Trauma-informed therapeutic framework for residential care project

Final Report: Stage One
(Development of a proposed trauma-informed therapeutic framework for residential care)

31st August 2015
Acknowledgements
Without the cooperation and support of residential care service providers and staff, Queensland government agency representatives, members of the Expert Advisory Group, Aboriginal and Torres Strait Islander workers with an interest in residential care, young people with a residential care experience, parents whose children have been in residential care, and colleagues such as CREATE Foundation Qld and Queensland Aboriginal and Torres Strait Islander Child Protection Peak, undertaking this project would not have been possible. PeakCare Qld Inc., Encompass Family and Community Pty Ltd and Paul Testro Consultancy Services would like to thank everyone for their goodwill and their enthusiasm about a trauma-informed framework for residential care of children and young people in Queensland, and for so generously giving their time to share experiences and views about what’s working well and areas for improvement across all aspects and levels of the service system.
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Acronyms and abbreviations used in this report

ACT Australian Capital Territory
AIHW Australian Institute of Health and Welfare (AIHW)
CALD culturally and linguistically diverse
CARE® Children and Residential Care Experiences
CSO Child Safety Officer
CRC-PaS Child Related Costs – Placement and Support
the department Department of Communities, Child Safety and Disability Services
EAG Expert Advisory Group
ICMS Integrated Client Management System
NSW New South Wales
QASIS Online Acquittal Support Information System
OOHC Out of home care
QATSICPP Queensland Aboriginal and Torres Strait Islander Child Protection Peak
SA South Australia
SILS Supported Independent Living Services
TCI Therapeutic Crisis Intervention
TRC Therapeutic Residential Care
UK United Kingdom
US United States of America
WA Western Australia

Terminology

The term ‘organisation’ is used in this report to refer to organisations or agencies providing residential care services.

The term ‘service’ is used to refer to residential care service outlets, that is, a residential care service provided within a house (usually) or other type of accommodation.

Typically, organisations providing residential care services are responsible for more than one service, and may operate many residential care services across different regions.

The term ‘residential care workers’ is used in this report to refer to workers in residential care services rostered to provide direct care services to young people (or direct support, in the case of SILS).

The term ‘residential care staff’ is used to refer to the wider staff group of a residential care service, including (as relevant) managers, supervisors, team leaders and clinical supervisors, as well as residential care workers. ‘Residential care staff’ includes staff employed on-site and off-site with direct responsibilities related to the residential care service.

Structure of this report

This report includes an overview of the project, including scope and methods of consultation and data collection (sections 2 and 3), data analysis (section 4), and literature review (section 5).

The report also includes consideration of a ‘best fit’ framework for Queensland, including key inputs from the consultation (section 6), key themes from the literature (section 7), assessment of current models in Queensland (section 8), and the rationale for the proposed framework (section 9).

Attachment 1 to this report is a stand-alone document which outlines the Proposed Hope and Healing Framework for Residential Care.

Attachment 2 to this report is a stand-alone document which considers issues relevant to implementation of the proposed framework and options/strategies for implementation planning.
EXECUTIVE SUMMARY

This project actions stage one of the Department of Communities, Child Safety and Disability Services’ ('the department') commitment to implementing Recommendation 8.7 of the Queensland Child Protection Commission of Inquiry. The department contracted PeakCare Queensland Inc. (PeakCare) to undertake the project, working with Encompass Family and Community Pty Ltd (Encompass) and Paul Testro Consultancy Services.

The three key objectives of this project were to assess existing frameworks operating in Queensland and other comparable jurisdictions, advise on the ‘best fit’ trauma based practice framework for Queensland, and provide advice and options for implementation of the framework. The framework is to apply to all types of congregate and non-family based care in Queensland, including non-family-based one-on-one care of young people.

The development of the proposed framework was informed by comprehensive consultation with government and non-government stakeholders across the state, analysis of available quantitative data and of the results of a comprehensive scoping study, and a review of the literature. A scoping survey of organisations providing residential care was completed by 34 organisations in relation to 192 residential care services (approximately 75% of total services at 31 March 2015). The quantitative data analysed related to 671 young people in residential care at 31 December 2014. Of note was the proportion of young people who were Aboriginal and Torres Strait Islander young people (47%) and in particular the proportion of the 150 children under 12 years in residential care at 31 December 2014 who were Aboriginal and Torres Strait Islander children (75%).

In considering a ‘best fit’ trauma-informed therapeutic framework for Queensland, information about the current Queensland context and about models of care currently in use was considered. It was noted that there is currently widespread variation in models and practice frameworks in use in Queensland residential care services, and that many of the organisations have limited understanding of what it means to work from a trauma-informed therapeutic perspective. Any framework which applies across all services needs to be foundational and flexible.

It is proposed that a framework specifically designed for Queensland will be a more effective approach to improving service delivery and outcomes for young people in residential care than adopting a commercially available model. For the purposes of this project, the concept of a ‘practice framework’ refers to an overarching approach to practice, rather than a model of service delivery. The framework will apply across different models of residential care. Some organisations in Queensland have made significant investments in commercially available trauma-informed models of care or in developing their own models – an overarching framework would be consistent with such models while providing foundational support for other organisations.

The Proposed Hope and Healing Framework for Residential Care sets out the foundation for caring and working with young people in residential care in a way that understands and responds to trauma-related needs and other complex needs, and is therapeutic in approach. The framework is outlined in Attachment 1 to this report. It incorporates four fundamental elements for practice in residential care (Safety, Nurture, Development and Healing) and four focus areas for a therapeutic approach (Relationship, Connections, Emotional Know-how and Positive Identity). The framework is future-focused with a vision of supported young people towards realising their hopes, dreams and full potential.

1 The term ‘young people’ as used in this report refers to children and young people aged 0 to 17 years.
The practical application of the framework spans the different phases of a young person’s journey in residential care, including *Transition in*, *Stabilising*, *Strengthening connections* and *Transition out*. The framework incorporates the four separate but related domains which have a role in helping to meet the needs of young people in residential care, including the residential care environment, connections to the young person’s world (family, community, culture and country), the residential care service provider, and the wider service system.

The ‘framework in practice’ includes roles and responsibilities directly related to the care of young people, as well as the roles which promote a functional service system. These are incorporated under the themes of *Caring with the young person in mind* (practice requirements for direct care, including Care Teams), *Supporting child-focused care* (key system requirements), and *Supporting a consistent approach* (tools and aides to effective practice).

For the proposed *Hope and Healing Framework for Residential Care* to be more than a statement of desired principles and methods, it will require a comprehensive implementation plan (to be further considered in stage two of the project). The report considers implementation issues and considerations for implementation planning. They include consideration of service system development, workforce development, ongoing monitoring and review and evaluation, along with preliminary consideration of resource requirements and costs issues. These implementation issues are outlined in Attachment 2 to this report.

The draft report of the project was distributed to residential care service providers and to relevant government and non-government stakeholders. Feedback on the draft framework has been positive, and has indicated widespread support for the application of a foundational framework to promote a consistent trauma-informed therapeutic approach to residential care of young people in Queensland. It is important that thorough consultation on implementation of the framework occurs during stage two of the project.
PROJECT OVERVIEW

1 Introduction

This project actions stage one of the Department of Communities, Child Safety and Disability Services’ (“the department”) commitment to implementing Recommendation 8.7 of the Queensland Child Protection Commission of Inquiry:

The Department of Communities, Child Safety and Disability Services partner with non-government service providers to develop and adopt a trauma-based therapeutic framework for residential care facilities, supported by joint training programs and professional development initiatives.

The three key objectives of this project are to:
- assess existing frameworks operating in Queensland and other comparable jurisdictions
- advise on the ‘best fit’ trauma based practice framework for the Queensland context
- provide advice and options for the implementation of the framework, including approaches to professional training and development, and indicative costs where possible.

The department contracted PeakCare Queensland Inc. (PeakCare) to undertake the project, working with a team of Encompass Family and Community (Encompass) personnel and Paul Testro Consultancy Services. The project commenced on 16 March 2015.

This project is stage one of the process towards implementing recommendation 8.7 of the Queensland Child Protection Commission of Inquiry. Subsequent stages will focus upon the development of an implementation plan for the endorsed approach (stage two) and active implementation (stage three).

2 Scope

The framework is required to apply to all types of congregate and non-family based care in Queensland, including non-family-based one-on-one care of young people2. The types of residential care in scope are:
- general residential care – grant or invoice funded through CRC-PaS
- Therapeutic Residential Care
- Safe Houses
- Supported Independent Living Services (SILS).

These services differ in terms of their purpose, target group, source of funding, and the nature and intensity of needs of young people using them. The range of young people using residential care includes sibling groups, under 12s, young people with significant cognitive impairments and physical disabilities, young people in between placements, and young people transitioning from care.

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2 The term ‘young people’ is used in this report to refer to all children aged 0-17 years, in recognition of the fact that the majority of children in residential care are aged 12 years and over, and the most common age group is 15-17 year olds. Where the term ‘children’ is used for clarity, it refers specifically to children under 12 years.
This project is to advise on a ‘practice framework’ for Queensland. It is recognised that the terms ‘framework’ and ‘model’ are sometimes used interchangeably. For the purpose of this project, a definitional distinction is made:

- ‘Framework’ refers to an overarching approach to practice applicable across different models of residential care, different cohorts of young people and different types of residential care services. A consistent framework provides for:
  - shared practice principles, allowing for differing contexts and circumstances
  - shared conceptual understandings of the needs of young people who have been trauma-impacted and of how these needs may be expressed
  - consistent core practice approaches in responding to these needs
  - shared understanding around the resource implications (e.g. for staffing training) around implementing these approaches.
- ‘Model’ refers to the package of principles, target group and goals, policies and procedures, services provided, and staffing, which together describe the program logic for how residential care is provided by a particular service provider within a particular service or program.

