Evidence Based Review of Therapeutic Residential Care Models

PREPARED FOR THE WESTERN AUSTRALIAN DEPARTMENT OF COMMUNITIES

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We respectfully acknowledge the Kaurna and Whadjuk Noongar Aboriginal and Torres Strait Islander Peoples and their Elders past and present, who are the Aboriginal and Torres Strait Islander Traditional Owners of the lands that are now home to the Australian Centre for Child Protection's offices in Adelaide and Perth. We are honoured to recognise our connection to the Kaurna and Whadjuk Noongar lands, and their history, culture and spirituality through these locations, and we strive to ensure that we operate in a manner which respects their Elders and ancestors. We also acknowledge the other Aboriginal and Torres Strait Islander People of lands across Australia where we conduct business, their Elders, ancestors, cultures and heritage.

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EXECUTIVE SUMMARY

Research, policy, and practice consistently reinforce the finding that children and young people living in Out of Home Care (OOHC) are a highly vulnerable population with significant needs. Most children in care will have experienced violence, abuse and/or neglect prior to their removal. Many will experience removal and separation from family, community and Country as further trauma, and some children will experience additional trauma and disruption while in care.

There are many different types of care arrangements, each with varying complexities and concerns, such as kinship family placements, foster care placements and group home environments. Some children and young people with complex psychological, emotional, and behavioural challenges require a higher level of intervention and support than what standard care arrangements provide. For these children and young people, Therapeutic Residential Care (TRC) is necessary.

TCR models represent specialised frameworks within the continuum of care services, promoting wellbeing, development and resilience of individuals who have experienced abuse, trauma, and significant challenges. However, residential care providers often struggle to balance the immediate care needs of children and young people requiring such care with the long-term goals of enhanced wellbeing, safety, and healing. Acknowledging the need for effective, trauma-informed, and therapeutic models of residential care, the Western Australian Department of Communities commissioned the Australian Centre for Child Protection (ACCP) to review the evidence base of TRC models.

> Therapeutic Residential Care includes "*... the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community based formal and informal helping resources*". (Whittaker et al., 2014, p. 24; also see Whittaker et al., 2016).

This review of TRC models and their evidence base includes five sections:

1. Introduction - setting the scene.
2. What the evidence says – A rapid review of the evaluative literature, highlighting the available outcome and implementation reviews.
3. What does practice look like in Australia - Exploration of current practices in Australia and comparable international contexts (New Zealand) in the form of a jurisdictional scan highlighting distinctive elements, models used and their impacts.
4. What do the dominant models look like? – An overview of dominant TRC models in use across Australia and highlighted in the literature, providing unique elements and theory of change information.
5. What makes a difference in the implementation of these models - Implementation considerations for TRC models to enhance practice outcomes.

Throughout the review, additional consideration has also been given to models specific to the Western Australian context and, specifically;

- children and young people who have displayed or who are at risk of displaying harmful sexual behaviours (HSB) and
- Aboriginal and Torres Strait Islander children and young people.

WHAT THE EVIDENCE SAYS

To assess the current state of the TRC evaluation literature, a rapid evidence assessment of the literature on the evaluation of TRC models and related interventions was undertaken for peer-reviewed literature in English from the previous ten years. Seventeen peer-reviewed articles were identified, which highlighted six organisation-wide, TRC models:

- The Sanctuary Model®
- Children and Residential Experiences (CARE)
- The Life Model of Residential Care for trauma-affected children and young people
- The Teaching Family Model (TFM)
- Emotional Warmth Model of Professional Childcare
- Trauma-Informed Care

The table below provides a high-level overview of the peer-reviewed journal articles identified in this review, which evaluate TRC models.

Table 1: Overview of peer reviewed evaluative research into the effectiveness of Therapeutic Residential Care models

Therapeutic Residential Care Program	No. peer-reviewed journal articles	High level overview of the studies
The Sanctuary Model®	3	These studies offer a multifaceted understanding of the Sanctuary Model's implementation, providing valuable insights from indirect care staff, decision-makers, and residential care staff.
Children and Residential Experiences (CARE)	2	One research study investigates the impact of a setting-level intervention on preventing aggressive or dangerous behavioural incidents among youth living in group care environments. Another study examines whether the CARE intervention improves the quality of relationships between children and caregivers. Both studies collectively highlight the importance of targeted interventions in enhancing safety and relationship dynamics within group care settings.
The Life Model of Residential Care for trauma-affected children and young people	1	This study examines the implementation of the Life Model and evaluates its effectiveness in helping youth achieve the intended outcomes. The research focuses on how well the Life Model is integrated into practice and assesses its impact on the youth's progress toward their goals.
The Teaching Family Model (TFM)	4	These studies explore various aspects of the TFM and their outcomes for children and young people. One study compares the effectiveness of TFM with other models in group homes. Another examines long-term outcomes for young people in TFM homes, finding that those who stay for six months or longer achieve better outcomes than those with shorter stays. A third study investigates the relationship between youth ratings of treatment fidelity, the quality of the therapeutic alliance, and symptom severity, providing insights into factors that contribute to successful treatment outcomes. Additionally, there is an examination of a framework for assessing quality in therapeutic residential care.
Emotional Warmth Model of Professional Childcare	1	This study evaluates the model's impact on children's and young people's outcomes.
Trauma-Informed Care	1	This study evaluates the implementation and effects of trauma-informed care on staff, with a focus on vicarious trauma.

Note: No. of peer-reviewed journal articles identified in relation to this study.

Despite the increasing popularity of many of these practice models over the past decade, the evidence base supporting their effectiveness remains limited. The review showed that implementing TRC can reduce destructive behavioural incidents (such as property damage, aggression toward staff, and children missing from placement) and enhance personal and interpersonal development. However, staff implementing therapeutic care often express uncertainty about how to effectively implement TRC, prompting concerns about the operationalisation of principles in practice. In general, the review highlighted that while TRC models show promise and align with theoretically accepted constructs such as applying trauma informed and culturally safe practices to OOHC settings, significant gaps in research for evaluating the efficacy of TRC models persists.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated three of these models (The Sanctuary Model®, CARE, and Teaching Family Model) as having promising research evidence. However, the evidence base supporting their effectiveness remains limited. The remaining three models have not been rated on the CEBC scientific rating scale. Gaps in the research evidence may be due to the operational challenges of implementing a model with fidelity and consistency that is based on high level principles and common elements rather than clear, practical, operationalised elements or activities.

The review reveals that while TRC models can reduce destructive behavioural incidents and enhance personal and interpersonal development, there are concerns about the operationalisation of principles in practice and gaps in evaluating efficacy.

Cultural models and practice

In Australia, Aboriginal and Torres Strait Islander Children aged 0-17 years represent 42.8% (56.8 per 1000 children) of all children in OOHC (AIHW, 2022; Productivity Commission, 2022). Australia's history of colonisation and subsequent policies has inflicted trauma upon individuals, families, and communities, which has frequently led to the loss of family connections, language, land, and culture (Lindstedt et al., 2017).

Among the six organisation-wide models reviewed, only one (The Sanctuary Model®), was found to embed cultural components into their overarching program model to support Aboriginal and Torres Strait Islander children and young people. However, several supplementary interventions were noted within the review to enhance cultural healing and promote the therapeutic environment. Four interventions and one policy designed to support Aboriginal and Torres Strait Islander children in OOHC in the Australian context were identified:

1. Cultural Safety Plans (CSP);
2. The Koorie Tiddas Youth Choir;
3. The Connecting to Sea Country;
4. Return to Country; and
5. Wrapped in Culture (Lindstedt et al., 2017).

Each were noted as interventions or programs for First Nations children and young people living in residential OOHC which aimed to increase cultural connection, as connection to culture has been recognised as an essential aspect of a healing environment for First Nations children (The Healing Foundation, 2021; SNAICC, 2023).

Harmful Sexual Behaviours related models

Unfortunately, the literature review did not reveal any TRC models or related programs specifically for children and young people who have displayed HSB. However, a review of the practices and models in use across Australia, (highlighted below) identified several models or approaches designed for implementation within a service system or specifically in OOHC settings:

- Power to Kids – The Power to Kids program is a psychoeducation-based model established by Mackillop Family Services and commonly implemented alongside their Sanctuary TRC model. It focuses on upskilling staff to enable greater discussion and communication with at risk, vulnerable young people in residential care settings. The program targets those at risk of sexual exploitation, absconding, and HSB.
- WA Department of Communities Framework for Understanding and Guiding Responses to HSB in Children and Young People – this framework provides a layered continuum to support frontline workers within OOHC and across child protection services. It helps recognise and respond to sexual behaviours across a continuum from appropriate through to concerning and harmful. The framework includes a set of guiding principles and is accompanied by companion training.
- New Street – In New South Wales, New Street offers a comprehensive therapeutic program for children and young people who have displayed HSB. Delivered by health, this program addresses behaviours across a continuum and age range, working with all children and young people in OOHC exhibiting concerning behaviours.

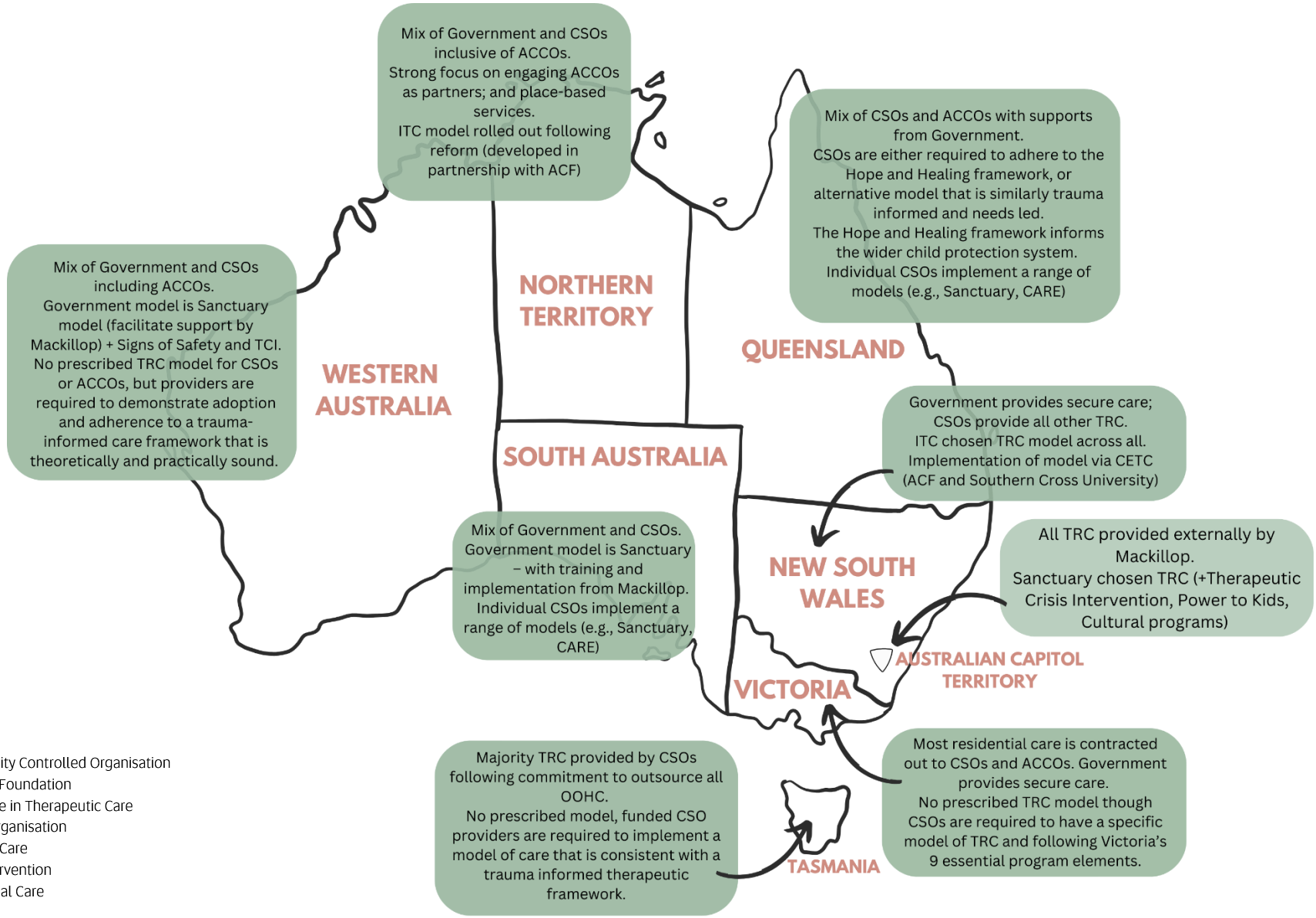
Despite their sound theoretical underpinnings and some evidence reviews, none have been evaluated within the peer-reviewed literature for their effectiveness within a TRC setting to enhance responses for children and young people who have displayed HSB. Other streamlined referral pathways and programs connected with OOHC do exist in other jurisdictions but fell outside the scope of these reviews and were not identified as specific responses to HSB within OOHC or TRC.

WHAT DOES PRACTICE LOOK LIKE IN AUSTRALIA

Across Australia, several prominent models being used within residential care, such as CARE, Sanctuary, and Intensive Therapeutic Care. These TRC models are often implemented broadly across a system of care rather than just within residential care environments. The nature of TRC models, being more akin to frameworks, lends itself to this broad system or organisation wide approach to implementation. However, given the significant variability of OOHC providers and structures across the country, the implementation of even the same model of TRC can look very different.

The objective of the jurisdictional scan was to canvas what models of TRC are currently utilised across national and international child protection sectors. The scan process relied heavily on a rapid review of publicly available material, associated grey literature, brief targeted consultations (where available), and a systematic review of this information.

The jurisdictional scan examined current TRC models across various Australian regions, highlighting diverse practices and the integration of therapeutic approaches within child protection services. TRC typically occurs in residential settings, including group homes and therapeutic communities, where professionals collaborate to help children overcome trauma. Each jurisdiction is committed to trauma-informed care, though approaches and specific program implementations vary widely, reflecting local needs and resources. Figure 1 highlights the jurisdictional variances between TRC models and their implementation formats.



ACCO – Aboriginal Community Controlled Organisation
ACF – Australian Childhood Foundation
CETC – Centre for Excellence in Therapeutic Care
CSO – Community Sector Organisation
ITC – Intensive Therapeutic Care
TCI – Therapeutic Crisis Intervention
TRC – Therapeutic Residential Care

Figure 1: Overview of Australian Therapeutic Residential Care models in practice

WHAT DO THE DOMINANT MODELS LOOK LIKE?

Prominent TRC models used in Australia include CARE, Sanctuary, ITC, TFM and Bunjil Burri.

The CARE model emphasises a competency-based curriculum to create therapeutic environments for children in OOHC, drawing on child development, trauma, and systems theories. It involves comprehensive staff training and a structured implementation process supported by the Residential Child Care Project at Cornell University. Life Without Barriers has successfully implemented the CARE model across multiple states, integrating it with additional evidence-informed interventions to address individual needs. This has improved relationships between children and staff, reduced behavioural incidents, and enhanced organisational capacity.

The Sanctuary Model®, developed in the United States, aims to facilitate organisational change by educating all staff on trauma impacts and fostering a supportive environment. It is based on four pillars: a) Trauma theory, b) the Safety, Emotion, Loss, and Future (S.E.L.F) framework, c) the Sanctuary Toolkit, and d) the Seven Sanctuary Commitments. Mackillop Family Services and the Mackillop Institute has adopted this model across multiple jurisdictions, supplementing it with programs like Power to Kids and Therapeutic Crisis Intervention (TCI). The model is praised for improving staff knowledge of trauma, enhancing client self-perception, and fostering a collaborative organisational culture, though its implementation requires significant time and resources.

Intensive Therapeutic Care (ITC) is a principle-based service system model that draws upon trauma, systems, and child development theories. It is specifically designed for young people over 12 years of age who have the most severe forms of trauma and subsequently extremely high and complex needs. Based on ten elements developed by the Centre for Excellence in Therapeutic Care (CETC) at the Australian Childhood Foundation and Southern Cross University. ITC proposes more effective and holistic safety, permanency, and wellbeing outcomes for young people through person-centred funding packages and consistent therapeutic care. It is considered a temporary measure aiming to achieve placement permanency and 'step-down' placements as a young person's needs become less intensive.

The TFM like the other models, is an organisation wide model of care that draws upon social learning and trauma informed theories whereby a family style setting is created. Currently provided by Berry Street within Australia, via an accreditation and training program under the Teaching Family Association, the TFM has four critical delivery systems (staff selection and training, competency-based management, quality assurance, and facilitative administration). The TFM aims to address behavioural concerns, improve social skills, and enhance emotional regulation capacity of the children and young people within placement as well as improve healthy family relationships.

The Bunjil Burri model, developed by the Victorian Aboriginal Child Care Agency (VACCA), focuses on providing culturally tailored TRC for Aboriginal and Torres Strait Islander children and young people. It integrates mainstream TRC elements with cultural pillars such as cultural safety, family and kinship structures, and resilience through cultural understanding. The model includes comprehensive culturally informed assessments, social networking maps, and cultural support plans, prioritizing connection to culture as the primary agent for healing from trauma. The Bunjil Burri model underscores the importance of cultural identity in achieving positive outcomes for Aboriginal and Torres Strait Islander children and young people in residential care.

WHAT MAKES A DIFFERENCE IN IMPLEMENTATION OF THESE MODELS

The rapid evidence review, and jurisdictional scan, have highlighted various prominent models across Australia with varying levels of evidence base. In many respects, the lack of evidence base for models is not necessarily due to their lack of efficacy, but rather a lack of purposeful peer-reviewed evaluations published in the literature. Across Australia, the most common models are the CARE and Sanctuary models of TRC. Both appear to have equal evidence base, though the CARE model generally has evaluative literature focused more on outcomes for children and young people related to behaviour changes. In contract, the Sanctuary model's evaluative research mainly focuses on carer/staff and children/young people perception and feedback of implementation. They are implemented at both the organisational and jurisdiction-wide levels in many jurisdictions.

Not surprisingly, regardless of their widespread use, they vary significantly in terms of their implementation. Several enablers and barriers to implementation have been identified in the literature through closer review of evaluative literature and from discussions with participating CSOs and jurisdictions. This leads us to articulate some key enablers for successful TRC implementation. While several elements have been identified from both literature and practice reviews across jurisdictions, these have the potential to both facilitate success and impede outcomes if not carefully considered. Figure 2 below provides an overview of these elements.

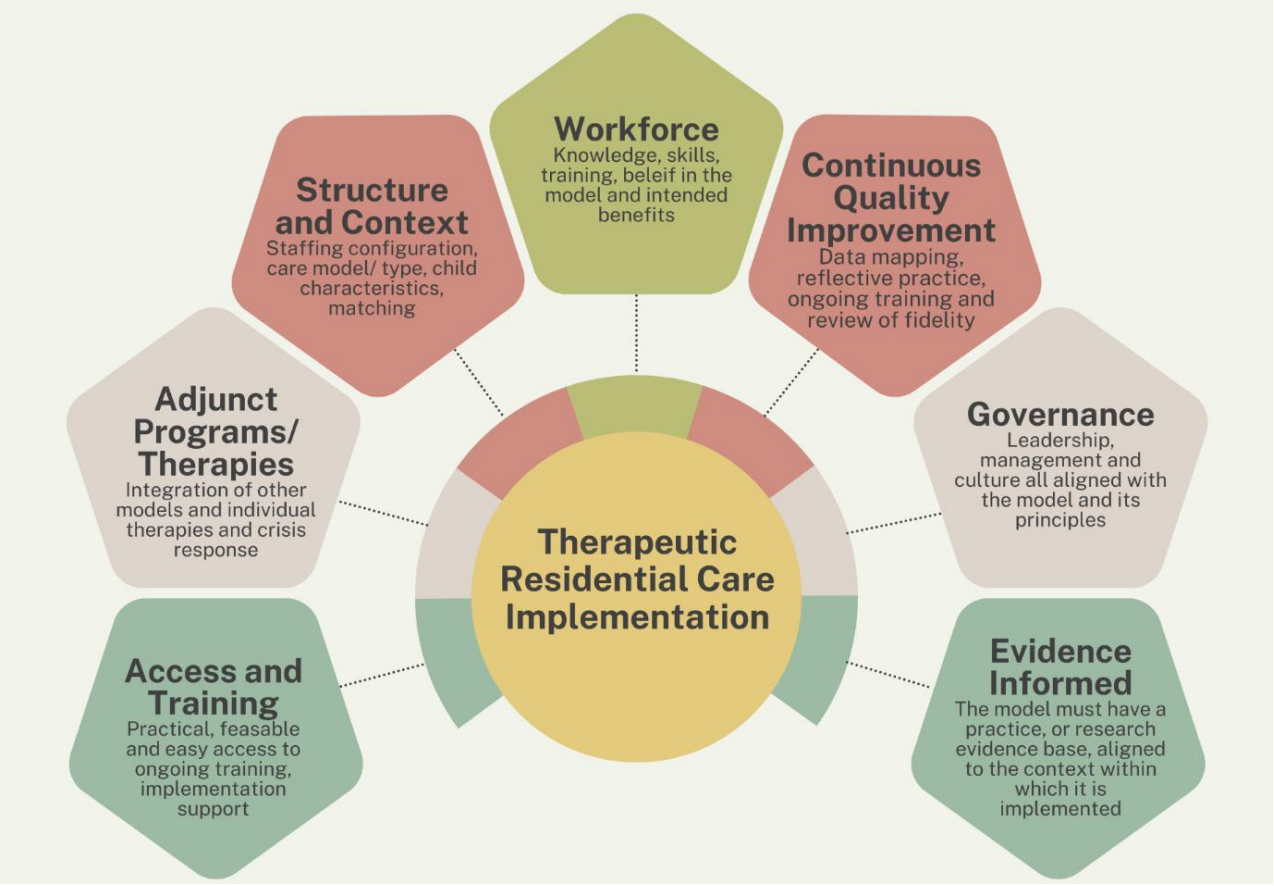


Figure 2: Key elements required for effective implementation of Therapeutic Residential Care models

SUMMARY

Children in residential care often exhibit high needs stemming from a myriad of complex factors, including histories of trauma, abuse, neglect, or familial disruption. TRC represents specialised frameworks within the continuum of care services that offer elevated levels of intervention and support to more effectively meet the intricate needs of children and young people who manifest complex psychological, emotional, and behavioural challenges.

Implementing TRC models in Australia presents various challenges and opportunities, with significant differences in evidence bases for these models. The lack of peer-reviewed evaluations often stems from ethical considerations in research involving vulnerable populations and the difficulty of uniformly defining and assessing models based on guiding principles rather than prescriptive activities. While emerging models tailored for Aboriginal and Torres Strait Islander children and young people show promise, there is a gap in specialised TRC models for those displaying HSB. The CARE and Sanctuary models are the most commonly used across Australia, each with its strengths and evidence bases, though they differ significantly in implementation across jurisdictions.

Despite the increasing popularity of TRC models over the past decade, the evidence base supporting their effectiveness remains limited. Further evaluative research into TRC models remains a critical priority for the field. The evidence base for TRC which is available continues to show that TRC models show promise for improving both staff knowledge and confidence and the outcomes of children in residential care. However, it is not possible to draw generalisable conclusions about the effectiveness of specific TRC models to compare commonalities, or the relative strengths or limitations of different approaches. There continues to be limited evidence in the studies identified on the specifics of how TRC models, which are often articulated in terms of high-level principles or common elements, are operationalised on the ground. Cultural safety and connectedness are critical elements of a therapeutic environment for First Nations children and young people (Krakouer, 2023; Krakouer et al., 2018; The Healing Foundation, 2021; SNAICC, 2023). Although evaluative research into Aboriginal and Torres Strait Islander designed and implemented interventions to improve cultural connectedness were encouraging, only one paper was identified examining four programs, and one policy highlighting an urgent need for more research in this area. The findings from the rapid evidence review do not enable definitive inferences or conclusions to be drawn in relation to 'best practices' in TRC, however TRC models continue to demonstrate promising evidence as a mechanism for providing a more healing and less damaging care environment for children in residential care.

Review of TRC across Australia led to several take home messages which align with the literature findings:

1. TRC is available in OOHC across jurisdictions, though there is a lack of operationalisation which presents a challenge.
2. There is a mix of recognised models and bespoke TRC in use across the jurisdictions. Several recognised models of TRC appear dominant to others, though their increased presence across jurisdictions is, in part, due to their use by national agencies and lack of available accreditation schemes for some TRC's in Australia.
3. There is a lack of clear, publicly available implementation procedures for any model or TRC framework.
4. There are limited tailored TRC options for Aboriginal and Torres Strait Islander children and young people; and for children and young people who have displayed HSB.

5. There is growing recognition that a reliance on a sole TRC model often falls short of adequately addressing the comprehensive care requirements of children and young people in TRC. Flexible frameworks of guiding principles and layering of additional programs are being used to overcome identified gaps.

BACKGROUND INFORMATION

Children in residential care often exhibit high needs stemming from a myriad of complex factors, including histories of trauma, abuse, neglect, or familial disruption. Meeting the diverse care requirements of these vulnerable children and young people poses a considerable challenge for residential care providers. The multifaceted needs of such children extend beyond traditional caregiving practices, requiring a comprehensive and tailored approach that encompasses physical, emotional, and psychological dimensions. The difficulty lies not only in addressing immediate concerns but also in fostering an environment that supports long-term healing and development.

Therapeutic residential care (TRC) models represent specialised frameworks within the continuum of care services, predominantly tailored to address the intricate needs of individuals, particularly children and adolescents, who manifest complex psychological, emotional, and behavioural challenges necessitating an elevated level of intervention and support than is provided within standard residential care, foster, and kinship care. The overarching goal of TRC is to promote the well-being, development, and resilience of individuals who have experienced trauma, abuse, neglect, or significant challenges. By offering a comprehensive and individualised approach, TRC aims to empower individuals to overcome difficulties and build a foundation for a healthier future. Therapeutic Residential Care involves the purposeful use of a multi-dimensional living environment designed to provide treatment, education, socialisation, support, and protection to children and youth with identified mental health or behavioural needs. This is done in partnership with their families and collaboration with a full spectrum of community-based formal and informal helping resources (Whittaker et al., 2014, p. 24; also see Whittaker et al., 2016).

Recognising this as an issue requiring active attention, The Western Australian Department of Communities ("Department") has sought to undertake measures to ensure best practice in relation to models of therapeutic residential care provided within Western Australia. The Department commissioned the Australian Centre for Child Protection (ACCP) to undertake a review of evidence-based therapeutic residential care models for children and young people living in out of home care (OOHC) and conceptualise implications for application within the WA context.

This review encompasses a closer look at both the literature and a jurisdictional scan to explore models commonly in use across Australia and within similar international contexts such as New Zealand. The objective of this project is to articulate a nationally relevant review of models of care, their efficacy where available, and articulate specific models or distinctive elements employed for use across two key priority populations:

1. Children and young people who have displayed or who are at risk of displaying harmful sexual behaviours (HSB)
2. Aboriginal and Torres Strait Islander children and young people

The project includes three streams of parallel work:

1. Articulating the evidence-based literature via a rapid scoping review of TRC models (with consideration for both priority populations).
2. Practice led jurisdictional scan of models currently in use across Australia and similar international contexts, across both priority populations.
3. Deeper articulation of common models of TRC currently in use across Australia.

This document provides a comprehensive overview of these pieces articulated across five sections:

- SECTION 1: Introduction
- SECTION 2: What the evidence says – a rapid review of the evaluative literature;
- SECTION 3: What does practice look like in Australia – a jurisdictional scan;
- SECTION 4: What do the dominant models look like; and
- SECTION 5: What makes a difference in implementation of these models.

SECTION 1: INTRODUCTION

Research, policy, and practice consistently reinforce the finding that children and young people in care are a highly vulnerable population with significant needs. Most children in care will have experienced violence, abuse and/or neglect prior to their removal, many will experience removal and separation from family, community and Country as further trauma, and some children will experience additional trauma and disruption while in care. The population of children in residential care is particularly vulnerable to disrupted and unstable care relationships. Children and young people with histories of trauma and care disruptions are disproportionately more likely to experience multiple and complex needs, including mental health, behavioural and emotional needs and impacts of their sense of self – needs which can be particularly difficult to meet in institutional settings. Those needs, nonetheless, must remain the focus of our care (Blackmoore et al., 2023). What meeting these needs looks like has undergone many changes over the years. While care providers and other services can offer therapy to children and young people in care, this is often restricted to a one-hour weekly appointment, which is insufficient to adequately support children with significant mental health and behavioural needs (Bath, 2015; McClean, 2018).

One way forward to address this gap is the implementation of therapeutic residential care models that can systemically address such needs.

> Therapeutic Residential Care includes *"... the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community based formal and informal helping resources"*. (Whittaker et al., 2014, p. 24; also see Whittaker et al., 2016).

Whittaker et al., (2016) and McLean (2018) identified a common set of needs and features of TRC; features include:

- Understanding/knowing young people's needs;
- Shared understanding between key stakeholders;
- Understanding young people's needs are similar, not disparate, leading to good client 'mix' and minimising 'contagion';
- Implementing specialist input and appropriate staffing;
- Therapeutic input is tailored to, and matched to, young people's developmental, cognitive or socio-emotional functioning;
- Best possible involvement with family and community; and
- Adult–child relationships are valued and continued post-care.

(Ainsworth & Hansen, 2018; Boel-Studt & Tobia, 2016; Knorth et al., 2008; McLean, 2016; Whittaker et al., 2016 in McClean, 2018, p. 9)

Traditional one-on-one 'therapy' sessions may be a component of the therapeutic input a child receives while in TRC, but the 'therapeutic' aspect of care is in creating a therapeutic environment, in which systems, staff, residence routines, rules and responses provide a care environment which is caring, non-

traumatising and which supports and enables healing. Notably, the trauma-informed nature of TRC models is critical (Daley et al., 2018).

Several models for TRC have been developed and formalised, these models include but are not limited to, the Sanctuary Model®, Children and Residential Experience Model (CARE), Attachment, Self-Regulation and Competency Framework (ARC), and Trauma Informed Care (TIC) (for more, see McPherson et al., 2019). The development of existing models and approaches has clearly been informed by existing theory, evidence, and practice on the needs of children in residential care and how best to respond to those needs. In a review of models, McPherson et al. (2019, p. 90) concluded:

> *"Common to the majority of the approaches was the use of trauma theory, trained staff and the establishment of a 'therapeutic milieu' as the foundation of care, supported by a congruent, whole-of-organisation commitment."*

While TRC are evidence-informed in their development and address a clear need for more holistic therapeutic responses to children in care, past research and reviews have highlighted a lack of a robust evaluative evidence base to inform decision making about which models are effective, under what conditions, or the essential elements of effective approaches (Bailey et al., 2017; James, 2013). Existing research into TRC has also highlighted that further work is required on the operationalisation of therapeutic processes within these models (McLean, 2018). In other words, we need a better understanding of how the principles of these models translate in what workers and carers are really doing on the ground.

