 mths post-entry	30-33 mths post-entry	36-39 mths post-entry
Completed surveys	29	38	38	38	35	24	12	1	1
% Return rate	100	100	100	100	95	92	100	100	100

Table 11 summarises return rate achieved: While return rates decrease with time, it is important to note that it would not be possible to have 100% return rates for all clients as they entered the TRCs at different dates. The third row in Table 11 provides the possible return rates which are very high.

Key variables from the pilot group quantitative surveys were analysed in a repeated measures format for use with the TRC group. This design is powerful in that it reduces within subject variation. However it does have the disadvantage of being sensitive to missing data.

With the number of collection points in this study, and the differing length of time in the TRC for each young person, it is unsurprising that there is missing data at different time points.

6.2.4   Comparison Group

The progress of 16 young people in general residential care was tracked as a comparison group. The comparison group data collection involved young people from four Agencies (Westcare, Berry Street Hume, Menzies and Berry Street Southern) and relates to the following time points:

*Figure 8: Comparison Group data collection time points*

This convenience sample was chosen from general residential care services nominated by DHS. Limitations in the capacity to access the general OOHC population meant that there was no attempt to match the comparison group and the TRC group on any demographic variables or length of time in residential care. The convenience nature of this sample meant that it is primarily there to provide some perspective on how severe the TRC group are compared to young people in OOHC.

6.3 About the Young People in the TRC

Figure 9 to Figure 12 provide an overview of the demographic characteristics and placement history of the young people at entry to the TRC Pilots. The TRC group is

mostly female (Figure 9). This contrasts with general residential care where DHS reports that 40% are female.

*Figure 9: Gender of TRC clients*
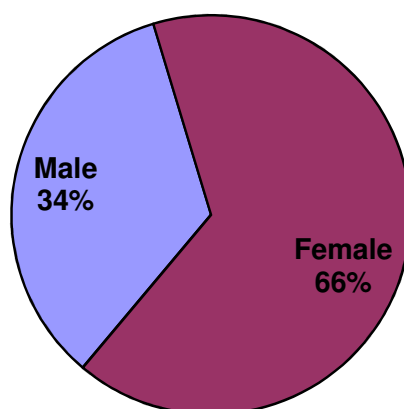
The median age at entry to TRC was 13 years, with the inter-quartile range being between 12 and 14.3 (Figure 10: Age of TRC clients at entry). The incidence of 5,7,8 and 9 year olds displayed in Figure 10 represents a TRC sibling group.

Table 12: Median vs Mean

"Median" has been used in many of the statistical tables and discussions below to provide an accurate picture of what is happening to/with the majority of young people in the TRC Pilot Group. Median refers to the middle value of a set of observations. As means are the average of the set of observations, they are prone to being misleading when there are a small number of extreme values. Both means and medians can be useful. For example, the observations (1,1,1,1,1,1,1,1,5,17,19) would return a mean (average) of 4.4; whereas the median value is 1.

Figure 10: Age of TRC clients at entry
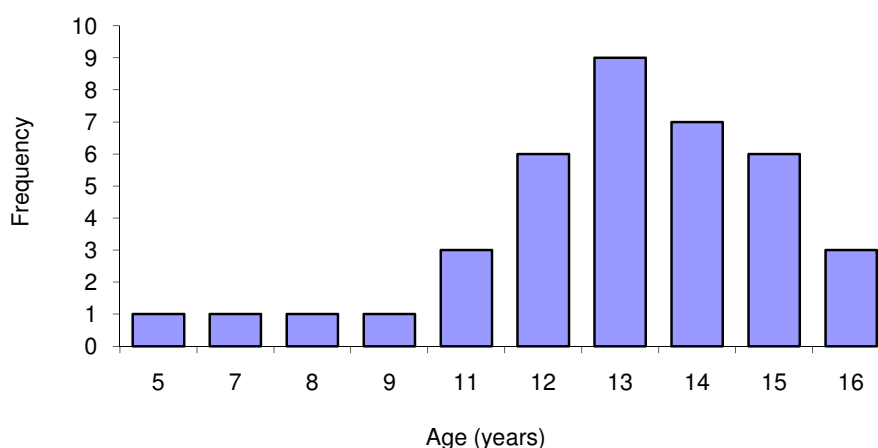
The median date of entry to the TRCs was April 2009 with the first client entering in November 2007 and the most recent client (being tracked for this evaluation) entering in April 2010. Other clients have since entered some TRCs, but are not part of this evaluation. The young people in the TRCs had been in OoHC at the time of TRC entry for an average of 31 months (median 17 months). This length of time ranged from 2 to 147 months (n=35) (Figure 11). There was a median of four residential placements reported and this ranged between one to 12 placements (n=35) (Figure 12).

Figure 11: Distribution of length of time in OoHC
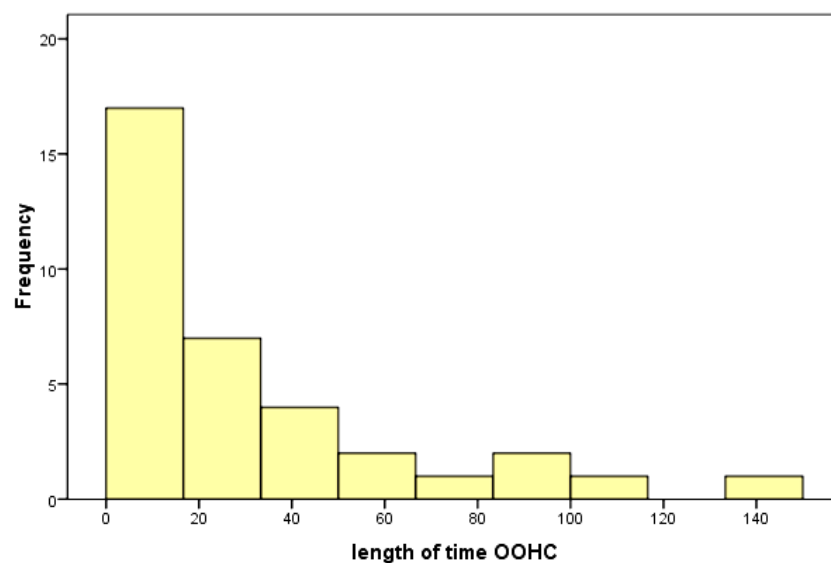
Figure 12: Number of residential placements at time of TRC entry
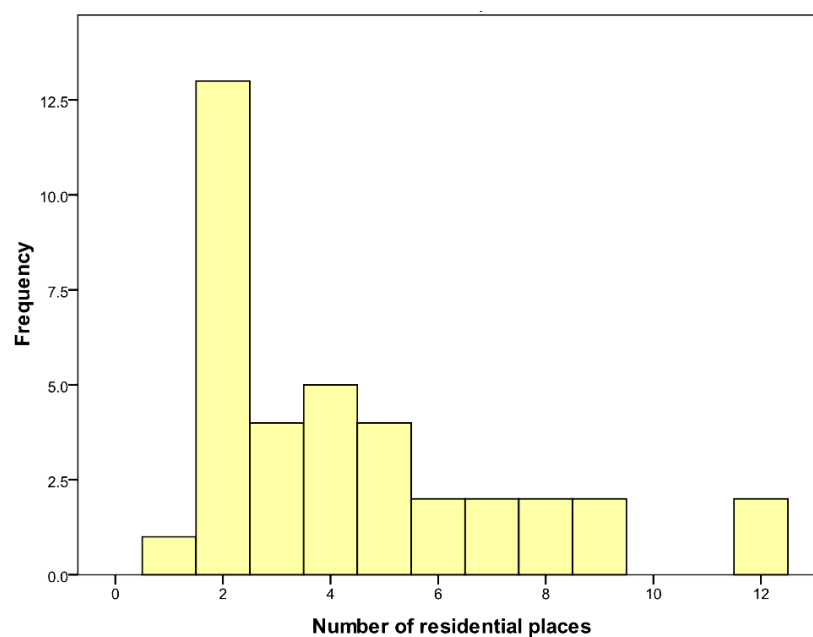
6.4 About the young people in the Comparison Group

The comparison group comprised 16 young people with a median age of 15 years. Fifty percent were female. There were proportionately more females in the TRC Pilots and the median age was younger at 13.

The Comparison Group (CG) had been in OoHC at the first collection occasion an average for 11 months and a median of 10 months (TRC 31 months, median 17 months). This is briefer than for the young people in the TRC group.

6.5 Impact of Therapeutic Interventions

6.5.1 Safety from Injury and Harm

Incident Report data

Incident report histories were obtained for the 38 young people in the TRC evaluation and the 16 young people in the CG, as the Department required this key information be included.

The quality of Incident Report data provided was not consistent, leading to the potential for inaccuracies in analysis and reporting. The consultants were also advised that in some cases an incident may be reported for each young person involved, regardless of the nature of their "involvement", whether it is instigator, victim or witness. This practice did not appear to be consistent between services. Therefore, the following analysis of the data provided should be interpreted with caution, and considered within the context of other data presented in this report.

All Category 2 and Category 1 incidents have been included in the analysis. Note that incidents described as "accidents" in the narrative description where the staff classified them as category 1 or 2 have been retained. A number of incidents were provided with no documentation of their category status being provided. These were retained unless they described an accident and then they were excluded. It is likely there is significant variation in agency or staff understanding of the categorisations of incidents and the incident data from DHS must be treated with some caution.

The date of TRC entry was used to divide incidents into pre and post-entry. Incidents have then been averaged over the number of months in the relevant period. The date between entry to TRC and the date recorded for first residential placement was used to establish the number of months prior to TRC entry. The difference between TRC entry and the last data entry form was used to estimate the months post-entry. Where no date of first entry to residential care was recorded, 18 months pre TRC entry was used to estimate the initial time frame. Where a different date was recorded for first residential placement, the very first date recorded was used.

From the table 15 below, it can be seen that the mean number of incidents per month increased from 0.92 to 1.47, and the median number of incidents increased from 0.42 to 0.77. Based on the evidence provided, it appears that the overall number of incidents has increased subsequent to TRC entry. Therapeutic Specialist and CSOs reported that they expected an increase in incidents immediately post entry to the TRC. Their perspective is that the change of placement, alternate routines and approaches and an increased attention to record keeping would impact on the number of incidents reported. They further qualify this perspective with the commentary that an incident report does not necessarily mean negative progress is being made by the young people. The following examples (Table 13 and Table 14) illustrate the challenges of using incidents reports as a primary source of information to provide evidence of poor outcomes.

Table 13: Hurstbridge Farm example

> At Hurstbridge Farm it is not uncommon that when a young person leaves the property without permission (absconds) that a residential worker will accompany the young person on the long walk to the railway station. It is normal that before the station is reached that the issue that led to the young person absconding is diffused and that the worker and the young person return. The event is reported as an 'incident'.

Table 14: Berry St Southern example

> A young person at Berry St Southern spent a significant number of nights away from the Unit sleeping rough when he was first admitted to the Unit. The Unit developed a strategy to help the young person feel safe and develop the trust that would result in him being able to sleep at the Unit. A residential worker sat by the young person as he slept under a bush and played guitar while he slept. This resulted in the development of trust that led to the young person being prepared to sleep at the Unit, first with his shoes on and then with them off. In the early stages of the young person sleeping in the Unit the worker continued to play the guitar outside his room at night; this provided the assurance he required. It took some time for him to stay every night in the Unit. While there were a significant number of incident reports related to his absences, the reports do not provide insight into the significant progress that was being made with the young person.

There are less incidents overall recorded pre TRC entry compared with post-entry (e.g. mean of 12 pre-entry compared with 27.9 post-entry), (Table 15: Incident Report Pre and Post-entry to TRC) however there are some indications in the data that there may be serious difficulties with the recording and/or extraction of this data from the department's system. Eleven young people had no incidents recorded in any OoHC prior to TRC entry. Given the targeting of the TRC program and an average of 31 months in OoHC prior to entry, some doubt may reasonably exist regarding incident reports. This subset of no incident young people had a mean number of incidents after entry of 37 or 2 per month suggesting that they may not have been untroubled young people. Five young people had no incidents recorded post TRC entry.

Table 15: Incident Report Pre and Post-entry to TRC

Number of incidents per month	Pre TRC	Post TRC Entry
Median	0.42	0.77
Mean	0.92	1.47
Minimum	0	0
Maximum	5	5.87

There were more incidents reported in the CG group on a monthly basis. It is unclear whether this reflects a difference in base rate of incidents or different criteria used to report.

The finding is that the incident report data is unreliable in providing insights into the change over time and the degree to which the young people are safe from injury and harm. It has also been hypothesised by CSOs that the greater diligence in regard to scrutinising the young people and recording outcomes may result in additional incident reports being raised.

6.5.2 Contact between the Young Person and their Family

Family

The TRCs maintain deliberate and multi-faceted connections to family. Examples of the way TRCs work with families include:

- One of the TRCs has a family therapist as part of the team

- A number of Therapeutic Specialists visit families and maintain connections to reduce impacts on the young person, to maintain support regarding positive strategies, to facilitate family reunification or an improved connection and relationships

- Staff from some TRCs visit families to reduce impacts on the young person, to maintain support regarding positive strategies, to facilitate family reunification or an improved connection and relationships commonly with support and mentoring from the Therapeutic Specialist

- Most Case Managers maintain connections with the family

- Family issues and inputs may be synthesised into care planning, and be incorporated into Care Team meetings and/or in Reflective Practice meetings

- Where appropriate, family member/s may be part of a young person's Care Team

- One of the TRCs provides opportunities for parents to view school work and where appropriate interact with the young person at the onsite school (this is a carefully managed process)

- Where appropriate a parent or other family members may meet in a non-threatening and neutral environment to facilitate improvements to the relationship (this is undertaken with the support of a residential worker)

> **Example**
>
> One TRC supports the involvement of a parent with her children by meeting in public places such as a park. Because the mother struggles to concentrate on more than one thing at a time only one child attends at a time accompanied by a residential worker. The mother is then able to cope without 'acting out'. This connection is positive and helps the mother remain connected to her children in a constructive manner for her and the children.

During the evaluation two meetings were held with the staff and management of the Residential Unit operated by the Mildura Aboriginal Corporation (MAC). The MAC program is in the process of developing as a TRC with alternate funding arrangements organised at Regional level. No data was collected for MAC as the timeframes precluded the young people entering the MAC TRC. The MAC team provided particular insights into family connections in Aboriginal communities that were echoed in consultations with VACCA they included:

- The possibility that the young person being supported in the Unit is known by indigenous staff in the Unit or, they may be a relative

- The possibility that there will be expectations from family and community regarding the care of the young person in the Unit that result in staff feeling pressured

- The possibility that there will be ongoing post exit connections to the young person

These issues create additional complexities for Indigenous Agencies.

Family reunification

Two CSOs commenced their TRC with a targeted focus on family reunification. Over the period of the evaluation it became apparent that there were very few young people across the system with the chronicity thought appropriate for the TRC Pilots (typically residential care complex[14]) where reunification was a plausible goal. These Pilots through the vehicle of their reference group altered their targeting while not reducing their commitment to support better family connections for young people where these connections could assist the young person.

The evaluators have identified the following examples of reunification:

- One of the young people has been successfully reunified with his family with significant support from the agency's Family Therapist and ongoing after care support from staff

- A young person has been able, with the support of the TRC staff, to develop a vocational pathway including an apprenticeship. Within the exit planning and post exit care he chose to live with a parent however he has been coached in and has developed a range of new skills that have supported this arrangement which still has many challenges. He has sufficient insight into his own triggers to enable him to generally cope. He has the ongoing access and a quality relationship with the staff of the Pilot enabling him opportunities to recalibrate as and when required. The staff also maintain communication with the parent.

- One young person through the course of the Pilot gained sufficient insight into their own behaviours to support deliberate steps towards being able to move out of the TRC Unit and into a 'host family' setting. The Case Manager identified that she drove the initiative and that she is making very strong gains. The family and the young person characterise the relationship as familial.

Other young people have been supported to develop insights into their families that have lessened their feelings of being rejected or has served to help them understand the impact of their family's dynamic on them and their behaviours.

Average quality of contact between the young person and their family

The average quality of contact between the young person and family is based on the perception of whether the relationship between young person and family is improving and becoming more appropriate (better boundaries, more appropriate expectations, clearer roles). The quality of the connection is not necessarily based on whether the young person is happy with their family. Figure 13 shows that about 40% of the young people in the comparison group had a 'Poor' or 'Very poor' quality of contact with their family and only about 20% had a 'High' to 'Very high' assessment. By comparison prior to entering the TRC Pilots, more young people in the TRCs had a poorer 'quality of contact' with their family and less 'High' to 'Very high' rates of quality of contact.

The finding is: that young people in the TRC pilots had poorer quality of contact with families prior to entering the TRC Pilots than the overall residential population experience with very low rates of 'High' to Very high' quality of contact with their family.

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[14] Residential care complex is for young people who display a significant level of complex behaviours, have multiple or complex needs and engage in high risk behaviours – previously RP3 level

Figure 13: Average quality of contact between young person & family - CG & TRC pre-entry
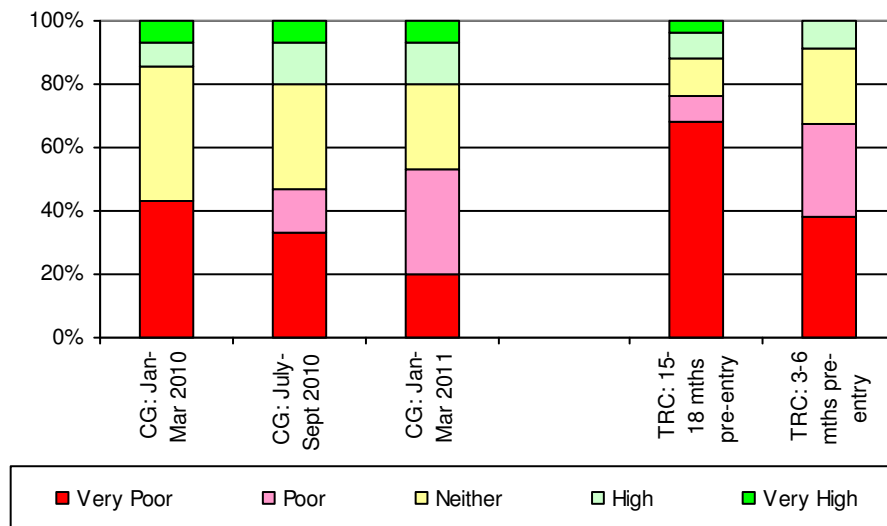
From Figure: 13 it can be seen that the young people in the TRC had higher levels of 'Very poor' to 'Poor' relationships with their family than the CG. Over the course of the year (three collection occasions), the CG show little change in the 'High' to 'Very high' quality of contact with their family compared to the TRC young people. This little change in the CG raises the question as to the extent of improvement or deterioration in the quality of family contact for young people in non-TRC programs. It should be kept in mind throughout the results to follow that the CG is not a random group from residential OoHC and so it is possible that the lack of change is restricted to these particular young people.

From Figure 14 it can be seen that the average quality of contact between young people and their families has clearly increased in their time in the TRC. In the period pre-TRC entry, the combined 'Very high' and 'High' ratings are reasonably constant, as are the combined 'Very poor' and 'Poor' ratings. From entry to the TRC onwards, there are increasing numbers of young people where the average quality of their relationships with their family is rated as 'High' to 'Very high' quality. Importantly, the improvements in relationships that seem to occur in the 'High' to 'Very high' ratings are maintained until the final collection occasion at 24 to 47 months after entry. This is considerably beyond what may have been considered a 'honeymoon' phase in the period immediately after entry to the TRC.

Figure 14: Average quality of contact between young person and family - TRC
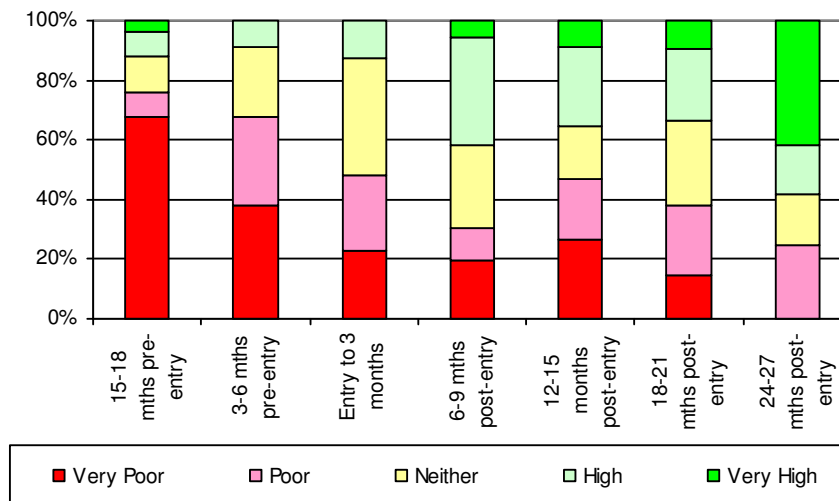
The finding is: that the quality of contact with family for the TRC group is less in the pre-entry to the TRC period than the CG. Importantly, the young people in the TRC pilots have experienced and sustained significant improvements to the quality of contact with their family during their period in the TRC.

Best quality of contact between the young person and their family

The 'best' quality of contact focuses on the single 'best' quality of contact the young person has with an individual family member. Similar to Figure: 14 the data is based on the perception of whether the relationship between young person and the individual family member (the best quality of contact) is improving and becoming more appropriate (better boundaries, more appropriate expectations, clearer roles). The quality of the connection is not necessarily based on whether young person is happy with their family member.

Similar to the average quality of contact, the best contact with families has improved from the pre TRC period and entry to the TRC. The improvement in best quality contact has been maintained beyond the initial phase. While CG data was not collected for this question, the finding that the average quality of the TRC group was as poor as the CG suggests that the best quality for the TRC group is unlikely to have been substantially better than the CG at pre-entry.

The finding is: that young people in the TRC pilots have experienced and sustained significant improvements to best quality of contact with their family.

Figure 15: Best quality of contact between young person and family - TRC
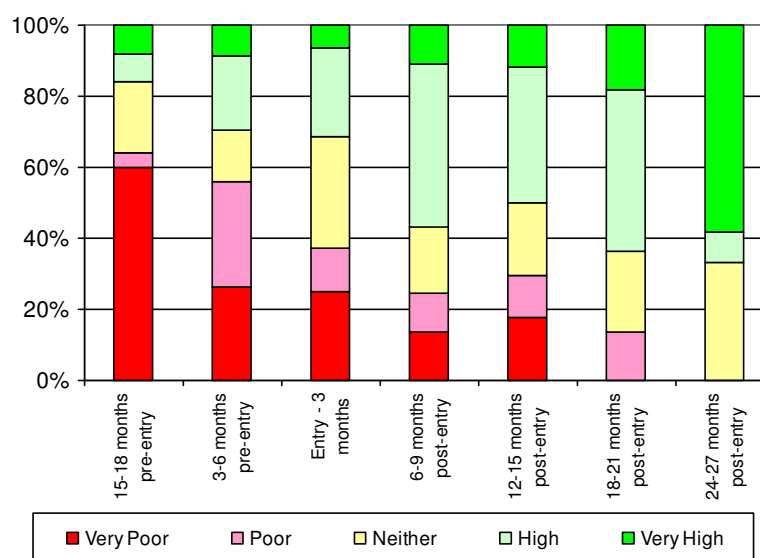
Family Relationships

Results from the HoNOSCA scale, Family Relationships, provided some cross validation of the findings illustrated in Figure 75. The HoNOSCA demonstrates a reduction in the mean score of 46% (high scores indicate increased severity) for family relationships with incremental improvements over the five time points from entry.

The finding is: that young people in the TRC pilots have experienced and sustained significant improvements in their relationship with their family **and** that through using multiple questions and two instruments the finding has been substantiated.

6.5.3   Contact with Residential Carers

Average quality of contact between the young person and residential carers
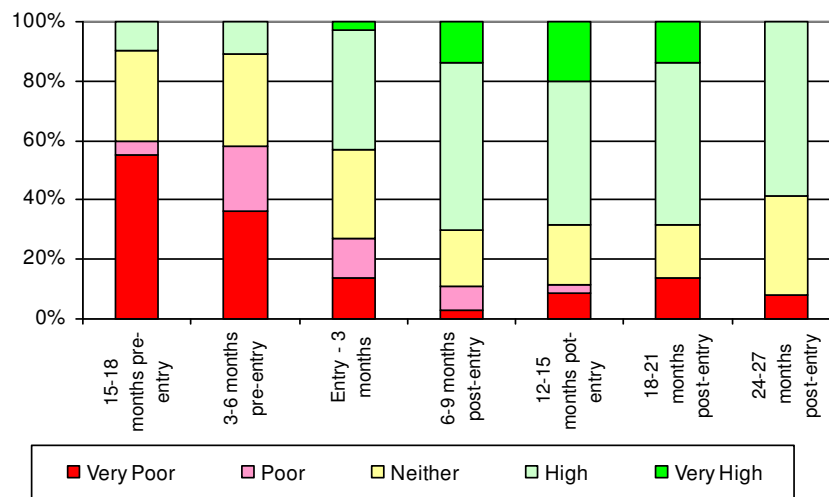
Figure 16 details the average quality of contact between young person and all the residential carers. The figure details the perception of the raters regarding the relationship between young person and all the residential carers, and whether it is improving and becoming more appropriate (better boundaries, more appropriate expectations and clearer roles). The quality of the connection is not necessarily based on whether the young person would state that they are happy with all the carers.

An analysis of Figure 16 reveals that the average quality of contact has improved and been maintained in the TRC pilots. Commentary from a selection of young people in the TRC Pilots is helpful in understanding how they compared their TRC experience with previous residential settings. In other words, their perception of the difference between the TRC and residential OoHC of those in the CG. In response to the question 'what is different in the TRC' the following comments are representative:

- "The carers didn't like me and I didn't like most of them [at the other residential placement]"

- "The carers had time for me when I was here by myself; they respected my opinions and my need to feel safe at night"

- "This place is different. It is therapeutic. That means that people are there to listen to you and talk. I am able to say things that are confidential and know that the things I say will be kept confidential. There are people to talk to."

Figure 16: Average quality of contact between young person & carers - TRC

The quality of contact with carers pre-entry to TRC appears poorer than in the CG (figure 17). The CG's average quality of contact with their residential carers was rated as 'Poor' or 'Very poor' for 37% of the group. This measure is markedly different for the young people in the TRC whose rating progressively reduces from 28% at entry to three months in the TRC to 9% at 24 months post-entry (Figure 16). What is even more powerful in regard to the program effect is the improvement to the 'High' or 'Very high' rating which was 75% compared to 38% for the CG (figure 17).

Figure 17: Average quality of contact between young person and residential carers - CG & TRC pre-entry

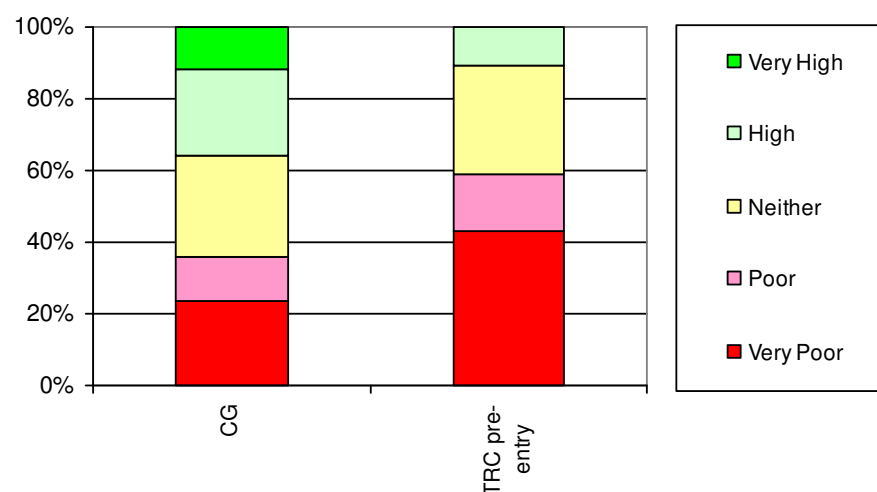Figure 18 shows the highest (best) quality of contact between young person and any residential carer. The data is based on the rater's perception of the best connection between the young person and one residential carer (How good is the quality of the best relationship?). There is a substantial reduction in 'Poor' and 'Very poor' ratings (60% at 15 to 18 months prior entry to TRC down to 10% for this rating over the

review period) the young people in TRCs have been able to form 'High' or 'Very high' contact with an individual carer and sustain that contact over their time in the TRC rising to over 90% at 24 to 27 months post entry.

Of interest is the improvement at 3 to 6 months prior to entry to the TRC which may well be a result of the TRCs' practice of taking time to build relationships with young people prior to entry and allowing 3-4 months (in most cases) to work towards a transition that is therapeutically informed and therapeutic in practice.

Figure 18: Best quality of contact between young person & carers - TRC
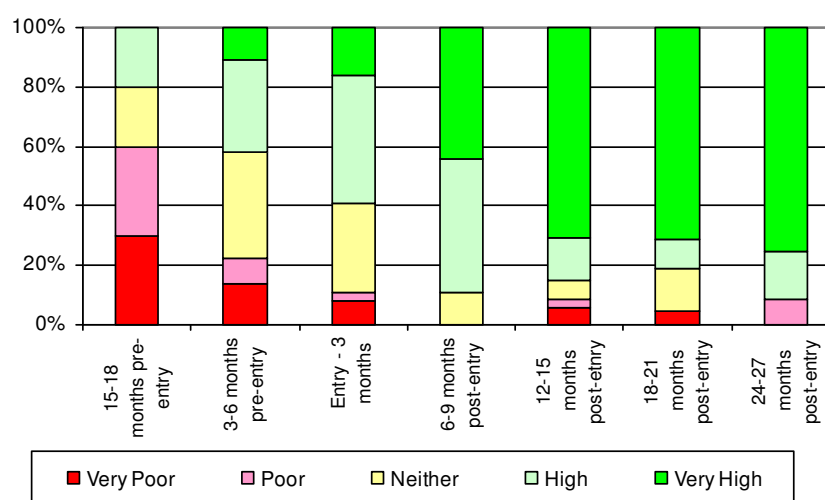
Overall Quality of contact between the young person and residential carers

A striking feature of the ratings of quality, Figure 16 and Figure 18, is that the amount of 'Very Poor' quality ratings decreased between the earliest collection occasion and the entry to TRC. The high quality of relationship is significantly improved for the young people in the TRCs compared to their experiences in residential care prior to entering the TRC and is significantly better than the experience of the CG.

Comparing the Likert scales with HoNOSCA (Figure 75), there is a demonstrated improvement of 46% in the mean score for family relationships with incremental improvements over all five time points from entry (high score indicate increased severity). This question in the HoNOSCA, that details 'family relationships', also incorporates carers in the glossary.

An essential underpinning of the TRCs is developing the capacity of the young people to build secure, nurturing, attachment-promoting relationships with older, capable adults, Figure 16 and Figure 18 demonstrate that this is occurring for the young people. Qualitative measures used throughout the evaluation also confirm that trust relationships are being consistently formed with most young people and that the quality of the relationship is facilitating positive outcomes over multiple measures.

The finding is: that young people in the TRC pilots are developing and sustaining better quality relationships with older, capable adults in the TRC Pilots. These relationships are a necessary element for the development of the secure, nurturing and attachment promoting relationships hypothesised to be a critical element of the Therapeutic approach embedded in the TRC model.

### 6.5.4 Connected to School and Optimal Education and Learning

Within this section 'School' may include an alternative school, tuition or work. It does not include programs that are therapeutic and occur outside of a school/vocational setting. The data excludes attendance at school that occurs at secure welfare or remand.

Expected days at school

In Figure 19 the number of days the young person is expected to attend school is recorded. Actual attendance is detailed subsequently. This figure provides insight into the disruption that may be caused by a change of placement. That is, the most variation in expectations occurs across the three time points spanning TRC entry: 3-6 months pre-entry, entry to 3 months and 6-9 months post-entry. Age may be a factor in these changing expectations with the mean average age at 15-18 months being 11.5 years and the 18 to 21 month being 14.5 years. By the time that a young person is settled in the TRC, expectations seem to have settled at four days per week.

Consultations with Therapeutic Specialist and CSOs have identified the likelihood that due to the more intense care planning and greater attention to stakeholder relationships, it is anticipated that school attendance expectations are likely to be revised. This is reflected in a slightly lower and what some suggest is a more realistic expectation at entry and 6-9 months post entry compared with pre TRC entry.

Figure 19: Days young person expected to be at school - TRC
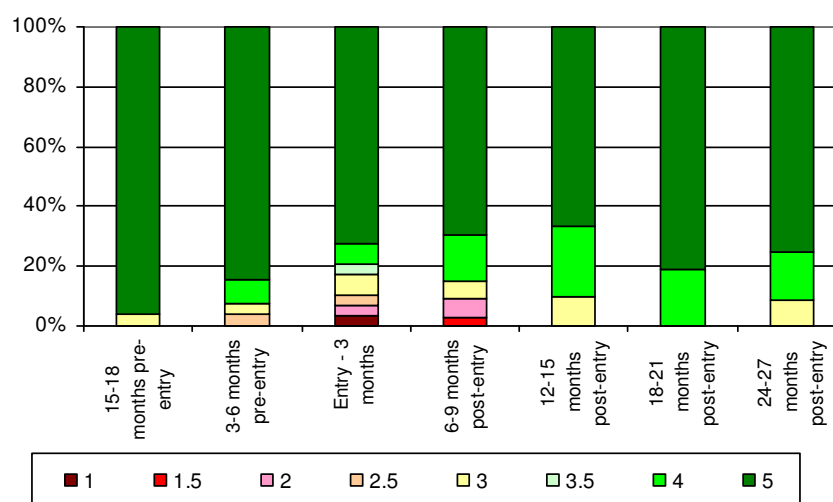
Mean attendance at school

Over the seven collection occasions, 83% of all the young people in the TRCs were attending school or a vocational option. The median days expected at school was five while the median actual attendance at school was about four days. It can be seen that there is a drop in the mean perceived school attendance early on followed by a rise back to a mean of approximately four days (figure 21). Young people in the CG were spending less time at school or in their vocational activity than those in the TRC (figure 20). This is particularly evident over time in the TRC. One of the HoNOSCA scales also addresses school attendance (see Figure 75) and includes:

• Truancy, school refusal, school withdrawal or suspension for any cause

• Attendance at type of school at time of rating, e.g., hospital school, home tuition, etc.

The HoNOSCA ratings (Figure 75) demonstrate a progressive improvement of school attendance consistent with Figure 21, Figure 22 and Figure 23.

Figure 20: Mean days attendance at school/vocational activity - CG & TRC pre-entry
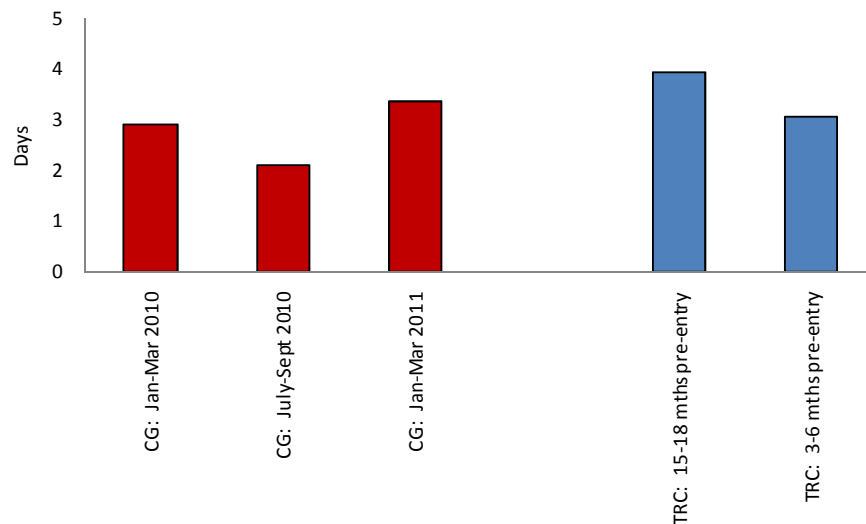
Figure 21: Mean days attendance at school/vocational activity - TRC
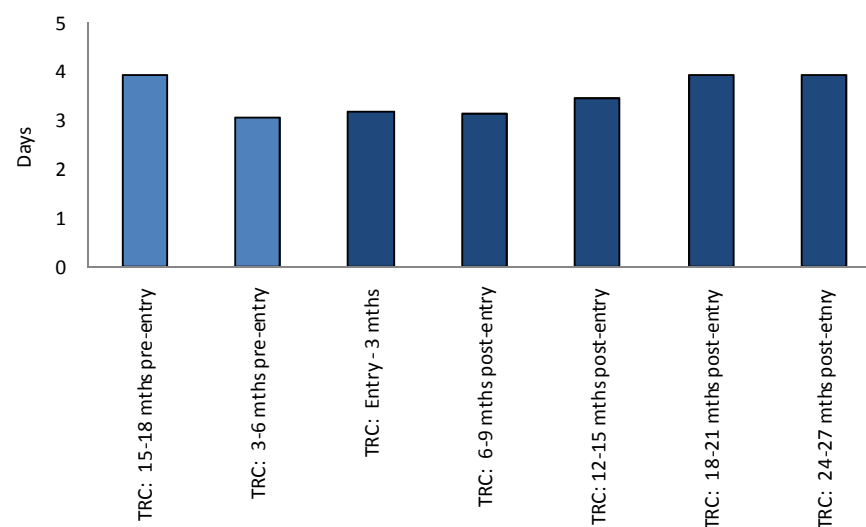
Figure 22: Monthly mean and median missed days at school - CG & TRC pre-entry
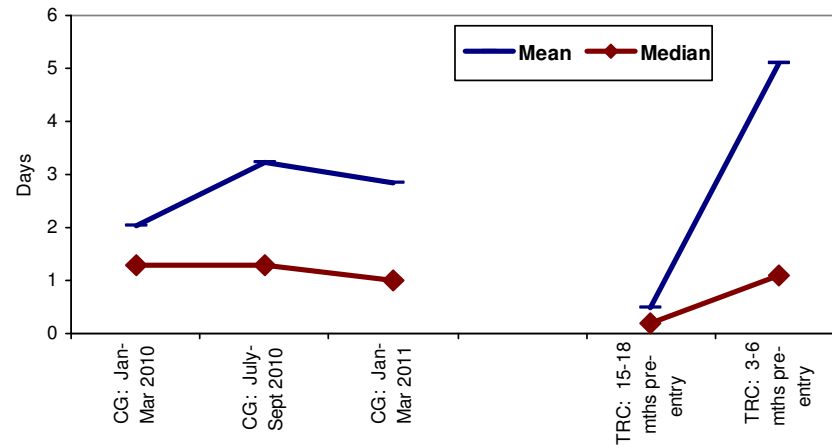
Figure 23: Monthly mean and median missed days at school - TRC
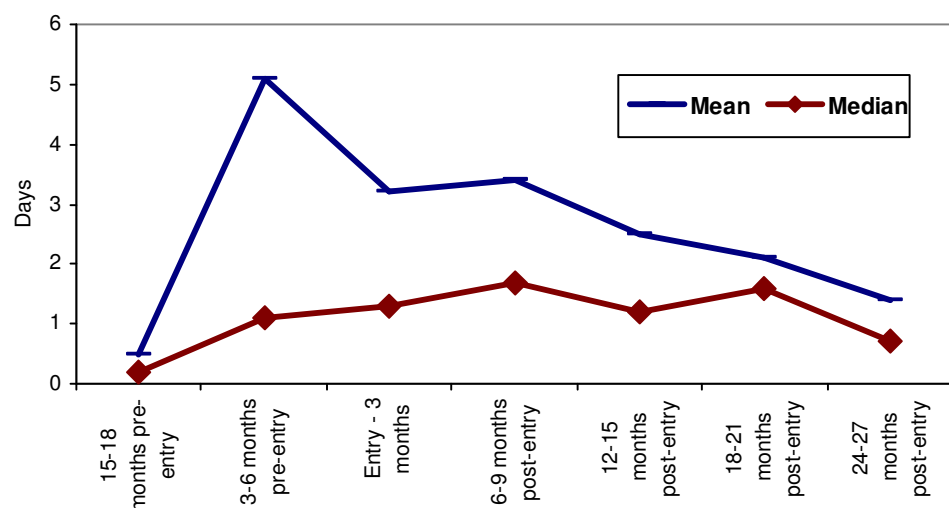
Attendance Summary and Findings

The findings are:

- Young people in the CG were spending less time at school or in their vocational activity than those in the TRC. This is particularly evident over time in the TRC. The CG were also more variable over time.

