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Therapeutic residential care services in Australia

A description of current service characteristics

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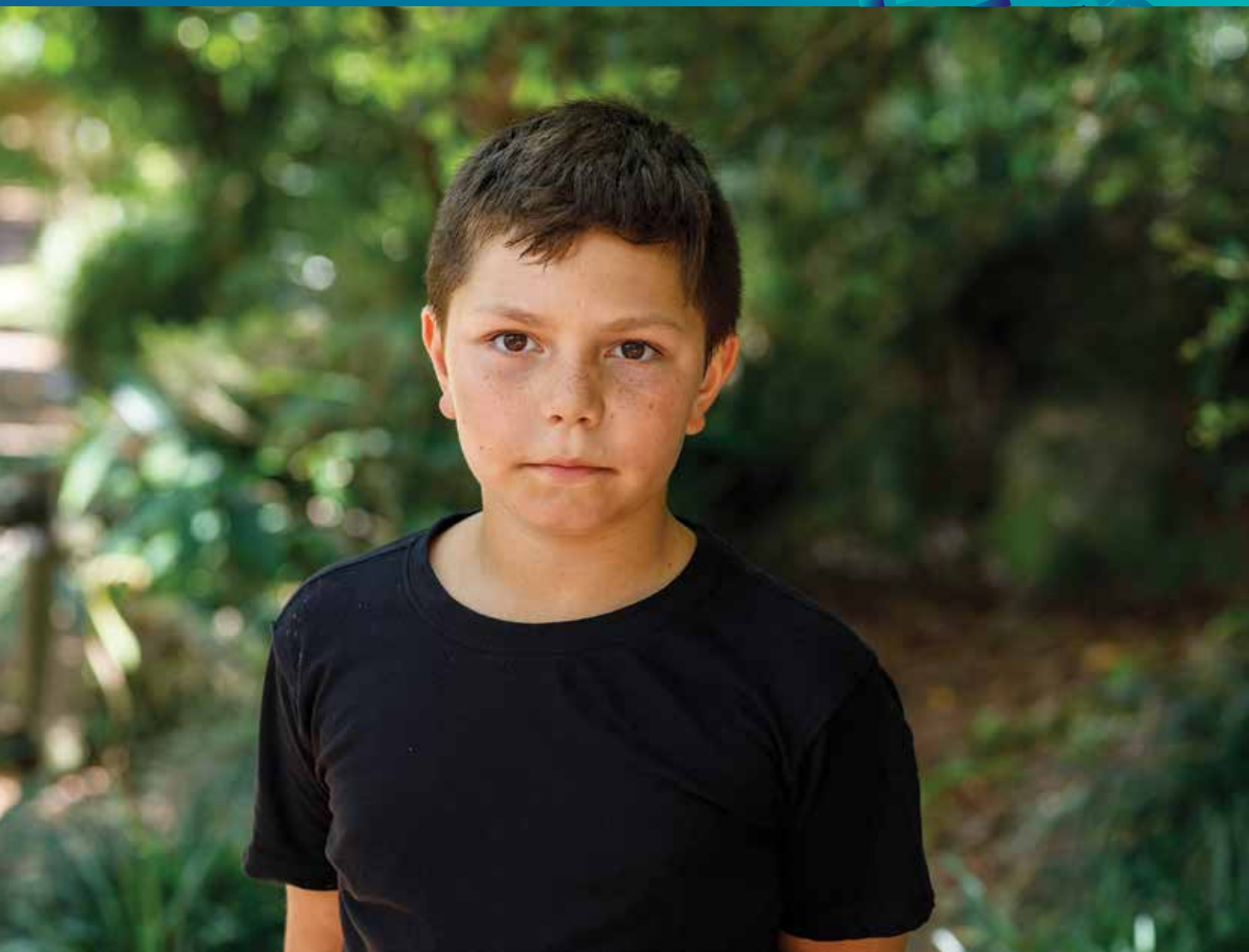

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CFCA Papers/52_Therapeutic residential care services in Australia

Overview

Therapeutic residential care is a relatively recent development in out-of-home care service provision for young people who are unable to be placed in family-based care. This report is intended to complement a recent CFCA publication on this topic, *Therapeutic residential care: An update on current issues in Australia* (McLean, 2018; CFCA paper No. 49). This companion paper provides a snapshot of current practice of therapeutic residential care services conducted in Australia. It describes the configuration and characteristics of current therapeutic residential care services in Australia. The views of therapeutic residential care service providers included in our consultations are summarised, together with issues to be considered in further development of this form of care for young people.

Key messages

- There is likely some variability in the way that the therapeutic residential care services we consulted with are configured, and in the framework and models that are drawn on to inform practice.
- A common configuration for therapeutic homes is a four-bed home, set in the community, with two on-site staff. However, other arrangements also existed; there is insufficient evidence about the benefit of one service configuration over another.
- Recommendations for further development included improving referral, matching and transitioning pathways for young people; more emphasis on a child-centred approach to service design; and the introduction of intensive and secure care models to meet the needs of defined groups of young people.
- Therapeutic residential care services may benefit from the introduction of specialised therapeutic residential care models and the development of specific assessment and outcome frameworks and tools that are useful to therapeutic care.
- Legislative changes are needed to 'enable' more effective therapeutic care and increase flexibility in the way services are commissioned and funded.
- Several aspects of service delivery, staffing and structure were identified as issues that warrant further exploration.

Introduction

Therapeutic residential care is a relatively recent development in out-of-home care service provision for young people who are unable to be placed in family-based care for a range of reasons. International research suggests that therapeutic residential care can be a positive and effective choice for some young people; and our knowledge about 'what works' in residential care continues to grow (see McLean, 2018).

Despite this, much of what occurs within residential care services remains a 'black box'; meaning the processes and activities of residential services are not transparent or well understood (Axford, Little, Morpeth, & Weyts, 2005; Harder & Knorth, 2015). This research was commissioned by the CFCA information exchange at the Australian Institue of Family Studies in order to better understand what service characteristics and activities currently exist in therapeutic residential care services in Australia; in order to contribute to the further development of this form of service for young people in care.

In particular, more detailed information is needed about: how residential care services are configured and funded; who they provide care for; and what activities they undertake, in order to assist funding bodies and service providers in planning and meaningful decision making regarding service delivery. This will provide a foundation for a more nuanced understanding of residential care services; and, ultimately, build capacity for the commissioning and evaluation of services based on the sound knowledge of service elements and therapeutic activities involved.

In recognition of this need, Lee and Barth (2011) argued for the adoption of a standard reporting framework that could facilitate meaningful comparison between residential care services, and help develop a shared understanding of the effective components of residential care over time. They proposed a set of reporting criteria that could be used to more clearly describe the staffing, program and therapeutic elements of residential care programs; thereby enabling us to see inside the 'black box' of residential care. While this reporting framework was based on international models of residential care, it does offer a foundation for adopting a similar structured approach to documenting Australian residential care services. Accordingly, this paper reports on the application of a reporting framework, adapted from the reporting standards of Lee and Barth (2011), to describe the configuration of Australian therapeutic residential care services.

The current research is intended as a companion to a related paper previously published by this author: *Therapeutic residential care: An update on current issues in Australia* (McLean, 2018). The previous paper (McLean, 2018) provided an overview of the developments in therapeutic residential care service provision since it was first recognised as an emerging form of service delivery (see also McLean, Price-Robertson, & Robinson, 2011; for a description of the history of therapeutic residential care in Australia).

The purpose of this paper is to provide a snapshot of current practice in Australian therapeutic residential care. It uses a reporting standards framework to capture emerging evidence about the key characteristics of Australian therapeutic residential care. Accordingly, this paper reports the results of an online survey of Australian services, adapted from the reporting standards originally proposed by Lee and Barth (2011). Four main areas will be explored in this paper:

1. the service and staffing characteristics of therapeutic residential care
2. the care needs of young people being supported
3. the therapeutic frameworks, models and activities that inform therapeutic residential care
4. participants' views about the key issues to consider to inform future developments in this sector.

The methodology for this paper is detailed in Appendix A.

Survey findings

Who completed the survey

Partial responses were received from 192 respondents. A visual inspection of this data indicated that incomplete responses were provided by frontline workers, who did not complete questions related to funding, staffing configurations or theoretical approaches. It was not possible to determine a response rate for this survey as the number of surveys distributed was not recorded.