AUSTRALIAN CONTEXT

Across Australia, there are several prominent models being used within residential care, e.g., CARE, Sanctuary, and Intensive Therapeutic Care. These TRC models are often implemented broadly across a system of care rather than just within residential care environments. The nature of TRC models being more akin to frameworks lends itself to this broad system or organisation wide approach to implementation. However, given the significant variability of OOHC providers and structures across the country, implementation of even the same model of TRC can look very different.

In Australia, as a consequence of direct and continuing impacts of colonisation, Aboriginal and Torres Strait Islander children are significantly over-represented in OOHC (SNAICC, 2023) and often experience detrimental disconnection from community, Country and culture while in care (Krakouer, 2023; Krakouer et al., 2018). The latest data released by the Productivity Commission (2023) highlights further increases of Aboriginal and Torres Strait Islander children in OOHC with a national level of 43.7%. Considering that higher proportions of Aboriginal and Torres Strait Islander children continue to enter OOHC than non-Aboriginal children, there is a need to understand what the optimal models of TRC for First Nations children are. and if and how these might differ from TRC for other populations of children. Additionally, within the Australian context, children who have displayed HSB in OOHC, particularly residential care, have been identified as a critical challenge in both research and inquiries (Commissioner for Family Violence Tas, 2023; Commissioner for Children and Young People WA, 2016; Moore et al., 2016; Royal Commission, 2017).

It is not known the extent to which existing TRC models specifically address the therapeutic care environment required to promote healing for children who have displayed HSB while maintaining safety for other children in care.

SECTION 2: WHAT THE EVIDENCE SAYS – A RAPID REVIEW OF THE EVALUATIVE LITERATURE

OVERVIEW

Children and young people in residential care are likely to have significant trauma histories and therapeutic needs. Most children in care will have experienced violence, abuse and/or neglect prior to their removal, many will also experience removal and separation from family, community and Country as trauma, and a further cohort will experience further trauma and disruption while in care. In recognition of these needs, residential care providers have been implementing TRC models for more than a decade. Therapeutic care models have typically been informed by theory, evidence, and practice, but historically there has been a limited evidence base on evaluations of their implementation in practice, and subsequent outcomes for children and young people. We must consistently review progress in this space for improvements to TRC models and the state of evaluation for TRC as a process.

To assess the current state of the TRC evaluation literature for TRC models, a rapid evidence assessment of peer-reviewed literature on the evaluation of TRC models and related interventions was undertaken. The search was limited to peer-reviewed literature in English from the previous ten years, which commented on the evaluation or outcomes of TRC models.

Seventeen peer-reviewed articles in this review presented information on organisation-wide, trauma-informed models and/or client-level evidence-based practice models. This review revealed that the implementation of TRC can reduce destructive behavioural incidents (property damage, aggression toward staff, and children missing from placement) and enhance personal and interpersonal development. However, staff implementing therapeutic care express uncertainty about how to effectively implement TRC, prompting concerns about the operationalisation of principles in practice. Moreover, research gaps for evaluating efficacy persist.

Despite the increasing popularity of TRC practice models over the past decade, the evidence base supporting their effectiveness remains limited. Further evaluative research into TRC models and frameworks remains a critical priority for the field. The evidence base for TRC which is available continues to show that TRC models and frameworks show promise for improving both staff knowledge and confidence and the outcomes of children in residential care. However, it is not possible to draw generalisable conclusions about the effectiveness of specific TRC models or frameworks to compare commonalities, or the relative strengths or limitation of different approaches. There continues to be limited evidence in the studies identified on the specifics of how TRC models, which are often articulated in terms of high-level principles or common elements, are operationalised on the ground. Cultural safety and connectedness are critical elements of a therapeutic environment for First Nations children and young people (Krakouer, 2023; Krakouer et al., 2018; The Healing Foundation, 2021; SNAICC, 2023).

Evaluative research into Aboriginal-designed and Aboriginal-implemented interventions to improve cultural connectedness were encouraging, however only one paper (which examined four program models) and one policy were identified, highlighting an urgent need for more research in this area. The findings from this rapid evidence assessment do not enable definitive inferences or conclusions to be drawn in relation to 'best practices' in TRC, however TRC models and frameworks continue to demonstrate promising evidence as a mechanism for providing a more healing and less damaging care environment for children in residential care.

The full methodological approach taken to glean this information can be found in Appendix A – Methodological approach to the rapid evidence review, and extraction table in Appendix B – Extraction tables for primary research articles.

WHAT THE RAPID EVIDENCE REVIEW REVEALED

The results below summarise the findings of the evidence base for various models noted in the literature. A distinction has been made between TRC models implemented throughout an organisation and those that serve as complementary or individual components of TRC.

Organisation-wide practice models

Six organisation-wide, trauma-informed models were identified within the eligible literature. The six models were:

1. The Sanctuary Model® (Esaki et al., 2014; Galvin et al., 2021; Galvin et al., 2022);
2. Children and Residential Experiences (Izzo et al., 2016; 2020);
3. The Life Model of Residential Care for trauma-affected children and young people (Boel-Studt et al., 2023);
4. The Teaching Family Model (TFM) (Farmer et al., 2017a; 2017b; Huefner et al., 2018; Hurley et al., 2017);
5. Emotional Warmth Model of Professional Childcare (Cameron & Das, 2019); and
6. Trauma-informed Care (Baker et al., 2018).

Every organisation-wide model discussed in this paper is supported by evaluative literature, whether qualitative or quantitative, providing insights into the fidelity of the model and its impact on the health and well-being of children and young people in OOHC.

External assessment

Of these models, the California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated three models (The Sanctuary Model®, CARE, and Teaching Family Model) as having promising research evidence. In comparison, the remaining three models (Emotional Warmth Model of Professional Childcare, Trauma-Informed Care, and The Life Model of Residential Care for trauma-affected children and young people) have not been rated on the CEBC scientific rating scale (Table 1). Peer-reviewed research on organisation-wide models published between 2013 - 2023 remains limited.

Table 1: *California Evidence-Based Clearing Housing – Scientific Rating Scale*

Classification System	Models
1. Well-Supported by Research Evidence	
2. Supported by Research Evidence	
3. Promising Research Evidence	Sanctuary Model® Children and Residential Experiences (CARE) Teaching Family Model
4. Evidence Fails to Demonstrate Effect	
5. Concerning Practice	
NR. Not able to be Rated on the CEBC Science Rating Scale	Emotional Warmth Model of Professional Childcare Trauma-Informed Care The Life Model of Residential Care for trauma-affected children and young people

The Sanctuary Model ®

The Sanctuary Model® is a trauma-informed, evidence-based, and organisation-wide model, designed for individual and systemic change. Structured around four pillars – Trauma Theory, S.E.L.F (Safety, Emotions, Loss, Future) Model, Seven Commitments and Sanctuary Toolkit – the model fosters a shared foundation of knowledge, values, language, and practice, with the aim to create a trauma-informed community (McPherson et al., 2018).

The peer-reviewed research within the past decade includes three studies (Esaki et al., 2014; Galvin et al., 2021; Galvin et al., 2022) and focuses on staff feedback over behavioural or experiential reports about children and young people in OOHC.

Galvin et al. (2021) explored the facilitators, barriers, and organisational experiences— encompassing both successes and challenges—encountered by executive staff members during the implementation of the Sanctuary Model®. This investigation involved nine semi-structured interviews conducted between September 2018 and February 2019. Similarly, in the study by Galvin et al. (2022), six focus groups and three semi-structured interviews were conducted with residential care staff between February and July 2020 to further understand the facilitators and barriers influencing the implementation of Sanctuary and how these factors contribute to the organisational successes and challenges. In contrast, Esaki et al. (2014) adopted a quantitative approach, utilising surveys to investigate staff readiness and perceived commitment to the Sanctuary Model®. The themes from the three studies will be unpacked in the subsequent sections of this review.

The research findings indicate that employees at all levels, from frontline staff to executives, reported satisfaction with implementation fidelity and highlighted the effectiveness of the Sanctuary Model's S.E.L.F Framework in facilitating open and honest conversations with young people and among staff members. Nevertheless, Galvin et al. (2021) found that some executive staff members were confused about the S.E.L.F framework, with one participant referring to the Emotion component as 'Experience' and the Loss Component as 'Learning'.

In addition to the S.E.L.F framework, staff members identified several practical interventions (Community Meetings, Red Flag Reviews, Safety Plans, Sanctuary Psychoeducation, and S.E.L.F Care Planning) which

are components of the 'Sanctuary Toolkit' and used to foster a trauma-informed culture to support young people and staff. When staff reflected on their practice of utilising the Sanctuary Toolkit, specific interventions were identified. However, discussions around them were inconsistent or misunderstood. For example:

> *"One participant was discussing their use of safety plans but kept referring to these plans as the self-care plan."* (Galvin et al., 2021, p. 5).

Similarly, staff expressed scepticism about the effectiveness of Community Meetings and discussed how Red Flag Meetings are underutilised and the confusion concerning their appropriate use. Additionally, the literature highlighted a challenge faced by residential care staff in striking a balance between implementing interventions and tools in a child-friendly organic manner, while successfully engaging with children and young people (Galvin et al., 2022).

Furthermore, Galvin et al. (2022) revealed that residential care staff held the belief that psychoeducation is "too clinical" and trained therapists should have the responsibility for implementing therapeutic interventions. The concept of blurred roles and unclear worker expectations contributes to the ambiguity surrounding the actions TRC workers should or should not undertake in supporting children. One participant encapsulated this challenge, stating:

> *"I think the roles get blurred for carers, and particularly with young people, because we sit there and say, 'hang on, I'm just a carer, you need to talk with your clinical team, your AOD workers, your counsellors'"* (Galvin et al., 2022, p. 663)

This blurred understanding may limit a child's access to therapeutic support within residential care, potentially stemming from misconceptions about staff roles and responsibilities. Additionally, staff may perceive themselves as needing to be more adequately equipped to implement evidence-based practice, abstaining from doing so under the assumption that allied health professionals will handle such tasks. This prompts reflection on the qualifications deemed necessary for TRC workers.

Alongside these qualitative studies, a quantitative study by Esaki et al. (2014) surveyed 37 indirect staff members from a voluntary welfare centre to evaluate the implementation of the Sanctuary Model®. The survey measured the extent to which staff perceived demonstration of the Sanctuary Model® Seven Commitments at the agency (nonviolence, emotional intelligence, growth and change, commitment to social learning, democracy, open communication, and social responsibility). The survey also included the Organisational Change Recipients' Belief Scale (OCRBS) to assess respondent's readiness for organisational change based on the following beliefs: appropriateness, discrepancy, efficacy, principal support, and valence.

The scores on OCRBS indicate that staff had some openness but did not demonstrate a strong commitment to change. Mean scores were highest for principal support (4.85), which is perceived support from leadership and peers within the organisation to implement change, and efficacy (5.18), representing the perceived capacity to effect change at both an individual and agency level. Respondents' perceptions of agency success in implementing the Sanctuary Model showed mean scores ranging from 2.94 to 3.53 out of 5, suggesting a moderate level of success in demonstrating each Sanctuary commitment. Notably, nonviolence received the highest score (3.53), while democracy received the lowest (2.94).

The employee group supervised by the survey respondents was rated the highest in demonstrating Sanctuary Model behaviour (4.06 out of 5). In contrast, the leadership team received the lowest scores

(2.90 out of 5). Interestingly, 18.9% of respondents noted differences in the demonstration of Sanctuary Model behaviour among individuals within the leadership team. However, respondents who perceived support from administrators, supervisors, and peers were more likely to view the agency as committed to successfully implementing the Sanctuary Model®. There was no association between tenure at the agency and readiness for organisational change.

The qualitative research findings are limited (Galvin et al., 2021; 2022), particularly in interview form, without further on-the-ground exploration of these reports. The results also stem from a single community service organisation, which may impact the transferability (a form of generalisability) of the study findings. However, the study by Esaki et al. (2014), while also limited to a single service organisation, employed a structured survey method, offering a systematic and standardised collection of data, thereby enhancing the study's reproducibility and the potential for comparison with other studies. These three studies collectively provide a comprehensive and holistic understanding of the Sanctuary Model. Sanctuary was rated as promising by the CEBC.

Children and Residential Experiences (CARE)

The CARE model is a principle-based program and aims to engage all staff at a residential care agency in an effort to provide trauma-informed living environments for children and young people. Six principles form the foundation of CARE: developmentally focused, family-involved, relationship-based, competence-centred, trauma-informed, and ecologically oriented (McPherson et al., 2018). As such, the approach is designed to cultivate personal investment and ownership among all staff levels at the organisation.

A five-year quasi-experimental evaluation included the examination of the impact of CARE on staff knowledge and beliefs, youth-adult interactions and relationships, and child behaviour, which resulted in two research papers (Izzo et al., 2016; 2020). A total of 13 agencies were non-randomly assigned to either cohort one or cohort two. Cohort one, comprising six agencies, underwent a baseline assessment and commenced CARE implementation immediately in 2010. Meanwhile, cohort two, consisting of seven agencies, underwent an assessment and waited 12 months before initiating implementation in 2011.

Data collection included a staff and child survey collected annually for four years in cohort one and five years in cohort two (the implementation of CARE spanned a duration of three years). The child survey included questions about the child's relationship to direct staff members, while the staff survey incorporated the use of an Organisational Social Context instrument and questions about the respondents' beliefs, knowledge, practice, and demographic characteristics. Agencies also provided monthly reports of behavioural incidents.

Findings from Izzo et al. (2016) found that there was a significant decrease in behavioural incident rates (aggression toward staff or peers, property damage, runaways, and self-harm) of four per cent to eight per cent per month for cohort one. Cohort two trends were slightly different for aggression towards peers and self-harm. Nevertheless, a noticeable decline in the frequency of behavioural incidents per child was observed throughout the four-year study. This decrease was consistent across both cohorts for property destruction, aggression toward staff, and runaway incidents. Despite demonstrating positive support for the implementation of CARE in reducing critical incidents associated with aggressive, problematic, and destructive behaviour, Izzo et al. (2016) speculates that the decline in behavioural incidents may be influenced by historical factors or other unique conditions within the group homes.

Across the 13 agencies, 733 children and young people completed the child survey to share their opinions about their relationship with direct staff and their experience of living at the agency. It was found that there were notable improvements in the perceived quality of youth-adult relationships following the implementation of CARE, with improvements seen at the end of each year of CARE implementation (Izzo et al, 2020). Moreover, a statistically significant CARE effect was identified among children and young people in both cohorts with two or more prior OOHC placement experiences (0.83, 95% CI [0.40, 1.28]) compared to those with one or fewer placements, or when the previous placements were unknown (0.11, 95% CI [-0.27, 0.48]; 0.23, 95% CI [-0.16, 0.61]; and 0.45, 95% CI [-0.05, 0.95], respectively).

The single study boasts several strengths, including a substantial sample size, the inclusion of a comparison group, and longitudinal insights. While the research primarily emphasised CARE's overall effectiveness, there was a lack of information on how the CARE principles were practically applied and the specific components of the model contributing to the observed behavioural changes and outcomes for children and young people. Additionally, the study outcomes are derived from a single community organisation, potentially influencing the generalisability of the findings. CARE is rated as promising by the CEBC.

Life Model of Residential Care

The Life Model was designed to fill a service gap for high-risk children and young people in OOHC, aged 5 – 18 years, with trauma-related behavioural problems and life skill deficits, which require a certain level of care between family-foster care placements. Youth placed in the program typically have a history of exposure to hardship and disruption in their homes and relationships, leading to child protective services involvement (Boel-Studt et al., 2023).

Boel-Studt et al. (2023) utilised a mixed-methods research design to investigate the implementation and outcomes of the Life Model of Residential Care in group homes. First, semi-structured interviews were conducted with 12 staff members (11 in-person, one via telephone call) to explore their perspectives of model implementation. Staff members discussed how the Life Model helped to create a safe and trusting home environment for children and young people, consistent with the principles TIC. One staff member drew a comparison of their experience with other residential care programs, expressing the importance of a family-like environment:

> *"Family environment is huge. You know everything kind of functions more like a family [here] than anything else that I have seen."* (Boel-Studt., 2023, p. 12)

Another staff member highlighted how the Life Model facilitates the inclusion of children and young people in decision making, contributing to an environment that feels less institutionalised:

> "*We try to include the kids in decision making and about what are we going to do Saturday? To make it less institutional and programmatic, it needs to be more like a family.*" (Boel-Studt., 2023, p. 14)

Staff members also discussed how the sense of *home* and *family* is not limited to individual group homes but extends throughout the entire agency, fostering a supportive agency culture and encouraging a team-oriented environment:

> "*I love the environment. Family, you know, even in the office, just friendships and comradery…*" (Boel-Studt., 2023, p. 14)

Second, a Community-Oriented Programs Environment Scale (COPES) survey was administered to both youth and staff at four different time points (baseline, three, six, and nine months) over a one-year period. The COPES survey aimed to measure three critical dimensions of a therapeutic environment: relationship, personal growth, and system maintenance. On the relationship dimension, staff mean scores ranged from moderately high (time points 2 and 4) to high (time points 1 and 3) across the four-time points, indicating an overall strong emphasis on relationships within the program. However, youth perceptions of relationships scored significantly lower than staff at each point in time.

Further, staff consistently reported high mean scores on the System Maintenance Dimension at time points 1, 2, and 4, with moderately high scores at time point 2. While youth scores were lower than staff scores at time points 2 and 4, there were no differences at time points 1 and 3, indicating a degree of consistency between youth and staff perceptions on this measurement. Staff reported moderate-high mean scores on the Personal Growth Dimension at time points 1 and 3 and in the moderate range at time points 2 and 4. This suggests an overall highly therapeutic environment from the staff's perspective. However, youth scores remained in the moderate range across all four-time points, indicating a moderate to high therapeutic environment from the youths viewpoint.

Third, to measure changes in behavioural health and well-being during the implementation of the Life Model, initial and quarterly follow-up assessments were conducted using the Child Assessment of Needs and Strengths (CANS) assessment. The assessment focused on four CANS domains: i) youth behavioural and emotional needs, ii) life functioning, iii) youth risk behaviours, and iv) youth strengths. In the domains of life functioning and behavioural emotional needs, children showed moderate improvements, while there were moderately large gains observed for child strengths.

Finally, the Life Assessment survey was employed to gauge youth progress in the five core areas of personal development: i) spirituality, ii) social, iii) educational, iv) physical, and v) vocational. Children and young people experienced statistically significant improvements in spiritual, vocational, and overall life-skill development, and moderate educational improvements over a one-year period. Further, discharge placement information cited 31 of 37 (83.8%) of young people transitioned from residential care into a family-based placement or supported independent living, achieving permanent housing at discharge and reducing placement disruptions (Boel-Studt et al., 2023).

The mixed-methods approach in this study, incorporating both qualitative and quantitative methods, provided a comprehensive understanding of the Life Model's implementation and outcomes. This allowed for nuanced insights that would not have been achievable through either method alone. However, it is crucial to acknowledge the limitations, such as the small sample size and the study's association with a single service organisation. As a result, caution should be exercised in generalising these findings to broader contexts. Nevertheless, the utilisation of surveys enhances the study's replicability, offering a potential avenue for further research to validate and extend these initial insights. The Life Model of Residential Care has not been rated by CEBC.

Teaching Family Model

The Teaching Family Model (TFM) employs highly skilled married couples or “teaching parents” as the primary caregivers, residing in a family-style home, that treats up to six to eight adolescents. The theoretical foundation is based on behavioural and social learning theory and is characterised by five key elements: experiencing family living, developing interpersonal and life skills, building and maintaining healthy relationships, developing oneself morally and spiritually, and attaining self-determination. The approach also integrates a token economy system and emphasises building positive relationships (McPherson et al., 2018).

One study, resulting in two research papers, explored the TFM (Farmer et al., 2017a; 2017b). A quasi-experimental mixed-methods study was implemented to examine a parsimonious framework for assessing quality in TRC and to examine differences across time for youth served in group homes utilising the TFM. The study sample included seven TFM agencies and seven non-TFM agencies, encompassing 46 residential homes (24 TFM homes and 25 non-TFM homes). The participating homes housed 554 children and young people (358 in TFM homes and 196 in non-TFM homes).

The data for the analyses were sourced from interviews with agency directors, agency staff members, youth, post-discharge caregivers, and in-home observations. Interviews with agency directors were conducted at the study's commencement, followed by interviews with staff members and youth every four months throughout the two-year study period. Staff members conducted observations during the initial six months of data collection, and post-discharge outcomes were gathered through telephone interviews with the youth's primary caregiver at 4 and 8 months after discharge.

Youth outcomes were further measured using the Strengths and Difficulties Questionnaire (SDQ), which evaluated changes in the intensity of psychological symptoms across five domains: emotional, conduct, hyperactivity-inattention, peer relationships, and prosocial. SDQ scores were calculated using information gathered through interviews with caregivers (both pre-admission and post-discharge) and agency staff when the child or young person resided in the designated group home.

Over 20 months, the average SDQ scores for youth showed improvement, decreasing from 19 (pre-admission) to 11 (20-month wave), demonstrating a shift from an elevated clinical score to a score within the "normal" range of the SDQ. Both TFM and non-TFM homes show an improved level of SDQ scores by the 4-month data point, maintaining relative stability up to the 12-month mark. TFM homes experienced significant improvements between 12 and 16 months, while non-TFM homes showed deterioration in mean scores by the 16-month juncture. However, by the last in-home assessment at 24 months, children and young people in the TFM programs had slightly better SDQ mean scores than non-TFM home (TFM 14.6 vs. non-TFM 15.8), but the difference is not significant ($t = 1.5$, adjusted $p = .86$) (Farmer et al., 2017b).

The findings from the youth interviews indicate positive views among children and young people regarding their group home experiences, with the majority considering it a "good place to live" in both TFM (80%) and non-TFM (85%) settings. Most youth endorsed the experience of staff caring for them, but no significant differences were noted between TFM and non-TFM homes. Nevertheless, youth who perceived staff as fair and helping them to learn new things were more likely to have positive outcomes prior to leaving care ($p < .05$) (Farmer et al., 2017a).

Variations in the systems and designs to reduce problematic behaviour and promote prosocial development between TFM and non-TFM approaches were noted. For instance, while all homes employed some form of incentive program for behaviour, TFM homes were notably more inclined to adopt a positive system rather than a punitive one (TFM 4.5 vs. non-TFM 2.7, $p < .001$). Observational data further indicated that homes adopting a motivational system yielded better outcomes for children and young people at discharge than those employing a punitive-focused system ($p < .001$) (Farmer et al., 2017a).

The in-home observations indicated acceptable levels of enactment with little variation across programs, such as maintaining a clean home and creating a 'home-like' environment. However, notable differences were found between TFM and non-TFM programs, particularly in variables like access to age-appropriate items (mean TFM 4.3 vs. non-TFM 3.9, $p < .001$) and the practice of youth and staff sharing meals together (mean TFM 4.6 vs. non-TFM 3.9, $p < .001$). Additionally, a set of observational measures

concentrating on staff interactions with children and young people found TFM staff engaged in the appropriate use of humour (mean TFM 4.3 vs. non-TFM 3.4, p < .001) and recognised when children and young people engaged in age-appropriate activities (mean TFM 5.0 vs. non-TFM 2.3, p < .001). Staff use of appropriate humour and language led to improved outcomes for children and young people eight months post-discharge (p <.05).

The mixed-methods approach in this study, incorporating both qualitative and quantitative methods, provided a comprehensive understanding of the TFM implementation and outcomes. The study featured a large sample size, including a comparison group comprising both TFM and non-TFM homes, thus enhancing the generalisability of the findings.

In addition to the research outlined above by Farmer et al. (2017a; 2017b), this rapid review identified two research studies which implemented adaptations of the TFM (Huefner et al., 2018; Hurley et al., 2017). First, an evaluation by conducted by Huefner et al. (2018), the adapted model, also referred to as the Treatment Family Home (TFH) model, was assessed to compare the long-term outcomes for youth in the program for ≤ six months with youth in the program for > six months.

Administrative 24-month follow-up data was used for youth formally placed in residential care over 19 years of age at the time of the interview. The criterion for using 19 years of age was based on the return-on-investment analysis, which considered adult outcomes (e.g., employment). All participants in the study were former TFH young people who left the program between July 2010 and December 2014.

The study compared two groups. Group one consisted of young people in TFH for ≤ six months (n=141), while group two comprised young people who were in TFH for > six months (n=1031). The results indicate that young people in group two were more likely to be employed (if not attending school) (64.3%), have a high school degree or higher (90.4%), and have a lower likelihood of being arrested for a crime (22.3%).

The projected net government fiscal benefit, encompassing increased tax revenues and reduced government spending, was estimated at USD$44.7 million for young people in the group with > six months in TFH. Similarly, the findings demonstrate a net societal benefit exceeding USD$450 million for this group compared to the group with ≤ six months. This positive impact results from increased high school graduation attainment, elevated employment rates, higher wages, and decreased recidivism rates (Huefner et al., 2018).

The study offers a comprehensive understanding of the economic benefits of TFH. Further, the study featured a large sample size, however the model is an adaptation of the TFM, therefore the study findings cannot be generalised beyond this study.

Second, Hurley et al. (2017) applied a quantitative methodology to investigate youth ratings of treatment fidelity and therapeutic alliance in relation to symptom severity. Two measures were used to assess treatment fidelity: i) a youth-rating of implementation quality, and ii) records of the ratio of positive statements to corrective statements. Children and young people aged 10 – 17 years, with a disruptive behaviour diagnosis, either by the Child Behaviour Checklist (CBCL) or a professional diagnosis and experiencing their first admission to the program were assigned to one of the participating agencies (124 service providers, representing 62 group homes). One hundred and seventy children and young people were eligible to participate, but only 145 had guardian consent.

After one month of residential care, CBCL scores ranged from 31 to 76 with a mean of 55.41, and one third of the youth were rated as exhibiting clinical or borderline behaviour problems. At six months into care,

CBCL scores ranged from 31 to 75 with a mean of 53.94, indicating a very small decrease in exhibiting clinical or borderline behavioural problems.

In addition to the CBCL, the Therapeutic Alliance Quality Scale (TAQS), a five-point scale, was used to assess the working relationship between a clinician and a child or young person. The TAQS was administered every two months over the first six months of care. The findings revealed that therapeutic alliance scores ranged from 1.20 to 4.93 within the initial six months in care, with a mean of 3.70. However, after two months into care, 25.23% of youth rated the alliance between themselves and their clinician as low, 56.76% as moderate, and 18.01% as high. Additionally, youth ratings of fidelity ranged from 1.82 to 4.00, with a mean of 3.23. The implementation benchmark was set at 3.00, and 72.4% of the scores were above the benchmark, indicating that most young people perceived the implementation of TFM as adequate.

The adherence to the token economy, represented by the percentage of positive interactions, spanned from 65.82% to 99.60%, with a mean of 90.59% (SD = 5.28). A mean of 90% positive interactions indicates that, on average, each young person encountered a ratio of 9:1 of positive interactions, which exceeds the benchmark of a 4:1 ratio. However, some youth experienced less than a 2:1 ratio, indicating variations in individual experiences with service providers (Hurley et al., 2017).

The quantitative study offers insights into the treatment fidelity and therapeutic alliance among children, young people, and their caregivers. The large sample size enhances the study's capability to detect genuine effect, thus enhancing external validity. The CEBC rates the TFM model as promising.

Emotional Warmth Model of Professional Childcare

The Emotional Warmth Model of Professional Childcare acknowledges the importance of relationships between children, young people, and their carer(s). Carers work with a psychologist to learn the skills to understand and respond to emotional, behavioural, and attainment difficulties youth in care may exhibit. Carers receive ongoing continual professional development training, which covers attachment theory, adaptive emotional development, authoritative parenting, the effective employment of young people's strengths, involving young people in decision making and the assessment of both the child and carer's progress and development (Cameron & Maginn, 2011).

A quasi-experimental research study by Cameron and Das (2019) aimed to examine the impact of the Emotional Warmth Model of Professional Childcare. The three-year research study involved 53 children, young people, and their carer(s) from two local authorities (North and South) across 11 group homes in the United Kingdom. A Progress and Development Checklist (utilising a five-point Likert scale ranging from 'very poor' to 'hugely improved) was administered at three time points: baseline, mid-intervention, and post-intervention. The assessment was completed by the young person's primary care worker, and the responses were assessed against the Eight Parenting Pillars and the three phases of the Cairns Model (Adaptation, Emotional and Reintegrative).

Following the implementation of the Emotional Warmth Model, significant improvements in both behavioural and affective measures were noted in the children and young people, as indicated by the Personal and Interpersonal Development (PID) measure ($Z (N=53) = 3.978$, $p < .001$).

The findings also revealed significant improvements in the personal and interpersonal development measure (acquiring a sense of well-being and self-identity, developing self-belief and efficacy, and building social interactions) ($Z(N=53) = 3.978$, $p < 0.001$).

Further improvements were seen in the Reintegrative Emotional Adaptation measure (Z(N=53) = 4.77, p < .OO1) and across individual measures of stabilisation (Z(N=53) = 4.181, p < .OO1), integration (Z(N=53) = 3.3O6, p < .OO1), and adaptation (Z(N=53) = 3.654, p < .OO1) when comparing pre-and post-intervention stages. Notably, the level of improvement displayed no significant variation across different study sites.

Lastly, the analyses of the individual Parental Pillars showed significant improvement between pre-and post-intervention scores in resilience (p = .OO4) and self-management (p = .OO3) in the Southern site, and close relationships (p = .OO5) and belonging (p = .OO4) in the Northern site.

Despite the relatively small sample size, the study spanned three years, facilitating thorough data collection. Additionally, the inclusion of children and young people from two authorities across the UK (North and South) enhances the generalisability of the findings. The Emotional Warmth Model has not been rated by CEBC.

Trauma-Informed Care

TIC represents a system-wide approach to service delivery aimed at combining an understanding of the impact of trauma and striving to mitigate its effects. The emergence of TIC stems from the recognition that settings serving trauma survivors often fail to incorporate research on trauma and its effects into their approaches, policies, and practices (Baker et al., 2O18).

Baker et al. (2O18) conducted a mixed-methods study to evaluate the implementation and effect of TIC on staff within one youth residential facility in rural Canada using the Risk Connection and Restorative Approach trauma training programs.

Staff (n=116) completed a Trauma Informed Care Belief Measure (5-point Likert scale) and a Professional Quality of Life Scale, which evaluated compassion satisfaction, burnout, and secondary traumatic stress at three time points: pre-test, post-test, and follow-up.

Participation in TIC training resulted in statistically significant improvements in staff beliefs favourable to TIC (t (114) = 1O.11, p < .OO1, d = 1.O2), and staff attitudes were found to change over time, improving from pre-test to post-test and maintaining at follow-up.