- Expectations regarding school attendance may be more realistic for TRC young people after they enter the TRC.

Quality of school contact

From Figure: 24 it can be seen that the TRC young people, prior to TRC entry had more problems in the quality of their contact with school than did the CG.

Figure 24: Average quality of contact between young person & school - CG & TRC pre-entry
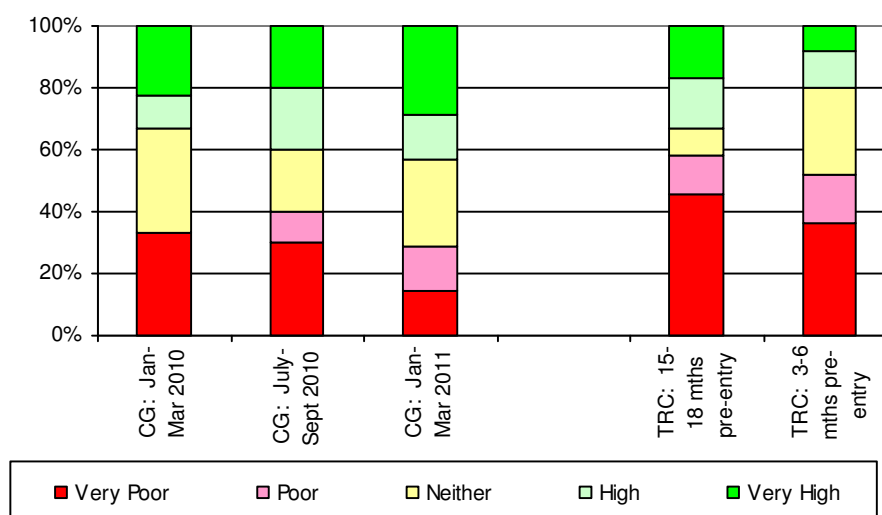
Looking at Figure 25, it is apparent that the quality of contact with school is showing a maintained decrease in 'Poor' and 'Very Poor' ratings. There is a much larger rise in 'Very high' ratings of quality by the 18 to 21 month period. Over time, the young people in the TRCs demonstrate a progressive increase in the 'High' to 'Very high' ratings.

Figure 25: Average quality of contact between young person & school - TRC
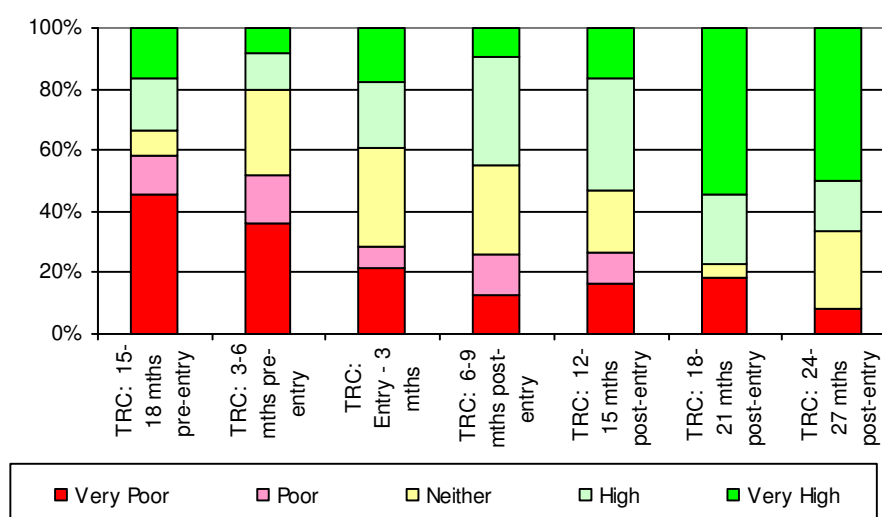
Quality of academic functioning

Figures 26 and 27 have been developed from data gathered in response to the question; "What is the quality of academic school functioning in this collection period giving consideration the expected school level (from above expected year level to below expected year level)?" School reports are referenced in providing this response giving consideration to how well the young person gone academically by subject.

In Figure 27 a progressive reduction in the 'Way below' and 'Below' quality of academic functioning and an increase in those achieving expected outcomes is detailed. It should be noted that the TRC pilot include 4 young people who have a

diagnosed intellectual disability (a target group for one of the pilots). The response for these young people was calibrated to the outcomes that could be reasonably expected giving consideration to their diagnosis.

The comparison group demonstrate significant improvements to the quality of academic functioning across the three time points (figure 26).

The evaluators' interviews with teachers demonstrated that over the period of the evaluation changes were perceived to have occurred in their response to the Therapeutic Approach and their capacity and willingness to adopt congruent practices in the class room and in their interaction with the young person. Examples include adoption of 'Calmer Classrooms', the 'school being involved in the management plan' and the cumulative effect of the Therapeutic Specialists and staff's advocacy and education of teachers e.g. a teacher said "being given strategies and what to expect in terms of behaviours has been a definite benefit". As this change has progressively occurred it could be expected that over time the quality of academic functioning may improve due to the impact of teachers who are more consistently acting in a manner that is congruent with the Therapeutic Approach.

Within HoNOSCA, there are two scales that bear on academic functioning: 'Problems with scholastic or language skills' such as:

- Problems in reading, spelling, arithmetic, speech or language associated with any disorder or problem, such as specific developmental learning problems, or physical disability such as hearing problems.

- Reduced scholastic performance associated with emotional or behavioural problems.

The HoNOSCA Figure 73 identifies that the young people in the TRCs experienced elevated scores on 'Scholastic and language skills problems' prior to and entry to the TRC. These high rates improved incrementally over the following four collection occasions with a total improvement of 39%. While the rates remain elevated, impacting negatively on quality of academic functioning, there have been ongoing improvements for the young people in the TRC over time.

The HoNOSCA also addresses 'Overactivity, concentration and attention' difficulties. The ratings include references to:

- overactive behaviour associated with any disorder such as hyperkinetic disorder, mania, or arising from drugs

- problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression

This measure details significant improvements from a peak score at 15 to 18 months pre-entry of 2.6 that progressively reduced to 1.3 at 24 to 27 months post entry to the TRC. It should be noted however that this level is about the same severity level as observed by CYMHS for concentration. Disruptions to concentration impact on academic functioning. Improvements to concentration should increase academic functioning of young people over time.

Figure 26: Quality of academic functioning - CG & TRC pre-entry
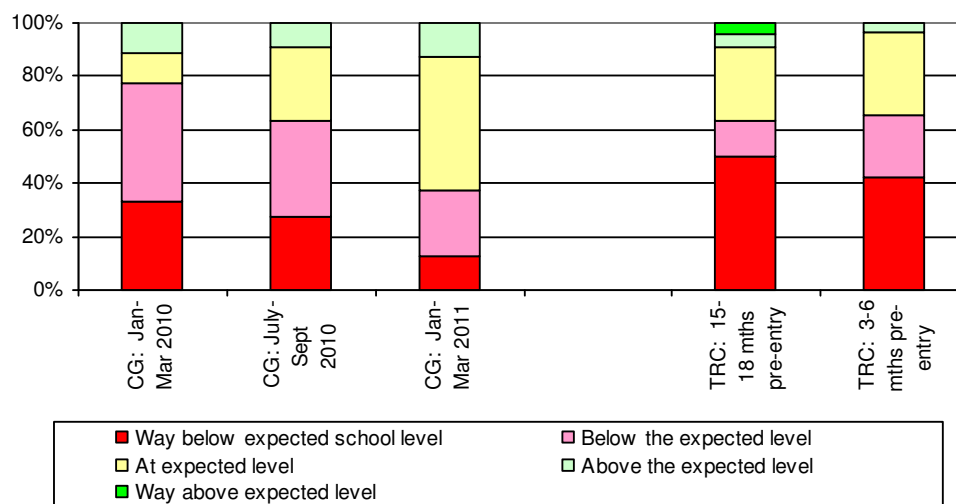
Figure 27: Quality of academic functioning - TRC
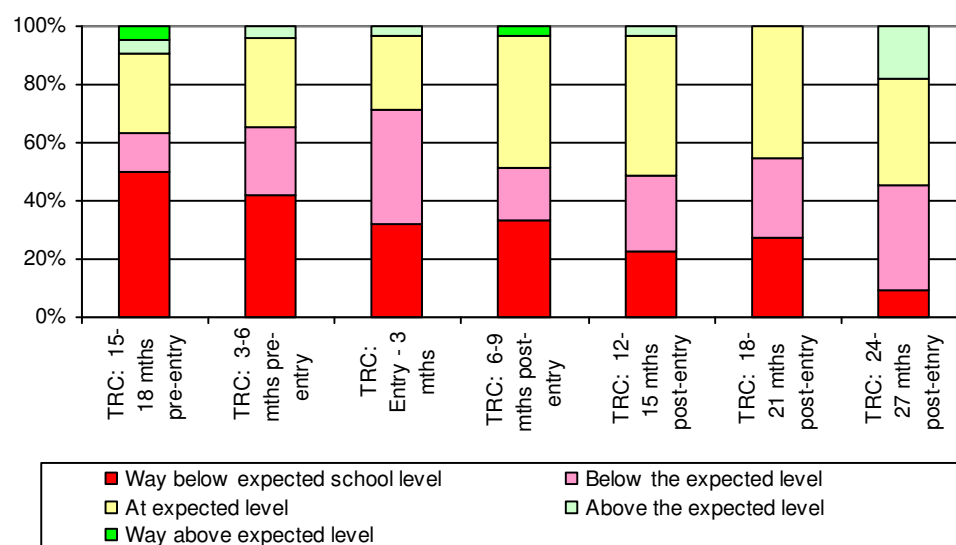
Overall academic functioning and quality of contact

The findings are: The young people in the TRCs are complex. The data identifies some improvement in the percentage of young people at the expected level or above as well as impairments and 'Poor' to 'Very poor' ratings for a significant group of young people (Figure 27).

As outlined the school environment appears to have become more congruent with the Therapeutic Approach and therefore over time the quality scales should demonstrate greater improvements than reflected at this juncture (see 4.1.4 effective service system relationships outcomes and improvements)

The findings: indicate an increased quality of school contact and attendance at school, improved HoNOSCA scores in scholastic and language abilities and a slow improvement in academic functioning. It is summised that as stability increases and

the as the home and school environment become more congruent that this may result in improvements in this area. A longer period is required to fully assess this outcome.

Quality of peer functioning at school

The quality of peer functioning at school is considered to be an important measure in this section; 'Connected to school and Optimal Education and Learning' as peer relationships impact on the motive of a young person to attend school or for some young people to withdraw or be absent (Asher & Coie 1990). In two retrospective studies a relationship between peer rejection and early school withdrawal is suggested.

The adverse quality of peer and social functioning at school is defined in Figure: 29 as mutually cooperative peer relationships being absent or a rating for dysfunctional peer relationships. The figure demonstrates that young people in the TRCs experience a significant reduction in dysfunctional and markedly dysfunctional quality of peer and social functioning and identifies that over time good and high quality peer and social functioning improves. Prior to entry to the TRC, the TRC young people had as many difficulties in this area as did the CG Figure: 28.

Figure 28: Quality of peer and social functioning at school - CG & TRC pre-entry
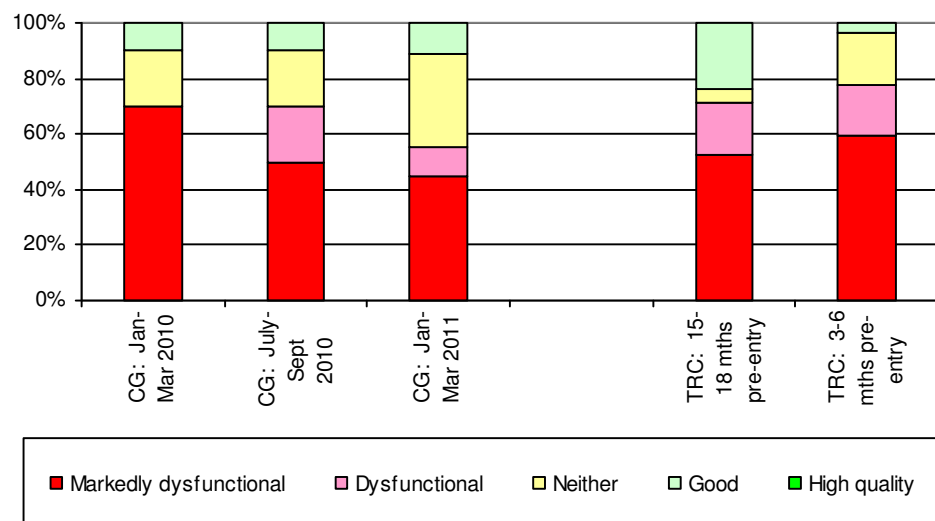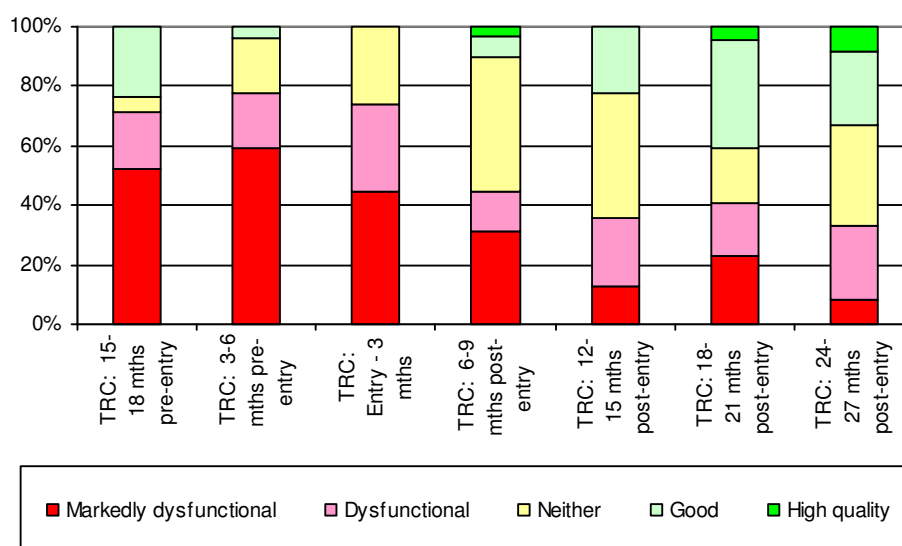
Figure 29: Quality of peer and social functioning at school - TRC

The other two instruments used in the TRC evaluation, the HoNOSCA and the SDQ provide additional commentary regarding peer relationships. Both of these measures look more broadly taking into account all peer relationships never-the-less these measures for the young people in the TRCs correspond with the data detailed in Figure 28. It should be noted that the quality of peer and social functioning at school is likely to interplay with positive sense of self, pro-social behaviour and other reductions in symptom severity and disorder predictors.

The findings are: Prior to TRC entry, the young people in the TRCs had as severe problems in peer relationships in school settings as did the CG. Since entry, the TRC program has seen a marked improvement in the quality of peer relationships. This suggests that the young people in the TRCs are less likely to withdraw from school as a function of peer problems. The improvements are evident in multiple measures.

6.5.5   Residential (stability of placements)

Elements that have been considered to measure residential stability of placement include; the number of residential placements at time of entry into TRC, time in OoHC, current placement length of time and residential stability.

Placement instability is a fundamental problem experienced by children and young people in the OoHC system, particularly among groups with complex care needs. Placement instability, or drift, is shown to be strongly linked to worse outcomes (Osborn & Bromfield 2007; Wise et al. 2010) including schooling and subsequent life chances for young people. Several studies support the contention that placement instability lasting for more than 12 months is more strongly linked with a higher prevalence of psychological, social, and educational difficulties (Osborn & Bromfield 2007; Cashmore & Paxman 2007; Stone 2007).

The number of residential placements and time spent in OoHC

A file audit of 20 young people in the TRC pilots using DHS's CRIS database provided a detailed perspective of placement history. Similarly 16 young people from the general residential care system were reviewed to provide a comparison.

For the audit group, the average age at first entering OoHC was 7.8 years of age. The average number of placements for this group is 10.5 over a 6 year period spent in the

OoHC system, before entering Therapeutic Residential Care. Based on the young peoples' placement histories and their age of first entry into the OoHC system, three distinct subgroups can be identified among the 20 young people in the TRC pilot audit population.

Sub group 1: Comprising of a group of eight young people who entered OoHC for the first time at under 4 years of age. For this eight young people, the average number of placements was 18.8, ranging from 5 to 45 (with a median value of 18). The average time spent in OoHC for this subgroup was 11.8 years and the average age of entry into the TRC pilot program was 13.6 years. Thus this group has experienced a care journey that commenced at a very young age, extending for several years, and is characterised by an extremely high number of placement changes.

Sub group 2: Comprising of a group of 4 young people who entered OoHC for the first time later, between 6 and 12 years of age. The number of placements is slightly fewer, with an average of 7, ranging from 4 to 10. The average time spent in OoHC was 4.6 years, and age at entry into the TRC pilot program was 14.1 years.

Sub group 3: Comprising of a group of eight young people who entered OoHC for the first time at an average age of 12.9 years, and had experienced the least number of placement changes (4 on average) prior to entry into the TRC pilot. The average time spent in OoHC was 0.8 years, and age at entry into the TRC pilot program was 13.8 years. Thus this latter subgroup entered the system at an older age, and has spent the least amount of time in OoHC prior to entering the TRC program.

Comparison group: The placement history and age at entry into OoHC is comparable between the comparison and the TRC audit group. For instance, of the 16 in the comparison group sub group 1: 3 entered OoHC for the first time under the age of 4 (average 1.1 years) and the placement history for this small group was an average of 12 placements (ranging from 5 to 21 placements). The remaining 13 young people in the comparison group sub group 2: entered OoHC at an average age of 13.1 years and an average of 4 placement changes.

Table 16: Pre-entry placement history

Audit Groups	Average Age at first entry to OoHC	Average number of placements	Range of placement Changes	Average span of years placement pre TRC	Age of entry into the TRC
CRIS Audit Group	7.8	10.5	2 – 45	6	13.4
Sub Group 1 (n8)	1.8	18.8	5 – 45	11.8	13.6
Sub Group 2 (n4)	8	7	4 – 10	4.6	14.1
Sub Group 3 (n8)	12.9	4	2-11	0.8	12.9
Comparison Group	10.8	5.5	1-21	NA	NA
Sub Group 1 (n3)	1.1	12	5 – 21	NA	NA
Sub Group 2 (n13)	13.1	4	1-9	NA	NA

The time spent in Residential Care immediately prior to entry to the TRC

All of the young people in the TRC pilots were in residential care prior to entering the TRC; the length of time ranged from 2 to 147 months.

Young people in the TRC pilots experienced between one to twelve residential placements with a median of four prior to entering the TRC Pilots. The young people in the TRCs had been in residential care immediately prior to entering the TRC pilot for an average of 31 months (median 17 months).

The audit data, and the collection occasions of 15 to 18 months prior to entry and 3 to 6 months prior to the entry to the TRC, provides a window to the experience of the young people in the TRC in the general residential care system with most of the TRC

population being continuously in residential care over these collection points. This insight supports an understanding of the quality and rate of change experienced by the young people in the TRC pilots. It also supports a comparison of their experience prior to entering the TRC (their experience in the general residential care setting) to their experience at and after entry to the TRC.

The young people generally experienced an unstable placement history prior to entering the TRC pilots.

Length of time in current placement

At the time of finalising the TRC evaluation, less than one third of the TRC Program population had exited. Thus whilst provisional at this point in time the average length of stay within the TRC program is currently 30 months. However, due to the rolling cohort, the length of stay in the current placement will not be known until the program has matured.

For many of these young people the TRC placement represents the most stable period in their life.

Residential Stability

Within the young people's experience in the TRC the following was reported.

Prior to entry to the TRC the maximum number nights any one young person was absent from residential care was 16 nights per month. The average number of nights absent was 1.9 per month with a median value of 0.

For young people at and after entry to the TRC, the maximum number of nights that a young person was absent was 28 nights per month. The median value was 0.1 nights absence per month and the average was 2.6. The data provided by the CSOs suggests that there are a small number of young people who have very large numbers of absences but overall these young people tended to not have unplanned absences.

Most young people in the TRC remain at the unit during their stay in the TRC, absences are generally planned.

Placement history impact

Young people in the TRC pilots experienced significant disruption prior to entry to the TRC. Improvements to placement stability affords these young people the opportunity to improve or establish; relational, community, sporting, educational, recreational and family connections. Therapeutic Specialists and staff identified that they play an important role in supporting young people to develop these connections and that these improvements are not simply about stability however without stability of placements the outcomes of improved connection could not be achieved.

Stable placement history may also support recovery from the damage experienced by young people because of multiple placements.

6.5.6   Community Connectedness

Average strength of contact between young person and community

The average strength of the young person's connection to their community relates to community that is perceived as relevant by the young person.

The Figure: 30 details an improvement in the strength of connections as shown in an increase in 'strong' and 'very strong' ratings and a reduction in the ratings of 'Weak and 'Very Weak' over the collection periods. There is also a marked increase in the percentage of those for whom the relationship is neutral by the last collection period

(representing only 12 of 38 TRC young people). It is possible that those who have been the longest in the TRCs face the most difficulty connecting, or that over time the relevant community for them starts to shift. When considering the pre-entry ratings there is a significant improvement in these ratings.

Figure 30: Average strength of connection between young person & community - TRC
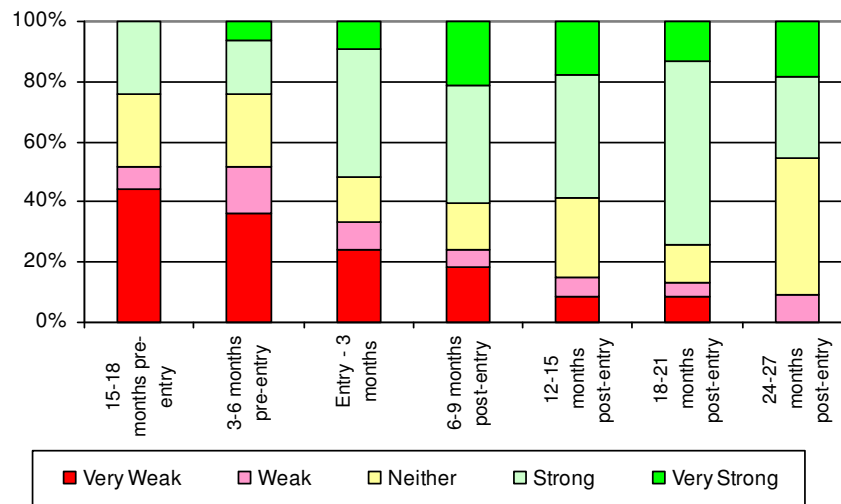
Quality of connection between young person and community

As with the strength of connection, the quality of the young person's connection to their community refers to community as perceived as relevant by the young person.

As described in strength of connection the quality of the connection between young people and their community has steadily increased. There is also a marked increase in the percentage of those for whom the relationship is neutral by the last collection period. The reasons for this needs to be explored further and could possibly be related to age that those who have been the longest in the TRCs face the most difficulty connecting, or that over time the relevant community for them starts to shift. Figure 32 indicates that for those in the TRC at 24 to 27 months the strength of the connection to the community agencies has continued to increase.

Prior to entry, the TRC group had a similar proportion of 'Poor' to 'Very Poor' ratings for the quality of their connection to the community as did the CG. Both groups have difficulties in this area.10% of the comparison group at two out of three time points experience a 'High' or 'Very high' rating of quality of connection.

Figure 31: Quality of connection between young person & community – CG & TRC
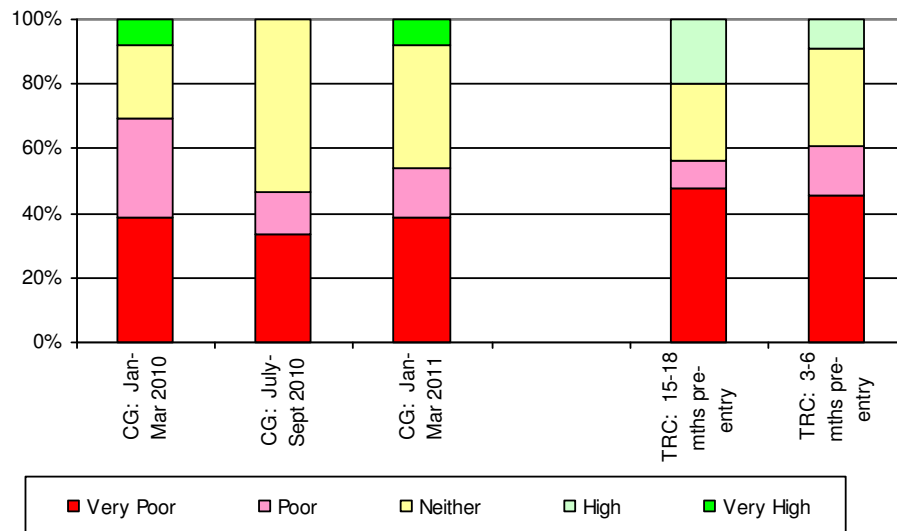
Figure 32: Quality of connection between young person & community –TRC
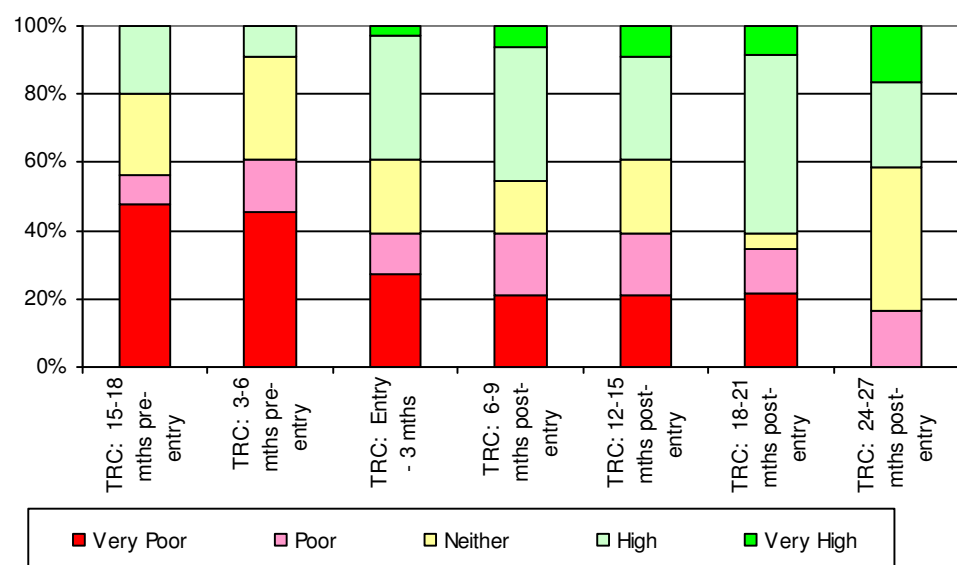
Quality and Strength of Connection to Community: Overview

As detailed in Figure: 30 and Figure: 32 young people in the TRC Pilots are more likely to engage in community activities. The types of community activities reported by CSOs include; pony club, playing football/netball or swimming lessons, or having a part time job. CSOs report that this is a marked difference to the experience of many young people in general residential care. The success of community relationships is enhanced by effective involvement of TRC staff and/or the Therapeutic Specialist or Case Manager. They provide information and education as to the thrust and emphasis of the Therapeutic Residential Care which supports consistent and congruent approaches as young people engage in and with the community.

The range and scope of community relationships is influenced and determined by the interests and motivation of the young people. Community relationships require a significant investment on the part of the TRC program. This includes TRC staff, transport to/from activities, and in some cases direct financial contribution (e.g.

swimming lesson fees, sports uniforms). Some TRC Pilots have accessed other grants and Agency initiatives to support activities such as holidays and to enhance recreation.

The outcomes data and consultations demonstrate that many of the young people on entry to the TRC Pilots are likely to be experiencing emotional and social isolation typified by feelings of emptiness, anxiety, restlessness, and marginality. Many of the Pilots have used social mapping tools which demonstrate the paucity of relationships that many of these young people experience. The long-term effect of being socially disconnected has been well documented (Popay et al. 2008; Mathieson et al. 2008) including reduced length of life. The study 'Social Relationships Are Key to Health, and to Health Policy' finds that there are multiple benefits in the reduction of social isolation (The PLoS Medicine Editors 2010).

Other factors in the TRCs to consider alongside the way stability reduces social isolation and increases connections to community may include but not be limited to:

• Increased resourcing and flexibility in the use of resources allows the young person's goals and interests to be supported facilitating greater engagement

• Positive sense of self results in the young people being more confident in interactions and therefore supports increased and improved community engagement

• A greater capacity for the young people to understand their trauma history and the impact on their feelings and on their responses supports improvements to reactions and responses to adverse situations in community, sporting and peer relationships e.g. losing in a sporting contest

Julianne Holt-Lunstad, co-author of 'Social Relationships Are Key to Health, and to Health Policy', said: "When someone is connected to a group and feels responsibility for other people, that sense of purpose and meaning translates to taking better care of themselves and taking fewer risks." (The PLoS Medicine Editors 2010).

The improvements to young people's pro-social capacity as shown in Table 17 reflect the positive improvement in community connections for the young people in the TRC Pilots and reductions in risk taking may be linked. It also shows that at pre-entry the TRC group were as or more problematic than the CG. Young people in the TRC are not at the easy end of the residential OoHC population of young people.

Table 17: Improved pro-social outcomes themes and measures

| Theme in relation to Improved Outcomes for the Young People in TRC Pilots	Measure	Comparison Group avg over 3 time points[15]	TRC Group 6-3 months pre-entry	TRC Group 18-21 months post-entry
Quality of connection between the young person and community	'High' or 'Very high'	9%	10%	62%
Frequency of recreation	Twice per week or more often	20%	28%	75%
Quality of peer and social functioning at school	Markedly dysfunctional or dysfunctional	63%	79%	35%
Pro-social functioning	Increasing score denotes improvement (scale 0-9)	n/a	4.2	6.3
Risk taking	'High' or 'Very high'	62%	68%	38%

[15] Comparison Group time points: January-March 2010, July-September 2010, January-March 2011

Average strength of connection between the young person and community agencies

The average strength of connection between the young person and community agencies (Figure 33) indicates the strength of the young person's connection to any community agencies (other than the TRC) taking the average strength of connection across multiple agencies (if there were multiple agencies). As with Figure: 30 and Figure: 32, 'community' in this instance refers to that perceived as relevant by the young person.

The young people in the TRC pilots have experienced significant improvements in the strength of their connection with community agencies and sustained those improvements over the collection points.

Figure 33: Average strength of connection between young person and community Agencies - TRC
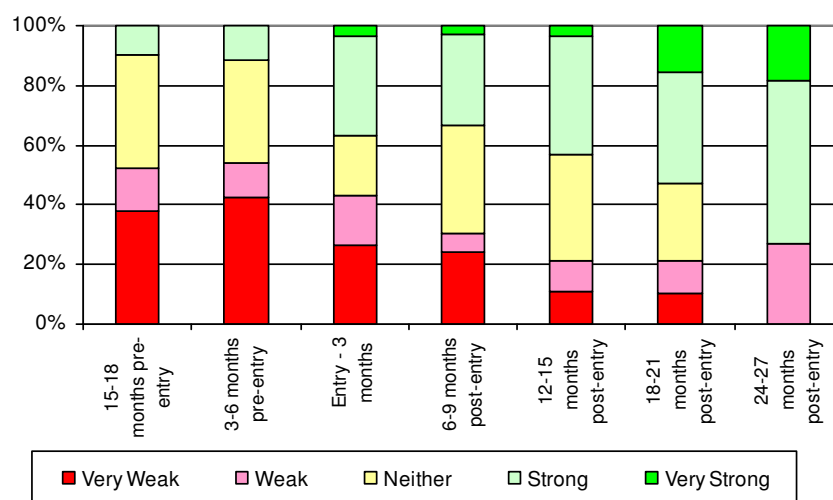
The finding is: Young people in the TRC Pilots are more likely to engage in community activities with 75% undertaking recreation activities twice per week or more at 18 months post-entry to TRC.

6.5.7   Connected to Indigenous Culture

Quality of information pertaining to the young person's Indigenous status recorded in Table 18 leaves some doubt regarding the number of the young people who may be Indigenous. The CSO responses to this question (second line in Table 18) suggests that up to a third of the TRC young people are Indigenous however other data reported by the CSOs that specifically asks; "Is young person's Indigenous status identified in documentation?" this information is recorded in the bottom line of Table: 18. This response reports a more creditable 18% of the TRC population who are identified as Indigenous.

Table 18: Quality of information pertaining to young person's Indigenous status – response rate

Collection period	15-18 months pre-entry	3-6 months pre-entry	Entry - 3 months	6-9 months post-entry	12-15 months post-entry	18-21 months post-entry	24-27 months post-entry
Completed surveys	29	38	38	38	35	24	12
Responses to this Q	12	13	13	12	8	8	6
Responses from YP identified Indigenous	4	7	7	7	6	5	1

Quality of information pertaining to the young person's Indigenous status

The CG recorded no response to quality of information pertaining to the young person's Indigenous status in the first two collections however there were five responses for the third collection period.

A lack of information or 'Very poor' information about the young people's Indigenous status is detailed in Figure 34.

Figure 34: Quality of information pertaining to the young person's Indigenous status (for those indentified as being of Indigenous background) - TRC
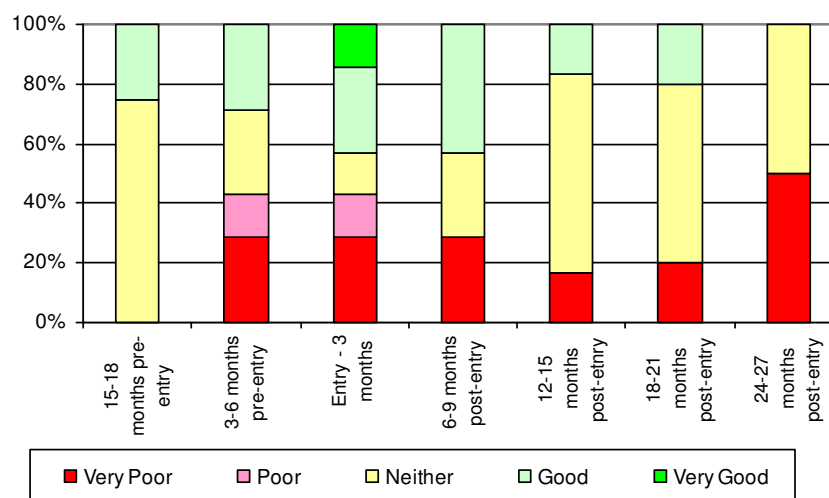
Strength of connection to the Indigenous community

The strength of connection between Indigenous young people in the TRC and their Indigenous community is detailed in Figure: 35.

Figure 35: Strength of connection to the Indigenous community for those identified as being of Indigenous background - TRC
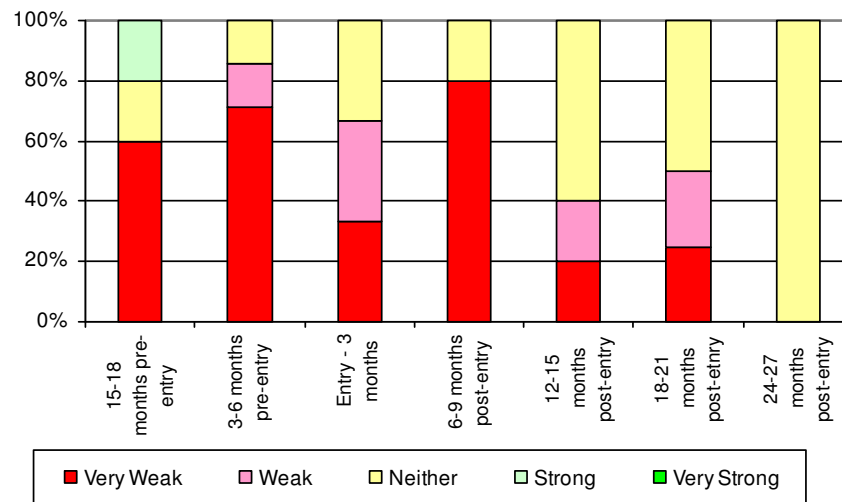
Quality of connection to the Indigenous community

Given poor documentation and apparent discrepancies in reporting there appears to be significant challenges in determining or improving either the strength or the quality of the connection to the Indigenous community.

Figure 36: Quality of connection to the Indigenous community for those identified as being of Indigenous background - TRC
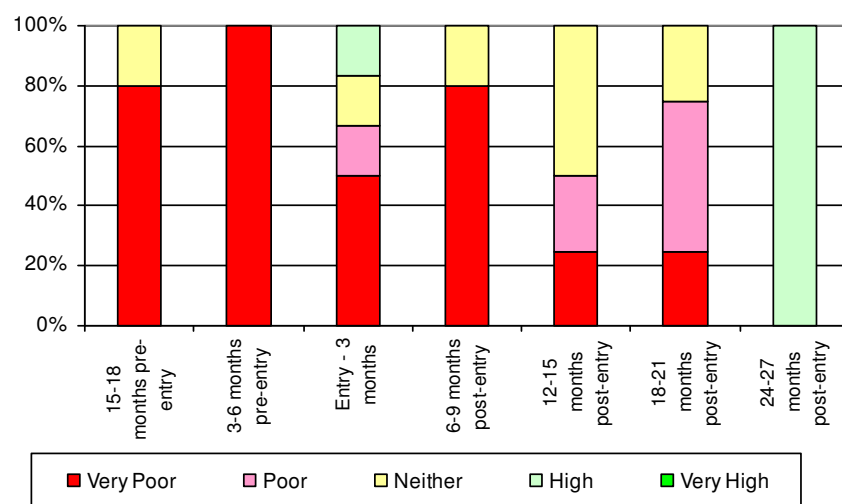
The finding is: The data demonstrates a lack of information and poor connection to community for young people who have identified as being Indigenous. This may demonstrate a need for CSOs to implement improvements in the current processes and systems for Indigenous identification in order to proactively provide a framework for positive connection.

6.5.8 Cultural Background

*Table 19: Cultural background – response rate*

Collection period	15-18 months pre-entry	3-6 months pre-entry	Entry - 3 months	6-9 months post-entry	12-15 months post-entry	18-21 months post-entry	24-27 months post-entry
Completed surveys	29	38	38	38	35	24	12
Responses to this Q	18	22	19	13	13	8	5

At entry to the TRC, the identified cultural groups by language were Aboriginal (3), African (1), Anglo Saxon (5), Australian (6) and Vietnamese-Australian (1). No language group was identified for 22 of the young people. There is a reasonable amount of information missing for the cultural questions. This suggests some uncertainty about what to do with issues of culture for those considered to belong to the dominant cultural group.

Quality of information about cultural background

The quality of information about cultural background improved over the collection periods Figure: 37 however low response rates for the 18 -21 and 24 – 27 months as detailed in Table 19 and Table:18 provides further context for interpreting this information. It is likely that over the entire audit population that the quality of information improved and was maintained as detailed in the 12 – 15 month period. This is consistent with CSOs and Therapeutic Specialist's reports that comprehensive information is generally lacking prior to entry to the TRC and that over the entry to 6 month period detailed records are developed.