Completed surveys were received from 31 participants, and a further six surveys met the '75% complete' criterion; yielding a total sample of 37 surveys. The completed surveys represented the views of 26 separate agencies and included responses from all Australian jurisdictions. There were insufficient data for each jurisdiction to allow cross-jurisdiction comparison; therefore, data from all jurisdictions were pooled for subsequent analysis. The distribution of participants across jurisdictions is reported in Table 1.

Table 1: Number of participating services by jurisdiction

Jurisdiction	No. of participating services
ACT	1
NSW	5
NT	3
Qld	8
SA	5
Tas.	3
Vic.	9
WA	3
Total	**37**

Participants were asked to identify their organisation; and their role within the agency they were reporting on. The majority of participating services identified as non-government service providers (91.8%; *n* = 34); and three identified as government providers of therapeutic residential care. The majority of respondents (*n* = 32) were in leadership roles; with only five frontline workers completing the survey. Table 2 presents participants' respective roles within the agencies they represented.

Table 2: Roles of survey participants

Role	No. of survey participants
CEO/Area manager	8*
Frontline worker	5
Practice lead	3**
Therapeutic specialist	8
Service manager	10
Staff supervisor	2
Quality manager	1
Total	**37**

Note: * = includes government and non-government respondents; ** = includes child safe leads and practice leads.

Each participating organisation was asked to estimate how many young people in total were cared for by their organisation. The estimate for each agency was combined to provide a rough estimate of the total number of young people whose needs were being reported on in this survey. Collectively, the 37 respondents in this study estimated that they were caring for approximately 1,236 young people.

If accurate, this number reflects a significant portion of the current residential care population. Nationally, approximately 2,396 (or 5%) of the 47,915 children in out-of-home care live in residential care (Australian Institute of Health and Welfare [AIHW], 2018). This suggests that the data collected may reflect the current care

circumstances of a significant proportion of young people currently living in residential care. Indeed, the estimate provided by participants suggests that the services that took part in this survey may collectively be caring for around half of young people who currently live in Australian residential care. Unfortunately, it is unclear what proportion of the total number of existing Australian residential care services are represented in this survey because at present Australia-wide information on the total number of residential care services in Australia is not collected or reported.

Overview of therapeutic residential care

The survey questions covered three main areas of interest that aimed to provide an overview of Australian therapeutic residential care services. The fourth area covered by the survey related to participants' views about therapeutic residential care as it is currently configured, together with their recommendations for further developing this form of service delivery. Taken as a whole, the findings of this survey are designed to provide a snapshot of current practice in Australian therapeutic residential care, in relation to:

1. service and staffing characteristics
2. the care needs of young people being supported
3. therapeutic frameworks, models and practices, and staff/program activities
4. key issues informing future development in the sector.

Each of these service characteristics and related issues is described in the following sections of this report.

1. Service and staffing characteristics

Participants were asked for information about how their service was funded and what kind of funding they received. Participants also provided information about the physical characteristics of their residential group homes: where these were located, how many residential homes their service had and of what size. Participants were given the opportunity to describe their staffing configuration and the qualifications and other characteristics of their workforce. In addition, they were asked to describe the strategies they used to support workforce retention. These characteristics of the care environment have been identified as key considerations for the delivery of therapeutic residential care (e.g. Boel-Studt & Tobia, 2016; McLean, 2018).

Funding for services

Participating services were asked about their funding type and source. Internationally, residential care services can receive referrals through youth justice and child mental health services, which may be funded by a variety of sources. In Australia, therapeutic residential care is predominantly within the statutory child protection sector, and funding is typically provided by the relevant state or territory government. The way that services are funded can influence diverse and nuanced aspects of the resultant care environment; including the configuration of staffing, the nature of the workforce, the capacity to offer longer-term contracts, and the degree to which services can influence their referrals and placements. For these reasons, it is important to better understand the way Australian services are funded.

Funding model

While all participants identified themselves as providers of therapeutic residential care (n = 37), not all services were funded accordingly. Services were asked whether or not they were funded to provide therapeutic care, with 31 services responding. Around a fifth of these indicated that they were not actually funded to provide therapeutic care (n = 8; 21% of total sample). This suggests that some services may be attempting to accommodate young people's needs within a general residential care funding model.

Funding sources

Services were asked about the sources of their funding. In order to answer this question participants were asked to select a response that best described their source of funding from a list of options. Thirty-six services provided a response to this question. Thirty-four services were able to identify a funding source, and two participants reported that they were 'unsure'.

Most services reported that they were funded through block funding (*n* = 14), and recurring government grants (*n* = 6). These are forms of funding that offer services a specified funding amount and for a defined period of time, typically with allowance for establishment costs, providing a measure of certainty and predictability for services that can enhance staff recruitment and retention. The next biggest group of services were those funded through a combination of block funding and individual funding (including individual funding packages or fee for service Child Related Costs Placement and Support Services (CRC PaSP) (*n* = 6). Five services reported being funded only by individual funding packages or CRC PaSP funding. Tailored financial packages such as these are typically provided in recognition of the additional complexity and support needs of some young people for whom they are allocated. A minority of services were funded via individual flat fee funding or a yearly estimate package (*n* = 2) based on an individual child's needs. One service received funding through an affiliated religious organisation.

Number and location of homes

Participating services were asked about how many therapeutic homes they ran; and about the size and location of these services. The size and location of residential care homes has been the subject of much debate in the international literature. Some argue that small 'home-like' environments situated in the community are ideal as they offer a normalised environment for young people and avoid the possibility of group contagion; while others argue that larger homes, or clustered home arrangements, afford an 'economy of scale' that can support the cost of highly qualified, multidisciplinary teams (see Ainsworth & Hansen, 2015; Ainsworth & Hansen, 2018; McLean, 2018).

Number of homes

There was wide variety in the number of therapeutic homes being run by each service. Across Australia, the number of homes provided by each service varied between one and 60. The median number of homes was 5–6 homes; but there were also a few services that were providing support to a larger number of homes. The modal (most common) number of homes provided by each service was two therapeutic homes.

Size of homes

There was less variation in the size of therapeutic homes across participating services. The median number of places for young people in each home was four. Four-bed homes were also the most common (modal) placement configuration across Australia. Across the group, the size of homes varied from one-bed homes to a much larger home that reported providing care to 16 young people at one site.

Location of homes

Services were asked about whether their homes were located in metropolitan, regional or rural locations. Thirty-six services provided information about the location of their residential homes. Of these, 26 indicated that they had homes in metropolitan areas, 25 had homes in regional areas and nine had homes in rural areas. Most services were providing some mix of metropolitan, regional and rural homes. Most homes were in metropolitan locations (the largest metropolitan service had 17 homes); and the median number of homes in metropolitan locations was three. The median number of homes in regional locations was also three. The largest number of rurally located homes was three. In open-ended responses, one service provider commented that they also had homes in remote locations; however, this information wasn't able to be quantified in the current study.

Physical characteristics of homes

Internationally, residential group homes can be offered in small suburban homes, in small clusters of homes grouped together, or in larger residential facilities. Service providers were asked to select which of these options best described the configuration of their homes. Thirty-seven services provided information about the physical characteristics of their residential homes. The majority of services (*n* = 30) identified that they delivered therapeutic care in small suburban homes located in the community. Five services reported that they co-located their residential homes in small cluster sites; typically as a collection of smaller homes or units with one home allocated to staff. Four services reported using larger freestanding facilities.

This indicates that although small community homes are the most common type of therapeutic residential care homes, most services used a combination of housing styles to meet young people's needs, service requirements,

and the practical constraints of service delivery. For example, many services are funded to provide four-bed homes, as this appears to be the accepted model for 'home-like' therapeutic service provision. Close co-location of homes *may* help services with the pragmatic concerns of providing supervision and support for a number of homes simultaneously, while providing young people with sufficient opportunity to develop independent living skills.

Staffing characteristics

Participating services were asked to describe how their services were staffed and how staff were trained and supported. It is widely acknowledged that the quality of the relationship between young people and staff is an important element in effective and therapeutic care (e.g. Holden et al., 2010; Verso Consulting, 2011). The attraction, support and retention of appropriate residential care staff is a critical ingredient for the delivery of high quality, evidence-informed care (Boel-Studt & Tobia, 2016; Bravo, del Valle, & Santos, 2014; Grietens, 2014; Holden et al., 2010; Lyons & Schmidt, 2014).

