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Therapeutic residential care in Australia

Taking stock and looking forward

Sara McLean, Rhys Price-Robertson and Elly Robinson

Therapeutic residential care (TRC) is becoming an increasingly relevant out-of-home care option for children and young people with multiple and complex needs. It is a new and developing approach in Australia, one aimed not simply at containment of the "hard cases"—as is often the case in traditional residential care—but rather at actively facilitating healing and recovery from the effects of abuse, neglect and separation from family. In this Issues Paper, therapeutic residential care is described and contrasted with other models of out-of-home care. The theory and evidence supporting the use of this form of care are examined and used to develop a set of key elements, which, it is argued, should guide the provision of therapeutic residential care in Australia.

Introduction

Following the move towards deinstitutionalisation in the second half of the last century, residential care was a mainstay placement option for children and young people who were unable to remain with their family due to protective concerns. More recently, however, it has become a last resort, used when other approaches, such as family support and/or foster care, have not been successful (Bath, 2009). Young people who display highly challenging and disruptive behaviours, such as those associated with conduct disorders, neuro-developmental problems and mental illness, are most often referred to residential care in order to avoid them harming themselves or others (Bath, 2009).

There is, however, an increasing understanding that these young people's histories are often littered with experiences of abuse, neglect and multiple placement breakdowns, which can hinder their ability to build trusting relationships with others. Many of these young people show signs of complex trauma and post-traumatic stress disorder (van der Kolk, 2005), which contribute to their maladaptive behaviours and emotions. Consequently, there is a growing shift to move beyond a traditional residential model of daily care and accommodation to a needs-based model of care that addresses the challenges posed by these young people's often compromised and complex developmental needs (Bath, 2009).

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This growing interest in how best to offer a healing, therapeutic environment within the context of residential care led to a proposal to hold a national workshop, which was endorsed by the Community and Disability Services Ministers' Advisory Council (CDSMAC) in late 2009. The National Therapeutic Residential Care Workshop was subsequently held in Melbourne in September 2010. The workshop brought practitioners and service providers together with researchers and government policy-makers. This paper draws on the proceedings of that workshop, Australian and international literature, and information about current models offered by jurisdictions within Australia to provide a picture of the increasing investment in therapeutic residential care and the key elements that characterise this model of care.

Definition of therapeutic residential care

One of the tasks of the National Therapeutic Residential Care Workshop was to provide a range of descriptions of therapeutic residential care that could be used in the development of a national definition. The definition has been refined at length by the national working group, and the final version is presented in Box 1. The definition has been developed to allow for various interpretations, according to the needs and scope of therapeutic residential care in different jurisdictions.

Box 1: National definition of therapeutic residential care

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

Source: National Therapeutic Residential Care Working Group

Residential care in Australia and internationally

Therapeutic residential care reflects a response to the need to provide out-of-home care service solutions applicable to the unique Australian context, in which demographics, geography, culture and care needs can differ in many respects from those found outside Australia. For example, greater population and geographic density in countries such as the United States or Canada means they have the capacity to justify the funding of larger residential homes with higher levels of specialist staffing (Ainsworth, 2007). As such, models developed in response to the service constraints in other countries cannot necessarily be directly and meaningfully translated to the Australian service and policy context. Nonetheless, such comparisons can help to identify solutions and innovations that might be useful in developing and refining existing models.

Comparing and contrasting therapeutic residential care in Australia to international forms of out-of-home care, and particularly to different types of residential care, is complicated by the absence of clear definitions and conceptualisations of the different forms of care (James, 2011; Knorth, Harder, Zanberg, & Kendrick, 2008). The specific treatment or therapeutic components of different residential care programs are rarely elaborated, rendering much of the residential service provision a "black box" of poorly understood elements that are difficult to generalise from or replicate (Hoagwood & Cunningham, 1992; Knorth et al., 2008). Comparison is also complicated by the continuing effect of traditional social and welfare models and values (Bath, 2009).