An overarching framework is foundational and provides the scaffolding that links the core components necessary to achieve positive outcomes for young people in residential care impacted by trauma. The same state-wide framework is able to accommodate different models of care consistent with the framework.

In considering the scope of the project it should be noted that:

- the framework is required to apply to residential care, and does not incorporate other forms of out of home care (OOHC)
- the project relates specifically to a therapeutic framework for care, and does not address wider issues such as the place of residential care within the service system
- the project includes considering funding and workforce issues as they relate to application of the framework, but does not address broader funding or workforce development issues.

While not specifically in-scope, wider issues which interface with the implementation of a therapeutic framework for residential care have been flagged for further consideration.

### 3 Methodology

#### 3.1 Consultation and engagement

A state-wide workshop was held on 13 April 2015 for purposes of briefing senior executives of organisations providing residential care services and relevant government departments and instrumentalities. The workshop was attended by 15 senior representatives of organisations providing residential care, as well as senior departmental officers and other government representatives.

This was followed by a comprehensive Consultation and Engagement strategy implemented during May and June 2015. A summary of these processes follows.

- Four one-day regional workshops were held in Beenleigh, Burpengary, Rockhampton and Townsville, and were attended by over 250 people, being a mix of government and non-government workers, including residential care workers.
A one-day workshop with Aboriginal and Torres Strait Islander workers from Aboriginal and Torres Strait Islander community controlled organisations and non-Indigenous organisations involved in delivering residential care services was held on 1 June 2015, with the assistance of QATSICPP, the Queensland Aboriginal and Torres Strait Islander Child Protection Peak. A total of 29 people from 12 organisations attended the workshop. These included representatives from across the state including some of the remote communities.

Discussions were held with two researchers who have examined issues for culturally and linguistically diverse (CALD) children and families in contact with child protection and out of home care services.

Consultation meetings occurred with targeted stakeholder groups across a range of government departments and instrumentalities. These were primarily small group consultations of about two hours in length, conducted as structured interviews and discussion sessions. They included a meeting with representatives of Child and Family Services (Department of Communities, Child Safety and Disability Services) on 29 May 2015. Appendix A lists the government agencies consulted.

Half-day meetings with most of the members of the Expert Advisory Group (EAG) were held on 17 April 2015 and 20 June 2015. The Expert Advisory Group comprises 11 members identified as thought leaders in the residential care sector, including two Aboriginal and Torres Strait Islander persons. Membership of the EAG is listed in Appendix B.

Targeted consultation occurred with three of the large service providers, Anglicare Southern Queensland, UnitingCare Community and Mercy Community Services, regarding their experiences in implementing specific models of therapeutic care: the CARE© model and a model grounded in the Sanctuary© model.

Additional discussions occurred following the Townsville regional workshop with three participants from the Townsville Residential Care Network, two from the non-government sector (from Uniting Community Care and Churches of Christ Care) and one from the Department, to discuss key points arising from the workshop and the application of the domains of residential care in practice.

In conjunction with CREATE Foundation (Queensland), 17 young people aged 12-18 years who are living or had lived in residential care were consulted in four areas of the state, Ipswich, Rockhampton, Brisbane and Logan. The young people’s views were sought about what works well in residential care and what could be improved, including safety, relationships, connections, and managing feelings and behaviours. Of the 17 young people involved:
- 9 were aged between 15-16 years, 5 were aged between 17-18 years and 3 were aged between 12-14 years
- 11 were female and 6 were male
- 13 were non-Indigenous and 4 were Aboriginal and/or Torres Strait Islander
- 12 were living in general residential care services, 3 were living in supported independent living services, one was living in kinship care and one had left care but was still being supported.

Telephone interviews occurred separately with 2 parents of young people in residential care.

Targeted discussion occurred with representatives of other jurisdictions undertaking residential care reform processes.
In addition to the range of forums held, methods to encourage ongoing engagement included:

- distribution of a digital recording of the state-wide workshop to all organisations providing residential care services in Queensland and others
- use of two Yammer on-line discussion groups – one for members of the Expert Advisory Group and one for the broader stakeholder group
- project Information Sheets distributed by Encompass and PeakCare in April 2015, June 2015 and August 2015
- PeakCare eNews items and emails
- general invitations to stakeholder groups and individuals to provide input to framework development.

3.2 Data collection

The project was informed by data collected through two main activities:

- an analysis of key demographic and reporting data made available by the department through the Integrated Client Management System (ICMS) and the OASIS reporting system
- a scoping survey of all organisations providing residential care to identify their functions, capacity, staffing, location, model of trauma-informed care, and the extent to which current activities align with the intention of a trauma-informed therapeutic framework.

The data collection applied to all residential care types – residential care, Safe Houses, Therapeutic Residential Care and Supported Independent Living Services (SILS). It included grant-funded services and residential services procured through CRC-PaS.

The scoping survey was distributed on 4 May 2015 to all organisations providing residential care as advised by the department, in all 38 organisations. They were requested to complete a separate on-line survey for each residential care service. The response was largely cooperative, with 34 organisations completing the survey for all or some of the residential care services they provide. Surveys were completed for a total of 192 residential care services; it is estimated that this was approximately 75% of the residential care services operational on 31 March 2015. A list of the organisations that participated in the scoping survey is contained in Appendix C. Four organisations did not participate.

The 192 services included in the survey spanned each of the service types:

- grant-funded residential care: 95 services
- CRC-PaS residential care: 65 services
- Safe Houses: 8 services
- Therapeutic Residential Care: 4 services
- Supported Independent Living (SILS): 20 services.

The 192 residential care services were located across the departmental regions as follows:

- Brisbane: 23
- Central: 25
- Far North: 21
- North Coast: 15
- North Queensland: 20
- South East: 46
- South West: 42
Data from the scoping survey should be viewed as a large sampling, given that not all organisations participated, provided information about all their services, or answered every survey question. Nevertheless, it provides a comprehensive picture of residential care across Queensland, and across service types and providers.

4 Data analysis

This data analysis commences with an overview of the historical growth in use of residential care, followed by analysis of current demographics and key results of the scoping survey.

4.1 Growth in use of residential care

Since 2003, the number of young people in out of home care in Queensland has more than doubled, from 3787 at 30 June 2003 to 8185 at 30 June 2014 (AIHW 2004; AIHW 2010; AIHW 2015).

Over the same period, the number and proportion of Aboriginal and Torres Strait Islander young people in out of home care has increased at a much higher rate than for non-Indigenous young people, from 813 to 3336, a four-fold increase (see Table 1).

Table 1: Number of young people in out of home care, by Indigenous status, at 30 June

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>2974</td>
<td>78.5</td>
<td>4547</td>
</tr>
<tr>
<td>A&amp;TSI</td>
<td>813</td>
<td>21.5</td>
<td>2481</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>3787</td>
<td></td>
<td>7093</td>
</tr>
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Whilst the rate of increase in the number of young people in out of home care slowed from 2009 to 2014, the impact of growth on the capacity of the service system in general and the non-government sector in particular to provide appropriate care and support has been enormous. The rate of increase for Aboriginal and Torres Strait Islander young people in out of home care is particularly alarming. For non-Indigenous young people, the increase from 30 June 2009 to 30 June 2014 was 0.52%; for Aboriginal and Torres Strait Islander young people it was 34.5%.

In addition to the broader impact noted above, the capacity of the service system to provide culturally appropriate care and support and comply with core elements of the Aboriginal and Torres Strait Islander Child Placement Principle has been severely compromised by the rate of increase and the number of Aboriginal and Torres Strait Islander young people entering out of home care.

Between 2003 and 2014, the growth in demand for out of home care and support services has been accompanied by significant changes in the types and mix of placements being used to provide care. The use of foster care has decreased from 74% of all placements as of 30 June 2003 to 51.6% as of 30 June 2014, whilst the use of kinship care has increased from 25% to 40.4% over the same period, and residential care has increased from 1% to 8% (see Table 2).
Table 2: Number of young people in out of home care, by type of placement, at 30 June

<table>
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<tr>
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<th>2003</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Foster care</td>
<td>2815</td>
<td>74</td>
<td>4270</td>
</tr>
<tr>
<td>Kinship care</td>
<td>929</td>
<td>25</td>
<td>2379</td>
</tr>
<tr>
<td>Residential care</td>
<td>43</td>
<td>1</td>
<td>444</td>
</tr>
<tr>
<td>Total</td>
<td>3787</td>
<td></td>
<td>7093</td>
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</table>

With residential care services generally providing care and support for between 1 and 4 young people at any one time, the increase in the number of young people placed in residential care from 30 June 2003 to 30 June 2014 has led to a significant increase in the number of grant funded residential care services, from 19 in 2003 (Department of Families 2003) to 149 in 2014.

Starting from such a low base, the rate of increase has had a significant impact on the capacity of the non-government sector to quickly develop the necessary infrastructure to support and provide quality care to young people and the capacity of the broader service system to meet their needs.

The proportion of Queensland young people placed in residential care is higher than in NSW, Victoria, Tasmania and the ACT but lower than in SA, WA and the NT. Queensland’s use of residential care increased from 2003 to 2014 when most jurisdictions, with the exception of SA, have either decreased their use of residential care or remained relatively stable (see Table 3).