Staff qualifications

Participants were asked to indicate whether or not their direct-care staff were required to hold a minimum level of qualification. All participants provided a response to this question. The majority of respondents (n = 26) indicated that they do apply a minimum qualification criterion. Nine services did not have formal specifications in place regarding qualifications of staff. Where further information was provided about the pre-requisite qualifications, the most common pre-requisite qualification sought by services was a Certificate IV in Child Youth and Family Intervention or similar (e.g. Community Services or Youth Work). Less commonly, services specified degree-level qualifications in psychology or social work, in combination with experience. This was more likely for clinical or therapeutic specialist positions, where a postgraduate qualification is desirable.

Staffing configuration

All services indicated that they use a rostered staffing model and provided details about this. Most services used '8-hour shift' rostering (n = 17); with the second most common rostering arrangement being '24-hour shift' arrangements (n = 10). Other arrangements included a combination of shifts, depending on days worked (e.g. three 8-hour shifts on weekdays and two 12-hour shifts on weekends; or rotating 12-hour shifts). The majority of services used active rostering for overnight staff (n = 21); followed by passive rostering (n = 12). Active overnight rostering means that there is always a staff member awake during the night to attend to young people's needs. Passive overnight rostering means the rostered staff member sleeps on site in the home with the young people. The remainder of responding services specified that they used 'other' rostering arrangements for night staff (n = 4); typically, an approved 'sleepover' arrangement in conjunction with an approved safety plan.

Services were also asked to describe their staffing ratios and to indicate whether or not there was a formally specified ratio of staff to young people for their agency. In response, 18 services indicated that a formal policy was in place for this; 16 indicated that they did not have formal specifications for staffing; and three were unsure. Of the 18 services that indicated that a ratio was formally specified, the most common staffing ratios were two staff : four young people (n = 9) or one staff : two young people in smaller homes (n = 5).

The decision about staffing ratios often was determined by funding bodies or, in some cases, by an assessment of young people's needs. Staffing ratios were typically reduced overnight. Where an overnight staffing ratio was reported, the most common overnight staffing ratio was one staff : four young people. Where no formal staffing ratio was specified, services reported that they nonetheless aimed for comparable staffing ratios; although many were providing higher staffing ratios (e.g. up to one staff : two young people or one staff : three young people) in many instances.

As a whole, this indicates that staffing ratios are generally quite high and many agencies are employing higher staffing ratios than would be suggested by their organisations' formal policy. This may reflect the emphasis placed on the relationship between workers and young people in a therapeutic approach. Alternatively, for some agencies, it may also reflect the need to provide care for young people with extreme behavioural and mental health support needs that require high levels of supervision.

Organisational practices

Services were asked what, if any, initiatives they employed to support staff and reduce staff turnover. Thirty services provided responses to this question. Of these, 27 reported initiatives that were aimed to increase staff morale, wellbeing, professionalism or support; and three services weren't able to identify any strategies that they currently used to address these issues. Responses to this question were sorted and reported according to themes. Many agencies used multiple strategies. Some of the staff retention strategies reported by participants included:

Clear therapeutic model and practice leadership: promoting consistent and effective responses; promoting professionalism in the role; using 'key worker' roles; 'leading not managing' staff; and providing cultural support and related workforce development.

Rostering: using shortened rosters for high-intensity clients; offering flexibility in rostering to support work–life balance; using permanent rostering lines, modified where necessary to manage workload; rotating staff to other programs when necessary; specifying maximum percentage of shifts in any one house; using family-friendly rostering when possible; and making rosters as predictable as possible.

Emotional and collegial support: engaging therapeutic specialists to support staff; privileging relationships and creating a supportive environment; debriefing and prioritising a positive team culture and staff communication; having staff recognition events; providing 'fitness passports' to local gyms; providing staff wellbeing and reflective practice programs; providing access to EAP, chaplaincy and professional debriefing sessions; and ensuring staff access to cultural/ceremonial leave entitlements.

Financial stability: providing salary packaging and a pro-rata training budget; providing appropriate remuneration; offering permanent full- and part-time roles wherever possible; providing a supervision focus on career planning; and providing access to further training, development and study leave.

Professionalism: creating role autonomy and the ability to contribute to the ongoing development of programs; including staff in operational decisions; providing fortnightly reflective space sessions; providing practice-focused coaching; and using reflective logs, supportive supervision and practice reflection.

Key findings

1. Service and staffing characteristics

- Most of the therapeutic residential care services surveyed are currently funded by block funding.
- Approximately one-fifth of services reported providing therapeutic residential care without explicit funding to do so.
- Four-bed therapeutic homes were the most commonly reported form of residential care homes.
- Small metropolitan homes located in the community were the most commonly reported type of therapeutic homes.
- The majority of therapeutic residential care services employed a range of initiatives aimed to increase staff morale, wellbeing, professionalism and support.

2. The care needs of young people being supported

Participating services were asked about care arrangements, therapeutic service goals, and the characteristics and therapeutic needs of young people in their service. This information is important as it helps to articulate the goals of service provision for young people, and the supports needed to achieve these goals. This includes consideration of the therapeutic needs of young people, the staff skills, therapeutic activities and other elements needed to support young people effectively, according to their needs (Knorth, Harder, Zanberg, & Kendrick, 2008; McLean, 2018).

Young people's care arrangements

Services were asked to indicate the care status of young people accessing their service. Participants were given five possible choices of care arrangements and were asked to rank the most common care arrangements for the young people in their services. Thirty-five participants provided a response to this question. The common

care arrangements for this group of services (listed here from most common to least common, according to group-ranked responses) were:

1. guardianships to age 18 orders
2. temporary/assessment orders
3. mixed care arrangements
4. voluntary care orders
5. other person guardianship.

When given the opportunity to provide additional comments, 12 participants indicated that other care arrangements such as family reunification/restoration, shorter-term care and/or interim accommodation orders were also common forms of care for this group of young people. This highlights the need to document and track these outcomes; and suggests the need to include these categories in future research about the placement needs of young people in therapeutic residential care.

Therapeutic goals of service

Services were asked to provide an indication of the main goal of the service by ranking agreement with options from a list of possible service goals. Thirty-three participants provided rankings for this question. As a group, participants indicated that their service aimed to support young people with the following goals (listed here from most common to least common, according to group-ranked responses):

1. recovery from trauma
2. transitioning to independent living
3. providing a permanent home until age 18
4. daily care/containment
5. re-connection with family
6. re-connection with education
7. needed placement following foster placement breakdown
8. emergency care
9. short-term care; with aim to reunify with family
10. short-term care; with aim to place in foster home.

As a group of services, the least common goals involved 'intensive mental health treatment', followed by the 'supportive placement of family group', and finally 'transitioning from secure care (e.g. bail housing)'. In open-ended responses, 18 participants emphasised the importance of addressing young people's criminal behaviour; stabilising young people's social and behavioural functioning; supporting cultural connection; and building young people's emotional regulation and relationship skills, suggesting the importance of developing service responses to these issues as well.

Young people's characteristics and primary support needs

Participants were asked to select from a range of 10 broad categories that best described their client groups' main characteristics and support needs. Thirty-three participants responded to this question. As a group, participants indicated that their service addressed the following support needs (listed here from most common to least common, according to group-ranked responses):

1. high risk/offending
2. Aboriginal/Torres Strait Islander
3. intellectual disability
4. sibling group
5. CALD
6. disability
7. children under 12.

Although clearly these categories can overlap, they provide some indication of the characteristics and main support needs of young people in residential care. In terms of sex groupings, mixed client groups were the most common client groupings; followed by male-only groups and, less commonly, female-only groups.

Key therapeutic issues

Respondents were also provided the opportunity to comment on the key therapeutic issues for young people in their care. Eighteen services provided a response to this open-ended question. Common therapeutic issues identified by participants include complex clinical support and health needs such as autism, intellectual disability, complex trauma, mental health needs, challenging behaviours, sexualised behaviours and risk of sexual exploitation. Young people were also considered by respondents to be a heightened risk due to alcohol and substance misuse; lack of supports and family and cultural connection; offending behaviour; disconnection from education; and risk of homelessness.