Out-of-home care service provision can also vary widely in ideology, structure and design. Models of service provision for children may differ conceptually in terms of their goals, the nature and "restrictiveness" of the intervention, and the staffing and support configurations attached to each. In the case of residential services, such services could be designed for children with mental health or behavioural problems, for juvenile offenders, or for those placed in out-of-home care for a range of reasons.

Despite these difficulties, it is possible to broadly compare therapeutic residential care, as it is currently conceived and practised in Australia, with other forms of out-of-home care. Traditionally, out-of-home care service provision has been conceptualised as occurring along a continuum of service options (Stroul & Friedman, 19964). Service models range along this continuum from the least intrusive and requiring the lowest level of support, to the most intrusive and support-intensive. Historically, residential care in all forms has been provided as a point of "last resort", rather than a "first placement" option, as mentioned previously. Children often end up in residential care following multiple placement failures, and it is said that children can "fail" their way into residential care.

Box 2 summarises the full range of potential configurations of out-of-home group care that exist internationally for children. The range of options represents what currently exists internationally, and not all of these models of out-of-home care services are employed in the Australian context. The service configurations summarised in Box 2 represent a continuum of care options, including those that are not exclusively used for children who have been removed from home due to abuse or neglect. Where possible, the service model is compared or contrasted to current Australian service provision.

Therapeutic residential care shares some components of psychiatric hospital/secure treatment unit care, and has many features in common with both treatment or therapeutic foster care and residential treatment care (see Box 2). Thus, while the residential treatment care model, for

instance, does not appear to exist per se in Australia, elements of this approach (e.g., therapeutic milieu) have been adopted in ideology in therapeutic residential care.

Therapeutic residential care is also unique in a number of ways. While it aims to facilitate healing of interpersonal trauma, it may do so largely without the intensive input of a multidisciplinary professional team such as exists in residential treatment care (see Box 2). It can be also be distinguished from treatment or therapeutic foster care or family group care because the aim is to provide a therapeutic service in a staffed, residential group home or cluster of homes, rather than to support therapeutic foster parents to carry out a program of intervention. Most residential care currently operating in Australian jurisdictions falls between family group care and staffed group care/congregate care models, supported by specialist consultancies.

Box 2: Range of out-of-home care support options

The following list of out-of-home care support options used in Australia and internationally leads from the least intrusive and requiring the lowest level of support, to the most intrusive and support-intensive. These service options are designed for a wide range of clients (not exclusively children in out-of-home care) and offered by a range of service providers (e.g., in mental health, juvenile justice or child welfare), making direct comparisons between models difficult. Delfabbro, Osborn, and Barber (2005) have suggested that out-of-home care services can be conceptualised as offering diverse care environments; for example, in regard to staffing configurations (on-site or "wrap-around" specialist support; treatment or containment role for staff), aspects of the physical setting (community or institution location; single unit or multiple dwellings; size of unit), and the management of the care environment (behavioural sanctions; orientation to care). The following are some of the support options that are reported in the international literature (see Stuart & Sanders, 2008, for more detail).

Less intrusive

Receiving homes

This is a form of home-based care provided by families who will take children on short notice for limited periods of time while long-term alternatives are organised. Although not commonly used in Australia, these can be considered to be analogous to emergency foster placements.

Kinship care

Kinship care is the provision of home-based care for children by adults who have a kinship bond with the child. This form of care is considered the most appropriate for children for whom it is important to maintain family and broader cultural connections; for this reason it is the first choice for Indigenous children in Australia.

Conventional foster care

This refers to the provision of home-based care by unrelated non-kin adults, and is a commonly used option for children who are removed from their homes due to abuse or neglect.