Figure 37: Quality of information about cultural background - TRC
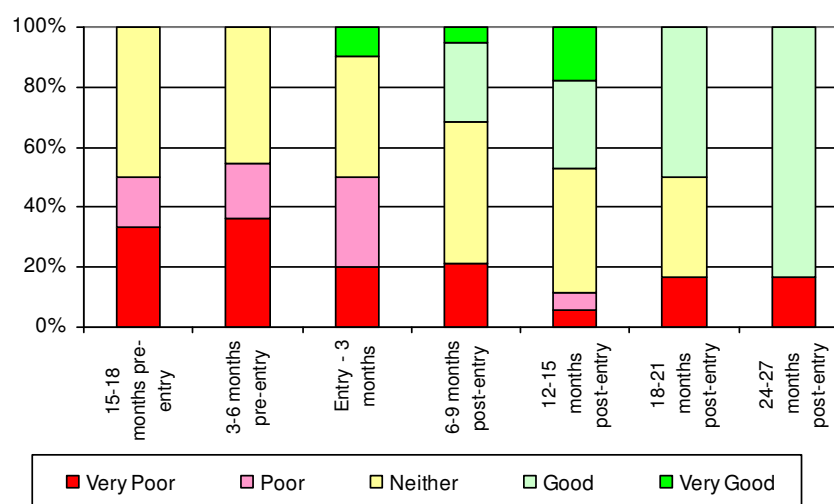
Strength of connection to cultural community

Significant improvements to the strength of connection to Cultural Community and a reduction in the very weak and weak ratings are detailed in Figure: 38.

Figure 38: Strength of connection to cultural community - TRC
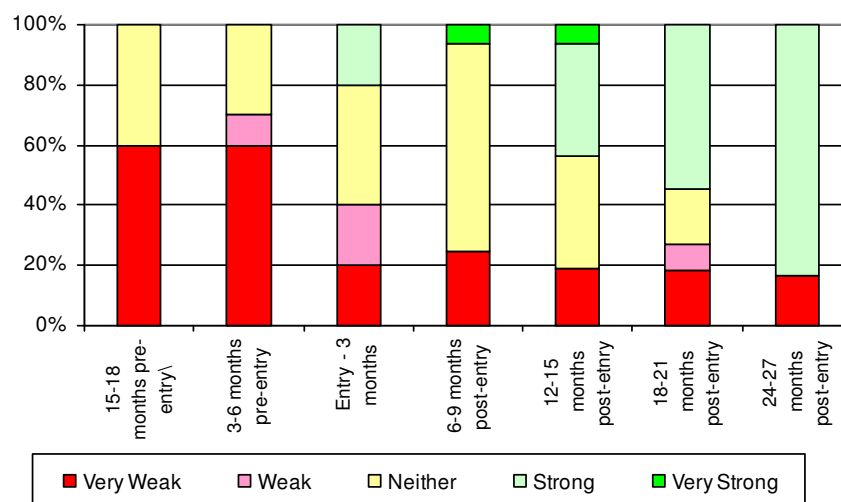
Quality of connection to cultural community

Improvements to the strength of connection to over 80% 'good' rating at 24 to 27 months and a reduction in the very weak and weak ratings are detailed in Figure: 39.

Figure 39: Quality of connection to cultural community - TRC
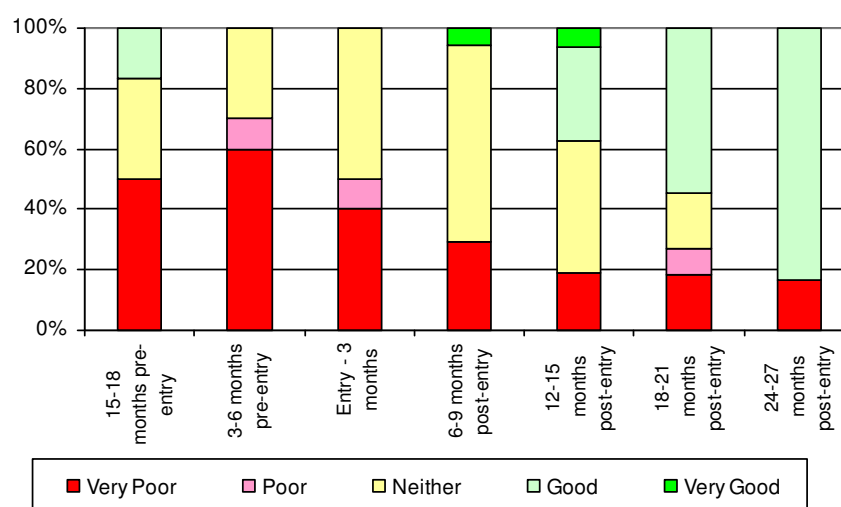
Overview of cultural connection

Improvements to family and community as detailed in 2.5.2 and 2.5.6 are factors that also influence improvements to the strength and quality of cultural connection. As reported by TRC staff improved quality of information (across many domains) to support detailed care plans. The quality of information facilitates good practice in responding to the young person's cultural background.

The findings are: TRC young people experienced improvements to the quality and strength of their connection to cultural community compared to their experience prior to entering the TRC. Improved information regarding the young people's cultural background, facilitated opportunities for TRC staff to proactively support connections. An important consideration that arose throughout this data collection

was the hypothesis that cultural connections are generally viewed as a relevant construct for those of a non-English speaking background.

6.5.9   Optimal Physical Health

The term 'documentation' is included in the outcome measures because the raters (i.e. therapeutic specialists and/or carers completing the survey) are not providing a professional medical opinion, but rather are reporting on what the documentation states. Whilst the raters are not directly assessing the medical or dental status per se, they are reporting on the documented improvements to the status. Therefore, data is being interpreted as improvements to the status (i.e. medical, dental, sleep) and not merely as improvements to the recording of the information.

Quality – medical status

Over the seven collection occasions, documentation relating to the young person's physical health increased.   There has been a clear and maintained interest in documenting the young people's medical status.

The CG had better documentation in relation to medical status than the TRC group pre-entry. The TRC group prior to entering the TRC had poorer health outcomes than the CG as evidenced by the documentation of medical status.

Figure 40: Quality of documentation on medical status - CG & TRC pre-entry
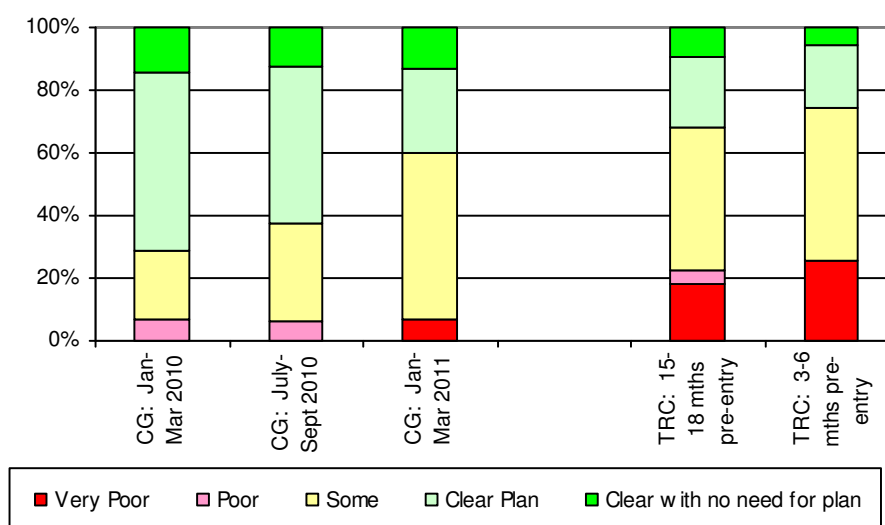
From Figure 41, it can be seen that the quality of medical status documentation has increased substantially. The number of young people with "no need for a plan" has increased as has the proportion with a "clear plan" for improving their medical status.

Figure 41: Quality of documentation on medical status - TRC
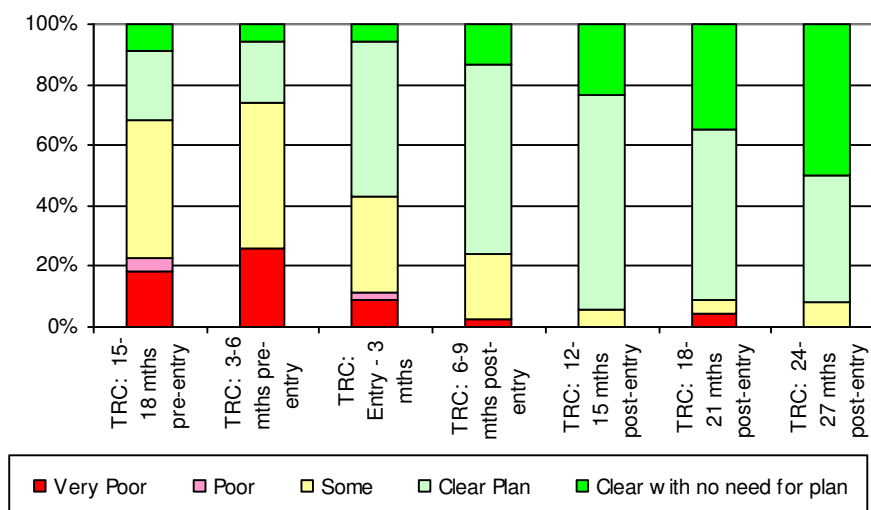
Quality – dental status

Over the seven collection occasions, documentation relating to the young person's dental status increased. There has been a clear and maintained interest in documenting the young people's dental status.

From Figure: 41 and Figure: 42 it can be seen that the quality of medical and dental status documentation has increased. The number of young people with 'No need for a plan' has increased as has the proportion with a 'Clear plan' for improving both their medical and dental status.

Figure 42: Quality of documentation on dental status - TRC
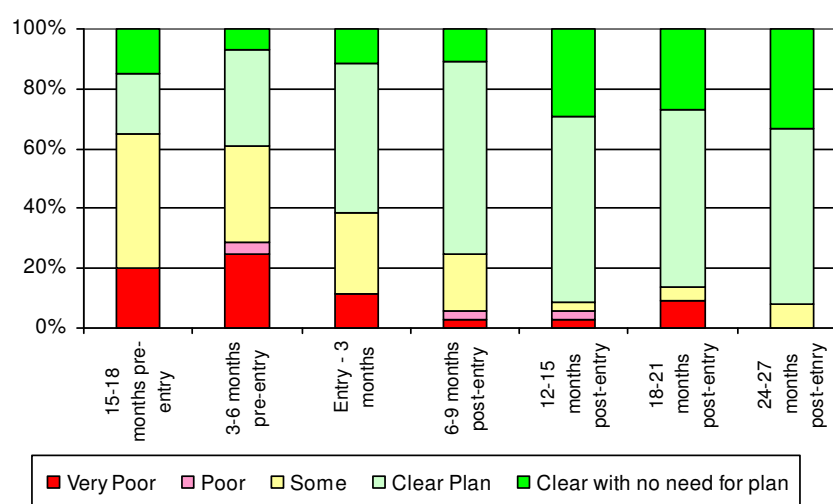
Quality – nutritional status

The documentation of the nutritional status of the CG appears better than the TRC group pre-entry. By 6-9 months into the TRC stay, the TRC group has improved documentation for improved nutritional status.

Figure 43: Quality of documentation on nutritional status – CG & TRC pre-entry
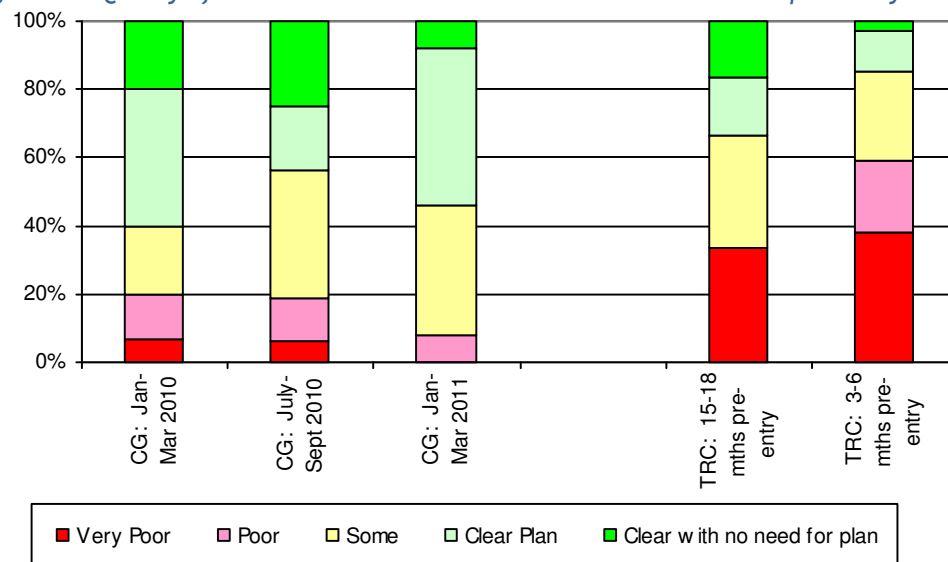
Figure 44: Quality of documentation on nutritional status –TRC
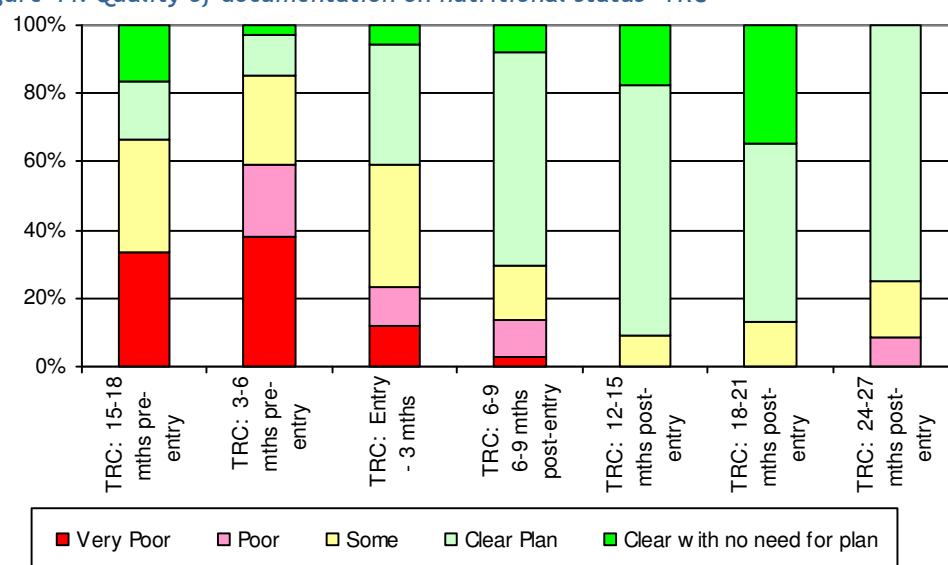
Quality – sleep status

The quality of documentation of sleep status was also better in the CG compared to the pre TRC entry although again, the TRC group developed much better sleep documentation by about 12-15 months.

Figure 45: Quality of documentation on sleep status – CG & TRC pre-entry
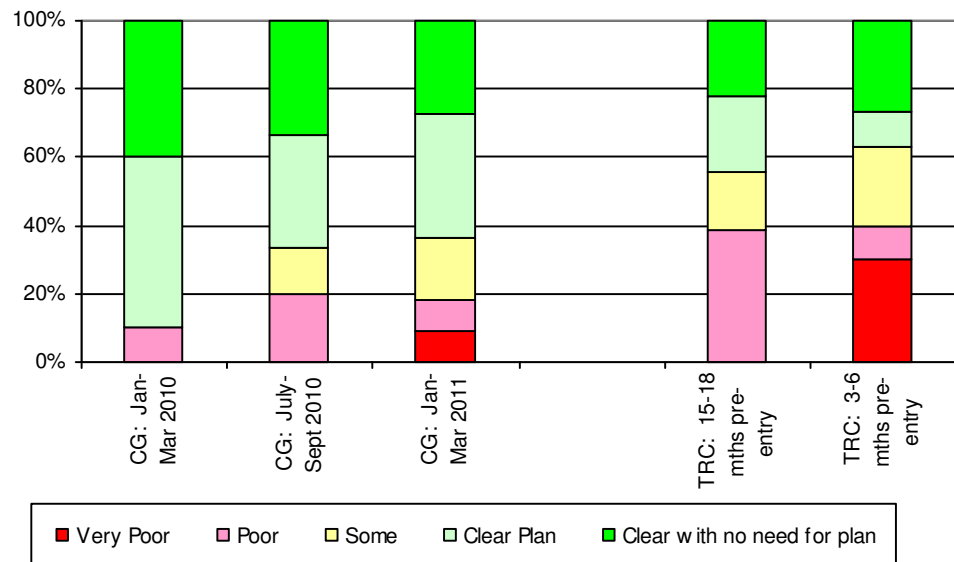
Documentation of sleep patterns shows a marked increase in the number of young people with "clear plans" for improving their sleep patterns as well as an increase in those with good sleep patterns and "no need for a plan" (Figure 46). These improvements are also reflected in reductions in the mean non-organic somatic[16] scores in the HoNOSCA (Figure: 74) with a marked reduction from pre entry and positive change over the 4 collection periods.

The effect of improvement in sleep patterns has multiple impacts such as improvements in the quality of connection with school and as evidence of the young people feeling safe with a resultant reduction in stress; as detailed:

- The staff of Baltara School at Hurstbridge Farm remarked, "as normal sleep patterns developed in the units there was a corresponding improvement in attendance in morning classes and the quality of engagement in learning"

- Therapeutic Specialists and agencies staff consider improvements to sleep to be linked to 'feeling of safety' and evidence of 'reduced stress'

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16 Physical symptoms such as sleep disruption, vomiting, elevated heart rate, bedwetting etc. with a non organic source

Figure 46: Quality of documentation on sleep status – TRC
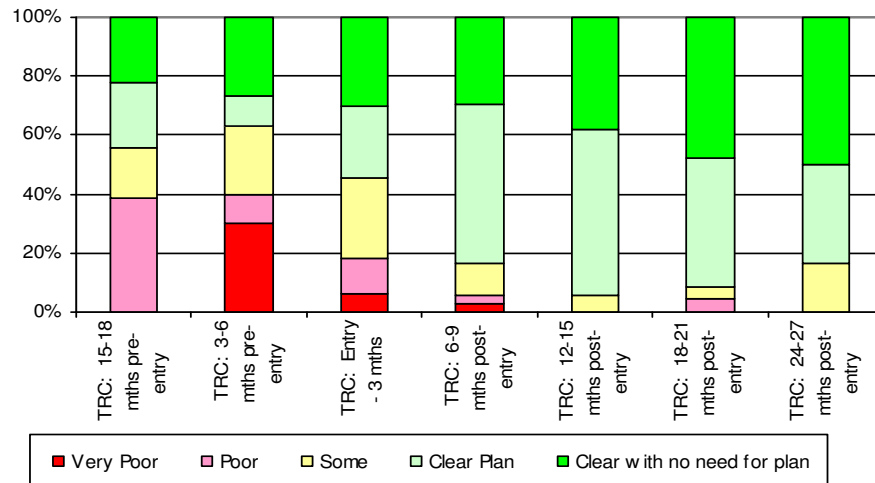
Quality – hygiene status

Documentation relating to the young person's hygiene status increased markedly post entry to the TRC compared to pre entry periods. Similarly to the improvements detailed in figure 47 the HoNOSCA (figure 75) details an improvement (16.3% reduction in the mean score) in self care that reflects a positive change from pre entry (3 to 6 months) to 6 to 9 months post entry. It also demonstrates reduction in the mean score over time.

Figure 47: Quality of documentation on hygiene status - TRC
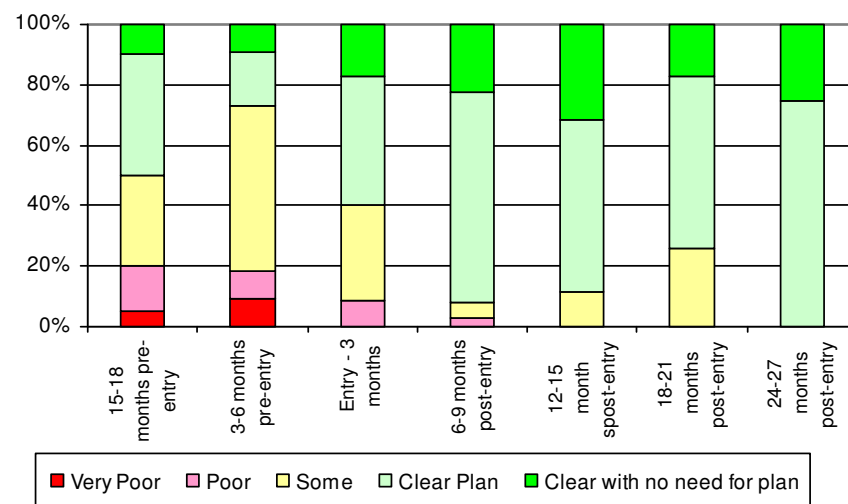
Quality of documentation of recreational patterns

The quality of documentation about recreation patterns was greater in the CG than the TRC in the pre-entry phase. There appeared to be little change in the CG over the course of the year. Young people in the TRC experienced substantial improvements in the documentation of recreation patterns from entry to the 6-9 month collection period and this improvement was maintained over subsequent collection periods. The majority of young people plainly had 'Clear plans' for improving their recreation of clear identification of good recreation habits as detailed in the rating 'clear with no need for a plan'.

Figure 48: Quality of documentation on recreation patterns – CG & TRC pre-entry
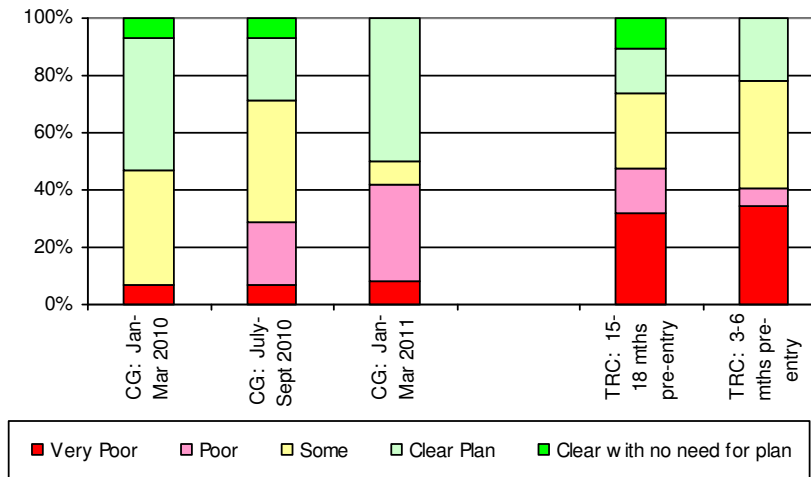
Figure 49: Quality of documentation on recreation patterns – TRC
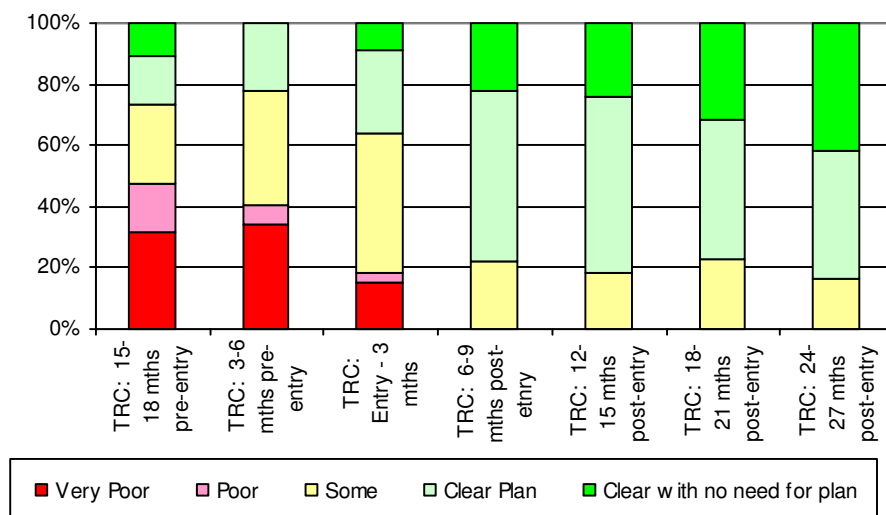
Frequency of recreation

While documentation is important, it needs to be accompanied by action. The frequency of recreation was less in the CG than the TRC group prior to entry to the TRC. On entry to the TRC, the frequency of recreation increased substantially over time, so that by the last two collection occasions, the majority were engaged in recreational activities twice a week or daily. It is interesting as a side observation that there appeared to be little change in the CG over the course of the year.

Figure 50: Frequency of recreation - CG & TRC pre-entry
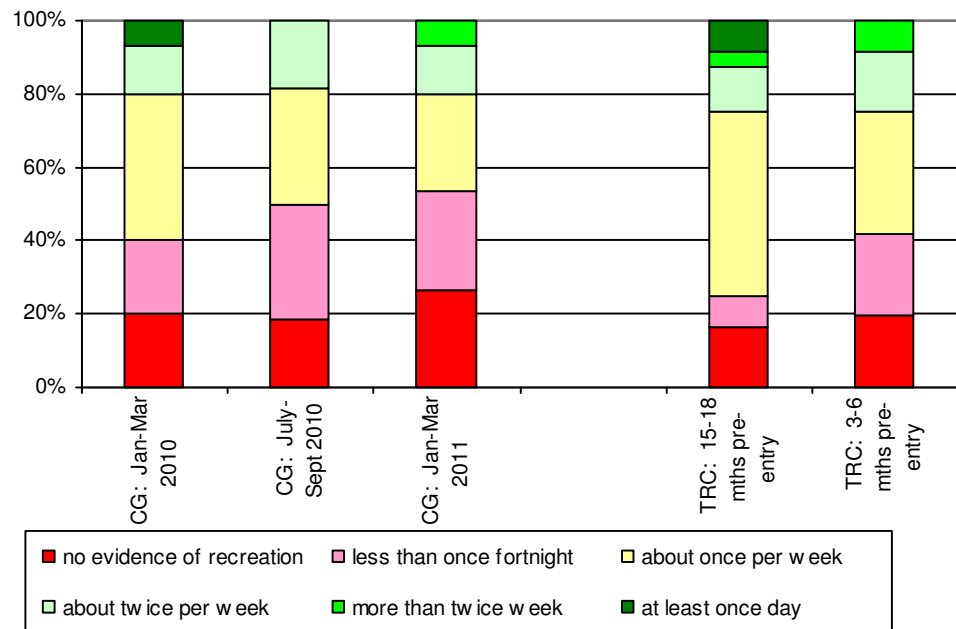
Figure 51: Frequency of recreation - TRC
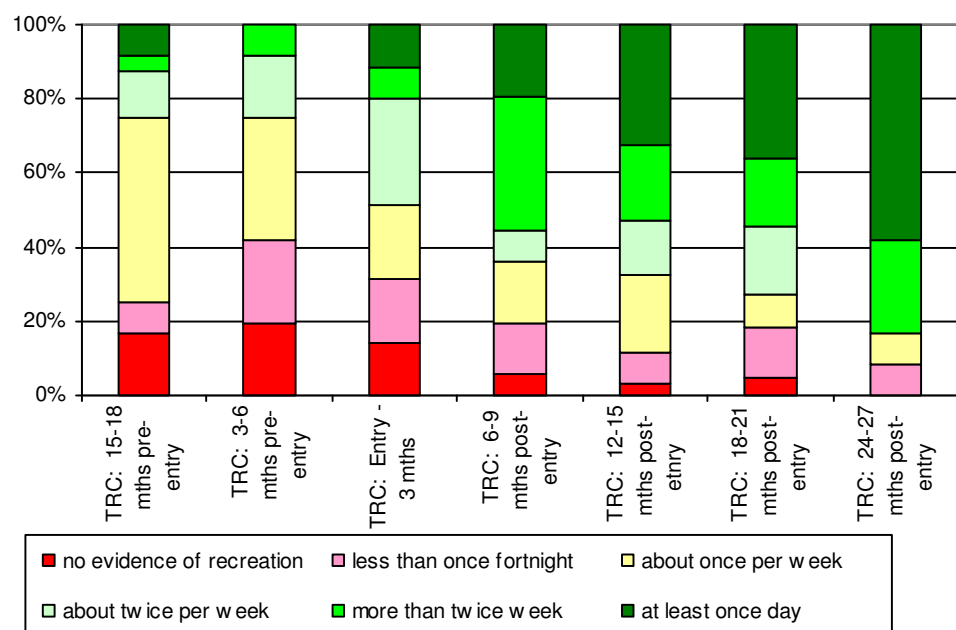
The quality of documentation of recreational patterns, and the frequency of recreation are considered to be linked. The connections includes links to stability of placement, connection to community, the quality of care planning and the capacity; additional resources, rostering arrangements and training of staff to enact the plan.

Quality of documentation on improved exercise

The CG was fairly consistent over the course of a year in the quality of documentation about exercise (Figure: 52). They were similar in the level of 'Very poor' to 'Poor' documentation prior to the 3-6 months prior to TRC entry. Curiously,

there was a very high amount of 'Some' documentation in the TRC group 15-18 months prior to entry. Over time in the TRC, the strongest theme is that of increasing 'Clear plans' or a 'Clear with no need for a plan' indicating good exercise patterns.

Figure 52: Quality of documentation on improved exercise - CG & TRC pre-entry
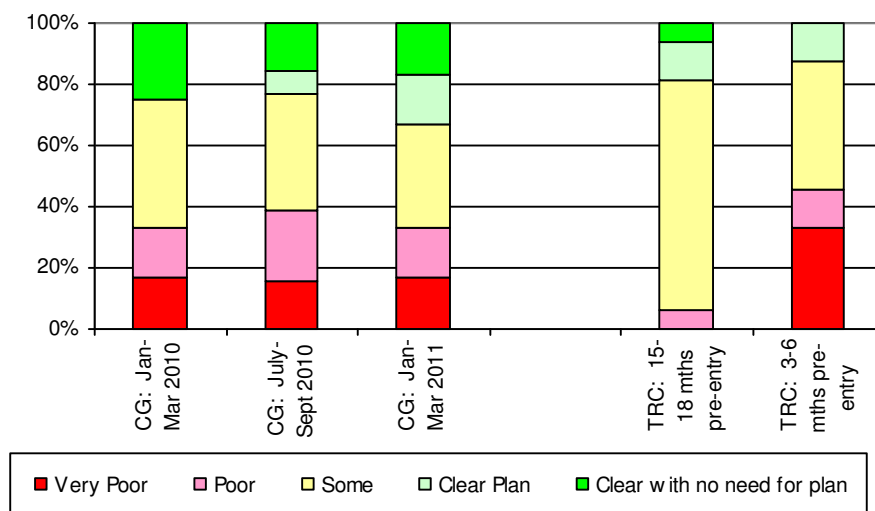
Figure 53: Quality of documentation on improved exercise - TRC
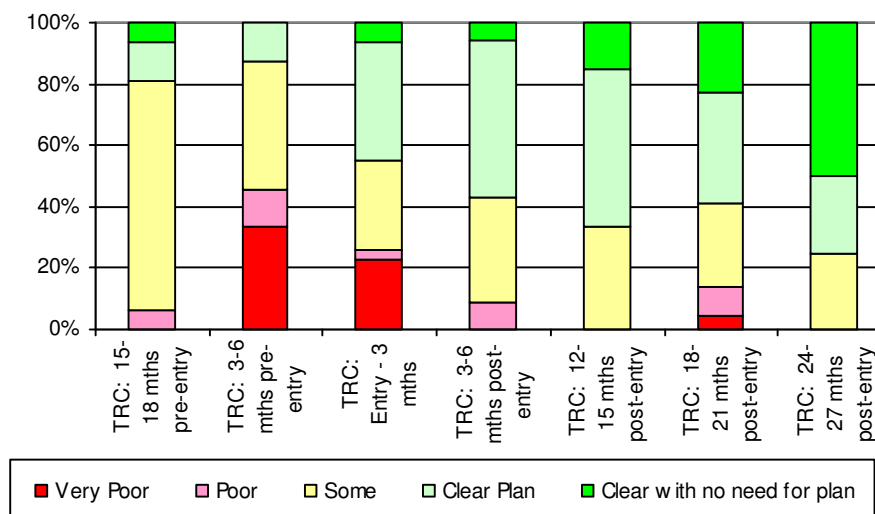
Frequency of exercise

Exercise frequency is an interesting difference between TRC and CG (Figure 54). The CG reflects a high and increasing level of 'No evidence of exercise'. In contrast the TRC group started with more exercise. It is uncertain why it is in this area that the CG appears to have higher levels of problems than the TRC group.

It may be that this reflects the older age of the CG compared with entry to the TRC (2 year age difference). It is clear that as the TRC group get older, they actually increase the frequency of their exercise patterns to twice per week or more and approximately half doing daily exercise.

Figure 54: Frequency of exercise - CG & TRC pre-entry
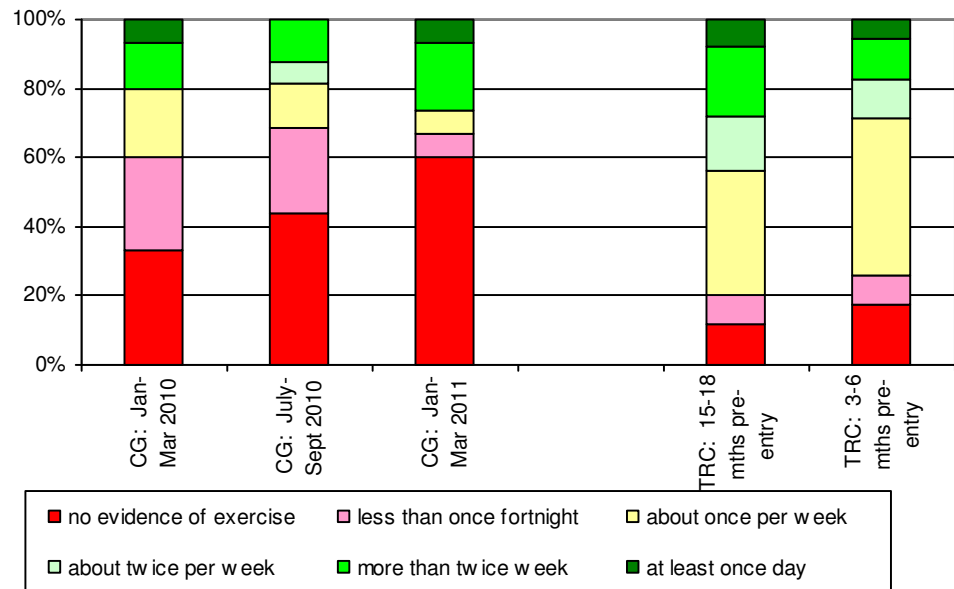
Figure 55: Frequency of exercise - TRC
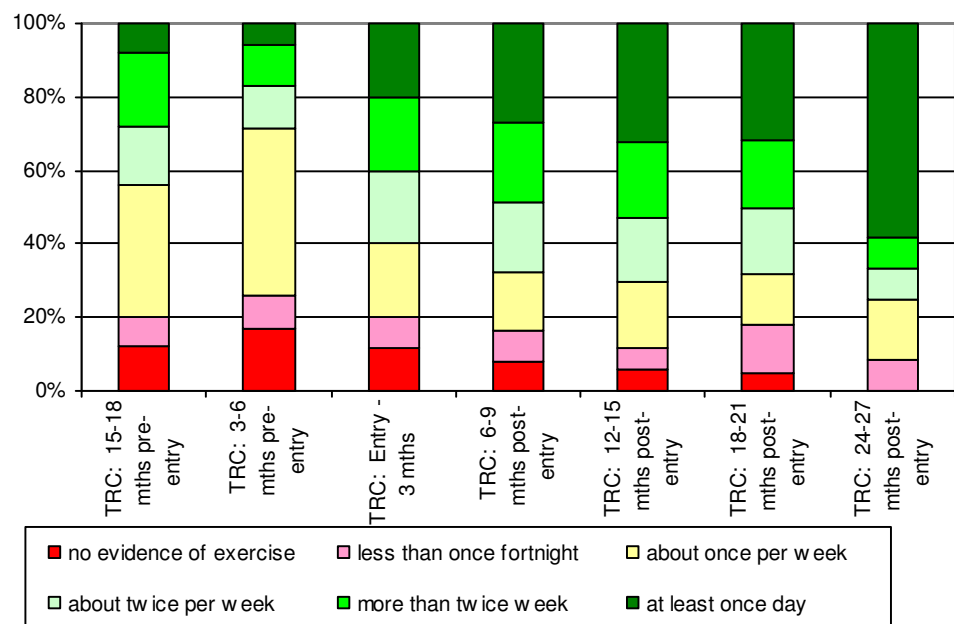
Summary of optimal health status

Optimal physical health includes: Quality of medical status; Quality of dental status; Quality of nutritional status; Quality of sleep status; Quality of hygiene status; Quality of documentation of recreational patterns; Frequency of recreation; Quality of documentation on improved exercise; and Frequency of exercise; totalling 9 measures. The data tables provide comprehensive insight into the overall health status of the young people in the TRCs. Young people in the TRCs showed improvement in all nine areas after entry to the TRC.

The five measures for the CG generally indicate that the TRC group are a more severe group. The CG was not established to examine comparative change as it is not a matched sample; however there was very little change for those young people over the course of the year. By comparison, optimal health status (over 9 measures) for the young people in the TRC improves with respect to their status prior to entering the TRC and those improvements are sustained.

The HoNOSCA includes a scale focusing on the impact of physical illness or disability and seeks ratings with reference to:

- physical illness or disability problems that limit or prevent movement, impair sight or hearing, or otherwise interfere with personal functioning and

- movement disorder, side effects from medication, physical effects from drug or alcohol use, or physical complications of psychological disorders such as severe weight loss

- self-injury due to severe learning disability or as of consequence of self-injury such as head banging

Using this measure TRC young people experience improvements with reduced symptom severity from a peak at 3 to 6 months prior to entry with a significant reduction occurring from the 12 to 15 month collection period onwards. By the 24 to 27 month period the overall symptom severity from the period 3 to 6 months prior to entry has declined by about 70%.

Of note are measures relating to the pre-entry optimal health status of young people in the TRC. It is important to note that at 15 to 18 month pre entry and 3 to 6 month these young people were in an existing residential care placement. Table: 20 demonstrates that high numbers of these young people had significant and persistent health issues (health, dental, nutrition, sleep and hygiene).

Table 20: Documented 'Poor' or 'Very poor' health status pre-entry to the TRC

Collection period	Quality of medical status	Quality of dental status	Quality of nutritional status	Quality of sleep status	Quality of hygiene status
15 -18 months pre-entry poor or very poor rating	22%	20%	32%	39%	20%
3 - 6 months pre-entry poor or very poor rating	24%	28%	59%	40%	18%

The findings are: Quality of documentation[17] regarding medical, dental, nutritional, sleep and hygiene status, the quality of documentation on recreational patterns and improved exercise, the frequency of exercise and recreation make up 9 measures used to gauge optimal physical health.

- Over 9 measures the young people in the TRCs Documentation of Optimal Health status improves and is maintained over time and is substantially better than their pre-entry status

- Over 9 measures the young people in the TRCs Documentation of Optimal Health status demonstrates a reduction in 'Poor' and 'Very poor' ratings with these ratings being almost completely absent

- The CG do not experience the change or quality of Documentation of Optimal Health Status that the TRC young people do

[17] The definition of documentation is detailed in the introduction to this Section: 6.5.9

- The documentation of pre-entry health status of young people points to serious concerns related to their health while in pre TRC residential care with rating of 'Poor' and 'Very poor'

- HoNOSCA reinforces these findings

Positive sense of self

From Figure: 56, it is apparent that both the CG and TRC group comprised young people with 'Low' or 'Very low regard for self'. Within the two groups, however, the TRC were more likely to have the extreme rating. The CG remains constant over the year.

The measure shows that the young people in the TRC sustain considerable improvement with 'Poor' and 'Very poor' ratings recorded for 81% at 3 to 6 months prior to entry reducing to 7% at 24 to 27 months. There is a clear rise in those whose self-regard is neither high nor low.

The improvements in this measure are significant in providing TRC staff and the Therapeutic Specialist with insight into the improvements in the mental health of the young people.