Key findings

2. The care needs of young people being supported

- 'Guardianships to age 18' was the most commonly reported care arrangement for young people living in therapeutic residential care.
- The most common therapeutic aims involved supporting young people's recovery from trauma and developing independent living skills.
- Therapeutic residential care appears to be common for young people with high risk or offending behaviour, for Aboriginal young people, and young people with an intellectual disability, among other needs.
- Complex clinical and mental health support needs, challenging behaviours and risk of harm were among the key therapeutic issues identified by participants.

3. Therapeutic frameworks, models and practices, and staff/program activities

Participants were asked to provide information about the therapeutic frameworks, therapeutic models and crisis-response models that guide their therapeutic practice; and about the staff-led practices and program activities through which these approaches are enacted. It is important to document the organisational frameworks and models that inform therapeutic residential care, as having a clear conceptual framework for workers' practice has repeatedly been identified as an important element of effective residential care internationally (Holden et al., 2010; Knorth et al., 2008; McDonald & Millen, 2012).

Therapeutic frameworks, models and practices

An important aim of this survey was to capture the main theoretical approaches and practices guiding therapeutic practice in the Australian residential care sector. The literature does not clearly distinguish between practices, model and frameworks; leading to the possibility that these constructs are confounded in discussions regarding effective therapeutic care. In order to support a clear distinction between frameworks, models and practices, the following definitions were provided by the author; these were developed in collaboration with the National Therapeutic Residential Care Alliance reference group for this project:

- Therapeutic framework: A therapeutic framework guides staff recruitment, policies, procedures and understanding of a young person's behaviour and needs.
- Therapeutic model: A therapeutic model guides daily interaction with young people, provides an understanding of their specific needs and shapes activity planning.
- Crisis intervention model: A crisis intervention model is what staff draw on when responding to escalating behavioural responses or reactive aggression.

Therapeutic framework

Services were asked which therapeutic framework best reflects their service. This question was prefaced by the definition of 'therapeutic framework' provided above. Thirty-four services provided a response to this question; with 30 choosing a model from among the available response options. The majority of services (n = 22) identified 'trauma-informed care' as their guiding therapeutic framework, followed by the CARE framework (n = 4), then Sanctuary (n = 3), and finally Hope and Healing (n = 1).

Participants that did not endorse any of the available response options (*n* = 4), provided further detail that indicated their service had developed a therapeutic framework that was not captured by the response options provided. Agencies that had developed their own therapeutic frameworks described these as drawing on the principles of attachment-based and trauma-informed approaches; or as using elements of evidence-informed models such as Sanctuary and CARE augmented by various practices such as needs-based assessment, positive behaviour support and restorative practice.

Therapeutic model

Services were asked which therapeutic model best reflects their service. This question was prefaced by the definition of 'therapeutic model' provided above. Thirty-five services provided a response to this item. The majority of services indicated that they used an attachment model (*n* = 12); followed by a developmental model (*n* = 5); then a teaching family model (*n* = 2); and, finally, social learning, positive peer culture and behavioural/token economy models equally (*n* = 1 each).[1]

In addition, a number of services indicated they draw on a therapeutic model outside of the choices provided in the survey (*n* = 11). Qualitative responses indicated that these services did not prescribe to commercially available models of care but instead had developed their own models for proactively addressing young people's needs, based on evidence-informed principles. For example, several services reported using multi-dimensional and needs-based developmental and biopsychosocial models, and models for creating supportive environments and skills development. Models based on principles of neuro-sequential programming, polyvagal theory and PACE were also reported.[2]

In giving their responses, participants differentiated between these therapeutically focused models and models they drew on for responding to safety concerns, which focused on de-escalation and crisis responses (i.e. crisis intervention models, as reported next).

Crisis intervention model

Services were also asked whether or not they had a formalised model for crisis management. This question was prefaced by the definition of 'crisis intervention model' provided above. Thirty-five services provided a response to this item. The majority of responding services (*n* = 30) indicated that they do have a formal crisis management model that they draw on; however, there were also some services (*n* = 5) that indicated they did not have a formal model of crisis de-escalation and safety.

Services were asked to provide further details about the crisis intervention model they employed. Twenty-six services provided further detail about the model they used. The majority of these services were using the Therapeutic Crisis Intervention model from Cornell University (TCI) (*n* = 22); this was followed by Non Violent Crisis Intervention (NVCI); either used in isolation as the sole crisis intervention approach (*n* = 1), or as a supplement to non-aversive reactive strategies informed by individualised positive behaviour approaches (*n* = 3) (see Box 1).

1 Note, there is some variation in how these models may be conceptualised and operationalised in practice. Broadly speaking, each of the models described here are characterised by different underpinning beliefs that inform practice. For example, attachment models rely on providing young people with the experience of safe and nurturing relationships as a means for facilitating change and growth. Developmental models view behaviour in terms of missed developmental opportunities, conceptualised within the range of typical child developmental experience, and emphasise the provision and scaffolding of normative developmental opportunities to provide the opportunity to address developmental gaps. The Teaching Family Model and other social learning models rely on the appropriate use of boundaries paired with modelling of desired and prosocial behaviours, together with competency building, as a foundation for providing corrective experiences to young people. The Teaching Family Model specifically uses house 'parents' to support a social learning program and to build prosocial responses. Behavioural models are similar to social learning models of practice but may rely more on managing environmental triggers and contingencies. A Positive Peer Culture model is a model for developing prosocial peer influence, and social and cultural responsibility, based on group norms and problem solving. For more information about these models see McLean, Price-Robertson, & Robinson (2011) or McLean (2018).

2 Neurosequential programming is an approach to developing therapeutic supports for vulnerable children that is based on understanding the timing and nature of past abuse, coupled with a mapping of the impact of the abuse to the developmental stage, brain region and neural networks thought to mediate neuropsychiatric difficulties. Therapeutic supports are shaped by this knowledge and delivered in the context of trustworthy relationships with significant others. This approach was developed by Bruce Perry and colleagues, and has been influential in shaping practice in out-of-home care in Australia (see McLean, Price-Robertson, & Robinson, 2011; Perry & Hambrick, 2008).
Polyvagal theory draws on knowledge of human evolution and the physiology of neural circuits to explain the interplay of adaptive and non-adaptive physiological responses in response to threats to safety (see Porges, 2007, for more information).
PACE is an approach that forms part of Dyadic Developmental Therapy. This approach was developed by Dan Hughes and it promotes what he believes are principles of therapeutic relationships that caregivers should aim to display towards young people: Playfulness, Acceptance, Curiosity and Empathy (PACE) (see ddpnetwork.org/about-ddp/meant-pace/ for more information).

Box 1: Crisis intervention and positive behavioural support in residential care

For more information on the Therapeutic Crisis Intervention model, see: rccp.cornell.edu/tci/tci-1_system.html

For more information on Non Violent Crisis Intervention, see: www.crisisprevention.com/CPI/media/Media/Resources/research/14-CPI-INT-003_empirical.pdf

For more information on non-aversive reactive strategies and positive behaviour approaches see:

- Crates, N., & Spicer, M. (2016). Reactive strategies within a positive behavioural support framework for reducing the episodic severity of aggression. *International Journal of Positive Behavioural Support*, *6*(1), 24–34.
- Weiss, N., & Knoster, T. (2008). It may be non aversive, but is it a positive approach? Relevant questions to ask throughout the process of behavioral assessment and intervention. *Journal of Positive Behavior Interventions*, *10*(1), 72–78.

Staff-led and program activities

Services were asked to describe the staff-led activities and program activities that were used in their services. Participants chose from a list of response options, and response scores were weighted according to group ranking. The need to better understand the kinds of activities that take place in therapeutic residential care services has been repeatedly emphasised in the literature (Axford et al., 2005; Knorth et al., 2008; McLean, 2018). The following definitions were provided to participants in order to provide guidance and consistency in responding to this question:

- Staff-led activities: Staff activities are the staff-initiated activities and programs that are intended to support young people's development.
- Program activities: The main activities that young people take part in as part of your program that are directed towards meeting their needs.