While TIC proved advantageous for staff in enhancing communication and relationships within group homes and across departments in the broader care system, organisational culture change driven by TIC was viewed as a gradual process. Challenges stemmed from resistance to change from some staff members who felt TIC led to less accountability for young people. Despite these challenges, the research suggests that staff perceived TIC as a framework for enabling the translation of theory into practice and supporting the long-term health and well-being outcomes for children and young people in OOHC.

Employing a mixed-methods approach, the study offered a comprehensive understanding of the impact of TIC training on direct-care staff. The large sample size enhances the study's ability to detect genuine effects, contributing to more reliable and accurate findings. Nevertheless, the results pertain to a single-service provider, potentially limiting their generalisability. Trauma-informed care has not been rated by the CEBC.

Supplementary interventions implemented with TRC models

Residential care providers often implement client-specific evidence-based interventions alongside or supplementary to the systemic therapeutic environment they aim to create through TRC. Daly et al. (2O18) highlight that care providers commonly employ clinical interventions such as Music Therapy,

Dialectical Behaviour Therapy, and Cognitive Behaviour Therapy. Residential care providers may also implement supplementary residential care-specific programs alongside TRC that target children's outcomes, such as physical health, diet, and life skills (e.g., Healthy Eating Active Living Program, Cox et al. 2018). This rapid evidence assessment excluded supplementary interventions for individuals and supplementary residential care programs which were not aimed at creating a therapeutic or healing environment. Excepted from this were interventions or programs for First Nations children and young people living in residential OOHC which aimed to increase cultural connection, as connection to culture has been recognised as an essential aspect of a healing environment for First Nations children (The Healing Foundation, 2021; SNAICC, 2023).

Four interventions and one policy designed to support Aboriginal and Torres Strait Islander children in OOHC in the Australian context were identified in the literature within this review:

1. Cultural Safety Plans (CSP);
2. The Koorie Tiddas Youth Choir;
3. The Connecting to Sea Country;
4. Return to Country; and
5. Wrapped in Culture (Lindstedt et al., 2017).

The Cultural Safety Plans (CSP) policy is implemented to varying degrees across Australia, with many states and territories self-reporting low rates of adherence and no method to quantify the results. A 2012 review of the CSP program in Queensland indicated 92.7% of Aboriginal and Torres Strait Islander children in OOHC had a current CSP; however, non-government child protection agencies found CSP to be incomplete and failing to meet the cultural needs of First Nations children (Lindstedt et al., 2017).

The four identified cultural programs (The Connecting to Sea Country, The Koorie Tiddas Youth Choir, Return to Country and Wrapped in Culture) underwent evaluation using narrative evaluative research (Lindstedt et al., 2017) and found three essential elements crucial for their success: i) the role of culture as a healing factor, ii) the significance of relationships, and iii) the integration of education for intergenerational healing. Further information on these programs are included below within the secondary search exploring specifically TRC models designed for First Nations children and young people (Lindstedt et al., 2017).

Secondary search

The secondary search aimed to identify TRC models and client-specific interventions for i) children and young people who have displayed HSB, and ii) First Nations children and young people. A single peer-reviewed journal article focused on cultural interventions was identified (Lindstedt et al., 2017); however, this paper had already been identified in the initial search and is also mentioned above. The secondary search for HSB yielded no peer-reviewed journal articles that met the inclusion criteria for this rapid evidence review.

Cultural models and practices

In Australia, First Nations children comprise 5.9% of the total child population, yet Aboriginal and Torres Strait Islander Children aged 0-17 years represent 42.8% (56.8 per 1000 children) of all children in OOHC (AIHW, 2022; Productivity Commission, 2022). Australia's history of colonisation and subsequent policies has inflicted trauma upon individuals, families, and communities, which has frequently led to the loss of family connections, language, land, and culture (Lindstedt et al., 2017).

One out of the six organisation-wide models were found to embed cultural components into their overarching program model to support Aboriginal and Torres Strait Islander children and young people.

The Sanctuary Model® adapted its' framework by introducing a fifth pillar, 'Cultural Safety', recognising it as an essential component. Within its implementation in the Australian context, this is being implemented via inclusion of Cultural Humility as a key component. The Sanctuary toolkit now includes the 'S.E.L.F for Cultural Healing', designed to support staff to connect with and understand the challenges faced by Aboriginal and Torres Strait Islander children and young people during their time in residential care (Galvin et al., 2022a).

Although cultural components are integral to the Sanctuary Model®, no studies were identified which included First Nations specific outcomes data regarding the effectiveness of the Sanctuary Model® for First Nations children.

Lindstedt et al. (2017) identified four client-specific interventions that incorporated relationship building, culture as a healing factor and the importance of intergenerational healing into the programs. The programs were:

1. The 'Koorie Tiddas Youth Choir', which offers young people the opportunity to connect with their language and culture through music;
2. 'Return to Country', a program designed to support young people to visit and connect with their land, families, communities and culture;
3. 'The Connecting to Sea Country', which organises educational day trips to learn about Port Phillip Bay and its Aboriginal heritage from an Aboriginal Elder; and
4. 'Wrapped in Culture', also known as 'Possum Skin Cloak Project', which involved teaching young people the art of crafting a possum skin cloak.

Using a narrative evaluative research approach, participants showed an improved sense of belonging and identity as an outcome of these programs.

DISCUSSION

This rapid evidence assessment aimed to synthesise the results of the evaluative information of the disparate TRC models to determine *the current state (quality and kind) of evidence for therapeutic residential care models.* Additionally, the review aimed to determine the extent to which the existing literature provided an evidence base for: (a) the overarching effectiveness of TRC models; (b) the operationalisation of principles and goals, and the extent to which specific elements could be linked to outcomes; (c) TRC models that met the needs of First Nations children and young people, including for cultural safety and connection; and (d) TRC models that met the needs of children who have displayed HSB. The findings from the rapid evidence assessment against each of these aims are discussed below.

Gaps in research

Critical research gaps persist in the TRC evidence base, marked by a notable lack of standardised evaluation of TRC models and interventions (Bailey et al., 2019; Barker et al., 2018; James, 2017; James et al., 2013; Lindstedt et al., 2017). There were a relatively small number of evaluative research studies of TRC identified in this review, which included publications in the period 2013-2023. This is consistent with the findings of previous reviews of the TRC evidence base, which similarly concluded there was a dearth of evidence (Baket et al., 2018; Izzo et al., 2020; James, 2017; Lindstedt et al., 2017).

The identified studies shared common characteristics, employing mixed-method approaches, incorporating qualitative and quantitative research methods—enhancing the overall depth of understanding of the research findings. While the sample sizes across studies varied, several studies

had relatively large sample sizes. The limitation in generalisability was noted, particularly in instances of single-site implementation evaluations. Despite this constraint, a subset of studies provided valuable outcome data, indicating enhanced functioning among children and young people in TRC.

Evaluations of implementation of a model, reviewing how closely a model is being implemented according to a set of pre-determined guidelines, processes and practices are important as it enables evidence-users to have confidence that the outcomes of an evaluation (positive or negative) are correctly attributed to the model rather than being a consequence of site-specific features of the implementation. Studies that did include aspects of fidelity reported misinterpretations of core model concepts apparent within user feedback (Galvin et al., 2022a). Some of the studies identified also reported leadership and staff 'buy in', challenges in staff training, and lack of knowledge of trauma as potential barriers to implementation (Cox et al., 2018; Baker et al., 2018; Daly et al., 2018; Esaki et al., 2014; Galvin et al., 2021; Galvin et al., 2022a; Holden & Sellers, 2019; James, 2017; James et al., 2013; Lindstedt et al., 2017), adding weight to the need for fidelity measures to be included in TRC evaluations.

Despite high-quality evidence in this review, evaluative research on TRC conducted between 2013 and 2023 remains somewhat limited. The continued lack of a substantial high-quality evidence base for TRC models is a significant evidence gap, particularly when considered against a policy and practice context which frequently holds a position that all children in residential care (a highly vulnerable population) should be growing up in a therapeutic environment (Royal Commission, 2017; Commissioner for Family Violence TAS, 2021)

More evaluative research into TRC models remains a research priority in this area. Features of rigorous evaluative research of TRC would ideally include multiple evaluation sites (to increase power and generalisability), examination of implementation fidelity, outcomes for staff, and outcomes for children. Research methods would also ideally include mixed methods approaches, inclusive of multi-site pre- and post-test outcomes measures with comparison conditions for staff and children, and qualitative research with all stakeholders including children and young people. A sustained focus on the development of a high-quality evidence base is crucial for continuous improvement and enhancement of the knowledge in this field.

What is known about the outcomes and implementation of TRC models?

The evidence base for TRC continues to show that TRC models show promise for improving both staff knowledge and confidence, and the outcomes of children in residential care. Identified studies included revealed positive outcomes, including a reduction in behavioural incidents among children and young people (aggression toward staff, property damage, and children missing from placement) (Izzo et al., 2016) and the perceived quality of child-adult relationships (Holden & Seller, 2019; Izzo et al., 2020). Further positive impacts were observed in the successful transition of young people from residential care into a family-based placement or supported independent living (Boel-Studt et al., 2023). Other noteworthy outcomes highlighted enhancements in a young person's sense of self, self-belief and improving social interactions (Baker et al., 2018).

The literature assessed suggests several essential elements to effective implementation of a TRC environment, which were common across several studies (Baker et al., 2018; Daly et al., 2018; Esaki et al., 2014; Galvin et al., 2021; 2022a; Hurley et al., 2017; Izzo et al., 2016; James, 2017; James et al., 2013) and included:

- Leadership
- Staff 'buy in'

- Effective and sustained training and professional development in the TRC model
- Staff knowledge and understanding of trauma

As a consequence of the extent of the evidence base, the different evaluation methods used, and the outcomes investigated, it is not possible to draw generalisable conclusions about the effectiveness of specific TRC models to compare the commonalities, or the relative strengths or limitations of each approach. There continues to be limited evidence in the studies identified on the specifics of how TRC models, which are often articulated in terms of high-level principles or common elements, are operationalised on the ground.

Meeting the needs of children in residential care when HSB are present

There were no studies identified which specifically addressed the features or approach of a TRC model where HSB were present.

Meeting the needs of First Nations children for cultural safety and connection

One study was identified which evaluated four interventions aimed at connecting children in residential care to culture. The evidence from this study was very encouraging in the improved outcomes across all four programs, with each reporting improvement in First Nations children's sense of belonging and identity (Lindstedt et al., 2017). Notably, a common feature of all four programs designed to improve children's cultural connection was that they were Aboriginal and Torres Strait Islander designed and implemented. This is likely to be an essential characteristic of successful programs designed to increase cultural connection.

Additionally, the review identified that the Sanctuary Model® had included Cultural Safety as a core element or principle for implementation (Galvin et al., 2022). However, a common limitation of TRC models is the lack of evidence for how cultural practices and interventions should be practically applied and embedded into the delivery of TRC. Culture plays a pivotal role in a child's development, sense of self, and overall wellbeing; if the gap in the evidence regarding effective implementation of cultural practices within TRC models is not addressed, there is a risk that lasting effects of trauma (including the collective trauma of colonisation) may persist. Looking ahead to the future of TRC, culture must be at the forefront when designing or adapting TRC models and/or individual therapeutic practice models. In future, evaluative research could investigate the embedding of cultural programs and practices for First Nations children, such as those evaluated in the study by Lindstedt et al. (2017) into TRC models– noting that a common feature of the four programs to improve cultural connection was that they were designed and led by First Nations people.

SECTION 3: WHAT DOES PRACTICE LOOK LIKE IN AUSTRALIA – A JURISDICTIONAL SCAN

OVERVIEW

The objective of the jurisdictional scan was to canvas what models of TRC are currently utilised across national and international child protection sectors. The scan process relied heavily on rapid review of publicly available material, associated grey literature, brief targeted consultations (where available), and systematic review of this information.

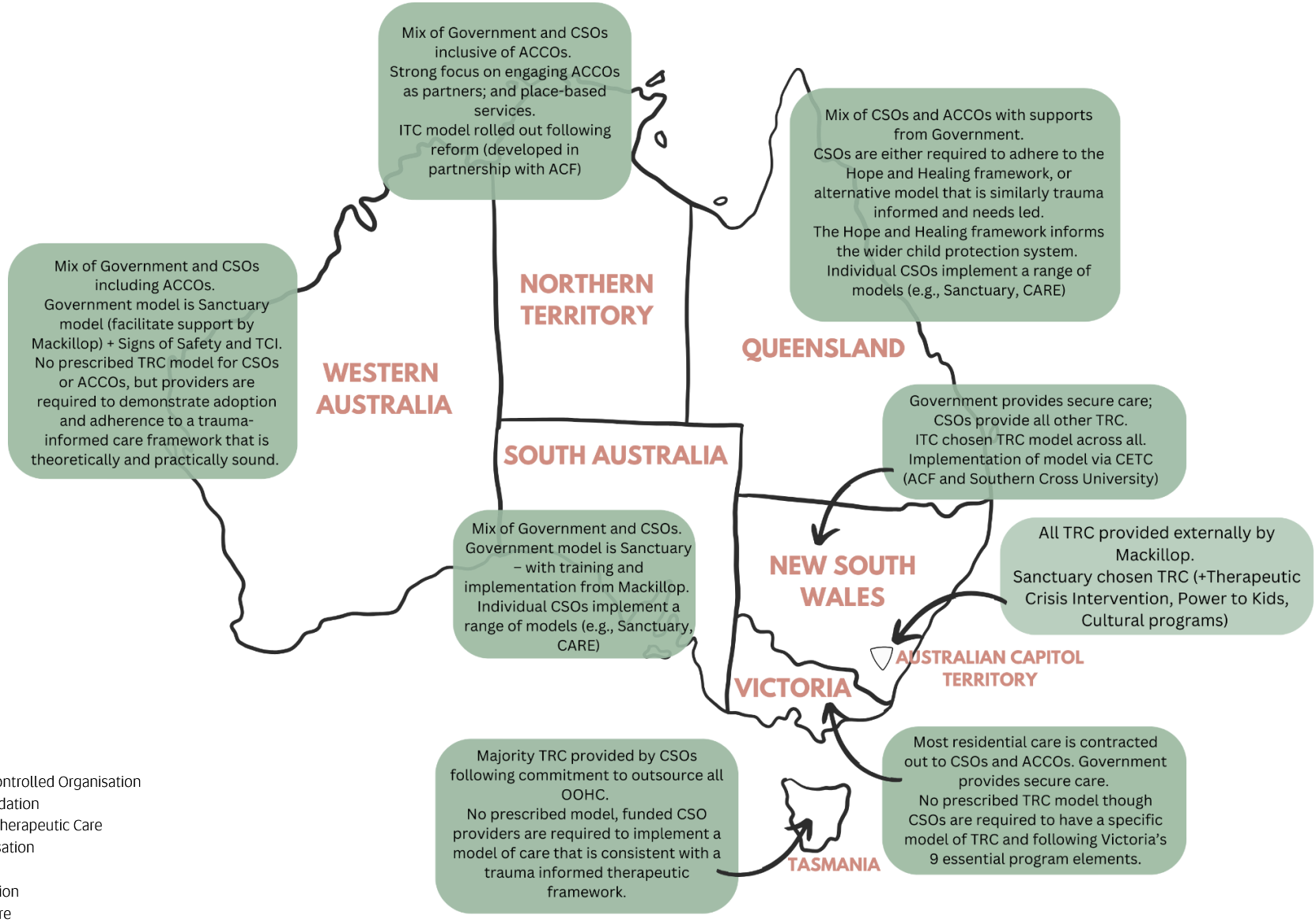
Models of TRC manifest primarily within residential settings, encompassing diverse structures such as group homes, treatment facilities, and therapeutic communities, where adept professionals collaboratively engage with residents to cultivate a therapeutic environment that enables children and young people to heal from their trauma more effectively.

The effectiveness of TRC is known to vary, and ongoing research and evaluation are critical to improving the quality of these programs.

There was wide variability in the publicly available information relating to TRC across the reviewed jurisdictions, with respect to both the amount of information and the detail contained within. That which was available was generally embedded within case practice frameworks, practice standards, or website information relating to OOHC services more broadly. There was a general lack of detail regarding how TRC was operationalised in practice even if there was an identified model, and the scope of TRC provision by Community Sector Organisations (CSOs) relative to government.

There was also considerable variability in the terminology used to describe TRC across the jurisdictions. This required the practice team to make some assumptions as to which care options offered by each jurisdiction aligned with the overarching description of a TRC. Where jurisdictions outlined multiple residential care service options, those entailing increased intensity of service provision and therapeutic support were taken as being the TRC care option even in the absence of a formal model being named.

The following includes a summary of each jurisdiction's TRC context, any named models of TRC used, and associated implementation information as available. Further information related to the approach and comparison extraction tables can be found in the relevant appendices to this report - Appendix C – Methodological approach to the Australian jurisdictional scan, and Appendix D – Comparison extraction tables.



ACCO – Aboriginal Community Controlled Organisation
ACF – Australian Childhood Foundation
CETC – Centre for Excellence in Therapeutic Care
CSO – Community Sector Organisation
ITC – Intensive Therapeutic Care
TCI – Therapeutic Crisis Intervention
TRC – Therapeutic Residential Care

Figure 1: Overview of Australian Therapeutic Residential Care models in practice

PRACTICE ACROSS THE JURISDICTIONS

Australian Capital Territory

Reviewed information for the Australian Capital Territory was restricted to grey literature, information garnered from direct website search, indirect commentary provided within interview with Mackillop Family Services (as the dominant provider of TRC services within the Territory), and written information provided by the delegated government representatives in response to the validation check.

The ACT Out of Home Care sector underwent major reform between 2015 and 2020, termed *A Step Up for Our Kids*. The state is currently within the next stage of reform 2022-2030 termed *Next Steps for Our Kids*. This phase will be multi-faceted, as it sits in the context of a range of Government commitments and wider reform efforts in the children and family services sector.

Therapeutic Residential Care applies to children and young people from 12 to 18 years of age appropriately assessed for residential care living arrangements. Therapeutic Residential Care placement may also occur for children under 12 years of age by exception. Family based care is the priority for all children and young people in out of home care and TRC placement is sought only when other suitable accommodation cannot be sourced to meet the level of need and support required by the child or young person. Residential care services within the Territory have been solely provided by Mackillop Family Services since March 2023. Prior to this, services were provided by Barnardos Australia.

Mackillop Family Services adopt the Sanctuary model® (Esaki et at., 2013) and implement this across all TRC services they provide. They integrate this with additional crisis response, cultural, and therapeutic programs to comprehensively meet the needs of the children to whom they provide care. Currently, these additional programs include Therapeutic Crisis Intervention (TCI; Holden et al., 2022), Power to Kids (McKibbin et al., 2020), and tailored cultural considerations.

The Sanctuary model® does not provide specific therapeutic focus on children who have displayed HSB, or Aboriginal and Torres Strait Islander children, however there are specific practice and care requirements applicable to Aboriginal and Torres Strait Islander children living in TRC. Mackillop also provide tailored cultural programs that allow for specific therapeutic focus for Aboriginal and Torres Strait Islander children within their TRC services.

Similarly, the Sanctuary model® does not provide specific focus on children who have displayed HSB, though Mackillop's TRC services do seek to support children who have displayed HSB by way of the application of the Power to Kids program. Power to Kids seeks to strengthen prevention and responses to HSB, sexual exploitation, and dating violence for young people in residential care. There are also bespoke arrangements (outside of the MacKillop contract) for a limited number of children and young people who are unable to live in mainstream out of home care arrangements and require an individual placement arrangement on a temporary, short term or long-term basis. The services provide specialised responses for children, young people and sibling groups who have been assessed as having significant complex needs and require an extreme level of support, including those who have displayed HSB.

New South Wales

Reviewed information for New South Wales included grey literature, information garnered from direct website searches, and an interview consultation with the nominated representative from the Department of Communities and Justice (DCJ). Response to the request for validation of the gathered material had not been received at the time of writing.

Intensive Therapeutic Care (ITC; the term NSW has given to its TRC) replaced traditional residential care services from July 2018. ITC is a service model that seeks to help children and young people recover from severe trauma, abuse, and adversity. ITC aligns with the NSW Therapeutic Care Framework which guides service provision and seeks to improve outcomes for children in Out of Home Care.

Children referred to ITC services are usually aged 12 years and above and have high and complex needs, who are either unable to be supported in foster care or require specialised and intensive supports to maintain stability in their care arrangements. Children aged younger than 12 years may be considered for placement within ITC if they have extremely complex needs. The interviewed representative indicated that, anecdotally, younger children are now being considered for placement within intensive therapeutic care more often.

Generally, ITC is time limited to two years, with the primary goal being for the child to successfully transition to a permanency option or "step down" into a carer-based placement or supported independent living placement to support transition to independence. Despite this, the needs of the child are prioritised over the time limit, allowing for children to remain in the placement longer if required (which is not uncommon). ITC services are provided entirely by community service organisations. Separate from ITC, the Department delivers secure care services. Currently there is no ITC service provision by Aboriginal Community Controlled Organisations (ACCOs). The interviewed representative indicated it is a government priority to move toward ACCO-provided ITC services in the future. Government funding options for CSOs allow for both four bed and two bed options for care placements. The two-bed option allows for higher levels of supervision and care support, providing one staff member per child in the placement. This model was introduced in 2022 to cater for children with high needs who may benefit from living in a lower configuration home.

Community service organisations providing ITC are expected to adhere to NSW Therapeutic Care Framework (TCF) and *10 Essential Elements of Therapeutic Care* (Centre for Excellence in Therapeutic Care, 2019). DCJ identified the 10 Essential Elements to operationalise the NSW Therapeutic Care Framework. The NSW Therapeutic Care Framework was developed by DCJ, Association of Children's Welfare Agencies (ACWA) and the OOHC sector to guide the delivery of best practice Therapeutic Care. The interviewed representative stated ITC and the Essential Elements were influenced by the model of care adopted by Victoria and Verso Consulting literature review that underpinned the development of the Victorian model. The 10 Essential Elements include:

1. Therapeutic Specialist
2. Qualified, Trained and Consistent Staff
3. Engagement and Participation of the Young People
4. Client Mix
5. Care Team Meetings
6. Reflective Practice
7. Organisational Commitment
8. Physical Environment
9. Exit planning and post-exit support
10. Governance and Reporting

These elements provide guides to practice that can be adapted flexibly for different organisations and program requirements. Service provision may look different between organisations, and within organisations depending on the care needs of the client cohort. The Centre for Excellence in Therapeutic Care (CETC) provides accessible practice guides for each essential element, and CETC staff

worked with state representatives across a 3-year implementation period to provide implementation support to embed the framework across the state. This implementation support included the use of Communities of Practice which were found to be incredibly useful.

While there is no specific therapeutic model for Aboriginal and Torres Strait Islander children and young people within ITC, cultural planning is embedded as a requirement within case practice aligned with the Therapeutic Care Framework. There are also staffing requirements to support cultural practice standards, including mandatory professional development.

There is no specific therapeutic model prescribed for HSB within ITC, though the Department of Communities and Justice encourages community service providers to demystify HSB and build practice and service responses around the child. Service providers are also encouraged to collaborate with HSB therapeutic specialists, such as NewStreet, for support in providing care and intervention to children and young people who have displayed HSB.

The ITC model has not been specifically evaluated. NSW's Permanency Support Program has recently been evaluated more broadly, which indicated poorer than expected outcomes. The interviewed representative indicated that the state was entering the preliminary stages of reform as a means of improving permanency outcomes for all children in care, which may lead to future changes to the use of ITC, the TCF and current service provision generally.

Northern Territory

Reviewed information for Northern Territory included grey literature, information garnered from direct website searches, and information provided by the Department of Territory Families, Housing and Communities.

The Out of Home Care sector in the Northern Territory underwent review and reform between 2019 to 2021. Recognising the need for change to improve outcomes for children in care and reduce the overrepresentation of Aboriginal and Torres Strait Islander children in care, Territory Families engaged Deloitte to review their existing service model. The review sought to capture the voices and insight of children and families, care givers, Aboriginal Community Controlled Organisations (ACCOs), community service organisations, and peak bodies.

The final review document (Northern Territory Government, 2019) outlines a new model of OOHC services that includes 5 care options, including *intensive therapeutic residential care* (ITRC). A new overarching child protection service model is outlined. This model prioritises:

- Cultural and placement stability;
- Early intervention services and reunification support services for families;
- Partnerships with Aboriginal communities and organisations to co-design and deliver support and services;
- Place-based service delivery that wraps around the child;
- Accessible therapeutic services for all children, young people, families, and carers;
- Improved care leaver support;
- Specialised and intensive homebased care for children with complex needs in regional locations; and
- Phase out of purchased home based care.

Intensive Therapeutic Residential Care placements are reserved for young people aged 12 to 17 years of age who present with complex or extreme needs that would benefit from a trauma informed therapeutic

care approach and prevent them from being placed in other care options. Children younger than 12 may be considered for placement in ITRC if they have been assessed as their needs being best met by ITRC or if they are part of a sibling group whose collective needs would benefit from ITRC services and being placed together. The goal of placement is to reduce the care need of the child or young person, such that they can transition into a less intensive care option.

All ITRC is procured out to external organisations, currently Life Without Barriers (LWB) and CASPA. Organisations providing ITRC must implement a model of therapeutic residential care though no specific models are prescribed. Implemented models must meets the following key objectives of ITRC:

- enhancing collaboration and connection with Children, their families, community, and culture throughout a Child's journey in OOHC;
- delivering therapeutic services that are designed and can be tailored to achieve positive outcomes and successfully transition Children out of ITRC to stable Placements, family care or independent living arrangements;
- providing therapeutic environments that support positive, safe, and healing relationships and experiences, to address individual and complex needs and work towards addressing the trauma experienced;
- building capability by working with the Territory, community, and the Service Provider to share knowledge and therapeutic evidence-based approaches; and
- establishing supportive systems to deliver the ITRC Services.

LWB implements the CARE Model within their ITRC placements. The model of care implemented by CASPA was unknown at the time of writing.

The ITRC model was developed with Aboriginal and Torres Strait Islander children presumed to be the priority focus population. The consideration of culture and importance of connection to family, culture, community, and Country is woven through all aspects of the model, with a strong focus on family preservation and family reunification as priority. Cultural case plans are required for all children and young people and TRC providers must demonstrate culturally appropriate healing frameworks for the assessment and support of Aboriginal children and young people. Access to culturally appropriate services through ACCOs and mainstream organisations is also essential.

Although there is no formal TRC focus on children and young people who have displayed HSB, there is capacity for an individualised care model to be developed for children and young people who have demonstrated HSB that complements the ITRC model.

Queensland

Reviewed information for Queensland was gleaned solely from grey literature and direct website searches, as delegates for the Department of Child Safety, Seniors and Disability Services were unable to be engaged for consultation. Efforts to obtain validation regarding the gathered public material were still pending at the time of writing.

Children aged 12 to 17 years with complex to extreme support need are eligible for TRC services within Queensland. Children younger than 12 may be considered for placement pending a comprehensive assessment if they present with complex needs, or if they are part of a sibling group who all present with complex needs or would be best placed together. Children older than 15 are supported to transition to supported independent living where possible, to enhance their readiness to transition from care. Publicly available information suggests that TRC is provided by community service organisations

and involves small group care with 4 and 6 bed residence options. The duration of therapeutic residential care placement is intended to be time limited, ranging from 12 to 18 months.

Care practitioners who provide TRC have enhanced intervention skills and are required use trauma informed models of care and service delivery. The Department of Child Safety, Seniors and Disability Services works in partnership with the agency providing care to identify, establish and maintain connections between the young person and their family, the community and culture, and others significant to them. A network approach is used to create collaboration with state government health, education, and police services within Queensland.

Queensland also has Aboriginal and Torres Strait Islander community residential care and family intervention services, which are commonly known as *Safe Houses*. These residential services are specifically designed to meet the unique needs of Aboriginal and Torres Strait Islander children and are located within remote Aboriginal and Torres Strait Islander communities to facilitate children to be provided care in their home communities. This service works closely with a related Family Intervention service that provides practical supports to families and parenting interventions during supervised contact to optimise permanency outcomes for the child.

The *Hope and Healing framework* (Department of Child Safety, Youth and Women et al., 2019) has been adopted by the Department of Child Safety, Seniors, and Disability Services to inform the wider child protection system within the state, including residential care. The framework was developed in collaboration with Peakcare and is intended to be foundational and flexible, enabling its broad application. The Hope and Healing framework is informed by the following principles:

1. Care is individualised, taking account of age, stages of development, and cognitive functioning and abilities,
2. Care is relationship-based,
3. Care promotes engagement in decision making and life choices,
4. Care occurs within the context of family,
5. Care supports links with community,
6. Care is culturally safe and culturally proficient, supporting Aboriginal and Torres Strait Islander cultural identity and culturally and linguistically diverse identities,
7. Care understands and responds to behaviour as communication,
8. Care provides unconditional commitment (persistent allegiance),
9. Care is collaborative and integrated across all services involved with each child and young person.

The framework document provides an overview of the guiding principles, phases of care, and domains of care to aid implementation of the model (Department of Child Safety, Youth and Women et al., 2019). Due to the foundational nature of the model, day to day care routines and processes will vary between organisations.

Individual community service organisations implement a range of TRC models that complement the Hope and Healing framework, including CARE and Sanctuary. No specific TRC focus on children who have displayed HSB was identified. Reference to care focus on Aboriginal and Torres Strait Islander children and young people is contained within the Hope and Healing framework and Queensland Standards of Care.

South Australia

Reviewed information for South Australia included grey literature, information garnered from direct website searches and written information provided by a representative of the South Australian Department for Child Protection (DCP).

TRC in South Australia is provided by both government and non-government agencies. In 2020, DCP committed to implementing a framework for therapeutic care across the department's residential homes and in 2021, commenced embedding the Mackillop Institute, Sanctuary Model® (Esaki et al., 2014) of therapeutic care. The Mackillop Institute is collaborating with DCP to provide training and implementation support. DCP requires all commissioned non-government agencies to adhere to a model of care consistent with a trauma informed therapeutic framework, though no specific models are prescribed. Moreover, DCP supports and collaborates with non-government partners and service providers to share the core principles and fundamental elements of the Sanctuary Model® and Sanctuary tools. Several information sessions and presentations have been conducted by DCP to facilitate this process.

Therapeutic residential care is available as a care option for South Australian children in OOHC who have exhausted family-based care options (including kinship and foster care), which are explored first as a placement priority. As such, there are no additional eligibility criteria for children and young people in DCP residential care to access TRC.