Table 3: State and Territory comparison data for percentage of all young people in out of home care who were placed in residential care, at 30 June

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>3.0</td>
<td>10</td>
<td>1.0</td>
<td>8.0</td>
<td>4.0</td>
<td>22</td>
<td>13</td>
<td>5.0</td>
</tr>
<tr>
<td>2009</td>
<td>2.2</td>
<td>9.0</td>
<td>6.3</td>
<td>7.1</td>
<td>8.6</td>
<td>7.4</td>
<td>10.7</td>
<td>4.4</td>
</tr>
<tr>
<td>2014</td>
<td>2.8</td>
<td>6.7</td>
<td>8.0</td>
<td>9.5</td>
<td>12.7</td>
<td>7.4</td>
<td>6.3</td>
<td>9.9</td>
</tr>
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</table>

In summary

There has been exponential growth in the use of residential care in Queensland in recent years, both in terms of the number of residential care services and the proportion of young people in out of home care who are placed in residential care. This is particularly marked for Aboriginal and Torres Strait Islander young people. A proposed framework for Queensland must take account of issues arising from this rapid growth, including the need for infrastructure support and consistency of practice and cultural proficiency.
4.2 The children and young people in residential care

Indigenous status

On 31 December 2014 there were 671 young people in residential care in Queensland. Of these, 314 (46.8%) were Aboriginal and/or Torres Strait Islander young people (see Figure 1). Of the 314 Indigenous young people, 85% were identified as Aboriginal, 9% as both Aboriginal and Torres Strait Islander, and 6% as Torres Strait Islander young people.

Data about young people of culturally and linguistically diverse (CALD) backgrounds are available only through OASIS returns (and so exclude CRC-PaS placements). During the quarter ended 31 December 2014, service providers reported that 44 (5.5%) of the young people in residential care were of CALD backgrounds.

Of the 314 Aboriginal and Torres Strait Islander children and young people in residential care at 31 December 2014, 20% were aged under 10 years and 35.6% were aged under 12 years. This compares to only 4.5% of non-Indigenous children and young people in residential care being under 10 years and 10% being under 12 years. At 31 December 2014, 75% of all children under 12 years in residential care were Indigenous (see Figure 2).

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Figure 1: Young people in residential care by Indigenous status (percentages) at 31 December 2014. N = 671

Figure 2: Children aged under 12 years in residential care, by Indigenous status (percentages) at 31 December 2014. N = 150
The purpose and use of Safe Houses has some bearing on this (25% of Indigenous children under 12 years in residential care at 31 December 2014 were in Safe Houses). However, it is clear that young Aboriginal and Torres Strait Islander children are much more likely than non-Indigenous children to be placed in residential care.

**Age and gender**

Of the 671 children and young people in residential care at 31 December 2014, 150 (22%) were aged under 12 years (see Figure 3). Younger children living in Safe Houses accounted for only 28 of these, meaning that 122 children under 12 years were living in other forms of residential care, excluding SILS. The mode (most common age) for young people across all residential care at 31 December 2014 was 16 years.

In each age category, male young people in residential care outnumbered females. Overall, 63% of young people in residential care at 31 December 2014 were male and 37% were female.

**Levels of needs**

Residential care services are caring for young people with significant needs. The scoping study indicated that, of 127 services (excludes CRC-PaS) that proved information about the category of need they were grant funded to provide:

- 49 services stated ‘complex’ and ‘extreme’
- 57 services stated ‘moderate’, ‘high’ and ‘complex’
- 16 services stated ‘moderate’ and ‘high’
- 5 services stated ‘moderate’ as the highest level.

**Type of placement**

As demonstrated by Figure 4, the majority of young people in residential care are placed in (general) residential care (69% of all young people in grant-funded placements for the quarter ended 31 December 2014). Supported Independent Living Services (SILS) account for 17% of the young people.
The data in Figure 4 exclude CRC-PaS services. However, of the 217 young people in CRC-PaS residential placements at 31 March 2015, none are in TRC services or Safe Houses, as these are grant-funded services, and only 5 were in SILS placements. It can therefore be concluded that most of the 217 young people in CRC-PaS placements are in residential care services. Of these 217 young people:

- 68 (31%) were in individual placements, that is, one-on-one care
- 144 (66%) were in congregate care (of these, 43% were in sibling groups)
- 5 (2%) were in SILS placements.

Siblings who were placed with at least one other sibling accounted for 21% of all young people in residential care at 31 December 2014. Of 401 young people recorded as having a sibling, 144 (36%) were recorded as placed with at least one sibling.

For children under 12 years in residential care at 31 December 2014, 68% of Indigenous children were placed with a sibling compared to 40% of non-Indigenous children under 12 years.

Table 4 demonstrates the distribution of children and older young people across the service types for residential care, and Indigenous status across the different service types. These data do not include children and young people in CRC-PaS residential placements.

Table 4: Selected data for quarter ended 31 December 2014: type of placement, by number of children and young people and proportion for that placement type (excludes CRC-PaS placements). N = 806.
**In summary**

In Queensland, the ages of young people in residential care range from 0 to 17 years, although the most common age is 16 years. They include young people in one-on-one residential care and in congregate care, which includes sibling groups. A significant proportion of the young people in residential care are Aboriginal and Torres Strait Islander young people. The majority of residential care services care for young people with complex to extreme needs. A framework for Queensland that is therapeutic in approach must be applicable across this range of cohorts and able to respond to these levels of need.

**4.3 Use of residential care**

**Regional variation**

As shown in Table 5, there is variation in the use of residential care across the regions. These data are not proportional to the population of the region, and are likely to be influenced by a variety of factors including regional demand, the regional service infrastructure and regional strategic planning and practice in relation to the use of residential care and other forms of OOHC.

*Table 5: Total number of young people in residential care, and number of young people in CRC-PaS placements, by region.*

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of young people in residential care on 31 December 2014 (% of all young people in residential care). N = 671</th>
<th>Number of young people in CRC-PaS placements at 31 December 2014 (% of all young people in CRC-PaS placements). N = 217</th>
</tr>
</thead>
<tbody>
<tr>
<td>Far North Queensland</td>
<td>138 (20.6%)</td>
<td>56 (26%)</td>
</tr>
<tr>
<td>South West Queensland</td>
<td>130 (19.4%)</td>
<td>56 (26%)</td>
</tr>
<tr>
<td>Central Queensland</td>
<td>105 (15.6%)</td>
<td>36 (17%)</td>
</tr>
<tr>
<td>South East Queensland</td>
<td>103 (15.4%)</td>
<td>17 (8%)</td>
</tr>
<tr>
<td>Brisbane</td>
<td>75 (11.2%)</td>
<td>22 (10%)</td>
</tr>
<tr>
<td>North Queensland</td>
<td>66 (9.8%)</td>
<td>15 (7%)</td>
</tr>
<tr>
<td>North Coast</td>
<td>54 (8.0%)</td>
<td>15 (7%)</td>
</tr>
<tr>
<td>Totals</td>
<td>671 (100%)</td>
<td>217 (100%)</td>
</tr>
</tbody>
</table>

*Note: The 671 young people in residential care on 31 December 2014 include those in CRC-PaS placements.*

**Time spent in residential care**

Data are available for the time spent by young people in CRC-PaS residential care placements. These data show regional variation in respect of placement duration. These differ for individual one-on-one care, compared to congregate care. Across the state, for young people in CRC-PaS residential care at 31 March 2015, the average time in placement was:
• for young people in one-on-one residential care – 1.4 years
• for young people in congregate care – 1.3 years
• for young people in SILS – 4.8 months.

On a regional basis, the average length of time in CRC-PaS one-on-one residential placement (at 31 March 2015) varied from 1.9 years (Brisbane region) to 7.5 months (North Coast region). In other words, the average time spent in one-on-one CRC-PaS residential care was 479 days longer in Brisbane region compared to North Coast region (other regions lie between these extremes).

There was less regional variation in the average length of time spent in congregate care for CRC-PaS residential care at 31 March 2015. Average time spent in congregate care varied from about 1.6 years (Brisbane region) to about 1 year (North Coast region).

For grant-funded services, data about the length of time young people spend in residential care are not readily available. While the following data relate to the young people in residential care at 31 December 2014 (N = 671), these periods of continuous time in OOHC may include periods in other forms of care prior to entering that residential care placement:
• 29% had been in OOHC for 5 years or more
• of those in OOHC for 5 years or more, 50% were aged 15 - 17 years
• 33% had been in OOHC for less than 1 year
• of those in OOHC for less than a year, 43% were aged 15 - 17 years.

As part of the scoping survey, most residential care services reported that there were no specific time restrictions on the length of placement, with ‘up to 18 years’ the most common response. Some residential services with particular functions, for example offering an emergency response, had short intended placement lengths (see Table 6).

Table 6: Number of (grant-funded) residential care services by the maximum length of placements usually provided by the service. N = 105

<table>
<thead>
<tr>
<th>Maximum length of placement normally provided</th>
<th>Number of services (grant-funded, including Safe Houses and TRC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 or 2 months</td>
<td>2</td>
</tr>
<tr>
<td>Up to 3 months</td>
<td>12</td>
</tr>
<tr>
<td>Up to 6 months</td>
<td>6</td>
</tr>
<tr>
<td>Up to 9 - 12 months</td>
<td>2</td>
</tr>
<tr>
<td>Up to 18 months</td>
<td>2</td>
</tr>
<tr>
<td>Up to 2 years</td>
<td>2</td>
</tr>
<tr>
<td>Up to 18 years or unspecified</td>
<td>81</td>
</tr>
</tbody>
</table>

Bed capacity of residential care services

Table 7 shows information provided by organisations about the number of residential care places (beds) approved for each of their grant-funded services. The most common bed-number is four. Some services with specific functions are approved for fewer or more than four (for example, Safe Houses are approved for up to 6 children and young people).
Table 7: Number of (grant-funded) residential care services, by the maximum number of places approved for each service. N = 103

<table>
<thead>
<tr>
<th>Number of approved places (young people able to be accommodated)</th>
<th>Number of services (grant-funded, including Safe Houses and TRC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>57</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
</tr>
</tbody>
</table>

Data specific to CRC-PaS residential care

The survey enabled data to be gathered about the 62 CRC-PaS services, at 31 March 2015.