Staff-led activities

Participants were provided with the definition of 'staff-led activities' as described above, and asked to select from a list of seven staff-led activities. Thirty services provided responses to this question. As a group, participants indicated that their service commonly used the following staff-led activities (listed here from most common to least common, according to group ranking):

1. educational/vocational programming
2. living skills training
3. recreational programming
4. sensory activities/programming
5. resident meetings
6. family therapy/family connection
7. sporting activities/training.

Participants were also given the opportunity to provide more detail through open-ended responses to this question. Thirteen services provided additional information. The main activity participants noted that was not on the existing list of response options was support for cultural connection, indicating this forms a large part of therapeutic residential care staff's role; and that it is an activity that is seen as distinct from family connection activities. Additional staff-led activities listed by participants revolved around building relationships, predictability and emotional safety using therapeutic parenting and social learning activities (i.e. where staff support positive relationships through modelling and opportunistic reparative learning experiences).

Program activities

Services were also provided with the definition of 'program activities' as described above, and asked about the main program activities that are undertaken in order to meet young people's needs. Participants were asked to select common activities from a list of nine options. Twenty-nine participants provided responses to this question.

As a group, participants indicated the activities that were undertaken to meet young people's needs (listed here from most common to least common, according to group ranking – note some responses received equal ranking):

1. Learning independent living skills
2. Educational/vocational programming
3. Cultural activities
4. Mentoring; and Sporting activities
5. Community volunteering
6. Part-time work
7. Group education sessions; and Tutoring.

Participants were able to provide additional detail in an open-ended response. Five services provided additional information, indicating that regular family access and family inclusion activities, regular health checks, psycho-education about self-regulation and self-care activities, and gardening were also program activities used to meet young people's needs.

Key findings

3. Therapeutic frameworks, models and practices, and staff/program activities

- The majority of services included identified 'trauma-informed' care as their therapeutic framework; although the related CARE and Sanctuary therapeutic frameworks were also reported as influential.
- Most therapeutic services identified that their practice and daily interactions were guided by attachment theory, developmental theory and social learning models.
- The vast majority of therapeutic residential care services used a clear crisis intervention model, with Therapeutic Crisis Intervention being the most commonly employed model for enhancing safety.
- The focus of staff-led activities was commonly on the provision of educational and vocational skills, life skills and recreational programming. Cultural connection was named as an important staff-led activity.
- The focus of daily programming was similar – addressing young people's need for independent living skills, educational and vocational programming, and cultural connection were central to programming activities for therapeutic services.

4. Key issues informing future development in the sector

The need to better understand and share knowledge about effective therapeutic care and the extent to which services are matched to need has long been acknowledged (James, 2014; McNamara, 2014; Whittaker et al., 2016). This can be summarised as a shift in thinking away from a 'one-size fits all' approach to service provision and towards an understanding of 'what works for whom, and when'. For this reason, it is important to learn from experienced service providers about what they think works well, and what needs to change, to further develop the effectiveness of this cost-intensive form of service provision.

Accordingly, service providers were given the opportunity to provide commentary in response to three broad questions:

1. Which young people benefit the most from therapeutic residential care?
2. Which young people are not suited to therapeutic residential care as it is currently designed and funded; and what changes could make it more effective for these young people?
3. How might therapeutic residential care be improved to better accommodate the needs of young people?

Results of open-ended responses were grouped by content themes and are presented below.

1. Which young people benefit the most from therapeutic residential care?

Twenty-seven respondents provided commentary on this question. Some respondents expressed the view that therapeutic residential care is potentially beneficial to *all* young people, provided staff worked therapeutically; suggesting it is the practice, not the young people's needs, that makes therapeutic care effective. Other responses centred more on the characteristics of the young people being placed in therapeutic residential care. These comments centred on the age, relationship needs, motivations and engagement of young people. Within the commentary on these broad factors, there was considerable diversity of views. Commentary themes are summarised as:

Young people's needs as a consideration

Responses in this category discussed the potential for therapeutic practice to help all young people. Open-ended responses indicated that therapeutic practice is likely to be helpful for young people who:

1. have experienced trauma, have complex behaviours, or who need intensive therapeutic support and stabilisation
2. have experienced placement breakdown or removal and can remain in, and tolerate, therapeutic placement long enough to build healthy attachments to staff and prepare for another type of family-based care
3. need high levels of supervision because of behavioural complexity or disability and/or are, therefore, unable to keep themselves safe.

Young people's age as a consideration

Views on how young people's age affected their suitability for therapeutic residential care were polarised. Some respondents felt that younger children were less disengaged from community, were less resistant, derived more benefit from a residential program; and workers felt more hopeful working with younger children as a result. Others felt that therapeutic residential care was a service of last resort that should work with older children; or that adolescents who require support and accommodation, who want more independence and don't want to be placed with a family were more suited to therapeutic residential care.

Capacity for relationship

Respondents also felt that a young person's capacity for relationship was an important factor in determining suitability for therapeutic residential care. On the whole, 'relationship' was seen as a shared responsibility; with both child- and staff-related factors seen as important. Staff capacity for providing consistency, warm relationships, safe and firm boundaries, and attuned care were commented on. At the same time, young people needed to be able to 'engage in a relationship' with significant adults in order to benefit from therapeutic residential care.

Capacity to engage

Respondents commented that young people who are engaged in some kind of learning or educational program were likely to be successful in therapeutic residential care. Engagement in these programs was seen by respondents as a marker of young people's motivation and 'future focus'. Drug use and criminal behaviour were viewed by respondents as indicators that a young person was disengaged and would be less suited to therapeutic residential care.

2. Which young people are not suited to therapeutic residential care as it is currently designed and funded; and what changes could make it more effective for these young people?

Twenty-four respondents answered this question. As previously noted, some respondents felt that *all* young people were potentially suitable for therapeutic residential care. The majority of respondents, however, did feel that some young people had needs that made them less suited for the therapeutic residential care model as it is currently offered. For example, some respondents felt that young children and those without high therapeutic needs were not good candidates for residential care. Most respondents indicated that young people with sexualised behaviours that involved coercion or with violent or high-risk behaviours associated with substance use were not suited to therapeutic residential care in its current form. Finally, young people who have reactive attachment disorder or other difficulties in forming attachment relationships were thought by respondents to need more intensive supports than were possible within therapeutic residential care. Generally, young people who negatively influence other young people or whose behaviour is characterised as non-cooperative or as coercive were thought to need augmented programs of care.

Suggestions for change focused on adjusting therapeutic models, staffing ratios and staffing qualifications to better meet the needs of young people with more complex needs. In other words, changing program designs, activities and staffing to create models that better address the needs of young people who may currently be falling through the gaps. Suggestions for program design include: reducing the use of shorter-term placements that do not allow sufficient time to build relationships with young people; referral and placement matching that considers young people's developmental level, relationship needs, and who therapeutic care is most suited to; and enhancing the focus on family, community and culture. Several comments noted the need for a continuum of options that should include secure care and/or a more specialised service model for young people with substance use issues or who are at high risk of serious physical or psychological harm to self or others. Young people with aggressive, coercive or challenging behaviour were viewed as needing more appropriate funding and staffing ratios and more skilled staff to support them.

3. How might therapeutic residential care be improved to better accommodate the needs of young people?

Thirty respondents answered this question. Several clear themes were identified:

Changes to referral, matching and transitioning pathways

Several respondents commented on the need for changes to current practice to allow young people to be assessed and properly matched to a placement – whether this is therapeutic residential care or foster care – rather than asking 'who has a bed right now?' Respondents commented on the need to legislate standards of care that ensure adequate identification of needs prior to intake, and an assessment of the ability of any service program to meet those needs. Others made more general comments about the need for systemic changes in the process of matching and transitioning, and the capacity to 'cap' placement numbers in homes to maximise stability and minimise the impact on other young people.

Specialisation of therapeutic residential care models

Participants commented on the need for a variety of specialised therapeutic models, with additional funding to ensure clinical, allied health and therapy services for young people were conducted by qualified staff with sound working relationships with the residential care staff. The need for access to specialist medical services, paediatricians, psychiatrists, clinical psychologists and occupational therapists was noted. Related to this was a perceived need for models to address high-risk behaviour, sexually harmful behaviour and substance use; and these models require higher ratios of staff and specialist mental health input. The need to maintain ongoing training and support for frontline staff was seen as essential. In addition to foundational training in therapeutic care, the need for training in supporting children with sexualised behaviour and intellectual disability was identified as important.