Figure 56: Positive sense of self - CG & TRC pre-entry
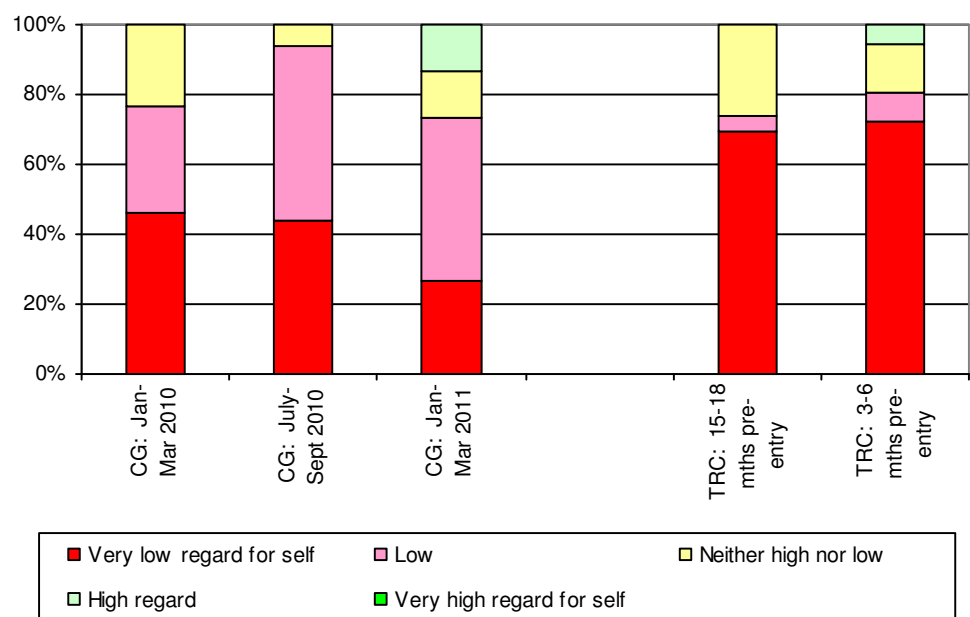
Figure 57: Positive sense of self - TRC
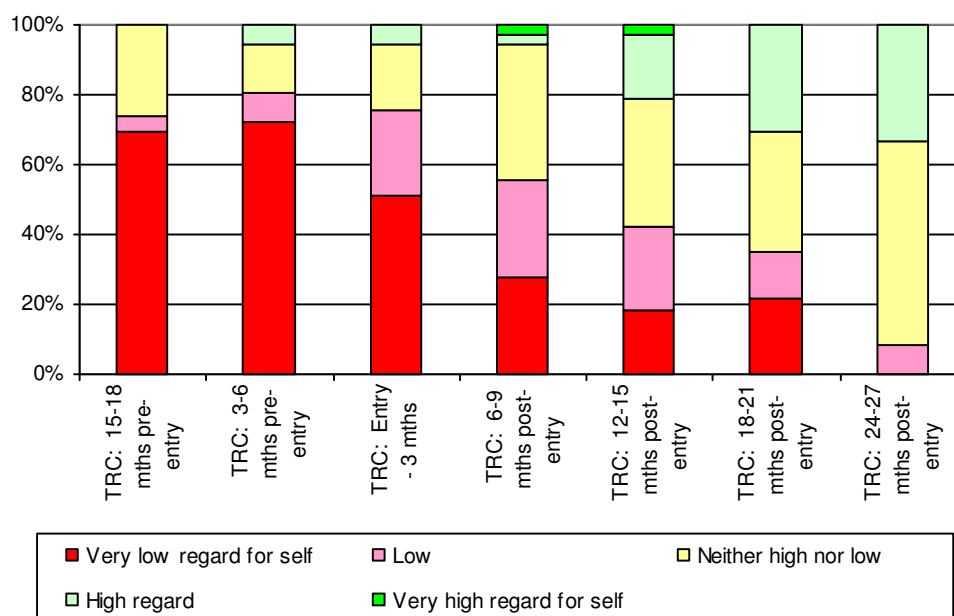
The finding is: Young people in the TRC have experienced and sustained significant improvements in sense of self and these are one indicator of improved mental health. Those young people in the comparison group have and maintain a 'Low' or 'Very low' regard for self.

6.5.10 Healthy Lifestyles and Risk Taking

Consultations with the young people and the staff in the TRC identified that risk taking behaviour is lessened in the TRCs due to the commitment to the attention to client mix, sufficient staff to enable the identification and response to escalating stress and or the triggers thus reductions in 'acting out'.

The young people particularly point out that they have someone to talk to. The outcome of these dynamics is that in the unit there is a reduced tendency for the house to be dominated by the young people's risk taking behaviour and the resultant consequences. This response from one of the young people interviewed exemplifies the difference young people have observed between their current TRC placement and their previous experience. "I have lived in heaps of places – foster care and residential units. It was not so good in those places because you fall in with other people in the units and start behaving in the same way. I went to the residential unit and began to smoke and drink alcohol. In the other places you just end up going along with others. There was no one really to talk to. They would take you out in the other places but not to talk to you" and "When there are too many people you just go their way and I get angry and frustrated."

Involvement with Police and Youth Justice

Table 21 details measurements that include; a count of the episodes of negative police involvement and police warnings (mean average) and charges (mean average) for the TRC and the Comparison Group. Each time series data point is for involvement with the police over the previous three months.

The data indicates that over the three measures the young people in the TRC have elevated rates of involvement with the police compared to the comparison group. As detailed in footnotes (21 and 22) the warnings and charges are restricted to up to 12 young people in TRC. The elevated rates of negative involvement with the police reduce over time for the young people in the TRC. By the 18 to 21 month period the negative police involvement had reduced by 53% compared to 3 to 6 months pre entry.

Table 21: Involvement with Police - CG & TRC

Involvement Type	Comparison Group (CG)			TRC Pilot Group (TRC)						
	Jan-Mar 2010	July-Sept 2010	Jan-Mar 2011	15-18 months pre-entry	3-6 months pre-entry	Entry - 3 months	6-9 months post-entry	12-15 months post-entry	18-21 months post-entry	24-27 months post-entry
Episodes of Negative Police Involvement	6	7	4	7	17	16	18	13	8	3
Police warnings (mean)[18]	0.1	0.31	0.12	0.50	0.48	0.36	0.75	0.30	0.22	0.70
Police Charges (mean)[19]	0.31	0.25	0.19	0.35	1.1	0.57	0.86	0.71	0.70	0.36

The number of young people involved with Youth Justice and whether they were meeting the Youth Justice expectations is detailed in Figure: 58 and Figure: 59 The majority have 'No involvement' while those who are involved tend to be meeting their expectations. It may reflect the younger age at entry to TRC, but fewer young people in the TRC are involved with Youth Justice prior to TRC entry compared to the CG.

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[18] Warnings are restricted to a small number of young people. Specifically, 9 and 11 young people respectively were the recipients of warnings in the period's pre TRC entry and post TRC entry.

[19] The median number of charges was 0 at every occasion. Charges occurred for 6 and 12 young people respectively in the period's pre and post TRC entry.

Figure 58: Involvement with Youth Justice - CG & TRC pre-entry
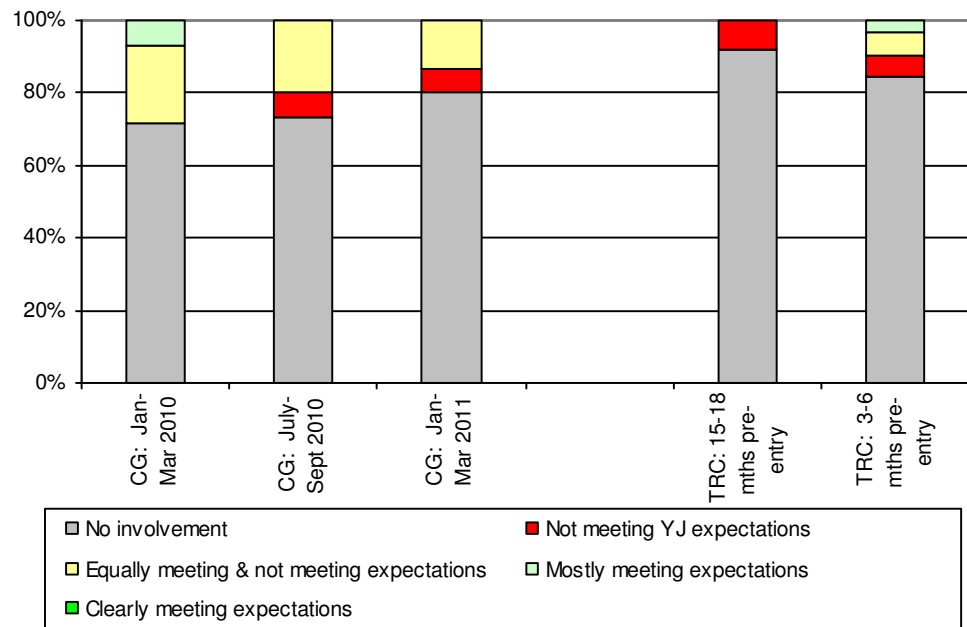
Figure 59: Involvement with Youth Justice - TRC
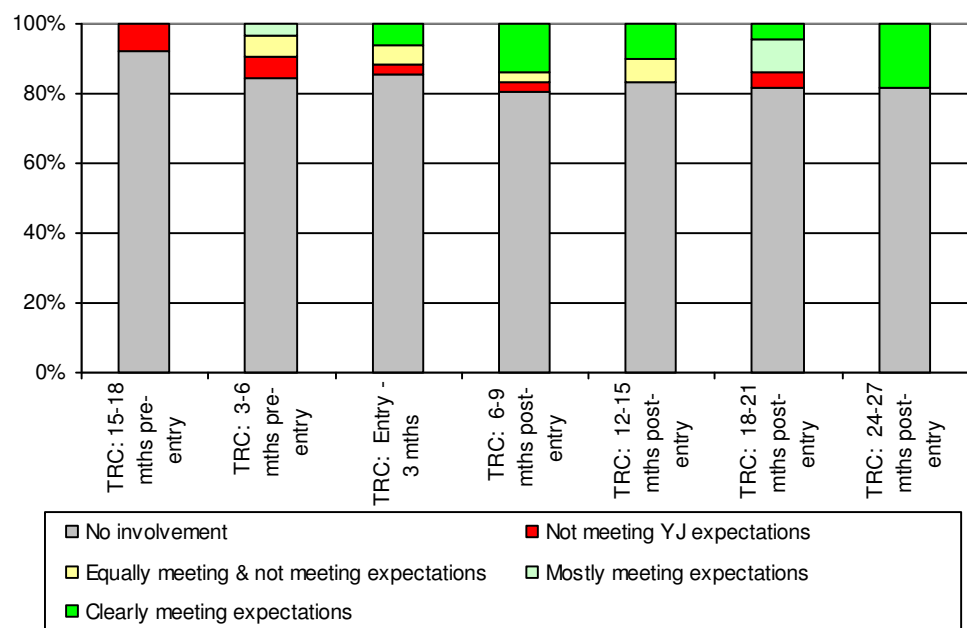
Secure Welfare admissions, Remand and Detox

Table: 22 details secure welfare admissions, remand admissions and admissions into detoxification units. Median data has been used to ensure that outlying results do not distort an understanding of the impact of the program on the young people in the TRC. Table: 22 shows that secure welfare admissions diminish from a high of 16 at entry to 3 months and are sustained at a lower rate over the next four collection periods to 3 at 18-21 months and 0 at 24 months. The remand and detoxification admissions remain at a median of 0.

While these latter two are important areas of concern for those in TRC, they occur at such low base rates that their use in evaluating the impact of the TRC over time is very limited. However, it is clear that there is a reduction in secure welfare admissions. It is likely that the improvement in relationships within the TRCs mitigates against the use of secure welfare admissions although it is not possible to exclude any changes in secure welfare procedures as the reason.

Table 22: Median Secure Welfare, Remand and Detoxification Unit Admissions

Collection period	15-18 months pre-entry	3-6 months pre-entry	Entry - 3 months	6-9 months post-entry	12-15 months post-entry	18-21 months post-entry	24-27 months post-entry
Secure Welfare admissions	1	14	16	5	8	3	0
Remand admissions	0	0	0	0	0	0	0
Detox median	0	0	0	0	0	0	0

Risk taking

On each Likert scale, there was the opportunity to record the option of 'No evidence' if it was considered impossible to judge the young person's state from any documentation or other source. No evidence was recorded for the young person's risk taking for the seven collection occasions as detailed in Table 23.

Table 23: No evidence available regarding the young person risk taking - TRC

Collection period	15 to 18 months pre entry	3 to 6 months pre entry	0 to 3 months TRC	6 to 9 months TRC	12 to 15 months TRC	18 to 21 months TRC	24 to 27 months TRC
% with no Evidence	24	3	8	5	9	21	33

One CSO contributed almost 40% of the 'No evidence' ratings in the final two collection occasions. It may be that some staff or Therapeutic Specialist changes at this time led to a difference understanding such that no evidence **about** risk taking was understood as no evidence **of** risk taking.

However, a misreading without staff changes seems unlikely given the use of the category of 'Very low levels of risk taking' at other collection periods. It may be that the previous concerns about incidents reports may be compounded with decreasing documentation of risk taking with time.

Overall, there has been a reported reduction in risk taking with an increase in the proportion of young people with 'Very low' levels of risk taking since the entry to TRC. The proportion with 'Very high' or 'High' levels of risk taking seems to be fairly constant since early on in the TRC.

Figure: 60 shows high levels of risk taking among the CG group comparable to the TRC group pre-entry. The TRC and CG groups are both quite severe in their levels of perceived risk taking. It should be noted that increased risk taking may be impacted by age. The average age of the CG is 15 while the average age at entry to the TRC was 13.

Figure 60: Risk taking – CG & TRC pre-entry
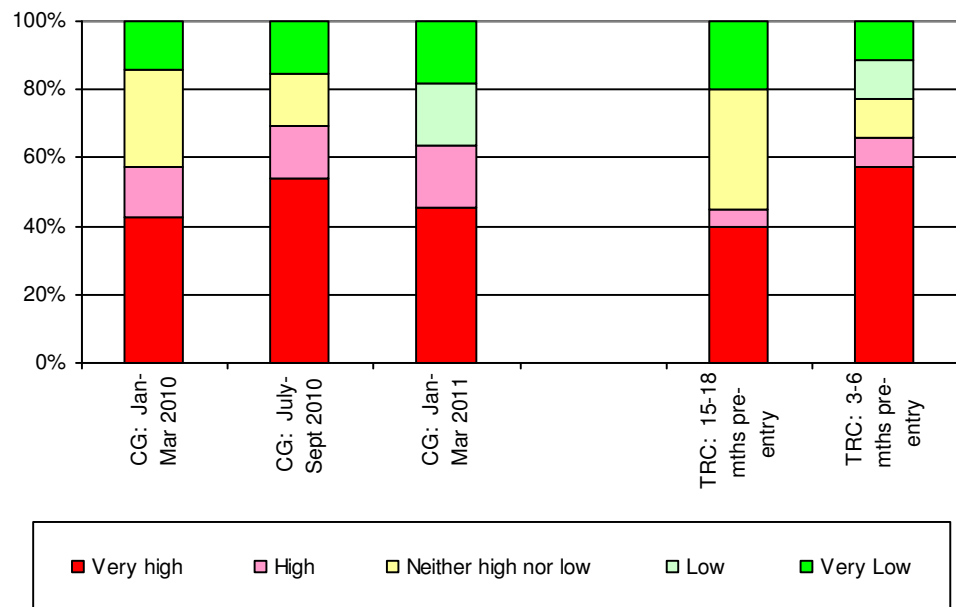
Examining the TRC group over time, it is apparent that risk taking is a major issue for the TRC group with reductions in overall levels only occurring with significant time. Figure 61: Risk taking – TRC has been configured to highlight only those young people where risk taking is rated. The right-hand axis of the figure details the number of young people rated and is consistent with Table: 23 No evidence available regarding the young person's risk taking – TRC. Ratings within each count record ratings within the scales for each count. This alternate data presentation in Figure: 61 is intended to highlight that risk taking is in evidence for only some of the young people in the TRC. This configuration supports comparison with other data tables within this report. Figure: 62 to Figure: 67 relate only to those young people where risk taking is in evidence. As detailed in Table: 23 and illustrated in Figure: 31 the number of young people in the TRC engaged in Risk Tacking reduces from a peak at 3 to 6 months (97% with evidence) and begins to decline significantly in intensity (Figure 61) and reduces by 24 to 27 months to a participation rate of 66%.

Figure 61: Risk taking - TRC
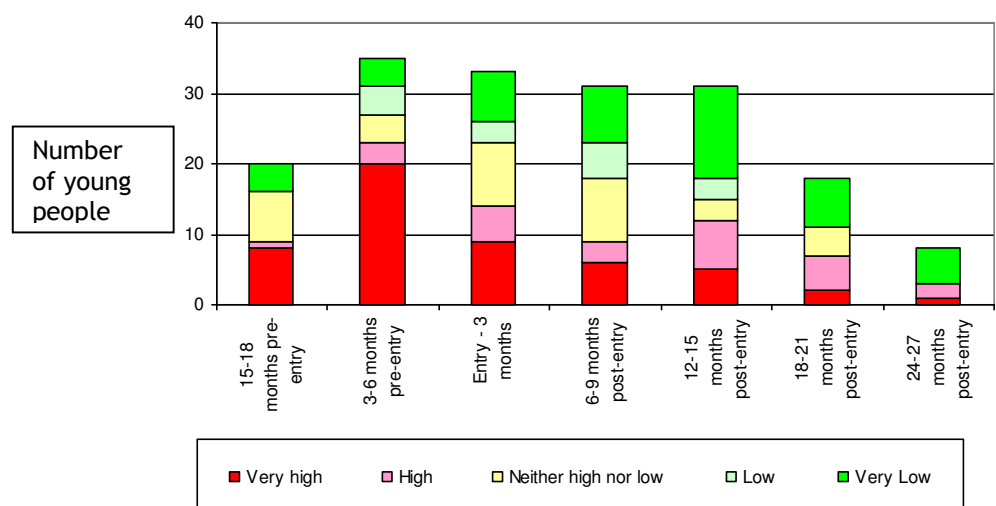
Alcohol, Drug use and Sexual behaviours for those who are risk taking

Risk taking with reference to Alcohol, Drug use and Sexual behaviours are detailed in Figure 62 **to** Figure 67. The questions focused on the contribution of factors to the risk taking of those where risk taking is in evidence. That is, a rise in the contribution of alcohol does not mean more young people are risk taking using alcohol, but that of **those who are risk taking**, alcohol played a role.

In the TRC group, across both pre-entry occasions approximately 26% had alcohol play some part in their risk taking. Almost twice as many young people in the CG were perceived to have had alcohol as a contributor in their risk taking (Figure 63). The lower rate among the TRC is in part due to the lower rates at the 15 to 18 months pre-entry collection.

Figure 62: Contribution of alcohol to risk taking - CG & TRC pre-entry
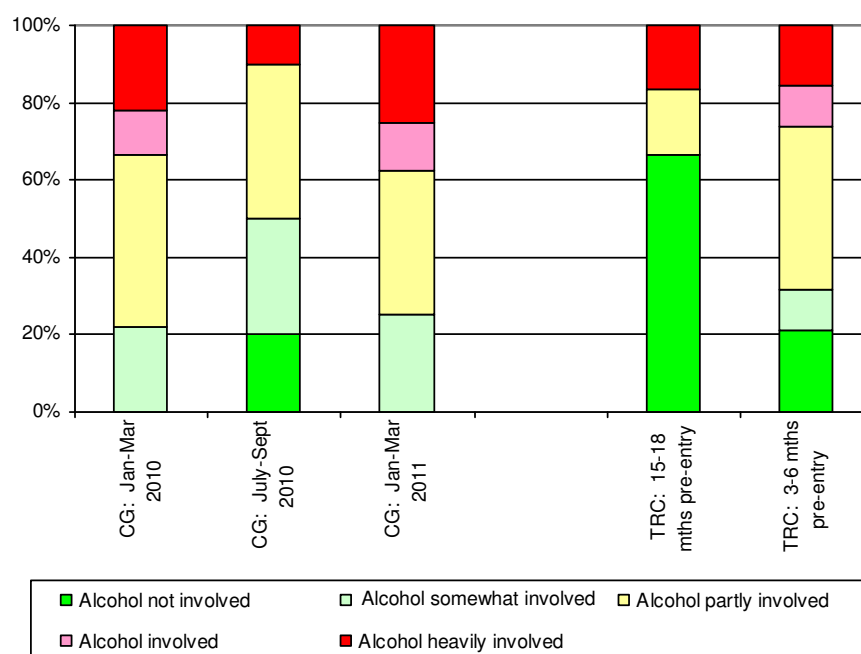
From Figure 63, it can be seen that the contribution of alcohol to risk taking diminishes over time for the TRC group. This is important to note, especially if it is considered that the higher rate in the CG compared to the TRC is a function of age. As the TRC group ages, alcohol is playing a lower role in their risk taking.

HoNOSCA measures substance misuse and the raters are asked to include problems with alcohol, substance or solvent misuse taking into account current age and societal norms. The results are less clear about reducing substance impact. To some degree, the large numbers where alcohol did not play a part does reduce the chances of finding a clear change.

Figure 63: Contribution of alcohol to risk taking - TRC
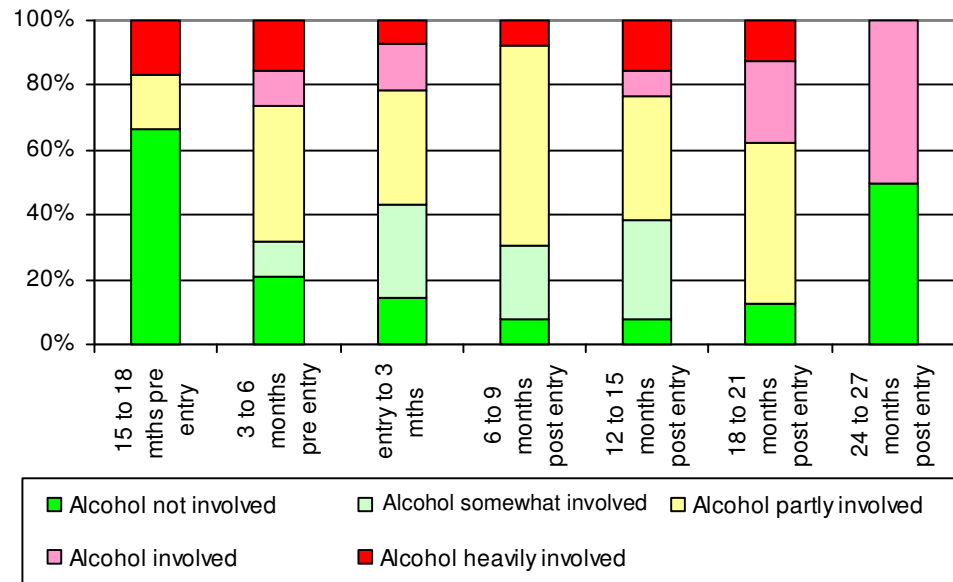
Drug use

For those young people who are risk taking Figure 64 demonstrates that drugs is partly involved, involved and heavily involved for average of 75% of the CG and averages 60% across the TRC pre entry data points indicating a higher occurrence of risk taking with drug as a contributing factor in the control group than for the young people in the TRC prior entry into the TRC.

Figure 64: Contribution of drug use to risk taking - CG & TRC pre-entry
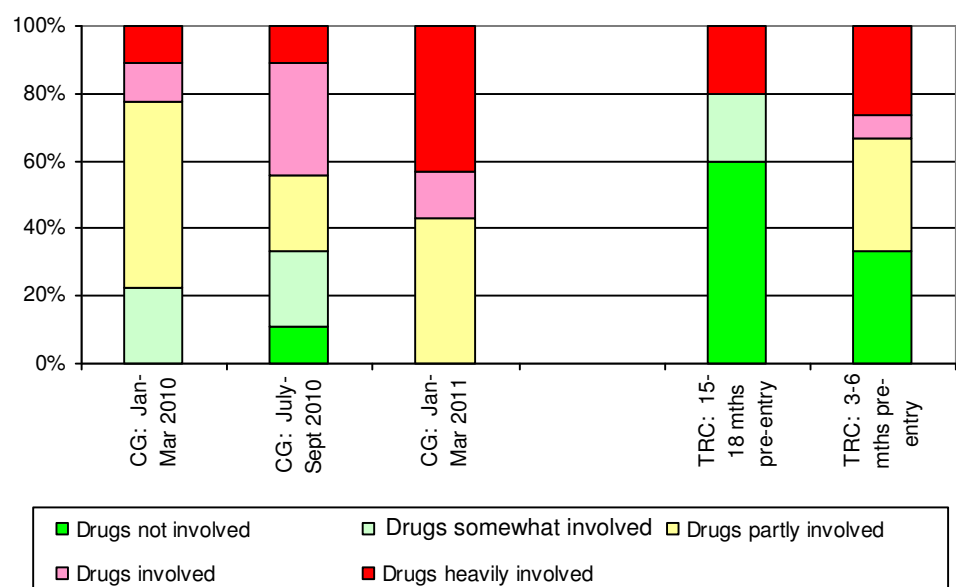
Figure 65: Contribution of drug use to risk taking - TRC
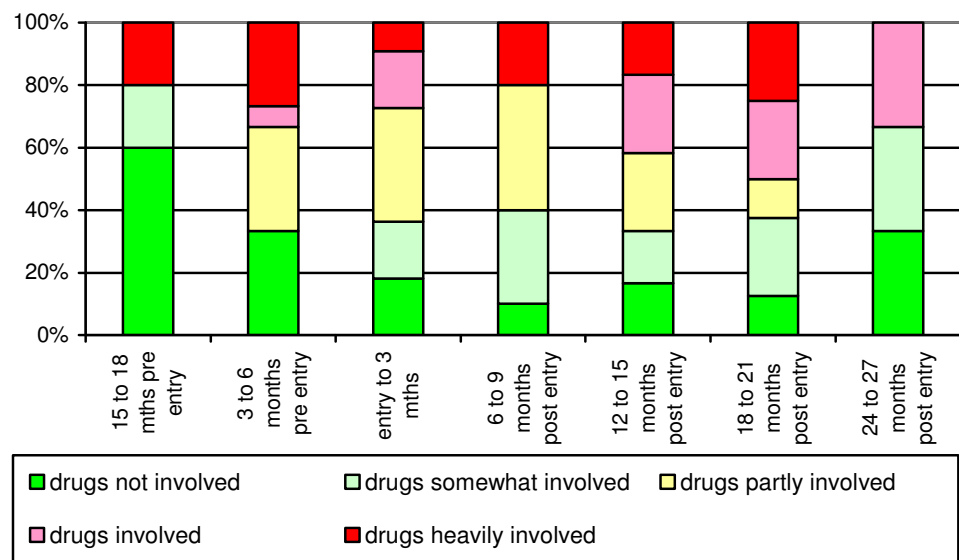
Sexual behaviours

For those young people who are risk taking Figure: 66 demonstrates that sexual behaviours are partly involved, involved and heavily involved for average of 76% of the CG and averages 56% across the TRC at pre entry data points.

Figure 66: Contribution of sexual behaviours to risk taking - CG & TRC pre-entry
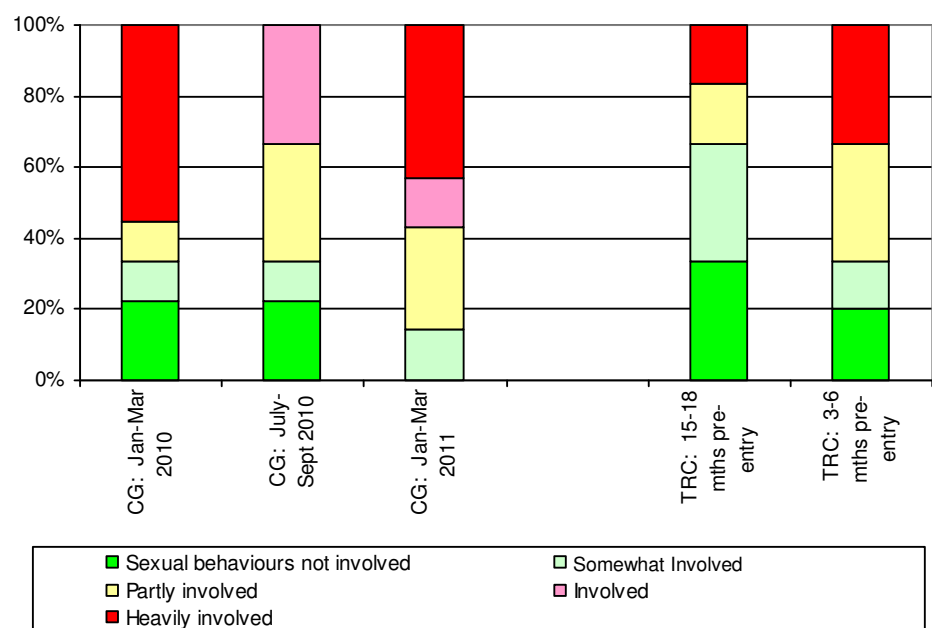
Involvement of sexual behaviours in risk taking is a fairly constant aspect for almost a quarter of the TRC group Figure: 67. This reduces by the 18 to 21 months post-entry point and heavily and involved ratings are not evident by 24 to 27 months.

Figure 67: Contribution of sexual behaviours to risk taking – TRC
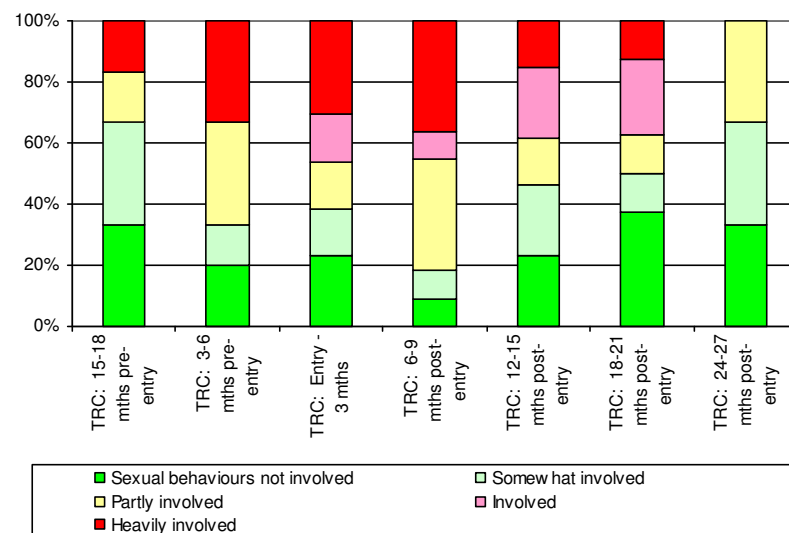
Trauma impact

Once young people had entered the TRCs, staff were very clear about the contribution of their trauma history to their risk taking. No evidence of the contribution of trauma to risk taking was recorded for young people as detailed in

Table 24: No evidence available risk taking as result of trauma impact- TRC

Collection period	15 to 18 months pre entry	3 to 6 months pre entry	0 to 3 months TRC	6 to 9 months TRC	12 to 15 months TRC	18 to 21 months TRC	24 to 27 months TRC
% with no Evidence	21	18	13	8	9	0	0

For those young people involved in risk taking Figure: 68 details that trauma history is a significant factor in risk taking for the comparison group and the young people in the TRCs; on average 59% of the comparison group and 60% of the TRC pre entry data collection points.

Figure 68: Contribution of trauma history to risk taking - CG & TRC pre-entry
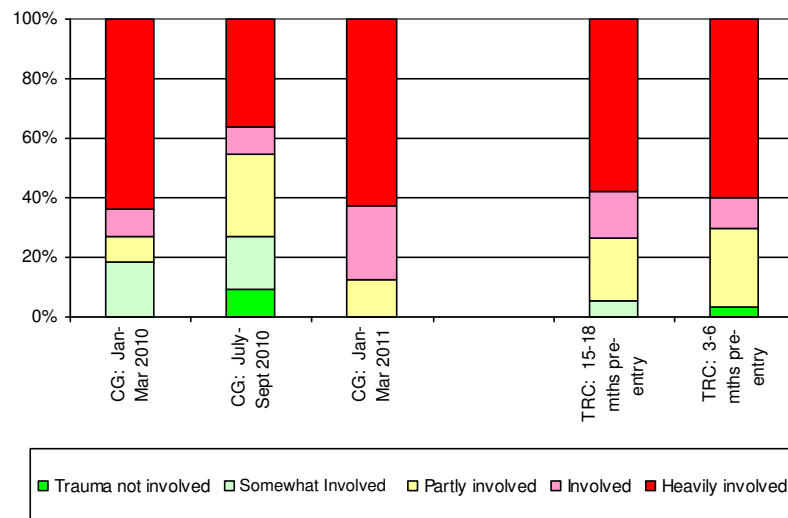
There are large numbers of young people in the TRCs where the trauma history played a role in risk taking (Figure 69 and he data presented in Figure 70 is consistent with Figure 61 and is intended to highlight only those young people where risk taking is considered in evidence; this does not include all young people in the TRC audit. Table 24: (No evidence available risk taking as result of trauma impact- TRC) details the counts of where no evidence of trauma involvement in risk taking was recorded by the raters using a field in the Brann Likert Scale.

This is substantial compared with the previous contributing factors although again it is only by the 18-21 months point that this starts to reduce.

Figure 69: Contribution of trauma history to risk taking - TRC
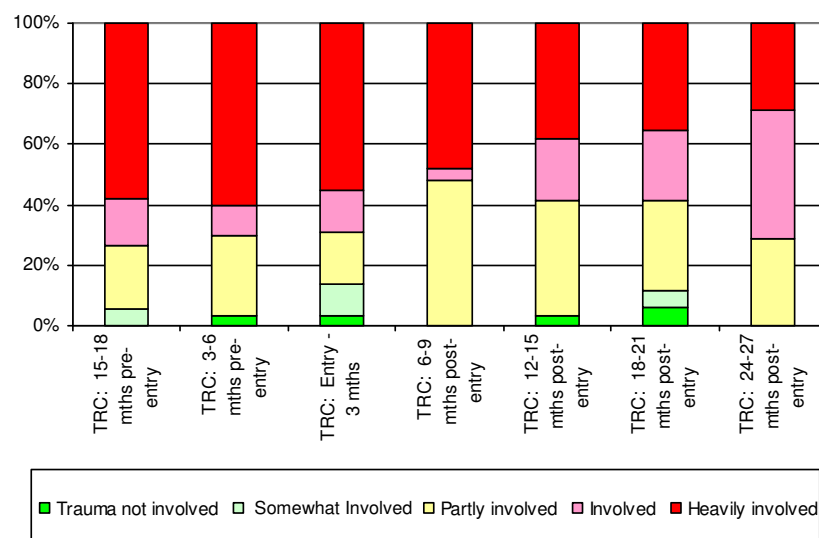
The data presented in Figure 70 is consistent with Figure 61 and is intended to highlight only those young people where risk taking is considered in evidence; this does not include all young people in the TRC audit. Table 24: (No evidence available risk taking as result of trauma impact- TRC) details the counts of where no evidence of trauma involvement in risk taking was recorded by the raters using a field in the Brann Likert Scale.

Figure 70: Contribution of trauma history to risk taking – TRC
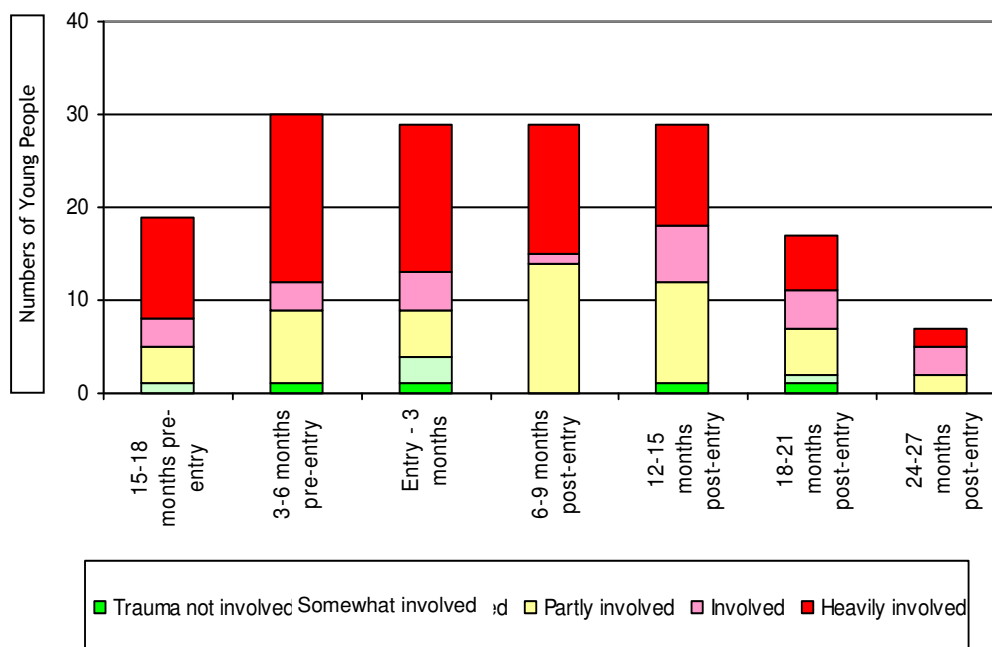
The findings are: Young people in the TRC experienced a reduction in risk taking which is evident over time in reduced episodes of negative police involvement (although not immediate), police charges, secure welfare admissions. CSOs report a reduction in risk taking (Figure 60) from a high of 64% in the 'High' and 'Very high' ratings at 3 to 6 months prior to entry in the TRC to 30% at 6 to 9 months for these ratings although this increases and remains at about 40% for the next three collection periods. Significant change occurs for the majority of young people in the TRC with very low ratings at 3 to 6 months pre-entry for only 11% of the young people in the TRC to this rating being applicable to 62% at 24 to 27 months. This is more significant as at 24 to 27 months the young people are at an age where risk taking peaks. Over time trauma history remains the most influential factor in risk taking with the impact of alcohol, drug taking and sexual behaviours reducing.

6.5.11 Symptoms

Measuring behaviour change and mental health

This section provides insight into behaviour and mental health using findings from the Health of the Nations Outcomes Scales for Children and Adolescents (HoNOSCA). The HoNOSCA is a comprehensive outcome measurement instrument used internationally with acceptable reliability and validity (Brann 1999; Brann et al. 2001; Gowers, Harrington, Whitton, Beevor, et al. 1999; Gowers, Harrington, Whitton, Lelliott, et al. 1999) and has been used in local child and adolescent mental health services. It comprises thirteen core scales (rated between 0 and 4) which address behaviours, symptomatology, disability, and social functioning (Gowers, Harrington, Whitton, Beevor, et al. 1999; Gowers, Harrington, Whitton, Lelliott, et al. 1999).

About the results

Of all returned questionnaires, only eleven (5%) were missing the HoNOSCA data.

HoNOSCA total scores, indicating overall symptom severity were elevated compared with available norms. The mean score at entry to TRC was considerably more severe

than the mean total score for children and adolescents entering CYMHS community teams across Australia (see Figure 71).

HoNOSCA total scores indicate overall symptom severity; this is elevated for this sample of young people compared to available norms. Based on over 46,000 observations from CAMHS/CYMHS across Australia, the mean total score at entry to community treatment is 14, and the median is 13. The mean score of 22 at 6 to 9 months post entry for TRC participants represents a percentile score that is more severe than 89% of CAMHS/CYMHS records.

Although this score is less of an outlier when compared with clients in intensive mental health programs within CAMHS/CYMHS, it does indicate significant levels of symptom severity consistent with that experienced by those requiring mental health treatment. On each scale, the TRC group typically have more severe symptoms compared with those entering CAMHS/CYMHS (see Figure 72).

The total score peaked prior to entry to the TRC and has gradually declined since then. This indicates a perceived reduction in symptom severity (see Figure 71).

In order to retain a large number of young people in the analysis, three HoNOSCA total scores were examined: The mean total score of the two collection occasions pre-entry to the TRC, the score at Entry and the mean of the scores post-entry.

For example, inclusion of all collection occasions up to 24-27 months post-entry allowed for only 12 young people to be included in the analysis.

With 29 young people having sufficient ratings at each of these points, repeated measures ANOVA revealed a significant difference in mean HoNOSCA total scores (F=3.96, df=2, p<0.05). Post hoc comparisons with Bonferroni adjustment (α=0.05) indicated that the source of this difference was between the pre and the post-entry scores. That is, the young people were significantly less symptomatic after entry than they were prior to TRC entry. They were not rated as significantly more or less symptomatic at entry compared with pre-entry (Table 25).