These services were caring for 115 young people on 31 March 2015 (see Table 8) being 72 males, 39 females, and 4 unknown. Note that this is only a sampling of the 217 young people reported by the department to be in CRC-PaS residential care placements at that date.

Table 8: Age ranges of children and young people in sample of 62 CRC-PaS residential care services, at 31 March 2015. (Source: scoping survey)

<table>
<thead>
<tr>
<th>Ages</th>
<th>Number of children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>2</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>15</td>
</tr>
<tr>
<td>10 or 11 years</td>
<td>16</td>
</tr>
<tr>
<td>12 to 14 years</td>
<td>47</td>
</tr>
<tr>
<td>15 to 17 years</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
</tr>
</tbody>
</table>

This accords with departmental data indicating that 32% of children and young people in CRC-PaS residential care at 31 March 2015 were aged under 12 years. Most (but not all) of the younger children in the surveyed sample were part of sibling groups.

For the CRC-PaS residential care services with more than one young person (half of the 62 services in the sample, see Table 9), 12 had sibling groups meaning all or some of the young people were siblings. This was true of all the services with 4, 5 or 6 children.

Table 9: Number of young people accommodated in the service, for sample of 62 CRC-PaS residential care services, at 31 March 2015. (Source: scoping survey)

<table>
<thead>
<tr>
<th>Number of young people accommodated in the service</th>
<th>Number of services with that number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>
The types of accommodation in use by CRC-PaS services included mainly long-term leased or owned housing (see Table 10):

Table 10: Type of accommodation used to provide residential care, for sample of 62 CRC-PaS residential care services, at 31 March 2015. (Source: scoping survey)

<table>
<thead>
<tr>
<th>Type of accommodation</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>House or unit (long-term lease or agency-owned)</td>
<td>53</td>
</tr>
<tr>
<td>House or unit (short-term or temporary lease for this purpose)</td>
<td>6</td>
</tr>
<tr>
<td>Motel or similar short-stay room-rental</td>
<td>1</td>
</tr>
<tr>
<td>‘Other’ – clinical facility</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
</tbody>
</table>

In summary

Use of residential care varies across regions, with variations between residential care services in terms of size of the service, length of time for which young people are typically cared for, and the type of accommodation utilised. A framework for Queensland must be flexible to take account of these variations.

4.4 Staffing of residential care

Numbers of residential care workers

No comprehensive data are available indicating the total number of residential care workers\(^3\) engaged on any given date. Data reported through OASIS, for residential care services excluding CRC-PaS, indicated that during the quarter ended 31 December 2014, a total of 1102 residential care workers were engaged. The number of young people cared for during that period (excluding CRC-PaS residential care) was reported as 806 (see Table 11).

Of the residential care workers engaged during the quarter ended 31 December 2014, 228 (21%) were Aboriginal and Torres Strait Islander workers. Table 11 shows the proportion of young people cared for in residential care (excluding CRC-PaS) during the quarter ended 31 December 2014 who were Aboriginal or Torres Strait Islander young people, and the proportion of Indigenous staff.

\(^3\) The term ‘residential care worker’ refers to direct care workers, that is, it does not include managers and other senior or supervisory staff of a residential care service.
Table 11: Number of residential care workers, and number of young people cared for, by residential care service type; number of Indigenous workers (% by service type), and number of Indigenous young people (% by service type), for quarter ended 31 December 2014.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Residential care</th>
<th>TRC</th>
<th>Safe House</th>
<th>SILS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of residential care workers</td>
<td>900</td>
<td>26</td>
<td>83</td>
<td>93</td>
<td>1102</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander residential care workers</td>
<td>148 (16%)</td>
<td>1 (4%)</td>
<td>70 (84%)</td>
<td>9 (10%)</td>
<td>228</td>
</tr>
<tr>
<td>Total number of young people</td>
<td>554</td>
<td>15</td>
<td>98</td>
<td>139</td>
<td>806</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander young people</td>
<td>207 (38%)</td>
<td>7 (47%)</td>
<td>98 (100%)</td>
<td>30 (22%)</td>
<td>342</td>
</tr>
</tbody>
</table>

Note: These data exclude CRC-PaS residential care.

Permanent vs. casual workers

Responses to the scoping survey indicated that most residential care workers are employed as permanent staff (see Figure 5). Of the 180 services for which this information was provided, 27 (15%) reported that they employed only permanent residential care workers, while 19 services (10.5%) employed only casual residential care workers. The most common arrangement was about 60% to 80% permanent workers – 44% of the services reported these proportions of permanent to casual workers. There was no particular trend related to service type.

Figure 5: Number of services, by percentage of residential care workers employed by the service in the last month (April 2015) who were permanent staff.
(Source: scoping study)

Of the 28 services that reported employing ‘one-off casuals’ (that is, workers who were not regular casuals) during the month of April 2015, the majority employed about 20% to 25% of residential care workers as one-off casuals, with the range from 5% to a maximum of 45%. These services were comprised of:
• 14 ‘general’ grant-funded residential care services
• 10 CRC-PaS residential care services
• 2 Therapeutic Care Services
• 1 SILS
• 1 Safe House.

Those with the highest percentages of non-regular casuals were two CRC-PaS services and a SILS. It should be noted that for some services with a small staffing contingent, 40% may represent only a few people. In addition, employment arrangements may differ, so that in some cases the long-term regular engagement of workers on a casual basis may be similar in effect to the engagement of permanent workers. Anecdotally, the turnover of workers in residential care positions is high. The scoping study did not canvass this issue due to the complexity of gathering accurate turnover data by this means.

Rostering of residential care workers

Arranging rosters of residential care workers to best meet the needs of individual young people is complex. Many services describing their rostering arrangement at the time of the scoping survey noted the challenge of trying to maintain consistency and stability while also being mindful of the demands upon workers of shift-work and of the sometimes stressful requirements of the role. The following are some of the themes:

• Continuity of worker for the evening (before bed) and the morning (on arising) is important for young peoples’ sense of stability, with some services struggling to provide this continuity
• Some services have or have tried longer shifts for continuity. In CRC-PaS residential care, shifts which last for 24 hours (with sleepover) are common
• Some services caring for younger children use houseparents supported by rostered workers
• The roster arrangements when several workers need to be involved each day can be complex
• Continual adjustment is required, depending on young people’s needs and, for example, whether and for what hours the young people attend school
• It is common for additional workers to be rostered for particular high-support periods
• Often there is a period of overlap of shifts to enable hand-over. However this is not always well catered for
• Some services try to keep a small team to ensure consistency with a particular young person. This may be less possible for CRC-PaS residentials providing emergency responses
• Some residential care services have a high use of casual residential care workers.

Practice principles applying for the care of young people in non-family-based care (that is, by rostered workers), as derived from issues raised during the consultations, include:

• Facilitate the capacity for the young person to form a strong bond with a particular residential care worker – use the concept of ‘key worker’ where possible
• For children under 5 years of age, pay particular attention to facilitating their capacity to form attachment – this requires consistency of a small number of adult figures who are present at key times for security and predictability
• Limit the use of one-off casual workers as far as possible
• Use small teams of consistent workers (compatible with the desired ratios) with consistent additional staff where required
• Use of fewer longer shifts is preferable to more frequent shorter shifts, balanced with workers’ needs
• Use house-parents where feasible, particularly for younger children, supported by rostered workers
• Welcome family and community members in the residential care service whenever possible, to provide consistent attachment figures.

**In summary**

The number of residential care workers in Queensland exceeds 1,100. Information provided by residential care services indicates that some 20% to 40% of residential care workers are engaged on a casual basis, with some residential care services employing only casual workers of which up to 45% are not regular casuals. A framework for Queensland which promotes consistency of practice in meeting young people’s needs will need to include core practice guidelines and related training.

Rostering arrangements vary dependent upon the needs of the young people cared for. Maintaining a balance between the need for consistency and stability, and the employment needs of workers, is a challenge. A framework for Queensland residential care must facilitate application of the principles for child-focused congregate care while allowing the workforce flexibility required for individualised care.

**4.5 Program activities provided in residential care**

The scoping survey asked organisations to report on some selected types of activities provided as part of their programs within each service. Table 12 lists the activities enquired about, and the number of services (of the total 192 services) that confirmed providing each type of activity.

<table>
<thead>
<tr>
<th>Program activity / work undertaken</th>
<th>No. of residential care services (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family reconnection work</td>
<td>143 (75%)</td>
</tr>
<tr>
<td>Cultural connection work</td>
<td>134 (70%)</td>
</tr>
<tr>
<td>Education (schooling) provided in-house</td>
<td>117 (61%)</td>
</tr>
<tr>
<td>Specific recreational services (e.g. camps)</td>
<td>87 (45%)</td>
</tr>
<tr>
<td>Vocational or employment readiness services (in-house)</td>
<td>84 (44%)</td>
</tr>
<tr>
<td>Counselling in-house (qualified)</td>
<td>41 (21%)</td>
</tr>
</tbody>
</table>

The extent and intensity of activities around family connection and cultural connection is not clear from this ‘tick box’ reporting. However the number of services that responded with an indication that these activities are part of their role is positive. Some of the comments made by services in the scoping survey were as follows.