Adopting a child-centred approach

Several respondents emphasised the need to work with young people in a child-centred way; rather than taking a 'child protection' perspective. This *may* reflect participants' belief in the need to adapt the service options to better suit young people's needs (i.e. work to accommodate a child's unique needs in a 'child-centred' way), rather than offering one model that a young person is required to adapt to (i.e. a 'one-size fits all' child protection service model).

According to participants, this included affording young people more autonomy and choice about decisions, promoting their independence in more effective ways, and offering a variety of models that are designed around young people's needs. Effective models could also include secure care for young people at particular times when they are unable to keep themselves safe, but also other models designed to wraparound young people. Participants described the need for better integration of care between juvenile justice, policing, and care and protection systems to ensure the safety of young people was prioritised, to avoid criminalisation of need and to ensure that young people can stay at the residential home long enough to benefit from therapeutic support.

Participants commented that a child-centred (rather than systems-centred) approach should also include more effective collaboration between services, service coordination and communication with young people in residential homes; and cross-government initiatives that include health, mental health, education and child protection working together to achieve better outcomes for young people in the care 'system'.

Finally, comments were made about the need to create a more 'normal' childhood experience for young people; as many aspects of the residential 'system' meant young people experienced unnecessary restrictions on their participation in friendship groups or other social groups, and were disconnected from family relationships and their broader cultural community. These comments may refer to practices such as police checks for sleepovers or physical re-location of young people away from community, which may create barriers to social connection that are not experienced by other young people. Suggestions for normalised and child-centred care put forward would have funding and staff training implications that fall outside current service parameters.

Providing secure care intensive options for young people at risk

Several respondents commented more specifically about the need for a secure therapeutic care[3] option for a proportion of young people; and that longer periods of time and more active therapeutic engagement is sometimes required than is available under current models in order to prepare young people for independence and living in a less restrictive environment. Secure care containment options were seen as beneficial for young people who regularly leave residential facilities to engage in drug use, and cannot be engaged in rehabilitation or detoxification within the constraints of the current therapeutic care model. The need for secure care to be well considered, appropriately funded and time limited was noted. The need for programs that address alcohol and substance use was also noted, especially outside of metropolitan areas where there are fewer treatment options.

Legislative changes

A range of comments were made about potential changes to existing legislation that may facilitate/support the provision of more effective therapeutic care. This included the need for a range of options other than 12-month or 18-year orders;[4] as well as legislation mandating access to therapeutic supports for young people in care. Participants also expressed the desire for mandated standards of care that ensure young people's needs are identified prior to intake, and that services are assessed on the ability to meet young people's needs and the service's duty of care to young people. Finally, there was a call for legislative standards and 'factually sound reasoning with evidence' regarding decision making; in particular, regarding criteria for deciding whether a child is 'at risk', or in recommending a change in placement for a young person in care.

3 Secure therapeutic care in this context refers to a facility or service that is legislatively supported to provide time-limited secure care for young people who are at substantial and significant risk of harm to themselves or others. The rationale for referral to secure care rests on the argument that the child's best interests may be served by eliminating their exposure to harm through temporary removal from risk by placement in secure care. The key considerations in this form of care (both internationally and in the Australian jurisdictions where this is available) involve the need for clear referral criteria, supportive legislation and oversight, strictly time-limited models, presence of step-down pathways; access to mental health support; active case management; and the explicit recognition of neuro-diversity, intellectual impairment and trauma as predisposing and perpetuating factors driving young people's risk. For a more detailed discussion of secure therapeutic secure care in Australia and internationally, see McLean (2016).

4 '12-month orders' in this context refers to a ruling that awards short-term/temporary custody of a child – typically to a guardian other than the child's biological parents – for a defined period of time (typically 12 months). '18-year orders' in this context refers to a child's legal custody being awarded to a senior statutory authority, until such time as the child becomes an adult.

Flexibility in service commissioning models

Participants commented on the need for more flexible models and for funding of care outside of a four-person model; including the capacity to 'cap' the number of young people and/or fund additional staff in a home when it is necessary (e.g. to stabilise a home). Related to this, there was a suggestion to allow groups of two (especially siblings) to live together without having to place another child in the home due to funding model requirements that stipulate the number of children to be placed in each home. Generally, higher levels of funding were viewed as a means to ensure two staff were on shift at all times, and for more flexibility in responding to young people's changing needs. Comments were also made about the impact of regional contracting models, which meant that young people cannot easily move into homes in other regions; and about the need to separate contract compliance from service delivery reporting. As a whole, participants' comments appeared to suggest that aspects of the referral and commissioning of services affected services' ability to respond in a flexible way to young people's needs.

Participants commented on the complexity involved in decisions about the suitability of therapeutic residential care for young people. As a whole, participants recognised that a young person's engagement and relationship skill, often related to a young person's age and time spent in care, was a factor in determining whether therapeutic care or a more specialised and intensive model would be suitable. It is worth noting that there is considerable debate about the suitability of therapeutic residential care for young children; although it may be, at times, the only option for larger sibling groups that include younger children (McLean, 2015). Generally speaking, participants raised several possible ways in which therapeutic residential care could be adapted to make it more suited to young people with additional and complex support needs, including building more flexible and responsive referral pathways and augmented models of care, based on need.

Key findings

4. Key issues informing future development in the sector

- There were variable views about which young people could most benefit from therapeutic residential care – whether all children could benefit from this service or those who needed high levels of supervision, or had complex behavioural, emotional or relationship needs.
- Views about the age range for therapeutic residential care were also mixed – some felt younger children offered more potential for change, others felt that older children and adolescents were more suited to this form of care.
- Respondents felt that young people with certain complex needs, coercive interpersonal relationships or high-risk behaviours were not suited to therapeutic residential care in its current form, and needed additional specialised input and programming.
- There was a perceived need to tailor models in consideration of young people's developmental, therapeutic and safety needs, resulting in a range of models that should include secure care to address prescribed needs. This should accompany greater legislative and funding flexibility.
- The need for changes to the referral, matching and transitioning pathways was noted, in order for there to be better alignment of services with need.
- The need for services to better respond to children's developmental need, rather than statutory concerns, was noted (be 'child-centred' not 'child-protection' centred).

Discussion and conclusion

Discussion

This paper appears to be the first to provide a snapshot of current practice in Australian therapeutic residential care, providing new information that can be built on to further inform service development in the future.

Open-ended responses were particularly helpful, and incorporating and quantifying this valuable information will inform the development and enhance the utility of this reporting framework in the future. Many of the comments provided by participants mirror contemporary issues in the literature; namely the referral and matching of young people in therapeutic residential care; the need for augmented and specialised care models, including secure care, for young people with complex needs and high-risk behaviours; the need for services and staff that can support cultural and family connection; and, finally, the need to nurture and retain high-quality staff (Ainsworth & Hansen, 2018; Bath, 2017; McDonald & Millen, 2012; Whittaker et al., 2016).

Notwithstanding the methodological limitations of the survey, some key themes were identified. In relation to funding, block funding was the most common model, either alone or in combination with packaged funding. Block funding refers to contractual funding provided in advance for the placement of a predetermined number of young people. The common use of block funding for residential care has potential consequences for service providers. One inadvertent consequence of this is that services may feel pressured to fill placements; which, in turn, can impact the stability and wellbeing of young people already cared for by the service provider. On the other hand, this funding model provides services with the security needed to plan and staff services effectively. The strengths and limitations of this model of funding, relative to other possibilities, warrants further exploration. It is noteworthy that around one-fifth of services report providing therapeutic care without the corresponding funding. The implications of this for service effectiveness and outcomes also warrants further exploration.

Most commonly, residential care is provided in small metropolitan homes with up to four young people, although other configurations are also used. Further analysis of the strengths and limitations of these funding and service configurations could be a valuable focus of research efforts in the future.

Among therapeutic services, a range of strategies were used to support staff and reduce staff turnover. These are strategies that might be useful in other forms of service delivery for young people with complex needs where relationships may be challenging.