Table 25: HoNOSCA mean total scores pre-entry, entry and post-entry

Time	Mean	Std Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre-entry	25.893	1.307	23.211	28.574
Entry	23.929	1.394	21.068	26.790
Post-entry (mean)	21.991	1.233	19.461	24.521

Selected HoNOSCA scales were examined to see if the difference pre to post entry was significant. While there was a trend for some of the examined symptom areas to improve over time, no one symptom area alone contributed to the overall decrease in symptoms. It appears that while symptoms have improved overall, there is no one area in which this could confidently be declared to have occurred.

Across the different scales (The line across Figure 73, 74 and 75 denotes the aggregated scores of young people at entry to specialist mental health services (CYMHS/CAMHS). A finer analysis is provided in Figure 72 which details CYMHS/CAMHS National entry data compared to the TRC and the change that has occurred for young people in the TRC (entry to 3 months to 24 – 27 months post entry).

In Figure: 73, Figure: 74, Figure 75 the pattern of reduction varies. For example, there are steady declines in Concentration, Scholastic, Family Relationship and School Attendance problems. Others such as Emotional, Illness/Disability appear to stay stable at first before decreasing, while some such as self-care and aggression show a decline and then plateau. Finally some areas have no clear pattern and appear to not change greatly (e.g. Substance Misuse, Abnormal Perceptions).

In five of the ratings where there were significant reductions in symptom severity the data indicates that these young people (at 24 to 27 months post entry to the TRC) still have ratings equivalent to or higher than entry level to CYMHS. The high ratings are in the following areas:

• Disruptive, antisocial or aggressive behaviour

• Scholastic and language skills

• Emotional and related symptoms

• Self-care and independence

• Family life and relationships

While the young people in the TRC have made significant progress toward the desired outcomes (reductions in symptom severity) over the post entry data collection points these reductions are still at levels that would be comparable with entry to specialist mental health services (CAMHS/CYMHS at an average 1.4 score). This suggests that with additional time in the TRC further reductions may be possible. These outcomes further highlight the complexities (significantly elevated symptom severity scores at entry to the TRC) of the young people in the TRCs and the importance of continued consistent therapeutic care. Stability of relationships is integral to the TRC framework, and while these young people are doing better than at entry, they are by no means asymptomatic. Ongoing involvement with TRC is likely to be a necessary condition in order to achieve the goals and measures outlined in the Child Protection and Family Services Outcomes Framework. This finding regarding complexity is also evident in the SDQ ratings detailed in Figure 77.

Figure 71: Symptom severity as indicated by HoNOSCA total score – TRC & CAMHS/CYMHS intake
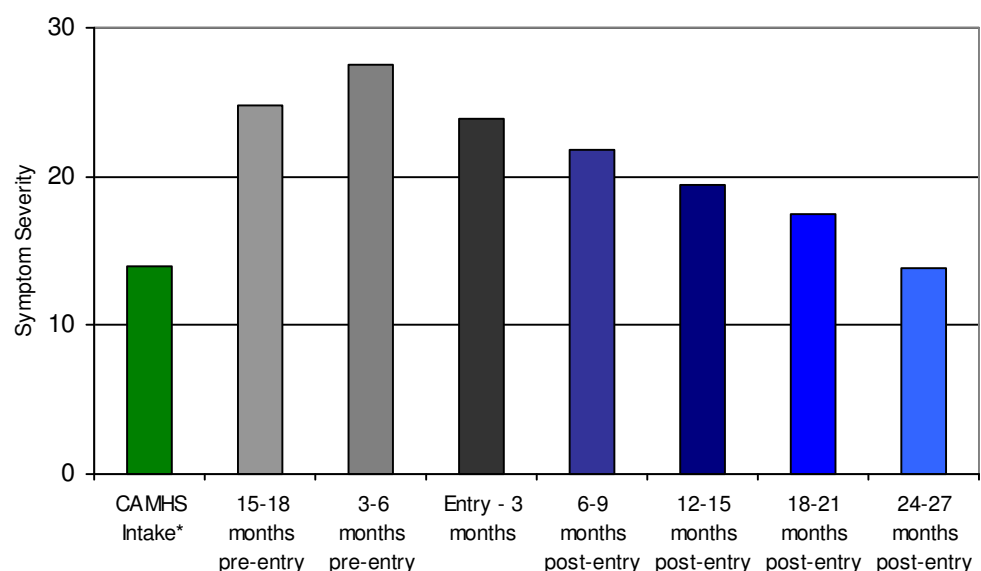
NB CAMHS/CYMHS Entry* = Mean and Median score at entry to CAMHS/CYMHS community teams across Australia from 46,000 records[20].

Figure 72: Mean HoNOSCA scores for entry to CAMHS/CYMHS community teams[21], entry to TRC and 24-27 months post TRC entry

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[20] http://amhocn.org/analysis-reporting
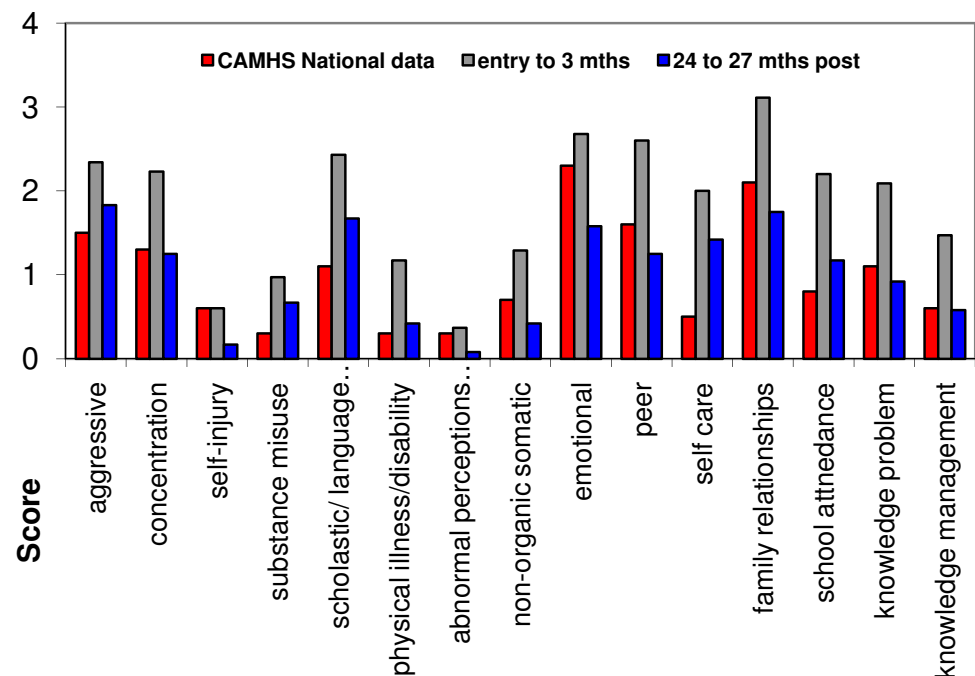
The line across Figure 73, 74 and 75 denotes the aggregated scores of young people at entry to specialist mental health services (CYMHS/CAMHS). A finer analysis is provided in Figure 72 which details (CYMHS/CAMHS) National entry data compared to the TRC and the change that has occurred for young people in the TRC (entry to 3 months to 24 – 27 months post entry).

Figure 73: HoNOSCA scales 1 to 5 mean scores – TRC
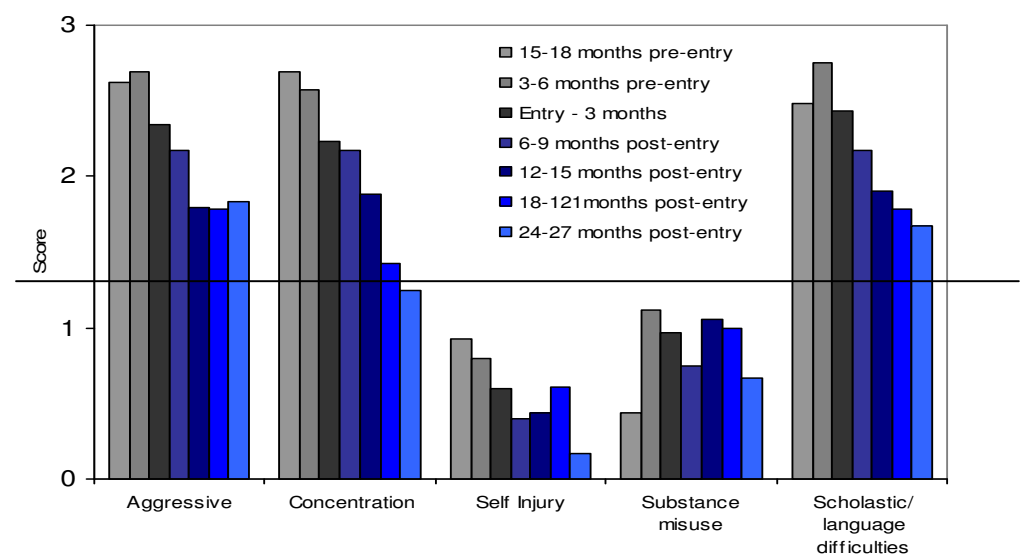
[21] Australian Mental Health and Outcomes Classification Network – AMHOCN, 2005

Figure 74: HoNOSCA scales 6 to 10 mean scores - TRC
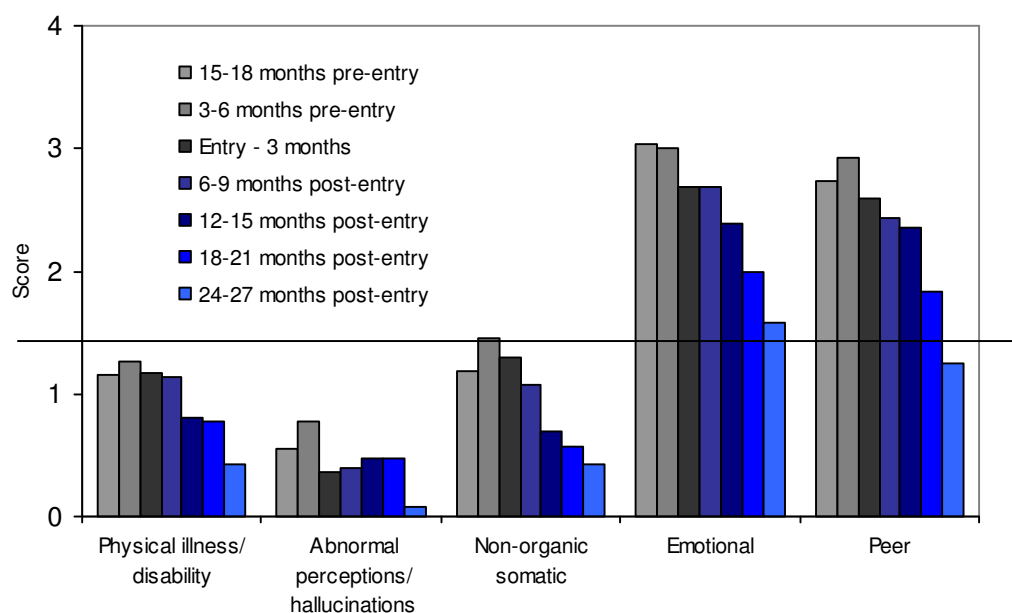
Figure 75: HoNOSCA scales 11 to 15 mean score - TRC
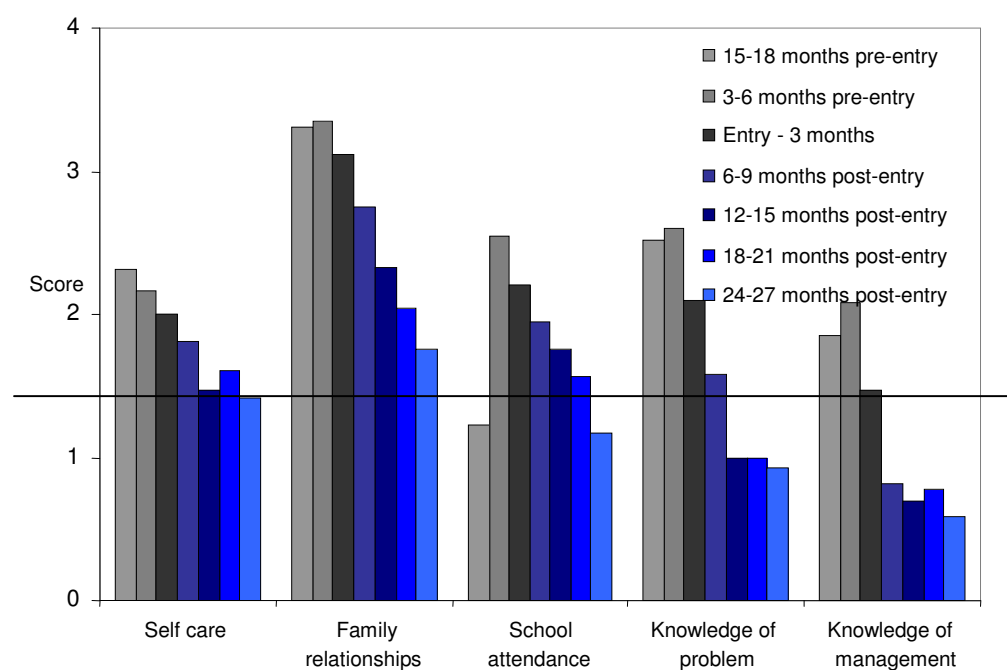
Cross Validating the Results

Of the 15 scales in the HoNOSCA, nine have been cross-referenced to outcomes within relevant areas of this section of the report including;

- 6.5.2 Contact between the young person and their family – HoNOSCA family relationships
- 6.5.3 Contact with residential carers – HoNOSCA family relationships
- 6.5.4 Connected to school and optimal education and learning – HoNOSCA School attendance, Scholastic/Language difficulties, Peer, Concentration
- 6.5.9 Optimal Physical Health – HoNOSCA Physical illness/disability, non –organic somatic, self care
- 6.5.10 Healthy Lifestyle and risk taking - HONOSCA substance misuse

All of these ratings with the exception of substance misuse cross validate the findings obtained from the application of the Brann Likert Scales.

The findings are:

- In 13 measures out of 15 the HoNOSCA provides clear results regarding reductions in symptom severity
- In 9 of the 15 measures improvements detailed in the HoNOSCA are confirmed by other data tools detailed in this report (family relationships, school attendance, scholastic/language difficulties, peer, concentration, physical illness/disability, non-organic somatic, substance misuse) with the exception of substance misuse which was inconclusive in the HoNOSCA
- The symptom severity is higher in the TRC young people than experienced in CAMHS/CYMHS intake data
- In particular the symptom severity in the TRC young people is higher than CAMHS/CYMHS data for 14 of the 15 measures at entry to the TRC and six of the 15 measures at 24 to 27 months post entry
- While the young people in the TRC have made significant progress toward the desired outcomes (reductions in symptom severity) over the post entry data collection points these reductions are to levels that are comparable with young people entering mental health services for treatment. This suggests that with additional time in the TRC, further reductions may be possible. Certainly, the progress to date has been in a consistent and stable environment. These outcomes further highlight the complexities of the young people in the TRCs.
- The symptom severity suggests that after 30 months in the TRC this group of young people have persistent mental health issues and elevated behaviours

6.5.12 Mental and Emotional Health

Data Collection - SDQ

The Strengths and Difficulties Questionnaire (SDQ) is a widely used measure of a young persons' (aged between 3 – 16 years) functioning from different perspectives. The SDQ asks about 25 attributes, some positive and others negative as well as items relating to distress, burden and impact (R. Goodman 1999; R. Goodman 2001). The 25 items are divided between five scales:

- Emotional symptoms
- Conduct problems
- Hyperactivity/inattention
- Peer relationship problems
- Pro-social behaviour

The SDQ along with the HoNOSCA provides particular insight into emotional health and mental health and has been used across many countries (Heiervang et al. 2008). Across the seven collection occasions to date, the majority of SDQs were collected at entry to TRC Table 26: SDQ count by collection occasion and version. The majority of SDQs were received from carers with less from Case Managers (n=28). There were a substantial number of self report SDQs received (n=79). As the Case Managers returns are quite low per collection occasion, these will not be presented further.

Table 26: SDQ count by collection occasion and version

Collection Occasion	SDQ version			Total
	Carer	Case Manager	Self-report	
15 to 18 months pre-entry	18	3	0	21
3 to 6 months pre-entry	24	4	0	28
TRC entry to 3 months	33	9	23	65
6 to 9 months Post	36	3	19	58
12 to 15 months post	31	4	17	52
18 to 21 months post	22	3	13	38
24 to 27 months post	10	2	7	19
Total	174	28	79	281

Mean total SDQ score

Overall, the CG is somewhat less severe in its difficulties in functioning compared with the TRC group prior to entry (Figure 76). All records prior to TRC entry and all CG records are collapsed here for ease of understanding.

The TRC group had significantly more difficulties than the CG (F=4.54, df=1.76, p<0.05) on the SDQ total difficulties score. From Figure 76 it can be seen that the CG level of difficulties are less than those of the young people who entered the TRC. They are similar to the TRC group at entry and 6-9 months post-entry.

While the total difficulties differed, the SDQ subscales did not differ. There was a trend for the TRC group to be more hyperactive and have more peer problems but these were not significant.

The total difficulties score has increased from the entry to TRC to the 6 to 9 months post TRC entry and has then declined further according to residential carers (Figure 76). The young people report a steady drop before a slight increase in difficulties at 2 years after entry.

As with the HoNOSCA, the SDQ produced a similar finding with the young people being rated as functioning better and having less problems after entry compared with prior to entry (F=6.89, df=3.44, p<0.01). However, post hoc comparison revealed that the sole source of the difference was from pre-entry. There was no difference from entry to post-entry. From the carers' perspective, the young people are functioning better within the first three months of entry to the TRC and then maintaining those gains (Table 27).

Table 27: SDQ mean total score pre-entry, entry and post-entry

Time	Mean	Std Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre-entry (mean)	24.065	1.348	21.269	26.861
Entry	20.000	1.271	17.363	22.637
Post-entry (mean)	20.703	1.110	18.401	23.005

Young people were not asked to complete an SDQ prior to entry and hence it was not possible to perform a parallel comparison with the SDQ data.

Figure 76: SDQ total mean scores – CG & TRC
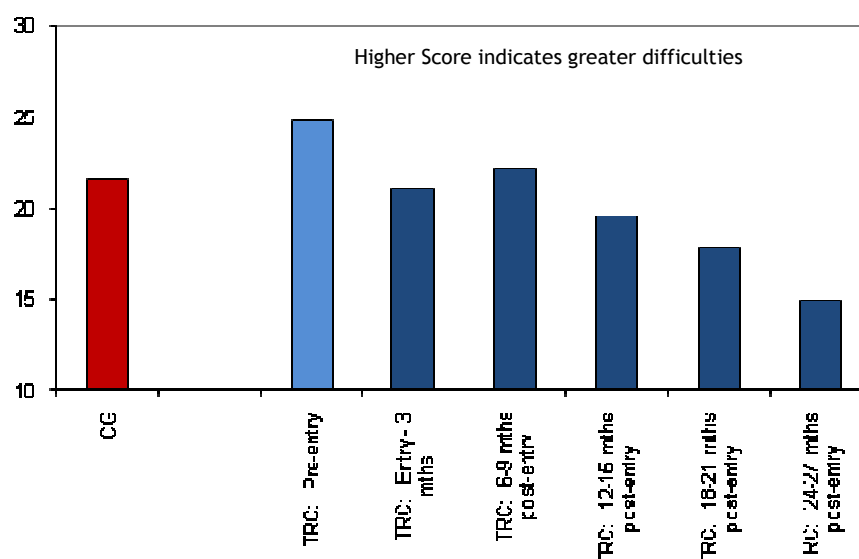
Likelihood of a disorder comparison

Figure 77 provides comparison data that illustrates the elevated likelihood of a disorder for young people in the TRC Pilots. This comparison is particularly useful as it confirms the complexity of young people in the TRC. In this figure Young People in the TRC are compared to the normative population scores, Take Two[22] scores at entry to the broad range of their OoHC services, CAMHS/CYMHS assessments at entry and the comparison group.

Insight into the Take Two scores are provided through the literature which states: "It is generally well understood that all children and young people who find their way into the OoHC system have experienced some degree of significant trauma, abuse or neglect" [Wise and Egger, 2007]. In Victoria in 2001-02, an audit of 1,600 children in home-based care conducted by the Victorian DHS showed that 95% of all children entering foster care had a history of protective involvement. Thus the vast majority of children entering care would have experienced some form of abuse and or neglect [DHS, 2003].

From Figure 77, it can be seen that more of the TRC young people have levels of difficulties in the most severe range. However, placing the CG against the other reference points (Normative, Take Two, CAMHS/CYMHS) highlights the severe difficulties that those in all forms of OoHC face. More of these young people have severe difficulties compared to the general population. While there is no implication that any[6] young person within the TRC or CG is not receiving any service from Take Two or from CAMHS/CYMHS, it is clear that overall the TRC group will have more young people with severe difficulties compared with the CG, CAMHS/CYMHS and Take Two.

When the presentations of the young people in the TRC Pilots are seen through the prism of a mental health instrument, the mean symptom scores tend to be quite elevated, and appear to be akin to the presentations of young people in mental

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22 'Take Two data: Frederico, M., Jackson, A., & Black, C. (2006). *"Give Sorrow Words" - A Language for Healing, Take Two - Second Evaluation Report 2004 - 2005*, School of Social Work and Social Policy, La Trobe University, Bundoora, Australia.'

health involved with the most intensive outreach teams. The range of presenting problems considered appropriate for referral to CAMHS/CYMHS in Victoria include:

- Young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development, and/or where there are substantial difficulties in the person's social or family environment

- Symptoms that may include impaired reality testing, hallucinations, depression and suicidal behaviour

- Children's emotional disturbances more often present in other ways such as: Hyperactivity, nightmares, fearfulness, bed-wetting, language problems, refusal to attend school, and stealing, these are among the behaviours that may indicate distress or disturbance

Figure 77: SDQ total scores comparison: community norms, CAMHS/CYMHS, Take 2 and CG
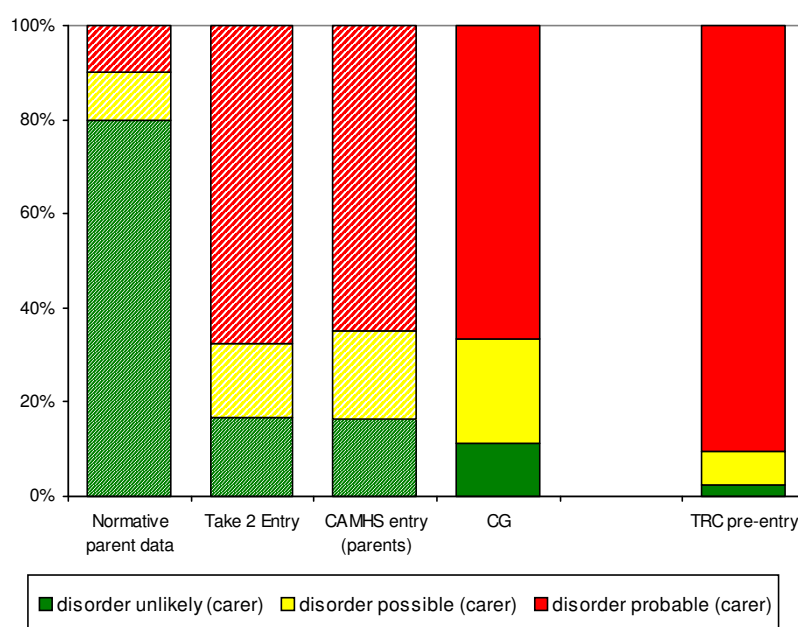
Emotional scores

The emotional sub-scale within the SDQ refers to 'mood or emotional responses dissonant with or inappropriate to the behaviour and/or stimulus'[23].

Figure 78 shows elevated emotional problem at 6 to 9 months in the carers rating before a decrease in emotional problems. The findings from the consultations with CSOs identifies that the detailed care planning, therapeutic specialist input and quality of relationship established with the young person leads to a greater understanding of the young person's emotional status. Interviews with the young people confirmed this finding. The attention paid to documentation in the TRCs also contributes to more thorough assessment. It may also be possible that young people's emotional problems are initially being more readily understood and acknowledged rather than an actual increase. This interpretation is consistent with observations provided by CSOs at workshops conducted in February and March 2011. In the workshops CSOs were asked to provide insight into the results presented in Figure 78. The insight they provided through the workshops particularly focused on

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[23] http://www.copmi.net.au/ee/youth/strengths_difficulties.html

their increased understanding and knowledge of the young person. It is also very clear that the impact of the young person's difficulties has declined according to both the carers and the young people.

For many of the young people their placement at 6 to 9 months post entry to the TRC is becoming the longest and most stable placement they have experienced (average placement for TRC pre entry 6.9 months). The young people and the carers report an improvement in emotional wellbeing during their time in the TRC.

When cross referencing this finding the HoNOSCA also demonstrates considerable positive change over time.

Figure 78: SDQ emotions mean scores - TRC
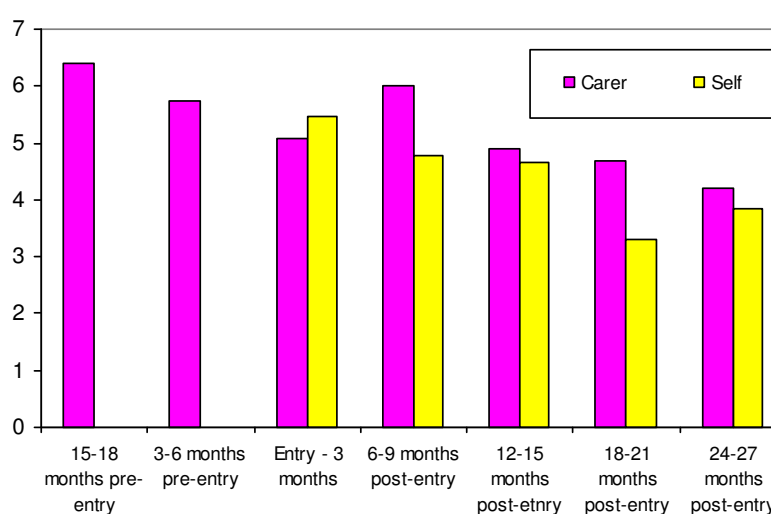
Mean conduct

The mean conduct score refers to 'identifiable behaviours in the individual that fail to conform to societal norms and encroach on the rights of others'.

While change occurs over time in the TRC the scores remain high.

The young people's increased scores over time in the TRC may indicate a greater self awareness rather than increased behaviours. CSOs report that young people gain a much greater appreciation of their issues and their placement in the TRC and what it may be able to do for them. Young people interviewed demonstrated an insight into the differences between the TRC and general residential care and how the differences may impact on them.

Examining the carers' SDQ across a number of the sub-scales found that there were some definite areas of improvement between pre-entry, entry and post-entry. Young people's conduct problems were one of these areas and were seen as markedly better ($F=10.19$, $df=2.21$, $p<0.001$) with the prime source of difference being between pre-entry and the subsequent entry and post-entry time points (Table 28).

Table 28: SDQ mean conduct score pre-entry, entry and post-entry

Time	Mean	Std Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre-entry (mean)	6.348	0.541	5.225	7.470
Entry (mean)	4.826	0.554	3.677	5.975
Post-entry (mean)	4.406	0.480	3.411	5.401

'Disruptive, Antisocial and Aggressive Behaviours' on HoNOSCA also showed a decrease before reaching a plateau.

Figure 79: SDQ mean conduct scores - TRC
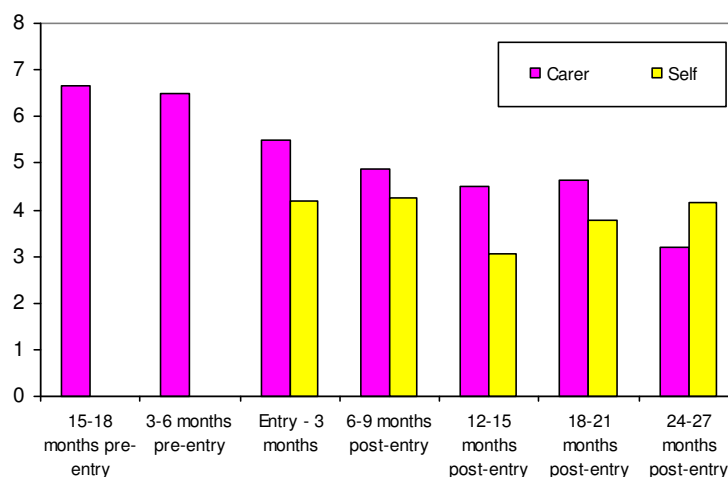
Hyperactivity

The hyperactivity score details levels of attention deficit or hyperactivity disorder, which is characterised by persistent and impairing symptoms of inattention, hyperactivity and impulsivity.

These scores improve overtime (about 30% from the peak rating). As detailed in the discussion on the emotional score and mean conduct there may be greater awareness by both the raters and the young people contributing to the ratings resulting greater insight as time progresses. If this observation holds true it would be expected that overtime there could be even further improvement in this measure.

Figure 80: SDQ mean hyperactivity scores - TRC
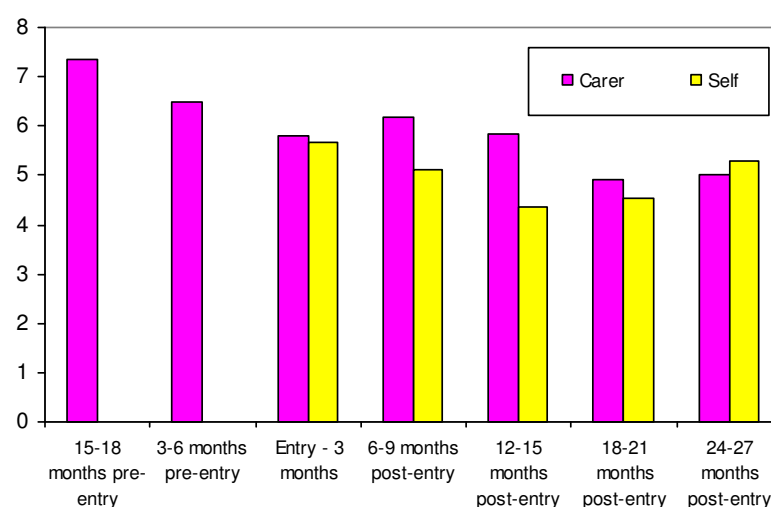
Peer relationships

The 'peer relationship measure', supports insight into the capacity of the young people to develop and maintain healthy friendships. There is evidence that children

who experience difficulty making friends and getting along with their peers are at increased risk of a wide range of psychosocial outcomes (Fergusson & Horwood 2001; Fergusson & Woodward 2002). Positive peer relationships are essential in healthy development therefore improvements in this measure may also be a precursor to a range of other developmental opportunities for the young people in the TRC.

As shown in the quality of peer functioning at school (Figure: 29) and the peer rating in the HoNOSCA there has been a positive improvement in these ratings. A contributing factor is the stability of placement (pre entry 6.8 months and current length of stay for TRC young people 23 months) and the development of congruency between schools and community organisations and services. Figure 81 also details improvements in peer functioning as described by carers and the young people.

Figure 81: SDQ mean peer relationships - TRC
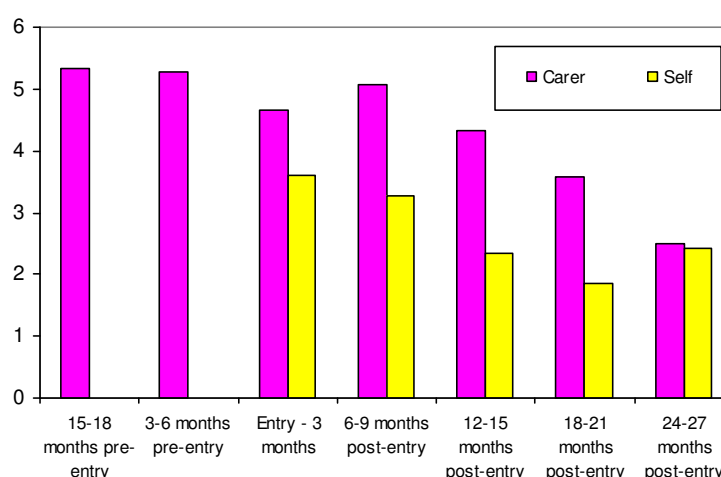
Pro-social behaviour

Pro-social behaviour is caring about the welfare and rights of others, feeling concern and empathy for them, and acting in ways that benefit others. Bergin, Talley & Hamer define this measure as 'voluntary behaviour that benefits others or promotes harmonious relations with others' (Bergin et al. 2003).

The findings regarding peer, family and carer relationships and connection to community, support the findings detailed in this rating. As detailed in the commentary regarding mean conduct scores the young people are likely to be demonstrating greater self awareness over time thus moderating their scores. Carers have identified consistent improvement.   Young people were seen as improving in their pro-social behaviours (F=3.52, df=2.21, p<0.05). The source of this difference was solely between the pre and post entry (see Table 29)

Please Note: when reviewing this table and figure that the scores are reversed here, i.e. higher scores = greater pro-social behaviours.

Table 29: SDQ mean pro-social score pre-entry, entry and post-entry

Time	Mean	Std Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre-entry (mean)	4.696	0.467	3.727	5.664
Entry	5.348	0.532	4.244	6.451
Post-entry (mean)	5.986	0.479	4.992	6.979

Figure 82: SDQ mean pro-social score – TRC
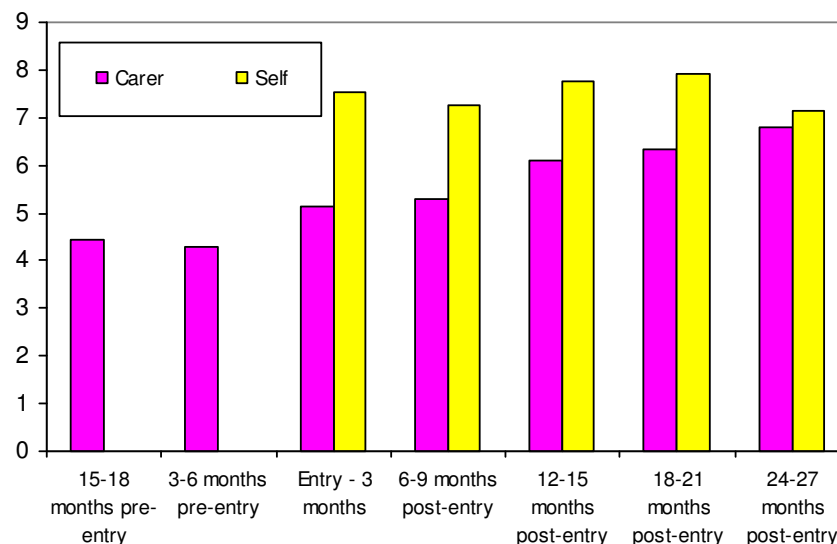
Mean Impact

The measure detailed in Figure 83 measures: chronicity, distress, social impairment, and burden to others.

Reductions in this measure while positive indicate that young people are benefitting from a longer stay in the TRC. Whether a longer stay in the TRC would produce even more reductions in impact seems likely but is currently speculative. According to the carers, there wa also a significant difference for young people in the impact of their difficulties (F=10.41, df=2.20, p<0.001). Again, the source of the difference was between the pre and post-entry (Table 30).

Please Note: when reviewing this table and figure that the scores are reversed here, i.e. higher scores = better functioning.

Table 30: SDQ mean impact score pre-entry, entry and post-entry

Time	Mean	Std Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Pre-entry (mean)	6.841	0.483	5.837	7.845
Entry	5.227	0.671	3.832	6.622
Post-entry (mean)	4.553	0.503	3.507	5.599

Figure 83: SDQ mean impact score - TRC
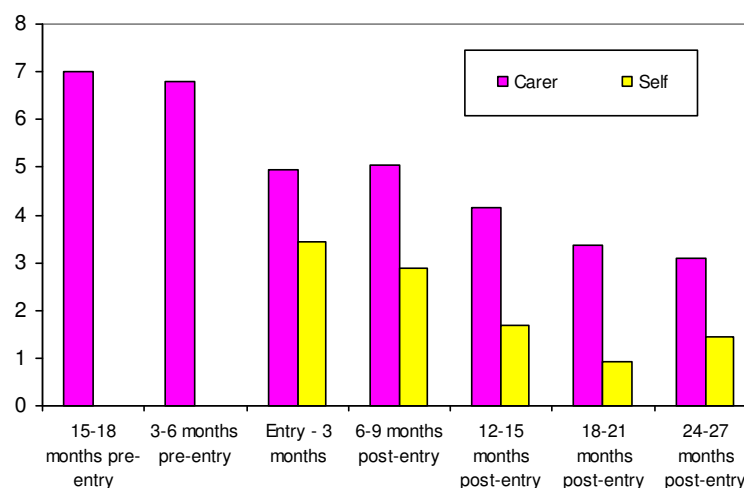
Findings

As detailed in Figure 77 the SDQ conclusively demonstrates that young people in the TRC were far more complex than the normative population, Take Two at entry, CAMHS/CYMHS and the comparison group with only 2.5% being rated as a disorder unlikely.

Across all of the SDQ measures the young people in the TRC experienced improvements

The improvements experienced by the young people as detailed in the SDQ ratings are borne out in other measures

The improvement to the young people's emotional, mental and behavioural health demonstrates the effectiveness of the approaches being used in the TRC compared to the young people's experience in residential care prior to entry to the TRC.

However, given the improvements made and the current scores that still remain elevated compared to normative data it seems plausible to consider that an even longer stay in the TRC would continue this positive progress.

6.6 Summary

6.6.1 Change for the Young People in the TRC

The rate and quality of change

The young people in the TRCs experienced considerable positive progress towards the desired goals as detailed in the Child Protection and Family Services Outcomes Framework over time in the TRC and as a comparison with their experience in General Residential Care. Two measures from the Brann Likert Scales provide insight into the quality and degree of change including a reduction in 'Poor' to 'Very poor' ratings and an increase in 'High' to 'Very high' ratings.

With regard to the change to 'Poor' and 'Very poor' ratings aggregated over the relevant measures from 3 to 6 months pre entry to TRC to 24 to 27 months post entry

to the TRC the change was a substantial 73.8% reduction in the number of young people with these ratings.

With regard to the change in 'High' and 'Very high' ratings aggregated over all relevant measures from 3 to 6 months pre-entry to 24 to 27 months post-entry to the TRC the change was a very substantial 237.9% increase in the number of young people with these ratings.

The most striking changes occurred in the period of 3 to 6 months prior to entry to 6 to 9 months post entry to the TRC; the reductions in the 'Poor' to 'Very poor' ratings for the young people is 56% and the improvement in the 'High' to 'Very high' ratings is 196.9%.

Figure 84 Aggregated Percentage Change for Young People in the TRC
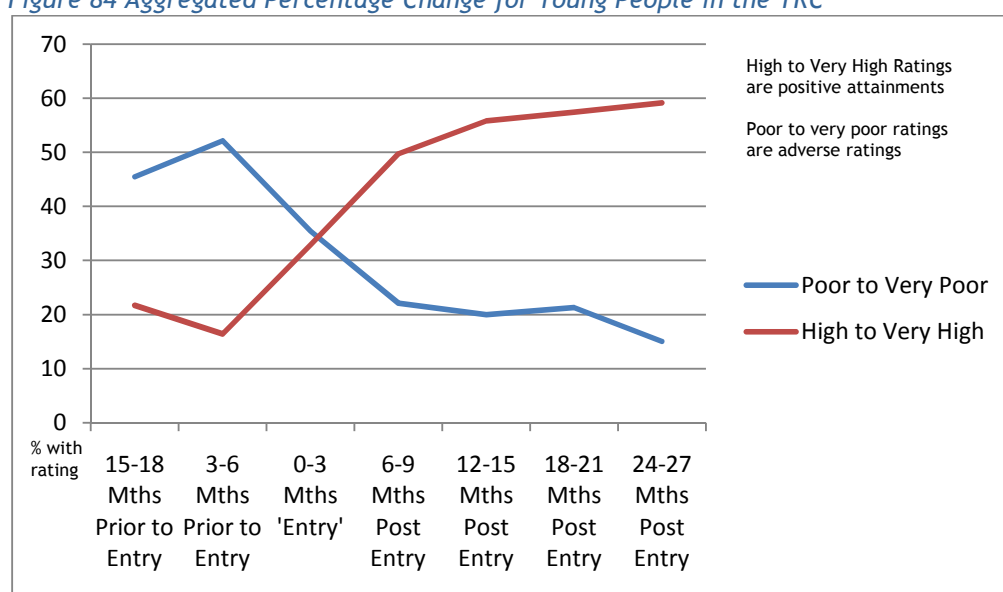
The type of change experienced by the Young People in the TRC

Relationship/Contact with Family

Young people in the TRCs had poorer quality of contact with families prior to entering the TRC Pilots than the CG. Time in the TRCs has led to the young people showing and sustaining significant improvements to the quality of contact with their family.