In relation to family connection work: *Family reunification has been the majority of the work, including practical support and advice to the parents and some counselling. Parents attend sessions at the residential house, and staff also go to the parents’ home to provide support and guide family interactions and practical advice.*
In relation to recreational services: Social activities, art therapy, play therapy, music therapy e.g. drumming etc, sensory activities, physical activities and exercise, personal development, life coaching, colour therapy, meditation, water activities, gardening, community participation in various forms, work experience, life skills and independent living skills, cooking and baking.

In relation to cultural connection work: Cultural mentoring through Men’s business and local Elder Education program, Community Service Volunteering opportunities.

Some respondents also specifically mentioned programs around social and living skills development, in particular for young people in SILS.

Life and social skills development: Access to subsidised accommodation plus support to identify post program housing; Life skills development modules; Social skills and network building.

Organisations were also asked about whether their residential care services provided specific support to Aboriginal and Torres Strait Islander young people and to culturally and linguistically diverse (CALD) young people. Responses are shown in Table 13.

Table 13: Number of residential care services (% of all services), by whether they reported providing specific support to Aboriginal and Torres Strait Islander young people, and CALD young people. (N = 192 services)

<table>
<thead>
<tr>
<th>No. of residential care services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific support provided to A&amp;TSI young people</td>
<td>112 (58%)</td>
</tr>
<tr>
<td>No specific support (A&amp;TSI young people)</td>
<td>69 (36%)</td>
</tr>
<tr>
<td>No response (A&amp;TSI young people)</td>
<td>11 (6%)</td>
</tr>
<tr>
<td>Specific support provided to CALD young people</td>
<td>47 (25%)</td>
</tr>
<tr>
<td>No specific support (CALD young people)</td>
<td>136 (71%)</td>
</tr>
<tr>
<td>No response (CALD young people)</td>
<td>9 (4%)</td>
</tr>
</tbody>
</table>

It should be noted that some services that selected ‘none specific’ were CRC-PaS residential care services that were not caring for Aboriginal and Torres Strait Islander young people or CALD young people.

Amongst the services that commented upon providing specific support to Aboriginal and Torres Strait Islander young people:

- 31 focussed on the cultural support plan developed by the department
- 16 referred to employing Indigenous staff and/or working with agencies such as the Recognised Entity
- 8 mentioned exposing young people to cultural activities such as dance festivals
- 7 mentioned specific activities that related to strengthening linkages for the young person with their family and community
- 6 mentioned encouraging contact with local elders
- 4 noted that as they are Safe Houses they are located within, and have strong links to, the child’s community.

It is clear that some of the services that responded have a strong commitment to actively keeping young people connected to community or to helping them with reconnecting while strengthening their cultural identity. Other services indicated a willingness to work to meet requirements of the cultural support plan without necessarily conveying that they are working to build and maintain linkages with members of the local Indigenous communities.
In relation to working with CALD young people, comments generally referred broadly to the aim of helping young people stay in touch with their culture. A number of services noted that they rarely or never had CALD young people using the service.

Access to therapeutic services for young people in residential care is mainly through external services, such as Evolve Therapeutic Services. The scoping study queried whether clinical/therapeutic services were provided to young people by a suitably qualified person employed by the organisation providing residential care. Responses for the 192 services were:

- ‘No’ 131 services (21 organisations)
- ‘Yes, for all young people’ 34 services (12 organisations)
- ‘Yes, for some as needed’ 27 services (9 organisations)

Note: some organisations gave more than one type of response, for different services.

Services that indicated that they did provide direct therapeutic or counselling support to young people were asked about clinical supervision. Responses generally indicated that some form of professional supervision was in place, for example:

Senior practitioners who are also registered psychologists provide therapeutic intervention for young people residing in the residential. They are also responsible for ensuring the placement remains a therapeutic environment. They have access to monthly external supervision.…

The Family Therapist gets professional supervision from Evolve Therapeutic Services.

The Program Manager is a Registered Psychologist with over 10 years’ experience working therapeutically with young people who have experienced complex trauma. The Program Manager provides clinical supervision to all therapeutic staff.

Services that do not provide in-house clinical services mostly stated that they access external therapeutic and counselling services for young people as required. Those that stated they did not access external services generally referred to a lack of need, relating to single-child placements, for example:

Young person is non-verbal and non-communicative. All therapy accessed is to support her medical needs.

Evolve were involved when the young person came to us in 2014 and then exited as circumstances settled.

In summary

The majority of residential care services indicated that they provide services that assist family reconnection, cultural connection, in-house education and vocational services, and (for a minority of services) in-house counselling by an appropriately qualified person. In most cases, therapeutic services are accessed externally. In relation to family connection and cultural connection, responses to the scoping survey indicated an emerging awareness of these as important aspects of the role of residential care. The proposed framework will build upon this.
5 Literature review – trends

5.1 Developments in other states / overseas

Increasing attention is being given in both Australia and overseas to the impact of trauma on young people in out of home care and the role and function of residential care in the context of the range of out of home care and support responses available to meet their needs.

In terms of residential care, there has been a general trend to developing a therapeutic focus for residential care across Australian states and territories. Victoria has developed and evaluated a pilot Therapeutic Residential Care program and, more recently has moved to extend a therapeutic approach across all residential care services. Western Australia has adopted the Sanctuary© model for all government provided residential care services. Queensland has undertaken an evaluation of its Therapeutic Residential Care Program and has commissioned this project to develop a trauma-informed therapeutic framework for residential care. The ACT and Tasmania have adopted more broadly based therapeutic frameworks for out of home care, and NSW is the process of developing a similar framework.

In some instances, these developments have been accompanied by moves to:
- clarify the role and function of residential care as a positive placement choice for particular groups of young people with particular needs (ACT, Victoria, Tasmania and South Australia)
- use processes or explore processes for better matching needs and services (NSW, Queensland WA, SA, Tasmania, NT and ACT)
- improve the capacity of family based care and support (Victoria)
- purchase flexible child-focused services which follow the child (ACT)
- develop other placement options such as professional foster care (ACT and Victoria).

Concern continues to be expressed about the capacity and capability of residential care to respond to the demand and growing complexity of young people’s needs. The reports of the Victorian Auditor General into residential care (2014) and the Commission for Children and Young People in Victoria (2015), for example, echo many of the concerns and recommendations of the report of Queensland’s Child Protection Commission of Inquiry (2013). The recommendations of the Victorian Commission for Children and Young People’s (2015) report into the sexual abuse and exploitation of young people in residential care include reducing the numbers of young people currently in residential care, refocusing residential care to short term intensive treatment before transitioning to an appropriate home-based care option, greater emphasis on connecting Aboriginal children to family and community, improved staff qualifications and training, linking funding of residential care outcomes for young people, and the introduction of professional foster care.

The Senate Standing Committee on Community Affairs inquiry into out of home care has also recently finalised its report. The Committee (2015) recommended the development of national therapeutic care standards and evaluation of best practice models of therapeutic care across all care types, increased resources to fund evidence based therapeutic models of care, implementation of a nationally consistent, best practice model of professional foster care, and mandatory training for all residential care workers.
The findings of the Royal Commission into Institutional Responses to Child Sexual Abuse are likely to continue the spotlight on residential care and have significant implications for reform.

Overseas, there is growing focus on therapeutic residential care in the US, the UK, and Europe (Whittaker, del Valle and Holmes 2015). However, each is influenced by different traditions, language, purpose and use of residential care (Thoburn and Ainsworth in Whittaker et al 2015). Care therefore needs to be taken with international comparisons and their application to Australia.

In the UK and the US concerns about the use of residential care and calls to clarify its role continue. In the UK, concern has been expressed about the use of residential care in response to crises, with the aim of the placement, beyond safe containment, not clearly set out or agreed. There has been a call to rethink support for adolescents in or on the edge of care (DfE 2014).

Strategies identified to address these concerns include:

- developing an adolescent-centred approach to protection, prevention and the promotion of adolescent resilience (Hanson and Holmes 2014; ADCS 2013)
- focusing residential care on assessment of need, and for preparing and matching young people to an appropriate foster placement, or successful return home (DfE 2014)
- providing a hub of specialist staff who could continue to provide support to young people across a range of in home and out of home care settings (DfE 2014)
- commissioning pathways through care rather than placements (DfE 2014; ADCS 2013)
- providing holistic, flexible responses to the needs of young people linking care, education, health and justice (ADCS 2013).

There are also concerns regarding the insufficient levels of qualification and specialist knowledge and skills in the workforce, inadequate career pathways and progression routes, and the lack of a strong identity or shared core professional standards (DfE 2012). These concerns have led to recommendations to increase the minimum qualifications required for staff and set defined timescales for existing staff to achieve these (DfE 2012).

In the US, there has been a decrease in the proportion of children placed in residential care. The Children’s Bureau US Department for Health and Human Services (2015, p.1) has stated that ‘Stays in congregate care should be based on the specialized behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting.’ The Children’s Bureau also expressed concern that 31% of children placed in residential care were aged 12 and younger:

*Strategies to reduce congregate care placements and improve outcomes of young children include the following:*

- Develop and implement a unified state-wide strategic plan
- Emphasize leadership and workforce development
- Focus resources on prevention and early intervention
- Strengthen community-based services and reduce barriers to access
- Implement a state-wide treatment-focused foster care model
- Allow current congregate care providers greater flexibility in service provision

(Children’s Bureau 2015, p. 2).
In 2014, the American Orthopsychiatric Association issued a consensus statement on congregate care for children and adolescents (Dozier, Kobak, Sagi-Schwartz, Shauffer, van Ijzedndoom, Kaufmann, O’Connor, Scott, Smetana and Zeanah 2014, p. 219):

Group care for children and adolescents is widely used as a rearing environment and sometimes used as a setting in which intensive services can be provided. This consensus statement on group care affirms that children and adolescents have the need and right to grow up in a family with at least 1 committed, stable, and loving adult caregiver. In principle, group care should never be favored over family care. Group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting.’