Treatment foster care (specialised or therapeutic foster care)

This is home-based care provided by foster carers who are recruited and trained to care for children in a therapeutic, trauma-informed way. These caregivers are typically reimbursed at a higher rate than conventional foster carers, in recognition of the complex needs of the children that they care for. It is well utilised in North America, where it may be employed for children with special needs or juvenile offenders. In Australia, there has also been increasing acknowledgement of the need for specialised or therapeutic foster care models to respond to the complex emotional and behavioural needs of children in out-of-home care. Treatment, specialised and therapeutic foster care can differ widely depending on the therapeutic framework used.

More intrusive

Family group care

This is similar to treatment foster care; however, the foster parents are also supported by workers on a shift basis. The home may be owned by the service provider, with the foster parents "living in". These homes may be larger than specialised or treatment foster homes, and may or may not exist in a cluster in close proximity to each other. This model of care does not appear to be widely used in Australia.

Congregate care (staffed group care or residential care)

Congregate care is provided in community-based residential homes, in which workers provide direct care of children on a rostered or shift-work basis. In Australia, these models have not typically received input or support from multidisciplinary teams or consultants, and do not necessarily provide a therapeutic or treatment aspect to children by design.

Therapeutic residential care

This intensive care placement for young people in statutory care within a residential setting aims to address the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences, informed by a sound understanding of trauma, attachment, and developmental needs. This option is "time-limited"; that is, efforts will be made to address critical issues and behaviours first before the young person is transitioned into a foster care placement. This emerging model is increasingly being suggested to represent optimal therapeutic care for children in the Australian out-of-home care environment.

Residential treatment care

Residential treatment care involves managing a fully staffed group home or a large campus under a common clinical supervisory structure, which may include day treatment programs or "on-site classrooms", and a multidisciplinary clinical support unit. These are not exclusive to young people in out-of-home care, and are generally of a time-limited nature. The residential treatment model may have a well-articulated theoretical framework—typically focusing on either mental health or educational/ training needs—using a therapeutic milieu or specific (cognitive/social) skills training, and may involve biological families in treatment.

Psychiatric hospital (secure treatment unit care)

These institutions contain all of the main ingredients of a residential treatment centre, but with the additional capacity to medicate or certify/secure a young person if they are considered a danger to themselves or others. They are not provided exclusively to children in out-of-home care and generally provide short-term care for children with acute needs.

Secure care/correctional facility

These are locked facilities to which young people are sent by court order, typically but not always as a consequence of criminal misconduct,[1] which are not exclusive to children in out-of-home care and do not generally provide therapeutic input. In the Australian out-of-home care sector, this option can be enacted for children when the Children's Court deems that there are serious concerns for the safety and wellbeing of the child on a protective order (used in some jurisdictions).

Source: Stuart & Sanders (2008)

1 Victoria, for example, has secure welfare that is a short-term placement option when there are serious concerns for the safety and wellbeing of a child on a protective order. This is not provided in relation to criminal behaviour.

Staffing structure of facilities

The jurisdictions differ somewhat in terms of the staffing structure within facilities. Some have clinical specialists working full-time or part-time alongside other trained staff. In other jurisdictions, all staff members receive training in trauma-informed care, and residential psychologists are available to support staff in providing care, but a full contingent of clinical specialists is yet to be achieved.

Staff training

The amount and type of specific training offered to staff also varies to some degree across the jurisdictions. Some jurisdictions offer residential care staff induction training in trauma-informed care and access to ongoing training in areas such as child development, brain development and the effects of trauma, and therapeutic crisis intervention. The training requirements of other jurisdictions are slightly more extensive, with workers in therapeutic residential care homes being required to participate in an initial two-day introductory training, followed by a five-day training program that is specific to the facility in which they will work. Of course, all such training is additional to the requirements necessary for employment in each particular jurisdiction.

Promising and problem practice elements

The jurisdictions were asked about what they saw as the most promising practice elements in their therapeutic residential care programs, as well as the elements that were less likely or had been shown not to work. Some jurisdictions indicated that an understanding of the effects of trauma on the functioning of the brain, as well as skills in responding to pain-based behaviour, had led to positive behavioural changes in children and young people. It was also noted that a strong emphasis on the provision of evidence-based practice and on well-articulated care and case plans appeared to be among the most promising practice elements.