Relationship/Contact with residential carers

Young people in the TRC Pilots are developing and sustaining secure, nurturing, attachment-promoting relationships with older, capable adults in the TRC Pilots (a critical element of the therapeutic approach). Young people in the TRCs experienced and sustained significant improvements to the quality of contact with their residential carers overtime in the TRC Pilots.

Schooling

School represents a critically important relationship in the lives of young people. The TRC group have clearly improved in their relationship with school over time. There has been a weaker improvement in academic functioning while peer and social functioning has improved substantially. Due to the achievements of the staff of the TRCs the school environment has become more congruent with the Therapeutic Approach and it would be expected that with further time the quality scales should demonstrate even greater improvements. The improvements and opportunities are evident across multiple measures.

Stability of placement

The young people in the TRC have had complex placement histories in OoHC (on average changing placements 10.5 times across an average of six years or a placement change about every seven months).

There appear to be several distinct residential pathways experienced by young people in the TRC population:

- Sub-group 1: young people who entered the OoHC system at a very young age (average age 1.8 years)

- Sub-group 2: those who entered as young children (average age 8 years)

- Sub-group 3: those who entered as teens/pre-teens (average age 12.9 years)

Placement changes for sub-groups 1 and 2 were at a rate of one every eight months and sub-group 3 was at a rate of one every 2.5 months. The instability experienced by sub-groups 1 and 2 is more likely to mean that these young people will also be linked with a higher prevalence of psychological, social, and educational difficulties.

All of the young people were in residential care prior to entry to the TRC. Their consolidated residential care history indicated an average of 31 months (median 17 months) in OoHC immediately prior to entering residential care (range 2 to 147 months).

Young people placed in a TRC have experienced greater stability compared to their previous experience (average period in the TRC 30 months contrasting to an average of seven months). Most young people in a TRC have remained at the unit during their stay, with absences generally planned.

Community Connection

Young people in the TRC Pilots are more likely to engage in community activities such as pony club, playing football/netball or swimming lessons, or have a part time job than young people in general residential care. Seventy-five percent engage in recreation activities twice per week or more.

TRC staff, supported by the Therapeutic Specialist, encourage the young people in their care to participate in these community activities, and assist them to develop the necessary skills.

These skills and the accompanying experience are expected to have long term benefits for the young people, as they continue to engage with the wider community through their adult lives.

There are interrelated impacts and measures that affect Quality of connection between the young person and Community they include; Frequency of Recreation, Quality of peer and social functioning at School, Prosocial Functioning and Risk Taking.

Connection to Indigenous Community

The data demonstrates a surprising lack of information and poor connection to community for young people identified as Indigenous. This may demonstrate that CSOs lack the processes and systems to identify and to provide a framework for positive connection.

Connection to cultural community

TRC young people experienced improvements to the quality and strength of their connection to cultural community compared to their experience prior to entering the TRC. Improved information regarding the young people's cultural background, facilitated opportunities for TRC staff to proactively support connections. It appears that culture is generally viewed as non English Speaking background.

Sense of Self

Young people in the TRC have experienced and sustained significant improvements in their sense of self, indicating improved mental health.

Optimal Physical Health

Quality of documentation regarding medical, dental, nutritional, sleep and hygiene status, the quality of documentation on recreational patterns and improved exercise, the frequency of exercise and recreation make up nine measures used to gauge optimal physical health.

Over these nine measures the young people in the TRCs health status improved and is maintained over time. Similarly, a reduction in 'Poor' or 'Very poor' ratings in these aspects of physical health was apparent with these ratings being almost completely expunged.

While this study was not set up to monitor longitudinal changes for a comparison group in residential care, it appears that the small sample accessed did not experience a change in health status like the TRC group.

The documentation of pre-TRC entry health status of young people points to serious concerns related to their health with implications for the wider OoHC system

Healthy Lifestyles and Risk Taking

Young people in the TRC experienced a reduction in risk taking which is evident over time in reduced episodes of negative police involvement (although not immediate), police charges and secure welfare admissions. CSOs report a reduction in risk taking. Examining the TRC group over time, it is apparent that risk taking is a major issue for the TRC group with reduction in overall levels only occurring with significant time (Figure 61). The percentage of young people with 'High' to 'Very high' levels of risk taking reduces from a peak of 64% at 3 to 6 months pre-TRC entry to 40% over three collection occasions. Similarly there is a rise in those with 'Very low' levels of risk taking. This improvement is perhaps even more striking given that as these young people get older, an increase in risk taking would be expected as part of normal development. Over time trauma history remains the most influential factor in risk taking with the impact of alcohol, drug taking and sexual behaviours reducing.

Symptom severity

The severity of mental health symptoms is higher in the TRC than that of the average level of severity of young people admitted to Australian CAMHS/CYMHS.

In particular the symptom severity in the TRC young people is higher than CAMHS/CYMHS data for all but one of the 15 measures at entry to the TRC demonstrating the broad range of measures where young people in the TRC had elevated levels compared to young people entering CYMHS/CAMHS. At 24 to 27 months post-entry this had reduced to six of the 15 measures consistent with the overall reductions of symptom severity experienced by the young people over time in the TRCs.

In 13 measures out of 15 the HoNOSCA provides clear results regarding reductions in symptom severity.

In nine of the 15 measures improvements detailed in the HoNOSCA are confirmed by other data tools detailed in this report (family relationships, school attendance, scholastic/language difficulties, peer, concentration, physical illness/disability, non–organic somatic, substance misuse) with the exception of substance misuse which was inconclusive in the HoNOSCA.

While the young people in the TRC have made significant progress toward the desired outcomes (reductions in symptom severity) over the post entry data collection points these reductions are to levels that are still elevated compared to CAMHS/CYMHS entry. This suggests that with additional time in the TRC further reductions may be possible.

The symptom severity suggests that after 30 months in the TRC this group of young people have persistent mental health issues and elevated behaviours.

Mental and Emotional Health

As detailed in Figure 77 the SDQ conclusively demonstrates that young people pre entry to the TRC were more complex than the normative population, Take Two at entry, CYMHS and the comparison group with only 2.5% being rated as unlikely to have a disorder.

Across all of the SDQ measures the young people in the TRC experienced improvements.

The improvements experienced by the young people as detailed in the SDQ ratings are borne out in other measures.

The emotional, mental and behavioural health improvements demonstrate the effectiveness of the therapeutic approach, as compared to the young people's experience in residential care pre TRC entry. However, despite the improvement gains, the current scores remain elevated compared to normative data, indicating that young people may benefit from a longer stay in the TRC to continue this positive progress. It is appropriate to consider the literature that indicates that the type of placement change experienced by the young people prior to entry to the TRC Pilots may have resulted in secondary trauma and be a contributing factor to the status of the young people's mental and emotional health[24].

6.6.2   Rates of Change – Program Effect

The following summary aggregates the ratings over the 16 measures into a count of 'Poor' and 'Very poor' ratings and 'High' to 'Very high' ratings to measure progress being made toward the desired outcomes for both groups of young people. The 16 measures have been used as there was a direct capacity to compare these measures with the comparison group.

Young People in the Comparison Group

Over 16 measures the aggregate rating of the comparison group of young people in generalist residential care demonstrates that:

- 42% had a 'Poor' to 'Very poor' rating at the first collection point

- 28% had a 'High' to 'Very high' rating at the first collection point

- The only area that substantially improved was 'Quality of academic functioning'

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24 Placement instability or drift, is strongly associated with worse outcomes (Osborne and Bromfield, 2007; Wise S, Pollock S, Mitchell G et al, 2010) including schooling and subsequent life chances for young people. Several studies support the contention that placement instability lasting for more than 12 months is more strongly linked with a higher prevalence of psychological, social, and educational difficulties (Osborn and Bromfield, 2007; Cashmore and Paxman, 2007; Stone, 2007).

- The 'Quality of documentation on recreation patterns' demonstrated a substantial deterioration over time

- All other measures showed minimal change

- 41% had a 'Poor' to 'Very poor' rating after one year

- 29% had a 'High' to 'Very high' rating after one year

Young people in the TRC

Over the same 16 measures for the young people in the TRC:

- 50.8% had a 'Poor' to 'Very poor' rating at 3 to 6 months prior to entering the TRC (while they were still in the general residential care population)

- 16.6% had a 'High' to 'Very high' rating at 3 to 6 months prior to entering the TRC

- 22.1% had a 'Poor' or 'Very poor' rating at 6 to 9 months after entering the TRC

- 49.3% had a 'High' to 'Very high' rating at 6 to 9 months after entering the TRC

- The change recorded for the 'Poor' or 'Very poor' rating from 3 to 6 months pre entry to 6-9 months (9 months later) was an reduction (improvement) of 56% in these ratings

- All 'Poor' to 'Very poor' ratings demonstrated reduction (improvements) from 3 to 6 months pre entry to 6 to 9 months (9 months later)

- Over the 4 collection periods (6 to 9 months, 12 to 15 months, 18 to 21 months and 24 to 27 months) further reduction (improvement) was from 22.1% to 13.3% with a 'Poor' or 'Very poor' rating

- The overall reduction (improvement) from 3 to 6 months pre entry to TRC to the 24 to 27 months was a substantial 73.8%

- The change recorded for the 'High' or 'Very high' rating from 3 to 6 months pre entry to 6 to 9 months (9 months later) was an increase (improvement) of 196.9% in these ratings

- Over the 4 collection periods post TRC entry (6 to 9 months, 12 to 15 months, 18 to 21 months and 24 to 27 months) a further increase (improvement) from 49.3% to 56.1% of young people with a 'High' or 'Very high' rating

- The most rapid change occurs early in the TRC program (the first 6 to 9 months)

- The overall increase (improvement) in the 'High' to 'Very high' ratings from 3 to 6 months pre entry to TRC to the 24 to 27 months was a very substantial 237.9%

Figure 85: % 'Poor'/'Very poor' and High to Very High Ratings ratings over one year – CG & TRC
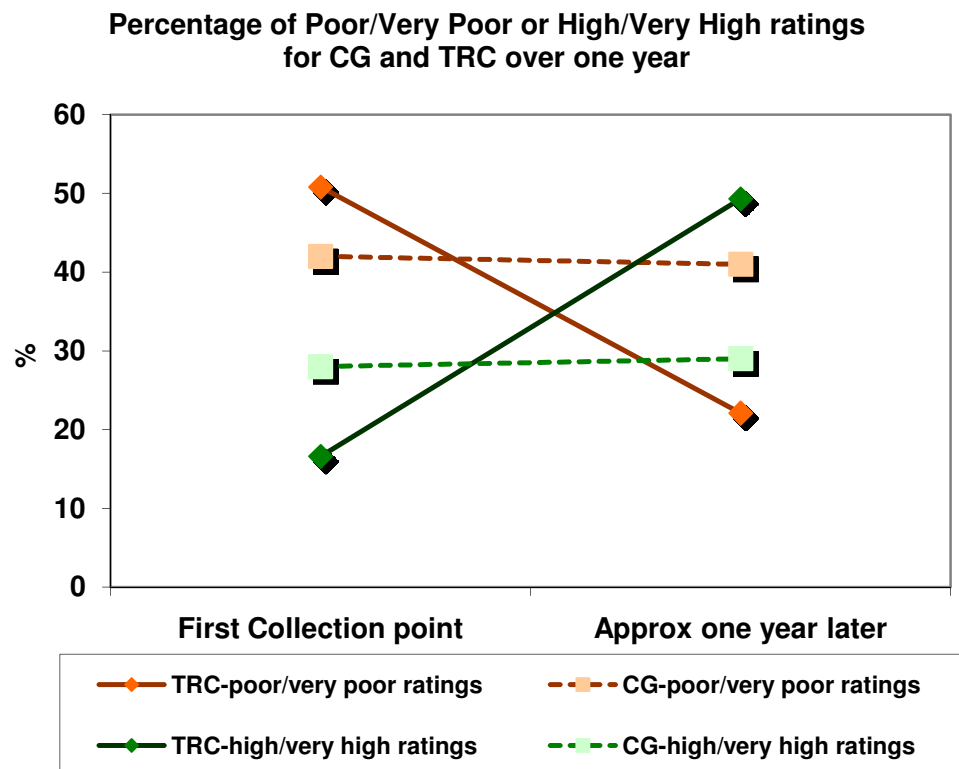
Percentage of Poor/Very Poor or High/Very High ratings for CG and TRC over one year

Contrast between the comparison group and the TRC

The comparison between young people in the TRC and young people in the generalist population is striking. The young people in the TRC have experienced positive change with significant reductions in 'Poor' to 'Very poor' ratings and even more significant increases in 'High' to 'Very high' ratings. By contrast the young people in the comparison group did not evidence change over the three time points.

6.7 Recommendations

Discussion

The young people who entered the TRCs demonstrated substantial improvement across many areas of well-being. This group of young people were more severe generally than a Comparison Group from residential OoHC at and prior to entry to the TRC. It would appear that the weight of the current evidence is that significant positive change is available by the application of trauma and attachment theory in a therapeutically informed environment.

The tentative finding that little change occurred within the comparison group over 12 months raises the need for further investigation into young people's trajectory in general residential care.

Recommendation 1:

That the 'pilot' status of the TRC programs be removed, authorizing them as a legitimate and on-going models of residential care

Recommendation 2:

Provide the Therapeutic Care Program to most of the general residential care services (this is consistent with Howard Bath's recommendations[25]) giving due consideration to:

- a recognition that all young people entering the system are likely to have suffered trauma and this trauma will impact significantly on their capacity to attain normal developmental goals and on their opportunities in life

- recognition that the current system increases the likelihood that secondary trauma will be imposed on these young people

- the opportunity (as demonstrated by the research in this report) to develop an alternate system and approach with the potential for far reaching impact on the young people and Australian society in general

- move the focus from mitigating effect of damaging behaviours (self and others) to supporting healing processes, the attainment of age appropriate milestones and being supported to achieve their goals (in program and after exit from the program)

Recommendation 3:

Progressively expand the TRC program to eventually incorporate most[26] residential OoHC sites across the State which will also necessitate the development of:

- alternate arrangements and models to respond to emergencies, to reception and with added contingency capacity

- an alternate model to manage intake processes including the time taken to facilitate appropriate transitions and to support the management of client mix in current TRCs

- the development of an implementation framework that includes and or considers elements such as; resources, budget, schedules, project management requirements, communication strategies, additional research activities, vital agreements required to realise recommendations, identification of barriers, knowledge management, cultural change, housing requirements, workforce capacity

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[25] Bath, H., 2008a Residential care in Australia Part 1: Service trends, the young people in care, and needs-based responses. *Children Australia*, 33(2), 6 - 17.

[26] Most: TRC staff and Therapeutic Specialists report that many young people over 15 years of age (at entry) who have experienced multiple placements and have ingrained behaviour are less likely to benefit from the therapeutic approach – within this recommendation consideration should be given to this cohort and what alternate arrangements would best suit their needs. It should also be noted that chronological age and developmental age will vary greatly.

7 Costs and Benefits

This section aims to determine the costs and benefits of providing the Therapeutic Residential Care Program. It addresses evaluation question 13:

"What are the unit costs of providing Therapeutic Residential Care (HBF and TRC pilots) as compared to general residential care and how does this compare with the benefits and outcomes achieved?"

7.1 Introduction

This analysis of economic factors and costs than can be avoided focuses on the short term benefits of TRC which can be monetised (as costs avoided) and longer term benefits that have not been monetised. The elements that can be monetised include; police time required to deal with TRC children and young people, fewer secure welfare placements, reduced admissions to hospital and other community services, greater placement stability and planned TRC exits.

TRC has achieved longer term benefits (outcomes) in addition to those for which we are currently able to estimate monetary benefits. For example, reduced risk taking and aggressive behaviour, improvements in physical and mental health, better educational opportunities and greater positive connection to family and community.

Unfortunately, a lack of available longitudinal data linking children and young people's experiences in care to their later life outcomes makes it extremely difficult to monetise the longer term benefits of TRC.

Since the financial impacts of the anticipated longer term benefits are not included, it is important to note that this analysis cannot answer if per dollar spent on TRC the benefits exceed costs. A longitudinal study would allow relevant information to be collected that would inform a broader analysis of TRC's longer term financial benefits.

However, we hope that by costing the short term benefits, we have demonstrated that TRC can reduce immediate costs to government by reducing police time, use of expensive secure welfare placements, the frequency of hospital admissions and other use of other community services.

These are not distant cost savings beyond the budgetary cycle, but in the short term amount to an average minimum economic benefit of $44,243 per annum for each year a child or young person is in TRC.

The economic analysis is comprised of three main components: an audit of client information held in DHS files; an examination of the young people's placement history and trajectory of placement change; and an estimate of the costs avoided in the first year after exit from TRC. In principle, the costs avoided calculated from this comparison data significantly offsets the cost of providing TRC. The Program benefits are reported in three broad time frames: the short term financial benefits and medium and longer term economic benefits.

Audits

To inform the economic analysis, a separate audit of TRC clients using the CRIS system was undertaken which included 20 young people who had been in the TRC for at least 18 months, as at 30 April, 2011.

The audit of TRC clients included two 3-month windows for data collection:

• 6 – 3 months pre-entry into the TRC

• Most recent 3-month period for those in the Program for at least 18 months

The dollar values attributed to the specific events captured within the CRIS file audit were obtained from the appropriate departments within DHS and the Finance & Budget Department of Victoria Police (refer to Attachment 5: 1.3.1 *Data Analysis and Assumptions*).

7.2   Costs

The extra cost per annum of the TRC Program (over the base funding for residential care) is $2.6 m. This allocation was made to support 40 children and young people, therefore the extra cost per child or young person can be calculated as an average $65,000 per annum.

Other costs associated with the TRCs that are not included in this figures are the training costs for compulsory TRC training and ongoing professional development as well as costs associated with the alterations and improvements to the physical environments of the residential homes.

7.3 Benefits

Benefits have been divided into three broad categories:

• Benefits to children and young people – direct benefits to the wellbeing of children and young people in TRC and that have the capacity to improve their longer term outcomes and life trajectories

• Benefits to the out-of-home care program – benefits to the effectiveness and quality of the out-of-home care programs and appropriate targeting of services and costs avoided as a result of these.

• Benefits to the community and government – benefits to government and community resulting from reduced immediate and longer term demand on services due to the impact of positive client outcomes and improved mental and physical health of children and young people in TRC

7.3.1   Benefits to Children and Young People

The client outcomes data presented in this report demonstrated significant improvements for children and young people over time in the TRC and also as a comparison with the experience in general residential care. Not all benefits can be quantified in terms of a monetary amount, however there are substantial benefits that have a positive impact on children and young people's lives immediately and a significant potential for these benefits to be carried into later life.

Short term benefits

There are short term benefits for the children and young people involved in TRCs that can be identified throughout this report, such as:

• Reduced risk taking and hospital admissions associated with risk taking

• Increased interaction with family with a deeper understanding of these relationships

- The development of stable relationships with trusted adults

- Improved academic functioning and school attendance

- Improved; health, sleep, nutrition, exercise, mental health and emotional health

- Greater stability of placement

- Improved self esteem

- Improved recreational and broader community participation

- Improved cultural identification and participation

- Reduced aggression

- Improved empathy and other pro-social skills

Medium term benefits

The medium term benefits are the outcomes of the immediate benefits that will be outworked over the following 12 to 24 months. These include:

- Increased potential for family reunification or a more constructive relationship with family

- Reduced potential to participate in or be a victim of crime

- Reduced necessity to be sentenced, hospitalised, attend a detoxification facility, and /or be required to go into secure welfare

- Higher likelihood of maximizing opportunities to participate in and achieve academic excellence, sporting accomplishments, citizenship experiences, part-time employment and the development of friendships

- A higher likelihood that age appropriate milestones will be achieved

Long-term Benefits

Longer-term Individual benefits

Longer term individual benefits are the outcomes that impact on the opportunities in life that the young person will experience. They can be summarized as:

- Greater opportunity for participation in the workforce

- An increased likelihood that the young person will be afforded the opportunity to experience health (including mental health) consistent with the wider community

- A reduction in the likelihood of being or becoming homeless

- Increased capacity to remain engaged in education and to maximise their personal capacity for learning and academic attainments

- Increased likelihood of being able to form and maintain relationships

- Reductions in incarceration and criminal behaviour

Longer term impacts

The benefits detailed in this section outline the longer term impacts of TRC that include impacts on physical health, school retention and academic performance, social interaction and relationships, risk taking and interactions with police.

These domains were chosen for more detailed discussion in this economic analysis as the Outcomes section of the report substantiates significant improvements for the young people in the TRC. The outcomes data also provides comparison data that

enables the young people's trajectory to be plotted without TRC interventions and supports broad comparisons.

An association between placement instability and young peoples' life trajectories is broadly demonstrable through literature reporting that poorer educational outcomes are strongly associated with lower workforce participation, a higher prevalence of interacting with the criminal justice system and other community support services (Morgan Disney & Assoc, 2006; Taylor, Moore, Pezzullo et al, 2008).

The following section draws on some of the measured outcomes for the 38 young people within the TRC Pilot Program evaluation and aligns these findings with the broader literature about longer term economic impacts.

Physical health documentation

Physical health documentation[27] was measured using the following nine domains: documented medical status; documented dental status; documented nutritional status; documented sleep status; documented hygiene status; recreational patterns; frequency of recreation; improvements in exercise; and frequency of exercise.

Overall, there were marked improvements in each of the physical health domains for the TRC young people over their time within the Program. These changes reflected better reporting due to participation in the Program and also most importantly, a significant shift toward having a 'clear plan' and 'clear, with no need for a plan', indicating positive shifts in the young person's participation. Actual rates of exercise and engagement with recreational activities were also markedly improved. The literature states:

• Physical health and nutrition in childhood and adolescence are key indicators for healthy adulthood (Bonomi et al. 2008).

• Poor nutrition, poor self-care, and obesity contribute significantly to the burden of disease and injury in later life (Bonomi et al. 2008).

• Sleep is a critical component of all aspects of a young person's functioning and their development. Adequate sleep impacts on physical health simply through having enough rest to engage in physical activity, concentrate, and also through the young person feeling well enough to do so.

• Exercise and recreation are also important aspects of maintaining physical wellbeing, mental health and encourages development of social skills, improved self esteem and other factors that help build healthy relationships (Taylor P et al, 2008).

The economic impact and implications are reductions in non-organic somatic presentations, improved sleep, self-care, nutrition, and participation in exercise and recreation all contribute to better health and wellbeing for the young person. Longer term these changes may have an economic benefit related to reductions in overall health system usage, but also in the development of healthier, productive young people who can make more positive contributions to their communities.

School retention and academic performance

School retention and the quality of the young person's experience with school are key factors in determining their performance in many areas in later life. For many reasons, children and young people who are in care may require a greater degree of

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27 The term 'documentation' is included in the outcome measures because the raters (i.e. therapeutic specialists and/or carers completing the survey) are not providing a professional medical opinion, but rather are reporting on what the documentation states. Whilst the raters are not directly assessing the medical or dental status per se, they are reporting on the documented improvements to the status. Therefore, data are being interpreted as improvements to the status (i.e. medical, dental, sleep) and not merely as improvements to the recording of the information.

assistance to stay at school, with many having diminished intellectual capacity and poorer academic outcomes (Taylor et al. 2008; CREATE 2006). Further literature states:

- Placement changes and associated changes of school are known to cause upheaval and educational disruption (CREATE 2006).

- The risk of education failure is already higher among young people who enter the OoHC system (due to a greater exposure to risk factors experienced by disadvantaged children generally) and the system has a poor record of mitigating poor academic performance (Wise et al. 2010).

- Disruptions to concentration have a major impact on academic functioning. Poor concentration levels are attributable to a number of possible causes, including reference to the following:

  - overactive behaviour associated with any disorder such as hyperkinetic disorder, mania, or arising from drugs

  - problems with restlessness, fidgeting, inattention or concentration due to any cause, including depression

- Improvements in concentration are expected to contribute to an increase in the young people's school engagement and the quality of their experience with school, thereby improving the chances for learning, and impacting on their academic functioning over time.

The group of young people within the TRC population exhibited improvements over time relating to factors other than academic performance, such as the quality of school contact, peer relationships, and attendance rates. These are significant improvements, placing the young people in an environment of improved opportunity to learn.

The economic impact and implications include: School retention and academic performance which are associated with reduced involvement in the criminal justice system. In the shorter term, whilst young people are engaged at school they have reduced opportunities to engage in offending behaviour. In the longer term, better academic outcomes create improved opportunities for employment and future life chances.

Relationships

The ability to build and maintain strong, positive relationships with others is a fundamental building block in childhood development which impacts on many aspects of later life including: mental health and well-being; parenting; community connectedness and participation; and employment (Morton et al. 1999; Bromfield & A. Osborn 2007). Young people who experience difficulty engaging with family, personal relationships and community participation are at a significantly higher risk of interacting with the criminal justice system (Morton et al. 1999).

As an outcome for the TRC Pilot Program, the quality of relationships experienced by the young people were gauged in a number of areas including: the quality of peer and social functioning; , the quality of community relationships; , and the quality of family relationships. Improving family relationships allow the young people to develop greater insights into their family dynamics, reducing their feelings of rejection, and enabling the development of deeper self-awareness. Overall, the young people in the TRC Program were more likely to engage in community activities such as pony club; football; netball; swimming lessons; and working part-time.

Relevant literature states:

- The quality of peer and social functioning at school is considered to be a critical factor impacting on school attendance, and is strongly linked to withdrawal and dropping out of school (Asher & Coie 1990).

- The long term effect of social isolation has been well documented (WHO) including reduced quality and length of life.

Economic impacts and implications include considerations such as: Each of these improvements are a step toward the young people being able to develop and sustain their own relationships among their own peer groups and participate more fully in their communities and at school, with subsequent economic benefits in the future.

Risk taking and interactions with police

Interactions with the juvenile justice system and police are greater among young people in the OoHC system than those in the general population (Brouwer 2010; Taylor et al. 2008). Drawing from the report "The Cost of Child Abuse in Australia" (Taylor P et al. 2008), the following section focuses on the longer term economic impacts of crime that are associated with the occurrence of child abuse and neglect.

Whilst assigning a direct cause to criminal behaviour among juveniles and adults is highly tenuous (National Crime Prevention 1999), numerous studies detail a high prevalence of child maltreatment among populations of incarcerated adults (Roe-Sepowitz et al. 2007; J. Siegel & Williams 2003; English et al. 2002; Currie & Tekin 2006). The findings from the National Longitudinal Study of Adolescent Health demonstrated that maltreatment in childhood approximately doubled the risk of engaging in criminal activities in adulthood (Currie & Tekin, 2006).Further literature states:

- Longer term, the economic costs include a higher likelihood of young people to graduate from juvenile delinquency into a life-course of persistent offending behaviour (Taylor P et al. 2008).

- In addition to the cost of perpetuating future criminal career-hood is a higher prevalence of second generation crime and intergenerational transfer of child abuse and neglect (Widom & Maxfield 2001).

- The costs of crime in Australia are substantial (Mayhew 2003; Rollings 2008). Recent figures estimate the cost as $35.8 billion (Rollings 2008). The largest component being the costs of the criminal justice systems: police, courts, correction, and other criminal justice-related government agencies.

The young people within the TRC Pilots demonstrated a substantial reduction in their interactions with police, in their risk-taking behaviour, and of the group involved in the youth justice system (approximately 20%) almost all were clearly meeting youth justice Order expectations at 24-27 post entry into the Program.

Economic impacts and implications include considerations such as: Reducing the likelihood of young people within the OoHC to proceed on a life-course that involves a career of crime has great potential future economic savings in terms of avoiding a myriad of costs related to crime. The types of future costs avoided include: lost productivity of victims of crime; the intangible costs of crime such as victim compensation costs; time spent dealing with crime; time away from work; financial costs incurred by the victim; medical costs associated with the crime; costs of crime to business; and the costs of related injury (Rollings 2008).

7.3.2 Benefits for the Out-of-Home Care Program

Many of the benefits to the out-of-home care program can be quantified in terms of costs avoided however there are also many additional benefits unable to be quantified due to their qualitative nature or as a result of time constraints in undertaking this level of analysis.

Short-term Program benefits

The short term outcomes of TRC which can be monetised include:

• Less police time spent processing missing person reports for young people in TRC

• Less police time executing warrants for young people in TRC

• Fewer placements in secure welfare

• Greater placement stability

• Planned exits from TRC

Benefits and costs avoided arising from less absconding and apprehensions by police

Costs and benefits were calculated based on a comparison of audited CRIS data for young people pre and post entry into the TRC Program. Financial benefits were realised based on the young people's reduced interaction with police, secure welfare, hospital and other community services. The calculation of costs avoided compared to the costs attributable to this population without TRC interventions is: $787,147 per annum for the program which can be expressed as $20,714 per annum for per young people person still in a TRC placement (see attachment 5 for details: 1.4.3 *Calculation of Avoidable Costs*).

Benefits arising from fewer placements in secure welfare

The costs avoided related to secure welfare are calculated based on audit of the CRIS data for 20 young people in the TRC (See Attachment 5: *Table (D) Audit findings secure welfare at pre/post entry estimates*). Extrapolating this data the following estimates can be applied to the 38 young people in the TRC population:

• The estimated annual cost of secure welfare admissions within the TRC program would be $136,658 (excluding the costs associated with a one off incident as the program was being bedded as noted)

• The annual cost of secure welfare without the TRC intervention (based on 0-6 months pre entry to the TRC) would be: $619,400

• The costs avoidable would be equal to an annual benefit: $482,742 or $12,703 on average per young person

Benefits associated with placement stability

Placement changes are a major component of system costs for young people in OoHC. Following entry into the TRC Program, the reduction in the number of placement changes compared with the young peoples' previous OoHC experience provided a financial Program benefit as well a potential future economic benefit both to the young people and society in general.

Conclusion: The calculation of costs avoided compared to the costs attributable to this population without TRC interventions is: $164,160 per annum for the program which can be expressed as $4,320 per annum for the each young people person still in placement (see attachment 5: 1.4.2 *Calculation of placement change*).

Benefits associated with planned exits

Planned exits from the TRC for five young people have resulted in the avoidance of costs to the OoHC system in the immediate 12 months post exit. The young people in the TRC have had a complex history. This history indicates that without the change experienced in the TRC that it would have been improbable for the five young people who experienced positive exit destinations to do so.

Conclusion: These exits have resulted in reduced or no further costs being incurred in the OoHC system. The costs avoided have been calculated as: $730,000 per annum for the TRC which can be expressed as $19,211 per annum for the young people still in placement (see attachment 5: 1.4.2 *Reduced cost associated with planned exits*).

No calculation of benefit was possible for the categories detailed below (however if the data was available the evaluators estimate that considerable additional benefit could be demonstrated when considering the costs that could be avoided let alone the societal benefit):

• The direct and administrative costs associated with young people's interaction with youth justice and the courts

• The direct costs of crimes committed by the young people (property, personal and broader community)

Table 31: Summary of Total Costs

Avoided Program & Associated System Costs per Year	$
Reduced broader system costs including secure welfare	$787,147
Placement stability	$164,160
Exit costs avoided	$730,000
Total = financial program benefit	*$1,681,307*
Per person cost avoided (N=38)	*$44,243*

Short term benefits identified above are the financial outcomes related to costs avoided due to placement change and reductions in the use of other parts of the system such as Secure Welfare. Other benefits which have both financial and organisational benefits include:

• Reduced turnover of staff due to greater job satisfaction – resulting in increased quality of care and placement stability and potential cost avoided in terms of staff recruitment

• Improved economies of scale in terms of staff training & development activities, retained corporate memory, and continuity of care

• Increased interest and creative endeavour from CSOs and professionals due to the hope that an improved and effective care system can be created

• Less crisis driven and more planned and proactive approaches that impact positively across all stakeholders

• Reduced use of the After Hours Service

Medium term Program benefits

Medium term financial benefits for the program that have been detailed in this report related to:

- Fewer SWS admissions, enabling the Program to more effectively manage demand as fewer of the young people are progressing to the highest threshold of response which is the most expensive accommodation option

- Reduced demand on After Hours Services

- Reduced administrative demand through fewer placement changes required

Longer term Program benefits

- Young people are more likely to benefit from less expensive models of care, post TRC, thereby releasing resources to provide TRC to other clients

- Stepping down to lower cost models is consistent with the objectives of the CYFA framework

7.3.3   Benefits to the community and government

There are wide ranging short and long term benefits to government and community as a result of the significant positive impact of TRCs. These arise from reduced immediate and longer term demand on services due to the impact of positive client outcomes and improved mental and physical health of children and young people in TRC. Some of these benefits are outlined below:

Short and Medium-term benefits to government

- A definable political benefit, stemming from reductions in the numbers of young people involved in crime; demonstrating a more effective system of OoHC

- An increased capacity to redirect resources to other areas, with a reduced draw on services such as police, court, juvenile justice, and juvenile detention

- A broader benefit to other government services and the community in general due to Police having greater capacity to do things other than transport at risk young people

- A reduced draw on health, welfare, and community services

- Reduced property damage (e.g. schools; residential units; general community)

- Reduced cost of Quality of Care investigations

- Reductions of re-entry into the OoHC system

- Reduced cost of post-exit supports

- Benefits of less use of hospital and other community services

Longer term benefits to government

- Reduced inter-generational welfare and related services

- Increased workforce participation and contributions to tax revenue

- Better citizenship

- More positive life trajectories improve the likelihood of a reduced demand on health and mental health services in the longer term

- Release of resources to work in other areas

- Reduced rates of incarnation of this population in adult life

7.4 Conclusion

There are clear financial and economic benefits of TRC – some quantifiable in the short term and some not, due to their qualitative nature or longer term impacts that have not yet been measured. Most identified benefits have a basis in or are supported by relevant literature and studies.

Costs, Costs avoided and economic benefits in this evaluation were calculated based on a comparison of audited CRIS data for young people pre and post entry into the TRC Program. Financial benefits were realised based on the young people's reduced interaction with police, hospital, secure welfare and other community services. Placement changes are a major component of system costs for young people in OoHC. Following entry into the TRC Program, the significant reduction in the number of placement changes compared with the young peoples' previous OoHC experience provided a financial Program benefit as well a potential future economic benefit both to the young people and society in general.

The cost of increasing the availability of Therapeutic Residential Care could be partially offset through costs avoided due to: fewer placement changes; and fewer interactions with police and other community services. As the Program matures it is likely that the costs avoided will increase and other costs that can be avoided will also be identified.

Longer term economic benefits are indicated through improvements in key outcomes that impact significantly on young people's life trajectories. Significant improvements were observed in the areas of: physical health (nutrition, sleep & exercise); mental health engagement in recreation; school attendance and concentration; peer and family relationships; and reduced risk taking behaviours.

8 Ongoing Evaluation Framework

This section responds to the evaluation question: What is an appropriate evaluation framework and related survey instruments that can be applied to all residential care services within the OoHC sector?

This section details the evaluation tools and the way they align with the Child Protection, Placement and Family Services Outcomes framework. Commentary is also provided that supports recommendations for an ongoing evaluation framework. Insight is also provided regarding other available data bases and the extent to which they may be used to provide data for ongoing evaluation. This section also makes recommendations regarding the survey instruments that the evaluators believe will provide DHS with robust evidence to support ongoing service improvements, high quality outcomes, change processes and justification for the funding levels required to support the Therapeutic Model. We have also provided recommendations regarding the applicability of the frameworks and instruments to the wider OoHC sector.

Summary of Findings

- The Child Protection, Placement and Family Services Outcomes Framework; which includes: (a) Outcomes, (b) Indicators and (c) Measures formed the framework used to report findings in this evaluation.

- The Framework is robust and with minor changes has been recommended as the framework for ongoing evaluation and has broad applicability across the OoHC system.

- Most data used in this evaluation was obtained through the administration of three instruments; the Brann Likert Scales, the HoNOSCA and the SDQ. These instruments were robust and cross validated the results. The Brann Likert scales provided the bulk of the data and this was designed to be aligned with the outcomes detailed in the Child Protection, Placement and Family Services Outcomes Framework. The more clinically sensitive and internationally validated instruments (the HoNOSCA and SDQ) were particularly important in describing the young people's mental and emotional health. These instruments should continue to be applied in residential services (general and TRC).

- Data from other sources were limited and difficult to access (particularly CRIS) and important information such as incident reports requires access to extensive file notes to interpret the meaning. The evaluators have proposed the development of a minimum data set with applicability and benefits to the OoHC system.

- The TRC has a treatment focus; this distinguishes the TRC from the Residential Care system which is focused on meeting basic needs and providing safe accommodation. Changing the system to reflect the KPIs in evaluation framework will require significant cultural, procedural and system changes. A quality system as described would aid this change.

8.1 Alignment with the Framework

The evaluation of the outcomes for the young people in TRC Pilots aligned with Youth and Families Act 2005 (CYFA) and the Best Interests Framework which states; "At the

heart of the Children, Youth and Families Act 2005 (CYFA) is a unifying set of 'Best Interests principles' that require family services, child protection and placement services to protect children from harm, protect their rights and promote their development in culturally, age and gender appropriate ways. The Best Interests framework for vulnerable children and youth has been developed to support a consistent understanding of these principles and their practice ramifications."

The Child Protection, Placement and Family Services Outcomes Framework was adopted in 2009 by DHS. The 'Framework' includes; (a) Outcomes, (b) Indicators and (c) Measures. The Client Outcomes (Section 6) in this report detail sub headings that generally align with the 'Framework's Outcomes'.

The survey instruments used in this evaluation are more comprehensive and insightful when measuring the outcomes domains 'Achieving Positive behaviour and mental health'. While reporting on this outcome the evaluators have decoupled positive behaviour and positive mental health thus providing measures that address both these issues. This enables a level of insight that the evaluators regard as being necessary when measuring progress for young people in the TRC and the evaluators would regard this information to be important across OoHC services.

The evaluation framework for this study measures:

- Outcomes contained within the Child Protection, Placement and Family Services Outcomes Framework

- Change for the young people over time against these outcomes

- Status of the young people against normative data or other similar service entry scores where available

- Change for the young people compared to their experience in alternate programs

8.2 Aligning Data with the Framework

8.2.1 Outcomes Evaluation Tools

Brann Likert Scale

The Brann Likert Scales developed by Dr Peter Brann for this evaluation are specifically designed to align with the Child Protection, Placement and Family Services Outcomes Framework. Sensitivity and validity of the tool was confirmed when measured against the two clinical tools used to evaluate the young people in the TRC Pilots, the HoNOSCA and the SDQ. The three tools provided cross validation regarding the outcomes for young people however only the Brann Likert Scales measures outcomes specific to program KPIs. Attachment 3 provides greater detail of the measures in the Likert Scales and demonstrates how they align with the framework outcomes and indicators and measures.

HoNOSCA

Nine of the fifteen HoNOSCA measures align partially or particularly with the child protection, placement and family services outcomes framework, indicators and measures; relevant areas include;

- Family relationships; Carer relationship are included in the family relationships score

- School attendance

- Scholastic/Language difficulties

- Peer Relationships

- Concentration

- Physical illness/disability

- Non –organic somatic

- Self care

- Substance misuse

The HoNOSCA was developed in response to the need to measure the health and social functioning of those suffering from mental illness[28]. As a tool to respond to the particular measures and indicators detailed in the child protection, placement and family services outcomes framework the HoNOSCA on its own has some limitations, for example; family relationships includes a broad range of considerations in the measure applied by the rater[29] which do not provide the particular detail being assessed in the 'frameworks' measures. In the example given there is only one data set reported in the HoNOSCA; a score for family relationship.