Whittaker et al (2015, p. 24) have sought to focus residential care on therapeutic care stating that there ‘is limited and declining value of any further discussions of residential care or residential services for high-resource using children and youth’ and suggest a focus on group care within therapeutic settings:

Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.

5.2 State of the evidence

The development of therapeutic residential care services has been influenced by the work of James Anglin (2002), Sandra Bloom (2005a, 2005b) and Bruce Perry (2006 in McLean, Price-Robertson and Robinson 2011). Models and frameworks of therapeutic residential care identified in the international literature include Sanctuary (Bloom 2005a), Children and Residential Care Experiences (Holden 2009), Positive Peer Culture, Teacher Family Model, Stop Gap Model, Re-ED, Models of Attachment Practice and Attachment, Self Regulation and Competency (James 2011).

In Queensland, the Sanctuary© and Children and Residential Care Experiences – CARE© models are the main existing trauma-informed models adopted by residential care service providers. Both Sanctuary© and CARE© are organisational models of change.

Sanctuary© – ‘... represents a trauma-informed whole of system approach designed to facilitate the development of structures, processes and behaviours on the part of staff, children and the community-as-a-whole that can counteract the biological, affective, cognitive, social and existential wounds suffered by the children in care.’ (Bloom 2005b, p.65). It seeks to develop a culture characterised by non-violence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility and growth and change. The model was developed by Bloom within the context of a short-term acute inpatient psychiatric setting and has been implemented and modified for the residential care of young people.

CARE© (Children and Residential Care Experiences: Creating Conditions for Change) aims ‘... to bridge research and practice to provide child caring organisations with a best practice model (that) serves the best interests of children.’ It seeks to support organisations ‘to guide their interactions with children and staff at all levels of the organisation, fostering an organisational culture and climate that sustains the integration of the principles’ (Holden
The principles are developmentally focused, family involved, relationship based, competence centred, trauma informed, and ecologically oriented. The model was developed by the Residential Child Care Project at Cornell University as a competency based curriculum.

It should be noted that whilst research into what works in therapeutic residential care is emerging, there is insufficient evidence to support one therapeutic model or intervention over another (CAAB 2009; James 2011; McLean et al 2011; James, Alemi and Zepeda 2013; Whittaker et al 2015). Much of the literature on residential care is focused on ‘therapeutic residential care’ and is largely UK, US and Europe based. Considerable work continues in defining the role and function of therapeutic residential care as reflected in the recent publication ‘Therapeutic Residential Care for Children and Youth – Developing Evidence-Based International Practice’ (Whittaker, del Valle, and Holmes (ed), 2015, p. 24), which had contributions from the US, UK, Europe and Australia). This work acknowledges the varied uses of residential care and focuses on therapeutic residential care as those ‘purposefully designed as complex interventions to meet the needs of high-resource using children and youth’. Australian literature is emerging in terms of the implementation of overseas models and the development of Australian based models or approaches (McLean et al 2011).

There is limited reference in the literature to the use of residential care for Aboriginal and Torres Strait Islander children (OGCYP 2015). Bamblett (2014) outlines the approach taken by the Victorian Aboriginal Child Care Agency (VACCA) in developing an Aboriginal therapeutic residential care program. Six cultural pillars are identified to provide the cultural foundation of the model: cultural safety, cultural rights and responsibilities, understanding of family and kinship structure, culture as resilience, best interest principles, and the child placement principle. The core components that promote healing through connection to culture are:

- Comprehensive culturally informed assessments and planning
- Social networking map
- Men’s and Women’s business
- Return to country
- Cultural support plans
- Community and cultural participation.

Young people’s experience of residential care and the ‘life’ of residential care are impacted by the residential environment, the organisation providing residential care, the broader service system involved with the young person and their connections whilst in residential care. Anglin (2002) highlighted the importance of congruence at all levels of the residential care service’s operation as well as across the broader service system.

In summary

The existing literature largely addresses the provision of purposeful therapeutic care for young people with significant therapeutic needs. There is a gap in the literature in considering the application of a trauma-informed therapeutic approach across all types of residential care services provided to all cohorts of young people. Despite this, the existing literature contains some messages which can help inform such an approach. These are discussed in the next section of this report.
CONSIDERING A ‘BEST FIT’ FRAMEWORK FOR QLD

This section of the report provides a summary of the evidence used to inform the development of the proposed ‘best fit’ therapeutic framework for Queensland. This has included input from the consultation processes, the Expert Advisory Group, consultation with young people living in residential care, consultation with parents, the literature review and the scoping survey.

6 Key inputs from the consultation processes

This section summarises key messages from the consultations that have informed the proposed framework.

6.1 Expert Advisory Group (EAG)

Members of the EAG advised that the framework should:

- demonstrate responsiveness to the healing needs of Aboriginal and Torres Strait Islander young people and their families, understanding the impacts of inter-generational trauma and the legacies of history
- identify requirements across the domains of life in residential care – individual/group, organisational, and the broader context
- identify the need for robust individualised assessment at entry to and transitioning from the service, attending to both individual and group needs
- support the use of processes to promote:
  - active listening to the young person’s voice
  - shared values across the organisation
  - leadership, with varying responsibilities, at all levels of management and staff
  - staff forming a clear, simple picture of what is required
  - a systemic ‘holding environment’, by describing the staff actions that are meaningful ‘every day and in every way’, in helping young people make safe decisions
- focus on transition from the residential within the context of the purpose of the placement, for example, reunification with family or transition to adulthood
- incorporate step down/transition support to provide continuity of workers and interventions
- support the creation of physical environments that are ‘spaces to create healing’
- promote congruence, to ensure that administering organisations’ senior management do not ‘undermine’ direct care workers.

EAG members emphasised that how the framework is implemented will impact whether the intended outcomes are achieved.

6.2 Regional consultations

The regional consultation and engagement processes indicated that the prospect of Queensland adopting a consistent trauma-informed therapeutic framework for residential care has widespread support.
Themes around the notions of care and of meeting young people’s needs included at their core a focus on safety, nurturing, meeting developmental needs, and healing. While extensive information was provided about care needs, the following contributions were emphasised:

- the need for care to be nurturing, safe and predictable, and the importance of understanding a young person’s sense of safety
- the need for care to be individualised
- acceptance and unconditional care
- engendering hope – a future orientation
- opportunities for participation in decision making
- attention to transitions in and out of the service, including, for older young people, pathways and direction to independence and adulthood.

The roles of the residential care workers were discussed in detail, noting the centrality of this role and the importance of relationship (young people’s connections to carers).

Programming of the residential care daily routine was raised as important in implementing a therapeutic approach, including the need for structure and routine as well as opportunities to ‘have fun’, to ‘learn to practice’ managing emotions, to explore and build relationships, to learn living skills within a safe and supported environment.

The importance of the physical environment of the residential was mentioned in relation to impact on young people’s sense of belonging, feeling ‘at home’ during their stay and the interplay between the physical environment and managing emotions. The physical environment includes the building, the arrangement of spaces within the building and the use of those spaces (by whom and when), appearance and signage, fixtures and furnishings, the grounds on which it is located, its location, and proximity to transport and access to schools, employment and activities.

A common theme was the interface between decision-making and planning at the residential care level and assessment and planning at the departmental level. Issues commonly raised were:

- the need for information sharing between the department and the residential care service so that residential care workers are aware of young people’s needs
- the specificity of day to day planning (what carers need to do in helping meet a young person’s needs)
- clarity of case management and casework roles and responsibilities between the department and the residential care service
- the timeliness of decisions relating to young people’s care (where otherwise they face uncertainty and increased anxiety)
- consideration of greater devolution of decision-making responsibilities, for example around activities involving family, community and culture, and less risk aversion.

There was a great deal of consensus around the need for a trauma-informed therapeutic framework to include a focus on building and maintaining connections. This includes both connecting ‘out’ – to the community – and connecting ‘in’ – bringing family and community members into the residential.

The importance of connections with family, community and country for Aboriginal and Torres Strait Islander young people was emphasised. In relation to connecting young people to their culture and country, common themes were the current limited understanding of what this means in practice beyond token attempts.

There is a good deal of shared understanding (despite different models) around the concepts of needs, trauma, and therapeutic care. Issues raised included:
the disconnect between knowledge and its application in practice
the challenges of staff engagement and buy-in to implement the model.

Matching was raised as an important issue in relation to meeting young people’s safety and therapeutic needs. It applies at both the individual level and the group population level.

Issues raised included:
- assessment frameworks and processes to identify individual need
- the impacts of poor matching (often re-traumatising) and young people reporting feeling unsafe in residential care services
- the need for shared decision-making by stakeholders around matching
- identifying need at the group (population) level and the range and mix of services required.

A common theme was that of ‘partnerships’ within the service system and the need for a partnership approach to support implementation of a trauma-informed therapeutic framework. This included an emphasis on:
- shared responsibility
- clarity about roles and responsibilities
- sharing of resources.