In addition to the guidance and training provided by the Mackillop Institute, the implementation of TRC across Departmental residential homes is supported by several practice frameworks and guidelines. Departmental staff are required to adhere to the DCP Manual of Practice and the DCP Practice Approach. Departmental TRC is also complemented by the following services and processes:

- *Complex Case Reviews*
    - Led by DCP's Chief Psychiatric Director, Complex Case Reviews are undertaken for matters which are complicated and require clinical oversight. The reviews ensure children and young people in care with complex needs and behaviours (such as HSB) and those in contact with other systems – including mental health and youth justice – receive coordinated care.
- *Therapeutic Carer Support and the Specialist Services teams within the Disability and Development program.*
    - The Specialist Services team focusses on the development and behavioural needs (including problematic sexualised behaviour) of young people in residential care. These staff assist residential care staff to understand the development needs of children and young people and to tailor their care accordingly.
- *DCP Psychological Services team*
    - This team comprises psychologists responsible for assessment and intervention across the spectrum of DCP work. This includes targeted work with young people and care teams to respond effectively to the therapeutic needs of children and young people who live in residential care settings.
- *Child development and attachment training*
    - This two-day training includes content covering the typical pattern of childhood development, the development of attachment relationships and the impact on children who experience poor attachment, the impact of trauma on children and young people's development, and how to provide support and guidance to families/carers about how to respond to children and young people who have experienced trauma.

DCP prioritises culturally responsive service delivery for Aboriginal children and young people, aiming to honour the inherent strengths of Aboriginal cultures. This commitment ensures that the voices of Aboriginal children, young people, and their families remain central to decision making processes. An Aboriginal Sanctuary Practitioner is also central to the DCP Sanctuary team, with this role providing specific support to Aboriginal children and young people residing in DCP residential care. DCP also employs Principal Aboriginal Consultants responsible for leading operational and strategic interventions for Aboriginal children, young people, and their families, and contributing to the development of Aboriginal culturally sensitive policies, programs, and practices. DCP works in close partnership across the government and with non-government partners to identify and overcome challenges, drawing on cultural knowledge, understandings, and strengths.

DCP has embedded professional development opportunities, practice guidelines, and other resources to support staff to effectively identify HSB and to appropriately respond. This includes:

- *Power to Kids program*
    - DCP residential staff are trained to deliver the Power to Kids program as a HSB specific complement to the Sanctuary model.
- *TAFE Certificate IV in Child Youth and Family Intervention*
    - New residential care child and youth workers complete this qualification within their first 12 months of employment, which covers three specific modules on trauma. The Certificate IV training also has two modules that cover sexualised behaviours. As the Certificate IV is contextualised to DCP, information about trauma, abuse-related trauma, and trauma-informed care strategies are embedded throughout delivery and assessment.
- The DCP Manual of Practice and related practice papers provide all child protection workers with detailed information to enable them to identify and respond to HSB amongst children and young people in care. Relevant topics include:
    - 'Supporting children and young people who display problem sexual behaviours;'
    - 'Safeguarding children and young people;' and
    - 'Protective behaviours and sexual education for children and young people'

DCP also recognises that children and young people who experience HSB require targeted support and therapeutic intervention. DCP workers are provided with guidance about facilitating children and young people who have displayed HSB to access therapeutic services. DCP works closely with its partner agencies responsible for relevant service provision (e.g., SA Health, CAMHS, NDIS and specialist non-government providers) to support the provision of therapeutic intervention.

Tasmania

Reviewed information for Tasmania included grey literature and information garnered from direct website searches, as well as information provided by government representatives during the validation process.

Tasmania has recently made significant reforms to the Strong Families, Safe Kids (SFSK) strategy (Tasmanian Government, 2021). In Tasmania, policy and practice is informed by a new Practice Approach titled "Feel safe, are safe," implemented in October 2023. The Practice Approach is a working document for Child Safety Practitioners to strengthen what is already in place and ensure consistency and quality of practice across a continuum of care for children and young people.

There are two key types of accommodation provided for children and young people in OOHC: Family Based Care and Salaried Care. Family based care encompasses foster, kinship, sibling group care, and emergency/respite care. Salaried Care is used to describe a mode of delivery of care in a family-like home in the community (e.g., rented accommodation) where 24/7 care is provided to children by trained/skilled employees of a provider organisation through rostered 8-hour shifts. This care type is provided to a small number of young people who have challenging behaviours and/or high support needs that cannot be addressed in a less intensive environment and/or where a family-based care arrangement is not suitable (e.g., older adolescents).

Department for Education, Children and Young People (DECYP) funds two services under Salaried Care services:

- Special Care Packages (SCPs), and
- Transitional Placement Services.

The Transitional Placement Service derives from the now-lapsed TRC service that had been provided by CatholicCare since its inception in 2015. Over this time, the service had established and matured and it was apparent to both DECYP and CatholicCare that young people required a service that would be more deliberately focussed on transition: a 'Transitional Care' service, geared ultimately towards either transition to independence (longer-term care), or short-term/time-limited care whilst assessment work was undertaken to identify and establish the preferred longer-term care arrangement for the young person.

Transitional care is provided from homes in the community to groups of young people (3-4) with a support model designed to facilitate recovery from the impacts of physical, psychological, and emotional trauma resulting from their experiences of harm or risk of harm. DECYP committed to outsourcing all forms of OOHC to the non-government sector in 2023, following recommendations from the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (2023). Non-government organisations providing salaried care are required to utilise a model of therapeutic behavioural management and support, however a specific model is not prescribed. Organisations are also encouraged to connect to specialist services as required for specific support.

Tasmanian OOHC staff are trained practitioners in The Trust-Based Relational Intervention™ (TBRI; Purvis et al., 2013), a trauma-informed therapeutic model of support for young people designed to facilitate recovery from the impacts of physical, psychological, and emotional trauma.

Children within salaried care placements are also provided therapeutic interventions by the Australian Childhood Foundation (ACF). ACF support the care team and work with the child or young person to develop a plan to help the child or young person to achieve their goals in ways which are trauma-informed, culturally appropriate and that support healing. The ACF also provides training and support to Tasmanian residential staff and carers.

No formal TRC models specific to Aboriginal and Torres Strait Islander children and young people are implemented, however services are tailored to the individual needs of the child or young person, including consideration of culturally appropriate responses and services, depending on the needs of the young person at the time. DECYP works closely with the Tasmanian Aboriginal Centre and other ACCOs to support the needs of Aboriginal families and communities in Tasmania. For Aboriginal and Torres Strait Islander children and young people, the care plan incorporates support for the young person to

maintain connection to culture, extended family, and community, which may include a therapeutic plan that involves referral out to relevant services or upskilling of care staff.

No formal TRC models specific for children and young people who have displayed HSB were identified as being used. However, a partnership of community-based organisations including the Sexual Assault Support Service (SASS), Laurel House Sexual Assault Support Service, and Mission Australia offers the Prevention, Assessment, Support and Treatment (PAST) program to Tasmanian children aged 17 and younger who are displaying harmful sexual behaviours. The PAST program provides early education and intervention for children and young people displaying developmentally inappropriate sexual behaviours, as well as interventions for those assessed as being at higher risk of problematic or HSB through clinical assessment, and the development of a therapeutic plan and treatment. The program includes young people involved within the criminal justice system, those displaying violent or aggressive behaviours, and those in detention. The program allows for secondary supports to be provided to family and carers, and provides training to organisations like schools and other facilities that come into contact with young people. The PAST program operates statewide through funding from the Tasmanian Government and is managed by DECYP.

Victoria

Reviewed information for Victoria included grey literature, information garnered from direct website searches, and an interview consultation with the nominated representative from the Department of Families, Fairness and Housing. Response to the request for validation of the gathered material had not been received at the time of writing.

TRC services are provided to children and young people 12 years and older who demonstrate extremely high or complex needs that cannot be met in alternate care options. TRC is considered a last resort care arrangement.

Placement within this care option is time-limited and children and young people are supported to transition into less intensive care options as soon as their level of care need permits. The Department of Families, Fairness and Housing provides a small number of residential care homes, though most residential care services are contracted to community service organisations, including ACCOs. Care residences are funded as a four-bed base model, though there is a level of variation to this across providers.

In addition to standard TRC placements, Victoria also offers the Keep Embracing Your Success (KEYS) program. KEYS provides time-limited intensive placement for 12-17 year olds who may have, or are currently experiencing;

- Complex mental health difficulties such as self-harming behaviours
- Significant neglect, physical and sexual abuse, witnessed and/or subjected to family violence, and exposure to family violence
- Show signs of reactive sexual behaviours
- Have criminal offending behaviours, including those with youth justice involvement
- Substance misuse
- High vulnerability to sexual exploitation and abuse.

Aboriginal and Torres Strait Islander children and young people eligible for the program are supported via the Aboriginal KEYS model.

The Department of Families, Fairness and Housing adopts the Looking after Children Framework (Department of Families, Fairness and Housing, 2017) as an overarching guide to Victoria's child protection system and contracted providers are required to adhere to this. Contracted service providers must also demonstrate adoption of a TRC model. The state does not prescribe what model must be used, however adopted models must adhere to the Department of Families, Fairness and Housing Therapeutic Residential Care Program Requirements (2016). The Guidelines outline expectations associated with placement transitions, placement environments, integrated multidisciplinary supports, risk management and response, continuous assessment, and case planning. All residential workers and carers are required to complete the Healthy Eating Active Living (HEALing Matters; Monash University, 2022) online training package and embed this learning into their care practice. HEALing Matters uses a trauma-informed philosophy to guide carers' understanding of the link between healthy lifestyle behaviours and improved physical, cognitive, social (interpersonal), and emotional outcomes (Department of Families, Fairness and Housing, 2016).

It is also expected that TRC models adopted by contracted providers align with a set of 'essential program elements'. These essential program elements are those identified in the 2011 evaluation of Victoria's Therapeutic Residential Care pilot program (Verso Consulting, 2011). This evaluation suggested that a particular set of program elements underpins the practice of TRC, and the application of these elements results in a range of improved outcomes for children and young people relative to standard residential care, regardless of program variance at an operational level or specific target group. The essential elements are:

1. Therapeutic specialist
2. Trained staff and consistent monitoring
3. Engagement and participation of the children and young people
4. Client mix
5. Care team meetings
6. Reflective practice
7. Organisational congruence and commitment
8. Physical environment
9. Exit planning and post exit support.

The Department of Families, Fairness and Housing provides guidance by way of practice guides to facilitate implementation of the essential elements. Much like other jurisdictions, CSO agencies appear to implement a range of recognised TRC models, including Sanctuary, CARE, and the Teaching Family Model, and other organisation based/developed models of care that are cited to be therapeutic and trauma informed. Examples of these include YLO's bespoke TRC practice framework that is said to draw upon the Sanctuary model (Esaki et al., 2014) and James Anglin's (2004) congruency of care.

As outlined above, children and young people demonstrating reactive sexual behaviours may be provided specialised placement within the KEYS program, though a description of what behaviours this term encompasses is lacking. The Department of Families, Fairness and Housing uses a bespoke model of risk assessment, the SAFER Children Framework (Department of Families, Fairness and Housing, 2021), to guide and support the highly specialised, statutory role of child protection, guiding practitioners to identify and assess risk and to plan for the safety, development, needs, and wellbeing of individual children within their family, culture, and community. This model is applied to children and young people who have displayed HSB. The Department of Families, Fairness and Housing also provides specialist practice resources to guide understanding and responses to HSB for both children (Evertsz & Miller,

2011) and young people (Pratt, Miller, Boyd, 2012). The resource provides specific information relating to children residing in OOHC, including appropriateness of placements and carer support considerations.

Whilst no specific reference to caring for Aboriginal and Torres Strait Islander children and young people is present in the essential elements, the Department of Families, Fairness and Housing has strict guidelines requiring cultural case planning and placement consideration for Aboriginal and Torres Strait Islander children, Aboriginal self-determination, the provision of cultural support to ensure cultural safety for children in OOHC, and consultation support from the Aboriginal Child Specialist Advice and Support Service (ACSASS). Adherence to their Aboriginal and Torres Strait Islander cultural safety framework by staff and funded agencies is also expected (Department of Families, Fairness and Housing, 2019). As mentioned earlier, a specific model of care is provided to Aboriginal and Torres Strait Islander children and young people who reside within KEYS placements, though specific detail on the model was not received at the time of writing. The Victorian Aboriginal Child Care Agency (VACCA), contracted by the Department of Families, Fairness and Housing to provide TRC, also provides a bespoke model of TRC developed specifically for Aboriginal and Torres Strait Islander children known as Bunjil Burri.

Western Australia

Reviewed information for Western Australia included grey literature and information garnered from direct website searches, as well as an interview consultation with the nominated representative from the Department of Communities.

TRC in Western Australia is guided by the recently released Western Australian Therapeutic Residential Care Framework (Department of Communities, 2024). The framework was developed to support Western Australia's residential care system to transition into a therapeutic care service, aligned with the '*Stable, Connected and Prepared: Residential Care Reform in Western* Australia' report. The framework highlights the need for therapeutic residential care in Western Australia to be "underpinned by key principles of therapeutic care and cultural responsivity, guided by the Sanctuary Model program, and practically driven by the Therapeutic Crisis Intervention system" (Department of Communities, 2024).

The Department provides TRC across 13 metropolitan locations and 9 regional locations. The Casework Practice Manual outlines that TRC care arrangements are reserved for children and young people who demonstrate extremely high care needs and challenging behaviours. Care arrangements are time-limited, ideally for two years or less. All residential care houses accommodate up to 4 children aged between 10-17 years per home. Care is provided in all these services by trained staff who undertake shifts using a rotating roster model.

Multidisciplinary teams provide holistic support within the TRC arrangements. Psychologists provide a therapeutic focus and support and oversee staff's therapeutic intervention with children. Therapeutic Care Policy and Practice leaders support the therapeutic care skill development of workers and support the consistent use of quality therapeutic practice. Education Officers aid staff and support children to access appropriate educational options. Aboriginal Practice Leaders provide consultation support for therapeutic care planning and assistance to staff in developing culturally safe practice. Recreation Officers provide opportunities for children and young people to develop and maintain social connections and engage in recreational programs. Therapeutic residential care across all Department-run care arrangements guided by the values and principles of Sanctuary at all levels.

Community sector organisations and ACCOs also provide a considerable proportion of TRC arrangement in Western Australia. The Department does not prescribe adoption of a particular TRC model, though requires agencies to demonstrate application of a trauma informed care framework that is theoretically

and practically sound. Desktop review of CSO service provision suggests agencies provide a mix of recognised TRC models, including the Children and Residential Experiences model (CARE; Cornell University, 2021) and Sanctuary, and frameworks of TRC developed by individual agencies.

Western Australia places a strong focus on providing culturally safe residential care services for Aboriginal and Torres Strait Islander children and young people and culturally and linguistically diverse children and young people. This includes commitment to a comprehensive Aboriginal cultural framework and integration of culturally responsive care literature into the theoretical underpinnings of the Western Australian Therapeutic Residential Care Framework (Department of Communities, 2024). The review did not identify the existing adoption of TRC models specifically designed for Aboriginal and Torres Strait Islander children. There is a body of work progressing as part of the Residential Care Reform involving the Department working alongside Elders in the community of Roebourne to develop a Cultural Residential Care Framework. This will involve the adaptation of current models and policies and a review of operational procedures to ensure that the cultural needs of Aboriginal and Torres Strait Islander children are met in regional TRC houses.

Additionally, the Yorganop Association website (a prominent ACCO out-of-home care provider in Western Australia) suggests they implement the Sanctuary model in a manner that is adapted for Aboriginal and Torres Strait Islander children.

No models of TRC are currently implemented within Western Australia to provide specialised therapeutic care arrangements to children and young people who have displayed HSB. The Department's case practice manual outlines risk management procedures aligned with the Signs of Safety model and emphasises the need to view risk behaviours, including HSB, as trauma related, and the need to provide a trauma-informed response. On a broader scale, there is a significant focus on HSB within the jurisdiction's wider OOHC sector, including workforce development and planning for enhanced specialised service provision. Aligned with this focus, Department released the Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People in 2022. The framework aims to build a better and more cohesive understanding of harmful sexual behaviours (HSB) in children and young people across WA to support practitioners, policy makers and carers to provide responses that are safe, effective and trauma informed (Department of Communities, 2022). Included in the Framework is additional considerations for the residential care setting to further support responses to children and young people who display HSB in OOHC.

New Zealand

New Zealand was included within this jurisdictional scan as it is home to the only specialist TRC service in Australasia for children and young people who have displayed HSB: Te Poutama Arahi Rangatahi. The service is funded by the New Zealand government and provided by Barnardos New Zealand. Reviewed information for New Zealand focused solely on this service and included grey literature, information garnered from direct website searches, and interview consultation with the nominated representative from Barnardos New Zealand

Te Poutama Arahi Rangatahi provides intensive wrap-around accommodation, and specialist intervention for males aged 13-18 years who have demonstrated, or are considered to be, an elevated risk of engaging in further HSB if they were to be treated in the community; some would have had interactions with the youth justice system. All referrals to the service are made through Orange Tamariki, New Zealand's Ministry for Children. There is no time limit placed on a child or young person's placement duration, with the focus being placed on treatment progress and increasing support and safety needs.

The facility has the capacity to provide accommodation and treatment for 8 individuals at any one time. Capacity was reduced from 12 beds recently to allow a higher staff/child ratio and intensity of care and treatment support.

Barnardos implements a bespoke model of TRC known as the Integrated Therapeutic Framework. The framework hinges upon core principles of cultural and emotional safety, the importance of family and family connection, restorative practice, and benefit of active therapeutic intervention. Residential staff are highly trained in trauma-informed care, assessment, and therapeutic intervention skills including AIM3 assessment and intervention, Daniel Hughes' DDP model, Good Lives Model and CPI Safety intervention (crisis intervention and prevention). All staff are provided with regular supervision, which includes encouragement of reflective practice, professional development opportunities, and wellbeing support. The residential staff team is fully supported by a clinical team of practitioners who provide service and support to the residents, incident debriefs, intervention plans, and consultation with staff. This includes social workers, therapists, and cultural advisors. The interviewed representative indicated that external cultural consultation and support is sought to meet the needs of the child or young person if they do not have the appropriate staff knowledge or skill to achieve this.

All children and young people placed in the service will have undergone a comprehensive assessment of their needs and behaviour using the AIM 3 model of assessment. This assessment is used to inform the child or young person's case and treatment plan and is reviewed at 6-monthly intervals as well as at the end of their treatment.

The model also places a strong emphasis on family connection and support, recognising the role families play in healing for the child or young person and their need for education and support to enable them to appropriately understand and respond to the needs of their child or young person. Family members are heavily involved in case planning and consultation, are involved in treatment through family therapy supported by community-based family therapists, and intensive supports are provided to prepare the family to receive their child or young person home upon their exit from the program (where relevant).

The child or young person is also provided with educational and vocational opportunities and support to continue their education and experience whilst in care, to enable their continued development and connections with community.

A comprehensive transition and support plan is provided when a child or young person exits the program. At the beginning of their journey in the program, they are allocated a clinical transition worker who supports them for 6 months (on some occasions, up to 12 months) post-exit from residential care. The transition worker ensures ongoing therapeutic care, support, and safety planning is provided to the young person within a community setting, ensuring inclusion of their family and support systems from other organisations and regularly communicating with the young person.

A network approach of collaboration is adopted between residential care staff, child protection, youth justice, community-based treatment providers and other agencies as required. The interviewed representative indicated that this multi-agency approach works very well and is a clear strength of the program and may be a motivating factor in helping the child or young person heal from their trauma and return to an expected developmental trajectory.

DISCUSSION

As noted, there was wide variability in the degree of information available publicly for the jurisdictions, however this information was integrated with that gathered from jurisdictional leaders where possible. Any additional information collected from jurisdictions, or resulting from validation checks of the gathered material, as the project progresses will be considered within the final report.

TRC delivery and parameters

Based upon the available information, it appears TRC is an available care option within OOHC across all jurisdictions, though the purpose and operationalisation of this (as distinct from standard residential care) is often not well defined. There is also variability of language used to reference and describe what TRC is, with terms such as residential care, therapeutic residential care, and intensive therapeutic residential care used to describe what appear to be seemingly similar care options: non-family-based care options that offer enhanced therapeutic environments and skilled staff for children and young people with extreme and/or complex needs.

TRC is time limited across most jurisdictions, often to a period of 12-24 months. Clear emphasis across the jurisdictions is placed on children and young people making gains across their time in TRC reduce the intensity of their care needs and allow them to either return home to family or transition into a less intensive care arrangement. Barnardos New Zealand do not place a time limit on TRC placement but seek to transition children and young people into 'stepped down' care arrangements as soon as appropriate, undertaking regular comprehensive reviews of progress to keep this on track.

TRC providers and models

Many jurisdictions have a mix of government provided TRC care placements and TRC placements that are contracted and operationalised by CSO organisations. Victoria, New South Wales, and Australian Capital Territory rely heavily on CSO service provision, contracting most TRC out externally. The jurisdictional review was not successful in gaining a clear picture of the CSO service picture across Australia, mainly due to the limited consultation and interview with jurisdictions. Several agencies appear to have a large national footprint, such as Mackillop Family Services, Life Without Barriers, Anglicare, and Barnardos (Australasia), though there are many other smaller, jurisdictionally bound agencies that also report to offer TRC care options.

There are several formal models of TRC that stand out as popular across jurisdictions, including the Sanctuary model® and CARE, though this is influenced by the fact that these models are adopted by national providers (including Mackillop, Anglicare Life Without Barriers respectively). Several jurisdictions implement bespoke TRC frameworks that are underpinned by guiding principles that allow flexible operationalisation across agencies and target populations, including ITC in NSW, ITRC in NT, and Victoria's *'9 essential elements'* of TRC (Verso Consulting, 2011). No jurisdiction appears to have clearly articulated implementation procedures for TRC that are publicly available, however multiple jurisdictions reference a level of general guidance or support within case practice frameworks and documents where TRC is underpinned by a set of guiding principles. Life Without Barriers and Mackillop Family Services outline a degree of implementation support to guide TRC practitioners, though each service acknowledges the day-to-day practice of TRC varies across their various TRC placements, either due to jurisdictional legislation variability, funding differences, or needs of the specific client cohort.

A prevalent theme observed across jurisdictions is the recognition that reliance on a sole TRC model often falls short of adequately addressing the comprehensive care requirements of children in TRC. This

observation aligns with the earlier findings from the evaluation of the Victorian TRC pilot program in 2011. To grapple with this challenge, government departments and CSOs are adopting diverse strategies. This includes the implementation of overarching frameworks characterised by operational flexibility within specified therapeutic parameters. Additionally, the adoption of a 'layering' approach is witnessed, where additional programs are provided alongside TRC models to more comprehensively meet the broad spectrum of needs of children and young people in TRC. These layered programs encompass facets such as crisis intervention, intervention for HSB, cultural safety and connection, independent living skills, and health and general well-being. While these endeavours exhibit potential advantages in comprehensively addressing the diverse needs of children and young people in TRC, a drawback arises in the inherent difficulty in structuring clear implementation frameworks and conducting robust evaluations.

Priority populations

The scan also suggested a dearth of tailored TRC care options for children and young people who have displayed HSB. All interviewed jurisdictions acknowledged that HSB is a significant concern and growing area of focus, though New Zealand is the only jurisdiction in Australasia to provide specialised TRC for this vulnerable population of children and young people. Victoria also recognises the care and intervention required for children who have displayed HSB and provides placement within the KEYs program which offers a higher intensity of service and mental health support, though it is not a specialist HSB program. New South Wales requires children who have displayed HSB to be placed in a 1:1 placement and encourages external providers to engage specialist HSB services to support the child or young person. Mackillop Family Services offers the Power to Kids program, complementing their Sanctuary TRC model. This initiative serves as a mechanism for enhancing the skill set of TRC practitioners and addressing the needs of children and young individuals who have displayed HSB. It is crucial to clarify that the Power to Kids program, while aligned with the overarching TRC framework, does not constitute a distinct TRC model.

Similarly, there is a gap in the tailored focus of specific TRC care options for Aboriginal and Torres Strait Islander children and young people. While most jurisdictions articulate an intention to incorporate cultural care planning, an understanding of and commitment to the Aboriginal Child Placement Principle, and the imperative of ensuring cultural safety for all children and young people within TRC placements, there is limited publicly available information indicating the translation of these intentions into concrete and specific care alternatives for Aboriginal and Torres Strait Islander children.

An exception to this trend is the VACCA, which has notably developed a TRC model known as Bunjil Burri, implemented across their TRC placements. Queensland also endeavours to provide specific TRC placement options for Aboriginal and Torres Strait Islander children situated in Aboriginal communities. Yorganop in Western Australia report to implement Sanctuary via a cultural lens to enhance its application and fit for Aboriginal and Torres Strait Islander children. In the Northern Territory, there is a pronounced emphasis on culture and cultural safety within their TRC model, with a stated commitment to appropriate cultural placement as a central focus. However, available public information is limited in articulating the operationalisation of these cultural emphases. It is acknowledged that tailored models of TRC for Aboriginal and Torres Strait Islander children may be being adopted by individual agencies, particularly ACCOs throughout Australia, and simply not termed a model of TRC, or not captured within this jurisdictional review which was limited to interviews with child protection agencies in each jurisdiction and grey literature reviews anchored to their publicly available information. Barnardo's New Zealand similarly places culture as a central focus of their TRC model, employing diverse strategies to achieve cultural safety and sustain cultural connections. This includes the utilisation of cultural advisors,

robust family inclusion in case planning, and engagement of the child or young person in culturally relevant activities and education. While this program is not expressly affiliated with Aboriginal culture, its focus on First Nations children lends it to be a valuable consideration in the broader reflection on culturally sensitive TRC initiatives.

Evidence and reform

Another notable observation arising from the scanning process is the acknowledgment that most jurisdictions have recently undergone substantial reforms within their OOHC sector, are presently immersed in reformative endeavours, or are contemplating such changes in the near future. It is noteworthy that Victoria stands as an exception, having reported no recent or imminent reform initiatives. New Zealand's status is excluded from this observation due to the absence of interviews conducted with the broader jurisdiction.

This pattern underscores an atmosphere of transformation within the TRC landscape across Australia. Jurisdictions collectively recognise the variable efficacy of TRC models in the achievement of permanency outcomes and improved care needs for children in TRC, prompting a shared acknowledgment of the necessity for review and evaluation. This suggests an awareness of the need for ongoing efforts to enhance the quality of TRC services extended to children and young people.

The information from this part of the project will be considered in conjunction with the outcomes of a rapid review of the evidence-based literature for current TRC models and used to conceptualise implications for application and operationalisation of TRC within the WA context to optimise the outcomes for children and young people in OOHC.

SECTION 4: WHAT DO THE DOMINANT MODELS LOOK LIKE?

OVERVIEW

In this section we provide an overview of the four models of TRC that featured prominently as being in current use across Australia within the jurisdictional review. Also summarised is the Bunjil Burri model that provides tailored focus on Aboriginal and Torres Strait Islander children and young people. The latter model was identified within the jurisdictional review.

CARE: CREATING CONDITIONS FOR CHANGE

CARE is a principle-based model that aims to develop a competency-based curriculum that enable staff working in TRC settings to create environments and establish practices that optimise the outcomes for children living in OOHC (McDonald et al. 2012). CARE draws upon child development, trauma, and systems theories and proposes a whole-of-organisation approach, emphasising the need for all staff to be trained in the CARE approach regardless of their role within the organisation. This approach purports to embed the CARE principles more effectively within the organisation, cultivating personal investment and ownership among staff, as well as a lasting relational and trauma-informed organisational culture. The CARE model has a clear theory of change, illustrated in Figure 1 below.

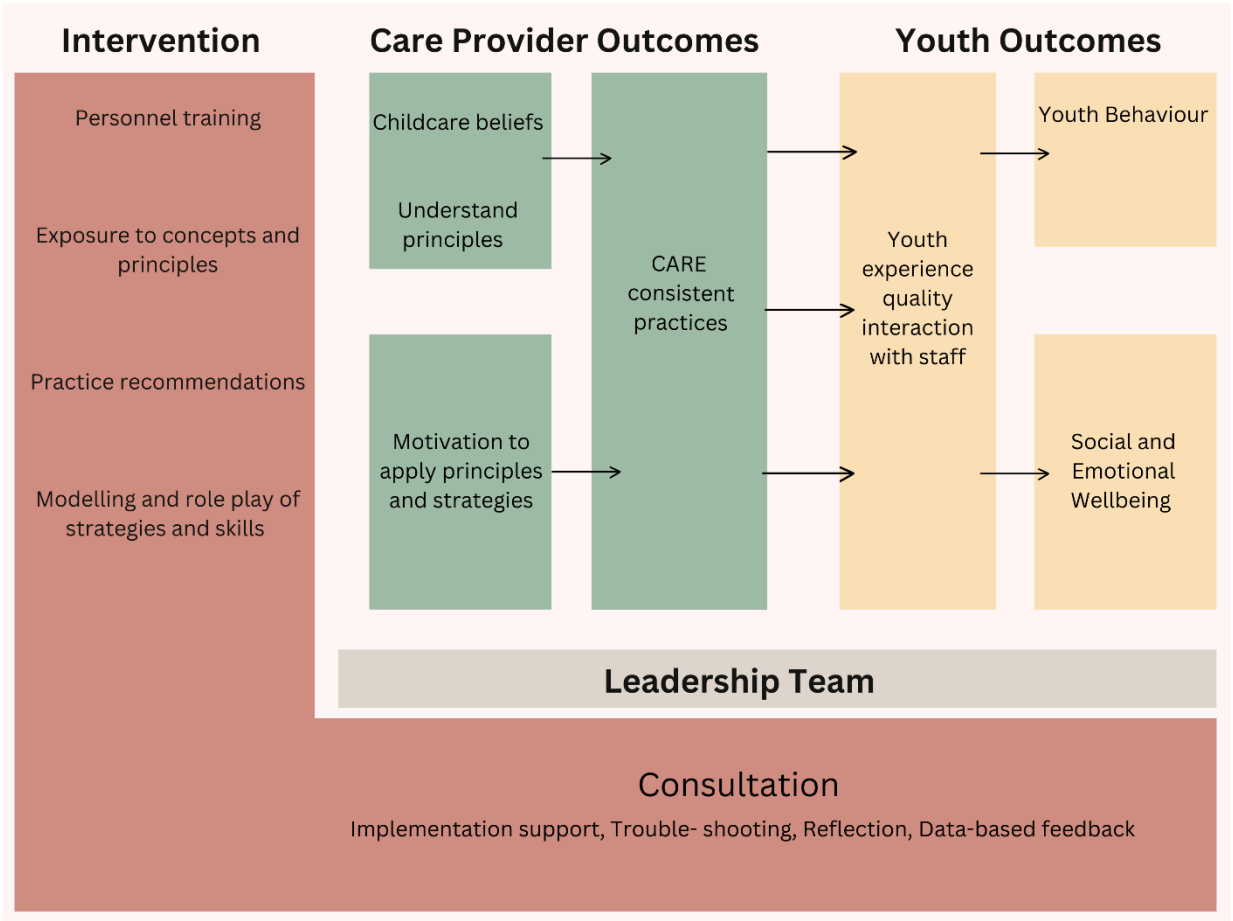


Figure 2. CARE theory of change (Holden & Sellers, 2019)

The 6 foundational principles of CARE are:

1. Developmentally focused – normative developmental experiences are provided, and expectations are adapted to individual needs.
2. Family involved – family involvement is promoted, and their cultural norms understood and adapted to.
3. Relationship based – healthy adult-child relationships modelled, and capacity built for future relationships.
4. Competence centred – self-efficacy fostered within young people as well as competence in problem solving real-life scenarios.
5. Trauma informed – young people's trauma history is considered, and professional practice is sensitive to individuals' histories.
6. Ecologically oriented – physical and social environments are meaningfully and intentionally designed to create a therapeutic milieu.