In terms of program elements that were not working as well, one jurisdiction indicated that staff expectations of the therapeutic residential care model were often too high, which could result in disappointment when the service users' problematic behaviours continued. It was also noted in this jurisdiction that there were difficulties in attracting and retaining appropriately experienced and trained management and care staff. Finally, a number of jurisdictions mentioned that developing congruence across the multiple government and non-government agencies involved in the provision of therapeutic residential care has proved to be quite difficult.

Service models or practice frameworks

The jurisdictions were further asked about the particular service models or practice frameworks that informed the operation of their therapeutic residential care programs. Although there are region-specific influences on the structure of practice frameworks—such as state/territory legislation or practice frameworks that have previously been adopted by their jurisdiction's child protection services—there are, in general, a number of key models and frameworks that were drawn on by the jurisdictions when designing their own therapeutic residential care programs. At a theoretical level, the field of therapeutic residential care has been heavily informed by attachment theory, trauma theory, the neurobiology of attachment and trauma, and the concept of resilience. Many of the jurisdictions explicitly noted that their programs were underpinned

Outside of residential care, highly effective treatment programs for young people with extremely challenging behaviour (i.e., multidimensional treatment foster care) (Chamberlain, 2003), include elements that might be adopted in the residential environment. For example, continuity of care, high levels of support for carers, complimentary individual behaviourally focused and (biological) family therapy, cooperation with school, justice and health, and coordination through case management. These elements of successful intervention could possibly inform the future development of residential care (Knorth et al., 2008; McCurdy & McIntyre, 2004)

Child-centred and responsive models of residential care

In Australia, traditional residential care units have often been seen "more as containment centres rather than as places where therapeutic interventions could be concentrated" (Delfabbro et al., 2005, p. 16). A young-person-centred approach, in comparison, is supported by literature and best practice as focusing on the needs and interests of the young person (Connolly, 2009). Delfabbro et al. (2005) argued that more effective service design may be arrived at by moving away from a paradigm in which residential care is seen invariably as a restrictive placement of last resort. In addition, a focus on the assessment of clinical issues and needs is critical (Hillan, 2005). Clearer consideration of the child's needs would mean that residential care could be used differently; for example, to provide respite for families, or to support graduated family reunification or shared care arrangements, rather than being a placement of last resort (Stuck, Small, & Ainsworth, 2000).

In cases where intensive support is required, Ainsworth and Small (1995) have argued that this may best be delivered in a large-scale model of care, similar to treatment residential care models in North America. The opportunity to bring together multiple professionals on the same campus or location (e.g., educational staff, court officers, psychologists, health workers and vocational counsellors), such as used extensively in North America, has been largely unexplored in Australia (Delfabbro et al., 2005). This could also be provided in smaller residential homes through the provision of "wrap-around" specialist services (Delfabbro et al., 2005), because the potential negative effects of bringing together children with difficult, aggressive behaviour has been noted (Dishion, Bullock, & Granic, 2002). Therefore, there is a pressing need to consider what form of residential care and at what point in a child's life can best support a child's mental health, behavioural, learning, family relationships and community connection needs. This may ultimately result in better alignment of residential service provision with those needs (Delfabbro et al., 2005; Stuck, et al., 2000).

Commitment to staff support

The way in which a therapeutic residential care setting is staffed will be highly influential in the success or otherwise of its work with young people. Perry (2010) argued that it can be preferable to be understaffed with the right people than to have adequate numbers of ineffective staff, bearing in mind that the best workers are the most sought after, which puts them at risk of burnout. Residential staff members are likely to make a lasting impression on young people, and strong, caring worker–client relationships can help a worker to build feelings of safety and positively influence a young person's behaviours and attitudes (Connolly, 2009).