### 6.3 Consultation with Aboriginal and Torres Strait Islander workers

Participants at the consultation with Aboriginal and Torres Strait Islander workers emphasised that culture and young person’s connections with family, community and country must be embedded in all aspects of caring for Aboriginal and Torres Strait Islander young people and must not simply be an ‘add on’. The views expressed by participants as to how residential care can meet the needs of Aboriginal and Torres Strait Islander young people were wide-ranging. Matters discussed with particular relevance to a trauma-informed therapeutic framework included:
- the importance of identifying cultural support requirements across each domain of the service system
- the need for cultural support planning to be individualised and to take account of the young person’s connection to their country as well as family and community
- better structural support for detailed cultural support planning information to be made available to residential care workers (e.g. through the Recognised Entity)
- the need for residential care service providers (that are not community-controlled or based in community) to be well-connected to local Aboriginal and Torres Strait Islander communities including elders groups
- increased accountability for non-Indigenous service providers to demonstrate cultural competence in the care of Aboriginal and Torres Strait Islander young people
- seeking ways to ‘build in’ young person’s connections to their everyday care, such as having family members being part of daily care within the residential by establishing the conditions in which this can be done safely.

### 6.4 Consultation with government agencies

Representatives of each of the government agencies consulted conveyed support for the concept of a trauma-informed therapeutic framework across residential care in Queensland. There was discussion of the concept of a continuum of need, that is, while every young person in care has suffered trauma, not all need therapeutic intervention.
It was noted that for an approach to be therapeutic, it must be nurturing and consistent. Continuity of workers is important, and ideally a key worker would continue contact with a young person after they transition from the service. It is important to ensure that young people do not become ‘more detached’ through the experience of care.

The importance of strong linkages between residential care workers and young people’s schools was noted in relation to educators being informed about and understanding individual needs.

The need to respond to behaviour in ways which convey understanding, provide reasonable and safe boundaries, and support the managing of emotions was frequently raised. Discussion included the ways in which a therapeutic approach can help to manage incidents. This included, where appropriate, avoiding the use of police authority to deal with behavioural incidents, noting police call-outs are often a pathway towards involvement in the youth justice system including detention.

The need to reinforce shared decision making about young people and for collaborative positive relationships between service providers and other services was noted. Information sharing was seen as essential, with the need to address current perceived barriers to sharing information. Better integration of case planning, and related care planning, is required, noting that young people may move between residential settings and family (and may ‘run to’ family). Case plan contingencies can accommodate this, such as shared parenting and increased communication within a ‘care team’ as a ‘co-parenting’ unit.

The need for consistency and congruence within and across organisations was emphasised, including the need for a shared understanding and identification of trauma and a working knowledge of ‘trauma analysis’ in partnership with residential care service providers, Child Safety Officers (CSOs) and other departmental representatives, and personnel from other government departments. It was also noted that service providers need the policies and procedures, and the confidence and authority, to support staff to make the sorts of (non-guardianship) decisions which would be appropriately made by parents in the same circumstances.

6.5 Consultation with CALD representatives

Consultation with CALD researchers emphasised that the framework needs to consider these points:

- The importance of collecting CALD information as part of departmental and non-government service information systems
- Cultural considerations should be child-focused and the risks of ‘cultural absolutism’ and ‘cultural relativism’ managed
- Recognising the importance of culture and acknowledging that a lack of recognition leads to a loss of culture and further traumatises young people
- The importance of obtaining the young person’s and family’s views of ‘matching’ and, where shame (collective culture) is an issue, assisting the young person and family to work through this
- All staff require training in CALD cultural awareness
- Staffing to be bi-cultural and reflect the diversity of young people
- Young people and staff in residential care services should have access to CALD cultural advisors
- Any framework must be culturally responsive at all levels of service delivery, including throughout organisations and the wider service system.
6.6 Young people's views and experiences

The 17 young people who participated in the consultation about the project contributed significantly to questions around what constitutes good quality residential care. A summary of their input is contained in Appendix D.

Young people's views and experiences highlight the importance of their relationship with residential care workers and the critical role they play in caring for, and working with young people. Establishing safety, building relationships, strengthening connections and managing feelings and reactions are all core aspects of therapeutic care. Young people’s views and experiences of residential care provide a rich source of information about what is important to them in relation to each of these areas, what they think is working well and what they think could work better, and what makes a good residential care worker.

There is a high level of consistency between what young people have to say about residential care and issues raised in the literature and by other stakeholders. The implications of young people’s views and experiences for a therapeutic approach to residential care are summarised below.

- **Safety**

Young people highlighted the significant role played by residential care workers in making them feel safe. Aspects of safety identified as important included physical, emotional and cultural safety, privacy, safety planning and living with siblings.

- **Being protected and looked after by staff.**
- **Physically** – I feel safe when I know that the workers are confident. When I know they can handle everything.
- **Staff making time for young people and talking with them.**
- **Following individual’s safety plan for young people.**
- **Having a worker on that is the same culture as the young person.**
- **Place siblings together** – didn’t have that when we were taken into care and we were separated. My sister didn’t do well, she’s totally off the rails now - it might have been different if they’d kept us together.

Safety and privacy were also highlighted as areas that need to be improved.

- **Having privacy from other young people in your bedroom and in the bathroom.**
- **Responses to young people at risk are not always good** – some workers help, others don’t do enough to make young people feel safe.
- **Workers come into our room to check on us constantly even if we don’t have issues** – there’s no privacy.

- **Relationships**

Communication was identified as the cornerstone of staff building positive relationships with young people. Other important strategies identified included openness and honesty, staying calm, having fun and doing activities, showing respect and caring, showing affection and maintaining confidentiality.
Spend time with young people and talk with them.

Honesty is really important to developing positive relationships otherwise you give young people false hope.

The workers shouldn’t yell, they need to stay calm.

Have fun with young people – join in with games that we like – participate in ‘silliness with us’.

Show and say they care.

New workers should build relationships based on their own personalities.

Giving hugs and showing affection to young people.

These elements of relationships with staff were identified by some young people as working well and by others as needing improvement, or as being used by some staff but not others. In particular, staff actively listening to young people was identified as an element needing improvement.

Let young people have their own say and opinions.

We want to be listened to and told of the outcomes when we make a complaint against a worker.

Living and interacting with other young people was also identified by some young people as working well and by others as needing improvement.

Good to be around other young people, it stops isolation.

Cooperation between young people.

Not good to have all young people with really high level issues – they shouldn’t all be put together cause they feed off each other and get worse.

Better matching of young people when placing them in the residential. Young people need to be matched as it really affects them e.g. age.

A range of characteristics that make a good worker was identified including being kind, honest, a sense of humour, friendly, generous, patient, strong, and empathic. Other factors contributing to a good worker were caring for young people and acting as a parent; worker skills, knowledge and experience; and assisting young people.

They treat you like a normal kid, they act like a normal parent would.

Nurturing instinct - do basic things that a parent would do.

Taking an interest in the young person and remembering things that they’ve done.

Have studied, have a diploma.

• Connections

Young people emphasised the important role of residential care workers in connecting them with parents, siblings and other significant people. Their views as to whether enough was being done to keep them connected varied significantly.

The factors identified as contributing to maintaining connections included being reminded about contact arrangements, being given access to the phone, being transported, being encouraged to keep contact and having siblings sleep over.
Transport to family contact appointments.

Let us use the phones to keep in touch with our family.

The factors identified as not contributing to maintaining connections included insufficient effort, practical difficulties of congregate care, lack of trust in young people, and different policies across residential care services.

Difficult to visit siblings from other placements as workers can’t transport me in the car (insurance).

The workers should encourage more planned activities to help with family contact – sometimes you don’t know what to say to family and planned activities would help.

• Managing how they feel and react

Giving young people space to calm down was stressed by young people as a means by which residential care workers could help them to manage how they feel and react when they are having a hard time in their lives. Other strategies for helping include safety planning, one-on-one time, rules and boundaries, external assistance and understanding mental health.

Giving young people space.

Have a plan in place for how a young person wants to be treated when they are upset and follow it.

Help you calm yourself down.

Don’t just do life skills with us; workers need to help young people work on their issues.

Help them to see a counsellor, convince them to see a counsellor, maybe talk to the young person about the counsellor.

Young people were generally familiar with the use of safety planning within residential care. A number of young people indicated that whilst safety plans were being developed they were not being used at times when they believed they should be.

• Other significant factors

Rules and boundaries also figured prominently in young people’s views and experiences of residential care. Whilst understood as part of life within residential care, young people raised issues of fairness about how rules and boundaries are applied across young people and residential care services.

Flexibility when dealing with the rules.

Rewards and consequences around behaviour need to be more even – if incentives are given for young people to go to school or do a task, then incentives also need to be given to young people who are doing the right thing e.g. going to school.

(There should be) fairness and the same rules across all residential houses.

Staffing of residential care services was identified by young people as significantly impacting their experience of residential care.

Rostering male and female staff together was identified by some young people as a positive feature of staffing. Longer shifts were also identified as allowing for more consistency in the care of young people.
Male and female workers provide good role-modelling for young people.

I think it is really good some services have a male and female worker on working together. It normalises the experience for kids. It lets kids learn to get along with people of both sexes. Some spend four years with just females, so that is not normal.

It’s good when youth workers are on longer shifts – this allows for consistency.

However, it was noted that gender issues and possible impacts on emotional safety of some young people also needs to be considered.

I don’t like male workers, sometimes they have a male and female worker on and I don’t feel safe, I don’t like male workers because of stuff that’s happened to me ....

Improvements to staffing were also identified including screening workers, training workers, putting workers on longer shifts and reducing staff turnover.

Screening should be done to ensure that the workers intend on staying.