Reflective practice, analysing organisational data and addressing organisational barriers to therapeutic and cultural change are key components of CARE in action, and is organisation-specific in practice.

The implementation process is structured and highly supported, with a usual timeframe of between 3 and 5 years. Implementation involves a partnership with the creators of the CARE model at the Residential Child Care Project (RCCP) based at Cornell University (the accredited provider), and consists of an initial development phase where agency leadership works with the CARE consultants to develop a tailored plan for the rollout and training of CARE within their agency environment. This occurs at a 4-day leadership retreat which incorporates change strategy planning specific to the organisation. Following this, selected staff members form a multi-level implementation team and are trained and certified as 'CARE educators' using a 'train the trainer' model via a 5-day manualised program. The implementation team is then responsible for training other organisation staff, facilitating reflective practice and providing modelling, coaching, and mentoring as required (CEBC, 2023). While training and policy and program changes are occurring in the agency, ongoing consultation and monitoring ensures that the integration and embedding of the model into the agency culture and overarching practice maintains fidelity to the model. This includes regular technical assistance via both onsite visits (approximately 3-4 times each year) and regular online/phone contact by CARE consultants from the accrediting body, with surveys administered to staff to assess alignment with the 6 CARE principles, such as the post training survey which focuses on staff knowledge, beliefs, and practices. Post-implementation, there is a 3-year sustainability agreement which includes ongoing online/phone support, access to resources and onsite visits by CARE consultants from the RCCP (CEBC, 2023).

The desired outcomes of implementation of CARE include decreased behavioural incidents, improved relationship quality between children and staff, reduced use of psychotropic medicine, decreased use of physical restraint/restrictive practices, reduced staff turnover, improved organisational capacity to use data in decision making, increased contacts between children and their families whilst in care, and vocational/school improvements for children/young people (CEBC, 2023).

CARE: CREATING CONDITIONS FOR CHANGE – LIFE WITHOUT BARRIERS

Life Without Barriers has progressively implemented the CARE model across their Child Youth and Family program, state by state, since 2016. To date Life Without Barriers has successfully attained certification in five jurisdictions (Queensland, Tasmania, South Australia, Western Australia, and the Northern Territory) with other states working towards this.

More recently, Life Without Barriers has become a partner agency with the RCCP at Cornell University to increase the accessibility of the CARE model to other Australian agencies. This means that CARE consultants in the Strategic, Innovation Design and Evaluation (Stride) Team within Life Without Barriers takes lead responsibility for providing implementation support and onsite technical assistance to agencies in Australia. The Stride team works in concert with the team at the RCCP, who actively review and update the CARE model and training curriculum based on the latest research. Edition 3 of the CARE model was released in 2023, which included the development of revised curriculum tailored to the Australian practice context. The Stride team mirrors the training and implementation processes of CARE to Australian agencies as Cornell University does internationally (as described above).

Life Without Barriers conceptualises CARE as a foundational model that provides a stable therapeutic base from which to provide effective therapeutic out-of-home care and family services. The agency also implements the Therapeutic Crisis Intervention (TCI) System across all their Child Youth and Family program sites (including TRC) as a complement to the CARE model. Additional evidence-informed interventions and practices are integrated within care sites as needed for the individual child or the young person. These additional clinical/treatment interventions are not prescribed but are selected based on congruence with the CARE principles.

The 6 principles of CARE are detailed below, with information provided by Life Without Barriers on how they are implemented within the organisation:

1. Developmentally focused
    - Time is taken to assess, understand and plan for and with the child, considering their developmental level.
    - Activities are designed with the child's zone of proximal development in mind.
    - Self-efficacy is strengthened through skill development, teaching and feedback to children.
    - Mutually agreed and achievable expectations for children are identified.
    - Active participation of children in care planning and decisions made about them.
2. Family involved
    - Seek and value input from children's families, strengthening these relationships.
    - Relational permanence is sought out with a child's family, culture, and community.
    - Work to rebuild connections lost or damaged when children enter care.
    - Staff work collaboratively to provide consistent care for children, with clear roles, responsibilities, and expectations for behaviour.
3. Relationship based
    - TCI and CARE support staff/carers to form developmental relationships as the 'active ingredient'.
    - Sensitivity – being aware and mindful of diverse cultural background, listening and learning from the young person and their family. Responding with compassion and calmness to the young person.
    - Availability – active involvement in the young person's daily life, being ready to provide support and assistance as needed.
    - Acceptance – of the young person for who they are and looking beyond challenging or pain-based behaviours.
    - Investment – believing in the young person's value and ability to succeed.
    - Relationships that are ruptured during crisis are aimed to be repaired quickly.
4. Competence centred

- Being strengths based and building on children's individual interests
- Assist young people to practice and learn to problem solve, achieve personal goals, build self-efficacy, collaborate with others, and communicate their feelings.
- Engage in play with children and young people to promote physical, cognitive, and interpersonal skill development.
- Negotiate expectations and routines that meet the needs of children, adjusting them if they do not.
- Positive and corrective feedback is expected and desired from team member communication and interactions.

5. Trauma informed
    - Respond sensitively and respectfully to young people's pain-based behaviours; shifting thinking and questions from 'what's wrong with you' to 'what's happened to you'.
    - Listen to young people to understand their experience.
    - Be aware of and notice triggers or re-experiencing symptoms.
    - Provide choice and control to young people.
    - Focus on developing young people's self-regulation and problem-solving capabilities.
    - Staff practice self-regulation and self-awareness, enhancing awareness of personal triggers and responses.
    - Staff engage in regular supervision and reflective practice by staff, and use of Employee Assistant Program when needed.
    - Staff supported to develop and use self-care plans, identifying in the moment and long term/proactive strategies for coping with stressors.
6. Ecologically oriented
    - Creating therapeutic milieus where structure, activities and interactions take place.
    - Routines, activities, and interactions are designed as purposeful and to help young people feel cared for and to achieve their goals.
    - Communicate belief in the young person to succeed, building on the young person's strengths, interests and hopes.
    - Investment in training, supervision, and support for staff to implement CARE and TCI, viewing feedback and crisis as opportunities for learning and change.

Life Without Barriers staff are provided a high level of support to develop and maintain their knowledge and practice of CARE aligned TRC. Staff are supported via training, guidance documentation and other supports to ensure their practice aligns with the tenets of the model. Communities of Practice are also used to create networks across the wider organisation where like-minded staff can share their knowledge and experience of implementing CARE to further develop and consolidate their learning and practice.

Reflective practice, supervision, and support post-training is recognised as critical to effective implementation of CARE. Supervision occurs in formal and informal ways and reflective practice is embedded in everyday practice with the support of resource tools with varying focuses (e.g., emotional competence, providing feedback). Additionally, regular meetings with targeted focuses are scheduled:

- Care Team Meetings – where the child's Care Team meet to plan and discuss their needs and supports.
- Team Meetings – focusing on reflective practice and keeping the best interests of children as the focus for teamwork.

Life Without Barriers strives to achieve the benefits and outcomes in line with the Theory of Change of the CARE model. The Organisation Social Context survey and Youth Perception Surveys are administered at regular intervals to obtain feedback from staff and young people, as part of analysis of data to support ongoing implementation. Internal monitoring of CARE implementation over the past 4-5 years via surveys and focus groups, is reported to have highlighted increased staff flexibility, improved quality of relationships between children and staff, a reduction of punitive responses to children and families by staff, and higher regard for family inclusion by staff.

THE SANCTUARY MODEL ®

Developed in the United States of America, the Sanctuary model® of care is not a specific intervention; rather, its goals are to facilitate organisational change whereby all staff (including leadership) are educated on the impacts of trauma on behaviour, staff's perception of clients' behaviour is understood as a result of injury rather than as a sickness, and to provide tools to facilitate individual and group behavioural changes (Esaki, et. al., 2013). Theoretical frameworks that the Sanctuary model® draws upon to improve organisational culture are inclusive of Constructivist Self-Development Theory, Burnout Theory, Systems Theory, and Valuation Theory of Organisational Change (Esaki, et. al., 2013).

The Sanctuary model is based on four pillars of guidance which are not rigidly prescriptive and can be adapted to various settings and populations. The four pillars are:

1. Trauma theory,
2. The Safety, Emotion, Loss and Future (S.E.L.F) Framework,
3. Sanctuary Toolkit,
4. Seven Sanctuary Commitments (Esaki, et. al., 2013).

Trauma theory

Staff are educated in the physical, behavioural, emotional, and cognitive impacts of trauma on not only clients, but staff. There is a focus on changing language within questions to clients (i.e., shifting from asking "what's wrong with you?" to "what happened to you?") to frame current behaviours and functioning as "injury" rather than "illness", and to move away from shame or blame to collaboration and understanding (Bloom & Sreedhar, 2008; Esaki, et. al., 2013).

The Safety, Emotion, Loss and Future (S.E.L.F) Framework

Categorising client problems within these four domains guides case formulation and treatment planning for clients. The S.E.L.F. Framework is also used for organisational and interpersonal problem solving within the organisation (Bloom & Sreedhar, 2008; Esaki, et. al., 2013).

Sanctuary Toolkit

There are 10 tools to be used by all staff within the organisation to develop and reinforce model concepts (Esaki, et. al., 2013):

1. Core team consisting of a cross-section of staff across all organisation levels to execute implementation steps.
2. Individual and group supervision reviewing performance and reflection on self-care.
3. Ongoing training in Sanctuary model concepts.
4. Community meetings involving staff and clients, with focus on feelings identification, future focus, and community connection.

5. Team meetings focusing on work, team functioning, and service delivery.
6. Self-care planning internally and externally to the workplace.
7. Red flag reviews in response to critical incidents with a solution-focused approach.
8. Safety plans for use in situations where inappropriate behaviours may be triggered.
9. S.E.L.F service planning.
10. Sanctuary psychoeducation, inclusive of trauma theories.

Seven Sanctuary Commitments

The philosophical underpinnings and values that the organisation and community members abide by (Esaki, et. al., 2013):

1. Nonviolence,
2. Emotional intelligence,
3. Democracy,
4. Open communication,
5. Social responsibility,
6. Commitments to social learning, and
7. Growth and change.

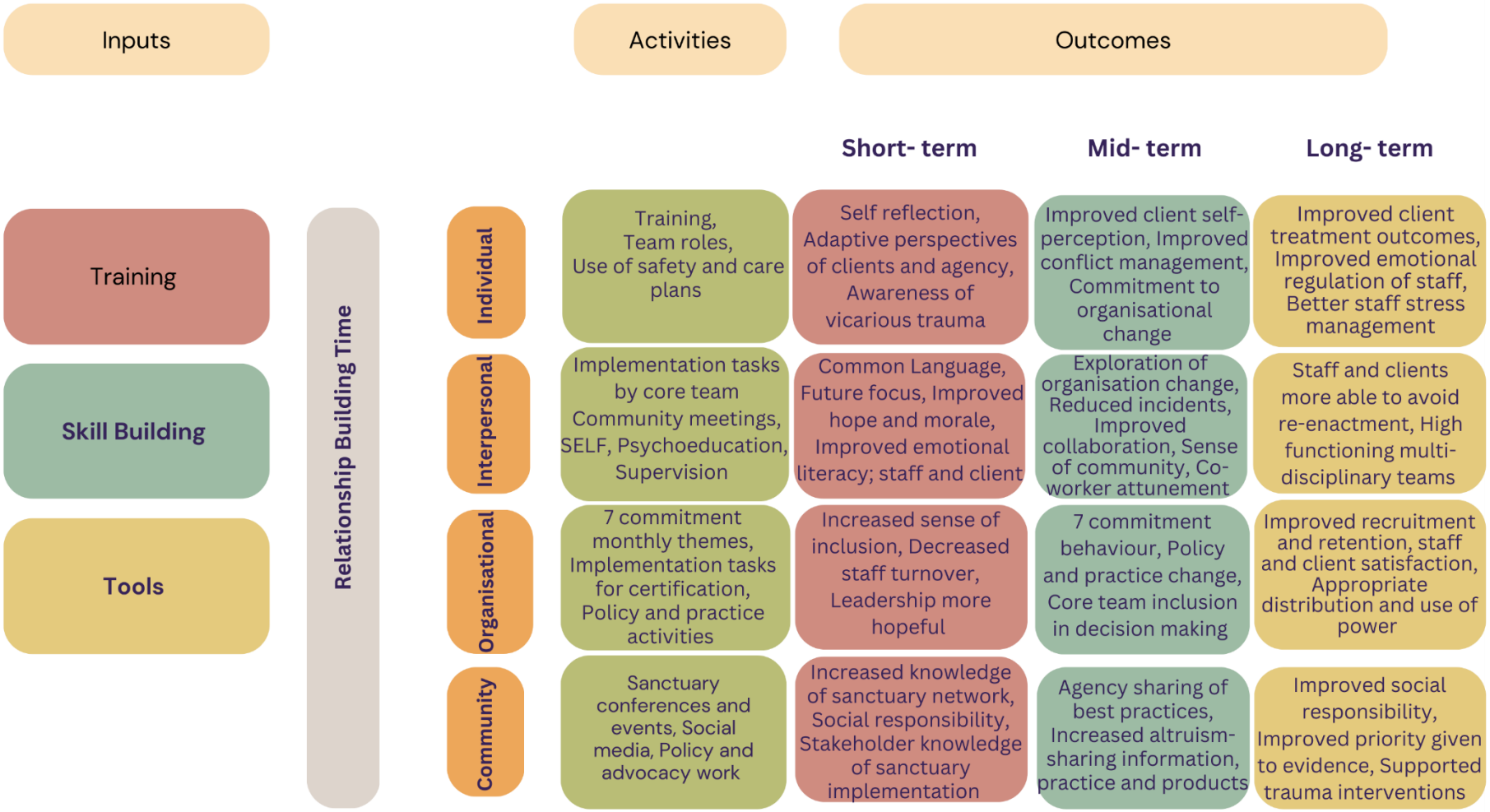


Figure 3. Sanctuary theory of change (Esaki et al., 2013)

The Sanctuary model® is used for a wide range of client populations, groups, and settings, with an age range of 4 years and above (NCTSN, 2008). Much of the implementation practices are agency- or population-dependent, inclusive of staff roles and skills, formats, and staff-client ratios. There are no specific cultural or HSB considerations, or active treatment inclusions, however there are provisions for adaption. Placement transitioning or exit planning is not prescribed and is agency- or population-dependent.

Training and implementation involve significant time and resourcing, as agencies must be fully accredited to implement the model, with re-certification procedures applicable. Following an assessment of the organisation, the leadership team of the organisation attends a five-day training to develop skills to implement the Sanctuary model® into the organisation (NCTSN, 2008). The Core Team attends three days of training, subsequently providing module training to other staff (18 hours for each staff member) (NCTSN, 2008). Full organisational implementation can take between 2 and 5 years, with the Core Team actively involved in implementation throughout this period for a minimum of 60 hours (NCTSN, 2008). Extensive leadership, staff, and client involvement is required for effective implementation (NCTSN, 2008).

The short-term benefits are reported as improved staff knowledge of trauma and self-reflection, development of a common language, an improved sense of staff community, and improved staff retention. Medium-term benefits are reported as an improved commitment to organisational change, changes to client self-perception, reduced untoward events, increased team collaboration, and changes to policy and practice that align with the Seven Sanctuary Commitments. Long-term benefits are reported as improved client treatment outcomes, improved staff wellbeing, high-functioning teams that can avoid and reduce trauma re-enactment and other behaviours, improved staff recruitment and retention, improved client and staff satisfaction, and appropriate distribution and use of power (Esaki, et. al., 2013).

THE SANCTUARY MODEL® - AS IMPLEMENTED BY MACKILLOP FAMILY SERVICES AND THE MACKILLOP INSTITUTE

The Mackillop Institute is the licenced provider of Sanctuary training and consultation to organisations in New Zealand and Australia since March 2016. MacKillop Family Services implements the Sanctuary Model® across the entire organisation which encompasses multiple jurisdictions and Therapeutic Residential Care sites. In this version of the Sanctuary model, the four pillars are adhered to, however are termed 'key domains', outlined here:

1. Shared knowledge (promoting staff to understand and implement trauma theory).
2. Shared values (referencing the Sanctuary Commitments).
3. Shared language (the S.E.L.F. Framework).
4. Shared practice (Sanctuary Toolkit).

Due to jurisdictional and program variations, the client populations, groups, and settings the Sanctuary Model® is implemented within varies. There are agency-prescribed minimum qualifications, essential and desired characteristics, as well as relevant safety checks for staff roles. Within MacKillop Family Services all staff are fully trained in the Sanctuary Model®, regardless of role. There are monthly Community of Practice sessions with leaders to ensure consistency and fidelity of the implementation of the Sanctuary Model®, which are three hours in duration and involve between-session tasks. In

addition to regular supervision processes, staff are encouraged to participate in reflective practice sessions within their teams to build and maintain the clinical capacity of the staffing group.

The same benefits and limitations are purported as the traditional Sanctuary Model®.

The MacKillop Institute implements the Sanctuary Model® as intended, however notes that this model is also complemented by other quality initiatives to address the diverse needs of children and young people accessing residential care services. Additional programs or interventions implemented alongside the Sanctuary Model® and integrated into TRC facilities include Power to Kids, Therapeutic Crisis Intervention, and Healthy Eating Active Living Matters (see below for program overviews). These programs are implemented with strong support and momentum from leadership.

INTENSIVE THERAPEUTIC CARE (ITC)

ITC is a principle-based, service system model that draws upon trauma, systems, and child development theories. The ITC system is designed to support young people (over 12 years of age) with complex support needs that have experienced the most severe forms of trauma, neglect, abuse, or adversity, and require specialised and intensive supports to maintain stable care arrangements.

A centralised referral pathway (Central Access Unit) determines whether a young person should enter ITC. Short-term Intensive Therapeutic Transitional Care may initially be provided for up to 13 weeks based on the Central Access Unit assessment of needs, before transitioning the young person to less intensive care types either across the ITC continuum (Therapeutic Sibling Option Placement, Therapeutic Supported Independent Living, Intensive Therapeutic Care Home, or, Therapeutic Home-Based Care) or non-ITC care (supported independent living, birth family, foster, kinship or relative care, guardianship, open adoption or exit care at 18 with support) (Communities & Justice, 2018). The goals of ITC are to provide a consistent approach to therapeutic care, facilitate recovery from trauma, identify clear pathways to permanency, and step-down to less intensive placement options wherever possible (The Centre for Excellence in Therapeutic Care, 2019).

The 10 elements of ITC (The Centre for Excellence in Therapeutic Care, 2019) are:

1. Therapeutic specialist
    - Generally, doesn't work directly (clinically) with the child or young person.
    - Supports staff in providing therapeutic care through facilitating reflective practice sessions, reviewing outcome measures, and consultation and advice around trauma, attachment, and development assessments.
    - Provides leadership and direct service in the clinical assessment and treatment of children and young people.
    - Contributes to assessing appropriate placements to best support maintenance of safe and healing environments for all residents.
2. Trained staff and consistent rostering
    - Training provided in the theoretical principles of Therapeutic Care and competency-based requirements inclusive of cultural proficiency.
    - Consistent rostering to ensure predictability within the placement required to achieve outcomes.
3. Engagement and participation of the young people

- On referral, exploration with the young person of their expectations of Therapeutic Residential Care, goals, and how they may benefit from the unit.
- Community meetings within the unit engage the residents in democratic processes regarding 'their home'.
- Development and implementation of children and young people's Care and Treatment Plans, as well as Exit and Post-Exit Plans occurs collaboratively with them.

4. Client mix
    - Consideration of the mix of clients within the unit that maximises the opportunities for all young people, including key staff with knowledge and understanding of the young people already resident.
5. Care team meetings
    - Held every 1-4 weeks to review individual cases of young people by relevant stakeholders. Recognition of the changing needs of the young person over time, and therefore the frequency and focus of the meetings will change accordingly.
6. Reflective practice
    - Staff are coached and supported to engage in reflective practice through becoming aware of their actions and responses, and the impact they have on the young people they work with.
    - Staff also reflect on young people's triggers, actions, and interactions to understand and attribute meaning to their behaviours.
    - Reflective practice meetings where the therapeutic specialist facilitates informed learning and opportunities for reflection and contribution from staff. This is differentiated from other team or staff meetings.
7. Organisational congruence and commitment
    - All levels within the organisation inclusive of Board Members commit to and are congruent with the approach.
8. Physical environment
    - Inclusion of private spaces, space for indoor recreation activities, opportunity for residents to personalise their bedrooms, spaces to which residents can safely withdraw, and space for staff to observe without intruding or isolating.
9. Transition planning, exit planning and post-exit support
    - Collaboration with the young person in exiting Therapeutic Residential Care.
    - Consideration of developmental age and ongoing impact of trauma in planning.
10. Governance and quality therapeutic practice
    - Consistency and congruence across organisations in implementation, as well as regular governance and quality practice sessions (at least six monthly).

ITC proposes more effective and holistic safety, permanency, and wellbeing outcomes for young people through person-centred funding packages and consistent therapeutic care. ITC is considered a temporary measure aiming to achieve placement permanency and 'step-down' placements as a young person's needs become less intensive.

TEACHING FAMILY MODEL (TFM)

TFM is an organisation-wide, system-drive model that can be applied to a range of settings inclusive of outpatient, inpatient, birth family homes, school, kinship care, foster care, group or residential care. TFM draws upon social learning and trauma-informed theories whereby a family-style setting is curated, with

up to 4 children or young people and 'Teaching Family Model practitioners' providing care and support (Berry Street, 2024).

Agency training is provided by qualified TFM trainers, and once TFM systems are implemented, 1 year of data and records is required to apply for initial accreditation. A review occurs via onsite assessment of fidelity to the model within 2 months of application for accreditation, and if successful, accreditation is backdated to the application date (Teaching Family Association, 2024a). Fidelity to the model is measured through 78 indicators across the model's Standards including Goals, Systems and Elements. Observations, supervision, training, evaluation, consumer feedback, interview with external consumers (e.g., families, other agencies), and internal staff are required as part of the fidelity assessment (CEBC, 2021). Post-accreditation support timeframes are agency dependent, however is typically provided for 12-24 months, and can occur through training, consultation, onsite observations, technical support, and on-call support (CEBC, 2021).

There are 4 critical delivery systems of TFM: staff selection and training, competency-based management (through consultation/supervision), quality assurance (through evaluation), and facilitative administration (CEBC, 2021).

TFM has seven essential elements:

1. Teaching systems,
2. self-determination,
3. client advocacy,
4. relationships,
5. family-sensitive approach,
6. diversity, and,
7. professionalism.

Proposed to be achieved through young people observing and imitating others, and strength-based teaching with positive feedback to build their strengths, problem-solving and interpersonal and leadership skills, the goals of TFM are (Berry Street, 2024; Teaching Family Association, 2024b):

- address any behaviours resulting in problems for children and young people (Teaching Family Association, 2024b),
- learning how to form healthy family relationships (Berry Street, 2024),
- improved social skills (Berry Street, 2024),
- identifying the main triggers cause the young person stress (Berry Street, 2024), and,
- better emotion management (Berry Street, 2024).

BUNJIL BURRI

Model was developed based on funding provided from the Department of Human Services to trial an Aboriginal model of TRC. First implemented around 2012 at VACCA's Reservoir residential service, this was later expanded to their Coburg service.

Development of the model

The approach adopted in developing the Aboriginal therapeutic model was informed by knowledge of trauma and therapeutic care, Aboriginal culture, and knowledge and an understanding of the impact and consequences of colonialism and racism.

Membership of the working group included residential programme staff, programme manager, senior manager, and project and policy workers.

The model is built upon six cultural pillars which provide a cultural foundation for the model (Bamblett, 2014):

1. Cultural safety
2. Cultural rights and responsibilities
3. Aboriginal Understanding of Family and Kinship Structure
4. Aboriginal Understanding of culture as Resilience
5. Adherence to Best Interest Principles
6. Adherence to Aboriginal Child Placement Principle

Program elements

The model incorporates elements of mainstream TRC, such as inclusion of a therapeutic specialist role and use of reflective practice, care team model, trauma-informed practice and care approach that is underpinned by understanding of child development, attachment and neurobiology, provision of active therapeutics supports to residents, and inclusion of the voices of the child and family in planning and decision making. However, the model seeks to prioritise, honour, and develop a child's connection to culture as the primary agent to achieve positive change and healing from trauma. (Bamblett et al., 2014).

Core elements of the model include:

- Comprehensive culturally informed assessments and planning
- Social Networking Map (alongside cultural planning tools to maximise opportunities for Aboriginal peer relationships)
- Men's and women's business (to ensure key developmental milestones are addressed in alignment with Aboriginal cultural practices).
- Return to Country
- Cultural support plans (focused on being child friendly to assist with helping the child and adults around them make sense of who they are)
- Community and cultural participation

SECTION 5: WHAT MAKES A DIFFERENCE IN IMPLEMENTATION OF THESE MODELS?

The rapid evidence review, and jurisdictional scan have highlighted various models of prominence across Australia with varying levels of evidence base. In many respects the lack of evidence base for models is not necessarily due to their lack of efficacy, but rather a lack of purposeful peer-reviewed evaluations published in the literature. The reasons for this are twofold; challenges in evaluating models that are based on frameworks and guiding principles applied to a particular care setting rather than a set of prescriptive activities (providing challenges to define uniformly 'what' is being assessed); and secondly, challenges associated with conducting research with children and young people in the OOHC setting. Certainly, employing various research methodologies in this context poses ethical challenges. It would be unethical to randomly assign a vulnerable child or young person to a particular type of care, irrespective of their needs and the most appropriate placement. Similarly, withholding a certain model of care would be unethical.

Although there are emerging models developed by First Nations communities and organisations for Aboriginal and Torres Strait Islander children and young people, and others which include cultural adaptations and guidance in their implementation, there are no identified models within this review that relate specifically to the specialised considerations required for children and young people who have displayed HSB. Further, although there have been some identified models for Aboriginal and Torres Strait Islander children, these models are often not specifically TRC models.

Across Australia, arguably the most common models are the CARE and Sanctuary models of TRC. Both appear to have equal evidence base – although the former generally has evaluative literature focused more on outcomes for children and young people related to behaviour changes; the latter having evaluative research mainly focused on carer/staff and children/young people perception and feedback of implementation. They are implemented at both the organisational and jurisdiction-wide levels in many jurisdictions. Not surprisingly, regardless of their widespread use, they vary significantly in terms of their implementation. Several enablers and barriers to implementation have been identified in the literature, on closer review of the evaluative literature and from discussions with participating CSOs and jurisdictions.

ENABLERS INFLUENCING THERAPEUTIC RESIDENTIAL CARE IMPLEMENTATION

The unique, yet often complex, nature of TRC environments suggests that multiple factors are likely to influence the effectiveness and implementation of evidence-based practice in OOHC. According to Daly et al. (2018), inadequate model implementation acts as a barrier to the successful implementation and execution of evidence-based practice. James et al. (2013), however, suggests implementation and effectiveness of evidence-based programs may be linked to the individual characteristics of youth and staff, the organisational culture, and considerations related to compliance with government policies. In navigating this terrain, understanding these multifaceted elements becomes imperative for informed decision-making and fostering optimal outcomes in TRC settings.

Several factors to support implementation of TRC were identified. Although these factors have the potential to facilitate success, their implementation was not consistently optimised (i.e., they were identified as both implementation facilitators and barriers). See figure 3 below.

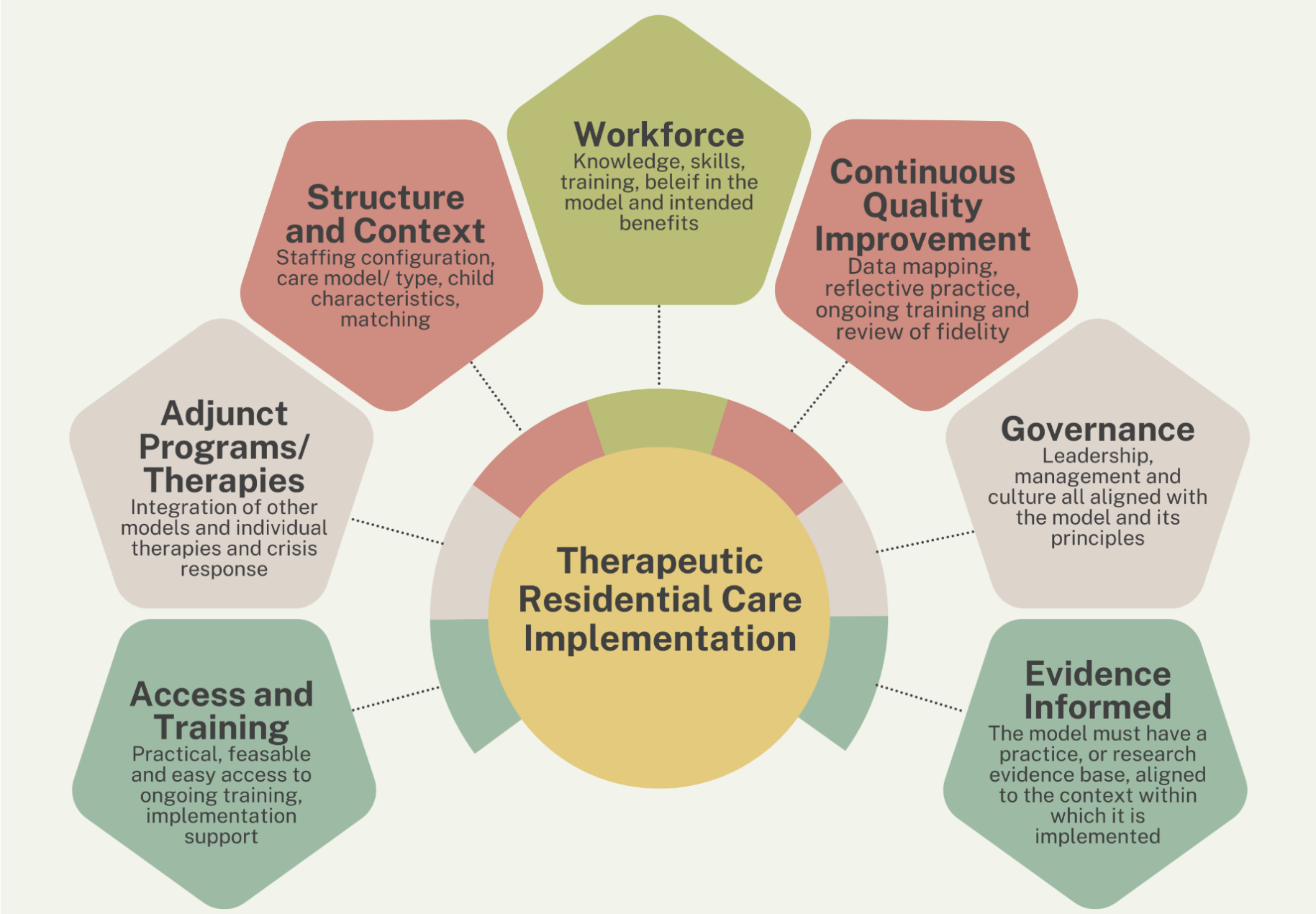


Figure 4: Key elements required for effective implementation of Therapeutic Residential Care models

Access and Training

Access to practical and ongoing training is an essential element for the successful implementation of TRC programs, directly impacting staff retention, the quality of care provided, and the overall therapeutic outcomes for children and young people. Reasons for training include, but are not limited to:

- Enhances staff competency;
- Ensures consistency in care;
- Adapts to evolving best practice;
- Supports professional development;
- Promotes therapeutic outcomes;
- Mitigates risk; and
- Fulfills regulatory and accreditation requirements.