Effective staff members are likely to have self-awareness of the impact of their own life events on their work, which will help them to respond effectively to young people and work ethically and purposefully (Connolly, 2009). A range of competencies is important across the staffing

- Place value on strong, positive relationships between staff members and young people, and emphasise these relationships as being integral to therapeutic healing.

- **Trauma-based orientation to program design**
  - Provide specialist training for staff members in the trauma theory model and its application (e.g., effects of trauma and disrupted attachment).
  - Ensure that staff members are able to identify specific behaviours and triggers as possible outcomes of trauma.
  - Include psycho-education about trauma in the program design.
  - Provide a safe, predictable environment in which young people are protected from re-traumatising experiences.
  - Provide young people with access to trauma and loss counselling.
- **Individualised therapeutic plans based on best available evidence**
  - Develop individualised personal treatment plans for each young person that guide the implementation of service delivery by all team members.
  - Ensure that the therapeutic approach is based on a theoretical framework suited to the young person's underlying issues and presentation.
  - Ensure that personalised treatment plans are reviewed regularly.
  - Provide psycho-education for young people about the trauma or abuse they may have experienced and the ways in which it is currently affecting them.
  - Provide prosocial modelling and reinforcement for prosocial behavior and positive peer culture.
  - Provide trauma-focused cognitive behaviour therapy.
  - Provide anger management and empathy training for juvenile offenders.
  - Ensure interventions and expectations are developmentally appropriate.
- **Participation of young people in shaping their care**
  - Ensure that program and staff members listen to young people and allow them to participate in decision-making processes regarding their therapeutic program and placement.
  - Clearly communicate with young people about the rationale of their care plan and give them opportunities to provide feedback.
  - Ensure young people have access to advocacy.
- **Engagement with young person's family, community and culture**
  - Engage with young peoples' family of origin (including siblings) where possible, and at whatever level possible (e.g., phone meetings, visits, family therapy).
  - Engage with relevant stakeholders in young people's lives (e.g., school, sporting, community).
  - Ensure that young people have opportunities to remain engaged with cultural practices (especially important for those from Indigenous and CALD communities).
  - Provide an approach to care that is sensitive and respectful and actively explores and seeks to understand each child's unique circumstances and experiences arising from the impact of their culture (especially important for those from Indigenous and CALD communities).
- **Support for young people to exit care and plan for post-care support**
  - Prepare comprehensive leaving care plans.
  - Ensure early engagement of post-care people and supports.

- Encourage formal and informal opportunities to maintain relationships (therapeutic or otherwise) with workers and significant others in the unit, and to return to visit the unit.

- **Evaluation framework**
  - Embed meaningful evaluation tools in routine documentation.
  - Incorporate young people's views in program evaluation.
  - Collaborate with external research bodies (e.g., universities) for the purposes of ongoing evaluation (see Boxes 4 and 5).
  - Conduct ongoing program level evaluation (see Box 5 for an example).
  - Ensure that the program is responsive to the changing evidence base.

Box 4: The importance of evaluation

The currently emerging models of therapeutic care in Australia are an important step forward in offering services that focus on young people's trauma histories and current developmental needs. The emergence of any new practice offers an invaluable opportunity to embed evaluation strategies from the outset, in order to assess whether change occurs for participants and, most importantly, whether the changes can be attributed to the intervention.

Workload, the crisis-driven nature of the work, lack of resources and resistance from staff can all make embedding research and evaluation tools in a residential environment difficult (Boyd, Einbinder, Rauktis, & Portwood, 2007; Butler, Little, & Grimard, 2009; Hair, 2005). Embedding research in practice and model development ultimately requires the support of senior staff and management, and the use of tools that have appropriate reading levels, are easy to administer and measure something meaningful (Butler et al., 2009). Challenges to the development of an evaluation culture among residential care staff can be minimised by collaboration between management, researchers and staff (Butler et al., 2009). While frequency counts of restraints and incidents of aggression may be readily attainable, as these tend to be routinely collected, they constitute a poor proxy for the psychological status of the young people participating in the program. Ultimately, there needs to be a balance between practical concerns and methodological rigour (Butler et al., 2009).