SDQ

The SDQ is used to meet the needs of researchers, clinicians and educationalists detailing; emotional symptoms, conduct problems, hyperactivity /inattention, peer relationship problems and prosocial behaviour.

Reporting Mental and Emotional Health

The HoNOSCA and the SDQ are sensitive and valuable tools to evaluate the mental and emotional health of the young people. The Brann Likert Scales measures the positive sense of self and a range of counts and measures relative to risk taking, remand, detox and use of mental health services however SDQ and HoNOSCA provide far greater insights into the measures of symptoms, chronicity and change to young people's mental and emotional health. The SDQ and HoNOSCA provide specific insight into the 'Frameworks' KPIs:

- 'Outcome: Achieving positive behaviour and mental health'

- 'Indicators: Children with mental health problems and children, and young people in OoHC who self harm'

- 'Measures: % of children and young people who are free from emotional and behavioural difficulties and % of children in OoHC who self harm – cat 1'

The HoNOSCA and SDQ are internationally validated tools that provide reliable insights into the progress of the young people's mental health and emotional functioning with the capacity to measure the chronicity against other studies, normative data, Take Two and CYMHS. However these tools do not broadly address the measures that uniformly or comprehensively align with the Child Protection, Placement and Family Services Outcomes Framework, indicators and measures.

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[28] http://www.liv.ac.uk/honosca/

[29] Family Relationships; Rating for problems with family life and relationships; Includes parent-child and sibling relationship problems; Includes relationships with foster parents, social works or teachers in residential placements; Relationships in the home with separated parents and siblings should both be included; Parental personality problems, mental illness, marital difficulties should only be rated here if they have an effect on the child or adolescent; Includes problems such as poor communication, arguments, verbal or physical hostility, criticism and denigration, parental neglect or rejection, over-restriction, sexual or physical abuse; Includes sibling jealousy, physical or coercive sexual abuse by sibling; Includes problems with enmeshment and overprotection; Includes problems with family bereavement leading to reorganisation

8.2.2   Other Data Sources

Other data sources are available to evaluate the framework outcomes, indicators and measures and drew information from VicPol and CRIS in the course of the evaluation. No information was drawn from DEECD (NAPLAN) although in an ongoing evaluation framework this data should be considered. We are unable to comment on the Child and Family Services Outcome Survey as it was not made available to the evaluators.

CRIS

The data drawn from CRIS involved significant resources (3 people for 2 weeks to provide limited data for 20 young people from the Department and significant additional analysis from the evaluators to use the data) as detailed in 7.5.2 Cost and Benefit and Analysis. The challenges involved in using this data included:

- the need to appropriate clearances and training to access the data

- the data not being organised in a manner that aligns with the framework

- the accompanying file notes need to read in many cases to qualify the data

- the need for additional analysis to be able to use and report findings from the data

Data included: length of stay in the TRC, placement history, secure welfare placements, warrants, hospital (detox, mental health service), age when first entering OOHC, and gender

Victoria Police

A particular study carried out in a police region was drawn on for the cost and benefit analysis. The study highlighted the wealth of data that may be both useful and available to measure the KPIs within the 'framework'. Data provided was for 47 young people who were residing in residential care and possibly in the wider OoHC care when they first came in contact with the police. The evaluators were able to use a particular study rather than access a generic data base. Details in the study included:

- Age of client as of 30/6/2011

- Addresses known to Police where client has resided

- First formal contact with Police

- Last formal contact with Police as at 30/6/11

- Police involvements in transporting clients

- Reports to Police for investigation

- Warrants executed by Police

- Warrants required to be cancelled by Police

- Warrants issued by Police/Courts for execution by Police (bench)

- Offences clients have been charged with

- Criminal Investigations conducted per client

DEECD (NAPLAN)

No use was made of this data however it may prove useful for future and ongoing evaluations.

Child and Family Services Outcome Survey

The evaluators note that the Child and Family Services Outcomes Survey is able to collect qualitative and quantitative data that when taken together report on the indicators in the 'Framework'. We understand that the survey partially or fully collects data that responds to 51 of the 64 measures with the balance (13) coming from LAC, CRIS, IRIS, Quality of Care and QID.

The evaluators are only able to make recommendation regarding the tools that have been employed in this evaluation; the Brann Likert Scale, the HoNOSCA, the SDQ and the quality of information sourced from an intensive file audit of the CRIS Data and information reported by Victoria Police. We appreciate:

- the conditions under which the data was collected

- the consistency of the findings (cross-validation)

- the management of data entry, and data analysis

- the qualitative measures used to cross validate findings

- the qualifications of those who supervised the ratings or collected the data

The evaluators were unable to comment on the degree to which the Child and Family Services Outcome Survey (CAFSOS) aligns with this robust methodology. The evaluators are uncertain about the degree to which the term partial applies (notes in 'measures see Attachment 3) in the application of this instrument. The evaluators are aware of the unreliable nature of some data from CRIS taken without reference to case file notes.

The child and family services outcome survey addresses some data sets that are outside the remit of the ongoing evaluation framework addressed in this response such as; Number of non-accidental deaths per year where the cause of death is attributed to child abuse or neglect. However as this tool has been designed to populate most of the measures in the framework it may form the basis of an alternate approach to the recommendations in this section.

8.2.3   Summary Aligning Data with the Framework

Attachment 4 details the manner in which the Brann Likert scales provides a comprehensive response to the measures in the Child Protection, Placement and Family Services Outcomes Framework within the context of a Therapeutic Residential Care model. Within this context Brann Likert Scales provide the most comprehensive and best aligned tool to support ongoing measures (also note the alignment with the National Standards for Out-of-Home Care July 2011 Attachment 4).

The SDQ and HoNOSCA provide a reliable and clinically appropriate tool to measure emotional and mental health.

These three instruments when combined provided rich and useful measures effectively reporting behavioural change and mental and emotional health change. The tools also measured progress being made towards desired outcomes. The three instruments have provided cross validation of the results detailed in client outcomes. The figure below plots the total standardised scores for each of the instruments, measuring reductions in adverse results. The alignment of trends supports the assertions made in this section. Also of note is the rapid change of behaviour scores measured by the Brann Likert Scales, versus the slower initial rate of change for the emotional and mental health ratings as described in the Client Outcome Section.

Figure: 86 Aggregated Outcomes plotting reductions in adverse measures
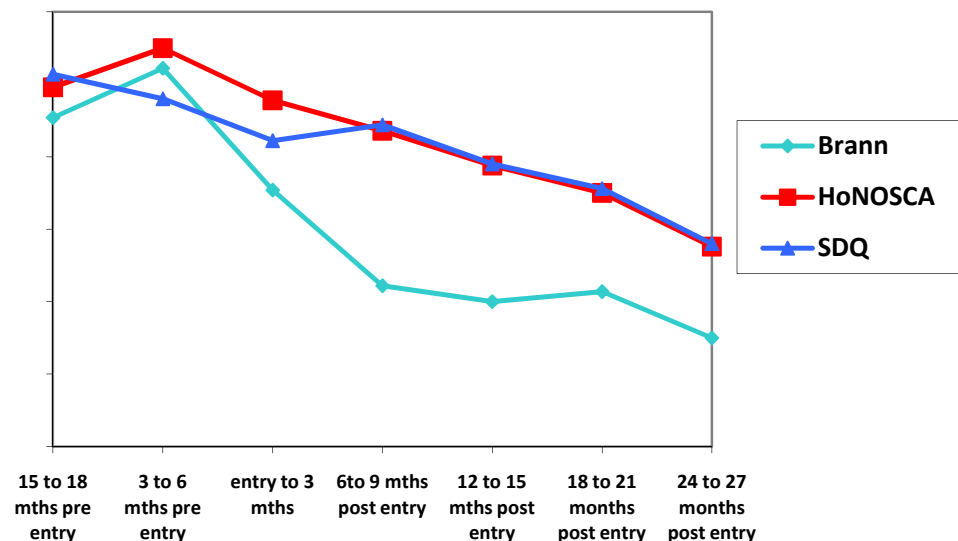
8.3 Developing a Minimum Data Set

Consideration should be given to developing a minimum data set to enable the DHS to collect and report on a range of critical 'framework' measures. The evaluators cite the Home and Community Care minimum data set as one such example.

The proposed elements of minimum data

The minimum data the evaluators consider would be required is:

- A unique identifier that remains with the child/young person over their journey in OOHC
- Links to other identifiers such as police and education
- Mother's Maiden Name (to provide a constant cross reference if other names change)
- Date of birth
- Gender
- Aboriginality
- For Each Episode of care (each and every subsequent placement the same data to collected):
    - Age and date of entry into OOHC
    - Length of stay
    - Type of care
    - Unplanned nights missing from care
    - Days expected at school
    - Days missed at school

- Age and date of exit
- Agency (code)
- Incident report: date, category, victim/perpetrator/witness, type of incident
- Missing Persons
- Warrants: raised, withdrawn, executed, (coded category of warrant)
- Secure welfare admissions and length of time in secure welfare (per episode)
- Hospital/detox/mental health episode (coded)
- Hospital/detox/mental health entry and exit date

The Benefits of this data set

A minimum data set of this nature would enable DHS to report on a limited range measures in the framework. Some of the data collected for this evaluation through CRIS provided significant and vital information that had not been fully reviewed in the format of the evaluation yet is critical regarding the young people's wellbeing such as one young person in the TRC experiencing 45 changes of placement prior to entering the TRC and a group of eight young people who have entered residential care 12 months prior to TRC and experienced on average four placement changes prior to entering the TRC. The Circle program reports that they do not have consistent information regarding the number and type of OoHC placements and therefore are unable to take the possibility of secondary trauma that may occur due to their child's unstable placement history.

The minimum data set would enable DHS to maintain robust data regarding the costs avoided in the TRC and other initiatives in the OoHC system.

The Client Outcomes Report provides evidence that the current critical incident data is possibly misleading and therefore improvements to the process, training and coding of these reports requires attention. In addition there would be benefit from accessing other data bases such as the police e.g. one male young person who had been in residential care had the following history of police involvement, the data was accumulated over eight years; 15 missing persons reports, 51 warrants of which 33 were executed with an additional two police/bench warrants and 227 charges with 34 criminal investigations.

A minimum data set as described could be uniformly applied across OoHC and would prove to be useful to Peak Bodies, planners, CSOs and to support funding arrangements. The minimum data set would not provide significant outcomes data on change over time for the children/young people and rates of change against the 'Framework'.

The proposed elements of minimum data

Several of the measures are proposed to ensure that the young person's placement history can be tracked overtime (mother's maiden name, date of birth, gender and unique identifier). The 'Framework Outcomes' that a minimum data set would address include:

- Safe from injury and harm: Incident reports, missing persons, warrants, secure welfare admission, hospital admissions/exits, unplanned nights missing from care

- Mental health & positive behaviour: change of placements and number of placements[30], hospital admissions/exits, links to police data base

- Connected to School and Community and Achieving Optimal Education and Learning: Days expected at school, days missed at school, change of placements and number of placements

8.4 The Context for Ongoing Evaluation

An ongoing evaluation framework with its associated measures and reports would provide the context and opportunity for service and quality improvements. Progress for the young person and the capacity of individual services to support the young people to realise the goals of the Child Protection, Placement and Family Services Outcomes Framework could be more readily and consistently achieved within a continuous quality improvement framework.

The evaluators considered the 'community reporting' used by the Department of Health and Ageing (DoHA) as a process that may be beneficial for the OoHC system. DoHA's community reporting system is a non punitive audit system that requires agencies to self rate and site visit audits and ratings conducted by DOHA that results in the development of a service improvement action plan that is periodically updated.

If a process of this nature was adopted by DHS it would facilitate considerable cultural and service design changes required to accommodate a significantly different premise for service delivery than the premise that currently exists particularly in general residential care.

The existing premise for residential care as described by DHS regional managers is, safe accommodation where the young people's basic needs are met. In his two-part review, Howard Bath describes the need to shift from a system that focuses on mitigating effect of damaging behaviours (self and others) to supporting healing processes, the attainment of age appropriate milestones and being supported to achieve their goals (Bath 2008a; Bath 2008b). Bath maintains that the current system merely meets care and accommodation needs.

The premise of the TRC is "If a particular set of therapeutic resources are applied consistently for children and young people in Therapeutic Residential Care settings it can be expected that outcomes for those clients will be superior in comparison to outcomes experienced by clients in residential care settings where those resources are not applied." In essence the new premise is treatment focus and commitment to meeting the multiple needs of young people (the attainment of age appropriate milestones and being supported to achieve their goals). This new premise as demonstrated in the TRC requires new ways of thinking and acting and it requires new systems and procedures. The focus on treatment requires an elevated capacity to monitor and evaluate clinical outcomes and processes within a quality framework and requires the input of a professionally accredited body.

The Brann Likert Scales, HoNOSCA and SDQ are reliable instruments to monitor and report, a quality reporting system would provide a context and opportunity for the ongoing evaluation to produce the required cultural and system change.

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30 Placement instability or drift, is strongly associated with worse outcomes (Osborne and Bromfield, 2007; Wise S, Pollock S, Mitchell G et al, 2010) including schooling and subsequent life chances for young people. Several studies support the contention that placement instability lasting for more than 12 months is more strongly linked with a higher prevalence of psychological, social, and educational difficulties (Osborn and Bromfield, 2007; Cashmore and Paxman, 2007; Stone, 2007).

A method used in the health system for quality reviews is the use of formalised peer review processes. This approach would have the opportunity of spreading individual learnings and innovation across the system.

8.5 Recommendation

The evaluators recommend that the Child Protection, Placement and Family Services Outcomes Framework form the basis of an ongoing evaluation framework for the OoHC system. The evaluators recommend that the indicators and measures be refined to reflect the specific targets of OoHC and measures related to mental and emotional health are consistent with wider clinical practice.

The evaluators recommend that the following be adopted with regard to an ongoing evaluation measures and processes with applicability to OoHC (including TRCs):

- A minimum data set be developed with associated reports (or refined from data sets already recorded within CRIS)

- The incident report data be collected in a consistent manner and codes be developed that support better interpretation of the data

- That the best use is made of other data bases to report outcomes

- A quality reporting system be adopted for all therapeutic OoHC services

That within residential care (TRC and Generalist Care) that the following instruments be adopted:

- Brann Likert Scales (with a reduced number of measures and counts); administered at entry into Residential Care programs and then at six month intervals after that date

- HoNOSCA; administered at entry into Residential Care programs and then at six month intervals after that date

- SDQ; administered at entry into Residential Care programs and then at six month intervals after that date

Administration of the tools is managed in a manner that ensures that the data remains reliable and return rates remain high with acceptable levels of missing data including the following:

- Persons who will administer the tool in individual agencies will require training

- Data gathering, entry, analysis and reporting is managed within a performance management framework

- Ethical Management of the data (de-identified format) and storage

- The findings are reported in manner consistent with the client outcomes data (Section 6) of this evaluation

8.6 Addendum to the Discussion

While completing the final report the National Standards for Out-of-Home Care (July 2011) were released[31]. The recommendations in this section are in accord with these standards. The ongoing evaluation framework proposed in this section would enable

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31 http://www.fahcsia.gov.au/sa/families/pubs/nat_std_4_outofhomecare/Pages/default.aspx; accessed 07/09/11

DHS and CSOs operating the services to evaluate the extent to which the standards are being realised. However to report on the measures additional attention would be required to gather responses from the young people. Minor adjustments and editing of the Brann Likert scales would enable the data gathered to be fully aligned to the measures contained in the National Standards.

9 Summary of Recommendations

The Recommendations and service improvements detailed below represent a synthesis of the full report narrative and findings. In many cases they align with specific Sections (in particular service improvements), however other Recommendations draw together a series of findings.

This section responds to the evaluation questions:

- What elements and learnings from the TRC pilots can be applied to other pilots and to other aspects of the out-of-home care service system?

- How and to what extent do these various program elements that together comprise the Hurstbridge Farm model (TRC Pilots) contribute to the outcomes achieved by clients? How can these elements be further improved?

- In what other ways can Therapeutic Resi Care be improved?

9.1 Recommendations

Recommendation 1:

Implement service improvements identified in this report and summarised in Section 9.2 Program Service Improvements.

Recommendation 2:

That the 'pilot' status of the TRC programs be removed, authorizing them as a legitimate and on-going models of residential care

Recommendation 3:

Utilise the findings of this report to shift from a 'care and accommodation' focus to a 'treatment' focus (Therapeutically Informed services) across OoHC (this is consistent with Howard Bath's recommendations[32]) giving due consideration:

- a recognition that all young people entering the system are likely to have suffered trauma and this trauma will impact significantly on their capacity to attain normal developmental goals and on their opportunities in life

- recognition that the current system increases the likelihood that secondary trauma will be imposed on these young people

- the opportunity (as demonstrated by the research in this report) to develop an alternate system and approach with the potential for far reaching impact on the young people and Australian society in general

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[32] Bath, H, 2008a Residential care in Australia Part 1: Service trends, the young people in care, and needs-based responses. *Children Australia*, 33(2), 6 - 17.

- move the focus from mitigating effect of damaging behaviours (self and others) to supporting healing processes, the attainment of age appropriate milestones and being supported to achieve their goals (in program and after exit from the program)

Recommendation 4:

Progressively expand the TRC Program to eventually incorporate most[33] Residential Care sites across the State which will also necessitate the development of:

- alternate arrangements and models to respond to emergencies, to reception and with added contingency capacity

- an alternate model to manage intake processes including the time taken to facilitate appropriate transitions and to support the management of client mix in current TRCs

- the development of an implementation framework that includes and or considers elements such as; resources, budget, schedules, project management requirements, communication strategies, additional research activities, vital agreements required to realise recommendations, identification of barriers, knowledge management, cultural change, housing requirements, workforce capacity

Recommendation 5:

Undertake and maintain population based planning to provide accurate predictions of the future demand for residential care with additional consideration being given to:

- the reducing availability of foster carers (a current National and International trend) with specific insight into how this will impact on the requirement for alternate OoHC arrangements

- the exploration of the relative effectiveness of Therapeutic Care in the alternate OoHC settings (literature suggests Residential Care may provide the best platform for the Therapeutic Care for young people who are trauma effected)

- explore therapeutic effectiveness with regard to the young person's age, placement history and chronicity

Recommendation 6:

Develop a minimum data set to; measure the effectiveness of the program and the quality of the program, to aid reporting on the program and to support continuous improvement. The data will be referenced to:

- Based on the Child Protection, Placement and Family Services Outcomes Framework

- That measures young person's chronicity at entry to the TRC

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[33] Most: TRC staff and Therapeutic Specialists report that many young people over 15 years of age (at entry) who have experienced multiple placements and have ingrained behaviour are less likely to benefit from the therapeutic approach – within this recommendation consideration should be given to this cohort and what alternate arrangements would best suit their needs. It should also be noted that chronological age and developmental age will vary greatly.

- That provides evidence of the young person's progress in the TRC against the Child Protection, Placement and Family Services Outcomes Framework

- That measures the effectiveness of each site against the Child Protection, Placement and Family Services Outcomes Framework and the key elements of TRC (detailed in this report)

- That measures the first 2 years of the young person's exit from the program (a new tool and protocol will be required to develop the data gathering)

Recommendation 7:

Develop an approach to continued resourcing based on the efficacy of the program for the young person and society and giving due recognition to the capacity to reduce costs occurring in other parts of the system both within DHS and across Government. This will require understanding and acceptance at Political and Departmental level of the required reallocation of resources, resource demands, timeframes for change, timeframes to reduce resource demands in other services and the benefits of such an approach.

Recommendation 8:

Undertake consultations to clarify information exchange and to overcome barriers with regard to facilitating effective therapeutic processes and assessments across TRCs. This process should include the development of a Cross-Government Steering Group including the development of recommendations, directives and the identification and support of legislative changes (if required). Consultations, barrier identification and new protocols (directives) to include the following groups:

- Inter-departmental (Government)

- Intra-departmental (DHS)

- Children's court/Legal profession

- Peak Body Organisations

- The Commissioner for Child Safety

- Therapeutic Specialist professional bodies and auspice organisations (Take Two, CYMHS etc.)

- Victoria Police

Recommendation 9:

Develop a more coherent and effective post exit care response and program that includes:

- Adequate resources such as; housing, vocational training, emotional support, Therapeutic Care, ongoing schooling and/or employment support

- Resourcing that aligns with population planning and data related to the likelihood of successful family reunification

- An approach that is consistent with the TRC model

- Recognition of the benefits to the young people and to communities (including the economic benefits) of post exit responses/destinations that ensure young people have access to the support they require particularly; education/employment, stable and secure housing and ongoing emotional and relational support.

Recommendation 10:

Support the development of a professional body for Therapeutic Specialists, encompassing accreditation, training, clinical support in order to further develop and maintain this emerging workforce.

9.2 Program Service Improvements

Table 32: Service Improvements Recommendations

Reference	Improvement	Detail
Service Improvement 1: Page 46	Develop an accord	Develop an accord regarding those elements of the Therapeutic Specialists work that cannot be compromised and a clear description of the Model and the identification of the active elements of a TRC Model that cannot be compromised. The accord should include CSOs, Take Two, CYMHS, DHS and the individual Therapeutic Specialists.
Service Improvement 2: Page 46	Develop a 'Community of Practice'	The Therapeutic Specialists would benefit from developing and maintaining a 'community of practice'. A community of practice could facilitate the exploration the evolving development of Therapeutic Approaches with regard to program implementation and clinical care. This includes the evaluation and appreciation of International developments in the field. The 'community of practice' could emerge as a National body with International links.
Service Improvement 3: Page 53	Mandatory training for CSOs	Require all staff working in the TRCs to undertake all Stages of the Therapeutic training (see above), with Stage 1 specifically included as part of their orientation prior to commencing work in the TRC

Require CSO Management to undertake the 'With Care' two day training as part of their orientation prior to commencing work with the TRC or for those in CSO Management who have not yet undertaken the two day 'With Care' training

Maintain a consistent regime of Stage 1-4 training with scope for additional sessions in response to CSO requests

Promote regular TRC CSO days as a platform (among other things) to share approaches to rostering, training and Reflective learning

(A number of initiatives have already been implemented or are in planning to support these recommendations) |
| Service Improvement 4: Page 53 | Remuneration increases for training attainments | Additional remuneration for staff who complete approved training programs associated with the Therapeutic Residential Care should be available. This would serve to:

- Underscore the value placed on the training by the CSOs and DHS
- Reinforce DHS's commitment to the program and its underpinning theories into the long-term
- To telegraph to staff an appreciation of their attainments and their commitment to the model and its impact on the young people |

Reference	Improvement	Detail
Service Improvement 5: Page 57	Child Protection and DHS Placement Coordination units training	(Building on Service Improvement 3), Child Protection and DHS Placement Coordination units should be required to participate the Take Two trauma and attachment 2 day training[34]. The recommended participation will support an understanding of the underpinning theories and practices of the TRC such as client mix and how it impacts on their role in referral and placement
Service Improvement 6: Page 57	Child Protection and Placement Coordination standardised background and referral documentation	Develop standard documentation regarding the profile of young people being targeted to fill a current vacancy. The documentation should collect the extensive information required in a treatment focused system compared to the current arrangements focused on care and accommodation
Service Improvement 7: Page 59	Ensure that Care Team meetings have the all relevant people in attendance	Ensure that all TRCs have a Therapeutic Specialist available to attend regular Care Teams and have a contingency arrangement to cover absences and vacancies. This is aimed at ensuring that the Care Team meeting regularly occur and that the pivotal role of the Therapeutic Specialist is a constant in those meetings. Care Teams have all relevant people attend including police where appropriate Supporting the participation of young people and families where appropriate
Service Improvement 8: Page 61	Ensure that Reflective Practice is supported consistently by the Therapeutic Specialist	Ensure that all CSOs have a Therapeutic Specialist available to attend regular reflective practice meetings and have a contingency arrangement to cover absences and vacancies. This is aimed at ensuring that not only do reflective practice meetings occur regularly, but also that the pivotal role of the Therapeutic Specialist is a constant in reflective practice
Service Improvement 9: Page 65	Develop a therapeutic system	Develop a 'therapeutic system' to facilitate the shift from systems and procedures that support accommodation and care to a therapeutic system that facilitates and supports a treatment focus. Elements include: The development of a quality system for the TRCs that includes practices for CSOs and all of the DHS personnel involved in the TRCs. The quality system would serve to provide a framework to measure the application of agreed practices for all parts of the system outside the Pilots and to facilitate improvements to cross department practices such as the interaction between Youth Justice, Child Protection and the CSOs. Develop better and a more consistent approach to accessing and sharing records across Departments and jurisdictions
Service Improvement 10: Page 65	Improve congruence through training and discourse	Make the 2 day 'With Care' Training available for all Regional DHS staff regularly interacting with the TRC or the individual young people in the TRC Begin organisation to organisation discourse to identify barriers to communication and engagement and develop a joint action plan to resolve blockages
Service Improvement 11: Page 65	Cross Agency Training and Briefings (courts and legal)	Magistrates and judges in the Children's Court and other associated legal professionals should be provided with briefings regarding the outcome of this evaluation and the underpinning theories

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34 Take Two provides trauma and attachment training for child protection and at the time of preparing this report plans were being developed to train DHS Placement and Coordination units.

Reference	Improvement	Detail
Service Improvement 12: Page 67	Maintaining the exterior of the TRC Units	Ongoing attention need to be paid to the exterior of the TRC homes so they are consistent with similar houses in street; to reinforce normalisation.
Service Improvement 13: Page 71	Develop the supports required to continue the emotional and mental health improvements	Develop a more coherent and effective post exit care response that supports the time and resources required to continue the emotional and mental health improvements experienced by the young people.
Service Improvement 14: Page 71	Ensure Congruent approaches to maximise outcomes for young people by avoiding premature exits	Build on service improvements 11 and 9 to ensure that young people can maximise the benefits of the TRC by remaining in the TRC for the length of time that will support behavioural change. This can be achieved through congruent arrangements internally within DHS and externally e.g. the courts
Service Improvement 15: Page 71	Make better use of all Government funded programs	Greater use could be made of all Government initiatives targeted to support young people at high risk such as vocational training options, employment services. TRC Pilot staff should be provided with comprehensive information regarding, housing, employment, vocational training, mentoring supports to assist them in exit planning and in the one-on-one discussion they have with the young people
Service Improvement 16: Page 86	Standardised documentation for filling vacancies	Establish a uniform approach for documenting and describing the client mix at the time of a vacancy arising and the characteristics and restrictions regarding the young person the CSO considers appropriate to fill the vacancy
Service Improvement 17: Page 86	With Care Training available to all stakeholders	Offer the 2 day with care training to all Stakeholders
Service Improvement 18: Page 86	Identify the information sources and information required and where and how to access the information	Identify the information consistently required by CSO's to enable a comprehensive background to be developed of the young person to facilitate therapeutic processes in the TRC; • identify where that information is held; • identify the protocols and clearances required to access the information • develop a system wide approach to overcoming the issues related to accessing this information. Information should include documentation such as; • full placement history; • full history of police history; • family history including the circumstances that have led to trauma; • family structures andinteraction; • academic performance; likes/wants/wishes/preferences; • behaviours and adverse reactions; • secure welfare; • hospital/detox/mental health (accompanying records); medical records; medications and details of medication reviews. Identify blockers and problem-solve to overcome these issues (perceived or actual).
Service Improvement 19: Page 91	Clearly articulate and manage the Knowledge of the TRC Model	Foster leading and evolving practice in the TRCs though knowledge management including; what is the knowledge, who holds the knowledge, the prime knowledge transfer and identify how the knowledge is transferred. To facilitate knowledge management an action plan should be developed and monitored

Reference	Improvement	Detail
Service Improvement 20: Page 93	All training programs being used in TRCs should be reviewed	Undertake a review of all training in the TRC. This process should support the maintenance of clarity regarding the essential elements of Therapeutic Residential Care and seek to cement these elements through training.
Service Improvement 21: Page 93	Review all tools used in the TRCs to support the development of a consistent, effective and sensitive set of tools to be used across TRCs and the OoHC system	Peer review and discussion regarding the usefulness and the application of tools should be undertaken to develop therapeutic practice in the TRCs. This type of review should result in recommendations regarding a range of standard tools for assessment of the young person and to measure the progress they are making.
Service Improvement 22: Page 93	Develop a practice and policy manual	The practices employed in the TRC Pilots should be developed into a policy and practice manual to be used as part of a continuous quality improvement process and to orientate new staff to TRC Pilots. This initiative could be invaluable in supporting the development of new pilots

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11 Attachments

- 1: TRC Evaluation Project Literature Review, Verso Consulting, December 2010

- 2: Essential Service Design Elements, DHS, September 2007

- 3: Child Protection, Placement and Family Services Outcomes Framework, DHS, (Approved 2009)

- 4: Brann Likert Scale Alignment with Frameworks

- 5: Cost and Benefit Analysis

CHILDHOOD TRAUMA AS A MENTAL HEALTH DIAGNOSIS: WHY WE CANNOT AFFORD NOT TO UNDERSTAND

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Joint Submission to the

Victorian Royal Commission into Mental Health, 2019

Contents

Forewords

Dylan Langley, Ambassador for '*The Home Stretch*'

Mr. Dylan Langley, Home Stretch Ambassador, Young Leader for the Centre for Excellence in Child and Family Welfare, & DHHS Youth Expert Advisory Group.

Home Stretch believe an option should be available for youth in the Out-of-Home Care system to remain in care until the age of 21.

The Centre for Excellence in Child and Family Welfare advocate for the rights of children and young people to be heard, to be safe, to access education and to remain connected to family, community and culture. They represent over 100 Victorian organisations working across the continuum of child and family services, from prevention and early intervention to the provision of out of home care.

In my experience as a child of the out of home care system I have witnessed poor mental health outcomes for many young people in OoHC, especially those transitioning into leaving care, resulting in aggression and violence, self-harm, destructive behaviours, and suicide. The current systems and processes need to change their way of thinking and approaches to the mental health of children in OoHC.

This submission shows the benefit of "injury approach" thinking over the "pathological approach" to human dysfunction. My experience was that only visible symptoms we treated by the system, and no one ever asked "what has happened to you?" That change alone would be hugely beneficial to young people, as it gives them the chance to share how they feel inside and the causes of their pain and not just their presenting behaviour.

It was certainly true for me that treatment approaches focused merely on labeling and putting my issues neatly in a box, and this was quite unhelpful, and I witnessed this to be true for many other young people.

The biggest impact on the mental health of young people in OoHC that I have seen is the frequency of transition and displacement, meaning that a kid never develops strong roots or significant ties that shape their lives. A far too common question is, "what is the point of getting settled if I will be uprooted in a few days or weeks?" Good mental health requires stability and routines that these young people currently don't have.

I wholeheartedly endorse this submission and am pleased to have my name attached to this Foreword.

Rev. Scott Hawkins, OoHC Carer & Executive Board Member for Brighter Futures

Rev. Hawkins is a Carer of 6 children, 3 of whom have an Out of Home Care lived experience (2 in Permanent Care, 1 in Foster Care).

He is an Executive Board Member of Brighter Futures. Brighter Futures works in Melbourne's outer eastern suburbs to create new opportunities, in their local communities, for young people with an out-of-home care experience. Brighter Futures works in Maroondah, Knox and Yarra Ranges and put each young person's own life goals at the centre of their work.

Scott has over 32 years of experience working with, and leading, organisations that focus on youth at risk, especially those with a lived experience of homelessness, abuse, addiction, disability, offending, indigenous health, and out of home care.

As a practitioner and carer I appreciate that this submission seeks to place the mental health needs of young people in OoHC placed centrally and focuses on assessment, resources and care plans that properly address the mental health needs of these children.

Trauma is so significant in the lives of all young people with a lived experience of out of home care, and to ignore this is to ignore a key cause of many displayed destructive behaviours of kids at risk. This is certainly true for the children that I directly care for and all that I have encountered through my employment. Trauma informed interventions do have a significant impact on compulsive behaviours, addictions, and mental Health.

Instead of dealing with trauma, too often the current system compounds that trauma repeatedly through the constant upheaval and transitioning of placements. This must change. Too many young people are leaving care without this addressed and are completely ill equipped to cope with adulthood in health ways.

It is my privilege to endorse this paper and the mental health issues that it addresses.

Introduction by Adela Holmes

Cat's in the Cradle: Reimagining definitions of underlying causes in Mental Health for more targeted and cost-effective resourcing and impact.

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1. Systems' underpinning frameworks by definition determine their potential efficacy. The 1970's Harry Chapin lyrics of this introduction's title makes the point neatly in describing the logical outcome of a disinterested father's thoughtless parenting as being a thoughtless and disinterested son with, unsurprisingly, no time for his father. In the same way a service system can only be as effective as the way in which it is conceptualised and therefore implemented. It has been widely observed that the definition of stupidity is to keep doing the same thing again and again and expect a different outcome.

2. Our Mental Health service system struggles to meet the needs of its potential service users largely because, as we contend we will demonstrate in this submission, it has not kept apace adequately with emerging knowledge regarding the underlying causes of certain diagnostic categories. As a consequence of this it fails both its real target population because of unavailability and other individuals struggling with psychological distress that could be dealt with more effectively by being understood and provided with service in other more well targeted and therefore more effective, ways. These are approaches that have already been proven to demonstrate success but have not been adequately acknowledged by the very system that could operate more adequately if it did so. We will not in this submission, engage in speculation about the underlying reasons for this other than to point out the competing paradigms that exists between what may best be described as "medical model' understandings of extreme human psychological distress and those grounded in a "neurobiological, psychological and ecological" set of understandings. These are often at odds with each other in a strange kind of tussle for dominance, when in fact, each is applicable in certain circumstances and the tension is really about which applies in which case rather than one to the exclusion of another. Donald Schön (1983) speaks to this phenomenon in his work, describing the historical dominance of what he describes as the "major" over the "minor" disciplines. We contend that this kind of thinking in the design and provision of Victorian mental health services has offered nothing positive to users and has effectively "silenced" the further development and implementation of many extremely promising initiatives over time as a result of 'closed system' thinking. Systems persist in mistaking effects for causes and are apparently surprised when, attempting to treat the effect as a cause, nothing changes.

3. In this submission we discuss the emergent knowledge frameworks over the past twenty years of complex trauma/Post Traumatic Stress Disorder as it arises from extreme developmental adversity, its impacts on neurobiological organisation and development and consequently its manifestations in the form of a range of symptomatic presentations. These include states of extreme psychological and existential distress, many childhood/adolescent behavioural disorders, the regular criminalisation of these within a system that is required to heal & provide care, the metamorphosis of these into later more complex and troubling social, emotional and psychological states and the common trajectory into tertiary mental health/psychiatric, drug and alcohol, homelessness and criminal justice systems.

4. The underlying frameworks of knowledge referred to are well documented in the work of Doctors Bessel van der Kolk, Judith Herman, Sandra Bloom, Bruce Perry, Gabor Maté, Daniel Siegel; Professor Allan Schore, Dr James Anglin and others. These frameworks all speak of the role of extreme developmental/complex trauma arising from exposure to family violence, parental substance abuse, profound neglect; physical & sexual abuse and emotional abuse & neglect both in utero and in the first five years of life and the 'pain-based' behaviours (Anglin, 2014a) that arise as a result. It has long been recognised that traditional Child & Adolescent Mental Health Services do not adequately meet the needs of individuals who have complex trauma/PTSD presentations. This recognition is what led, in 2002, to the development of Take Two as a targeted outpatient service for children and young people so affected and then to the development of the model for the Victorian Therapeutic Residential Care pilots in 2008, including the prototype program, Hurstbridge Farm, the practice model for which was written and developed by the writer.

5. These frameworks guide towards what Dr Sandra Bloom (Bloom & Sreedhar, 2008) describes as the 'injury' rather than the 'pathological' approach to individuals who are troubled with extreme psychological and often existential distress.

6. If we take the 'pathological' approach to human dysfunction (what's wrong with you?) rather than, as Sandra Bloom suggests take the 'injury' approach (what's happened to you?) we spend our efforts on treating symptoms rather than what brought the symptoms about, thus never addressing the antecedent causes of the problem. Sitting directly behind the issue of our systems approach is the fact that our intervention service systems clearly seem to be predicated on this understanding, which, effectively mistakes on a grand conceptual scale, effects (symptoms) for causes.

7. An injury approach requires us to do more than just manage symptoms as if they were causes in and of themselves: it suggests, or presses us towards an intervention that addresses these causes-how could it not? The problem lies within how we define the task. Falsely premised and ill-focussed definitions lead to less than useful interventions.

8. Dr Thomas Insel (Insel et al., 2010), then chair of the American National Institute of Mental Health, stated his disappointment, at the publication of the DSM-5 in 2013, that the manual had continued to focus on symptoms as being the 'gold standard' for diagnostic categories alone rather than to

begin to incorporate the underlying causal factors Dr Insel saw this as a matter for regret and of lost opportunity to "lay the foundation for a new classification system" that "was not based on clusters of symptoms alone". Dr Insel stated that "symptom-based diagnosis, once common in other areas of medicine, has largely been replaced in the past half a century as we have understood that symptoms alone rarely indicate the best choice of treatment". Dr Insel, previously founding Director of the Centre for Behavioural Neuroscience at Emory University, Ohio, USA, has a background in psychiatry and neuroscience and speaks now of what we have long considered mental illnesses to be brain-based disorders, understandings related to the same underpinnings involved in new understandings of the neurobiology of traumatic adverse developmental experiences. Dr Insel has a major issue with the performance of established American psychiatric systems and what he sees as their failure to really help their patients. In his public speaking tour to Sydney he said that Australia was "leading the way in the three concurrent revolutions of neuroscience, genomics and technology & information science that could ultimately solve the crisis" in suicide rates that he states exists across the Western world. Dr Insel stated that of the utmost importance was that "we had learned that brain plasticity…had given hope that psychotherapies, learning tasks and brain exercises could give great benefit" (Insel, 2016).

9. Systems and 'treatment 'approaches that merely seek to label individuals but do little to address the underlying causes of what ails them are less than helpful. We know this because our mental health system struggles under the weight of the logical consequences of this kind of systemic conceptualisation, which is that individuals do not 'get better'. Rather they bounce back repeatedly into poorly targeted treatment services, clogging up a system which is unable to meet their needs. This circumstance is not limited to the mental health service system but affects many allied systems for the same reasons.

10. Our current mental health systems are, as a consequence, a dismal failure and are so overwhelmed that they seek to exclude and reject rather than include and provide sanctuary in times of extreme existential pain. We need only look at how our mental health systems are coping and and the existence of a Royal Commission into this to know that this is true.

11. In this submission we propose suggestions for a more calibrated framework for understanding of the continuum of states of mental and psychological distress. This utilises newer knowledge

frameworks and diagnostic categories arising from the fields of developmental/complex trauma, neurobiology and attachment and the causal relationship between profoundly traumatic early developmental experiences and the very troubled presentations arising from these.

12. We provide information regarding a particular approach that was piloted in Victoria between 2007 and 2010, formally evaluated to be successful (Verso Evaluation of Victorian Therapeutic Residential Care Pilots, 2011) but which has not to date been fully funded as recommended in the evaluation despite its level of success with a client group of approximately fifty extremely troubled young adolescents across 12 individual programs using the same model. Subsequent iterations of this model have had similar success which now demonstrates a sturdier number of more than 200 young people showing improved outcomes across the sample groups.

13. We suggest that the essential elements of this approach, which is firmly grounded in evidence from the fields of neuroscience and attachment provide a compelling and effective potential platform for the development of trauma informed interventions with a substantial segment of the Victorian community who are troubled with the lasting impacts of complex trauma leading to drug & alcohol addictions, psychological distress manifesting in presentations that lead to states of extreme marginalisation such as child protection apprehension, placement into out of home care, chronic homelessness, family violence, youth and adult justice issues and incarceration and recidivism. Many of these presentations are co-morbid with what are loosely termed 'mental health' conditions but may be (more effectively) dealt with in a system that recognises the causal factors involved and treats these definitively.