The peer-reviewed literature in this report does not assess how staff training is delivered or provide context on the outcomes of such training, though suggests training typically occurs at the onset of staff onboarding, typically lasting 3-5 days, with no further ongoing training provided thereafter. The jurisdictional scan suggests statutory bodies and external organisations providing TRC embed expectations for accessible and ongoing training, however there is often lacking detail as to how this is implemented and monitored. It is evident that staff often express uncertainty about implementing certain aspects of TRC programs, raising concerns about their ability to effectively carry out their roles. Ongoing training and monitoring of staff confidence and competence is essential for maintaining high standards of care across the board, ensuring that all staff members, regardless of their initial skill level or experience, continuously understand and apply the core principles and practices of TRC.

Accessibility to models of TRC that can be implemented effectively in Australia is critical. Probably the most dominant model in Australia with the widest adoption is the Sanctuary model. This is likely due in large part to its accessibility locally. A local provider has the licence to provide the accredited training, implementation support, and resources, ensuring timely, cost-effective access to material, workforce development and ongoing implementation support during early years of adoption. Whilst this is an evidence-based model, its localised implementation supports and accreditation mechanisms make it more attractive and financially viable than those system-wide models which must be sourced overseas.

Use of adjunct therapies, programs, and allied health staff

While TRC is crucial, and adoption of a model is ideal, no one program alone is sufficient to meet the broad and complex needs of children and young people in care. The 'Therapeutic Specialist' role is highly valued across models and jurisdictions for its provision of specialised therapeutic interventions and support aimed at addressing trauma and behavioural problems experienced by children and young people in care. However, it is recognised that Therapeutic Specialists alone cannot holistically meet these needs.

Jurisdictionally, it is commonplace for adjunct programs, therapies, and allied health staff (e.g., psychologists) to be integrated alongside and within the model of care provided. Some providers have inbuilt access to psychiatric support, psychologists, and in-house practice specialists. These additions not only work directly with children and the young people, but also with carers and other staff. In many instances they convene special case reviews following intake, assessment or lead reflection following critical incidents. This level of integration of additional specialist roles elevates the ongoing implementation of TRC models, particularly adherence to certain principles and guiding frameworks. They also work to provide the staff with ongoing learning on trauma and its impacts in a nuanced and

contextualised way for individual children. Lastly, this level of integrated therapeutic services ensures that individual, group, or family-based therapy outcomes can be integrated and generalised into the care environment; often bypassing lengthy waitlists and communication issues that can occur when children or young people access outside therapeutic supports.

In addition to specialised therapeutic roles, many TRC models advocate for the use of adjunct programs to complement the TRC model of choice, adding to the implementation success. Such models include Power to Kids (designed to improve healthy sexual development and conversations), Therapeutic Crisis Intervention (TCI: aimed at de-escalating crises and developing a child's self-regulation) and Healthy Eating Active Living Matters (HEALing Matters: supporting children and young people to develop enhanced wellbeing).

With specific focus on sexual exploitation, absconding, and HSB, the Power to Kids program is implemented within some residential care settings and involves prevention strategies in the form of:

1. "Whole-of-house respectful relationships and sexuality education" involving education on ten topics fortnightly (rights of children and young people, gender stereotypes and diversity, sexual health, normal and problematic sexual behaviour, respectful relationships and love, consent and age, grooming and abuse, disclosure and informed friends, online sexual safety, and pornography), and reinforcement of this education within the home.
2. "Missing from home strategy" as a secondary prevention initiative targeting risk of children or young people missing from the home or placement.
3. "Sexual safety response" as an early intervention strategy for identifying and therapeutically responding to Harmful Sexual Behaviours, Child Sexual Exploitation and Domestic Violence (McKibbin, Bornemisza, & Humphreys, 2020).

Therapeutic Crisis Intervention is a trauma-informed program through noncoercive, nonaggressive environmental and behavioural strategies and interventions aimed to de-escalate crises and develop the child's self-regulation capacity (The California Evidence-Based Clearinghouse for Child Welfare, 2023). The training aims for staff to understand the impacts of trauma, identify and recognise behavioural patterns that reflect trauma experiences, utilise trauma-informed principles when interacting with children to avoid re-traumatisation, and be sensitive to the unique perspective of the child (Holden, et. Al., 2022). The essential components of TCI include: child and family inclusion, leadership and program support, clinical participation, supervision and post-crisis response, training and competency standards, documentation, incident monitoring, and feedback (Holden, et. Al., 2022).

The Healthy Eating Active Living Matters (HEALing Matters) program, developed at Monash University and funded by the Victorian Government, is an online training package and platform designed for residential workers, foster carers, and kinship carers. Trauma-informed philosophy frames the program which aims to improve physical, cognitive, social, and emotional outcomes for young people in care through training carers. The online training, launched in 2019, consists of six core modules designed to be completed in the order listed: 'Attunement', 'Shaping Routines', 'Food for Thought', 'Physical Activity for Thought', 'Health Literacy', and 'A Moment for Yourself'. Eight additional modules have been added to the training platform: 'Understanding Eating Behaviours', 'Sexual Health & Respectful Relationships', 'Gender & Sexuality Diversity', 'Oral Health', 'Physical Activity & Disability', 'Healthy Eating & Disability', 'Living Smoke Free', and 'Mental Health'. The modules each take approximately 1 hour to complete. Additional resources are provided to trainees inclusive of recipes, tips for shopping, local sporting opportunities and more (Monash University, 2022).

As noted in the evidence review, there are also several culturally-responsive programs that are sometimes integrated within or alongside TRC models with positive effect:

1. The 'Koorie Tiddas Youth Choir', which offers young people the opportunity to connect with their language and culture through music;
2. 'Return to Country', a program designed to support young people to visit and connect with their land, families, communities, and culture;
3. 'The Connecting to Sea Country', which organises educational day trips to learn about Port Phillip Bay and its Aboriginal heritage from an Aboriginal Elder; and
4. 'Wrapped in Culture', also known as 'Possum Skin Cloak Project', which involves teaching young people the art of crafting a possum skin cloak.

Children, young people, and kin involved in these programs showed an improved sense of belonging and identity as an outcome of implementation (Lindstedt et al., 2017).

There is no one-size-fits-all approach to this element to support implementation of a TRC model, but it is highly advisable that a focus be placed on adjunct programs and use of integrated therapeutic staff to provide inclusive and integrated therapeutic supports to the children and young people in the residential care, and the staff supporting them and implementing the TRC model.

Structure and context

This report reveals a gap in the literature concerning key aspects to TRC like staff-to-child ratio, child mix, and staffing models within TRC. Notably, none of the TRC models under review comprehensively address these critical elements, indicating an absence of universally accepted 'best practice' standards in these areas. The jurisdictional scan suggests these elements are often subject to legislative requirements and contract and funding terms. A four-bed model is the most common nationally, as is the approach of reducing client numbers and/or increasing the staff to child ratio congruent to client need and complexity (e.g., when a child displays extreme levels of HSB).

The absence of a universally accepted best practice standard means that care levels can vary significantly between TRC settings. Whilst this enables flexibility to tailor care commensurate to client need, it also leaves room for poorly planned practice that may be reactive and/or not conducive to client needs and outcomes. Moreover, a lack of information on key operational aspects makes it challenging to research and evaluate TRC programs effectively. This can hinder the development of evidence-based practices and the continuous improvement of TRC models based on empirical evidence. The identification of these gaps highlights the need for the establishment of nationally recognised principles to guide these critical elements, ensuring optimal outcomes for children and young people. Moreover, it calls for a comprehensive framework that respects and acknowledges the complexities of client need and draws attention to the identified priority groups, including Aboriginal and Torres Strait Islander children and young people and those who have displayed HSB. Such principles would not only standardise care across various care settings throughout Australia, but also ensure that the cultural, emotional, and behavioural needs of these priority groups are met with tailored, respectful, and effective interventions.

In the absence of such guidance, it is critical that implementation of TRC models (regardless of type) be cognisant of the individual impact of:

- Child to carer ratio in a single dwelling
- Case manager and therapeutic practitioner to child in each system (ensuring that there is adequate provision for therapeutic intervention, supports and guidance etc)

- Case manager and therapeutic practitioner to carer ratio in each system (ensuring that there is adequate provision for therapeutic supervision, ongoing quality improvement, workforce development, governance etc)
- Appropriate staffing roster (consideration for standing/ wake night shifts, additional staff during critical times such as bedtime, during meals etc, use of assigned versus general workers and role clarity, use of consistent predictable care staff on predictable patterns of shifts)
- Child matching (ensuring that a child matches not only the placement type, but also the other children and carers in a particular placement context)

Workforce

The success of children and young people in TRC hinges on the care they receive from direct care workers. Even the most competent staff require ongoing training and development to deliver the most up-to-date and culturally appropriate therapeutic care. Staff working in residential care homes are the primary focus of TRC interventions because increasing staff knowledge, awareness, and skills should change the way residential carers respond to and interact with the children in their care. However, a consistent theme from the literature regarding the implementation of TRC models was persistent concerns regarding the actual implementation and effectiveness of the training provided. A notable barrier to intervention implementation is the insufficient provision of practice-based learning for staff to acquire practical skills for effectively implementing therapeutic care (Cox et al., 2018; Daly et al., 2018; Galvin et al., 2021; James, 2017; James et al., 2013).

Galvin et al. (2022) observed that residential care staff frequently experience uncertainty during the implementation of TRC, echoing Baker et al.'s (2018) argument that one-off professional development training is inadequate for initiating a genuine culture shift toward TRC. As such, there is a need for continuous and regular workforce development to ensure the delivery of therapeutic care because, without a well-trained workforce, the implementation of therapeutic care is unlikely to be effective.

The success of any intervention or organisational culture change centres on the willingness of staff and the organisation to embrace change. A consistent theme from the literature highlights the importance of "buy-in from key stakeholders" and collective support from staff at all organisational levels for effective implementation of TRC (Cox et al., 2018; James et al., 2017). Esaki et al. (2014) further affirm that staff members who perceive greater support from administrators, supervisors, and peers were more likely to feel that the agency was committed to successfully implementing the model.

In the case of the Sanctuary Model ® impact on children and young people in care, residential care staff explicitly acknowledged that the model's effectiveness is directly linked to their active engagement and embrace of its principles (Galvin et al., 2022). Staff members recognised that if the model fails to influence their perspectives and practices, its impact would be minimal on the children and young people in care.

Nevertheless, identified barriers to staff buy-in point to a lack of formal consequences for implementing TRC, resulting in inconsistent engagement and reinforcement of TRC implementation (Baker et al., 2018). This discrepancy places staff members willing to drive positive organisational change at odds with those resistant and unwilling to adhere to the model's framework. This raises broader concerns about staff alignment and the significance of fostering staff commitment to implement TRC successfully.

Continuous Quality Improvement

Data collection and ongoing quality improvement, including reflective practice, are critically important to make informed decisions, to build trust and credibility among funders and stakeholders, and to

monitoring the wellbeing of children and young people in care. TRC models require ongoing monitoring to ensure they are being implemented appropriately. Given their reliance on guiding principles, and frameworks in many cases, it is critical that practice is monitored for evidence that these are being implemented. This may include both evidence that staff are knowledgeable in the model, but that practice is evidenced in case files, via child and young people reports, evident in practices, and observed by others within the care context. Likewise, it is important to ensure that behavioural and wellbeing indicators of change are closely monitored within an environment; these may include behavioural indicators such as critical incidents, incidents of absconding, violence towards staff etc, but they should also include wellbeing measures for children and young people such as self-efficacy, emotional wellbeing, connectedness etc.

Together, both the evidence of the model being implemented and the evidence of outcomes/impact or change of desired behaviour and wellbeing for children and young people can begin to provide valuable information for care staff and leaders in the care system to ensure implementation is kept on track and applied with fidelity to the model. This element has the added benefit of continuing to feed into the evidence base for those models that are under evaluated or emerging from the practice space.

Governance

Effective change in residential care settings necessitates robust leadership and management, as highlighted by Galvin (2021), who emphasised these elements as "non-negotiables". Leaders and champions play a pivotal role in guiding and supporting the values embedded in therapeutic care models, thereby fostering successful implementation. Moreover, influential leaders can create an environment where staff members feel supported and empowered to seek guidance or pose questions when hesitant to approach someone within their direct team, contributing to a culture of organisational safety (Galvin et al., 2022).

Holden and Sellers (2019) highlight the importance of leaders and supervisors modelling the care principles inherent in TRC. This modelling sets expectations and reinforces a shared understanding and commitment to the principles underpinning effective care. Champion leaders committed to implementing evidence-based practices are identified as a crucial need by James et al. (2017). These leaders serve as catalysts for change, advocating for the incorporation of best practices and driving a culture of continuous improvement within the organisation.

Despite this ideology, the level of commitment among staff members to implement TRC may vary across different organisational levels, potentially affecting the implementation of a specific model. For example, Esaki et al. (2014) observed that the demonstration of the Seven Commitments of the Sanctuary Model® varied among staff members at different organisational levels, and staff members from the leadership team were rated the lowest for demonstrating Sanctuary Model® behaviour. However, demonstration of Sanctuary behaviour varied among members of the leadership team. This observation suggests that despite the conceptual framework of TRC models, without great leadership and a committed workforce, discrepancies in the implementation of a model can arise.

Nevertheless, a consistent theme from the literature was that leadership and management that guide, support, and champion TRC for children and young people are indispensable elements for success. Leaders not only guide the implementation of therapeutic care models, but also create an environment conducive to organisational safety, where staff members feel supported and encouraged to uphold the principles that can enhance the well-being of the children in their care.

Evidence Informed

Evidence-informed is broader than just research evidence, and should be seen as a culmination of practice, lived, and research knowledges. Particularly when reviewing models appropriate for First Nations Australians, or for those who have displayed HSB, a lack of evaluative or peer reviewed literature does not necessarily equal a lack of efficacy; it simply means the evidence has not been documented in a traditional structure yet. It is critical to ensure that regardless of the TRC model implemented, there is an articulated evidence base. This articulation should accompany a common understanding between those implementing the model, be based on sound theoretical principles, and be evidence informed – combining where possible practice, lived experience, and research.

Shared knowledge and understanding of trauma-informed care also play a pivotal role in implementing TRC, fostering a collective awareness of the impact of trauma across the entire organisation, and contributing to the transformation of organisational culture. This has not only contributed significantly to the transformation of organisational culture but has also been validated by studies such as Galvin et al. (2021).

The Importance of trauma-informed knowledge is further underscored by the findings of Izzo et al. (2016), who observed that staff with an enhanced understanding of trauma reported fewer confrontations, diminished power struggles, reduced fear, and an overall more peaceful environment in the homes. This points to the tangible positive outcomes stemming from applying trauma-informed principles within TRC settings. In essence, a shared comprehension of trauma not only influences organisational culture positively, but also directly contributes to a more harmonious and supportive environment for both staff and the youth under their care.

SUMMARY

Children in residential care often exhibit high needs stemming from a myriad of complex factors, including histories of trauma, abuse, neglect, or familial disruption. TRC represents specialised frameworks within the continuum of care services, offering elevated levels of intervention and support to address the intricate needs of children and young people who manifest complex psychological, emotional, and behavioural challenges.

The Department commissioned ACCP to review evidence based TRC models for children and young people living in OOHC, including customised models for Aboriginal and Torres Strait Islander children and young people who have displayed, or who are at risk of displaying, HSB.

To achieve this, the ACCP undertook a twofold rapid approach guided by both research and practice expertise:

1. A practice-led jurisdictional scan of models currently in use across Australia, including comparison of approaches and discussion of overarching themes; and
2. A rapid review of the evaluative literature on TRC models.

Despite the increasing popularity of TRC models over the past decade, the evidence base supporting their effectiveness remains limited. Further evaluative research into TRC models remains a critical priority for the field. The available evidence suggests that TRC show promise for improving both staff knowledge and confidence and the outcomes of children in residential care. However, it is not possible to draw generalisable conclusions about the effectiveness of specific TRC models, compare commonalities, or assess the relative strengths or limitations of different approaches. Limited evidence continues to exist on how TRC models, often described as high-level principles or common elements, are operationalised in practice. Cultural safety and connectedness are critical elements of a therapeutic environment for First Nations children and young people (Krakouer, 2023; Krakouer et al., 2018; The Healing Foundation, 2021; SNAICC, 2023). Although evaluative research into Aboriginal and Torres Strait Islander designed and implemented interventions to improve cultural connectedness is encouraging, only one paper was identified examining four programs and one policy, highlighting an urgent need for more research in this area. The findings from the rapid evidence review do not enable definitive inferences or conclusions to be drawn in relation to 'best practices' in TRC. However, TRC models continue to demonstrate promising evidence as a mechanism for providing a more healing and less damaging care environment for children and young people in residential care.

A review of TRC across Australia led to several take home messages which align with the literature findings:

1. TRC is available in OOHC across jurisdictions, though a lack of operationalisation presents a challenge.
2. There is a mix of recognised models and bespoke TRC in use across the jurisdictions. Several recognised models of TRC appear dominant to others, though their increased presence across jurisdictions is, in part, due to their use by national agencies and lack of available accreditation schemes for some TRC's in Australia.
3. There is a lack of clear, publicly available implementation procedures for any model or TRC framework.

4. There are limited tailored TRC options for Aboriginal and Torres Strait Islander children and young people; and for children and young people who have displayed HSB.
5. There is growing recognition that relying on a sole TRC model often fails to adequately address the comprehensive care requirements of children and young people in TRC. Flexible frameworks of guiding principles and layering of additional programs are being used to overcome identified gaps.

There is significant variability of TRC implementation, even when using the same TRC model framework with set principles or guiding practices. This variability highlights the limitation of relying on any single TRC model as the sole solution to supporting the ongoing healing and wellbeing of children and young people within residential or OOHC more broadly. Therefore, it is crucial to focus on key implementation facilitators to ensure TRC is provided in the most appropriate, trauma-informed, targeted and culturally safe way. This approach should be sustainable and promote ongoing quality improvement driven by action research methodologies. Implementation considerations include:

- Training should be accessible, affordable, and sustainable to meet workforce demands, including addressing staff transience and growth needs.
- The capacity to integrate adjunct programs or therapies within a TRC model, to promote more complex trauma recovery, cultural connection, healing, and enhanced physical and psychological wellbeing.
- Staffing configuration (including roles, responsibilities, skills, staff to child ratios etc.) must align with the TRC model. This includes matching children's characteristics, (e.g., age and complexity) to the chosen model and ensuring the environmental context supports the TRC model.
- Ensuring the workforce capability and capacity to support the TRC implementation and ongoing facilitation as intended, maintaining fidelity to the model.
- Built-in quality improvement mechanisms must be in place to both support the implementation and monitor outcomes, ensuring a feedback loop and culture of continuous improvement.
- Effective governance from the board to the frontline is crucial. Models like Sanctuary and CARE require a system-wide implementation approach to ensure fidelity, necessitating significant cultural governance adoption.
- While current evidence for TRC is limited, the underpinning therapeutic frameworks must be sound, and evidence informed. Implementation should seek to explore and contribute to the evidence base, understand the models' limitations and identifying additional programs needed to support positive outcomes for children and young people.

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APPENDIX A: METHODOLOGICAL APPROACH TO THE RAPID EVIDENCE REVIEW

To thoroughly, though quickly, address the body of evidence for TRC models, we undertook a rapid evidence assessment form of scoping (see Thomas et al., 2013). Rapid evidence assessments follow the methods and principles of a systematic search and review, with some purposeful modifications. Rapid evidence assessment, while a shortcut to producing reviews, has often been completed without detail on what was rapid in that assessment. It is essential to detail what was changed from a systematic review to align with the rapid needs of this assessment (Watt et al., 2008; Varker et al., 2015). In the simplest terms, the review included a tight boundary on search terms (see Table 1 below), limited to the previous ten years, and primarily focused on aligning the current assessment of evidence with the earlier review cited in the introduction literature rather than "reinventing the wheel" or duplicating past reviews. Furthermore, we chose to only use a single reviewer for the screening process (Author - DP) rather than the double coding required in a gold standard systematic review, which involves additional steps (and time) to resolve coding differences. Rapid evidence assessments are particularly useful for assessing the research evidence to inform policy, where policymakers are typically working within tight timeframes in which a gold standard systematic review or meta-analysis is not feasible, but they still need a thorough, transparent, and robust assessment of the existing evidence-base. The literature pool was also restricted to publications written in English.

SEARCH STRATEGY

Table 1 below provides information on the data sources for the search. Table 2 details the search terms and steps used for the search (variations within different databases were recorded and within expectations). Identified papers were screened through a systematic set of inclusion eligibility criteria (detailed below), and relevant data were extracted for analysis. The included papers were critically analysed, and the interpretation of the findings is presented in the results below.

Table 1: Data Search Types and Sources

Search Type	Data Sources
Databases (Peer-reviewed literature, published after 2013 in English)	• Scopus • MEDLINE via Ovid • PsycINFO via Ovid • ProQuest Central • Cochrane Library

The search terms used within this review were included to cover the topics of both TRC and intervention, given that, in some cases, evaluation may occur for either the systematic organisational approaches, specific intervention points, or both. Further additional searches were also made for Indigenous cultural considerations and, separately, HSB, given these two issues as points of care and importance in the Australian context.

Table 2: Search Terms and Steps

Step	Search Terms
Limiters	Peer Reviewed, After 2013, English
1	"group home" OR "out of home care" OR "group care" OR "residential care" OR "resi care" OR "therapeutic residential care" OR "looked after children"
2	"therapeutic residential program*" OR "evidence-based models" OR "evidence-based strategies" OR "practice elements" OR "evidence-informed" OR "implementation" OR "sanctuary" OR "children and residential Experiences model"
3	1 AND 2
4	"Aboriginal" OR "Indigenous" OR "First nations" OR "Torres Strait" OR "Māori" OR "Pasifika" OR "Native American"
5[#]	3 AND 4
6	"harmful sexual behavio*" OR "child sexual abuse" OR "rape" OR "sex offender" OR "sexually abusive behavio*" OR "sexually reactive behavio*" OR "problem sexual behavio*" OR "sexually harmful behavio*" OR "juvenile sex offender" OR "adolescence sex offender" OR "sex offender" OR "sexual aggression"
7[#]	3 AND 6
[#] secondary search	

Inclusion exclusion criteria

Literature was included should it meet the following criteria:

- Peer reviewed;
- Focus: Child and Adolescent AND Residential Care;
- Topic: Function/outcome/evaluation of a model of TRC or intervention;
- Quantitative or Qualitative study design (reviews permitted);
- Secondary searches;
- Cultural considerations of models; and
- Considerations for Harmful Sexual Behaviours.

The exclusion criteria for literature were:

- Focus: Generalised intervention – e.g., a school and residential care setting intervention; juvenile detention or specified treatment facilities, or other focus;
- Topic: External intervention – e.g., therapeutic specialist treatment outside of care;
- Non-peer-reviewed;
- Opinion pieces;
- Description without claim to evaluation or outcome;
- Model theory papers (pre-implementation; registration of evaluation methods); and
- Residential care specific programs and interventions that did not aim to create a therapeutic residential care environment (as defined above).

This search strategy resulted in 2,026 articles retrieved, 844 duplicates removed, and a total of 1192 articles screened by title and abstract by one reviewer (DP). Of these, 77 papers met the inclusion criteria for abstract screening. After the abstract and rapid full text, 15 articles were retained after assessing the full text, as illustrated in Figure 1. All 15 papers in this review originated from Australia, Canada, the United Kingdom, and the United States of America and presented information on organisation-wide, trauma-informed models and/or client-level evidence-based practice models.

It was apparent in the outcomes of the search that some individual therapeutic interventions may be used in conjunction with a systemic TRC model. For example, an organisation might implement CARE or Sanctuary to create a therapeutic milieu for the child while also incorporating Life Story work to address the individual therapeutic needs of children and young people in residential care in a child-centred way. Other independent models or programs may be adopted in support of the implementation of specific principles or tools within TRC frameworks but are not included in this review and would need to be evaluated separately if they were not already evidence based.

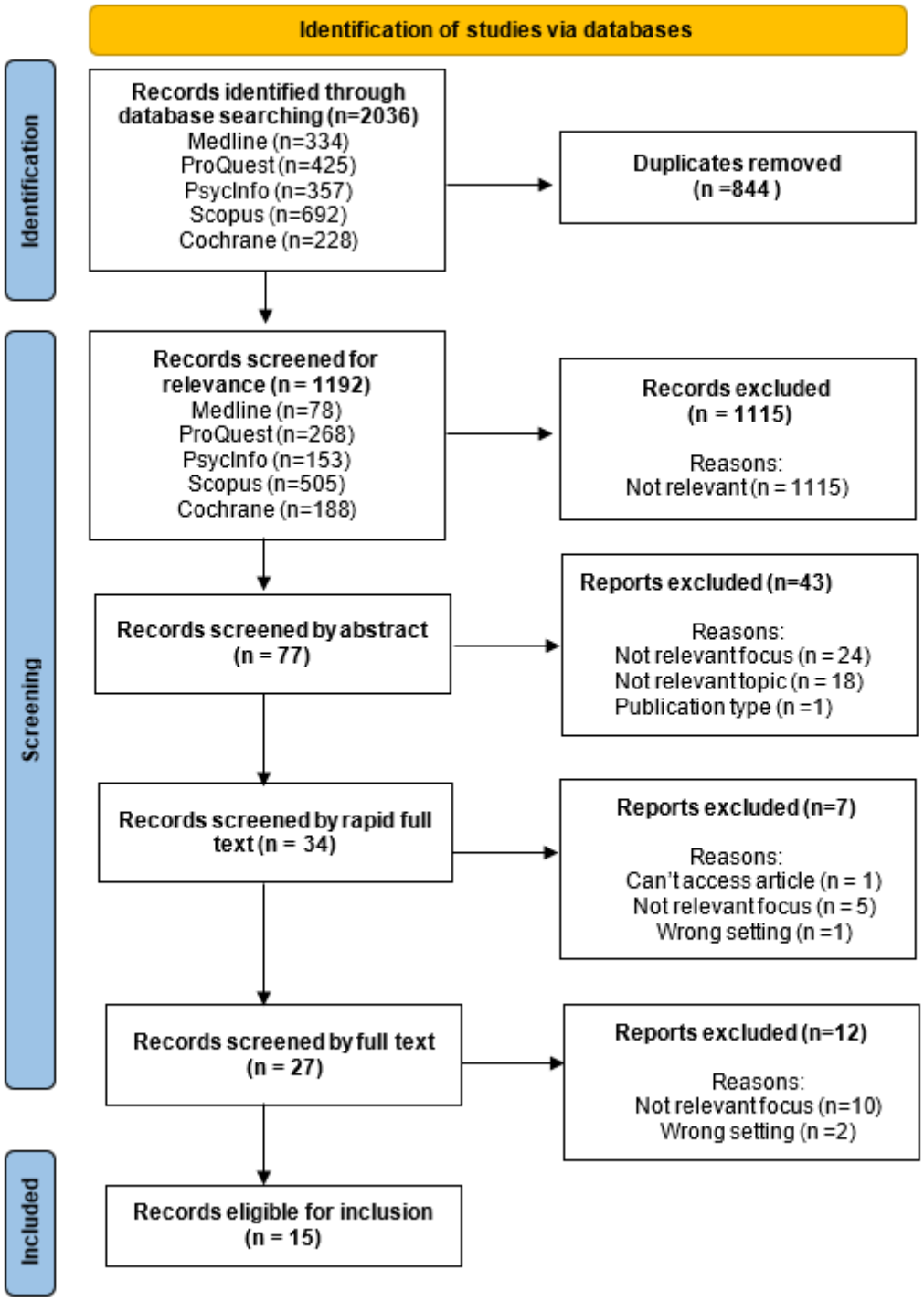

Figure 1: PRISMA Search Strategy

Additional pearling

Of the 15 papers identified through the search, 10 were noted as primary research articles, and five were review, summary, or discussion related papers. The 'pearl growing' strategy was employed to cross-check the ten primary research articles, with those included in the five review and discussion papers, ensuring the inclusion of all relevant articles. Through the application of this approach, two additional

primary research papers (Farmer et al., 2017b; Huefner et al., 2018) were identified. Therefore, the total number of primary research papers focusing on TRC models included in this rapid review is 12. Table 3 summarises the 12 primary research articles utilised to examine the identified TRC models in this paper. Concurrently, Table 4 summarises the crucial reviews in offering context and facilitating additional analysis throughout the discussion.