It appears therapeutic residential care is still used most commonly for children under longer-term guardianship, with some focus on care and containment and providing a home until age 18. While the most commonly stated aim of therapeutic residential care was recovery from relational trauma, there was also evidence that the recognition of pervasive developmental and mental health issues that require specialist targeted clinical supports is growing among service providers; suggesting the need to integrate evidence-based approaches to address these issues into ‘mainstream’ therapeutic residential care. In terms of therapeutic approaches, attachment-based models still influence therapeutic care but recognition of the need for evidence-informed principles and models also appears to be growing in this sector.

There appears to be some division of opinion around who is suited to therapeutic care, with some believing all children can benefit from skilled therapeutic care and others suggesting augmented models might be more appropriate for young people with certain complex behavioural or relational needs. This is an area that could benefit from focused and sustained research in order to develop a more sophisticated and nuanced service sector into the future. Common themes emerging from qualitative analysis include the need to improve referral and placement matching; the need to consider a wider range of specialist models including secure care under prescribed conditions; and the need to make systems, legislation and funding more ‘child-centred’ to support providers of therapeutic residential care services to be more flexible and responsive to young people’s needs.

Conclusion

To date, there has not been much information available about how Australian therapeutic residential care services are configured and currently operating. To some extent, this has meant that the capacity to engage in meaningful comparisons between services has been limited. This study has contributed to our understanding of current Australian therapeutic residential care services and contemporary practice in this sector. The survey results indicate that therapeutic residential care is commonly still used for young people under longer-term care orders, provided in small (2–4 bed) community homes, although some other configurations were also evident. This form of service provision offers the advantage of a 'home-like' environment; but other models may be more suited to young people who need high levels of supervision and oversight, or who may be at increased vulnerability of exploitation in smaller, isolated environments. This is an issue that warrants further exploration.

The views of participants about the effectiveness of therapeutic residential care as it is currently configured were particularly valuable and offered considerable insight into how this form of service provision could further evolve and specialise. Taken together, this information constitutes useful baseline information that can be further built on; for example, to map changes in service design and practice over time, in step with developments and innovations in service provision, based on the recommendations provided by the experienced staff in this study.

Author and acknowledgements

Sara McLean is a psychologist with expertise in young people with developmental difference arising from early adversity, prenatal substance exposure, and interpersonal trauma and neglect. Sara's publications synthesise emerging knowledge from the fields of neuropsychology, clinical psychology and forensic psychology; and translate this knowledge into evidence-informed approaches to support young people living in out-of-home care settings. Sara was awarded the ACU Linacre Fellowship at Oxford University in recognition of her work supporting young people in care with complex behavioural needs. She is a Consultant Psychologist in Child Protection; an Adjunct Research Fellow at the Australian Centre for Child Protection, University of South Australia; and a member of Emerging Mind's National Workforce Centre for Child Mental Health.

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Appendix A: Methodology

An online survey methodology was used to collect information on service provision in a sample of services that self-nominated as providing therapeutic residential care. The purpose of this survey was to document the service and staffing characteristics, care needs, therapeutic frameworks, models and practices, and other key issues that characterise current Australian therapeutic residential care. The survey was commissioned by the CFCA information exchange at the Australian Institute of Family Studies.

Research ethics approval for this survey was received from the University of South Australia's Human Research and Ethics Committee and reviewed and noted by the Australian Institute of Family Studies' Ethics Committee.

The survey was promoted by the CFCA information exchange at the Australian Institute of Family Studies via their newsletter and website, and by the National Therapeutic Residential Care Alliance of Australia via their membership list and distribution pathways. The Australian Institute of Family Studies also promoted the survey directly to services that were identified from its existing network of services and other organisations working in the sector, such as peak bodies; and information about the survey was distributed by the author opportunistically at key industry events during the study period.

The survey questions were based on the index of reporting standards proposed by Lee and Barth (2011) with amendments, based on the outcome of a consultation with the National Therapeutic Residential Care Alliance reference group. The final survey questions were tested for comprehension and usability by the author and the Australian Institute of Family Studies. Data collection was between 5 July and 5 October 2018. Completed data were uploaded and securely transferred by a password-protected link to the primary author for analysis.

Each survey contained 35 questions (see Appendix B). This included a mix of questions targeting:

- demographic and other descriptive information (8 questions)
- characteristics and needs of young people being cared for (2 questions)
- service characteristics such as location and size (4 questions)
- staffing configuration, staff retention and training (11 questions)
- therapeutic approaches, models and activities (6 questions)
- open-ended prompting questions aimed at obtaining feedback about residential care and suggestions for further development (4 questions).

All survey data were reviewed with reference to predetermined inclusion criteria. Surveys were selected for inclusion if: a) all relevant demographic data and services information was completed; and b) survey responses were least 75% completed overall.

All responses were combined for each question and reported as a group. Data from individual services and/or jurisdictions were not reported separately.

The survey questions required a mix of quantitative and qualitative responses; and the scoring and reporting of responses obtained from participants varied accordingly. Box A.1 provides more information about how survey responses were scored; depending on the type of responses required. Throughout the survey, participants were asked to:

1. provide demographic information
2. provide numerical responses
3. rank options from a list of response choices
4. provide open-ended responses.

Box A.1: The scoring of survey responses

This survey used a mix of quantitative and qualitative survey questions. Scoring and reporting of survey responses depended on the type of responses obtained from participants. Throughout this report, survey responses are reported as group medians, group modal scores, simple weighted rankings or content themes, depending on the type of data being analysed.

Survey responses reported as median scores

Some questions asked participants to provide a discrete numerical response; for example, *'How many therapeutic residential care homes does your service run in this state/territory?'*. Throughout this report, these discrete numerical responses were averaged to produce a group median score. A median score was considered more appropriate than a group mean score due to the presence of outliers in the data.

Survey responses reported as modal values

Some questions asked participants to provide a discrete response, in response to a forced-choice question; for example, *'Is your agency funded to provide therapeutic residential care?'* (yes/no). Throughout this report, these responses were reported as group modal values. In this context, a modal value refers to the most common response.

Survey responses that were reported as rankings

Some survey questions required participants to rank options from a prescribed range of response choices; for example, *'What are the most common care arrangements for young people in the homes run by your service? – Please number each box in order of preference from 1 to 5: 1. Voluntary care orders; 2. Other person guardianships; 3. Temporary/assessment orders; 4. Young people with mixed care arrangements; 5. Guardianships to age 18.'*

In some cases, participants were able to rank only the top five choices. Each response option was ranked according to a simple weighted group score (a response option that was ranked 1 by a participant received a higher score than a response option that was ranked 5, to produce total scores for each response option). The resultant ranked score for each of the possible response options was reported. Participants were also given the opportunity to provide additional information or to provide responses other than those listed; and this is also reported where available.

Survey responses that were reported as themes

Survey questions that required open-ended commentary were grouped by content themes; and broad content themes are reported in this paper. There were four broad questions that asked for this kind of qualitative information from participants.

Limitations

This survey has limitations due to the categorical or ranked nature of most responses. The decision to adopt questions based on the reporting framework of Lee and Barth (2011) offered the advantage of gathering information in a way that can be compared in a meaningful way with service providers internationally; but there were also limitations imposed by adopting categories that may be more applicable to services outside of Australia. On the whole, however, the responses to this survey, when considered in conjunction with participants' narrative responses, provide foundational information that can be used to further refine future survey questions and identify areas of further exploration.

While a number of participants began the survey, it was evident that only staff in leadership positions were able to provide the kind of information about recruitment, funding and theoretical approaches asked for in the study. This inevitably meant that the views of leadership dominated this research, and the views of workers 'on the floor' are not well-represented in this study. While cross-jurisdictional comparisons were not possible due to the small number of services in some jurisdictions, this should be considered in the future if feasible.

A significant consideration in interpreting the results of this survey is that the sample is not representative of all services offering therapeutic residential care in Australia. The results offer first insight information into current practice in Australian therapeutic residential care. Another significant consideration in interpreting the results of this survey is the extent to which participating services are indeed offering therapeutic care, as opposed to being described as a therapeutic service; and how a residential care service is defined by funders as providing therapeutic care (for a broader discussion related to the definition of therapeutic residential care in Australia, see McLean, 2018). To further develop this important form of service delivery, there is a need for researchers, practitioners and funders to invest in the development of an agreed methodology for defining and operationalising therapeutic service elements, and for monitoring outcomes in a way that is meaningful for service providers, case managers and funders.