An important aspect of evaluation across current Australian therapeutic residential care services is the need to evaluate outcomes using a common set of definitions and principles. In this way, "like" is compared to "like" and a clearer view of what works becomes apparent. This may also involve establishing a set of agreed outcome measures, such as developmental outcomes or behaviours, and questions that are used to effectively measure these. Research has suggested that more emphasis needs to be placed on socially relevant outcomes, such as employment or school attendance (see Curtis et al., 2001). Curry (1991) was critical of outcome measurement that takes a "static" (p. 356) view of residential placement as an isolated event, and advocates for a process view of outcome measurement, using multiple level indicators (symptom and program components) at multiple points. This includes measures of behaviour and affective difficulties, adaptive strengths, relationship capacity, program engagement and coping styles, and measures of post-care follow-up. Routine clinical measures and screening tools may not be sufficient to capture these dimensions. As such, research is needed into the development of assessment tools tailored to the needs of children in residential care.

Performance measures of residential care should reflect practice and priorities, and be linked to external research bodies, such as universities. This calls for greater interface between researchers and practitioners so that any research can be more easily integrated into service model development. This is greatly enhanced by services having access to funds to evaluate emerging models of practice (Hillan, 2006).

Box 5 provides one example of an evaluation of a therapeutic residential care program in Victoria. While there is still a considerable amount of work to be undertaken to develop an evidence-informed evaluation strategy, this example constitutes one of the primary efforts in informing therapeutic residential care practice through evaluation.

The way forward

Currently in Australia, there is much energy and enthusiasm directed towards establishing therapeutic residential care as a legitimate option in the range of out-of-home care alternatives available to children and young people. This Issues Paper was borne of this energy and enthusiasm, as well as the important work conducted at the National Therapeutic Residential Care Workshop in Melbourne in 2010 and being sustained by the National Therapeutic Residential Care Working Group.

Therapeutic residential care is still a developing placement option, however, and much work remains to be done to establish it as an evidence-based form of care that contributes positively to outcomes for children and young people. It was originally planned that this Issues Paper would include a detailed snapshot of the current state of therapeutic residential care in each Australian jurisdiction. Although many of the jurisdictions were able to provide some information, it became evident that the stage of development, implementation and evaluation for each jurisdiction varied considerably. It was decided, therefore, that a detailed snapshot of the current state of therapeutic residential care in this country would, at the current time, be premature, and therefore only a broad outline is offered in the current paper.

Meaningful appraisals of therapeutic residential care in Australia will be enhanced by assuring that three components are in place:

- an agreed-upon national definition of therapeutic residential care—the definition developed by the National Therapeutic Residential Care Working Group and presented in Box 1 of this Issues Paper is intended to offer this;
- a list of agreed-upon key elements of effective therapeutic residential care, upon which service models and practice frameworks can be based—the list of key elements proposed in this Issues Paper may assist to catalyse a national dialogue around this issue; and
- a national therapeutic residential care evaluation framework—this framework, based on the list of key elements of effective therapeutic residential care, and using measures specifically designed for this population, would allow for intra-jurisdictional evaluations and cross-jurisdictional comparisons, and would be a major step towards establishing therapeutic residential care as an evidence-based placement option.

The will is there; the way forward is to continue discussion and collaboration in a steady movement towards establishing therapeutic residential care as an evidence-based care option that leads to the best possible outcomes for some of the most vulnerable children and young people in Australia.

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Appendix 1: Examples of promising programs that may inform the development of therapeutic residential care

Sanctuary® model

The Sanctuary® model, originating from the Andrus Children's Centre in New York, is a systems-level approach that targets the entire organisation. The focus is to create a trauma-informed and sensitive environment within which specific trauma-focused interventions can be carried out. Trauma-sensitive organisational structures and trauma recovery frameworks are central to the model. These support staff to process and address those children's needs that are seen as arising out of a traumatic background. Within the culture, the model uses a 12-week recurring program of weekly explicit psycho-education. The program also engages family members wherever possible.