Table 3: Primary research – organisation-wide therapeutic residential care models

#	Author	Title	Year of publication	Location
1	Baker et al.	The implementation and effect of trauma-informed care within residential youth services in Rural Canada: A mixed methods case study	2018	Canada
2	Boel-Studt et al.	A mixed-methods evaluative study of the life model of residential care for trauma-affected children and youth	2023	USA
3	Cameron, R. J. S. & Cas, R. K	Empowering Residential Carers of Looked after Young People: The Impact of the Emotional Warmth Model of Professional Childcare	2019	UK
4	Esaki et al.	Sanctuary Model Implementation from the Perspective of Indirect Care Staff	2014	USA
5	Farmer et al.	Would we know it if we saw it? Assessing quality of care in group homes for youth	2017	USA
6	Farmer et al.	Does model matter? Examining change across time for youth in group homes	2017	USA
7	Galvin et al.	Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges	2021	Aus
8	Galvin et al.	Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed Approach: The Sanctuary Model	2022	Aus
9	Huefner et al.	Economic evaluation of residential length of stay and long-term outcomes	2018	USA
10	Hurley et al.	The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care	2017	USA
11	Izzo et al.	Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model	2016	USA
12	Izzo et al.	Improving relationship quality in group care settings: The impact of implementing the CARE model	2020	USA

Table 4: Reviews and discussion papers

#	Author	Title	Year of publication	Location
1	Bailey et al.	Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings	2019	Aus
2	Holden & Sellers	An evidence-based program model for facilitating therapeutic responses to pain-based behaviour in residential care	2019	USA
3	James et al.	Effectiveness and implementation of evidence-based practices in residential care settings	2013	USA
4	James, S.	Implementing Evidence-Based Practice in Residential Care: How Far Have We Come?	2017	USA
5	Lindstedt et al.	Realist review of programs, policies, and interventions to enhance the social, emotional, and spiritual well-being of Aboriginal and Torres Strait Islander young people living in out-of-home care	2017	Aus

ANALYSIS

Each of the 12 primary research articles were reviewed according to a predetermined extraction template including various areas of information relating to the research methodology, participants, data capture tools or data points used, and the overall research results. The complete extraction template results can be found in Appendix B below.

QUALITY OF EVIDENCE

Several high-quality reviews (Bailey et al., 2019; Daly et al., 2018; Downey et al., 2015; James., 2017; Lindstedt, 2017) were identified in this rapid evidence assessment, offering additional support for some of the claims made in this article. While one randomised control trial was found, it primarily focuses on health outcomes rather than psychosocial outcomes, limiting its relevance to TRC (Cox et al., 2018).

The majority of the findings presented stem from quantitative research, providing objective evaluations of the models under review, while three studies employed a mixed-methods approach to enable a more thorough comparison of the findings, offering a deeper insight into the therapeutic outcomes or efficacy of TRC models. Moreover, two studies were based on qualitative feedback from staff regarding the models, which traditionally are considered a weak indicator for the quality of evidence without triangulation (despite revealing meaning and process elements that other methods cannot).

It is worth noting and acknowledging that there are challenges in undertaking gold standard evaluative research into TRC models. Gold standard evaluation research comprises randomised control trials in which participants and staff are blind to experimental and control conditions. Many of the elements of a gold standard randomised control trials are not feasible or ethical in a residential care environment – such as randomising a child to a residence rather than placing a child into the best available placement for their specific needs. Statistical power can also be difficult to achieve given the number of children typically placed within a single residence/group home. These constraints notwithstanding, evaluative research that incorporates pre- and post-test (Baker et al., 2018; Boel-Studt et al., 2023; Cameron & Das,

2019; Farmer et al., 2017a; 2017b; Hurley et al., 2017; Izzo et al., 2016; 2020) and comparison group data (Baker et al., 2018; Boel-Studt., 2023; Esaki et al., 2014; Farmer et al., 2017a; 2017b; Huefner et al., 2018; Izzo et al., 2016; 2020;), and which includes a focus on implementation and fidelity as well as outcomes for the operating environment, staff, and children would provide a high standard of evidence for TRC models. Common challenges and constraints for research into interventions targeted outcomes for residential care homes impact the likelihood of interventions in this area attaining evidence-based ratings in repositories assessing the extent to which an intervention is evidence-based such as the California Evidence Based Clearinghouse (CEBC).

APPENDIX B: EXTRACTION TABLES FOR PRIMARY RESEARCH ARTICLES

Table 1: Primary Research Literature – general description extraction information

#	Author	Year	Title	Location	Aim	Which TRC model/s discussed	Research Design	Target of research	Pre/Post evaluation
1	Baker, C. N., Brown, S. M., Wilcox, P., Verlenden, J. M., Black, C. L., & Grant, B. E.	2018	The implementation and effect of trauma-informed care within residential youth services in Rural Canada: A mixed methods case study	Canada	To evaluate the implementation and effect of trauma-informed care on staff within 1 residential youth services division in rural Canada using Risking Connection and Restorative Approach trauma training programs, with a focus on vicarious traumatization.	Trauma informed care	Mixed methods	Implementation, Impact, Satisfaction	Yes
2	Boel-Studt, S., Deichen Hansen, M., & Dowdy-Hazlett, T.	2023	A mixed-methods evaluative study of the life model of residential care for trauma-affected children and youth	USA	To examine the implementation and outcomes of the Life Model of residential care. And specifically, to determine whether program implementation was consistent with the model's key principles and intervention components, and to examine the effectiveness of the Life model on youth's achievement of the intended outcomes.	The Life Model	Mixed methods	Implementation, Outcome.	Yes
3	Cameron, R. J. S., & Das, R. K.	2019	Empowering Residential Carers of Looked after Young People: The Impact of the Emotional Warmth Model of Professional Childcare	UK	To examine the impact of the professional childcare model in a 3-year project involving children and young people in local authority children's homes.	The Emotional Warmth Model	Quantitative	Impact, Outcome	Yes

4	Esaki, N., Hopson, L. M., & Middleton, J. S.	2014	Sanctuary Model Implementation from the Perspective of Indirect Care Staff	USA	To assess the implementation of the Sanctuary Model from the perspective of indirect care staff within a Northeast voluntary child welfare agency.	The Sanctuary Model	Quantitative	Implementation, Satisfaction.	No
5	Farmer, E. M., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017a).	2017 a	Would we know it if we saw it? Assessing quality of care in group homes for youth	USA	To propose and examine a parsimonious framework for assessing quality in therapeutic residential care.	Teaching Family Model	Mixed methods	Outcome, Satisfaction (including youth satisfaction)	Yes
6	Farmer, E. M., Seifert, H., Wagner, H. R., Burns, B. J., & Murray, M.	2017 b	Does model matter? Examining change across time for youth in group homes	USA	To examine differences across time for youth served in group homes utilising the Teaching Family Model (TFM) and geographically proximate homes using more eclectic approaches.	Teaching Family Model	Quantitative	Outcome, Impact	Yes
7	Galvin, E., Morris, H., Mousa, A., O'Donnell, R., Halfpenny, N., & Skouteris, H.	2021	Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges	Aus	To examine the enablers, barriers, organisational successes, and challenges experienced by decision makers (mangers and executive staff) when implementing The Sanctuary Model in residential out-of-home care.	The Sanctuary Model	Qualitative	Implementation, Fidelity	No
8	Galvin, E., O'Donnell, R., Avery, J., Morris, H., Mousa, A., Halfpenny, N., Miller, R., & Skouteris, H.	2022	Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed Approach: The Sanctuary Model	Aus	To explore and better understand the enablers and barriers of implementation and how these impact on the organisational successes and challenges of adopting The Sanctuary Model, as perceived by residential care staff.	The Sanctuary Model	Qualitative	Implementation.	No
9	Huefner, J. C., Ringle, J. L.,	2018	Economic evaluation of residential length of	USA	To compare long-term outcomes for youth in an evidence-based	Treatment Family Home -	Quantitative	Outcome	No

	Thompson, R. W., & Wilson, F. A.		stay and long-term outcomes		residential care program for 6 months or less with youth in the program for more than 6 months.	based on the Teaching Family Model			
10	Hurley, K. D., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M.	2017	The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care	USA	To examine youth ratings of treatment fidelity and therapeutic alliance in relationship to symptom severity and outcomes.	The Teaching Family Model	Quantitative	Outcome, Implementation, Fidelity	Yes
11	Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E.	2016	Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model	USA	To examine the impact of a setting-level intervention on the prevention of aggressive or dangerous behavioural incidents involving youth living in group care environments.	Children and Residential Experiences Model (CARE)	Quantitative	Impact	Yes
12	Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A.	2020	Improving relationship quality in group care settings: The impact of implementing the CARE model	USA	To examine whether CARE intervention leads to improvement in relationship quality between children and caregivers.	Children and Residential Experiences Model (CARE)	Quantitative	Outcome, Implementation	Yes

Table 2: Primary Research Literature – participant information extraction information

#	Paper	Participant description	Comparison group Y/N	Attrition related information
1	Baker, C. N., Brown, S. M., Wilcox, P., Verlenden, J. M., Black, C. L., & Grant, B. E. (2018). The implementation and effect of trauma-informed care within residential youth services in Rural Canada: A mixed methods case study	*Quantitative* • One hundred and sixteen (n=116) staff who worked in residential treatment facilities, outpatient treatment services, and related fields, who served children and youth, and who participated in RC and RA training. • Half of the participants were direct care staff (caseworkers, residential care workers). Almost a quarter of participants (23%) identified their job type as 'other' (therapists, nurses, teachers, supervisors, and administrators). *Qualitative* • Five direct care staff (caseworkers, residential care workers) and five other staff (supervisors, therapists).	Y - comparison between job roles at pretest	• The ProQOL was administered at pretest, posttest, and follow-up. The final two RC Basic training groups did not complete the ProQOL at posttest because of administrative error; thus, the posttest sample size for this measure is n = 82
2	Boel-Studt, S., Deichen Hansen, M., & Dowdy-Hazlett, T. (2023). A mixed-methods evaluative study of the life model of residential care for trauma-affected children and youth	• Forty-two (n=42) adolescents (21 males, 21 female). • Residential group homes located at four campuses in the northwest (n = 2), northeast, and central regions of the state. • Most youth were referred through the child welfare system (n=36) due to abuse in their homes or disrupted out-of-home placements (e.g., foster home, group home). • Twelve (n=12) staff from the residential group homes were interviewed.	Y - comparison between youth and staff	• There was a change in participant numbers between time points for both staff and youth. • Youth only stayed in the program for slightly over a year on average. • No explanation was provided as to why the number of staff differed at each time point.
3	Cameron, R. J. S., & Das, R. K. (2019). Empowering Residential Carers of Looked after Young People: The Impact of the Emotional Warmth	• Fifty-three (n=53) children and young people and their carers in children's homes in 2 UK sites (Northern and Southern England). • The Northern site comprised 3 children's homes (totaling 25 children), the Southern site comprised 8 children's homes (totaling 28 children).	Y – comparison between Northern and Southern children's homes	• All 53 children and young people remained in the study for its entirety

	Model of Professional Childcare			
4	Esaki, N., Hopson, L. M., & Middleton, J. S. (2014). Sanctuary Model implementation from the Perspective of Indirect Care Staff	• Thirty-seven (n=37) indirect care staff at a Northeast child welfare agency. • Eighty-five (n=85) were invited to participate in the research study, however, only 37 agreed to participate.	Y - comparison of employee groups	• N/A
5	Farmer, E. M., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017a). Would we know it if we saw it? Assessing quality of care in group homes for youth	• Five-hundred and fifty-four (n=554) children and young people who resided in the participating homes (358 TFM homes; 196 non-TFM homes). • Interviews were completed with one lead agency administrator from each participating agency and one lead staff member from each home. • The sample included seven (7) TFM agencies and seven (7) non-TFM agencies. Within these agencies, youth resided in a total of 49 homes (24 TFM homes; 25 non-TFM homes).	Y - TFM vs non-TFM	• Only 15 youth had not been discharged by the end of the study period.
6	Farmer, E. M., Seifert, H., Wagner, H. R., Burns, B. J., & Murray, M. (2017b). Does model matter? Examining change across time for youth in group homes	• Five-hundred and fifty-four (n=554) children and young people who resided in the participating homes (358 TFM homes; 196 non-TFM homes). • Interviews were completed with one lead agency administrator from each participating agency and one lead staff member from each home. • The sample included seven (7) TFM agencies and seven (7) non-TFM agencies. Within these agencies, youth resided in a total of 49 homes (24 TFM homes; 25 non-TFM homes).	Y - TFM vs non-TFM	• Only 15 youth had not been discharged by the end of the study period.
7	Galvin, E., Morris, H., Mousa, A., O'Donnell, R., Halfpenny, N., & Skouteris, H. (2021). Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes, and challenges	• Nine (n=9) senior staff members (8 executive staff members, 1 HR Manager) responsible for strategy and leadership within OOHC services at MacKillop Family Services.	N	• N/A
8	Galvin, E., O'Donnell, R., Avery, J., Morris, H.,	• Thirty-eight (n=3) 38 residential care staff (1Area Manager, 8 Residential Care Coordinators/House Supervisors, 25 Case Mangers/Residential Care Workers, 3	N	• N/A

	Mousa, A., Halfpenny, N., Miller, R., & Skouteris, H. (2022). Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed Approach: The Sanctuary Model	Principal Practitioner/Therapeutic Specialists, and 1 Children in Residential Care Educator) from MacKillop Family Services. • Twenty-four (24) participants worked in a General Residential Care Home, 14 participants worked in a Therapeutic Residential Care Home. 27 participants worked in a Metropolitan Home, 11 participants worked in a Regional Home.		
9	Huefner, J. C., Ringle, J. L., Thompson, R. W., & Wilson, F. A. (2018). Economic evaluation of residential length of stay and long-term outcomes	• One-thousand, four-hundred and seventy-six (n=1476) former TFH young people who left the home campus program (n=1105) or one of the eight other program sites around the country (n=317) between July 1st 2010 and December 31st 2014. • Of the 1476 possible participants, 1172 (79.4%) completed the survey, 276 (18.7%) were unable to be contacted, 23 (1.6%) refused to participate, and 1 client was deceased (< 1%). • There were 141 youth in the ≤6 months and 1031 Survey data were collected as part of a routine data collection.	Y - youth in care >6months vs <6months	• N/A
10	Hurley, K. D., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care	• One-hundred and seventy (170) children and young people were eligible for participation and 145 (85%) had guardian consent and youth assent. • Children and young people aged 10 to 17 years old, experiencing their first admission to the program who were identified with a disruptive behavior diagnosis via either a professional diagnosis, Diagnostic Interview Schedule for Children (DISC) or the Child Behavior Checklist (CBCL). • One-hundred and twenty-four (124) service providers participated during the study period, representing 62 group homes.	N	• A subset of 112 youth remained in the same group-home during the course of the data collection.
11	Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the Setting Level to Prevent Behavioral	• Eleven (11) agencies across the state were included in this study. • Youth referred by social services, having not already been exposed to CARE, willingness to be placed on a 12-month waitlist if needed, and being licensed by a state agency.	Y - Cohort 1 vs Cohort 2	• All 11 agencies remained in the study for its entirety. However, in seven cases, agencies changed to a new management information system after the first 1–2

	Incidents in Residential Child Care: Efficacy of the CARE Program Model			years of data collection but reported that this had no effect on whether reports were submitted. • Not all youth remained in the study.
12	Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2020). Improving relationship quality in group care settings: The impact of implementing the CARE model	• Thirteen (13) agencies from 2 Southeastern states in USA. • Consent to participate in the study was obtained for 1118 children and young people, however only 733 children completed the child surveys. The remaining 385 were missed due to non-consent, being unavailable or unwilling to participate, or incomplete survey record.	Y - Cohort 1 vs Cohort 2	• All 13 agencies remained in the study for the full 3-year period. However, most children in each agency were discharged within 1 year of placement, making assessment of the children over the 3-year period not possible. Most children were only at the agency long enough to complete one survey.

Table 3: Primary Research Literature – Measures and results extraction information

#	Paper	Description of measures used	Results relating to staff	Results relating to children and young people
1	Baker, C. N., Brown, S. M., Wilcox, P., Verlenden, J. M., Black, C. L., & Grant, B. E. (2018). The implementation and effect of trauma-informed care within residential youth services in Rural Canada: A mixed methods case study	*Quantitative Study Measures* • Staff completed the Trauma- Informed Care Belief Measure, a 19-item measure of beliefs favorable to TIC, at pretest, posttest, and follow-up. • Items are rated on a 5-point Likert scale and an average score was created. • The Professional Quality of Life Scale (ProQOL) (30-item measure) used to evaluate the positive construct of compassion satisfaction (i.e., the pleasure derived from being able to do one's work well) and the negative constructs of burnout (i.e., feelings of hopelessness and difficulties dealing with work) and secondary traumatic stress (i.e., negative effects such as sleep difficulties and intrusive images experienced when working with clients who have trauma histories). *Qualitative Study* • An interview guide that targeted follow-up questions related to the quantitative findings was designed in consultation with a community partner.	• TIC training led to an improvement in staff attitudes favorable to TIC, but that staff experience of VT increased after RC and RA training. • The division had fully and successfully adopted the essential elements of TIC, confirming the quantitative finding that RC and RA training improved staff attitudes favorable to TIC. • RC and RA training statistically significantly improved staff beliefs favorable to TIC from pretest to posttest • Staff attitudes favorable to TIC statistically significantly changed over time,, p <.001, improving from pretest to posttest and maintaining at follow-up. • Burnout scores moved in an unfavorable direction from pretest to posttest • Traumatic stress scores also moved in an unfavorable direction from pretest to posttest. • Pretest differences by job role were analysed. Findings indicated that direct care staff had significantly less favorable attitudes toward TIC than other trainees at pretest.	• N/A

			• No pretest differences were apparent for compassion satisfaction, burnout or secondary traumatic stress.	
2	Boel-Studt, S., Deichen Hansen, M., & Dowdy-Hazlett, T. (2023). A mixed-methods evaluative study of the life model of residential care for trauma-affected children and youth	• The Child Assessment of Needs and Strengths (CANS) is a multi- purpose assessment used to support service planning and progress monitoring for children ages 5–17. • To measure changes in behavioral health and well-being during treatment, scores from the initial and last assessments from four CANS domains were examined: Life Functioning, Youth Behavioral and Emotional Needs, Youth Risk Behaviors, and Youth Strengths. • Items from the Life Functioning scale assess areas such as children's living situation, medical and physical functioning, and school attendance and are scored on a four-point Likert-type scale. • Youth Behavioral and Emotional Needs scale includes depression, anxiety, and anger control and these are rated using a four-point scale. • The Youth Risk Behaviors subscale includes items that assess risks such as suicide, self-mutilation, and runaway using a four-point scale. • The Life Assessment was created by the agency to measure children's progress in the five core areas of personal development. The Life Assessment consists of five dimensions: Spiritual,	*Interview Results* • House parents described their roles as "parenting". • House parent said: "Family environment is huge. You know everything kind of functions more like a family [here] than anything else that I have seen." • Example of how the program functions as a family was described as: "We try to include the kids in decision making and about what are we going to do Saturday? To make it less institutional and programmatic, it needs to be more like a family." and "You create an atmosphere that's homey. They feel comfortable and they feel a sense of love." • "[Family involvement] . . . depends on the case manager. It depends . . . case by case, every case is different, individual is different." • A common thread across interviews was an emphasis on understanding who the youth are and getting to know them through listening, asking questions, and seeing their behaviors through a lens of their life experiences. • "The relationship part is making sure they know that they are wanted here." • The Life Model was described as providing structure and that a team	*COPES Results* • Youth perceptions of the relationships within the program were significantly lower than staff at each time point. • System Maintenance Dimension for youth were high at time 1, 3, and 4 and moderately high at time 2, youth scores were significantly lower than staff scores at time 2 and 4. • Youth scores on the Personal Growth Dimension were moderate at all four time points and significantly lower than staff scores. • Total scores for youth across all 4 time points indicated a moderately to highly therapeutic environment. *CANS Results* • Comparisons of the initial and final CANS assessments show that youth experienced significant improvements in the Life Functioning, Behavioral and Emotional Needs, and Child Strengths domains (supplied). *Life Assessment Results* • An incremental increase in mean scores across all five domains of the Life Assessment was observed. • Children experienced statistically significant large improvements in spiritual, vocational, and overall life skills development and educational

		Social, Educational, Physical, and Vocational. • The culture of care principles was assessed using the Community-Oriented Programs Environment Scale (COPES). The COPES assessment was administered at four time points and measures three key dimensions of a therapeutic community: Relationship, Personal Growth, and System Maintenance. The Relationship Dimension reflects a combination of active engagement, support, and openness to sharing emotions among youth and staff. • Semi-structured interviews were completed with 12 staff, 11 in person and 1 over the phone. Staff were asked to describe their primary roles and responsibilities in the program, provide examples of the program functions, and describe how the agency promotes a supportive team environment.	approach that is inclusive of the child is used to identify and develop individualized goals. • "I love the environment. Family, you know, even in the office, just friendships and comradery. . ." *COPES Results* • On the Relationship Dimension mean scores from staff surveys were in the high range at time 1 and 3 and moderate-high range at time 2 and 4 reflecting an overall strong emphasis on relationships in the program • Staff scores were significantly higher at each time point than youth's. • System Maintenance Dimension were consistently high among staff at all four-time points. Staff scores were significantly higher than youths at time 2 and 4, but results of the t-tests showed no differences at time 1 and 3 supporting some level of consistency between youth and staff on this dimension. • Personal Growth Dimension, staff surveys were in the moderate-high range at time 1 and 3 and moderate at time 2 and 4, staff scores were significantly higher than youth's scores at all 4 time points on this dimension.	improvements were in the moderate range.
3	Cameron, R. J. S., & Das, R. K. (2019). Empowering Residential Carers	• The Progress and Development checklist measures both a child's response to the positive parenting and	N/A	• Significant improvements in both behavioural and affective measures on the Personal and Interpersonal Development measure of the children

	of Looked after Young People: The Impact of the Emotional Warmth Model of Professional Childcare	post-trauma stress support that carer has provided. • It has a 5-point Likert-type scale with items ranging from 'very poor' to 'hugely improved' and assesses items on each of the eight Parenting Pillars, as well as the three phases of the Cairns model (Reintegrative Emotional Adaptation). • The assessment was completed by the child's key worker and a colleague to increase the reliability of the ratings.		were observed following the implementation of the model. • Significant improvements were also observed between pre- and post-intervention on the Reintegrative Emotional Adaptation measure overall. • Improvements in individual measures of Stabilisation. • Analyses of the individual Parental Pillars of the PID measure showed significant improvement between pre- and post- intervention scores in resilience and self-management in the Southern sites, and close relationships and belongings in the Northern sites.
4	Esaki, N., Hopson, L. M., & Middleton, J. S. (2014). Sanctuary Model implementation from the Perspective of Indirect Care Staff	• The survey combined two measures: the first, measured the extent to which staff perceived demonstration of the Sanctuary Model Seven Commitments at the agency (nonviolence, emotional intelligence, democracy, open communication, social responsibility, commitment to social learning, and growth and change). • The survey also included the Organizational Change Recipients' Belief Scale (OCRBS) a reliable and valid measure of the following beliefs related to readiness for organizational change: Discrepancy, appropriateness, efficacy, principal support and valence. • Participants were asked to report on the extent to which different stakeholder	• Scores on OCRBS represented some openness, but not strong investment in the change. • Mean scores were highest for principal support, which is perceived support from the leadership, supervisors, and peers in the organization to implement the change, and efficacy, which is the perceived capacity to implement the change initiative at the individual and agency level. • Perceptions of agency success in implementing the model showed means, ranging from 2.94 to 3.53 out of 5, suggesting moderate success in demonstrating each commitment. • Nonviolence received the highest score. • Democracy received the lowest.	N/A

		groups demonstrated Sanctuary Model behavior. • Perceived commitment to Sanctuary Model implementation was measured with a question asking to what extent participants agreed with the following statement: "There is a commitment to the Sanctuary Model." Responses could range from 1 = not at all to 5 = a very great extent.	• The employee group that was rated most strongly for demonstrating Sanctuary Model behavior comprised those supervised by the respondent. • Supervisors of respondents received the next highest score. • The lowest scores were attributed to the leadership team. • 18.9% of the respondents indicated that demonstration of Sanctuary Model behavior varied by person within the leadership team.	
5	Farmer, E. M., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017a). Would we know it if we saw it? Assessing quality of care in group homes for youth	*Youth Outcomes* • Strengths and Difficulties Questionnaire (SDQ) is a 25-item measure that assesses level of psychological symptoms across five domains (emotional, conduct, hyperactivity-inattention, peer relationships, and prosocial). • SDQ total problem scores were calculated based on data from inter-views with caregivers (preadmission and post discharge) and agency staff (while the youth resided in the focal group home). *Agency Director Interviews* • Interviews with a lead agency administrator from each participating agency included an overview of the model, questions about staffing, and a discussion of broader system issues, opportunities, and challenges. *Staff Interviews*	• Behavioural objectives - TFM homes were significantly more likely to be using a system that was more positively focused (vs. a more punitive system; TFM = 4.6 vs. non-TFM = 2.7; p < .001). • Staff who were rated as using more appropriate humor in their interactions with youth showed better outcomes by 8 months post discharge (p < .05). • Training was related to outcomes, TMF and non-TMF differed in the number of training hours provided to new staff as well as whether the agency required in-service training on an annual basis.	• Youth expressed very positive views of their experiences in their current group home. More than 80% to 85% in both TFM and non-TFM homes indicated that they thought their group home was a "good place to live if kids can't live at home." • When asked about whether the staff in their group home were fair, cared about them, and helped them learn things, the majority of youth endorsed "certainly true," and results did not differ by treatment model. • Observational data suggested that homes with more positively focused motivational systems had outcomes that were significantly better by the time of discharge than those with more punitively focused systems. • Descriptive statistics suggested that youth perceptions of quality and

		• Staff provided information on overall features of the home as well as specific information about participating youth within the home. Staff also provided information on their relationships with their supervisors and their relationship with youth. This latter construct was tapped via the Trusting Relationship Questionnaire (TRQ) an 11-item measure that assesses the level of positive affect between the staff member and youth. *Youth Interviews* • Data on their perception of the program's quality and their own personal safety and satisfaction. • 3-point scale (not true, sometimes true, certainly true) to rate the extent that staff care about them, staff are fair, staff help them learn things, and the program stays the same no matter who's on duty. *Group Home Observations* • Observations were included to gather information on dimensions of quality where there were concerns about administrators', staff members', and youth's awareness or honesty to report. • Collected data on 39 focal domains which were subsumed under four general categories (youth skills, staff skills, structure and systems, and home environment). • Each item was coded to capture the observer's satisfaction with the extent		satisfaction did not differ systematically by treatment model. • Youth who saw their group home staff as fairer and helping them learn things were more likely to have positive outcomes by the time they were discharged. • Differences between TFM and non-TFM programs included "access to age/interest-appropriate items" and "youth and staff shared meals together." • Homes with more age/interest-appropriate items (e.g., equipment, toys, games, books) showed better youth outcomes by the time of discharge than homes with less adequate items in this arena, even after considering the home's treatment model and severity and demographics of the youth.

		to which the item was present in the home (from 1 = extremely dissatisfied to 5 = extremely satisfied).		
6	Farmer, E. M., Seifert, H., Wagner, H. R., Burns, B. J., & Murray, M. (2017b). Does model matter? Examining change across time for youth in group homes	• Data collected across a 24-month period, for each participating home. Every four months, interviews were conducted with staff members and youth. *Youth Outcomes* • Strengths and Difficulties Questionnaire (SDQ) is a 25-item measure that assesses level of psychological symptoms across five domains (emotional, conduct, hyperactivity-inattention, peer relationships, and prosocial). • SDQ total problem scores were calculated based on data from interviews with caregivers (preadmission and post discharge) and agency staff (while the youth resided in the focal group home). *Interviews* • Interviews were conducted with a lead staff member in each home. These interviews asked questions about the home (e.g., staffing, programming, peer relationships) as well as individual questions about each youth (e.g., behavior, relationships, school performance, etc.). *Post-Discharge Period* • Data from the post-discharge period were collected twice: at approximately	N/A	• Youths' average SDQ scores improved from approximately 19 (immediately prior to admission) to 11 (at the 20-month wave). • Both TFM and non-TFM homes show a similarly improved level of SDQ scores by the 4-month data and relative stability through 12 months. • TFM homes show marked improvements between 12 and 16 months, whereas non-TFM youth show slight worsening of mean scores by 16 months. • In the last in-home assessment, youth in TFM programs show slightly better SDQ mean scores than youth in non-TFM homes. This difference is not significant. • By post-discharge interview at 8 months, youth who resided in TFM homes showed significantly better average SDQ scores than youth served in non-TFM. • Model of treatment was not significant for predicting outcomes while the youth was residing in the home. Predicting improvement by the time of the final post- discharge assessment was related to better SDQ scores at both pre-admission and the last in-home

		4 months and 8 months after discharge from the home.		assessment as well as placement in a TFM home.
7	Galvin, E., Morris, H., Mousa, A., O'Donnell, R., Halfpenny, N., & Skouteris, H. (2021). Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges	• Open-ended and non-leading questions formulated an interview guide to identify and explore the perceived enablers, successes, barriers, and challenges of implementation.	• Enablers of implementing the Sanctuary Model in residential out-of-home care: shared trauma-informed knowledge and understanding, leadership and champions, structures and creativity and flexibility. • Barriers of implementing the Sanctuary Model in residential out-of-home care: infidelity of the model, lack of practice-based and refresher training, and poor resources. • Organisational successes of implementing the Sanctuary Model in residential out-of-home care: According to the study participants, The Sanctuary Model has been most successfully implemented throughout MacKillop Family Services by means of: the Sanctuary Commitments; the S.E.L.F Framework; and reflective practice.	• N/A
8	Galvin, E., O'Donnell, R., Avery, J., Morris, H., Mousa, A., Halfpenny, N., Miller, R., & Skouteris, H. (2022). Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed	• Open-ended and non-leading questions formulated an interview guide to identify and explore the perceived enablers, successes, barriers and challenges of implementation.	• Enablers were social support systems and resources, shared trauma-informed knowledge and understanding, and leadership and champions. • The Sanctuary Model enabled a shared language and understanding of trauma-informed care, providing them with "the framework for knowing what to do and how to intervene". • The SELF framework provided the tools and concepts to have open and honest discussions with young people and	N/A

	Approach: The Sanctuary Model		"support them, to help them regulate, and support themselves emotionally". • Participants described Reflective Practice as providing a "safe environment", where they feel "supported" in "having honest conversations". • Barriers Influencing Implementation include informal practice, lack of practice-based training, poor introduction to young people, and resources. • All homes expressed that the model was implemented "informally". • Flag Meetings and Community Meetings occur in the homes with young people; however, staff do not use the correct "language", "templates" or "processes". • Staff struggle to find the balance of implementing the tools in a "child-friendly", "natural and organic" manner and using the "appropriate language". • Lack of practice-based training. • Lack of "formal" and "structured" introductions for young people and their families. • Time constraints and limited access to information and resources as major barriers. • Poor access to information and resources was noted as a significant barrier to implementation of the Sanctuary Model.	