Appendix B: Survey questions and response options

Survey question		Response option
1.	What is the name of your organisation?	Text response
2.	Is your agency funded to provide therapeutic residential care?	1. Yes 2. No
3.	Does your agency provide therapeutic residential care?	1. Yes 2. No
4.	Which of the following best describes your role in the agency?	1. CEO/Area manager 2. Service manager 3. Staff supervisor 4. Quality manager 5. Frontline worker 6. Therapeutic specialist
	If your position does not match one of the above options, please provide your role in the box below.	Text response
5.	Your organisation may provide services in more than one state or territory. We would like you to provide information for one state or territory per survey. Which state or territory are you providing information about?	1. Australian Capital Territory 2. New South Wales 3. Northern Territory 4. Queensland 5. South Australia 6. Tasmania 7. Victoria 8. Western Australia
6.	How many therapeutic residential care homes does your service run in this state/territory?	Numeric entry
7.	Can you estimate how many young people in total your service provides care for in this state/territory? (Estimate the total number of young people in all your residential homes combined.)	Numeric entry
8.	Can you estimate the average number of young people you would have in any one residential home? (Provide a comment, if needed.)	Text response
9.	How is your service funded? (e.g. block funding, individual packages)	Text response
10.	What are the most common care arrangements for young people in the homes run by your service?	Please number each box in order of preference from 1 to 5 1. Voluntary care orders 2. Other person guardianships 3. Temporary/assessment orders 4. Young people with mixed care arrangements 5. Guardianships to age 18
	If your service uses any other common care arrangements, please describe them in the box below.	Text response
11.	What are the most common characteristics and/or primary support needs of the young people in the homes run by your service?	Please select at most 5 answers Please number each box in order of preference 1. Disability 2. Sibling group 3. ATSI 4. CALD 5. Intellectual disability 6. High risk/offending 7. Children under 12 8. Males only 9. Females only 10. Mixed gender home

	Survey question	Response option
	If the young people in the homes run by your service have any other common characteristics and/or primary support needs, please describe them in the box below.	Text response
12.	What are the main therapeutic aims of your service? What is the main purpose for which a young person is placed in your service?	Please select at most 5 answers Please number each box in order of preference 1. Intensive mental health treatment 2. Providing a permanent home until age 18 3. Emergency care 4. Short-term care; with aim to place in foster home 5. Short-term care; with aim to reunify with family 6. Recovery from trauma 7. Daily care/containment 8. Re-connection with education 9. Re-connection with family 10. Transitioning to independent living 11. Transitioning from secure care (e.g. bail housing) 12. Supportive placement of family group 13. Needed placement following foster placement breakdown
	If there are any other main therapeutic aims of your service, please describe them in the box below.	Text response
13.	How many homes run by your service are located in the following areas? Please provide numbers for each type. *Please answer only for the state or territory that you are providing information about.* a. Metro? b. Regional? c. Rural?	Numeric entry
14.	Some residential care services are delivered in small co-located groups of homes (clusters); some in larger free-standing facilities and some in smaller homes located in the community. For each of the configurations listed, please indicate how many homes your service has. *Please answer only for the state or territory that you are providing information about.* a. Home clusters? b. Free-standing facilities (campus-style larger facility)? c. Free-standing homes?	Numeric entry
15.	Please provide any further details on the set-up of the homes run by your service if required.	Text response
16.	What is your staffing model and your typical staffing configuration? *If your service uses more than one staffing model, please select the most common model.*	1. Live in-house parents 2. House parents and staff support 3. Rostered staff model 4. Other 5. Don't know
	If your service uses a staffing model not listed above, please describe your staffing model in the box below.	Text response
	If you are unsure, please provide what information you can about your staffing model in the box below.	Text response
17.	What shift rostering model do you use? *If your service uses more than one shift rostering model, please select the most common model.*	1. 8 hour 2. 24 hour 3. Active 4. Passive 5. Other 6. Don't know
	If your service uses a rostering model not listed above, please describe your rostering model in the box below.	Text response
	If you are unsure, please provide what information you can about your rostering model in the box below.	Text response

Survey question		Response option
18.	What overnight staffing model do you use? *If your service uses more than one overnight staffing model, please select the most common model.*	1. Active 2. Passive 3. Other 4. Don't know
	If your service does not use one of the overnight staffing models listed above, please describe your overnight staffing model in the box below.	Text response
	If you are unsure, please provide what information you can about your overnight staffing model in the box below.	Text response
19.	Does your agency have a formal policy regarding a minimum ratio of workers to children?	1. Yes 2. No 3. Don't know
20.	*If answered yes to Q19* What is the ratio?	Text response
21.	*If answered no to Q19* What ratio of workers to children does your service aim for when drafting the staff roster?	Text response
22.	Does your agency require a minimum level of qualification for direct care staff?	1. Yes 2. No 3. Don't know
23.	*If answered yes to Q22* What is the minimum qualification required from your staff?	Text response
24.	*If answered no to Q22* What selection criteria do you use when recruiting staff? Describe your selection criteria.	Text response
25.	What formal training do you require direct care staff to complete?	Text response
26.	Please provide comment on what your service does (if anything) to minimise staff turnover? (e.g. rostering initiatives, financial initiatives, professionalisation of the role)	Text response
27.	What is your service-wide therapeutic framework (if any)? *A therapeutic framework guides staff recruitment, policies, procedures and understanding of a young person's behaviour and needs.*	1. Trauma-informed care 2. Sanctuary 3. CARE 4. Hope and Healing 5. Other 6. Don't know 7. None
	If your service uses a therapeutic framework not listed above, please describe it in the box below.	Text response
	If you are unsure, please provide what information you can about your therapeutic framework in the box below.	Text response
28.	What therapeutic model does your service use (if any)? *A therapeutic model guides daily interaction with young people, provides an understanding of their specific needs and shapes activity planning.*	1. Teaching family model 2. Positive peer culture 3. Attachment model 4. Behavioural/token economy 5. Developmental model 6. Social learning model 7. Other 8. Don't know 9. None
	If your service uses a therapeutic model not listed above, please describe it in the box below.	Text response
	If you are unsure, please provide what information you can about your therapeutic model in the box below.	Text response
29.	Does your organisation have a formalised crisis intervention model? *A crisis intervention model is what staff draw on when responding to escalating behavioural responses or reactive aggression.* *(e.g. TCI = Therapeutic Crisis Intervention, NVCI = Non violence crisis intervention)*	1. Yes 2. No 3. Don't know
	Please describe your formalised crisis intervention model *(e.g. TCI = Therapeutic Crisis Intervention, NVCI = Non violence crisis intervention)*	Text response

Survey question		Response option
30.	What are the main staff activities you use in your programs? *Staff activities are the staff-initiated activities and programs that are intended to support young people's development.*	Please select at most 5 answers Please number each box in order of preference 1. Family therapy/family connection 2. Educational/vocational programming 3. Recreational programming 4. Sensory activities/programming 5. Resident meetings 6. Living skills training 7. Sporting activities/training
	If there are any other main staff activities you use in your programs, please describe them in the box below.	Text response
	If you are unsure of the main staff activities used in your programs, please provide what information you can in the box below.	Text response
31.	What are the main activities that young people take part in as part of your program that are directed towards meeting their needs?	Please select at most 5 answers Please number each box in order of preference 1. Mentoring 2. Educational/vocational programming 3. Group education sessions 4. Learning independent living skills 5. Community volunteering 6. Part-time work 7. Tutoring 8. Sporting activities 9. Cultural activities
	If there are any other main activities that young people take part in as part of your program, please describe them in the box below.	Text response
	If you are unsure of the main activities that young people take part in as part of your program, please provide what information you can in the box below.	Text response
32.	In your view, which young people benefit the most from therapeutic residential care?	Text response
33.	In your view, which young people are not suited to therapeutic residential care as it is currently designed and funded? What kinds of changes to therapeutic residential care could make it more effective for these young people?	Text response
34.	How might therapeutic residential care be improved to better accommodate the needs of young people? (e.g. legislative changes, more intensive clinical models, funding models, capacity for secure care, etc.)?	Text response
35.	Do you have any other comments you would like to make about therapeutic residential care in Australia?	Text response