The core elements include the development of a culture of: non-violence (teaching and modelling safety skills); emotional intelligence (teaching and modelling affect regulation/management skills); inquiry and social learning; shared governance (teaching and modelling self-discipline and appropriate use of authority); open communication (teaching and modelling healthy interactions and boundaries); social responsibility (social connections and healthy attachments); and growth and change (focus on hope, meaning and purpose).

The Sanctuary® model has been subject to limited evaluation. When compared with a non-randomised control group (residential treatment as usual), youths who undertook programs based on the Sanctuary model demonstrated improvements in the areas of interpersonal conflict, personal control, verbal aggression and problem-solving skills (Rivard et al., 2005). Measures of "therapeutic culture" at six-month follow-up also picked up changes on dimensions of the organisational environment that are considered essential to a trauma-sensitive culture.

Stop-Gap model

The Stop-Gap model, originating from the Devereux Centre for Effective Schools in Pennsylvania, is a short-term residential group care model specifically targeted at children with disruptive behaviour disorders (McCurdy & McIntyre, 2004). The program has two main treatment components: (a) the provision of environment-based interventions, and (b) discharge-focused services. Environmental interventions include the use of a token economy (i.e., a reward system for preferred behaviours), academic support, explicit teaching of social skills and problem-solving and anger management skills. At the same time, active planning related to discharge, such as parent behaviour management training, community integration and ongoing case management is implemented. More problematic behaviour is addressed by intensive functional behavioural analysis. One preliminary evaluation indicated a reduction in physical restraints at 12 months following program implementation, compared with a matched non-randomised control group (McCurdy & McIntyre, 2004).

Teaching Family model

The Teaching Family model is a well-known model of service delivery originally designed for juvenile offenders, but used for other children with behavioural issues. It is used and researched more extensively than other models of group care (James, 2011) and has formed the basis of many residential services in North America. A modified form of the model was used at Boys

Town in Australia (Daly & Dowd, 1992). The model uses "teaching parents" to provide a family-like atmosphere to residential care. The teaching parents help children to learn positive social interaction and living skills. It is a competency-based skill development program, using clearly defined goals. The carers (or "teaching parents") receive support and training as accredited and professionalised carer treatment teams.

Compared with non-matched "treatment as usual" residential care, this model of care has reported significant differences in academic attainment (Thompson et al., 1996), and observer ratings of parent–child treatment interactions and offending behaviour (Bedlington, Braukmann, Ramp, & Wolf, 1988).

Positive Peer Culture model

The Positive Peer Culture treatment model was developed by Vorrath and Brendtro (1985) and forms the basis for many residential programs in North America. It was specifically designed for "troubled and troubling" youth, in response to the need to deal with negative peer influences among offending youth (James, 2011). The key targeted outcome is the development of a socially motivated orientation of "care and concern" or social interest orientation. The culture conveys a belief in the capacity of youth to achieve. The focus is not on conforming to authority per se, but motivating this via responsibility for actions, reinforcement of prosocial behaviours and peer-helping. The aim is to foster a commitment to helping others, and hurtful behaviours are reduced as a by-product. The essential elements are assumed to be: the development of a norm of group belonging and responsibility (similar to the home environment); group meetings (problem-solving using a "common language" list of problem behaviours); use of community service learning (community service projects in the community); and teamwork focus (staff are organised in teams around distinct groups of children).

The evaluation of this model has been limited. One randomised control study demonstrated reduced recidivism and behavioural and social gains relative to control conditions (Leeman, Gibbs & Fuller, 1993). Reductions in unhelpful cognitive distortions and covert antisocial behaviour have also been found following this intervention (Nas, Brugman, & Koops, 2005).

For more detailed information about these programs, see James (2011).

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