			• Psychoeducation is too "clinical" and "educational" and staff admitted that they typically "leave it to the Therapeutic Practitioners". • The implementation of Community Meetings with young people was described as "difficult". • Red Flag Meetings are "misused", "non-productive" or a "token gesture". • Young People's Behaviour and Engagement within the home was a cumulative challenge of implementing The Sanctuary Model.	
9	Huefner, J. C., Ringle, J. L., Thompson, R. W., & Wilson, F. A. (2018). Economic evaluation of residential length of stay and long-term outcomes	*24-month Follow-up Surveys* • 35-item follow-up survey was administered at 24 months after case closure, focusing on safety, permanency, and well-being. • To complete the interview, the interviewee could either be the youth who received treatment or someone with direct knowledge of the youth. *Family Home Return on Investment* • Return on Investment Tool (ROI tool) was used to calculate return on investment of the out-of-home care program, it consists of six questions pertaining to size and cost of the programs that are being compared.	N/A	• Youth in the >6-month group were significantly more likely to be employed, to have at least a high school diploma, and were less likely to have been arrested for a crime. • The net governmental benefit of completing the program was just under 45 million, while the net societal benefit was more than $450 million. *SDQ Questionnaire Results* • Young people >6 months were 2.7 times more likely than the ≤6 months group to be in a treatment or locked facility at the time of admission. • Youth in the >6 months group were 15.7 times more likely to be program completers than youth in the ≤6 months group. • 86.9% of the >6-month group were program completers, whereas 42.6% of

				the ≤6 months group were program completers. • 20.0% of non-completers in the >6-month group ran from the program, while 29.6% of the non-completers in the ≤6 months group ran from the program.
10	Hurley, K. D., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care	*Youth Behavioural Functioning* • Direct-care staff provided reports of each youth's externalizing and internalizing behavior via the CBCL - a 112-item assessment where each item is measured on a 3-point response scale. *Therapeutic Alliance* • The Therapeutic Alliance Quality Scale (TAQS) is a five-item youth-rated scale used to assess the working relationship between a clinician and a youth. Items are rated on a 5-point response scale (1 = not at all, 5 = totally) and averaged to yield a total score. Higher total scores are associated with higher quality of therapeutic alliance. *Token Economy Adherence* • Token economy adherence was derived from a review of point cards that staff and youth use to record and track youth–staff interactions. *Overall Implementation Quality* • Each item was rated on a 4-point response scale (0 = strongly disagree, 1 = disagree, 2 = agree, 3 = strongly agree) and the items were combined and averaged to form a total score.	N/A	• After 1 month of residential care, CBCL Total Problems scores ranged from 31 to 76. • Over one third of youth (n = 42) were rated as exhibiting clinical or borderline behavior problems. • At 6 months into care, CBCL Total Problems scores ranged from 31 to 75. • Over the first 6 months of care youth ratings of therapeutic alliance ranged from 1.20 to 4.9. • At 2 months into care, 25.23% of youth rated the alliance between themselves and their clinician as low, 56.76% as moderate, and 18.01% as high. • Youth ratings of implementation fidelity ranged from 1.82 to 4.00. • Token economy adherence ranged from 65.82% positive interactions to 99.60% positive interactions with a mean of 90.59% (SD = 5.28). • Therapeutic alliance and token economy fidelity were statistically significant predictors of 6-month CBCL scores. Both variables were negatively associated with CBCL scores whereas youth that developed higher quality

				alliance with their family-teachers, and youth that experienced larger percentages of positive interactions, had significantly lower CBCL scores at 6 months.
11	Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model	• Agency personnel completed an anonymous survey. • Each year, agency quality assurance staff counted the number of incident reports filed in the previous year, indicating the monthly frequencies for each of five incident types: verbal threats or physical aggression toward staff, verbal threats or physical aggression toward peers, an act or threat of self-harm, property destruction, and attempted or completed runaways. *Behavioural Incident Data* • The number of incidents for each of the five incident types, aggression toward staff, aggression toward peers, self-harm, property destruction, and runaways, was recorded for each month. *Baseline Staff Assessment* • Organisational Social Context (OSC) survey was used to assess dimensions of culture (proficiency, resistance, rigidity) and climate (stress, engagement, functionality) at the agency level. *Implementation Progress*	• LIP ratings averaged across the seven dimensions indicated that six agencies had made "consistent" or "exemplary" progress and four agencies made "sporadic" progress. • There was no simple relationship between OSC profile and LIP ratings. • The three agencies with positive profiles, ranging from 2.8 to 3.0, showed only sporadic progress, while the two in the negative range showed consistent progress. • The six agencies with average profiles were distributed evenly across the range of LIP ratings.	*Start of care* • Having a parent organization and having a positive OSC profile were associated with substantially lower rates of aggression toward peers and property destruction. *Baseline* • There was an increasing trend for aggression toward peers, aggression toward staff, and property destruction during baseline for cohort 1. In cohort 2, an increasing trend was evident for property destruction, and other incident types showed no change. • More negative OSC profiles were associated with a steeper baseline increase in aggression toward peers. • OSC profile was unrelated to the baseline trends for other incident types. *Implementation Period* • During CARE implementation, significant decreases in incident rates of 4 to 8 % per month were observed for all outcomes in cohort 1. • Cohort 2 trends did not differ from cohort 1 for aggression toward staff, property destruction, and runaway, but they did differ for aggression toward peers and self-harm.

		• Local implementation progress (LIP) reflects agency-level efforts to use the CARE principles to critically review and modify their own practices with regard to childcare, programming, and staff management. LIP ratings using a five-point scale: 1 = "no progress," 2 = "planning," 3 = "sporadic progress," 4 = "consistent progress," and 5 = "fully achieved/exemplary."		• OSC profile moderated the implementation trend for runaway incidents with more negative OSC profile associated with greater improvement during the implementation period. • For aggression toward staff, property destruction, and runaway, there was a declining trend during implementation, and it was significantly different from the baseline trend. This same pattern held for aggression toward peers and self-harm but was limited to cohort 1.
12	Izzo, C. V., Smith, E. G., Sellers, D. E., Holden, M. J., & Nunno, M. A. (2020). Improving relationship quality in group care settings: The impact of implementing the CARE model	*Child Surveys* • Child surveys occurred annually from the beginning of the study until the end of Year 3 implementation. • For each child, two direct-care workers (one from each shift) who could accurately complete a rating form on child social-emotional adjustment. • Two measures were used to assess children's perceptions about the quality of their relationships with direct care staff at their agency - The Youth Perceptions of Relationship Quality (YPRQ); The Inventory of Parent and Peer Attachment (IPPA). The Strengths and Difficulties Questionnaire (SDQ) • Used to measure social-emotional adjustment, the SDQ is a 3-point scale (1 = not true, 2 = somewhat true, 3 = certainly true) and includes five	N/A - No Staff related results included. Some info included in Discussion.	• There was a statistically significant interaction with number of previous placements (p=.034) • CARE effect was stronger among children with 2 or more previous placements compared to those with 1 or fewer placements and those with an unknown number of previous placements. • YPRQ scores increased from the Pre-CARE period to the CARE implementation period. • The CARE effects, Years 1 and 2 were not statistically significant, while Year 3 was statistically significant. • The perceived quality of child-adult relationships within agencies increased significantly after CARE implementation began, with improvements observed at the end of each year of CARE implementation.

		domains of adjustment including emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial skills *Staff Surveys* Staff surveys (Organizational Social Context (OSC) about organizational culture and climate were administered anonymously to all agency personnel 2–4 weeks prior to the agency's first training session.		

Table 4: Review and Discussion Literature – general description extraction information

#	Author	Year	Title	Location	Aim	Which TRC model/s discussed
1	Bailey et al.	2019	Systematic review of organisation-wide, trauma-informed care models in OOHC settings	Aus	To investigate the current empirical evidence for organisation-wide, trauma-informed therapeutic care models in OOHC.	The Sanctuary Model Attachment Regulation and Competency framework (ARC) Children and Residential Experience model (CARE)
2	Holder, M. J & Sellers, D.	2019	An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care	USA	To describe the CARE Model, its implementation, and evidence for its effectiveness.	Child and Residential Experience Model (CARE)
3	James et al.	2013	Effectiveness and implementation of evidence-based practices in residential care settings	USA	To address three questions: (1) Which EBPs have been tested with children and youth within the context of RCS? (2) What is the evidence for their effectiveness within such settings? (3) What implementation issues arise when transporting EBPs into RCS?	-
4	James, S.	2017	Implementing Evidence-Based Practice in Residential Care: How Far Have We Come?	USA	To answer two questions based on the available conceptual and empirical literature: (a) What is the current status on milieu-based program models that were developed for residential care settings with a therapeutic focus? (b) What is known about the implementation of client- or disorder specific evidence-based treatments into residential care settings?	-The Sanctuary Model Child and Residential Experience Model (CARE) Teaching Family Model
5	Lindstedt et al.	2017	Realist review of programs, policies, and interventions to enhance the social, emotional, and spiritual well-being of Aboriginal and Torres Strait Islander young people living in OOHC	Aus	To identify programs and policies to improve the mental health and wellbeing of Aboriginal and Torres Strait Islander young people in OOHC and to analyse the strengths of the current system, as well was what has been inadequately addressed based on the literature.	-

APPENDIX C: METHODOLOGICAL APPROACH TO THE AUSTRALIAN JURISDICTIONAL SCAN

The initial step in the scan approach was to search for publicly available information relating to the use and implementation of TRC by Australian child protection jurisdictions. This began by searching the online footprints for each jurisdiction, including examination of their dedicated websites for policy and process documents, practice guides, graphical service representations, and intext information relating to their TRC. Additional internet searches were also conducted for related grey literature using the search terms "therapeutic residential care," "residential care," child protection," and each jurisdiction name. These searches turned out information primarily relating to TRC services provided by community service organisations (CSOs) within each jurisdiction.

To further inform this scan, and to validate the collected public information, the project team sought to consult with the appropriate child protection leaders in each jurisdiction. The commissioning project team from the Department provided input to identify the appropriate contacts for each jurisdiction, and a senior member of the commissioning team sent an initial email to the identified individuals outlining the purpose of the project and request for cooperation and consult with ACCP project team. In several cases, the identified contact informed the ACCP team they were not the most appropriate person to liaise with and snowballing techniques were implemented to identify suitable alternatives. Once agreement to participate in the consultation process was confirmed, interviews were arranged via Microsoft Teams. Prior to the interview, further detail was provided via email regarding the scope of information being sought in the consultation, and it was confirmed that information within final summary report of the scan outcomes would be made publicly available at the conclusion of the project. Questions covered within the jurisdictional interviews included:

1. Is a formal model of TRC currently implemented? If so, what model?
2. If a formal model of TRC is not implemented, are there guiding principles or overarching framework of care expectations in place relative to TRC care options?
3. Who provides TRC within the jurisdiction?
4. How is TRC operationalized and implemented? Are there implementation guidelines available, or is there variability in practice depending on service provider and target groups?
5. Is there current reform occurring, or plans for this to occur soon?
6. What cohort of children and young people are placed in TRC? Are there specific eligibility considerations?
7. Are there specific TRC care options or models in place for Aboriginal and Torres Strait Islander children?
8. Are there specific TRC care options or models in place for children and young people who have displayed HSB?
9. Has formal evaluation of the TRC model/framework occurred?

The level of response from the jurisdictions to the request for consultation and interview to support the project was variable; it should be noted that although no jurisdiction declined, some did not respond to requests. See table 1 below for participation details. Initial responses to engage were received from two jurisdictions regarding delegation of the consultation to more appropriate members of staff. The ACCP project lead followed up with the nominated individuals on two occasions to secure an interview time, however no further response was received from either jurisdiction. A late request for consultation and

interview was also made to Barnardos New Zealand, based on the understanding they provide a specialised TRC designed to support children and young people who have displayed HSB.

Consultation and interview requests to support the project were also put to Mackillop Family Services and Life Without Barriers, as national providers of two prominent TRC models across jurisdictions. The primary purpose of these interviews was to gain information on the operationalisation of the models of TRC adopted by each agency, the Sanctuary model and the CARE model.

DEVELOPMENT OF COMPARISON GRID

Initial comparison categories were generated within the project team, informed by the team's practice knowledge, and understanding of TRC models. The comparison table was altered progressively as information was collected or not found to reflect important elements of the jurisdictional application and likewise the models used.

A complete overview of the jurisdictional scan comparison grid can be found in Appendix E below.

VALIDATION CHECKS

Following collation of the publicly available and consultation information, each jurisdiction was provided with their relevant summary and comparison grid information to review for accuracy. Responses are yet to be received from two jurisdictions at the time of writing. Of the 11 states, territories and agencies contacted, 9 have reviewed, adjusted (as necessary) and returned these at the time of the final report.

Table 1: Jurisdictional and Agency Participation

Jurisdiction	Participated in Interview	Validated Information
Australian Capital Territory	No	Yes
New South Wales	Yes	Yes
Northern Territory	No	Yes
Queensland	No	No
South Australia	No	Yes
Tasmania	No	Yes
Victoria	Yes	No
Western Australia	Yes	Yes
Barnardos New Zealand	Yes	Yes
Life Without Barriers	Yes	Yes
Mackillop Family Services	Yes	Yes

APPENDIX D: COMPARISON EXTRACTION TABLES

Table 1: Out of Home Care landscape and TRC delivery detail

State	Out of Home Care		TRC delivery and parameters			
	Plans for reform/review	Description of residential care within OHC	Existence of a TRC	Client Population of TRC	Bed/Staff Ratios for TRC	Time limits for TRC care arrangements
Australian Capital Territory	ACT underwent major reform from 2015-2020 and are currently in a transition phase to a new model of care. Mackillop took over from Barnardos in March 2023.	Residential care is considered a more intensive form of care arrangement that is considered where family-based care arrangements are not suitable. There is reference to residential care and intensive residential care.	Yes	Children and young people from 12 years and up to 18 years of age appropriately assessed for residential care living arrangements. TRC placement may also occur for children under 12 years of age by exception. Family based care is the first priority for all children and young people in out of home care.	Unknown	Unknown
New South Wales	Yes. Entering the preliminary stages of reform after an evaluation of the state's various permanency programs indicated poorer than expected outcomes. (This did not specifically evaluation	Yes. There is 'residential care,' and 'intensive residential care'. Intensive residential care appears most like TRC. There is an 'interim care model' that sits below intensive	Yes	Generally, children and young people aged 12+ with high/ complex needs. It is considered a last resort care arrangement. Children aged <12 may be considered if they	2 and 4 bed options. 2 bed option has 1:1 kids staffing 4 bed option as 1:2 kids staffing during the day and 1:4	General idea of a 2-year time limit, ideally aiming to achieve exit from care or a step down into other care due to reduced care needs. In reality, the 2-year timeline is not fixed, and children can

	the current TRC model however).	residential care. This is intended as a 2 week stay model, though many children remain here for up to 6 months. Sibling groups are often placed in this model.		have very complex needs or are part of a sibling group. Anecdotally, more children are coming into TRC.	kids overnight. 2 bed model was introduced in 2022 for children with higher needs. Sometimes only 1 child will be placed in a home if they have extremely high need. Case management ratio 1:6 kids Therapeutic specialist 1:12 kids	remain longer if required (and often do).
Northern Territory	Review and reform occurred between 2019 -2021, in partnership with Deloitte. Road map indicates full implementation of the new model was due to be finalised in 2021. Grey literature also	Possibly. The reform document indicates two levels of care 'above' foster care: - Therapeutic home-based care - Intensive therapeutic residential care	Yes	Unknown	Unknown	Noted to be time limited. Strong focus on returning children and young people to family-based care when their level of need allows.

	suggests the Australian Childhood Foundation was employed to develop a model of TRC and implement this across NT.					
Queensland	Unknown	Offer residential care and Therapeutic residential care (similar split to the group homes vs Tier homes in WA). It is unclear if both care provisions meet the definition of therapeutic care.	Yes	TRC is offered for ages 12-15 years. Children younger than 12 may be considered dependent on comprehensive assessment of needs, or if they are part of a sibling group.	Unknown	TRC duration is outlined to be up to 18 months. It is unclear if this is rigidly adhered to, as most jurisdictions are flexible based on child need.
South Australia	Government provided TRC underwent change of procured provider in 2021. Sanctuary was rolled out state-wide in all govt residential homes in 2021.	TRC is distinguished from family-based care options. All forms of residential care are seen to be therapeutic.	Yes	Available to any child or young person who has exhausted family-based care options.	Small group care of up to 4 children per residential home.	Unknown
Tasmania	Recent review has occurred with the current model having been newly rolled out in 2023.	Two key types of accommodation provided for children and young people in Out of Home Care (OOHC), - Family Based Care - Salaried Care.	Yes	Children with challenging behaviours and/or high support needs and/or where a family-based care arrangement is not	Small group care of 3-4 young people.	Not specifically. Geared toward preparing the young person to being ready to transition to

		DECYP funds two services under Salaried Care services: • Special Care Packages (SCPs), and • Transitional Placement Services (previously known as TRC)		suitable (e.g., older adolescents).		independent or lower-level care.
Victoria	No.	Yes There is general residential care and then the 'KEYS' model. The KEYS model sits within TRC (6 homes) and provides an 18-month intensive option that includes mental health services built in. This option is for extremely high needs and is designed to stabilise the child or young person so they can be stepped down to a less intensive care option.	Yes	TRC Generally children and young people aged 12+ with high/complex needs. It is considered a last resort care arrangement. KEYS Young people referred to KEYS are currently in residential care or are likely to move into it. They may have or are currently experiencing one or more of the following difficulties: - Complex mental health difficulties such as self-harming behaviours - Significant neglect,	4 bed base model. There is some variation to this across providers.	Duration can be varied. Ideally, young people are supported to move into less intensive care options as soon as their level of need permits this.

				physical and sexual abuse, witnessed and/or subjected to family violence, and exposure to family violence - Show signs of reactive sexual behaviours - Have criminal offending behaviours, including those with youth justice involvement - Substance misuse - High vulnerability to sexual exploitation and abuse.		
Western Australia	Western Australian is currently amid reform of their residential care services and are reviewing their provided model of therapeutic residential care.	Offer residential care and therapeutic residential care. Secure care is also offered as the most intensive care option, with capacity for 6 children in a locked down facility.	Yes	TRC is offered to children with extreme care needs and behaviours. Within metropolitan locations children must be aged between 10-17. Age restrictions are not as specific in regional areas, where it is cited that children with a "range of ages and abilities" may be placed.	4-bed model. These numbers may be slightly exceeded to cater for large sibling groups on a case-by-case basis.	TRC service are time limited, ideally for two years or less.
New Zealand	Not to the HSB program. The bed	There are a range of 'intensive care options'. Most of these fall	Yes	Barnardos HSB service offers service to 12–18-	The HSB-specific house has 8 beds	No. Young people can remain in the

	capacity was reduced recently from 12 to 8 as it was recognised that a 12-bed capacity stretched staff capacities to fully meet each individual's developmental and therapeutic needs.	under the Youth Services Strategy. Those most closely matched to TRC include specialist group homes for conduct disorder and HSB provided by NGOs, Programs including MST, Functional Family Therapy, and Te Poutama Arahi Rangatahi (TPAR). Also includes 4 'CYF family Home Plus Pilot Services, 4 Supervised Group Homes, and 4 care and protection secure residences.		year-olds who have had youth justice involvement relating to their HSB.	with a high staff ratio that is flexible depending on client need. The direct care staff are supported by a clinical staff team.	Barnardos HSB program for as long as is required. This may span from several months to years.

Table 2: Service providers and articulated approaches to TRC

State	TRC Provider and models			Guiding frameworks, processes, documents		
	Providers of TRC (Gov, CSOs, ACCOs)	Presence of program requirements (Gov for CSOs/ ACCOs)	Current TRC model/framework	Presence of guiding principles or framework	Articulated implementation procedures	Supporting implementation documentation
Australian Capital Territory	All TRC provided externally by CSO. Previously Barnardos, now Mackillop.	N/A	Sanctuary	Mackillop also integrate other programs with the Sanctuary Model to meet the needs of the children and young people more fully. These include 1. TCI 2. Power to kids 3. Cultural program	The implementation of the model and agreed accommodation/housing arrangements is detailed in the contract executed between the Territory and MacKillop Family Services Limited. There is only one provider for TRC and no variability in practice according to target groups with the exception of residential and intensive residential TRC.	Fidelity checklists and self-monitoring guidance.
New South Wales	Govt provides secure care. CSOs provide all other TRC. No ACCO providers currently though are	Yes.	Intensive Therapeutic Care The current model was developed between 2013-2016 in partnership with CETC (ACF/Southern	Yes. ITC is based upon 10 'Essential elements', developed by CETC. The 10 ITC 'elements' are 1. Therapeutic	The state had a 3- or 4-year contract with CETC that included implementation support. Contract has now ceased.	CETC have accessible practice guides for each essential element Case practice manual

	looking to change this.		Cross Uni). It was influenced by the Vic model and based on the Verso consulting literature review.	Specialist 2. Trained Staff and Consistent rostering 3. Engagement and Participation of the Young People 4. Client Mix 5. Care Team Meetings 6. Reflective Practice 7. Organisational Congruence and Commitment 8. Physical Environment 9. Transition planning, exit planning and post exit support 10. Governance and Quality Therapeutic Practice	CoPs were used to aid implementation. These were fantastic. Unsure if these are still running (self-motivated by staff).	
Northern Territory	Grey literature suggests a mix of government and CSO provision. Strong focus on engaging ACCOs as	Unknown	Grey literature indicates roll out of the "Intensive Therapeutic Residential Care Model" following OOHC reform	Unknown	Not that is publicly available.	Not that is publicly available

	partners to improve service planning, delivery and outcomes for children and young people in OOHC. Strong focus on place-based services where possible to avoid enable ongoing connection to family, community, and culture.		between 2019-2021. It seems likely that this model is like the Intensive Therapeutic Care Model used in NSW, as both were developed in partnership with ACF.			
Queensland	Grey literature suggests a mix CSO provision, with supports from government.	It appears that CSOs are either required to adhere to the Hope and Healing framework, or alternative model that is similarly trauma informed and needs led (meeting the Hope and Healing framework).	The Hope and Healing framework informs the wider child protection system in QLD, of which residential care is an element. It is intended to be foundational and flexible. It is unclear if TRC adheres to an additional model of TRC.	Yes. Hope and Healing has the following principles; - Care is individualised, taking account of age, stages of development and cognitive functioning and abilities - Care is relationship-based - Care promotes	Not that is publicly available. There is a framework document developed by Peakcare (who collaborated with the state govt to develop the framework) that provides an overview of the guiding principles, phases of care, and domains of care. The framework is intended to be flexibly applied across a range of child protection services and agencies; therefore, implementation	Not that is publicly available

			Individual CSOs implement a range of alternative models (inc CARE and Sanctuary).	engagement in decision making and life choices - Care occurs within the context of family - Care supports links with community - Care is culturally safe and culturally proficient, supporting Aboriginal and Torres Strait Islander cultural identity and culturally and linguistically diverse identities - Care understands and responds to behaviour as communication - Care provides unconditional commitment (persistent allegiance) - Care is collaborative and integrated across all	procedures carry on the organisational level.	

				services involved with each child and young person.		
South Australia	Mix of government and CSO provision	Yes. Funded CSO providers are required to implement a model of care that is consistent with a trauma-informed therapeutic framework. No specific models are prescribed, however.	Sanctuary (government) CSO providers implement a range of different models of care.	Yes. TRC adheres to MacKillops Sanctuary model, which provides a whole-of-agency framework for practice.	Not available publicly via state govt website. However, the Mackillop Institute provides all training to the government care homes suggesting implementation procedures may mirror that of the Mackillop Institute.	Assuming fidelity checklists and self-monitoring guidance as provided by MacKillop.
Tasmania	DECYP committed to outsourcing all forms of OOHC to the non-government sector in 2023, following recommendations from the Commission of Inquiry into the Tasmanian Government's	Yes. Funded CSO providers are required to implement a model of care that is consistent with a trauma informed	Tasmanian OOHC staff are trained practitioners in The Trust-Based Relational Intervention™ (TBRI; Purvis et al., 2013).	No	Varies per organisation	Varies per organisation

	Responses to Child Sexual Abuse in Institutional Settings (2023). Australian Childhood Foundation provides therapeutic interventions to the children and young people and trains/supports staff.	therapeutic framework. No specific models are prescribed, however.				
Victoria	Most residential care is contracted out to CSOs. Govt provides secure care (2 homes). Includes ACCOs. Residential care is considered the last care option for children with high needs.	Yes.	State does not prescribe a specific TRC model. CSOs are required to have a specific model of TRC and abide by Govt outlined program requirements. A variety of programs are currently being used. No plan to move away from this format.	Yes. 9 essential program elements identified within the Verso evaluation are suggested to underpin successful models of TRC - though each may differ on an operational level. 9 Elements include: 1. Therapeutic specialist 2. Trained staff and consistent	No	Not specific to TRC models as these are agency determined. Govt provide detailed case practice documents and documents outlining other relevant legislative, policy, program, and procedures.

				monitoring 3. Engagement and participation of the children and young people 4. Client mix 5. Care team meetings 6. Reflective practice 7. Organisational congruence and commitment 8. Physical environment 9. Exit planning and post exit support		
Western Australia	The Department of Child Protection and Family Support ('Department') provide TRC across metropolitan locations and regional locations. CSO organisations also provide a significant amount of TRC, including ACCOs.	CSO providers are required to demonstrate adoption and adherence to a trauma-informed care framework that is theoretically and practically sound.	The Sanctuary model is adopted across the Department and implemented within all TRC placements in conjunction with the Signs of Safety case practice model.	Yes. TRC adheres to the principles of the Sanctuary model, which provides a whole of agency framework for practice.	Comprehensive case practice model is available online, though this does not operationalise TRC. Manuals of care are not publicly available	Unknown
New Zealand	There is a mix of government and CSO	N/A	Barnardos implement the	Not that we have specifically been	Not provided	Not provided

	providers of TRC. Barnardos is a significant provider of TRC. Barnardos provides the only HSB specific residential service in Australasia. This service is Te Poutama Arahi Rangatahi.		"Integrated Therapeutic Framework" within the HSB program.	provided, however, the representative of Barnardos emphasised the model is heavily focussed upon tailoring wrap-around services to meet the needs of the young person. There is a strong focus on restorative practice, cultural safety and understanding, maintaining cultural and family connection, and engaging in therapeutic services to reduce trauma symptoms.		

Table 3: Priority population service provision and presence of evaluative data

State	Priority populations		Evidence
	Focus on Aboriginal and Torres Strait Islander children	Focus on HSB	Evaluations of the TRC model
Australian Capital Territory	There are practice and care requirements applying to Aboriginal and Torres Strait Islander children. Mackillop integrate cultural considerations into their care practice, layering this with the Sanctuary model.	Mackillop layer the Power to Kids program with the Sanctuary model, providing focus on HSB. There is capacity for bespoke 1:1 'intensive' TRC placements for children and young people who have displayed HSB.	Not as yet. The Territory is progressing through a Performance Management Framework with evaluation and reporting occurring twice during April-October 2024.
New South Wales	No specific model or focus on Aboriginal Australians. There is required cultural planning embedded within case practice. There are also staffing requirements to support cultural practice standards (i.e. cultural professional development).	No specific model or focus for children who have displayed HSB. It is a service requirement within ITC that requires a 1:1 placement. The state does encourage providers to engage NewStreet services and demystify HSB Providers are also encouraged to build practice and service responses around the child.	Not specific to the model.
Northern Territory	Culture is described as central to the model, with cultural placement being a primary focus.	No indication of a specific focus on HSB	No
Queensland	Hope and Healing framework contains a principle that requires care to be safe and culturally proficient, supportive of Aboriginal and Torres	Not specifically.	No.

	Strait Islander cultural identity and culturally and linguistically diverse identities. QLD also has separate residential care homes for Aboriginal children and young people located within Aboriginal Communities, known as Safe Houses.		
South Australia	Not a specific focus, though provided care respects and responds to the unique cultural needs of Aboriginal Australians. Aboriginal Sanctuary Practitioner is also central to the DCP Sanctuary team, with this role providing specific support to Aboriginal children and young people residing in DCP residential care. Principal Aboriginal Consultants are responsible for leading operational and strategic interventions for Aboriginal children, young people, and their families, and contributing to the development of Aboriginal culturally sensitive policies, programs, and practices.	Staff are provided professional development opportunities, practice guidelines and other resources to support staff to effectively identify HSB and to appropriately respond. - Power to kids program - Cert IV in Child, Youth and Family intervention modules. - Practice manual and papers	No - remains in the transition/early implementation phase.
Tasmania	DECYP works closely with the Tasmanian Aboriginal Centre and other Aboriginal Community Controlled Organisations to support the needs of Aboriginal families and communities in Tasmania. For Aboriginal and Torres Strait Islander children and young people, the Care Plan incorporates support for the young person to maintain connection to culture, extended family and community, which may include a therapeutic plan	No formal TRC models specific for children and young people who have displayed HSB were identified. However, a partnership of community-based organisations including the Sexual Assault Support Service (SASS), Laurel House Sexual Assault Support Service, and Mission Australia offers the Prevention, Assessment, Support and Treatment (PAST) program to Tasmanian	No

	that involves referral out to relevant services or upskilling of care staff.	children aged 17 and younger who are displaying harmful sexual behaviours. The PAST program operates statewide through funding from the Tasmanian government and is managed by DECYP.	
Victoria	Vic holds a strong cultural focus that is woven across its various care arrangements CSOs are expected to adhere to govt policies relating to improving the lives of Aboriginal children and young people in care. These include, the Aboriginal and Torres Strait Islander cultural safety framework and Wungurilwil Gapgapduir Aboriginal Children and Families Agreement, and guidelines supporting self-determination. The state does fund home based care options for Aboriginal children and young people that use the Healing Matters model.	KEYS model provides specific care for children and young people demonstrating "reactive sexual behaviours" DFFH also developed a specialist practice resource for understanding and responding to "problematic sexual behaviours". SAFER Children Framework provides model of risk assessment and planning. There are sexual exploitation specialists in place.	Yes - on the guiding principles.
Western Australia	Western Australia places a strong focus on providing culturally safe residential care services for Aboriginal and Culturally and Linguistically Diverse (CALD) children and young people. This includes emphases on practices that allow self-determination and commitment to the Aboriginal Child Placement Policy. The review did not identify the adoption of TRC models specifically designed for Aboriginal Children, though the Yorganop Association website suggests they implement the	No models of TRC are currently implemented within Western Australia to provide specialised therapeutic placement to children and young people who have displayed HSB. The case practice manual outlines risk management procedures aligned with the Signs of Safety model and emphasises the need to view risk behaviours, including HSB, as trauma related, and the need to provide a trauma-informed response.	No

	Sanctuary model in a manner that is adapted for Aboriginal children.	On a broader scale, there is a significant focus on HSB within the jurisdiction's wider OOHC sector, including workforce development and planning for enhanced specialised service provision.	
New Zealand	Yes, the model offers a bicultural focus as central to their practice. There is a Māori cultural practice specialist on staff and external cultural consultation is sought where required (i.e., for Pacifika children).	Yes. This is a central focus of the model.	No

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