14. We contend that to do so would reduce pressure on a stretched mental health system by channelling into it only those with diagnosed psychiatric conditions who correctly belong within its treatment umbrella and capacity.

15. Reshaping the system in this way would potentially achieve a number of outcomes:
    15.1. Reduction of demand on the mental health system to a more manageable number
    15.2. Proper targeting of resource allocation in a way that matches service delivery to need and antecedents far more accurately and with far greater potential benefit

15.3.   Cost benefits across the entire service system along a time continuum and substantial improvements to the Victorian community's social capital

15.4.   Measurable improvement in outcomes for service system users

15.5.   Improved outcomes for children & young people within the Out of Home Care system

15.6.   Improved outcomes for children & Young People in the Youth Justice system including a reduction of children who graduate into it from out of home care as an unhelpful response to the acted-out symptoms of trauma

15.7.   Reduction over time in frequency & intensity of demand on family violence services

15.8.   Reduction over time of demand upon drug & alcohol service system

15.9.   Reduction of homelessness and services to address homelessness

15.10. Commensurate reduction of demands upon the policing system, criminal justice system both youth and adult.

15.11. Impact on the long term intergenerational nature of required child protection intervention.

16. People struggling with lifelong impacts of trauma would be helped to heal rather than become diagnosed out of or funnelled further through a poorly focussed mental health system as is now the case.

Adverse Childhood Events (ACEs) Impact as a Mental Health Disorder Construct by Katrina Streatfeild

Lifetime Economic Liability of poor mental health and socio-economic vulnerability

1.1. The reality of all support systems in communities, is that the bottom-line matters. That the investment is worth the outcome – that is how much does it cost to support a person with complex needs verses how much does it cost not to? And what does that support need to look like so outcomes are maximised and expenditure is minimised?

1.2. In speaking to vulnerable populations impacted by childhood trauma; here we refer to those families imbedded, often in more than one, of our most challenging helping and containment systems: Child Protection, Juvenile Justice, Adult Forensic Systems, Psychiatric and Public mental health systems, Drug and Alcohol Systems and so forth, the equation is a complex and long-term intergenerational one. To truly understand requires knowledge of many things, but for the purpose of this paper I offer the following two not negotiables:

1.3. A capacity to monetise the costs of the plethora of complex multi-generational, lifetime psycho-social impacts of not adequately addressing the needs of this population for our community – a challenging task within a 4-year, budget focused government planning process that will require unprecedented and significant fore-sight, an implicit understanding of wellbeing economics and the capacity to educate the wider community on the costs of not acting on this issue with political vigour,

1.4. A capacity to implicitly understand the impact of childhood trauma on an epidemiological, neurological, developmental, relational, emotional, psychological, social, occupational and somatic level, understand where and how this population presents in our support system and, consequently, fund appropriately targeted interventions using an intergenerationally-lensed perspective, tolerating that the most significant outcomes will be intergenerational in nature,

and that the community must be educated and on-board to ensure the philosophy is not diluted or lost over time.

1.5. To fund intervention for childhood trauma impacted populations using a short-term lens, is destined to fail not only our most vulnerable citizens, but the wider community. Until we begin to talk about matching intervention funding to lifetime economic liability we will plan to fail because we have failed to plan.

Where's the bang for our buck? Making sense of why dollars don't always equal outcomes for those deserving of help.

1.6. ACEs Research – The irrevocable link:

1.7. In 2012, UK Paediatrician, Dr. Nadine Burke Harris published her book, The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. She summarised strong historical thinking and pushed community advocacy about the link between adverse events in childhood and poor long term bio-psycho-sociological outcomes - bringing the issue into the current public arena, facilitating wide-spread education about the evidenced links between Adverse Childhood Events (ACEs) and life-long impacts on mental and physical health (Burke Harris, 2012).

1.8. ACEs studies have now been carried across much of the first world utilising the ACEs checklist in Appendix 1 (Robert, 2016). The epidemiological evidence is overwhelming: The greater the number of Adverse Childhood Events experienced and the greater the impact on the parent/carer-child relationship, the poorer the long term mental and physical health of the individual (Austin & Herrick, 2014; Bellis, Lowey, Leckenby, Hughes, & Harrison, 2013; Felitti, 2009). Such studies provide compelling correlations between childhood trauma, poorer long term mental and physical health and increased need for support services. Evidence clearly indicates that populations impacted by substantial childhood adverse events have a higher lifetime economic liability to the community, not to mention suffering markedly as individuals.

1.9. In order to understand:

1.9.1. Why and in what way, high numbers of ACEs can impact so markedly,

1.9.2. Why some individuals, despite an experience of substantial ACEs do well,

1.9.3. Why some populations seem at greater risk of ACEs and/or the impact of ACEs,

1.9.4. Who those most at-risk populations are, and,

1.9.5. How useful interventions and assistance must to look different for this group,

1.9.6. We must understand the mechanism of ACEs impact, how it differs from the impact of trauma or adverse events that occur in adulthood and what can work to mitigate their impact at various ages and stages over the life cycle.

1.10.   The following outlines the contributions that recent advances in mental health research and theory make to our wider understanding of these phenomena.

Understanding the mechanisms of ACEs impact: ACEs as childhood trauma

3.1 Bruce Perry (Perry & Hambrick, 2010), a US Child Psychiatrist, has spearheaded significant research along with others such as Daniel Seigel(Siegel & Solomon, 2003) and Bessel Van der Kolk (Van der Kolk, 2003, 2015) towards understanding the neurobiology of childhood brain development and the impacts of significant trauma on the developing brain and body.

3.2 Such works have provided a framework for understanding childhood brain development as a hierarchical and sequential process that follows a bottom-up, that is lower brain/brain stem to higher brain/pre-frontal cortex normative trajectory, where the mastery of each development stage and associated tasks build the foundation for the next.

3.3 Furthermore, they have evidenced the significant deleterious impacts of early trauma on this process, able to be scientifically evidenced as non-normative structural and hormonal differences in the brain of children who have experienced significant trauma through adverse childhood events.

3.4 The mechanism of impact mooted by this developmental and neuro-biological trauma research is several-fold:

3.4.1   Increases in stress hormones in the brain during experiences of trauma such as that experienced in substantive adverse childhood events - particularly those that involved continuing exposure where cumulative impact is exponential rather than summative - cut off neurological pathways engaged during in thinking and learning (higher brain) to preference instinctive, reactive 'safety' oriented processes (lower brain).

3.4.2   In the absence of the mediating factor of a secure and attuned care-giving relationship (e.g. parent-child relationship) and, where adverse events are substantive enough, also impact or contributed to by that caregiver and are therefore not able to mediate the stress hormone response in context of a child experiencing an adverse event as a potential threat to their existence, the child's developmental progress and learning is sacrificed for the more urgent need to stay safe. In this case, rather than the child developing new neural connections in the context of their sequential hierarchical learning and development, the lower, instinctive parts of the brain responsible for safety and self-preservation, including hypervigilance, anxiety and mistrust, become practised and overdeveloped and, importantly, form the normative basis for the ongoing development of the brain. This means, the person comes to experience hypervigilance, self-preservation, anxiety and basic mistrust in the world not only as a *normal* state of being, both in the somatic experience of stress in the body and its impact on thinking and behaviour, but as an implicit and necessary state to be preferenced above all other psychological processes – including learning through cause and effect, self-reflection and empathy as a capacity to be mindful of others (Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

3.4.3   The result can be catastrophic and devastatin without adequate understanding and intervention, a lifetime, of core motivations regarding sense of self, relationships with others and how one places themselves in the world, that are driven by fear, mistrust and self-preservation above all else (Briere & Spinazzola, 2009).

3.4.4   In desperate attempts to quell the somatic pain of emotions associated with this state of being, survivors of substantive childhood adverse events can self-medicate, distract

and drown out deeply painful memories, often experienced as confusing somatic and emotional experiences without context due to the loss of narrative memory prior to three years and/or a lack of understanding of how painful early events are impactful in the long term. These attempts to self sooth can manifest as over-medicating, alcohol and other drug use, addictive, high risk and aggressive, self-harming behaviours towards self and other, and a multitude of trauma-based psychiatric symptoms across the spectrum of dissociation, psychosis and mood disorders (Briere & Spinazzola, 2009) - seeing our hurt survivors present in some of our most challenging government systems - child protection, juvenile justice, forensic, family law, psychiatric and alcohol and other drug services.

3.5 The risk of impact from ACEs is very individual, accounted for by the intersectionality of individual temperament, personal experiences of adverse effects, capacity to access, receive and benefit from attuned attachments as well as the contextual environment, including intergenerational trauma in a person's lived childhood experience (Hambrick et al., 2018; Perry, 2001).

3.6 In this respect the presentation of complex trauma sequalae as a result of ACEs is far from a one size fits all, however:

3.6.1 The framework, provided by our current neurobiological understandings of childhood development, the impact of early trauma and its mechanism and ACEs research,

3.6.2 Can not only be applied across the spectrum of complex trauma presentations to create meaningful clinical understanding as a basis for individual intervention planning,

3.6.3 But also reminds us to consider the role of early trauma for every individual whose presentation is an evoking cry for containment and assistance in the context of complex presentation in our most challenging helping and containment services.

3.7 Furthermore, Dr Bessel Van der Kolk in his book, The Body Keeps Score (Van der Kolk, 2015), speaks to the importance of understanding the concept of somatic trauma memories in case formulation and intervention. Imperatively, he assists our understanding of the unhelpful application of cognitive based (talking and thinking) therapies before the developmental, relational and somatic impacts of early trauma are assessed, understood and treated. Not only

can poorly targeted interventions applied early in treatment of ACEs impact be unlikely to achieve sustainable treatment outcomes, such a process can be re-traumatising and *cause further harm*, in that the individual comes to notice that they are beyond help, re-triggering early somatic experiences of helplessness, hopelessness, abandonment and rejection by a plethora of ever-changing carers, professionals and services that engage then move on. The impact of this cumulative trauma over the lifespan can lock individuals into a cycle of systemic dependence and chronic re-presentation(Bateman, Henderson, & Kezelman, 2013).

3.8   Neurobiological research increasingly speaks to the correlation between long term exposure to stress hormones, chronic inflammation and the development of chronic health disorders such as Type II diabetes, cancer, neurological disorders and so forth. Increasingly epistemological research is suggesting that ACEs also make a marked contribution to individuals presenting to health systems with chronic disorders also (McEwen, 2005).

3.9   Fortunately and unsurprisingly in context of our emerging understandings of the mechanisms of impact of early adverse events, research is presenting an emerging picture of mediation of early adverse event impact, that offers substantial hope for individuals and systems and assists our understanding of why some individuals experience early adverse events and do not succumb to poorer longer-term outcomes – that is, attuned attachment achieved through developmental, relational and trauma framed child-focused parent or residential therapeutic care models and the resulting capacity to safely integrate trauma through bi-lateral (mind-body/left-right brain) and somatic processing (Anglin, 2014b; Gaskill & Perry, 2017; Hughes, Golding, & Hudson, 2019; Ludy-Dobson & Perry, 2010).

Mental Health diagnosis in context of Childhood Trauma: Complex Post Traumatic Stress Disorder (CPTSD)

4.1 In the lead-up to the International Classification of Disorders (ICD) 11's (World Health Organisation, 2018) recent (late 2018) inclusion of Complex Post traumatic Stress Disorder (CPTSD) as a diagnostic category, the diagnostic 'capture' of the sequalae borne of exposure to

significant childhood adverse events, and its unique somatic, psychological and developmentally impacted presentation, was, in the least, complicated and confusing.

4.2 It is important to note that exposure to significant adverse childhood events including attachment disruption, is not the only potential aetiology of CPTSD. However, CPTSD is currently our best diagnosis for capturing the impact of significant adverse childhood events in the context of disrupted attachment and hierarchical brain development as outline in the previous section.

4.3 Whilst Post traumatic Stress Disorder (PTSD), historically associated with War trauma and later recognised in numerous traumatised populations, captures the triad of post-trauma symptoms including re-experiencing (flashbacks, dreams, intrusive thoughts and re-enactments or traumatic play in children), avoidance behaviours (physical and psychological avoidance of reminders of the event including self-medication and high risk behaviours) and hypervigilance (remaining on high alert for enacting of safety behaviours – fight, flight, freeze and dissociation), it failed to capture the unique impact of prolonged and repeated exposure to trauma that is a central feature of CPTSD (Spinazzola et al., 2017).

4.4 Dr Bessel Van der Kolk has spearheaded advocacy towards the inclusion of a further, 'Developmental Trauma Disorder' diagnostic category since 2009 (Van der Kolk, 2017) after he established the US-based National Child Traumatic Stress Network in 2001 (van der Kolk, 2009). Van Der Kolk argues that the presentation of impacts of significant ACEs in childhood, whilst meeting criteria for CPTSD, is in fact, a unique category of trauma-disorder, given the context and impact of attachment and hierarchical brain developmental disruption, and, thus, requires its own diagnostic category to reflect this. The acknowledgement of CPTSD as a disorder may proof a segway towards inclusion of a childhood-specific presentation into the future. For now, the CPTSD diagnosis provides an improved criterion for capturing the mental health and somatic impacts of significant ACEs.

4.5 Historically, in both Child and Adolescent and Adult mental health populations, the lack of a CPTSD-like diagnosis resulted in the use of multiple dual and differential diagnoses attempting to capture complex clinical presentations (Streatfeild, 2012) – not to mention the potential for

missed diagnoses of CPTSD in systems outside of traditional mental health pathways – such as child protection and forensic settings, putting ACEs impacted individuals at risk of further harm through 'system' trauma and increased likelihood of embedded cyclic and intergenerational system dependence/chronic re-presentation.

4.6 The ICD 11 (World Health Organisation, 2018) Complex Posttraumatic Stress Disorder criterion are as follows:

4.6.1 "Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

4.7 Importance of a CPTSD diagnostic category

4.7.1 A formal CPTSD diagnostic category provides a meaningful link between mental health and complex client presentations leading to chronic re-presentation in helping and containment systems such as child protection, juvenile justice, adult forensic, mental health, and, drug and alcohol services.

4.7.2 The diagnosis lends itself to a communal understanding of an individual's experience, challenges and needs, and compels helping professionals to consider ACEs impact in the shifting space of case formulation and intervention planning contextually with new knowledge of neuro-sequential brain development – "What's happened to you?" rather than 'What's wrong with you?,' bringing greater clarity to origins of diagnosis and therefore better-informed and targeted treatment planning and ongoing evidenced-based research in this area.

Brain Based Healing in Complex Helping Systems

5.1 For complex client groups impacted by ACEs and meeting CPTSD criteria, assessment and treatment interventions that miss the mark not only fail to produce useful outcomes, they contribute to making the problem worse; there is no 'do no harm' in the context of early and cumulative trauma (Bateman et al., 2013).

5.2 The Neuro-sequential brain development model of assessment and treatment planning notices where the individual is starting from, from developmental, relational and trauma perspectives (Perry, 2006).

5.3 This triad is the core of targeted assessment and treatment planning for this client group, no matter what the therapeutic modality, lending this framework to use across systems, multi-disciplinary teams and over the lifetime of an individual.

5.4 An implicit understanding of this triadic sequalae enables trained professionals to ensure trauma and attachment interventions are delivered in a way that makes them accessible and reduces the likelihood of re-traumatisation (Perry, 2006).

5.5 Furthermore, systemic decision making informed by this model of care, across government and NGOs systems with an over-representation of CPTSD, has the potential to support positive long term, intergenerational outcomes (Bateman et al., 2013; Bloom & Sreedhar, 2008; Esaki et al., 2013).

5.6 This model of care for ACEs impacted and CPTSD clients sits well with the availability of comprehensive assessment and intensive interventions in Stepped models of Care now being embedded into Australian helping systems.

# When dollars do equal outcomes: Measuring Brain Based Healing Intervention in Australia by Doug Faircloth

Summary of Understanding the Needs for Children & Young People in Out of Home Care

Introduction

1.1 Out-of-home care is the care of children and young people (CYP) who are unable to live with their primary caregivers. It involves the placement of a CYP with alternate caregivers on a short- or long-term basis. Commonly CYP are placed in out-of-home-care by statutory authorities or courts due to cases of abuse, neglect or family violence.

1.2 The unabated growth of children and young people entering out of home and the significant numbers indicates that there is a large population of children and young people that have been exposed to early childhood trauma.

Figure 1: Growth of Children and Young People in Out of Home Care: Victoria

Children in out of home care Victoria
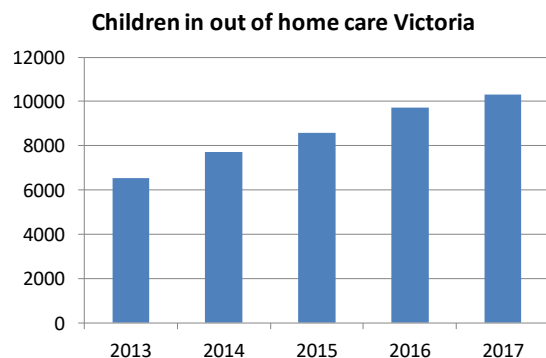
Source: Australian Institute of Family Studies (data originally https://aifs.gov.au/cfca/publications/children-care produced by AIHW 2018a)

1.3 Studies indicate that the trauma is likely to have been exacerbated by removal and subsequent events while in placement or when placements break down. Placement instability or drift, is strongly associated with worse outcomes (Osborne and Bromfield, 2007; Wise S, Pollock S, Mitchell G et al, 2010) including schooling and subsequent life chances for young people. Several studies support the contention that placement instability lasting for more than 12 months is more strongly linked with a higher prevalence of psychological, social, and educational difficulties (Osborn and Bromfield, 2007; Cashmore and Paxman, 2007; Stone, 2007).

What are the needs of CYP in out-of-home care?

2.1 The evidence gathered by Verso Consulting (Faircloth D.) and detailed in this discussion demonstrates that there are young people living in Out-of-Home-Care with significant mental and emotional health needs as detailed in the following figures.

Figure 2: SDQ total scores comparison: community norms, CAMHS/CYMHS, Take 2 and CG
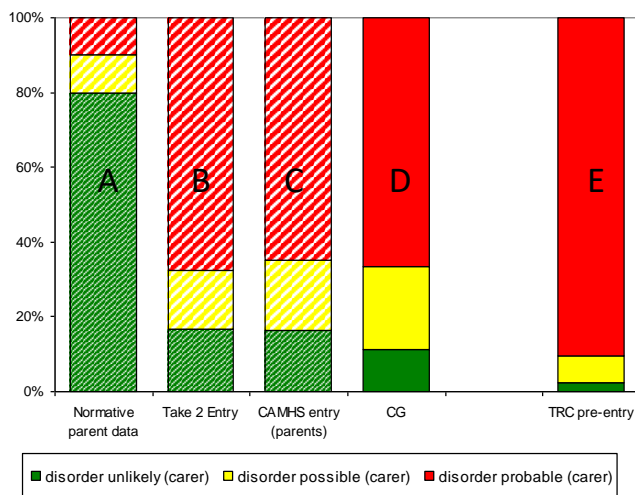
Source: Evaluation of Therapeutic Residential Care Pilots DHS 2011; Verso Consulting (figure 77)

Results:

A: Normative CYP Group = 10% have a probability of a disorder

B: Take 2 Entry (a cross section of all types of out-of-home care) = 68% have a probability of a disorder

C: CAMHS entry = 65% have a probability of a disorder

D: A selection of CYP living in residential care not being supported with TRC. = 67% have a probability of a disorder

E: Selection of CYP prior to entry to TRC = 91% have a probability of a disorder

Groups B, D and E exceed C, being the entry into specialist mental health service

2.2 Implications:

2.2.1   There are significant proportions of young people living in OoHC who are likely to have a disorder proportionately with greater severity than populations entering specialist mental health services. This indicates the poor mental health outcomes for children and young people living in OoHC may be greater than recognised and or addressed by OoHC services.

2.3 The range of presenting problems considered appropriate for referral to CAMHS/CYMHS in Victoria include:

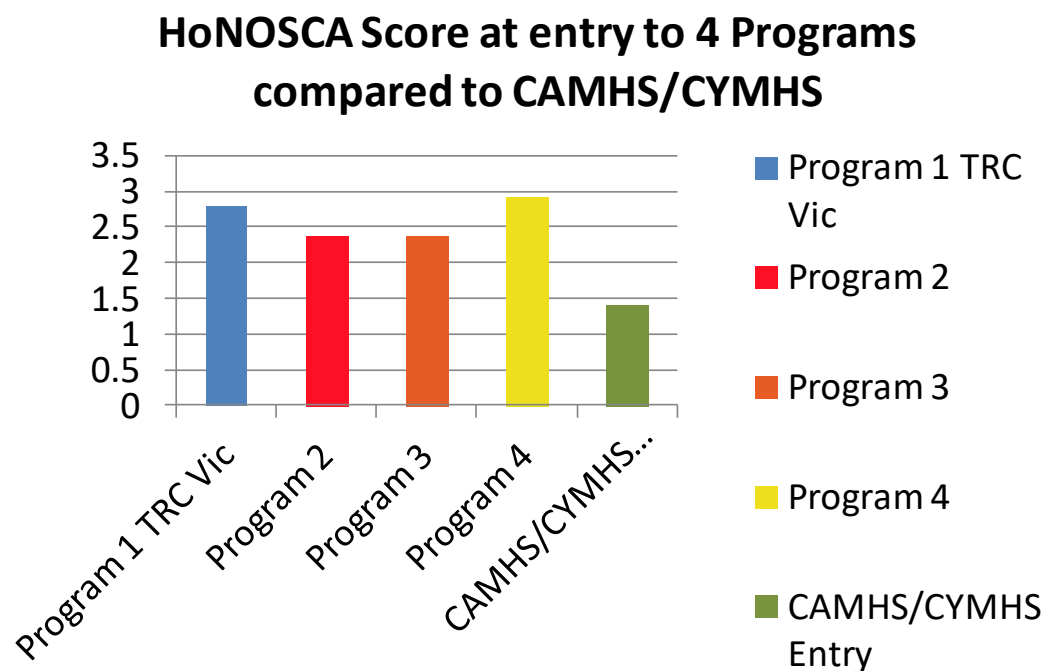2.3.1   Young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development, and/or where there are substantial difficulties in the person's social or family environment

2.3.2   Symptoms that may include impaired reality testing, hallucinations, depression and suicidal behaviour

2.3.3   Children's emotional disturbances more often present in other ways such as:

> Hyperactivity, nightmares, fearfulness, bed-wetting, language problems, refusal to attend school, and stealing, these are among the behaviours that may indicate distress or disturbance

2.4 The outcomes for children and young people when the SDQ was applied in the TRC evaluation population is consistent when the outcomes when the HoNOSCA was applied to the same population. Figure 3 details a comparison of the TRC population aggregated symptom severity data when the HoNOSCA was applied compared to the same data for entry into CYMHS/CAMHS at the time of the evaluation. Contemporary data for three other TRC programs in three jurisdictions are also detailed to demonstrate the consistency and universality of symptom severity at entry to residential settings (*n=191*).

Note: In figure 3 the higher the score the greater the symptom severity.

Figure 3: HoNOSCA Comparison to CAMHS/CYMHS at entry to TRC programs

HoNOSCA Score at entry to 4 Programs compared to CAMHS/CYMHS

- Program 1 TRC Vic
- Program 2
- Program 3
- Program 4
- CAMHS/CYMHS Entry

Source: Verso Consulting published and unpublished data

2.5 Many of the young people in OoHC do not have access to Therapeutic Residential Care (TRC). This approach has been demonstrated (Faircloth D. et al Evaluation of Therapeutic Residential

Care Pilots DHS 2011; Verso Consulting) to effectively reduce the severity of symptoms. A range of symptoms may be present such as; impaired reality testing, hallucinations, depression and suicidal behaviour.

2.6 The effects of long term out-of-home care and in particular placement instability can have significant adverse effects on children. Studies have found that continued instability is associated with poor educational, employment, social and psychological outcomes, as well as behavioural and emotional problems (Johnson, Natalier, Liddiard, and Thoresen (2011) and Australian Institute of Family Studies, Chapin Hall Center for Children University of Chicago, & NSW Department of Family and Community Services, 2015)). The entry scores for CYP in figure 2 and 3 details elevated symptom severity and likelihood of a disorder. In two of the programs outlined in figure 3 Verso holds specific placement fata. Placement change was a significant factor for children living in these programs; Program 1 (the TRC Evaluation population) experienced an average of 10.6 placements and program 2 the children and young people experienced an average of 9.2 previous placements prior to entry into the TRC.

2.7 CYP with a history of disrupted early care giving, whose earliest experiences were characterised as chaotic, neglectful, and/or unpredictable often have difficulties forming and maintaining relationships.

2.8 Community services and Government Departments have found that there is a group of young people in the out-of-home-care systems who 'fail up' through the system through multiple placements (consultations undertaken for the evaluations[1] ongoing sector consultations Verso).

2.9 The "failing up" suggests that repeated placement breakdowns are managed by organising another placement rather than having a comprehensive capacity to address the underlying issues of trauma.

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[1] Faircloth D. et al Evaluation of Therapeutic Residential Care Pilots DHS 2011; Faircloth D. et el and Evaluation of Placement, Prevention and Reunifications Services for Aboriginal Children and their Families July 2016 DHHS; Verso Consulting

The Benefits of TRC

3.1 The combination of the experiences that led to the placement, the increased exposure to abuse and trauma while being in placement including placement instability results in CYP in out-of-home-care living with pervasive effects of trauma.


3.2 Extract: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report[2]

3.2.1 However, trauma experts (e.g. van der Kolk; Ford; Marans; Herman) emphasise the need to distinguish the nature of discrete trauma from the more pervasive and complex forms. This difference between the two types is summed up by Herman:

3.2.2 'People subject to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder that invades and erodes the personality. While the victim of a single acute trauma may feel after the event that she is "not herself", the victim of chronic trauma may feel herself to be changed irrevocably, or she may lose the sense that she has any self at all' (Herman 1997, p.86).

3.2.3 The experience of complex trauma for children and young people is extremely pervasive as it occurs within the daily context of primary care giving relationships therefore, the potential 'triggers' are very diverse and constant (van der Kolk et al. 2005). They may include seemingly benign, normal sensory experiences such as a particular smell, taste, sight, sound, tactile experience, and relational interactions such as for example facial expressions, tone of voice, and physical contact (van der Kolk et al. 2005).

3.2.4 Herman states that in order for children and young people to survive and negotiate chronically traumatic events, they tend to develop maladaptive coping styles resulting in '...an immature system of psychological defences' (Herman 1997, p96).

3.2.5 Trauma is understood to be just as much a neurobiological and psychophysical experience as it is psychological and emotional (van der Kolk 2006). Importantly, the physical dimension to the trauma has implications for therapy because people experiencing the trauma have limited conscious control over their actions and emotions (van der Kolk 2006). The profound and pervasive effects of neurobiology on behaviour are highlighted by van der Kolk:

3.2.6 'The fact that reminders of the past automatically activate certain neurobiological responses explains why trauma survivors are vulnerable to react with irrational, sub-cortically initiated responses that are irrelevant and even harmful in the present. Traumatised individuals may blow up in response to minor provocations; freeze when frustrated, or become helpless in the face of trivial challenges' (van der Kolk 2006).

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[2] Faircloth D

3.3 Addressing this trauma through TRCs has proven positive results. The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) is a clinician rated instrument comprising 15 simple scales measuring behaviour, impairment, symptoms, social problems and information problems for those under 18 years of age. The following figure (4) indicates the progressive improvement of young people and children when they are placed in TRC.

Figure 4: HoNOSCA; Change over time 2 programs and a Comparison to CAMHS/CYMHS entry
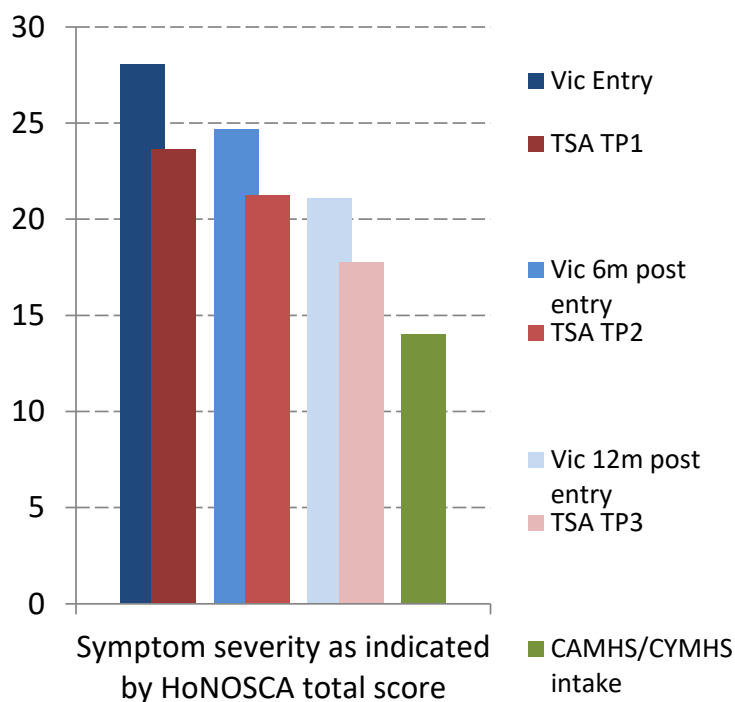
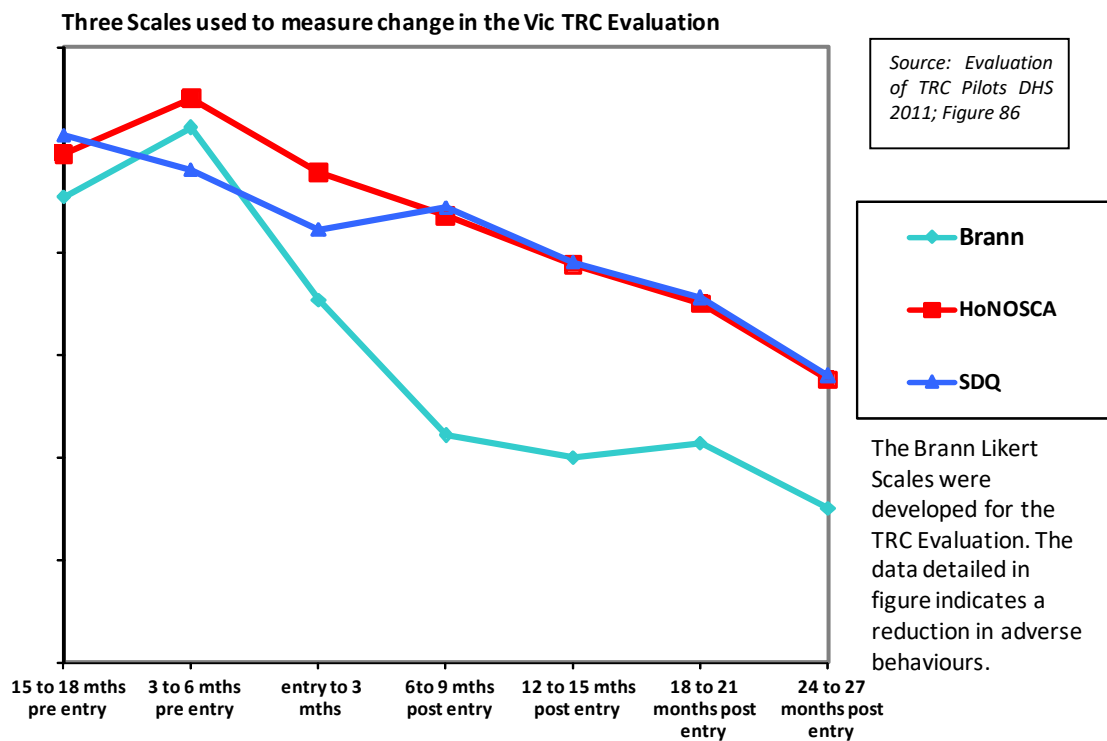*Source: Verso Consulting Evaluation data (TRC's Victoria and Tasmania)*

Analysis: The HoNOSCA for two programs demonstrate improvements for children and young people in the TRC Pilots (Vic) and a program in Tasmania (TSA). Verso evaluated the conditions under which the change occurred. Both programs were delivered with fidelity to the same set of essential elements of therapeutic residential care. Both programs demonstrate change over time.

The TRC evaluation identifies that compared to the young person's previous experience and to a comparator group these changes are positive and very significant (Faircloth D et el Evaluation of Therapeutic Residential Care Pilots DHHS 2011).

3.4 Table 5 details three scales used to gather outcome data relating to the children and young people's progress in the TRC over their time in the program. Of particular interest is the more immediate impact on adverse behaviour and the more gradual reduction in symptom severity and the likelihood of a disorder. The three tools were used to provide cross validation of the outcomes. The trajectory of change and the merging of the SDQ and HoNOSCA support the claim that the children and young people in the TRC pilots

experienced positive change with improvements in mental and emotional health and a reduction in adverse behaviours. Data the last two time points relates to a small sample and therefore should be seen as an indicator rather than evidence.

Figure 5 Change experienced for Children and Young People in the VIC TRC Pilots over time

Three Scales used to measure change in the Vic TRC Evaluation

Source: Evaluation of TRC Pilots DHS 2011; Figure 86

- Brann
- HoNOSCA
- SDQ

The Brann Likert Scales were developed for the TRC Evaluation. The data detailed in figure indicates a reduction in adverse behaviours.

Earlier Intervention – a better approach

3.5   Early intervention provides children and young people the best possible opportunity to fully recover from their past trauma experiences so they can become productive members of society. It is critical, whenever possible, to engage the child's family and other important people in the child's life (The Village Network: http://the villagenetwork.org/, accessed 25/3/19). Younger children will benefit from the application of evidence based therapeutic models. More commonly this support will be most appropriately delivered in home-based care settings however there are young people that can benefit from therapeutic residential care.

The brain's ability to change in response to experiences

Amount of effort such change requires

Age in years

0   2   4   6   8   10   20   30   40   50   60   70
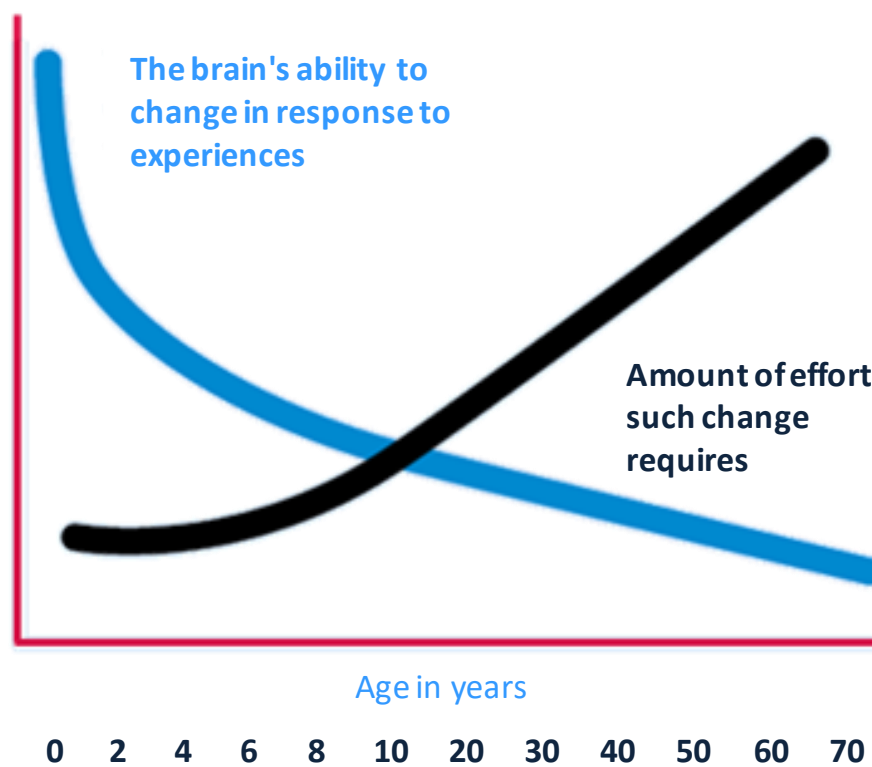
Source: Source: [adapted from] Levitt, P 16 (2009)

3.6   Consultations undertaken by Verso and unpublished data held by Verso demonstrates that there is a drift in Victoria to use the TRC program as a last resort option. This approach is resulting in young people being placed in this option with a reduced capacity to assist them due to their age (an average 16 years plus). This age profile is much older than the DHS TRC Evaluation population. The DHS TRC Evaluation report states, "The median age at entry to TRC was 13 years, with the inter-quartile range being between 12 and 14.3". Lowering of the entry age to the TRC was considered to be a beneficial change considered by Providers who

participated in the DHS TRC Pilots; 'there is a growing recognition that in practice, the effectiveness of the therapeutic approach is increased with younger age at entry, 11 years of age being regularly suggested'. NGOs delivering the DHS TRC pilots commonly made some adjustments to recruit younger people as they entered the pilots during the evaluation period.

Conclusion

5.1 Young people and children in the out of home care would benefit from having their mental health needs addressed; these needs are consistently more complex than children and young people referred to specialist mental health services.

5.2 The current system fails to comprehensively address the pervasive impact of trauma and in many cases administers a system where the events that led to removal are exacerbated or repeated within the system.

5.3 Until the underlying trauma and its neurobiological impacts and subsequent effect on behaviour and development are addressed through evidence-based recovery models many young people and children in OoHC will consistently experience life trajectories that are very poor compared to the general population.

5.4 Health services have demonstrated through clinical governance frameworks that the health needs of persons being cared for can be prioritised above the fiscal and administrative requirements of bureaucratic systems. Placement decisions need to be primarily managed by a system approach that places the health needs of all children and young people in OoHC as a central tenant. The data demonstrates that regardless of policy statements contemporary practices do not support this position. An urgent transition of placement decisions and health management needs to occur. This should be built upon a universal assessment and treatment regime. This regime should be developed with a sophisticated understanding the underlying neurobiological and pervasive impacts of trauma.

Submission Conclusion by Adela Holmes

"All roads" do not "lead to Rome"

1. This archaic statement denoted a belief during the Roman conquests that Rome and the Caesar were the centre of everything that existed. This proved to be so for a time but in the way of all things they do not stay true for ever. In the same way, whilst for a period in the history of the development and implementation of services to vulnerable people whose 'minds' are unwell and in a state of existential distress, the dominant view of treatment has been one driven by a medical and determinist paradigm which has, in turn, been driven by the underlying frameworks of knowledge regarding categorisation of mental illnesses. As time moves forwards our ever-enquiring human minds seek new definitions, understand matters in a more calibrated and sophisticated way and, in a healthy system, adjust accordingly. It is our contention that the prevailing Victorian mental health service system seems to have reached a place where it has not kept up with changing knowledge. In fact, it has had at its disposal possible new understandings and approaches available which it has consciously or unconsciously rejected or ignored at the expense of the vulnerable individuals who require its help. In so doing it has reached a kind of service overload. In this condition the system has 'circled its wagons' somewhat defensively and ignored new understandings as we have outlined in this body of work.

2. The proof of any pudding is in the eating: when our interventions clearly do not work for vulnerable people our systems are clearly under some strong ethical pressure to fully review their fundamental approach-not just fiddle around the edges. It is surely this that has brought into being this Royal Commission of Enquiry.

3. In this submission we have proposed a new understanding of and approach to systems interventions that recognises the multiplicity of causal factors that sit behind what our society terms 'mental health' issues. The use of traditional diagnostic criteria can only take us a part of the way towards determining appropriate treatments and interventions. One of the conundrums of providing services to very troubled individuals is that the services themselves can, and often do pick up these maladaptive ways of operating in a parallel process and begin to operate in a traumatised way themselves. Bloom and Sreedhar (Bloom & Sreedhar, 2008) identify this in their development of the Sanctuary model for the operations of organisations providing these types of services.

4. We tender this submission to the Victorian Royal Commission into Mental Health and request also, the opportunity to give evidence in person so that we may further describe our observations and suggestions.

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Appendix 1

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

(Robert, 2016)

Appendix 2

Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4th of November 2011 DHHS; Faircloth D. Southern D. Brann P. and Ribarow L.