Training needs to be done with the workers to ensure that they are aware of what to expect in the workforce and in the houses so they don’t leave - before young people get attached to them and they leave. This would lessen young people’s heartbreak.

Put youth workers on longer shifts.

Worker turnover. It’s way too high. People come in and do one or two shifts or stay a couple of weeks and then leave. Makes it really difficult to build relationships, makes it hard to feel safe especially for young people who haven’t had good relationships with people. Makes us angry.

6.7 Parents’ views and experiences

Throughout this project, consultations reinforced the importance of connections for young people in residential care, including in particular connection with family and with culture. Attempts were made to speak with family members of young people living in residential care, to ascertain their unique views. This resulted in two parent-figures of young people living in residential care being interviewed. They were the parent of a 16 year old non-Indigenous boy and the long-term foster carer of a 13 year old Indigenous boy. This small number does not provide representative views. Their experiences are however indicative of the possibilities for collaborative relationships between residential care services and parents.

The different cohorts of young people in residential care include differing levels of connection at the time of entering residential care. Some young people have been in out of home care for many years and may be disengaged from family or have few family members maintaining contact. Others have entered residential care from disrupted family settings, and family bonds, though conflicted, are intact. For some young people, contact with some family members brings emotional risks which must be monitored. For all, establishing and/or maintaining a level of contact which is optimal for them at various stages of their journey in residential care is important.

The two parent-figures to whom we spoke highlighted issues which are reflected in literature about residential care and which are part of the framework developed through this project. These are summarised below.
• **Building a working relationship with the young person’s primary family members facilitates connections**

It is acknowledged that connections work is important. It must also be acknowledged that helping a young person build connection in turn requires that the residential care staff facilitating this have a working relationship with the family. This was illustrated by the parents with whom we consulted:

*Especially at the beginning, they would always have a chat. They are always warm and welcoming – not just dropping him off at the front gate.*

*I have met most of the staff.*

In discussing the relationship between residential care workers and family members, the building of trust was a recurring theme:

*It is nice for him to know they (the workers) are trusted in my house.*

*They trust in me. I don’t feel like they are looking over my shoulder all the time.*

*When they say they are going to do something, they do (like dropping him off and picking him up).*

In general, the need for good communication between the residential care staff and family members was emphasised, with the ability to communicate seen as a key attribute for residential care workers:

*The staff are easy-going, easy to talk with – I suppose you’d call that communication, that’s good.*

For Indigenous young people, the need for residential care workers to facilitate family contact within their community was acknowledged, even if the residential is at some distance:

*He has time with his own family. They are at (a remote Aboriginal community). He goes there during some school holidays and stays at the Safe House. He rings me from home when he is there* (non-Indigenous long-term carer of an Indigenous young person).

• **Family members should be part of the care team for a young person**

The concept of being a ‘team member’ was important to the parents with whom we spoke, where active shared caring was occurring:

*They treat me as a team member. They listen.*

However even in these circumstances, parents did not always feel that they were included in decision-making or felt that their inclusion in planning dropped off after initial planning:

*I’m not involved in care planning at this stage. I was at the beginning when he first started coming home, sitting down and looking at his routines. Not sure why I am not involved in care planning now. I was when he was in foster care – I was the main person then.*

*They do keep me informed but not all of the time. He is with me four days a week now, so he is with me more than with them. We have Family Care Meetings with the department, the head of the residential and someone else. We had a few of these meetings early on until he settled but less often now.*
• Residential care can be part of shared care, including family-based care

Both the parent figures with whom we spoke were part of shared care arrangements in which the role of the residential care staff was crucial in supporting the arrangement:

*He is with me four days and with them three days. They transport him to and from home. The transport is very helpful as it is a 90 minute trip.*

*He comes to me on the weekends. They do the transporting.*

In each of these cases, residential care staff provided vital support for the young person’s home stays, including transport to and from the family home, and material support:

*They send him with food and stuff, which is very helpful as I don’t get any money for him now.*

Both these parents also appreciated that residential care staff shared, and sought, information which was important for consistency in shared care:

*Sharing of information has been good. They chat when they come to pick him up. They let me know to be aware of stuff.*

*They are positive, try to work out problems. I can rely on them, they are happy to share information.*

• The attributes of good residential care include understanding the young person’s (and family’s) circumstances and responding with empathy

The parents with whom we spoke both conveyed that feeling ‘understood’ by the residential care workers caring for their young person was important for them as well as for the young person. This may link to the complexity of emotions held by parents of young people who have entered care as adolescents, for reasons related to conflict within family and the inability of family members to meet their needs.

(Residential care workers need to show) *lots of patience, being caring and understanding, think about what’s been happening, look at where parents have come from too.*

(For the young person) *They are patient and understand him. It helps having younger staff, especially with his age.*

(For the young person) *The workers need to show empathy, be strict but flexible, not just giving them anything they want, have a routine.*

While both parents spoke of working with residential care workers to better understand their young person, the need to be cautious about expectations to ‘fix’ the young person was also evident:

*For someone in my circumstances it (the young person being in residential care) has been great. His physical and verbal violence has really settled down. They have helped him see that it is not okay.*

*There is a diverse group of people, young and old, which helps keep him in line.*

• Parents want to know that their young person is being safely cared for (physically and emotionally) and that their needs are being met

The two parent-figures with whom we spoke were satisfied that their young person was ‘in good hands’ in residential care:
Yes, no problem with that at all.

He has run-ins with other boys but nothing that you wouldn’t have here at home.

For one, it was reassuring to have seen the home:

I’d say it (the house) was fine. Nothing new and fancy, but no problems with it.

The other parent-figure had never been to the house because of distance. However she was aware of some issues which impacted her young person:

At times when different kids come in there is upheaval – physical fights and incidents. New ones coming in can lead to bullying, asserting the pecking order.

He has learned to lock his door so that stuff doesn’t get taken.

Part of appropriate care is schooling, recreational activities and (for Indigenous young people) cultural activities. The parents to whom we spoke were satisfied about the actions of the residential care services in these aspects:

He is now starting to go to school full-time. He has been on a moderated program.

(He does) stuff he loves, eg basketball. He was doing boxing at the PCYC. It’s all about body image. Most of his activities (from before he went into care) have continued.

He goes to church now.

They (the residential staff) take him to Indigenous festivals etc. When he was with me, he went to Indigenous art and footy at (an Indigenous support service). It’s too far away now.

In summary, while these two parent-figures are not necessarily representative of parents of young people in residential care, their experiences illustrate the positive working relationships which can exist between parents and residential care staff, to the benefit of young people. Their comments highlight the important role that residential care can play in engaging and working with parents, and how this can support establishing and/or maintaining and strengthening connections between young people and families.

7 Literature review – key themes

The following is a review of key literature which has informed the evidence base for the proposed trauma-informed therapeutic framework for residential care in Queensland.

7.1 Trauma-informed care

The emphasis on trauma and its impact on the needs of young people is part of an ongoing journey in how we understand the needs of young people in out of home care and the development of services to meet those needs. Wise (1999), Bath (1998) and Morton, Clark and Pead (1999) have documented that change from ‘care’ and notions of dependent young people, to defining the developmental needs of young people, to the impact of trauma.
Trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful — they are also shocking, terrifying, or devastating to the survivor, resulting in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness. (Courtois, in ACPMH 2014, p. 12).

Young people may have been exposed to trauma prior to coming into care, through entering care and whilst in care. (ACPMH 2014; CCYP 2013) For Aboriginal and Torres Strait Islander young people trauma may also be inter-generational through the continuing impact of colonisation and the forced removal of children (Atkinson 2013; Healing Foundation 2013). There is increasing acknowledgement of the notions of cultural safety (VACCA 2008; Williams 1999) and the importance of cultural approaches to healing (Atkinson 2013; Healing Foundation 2013).

The Mental Health Coordinating Council (2013) identified eight foundational principles of trauma-informed care and practice based on a review of the literature. For the purposes of this project, these principles have been adapted to focus on young people as follows:

Understanding trauma and its impact. Understanding traumatic stress, and how it impacts young people, and recognising that many challenging behaviours and responses represent adaptive responses to past traumatic experiences.

Promoting safety. Establishing a safe physical and emotional environment where young people’s basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.

Ensuring cultural competence. Understanding how cultural context influences perception of and response to traumatic events and the healing process: respecting diversity; providing opportunities for young people to connect with family, community, culture and country; and providing care that is respectful of and specific to cultural backgrounds.

Supporting young people’s control, choice and autonomy. Helping young people regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy, keeping young people well-informed about all aspects of their care, outlining clear expectations, providing opportunities for young people to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

Sharing power and governance. Promoting democracy and equalisation of power differentials; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures.

Integrating care. Maintaining a holistic view of young people and their healing process and facilitating communication within and among service providers and systems, and coordination of interventions.

Healing happens in relationships. Understanding that safe, authentic and positive relationships can promote healing and restoration.

Restoration is possible. Understanding that restoration is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for young people and former young people’s involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.
As noted above, there is a gap in the literature in the application of the understanding and knowledge of trauma to caring for and working with young people in residential care services beyond that in therapeutic residential care. In Australia, the work of Bath (2008, 2015) and Downey (2009 and in Commission for Children and Young People 2013) has contributed to the practical application of this understanding and knowledge to day to day care and working with children in residential care. McLean’s (2013) work on frameworks for understanding challenging behaviour in out of home care highlights the diverse views held by stakeholders about the origin and solution to challenging behaviour, and the under-representation of accounts attributing problem behaviour to traumatic experiences.

Bath (2015) notes that much of the healing from exposure to trauma takes place in non-clinical settings and the importance of relational support and guidance in responding to trauma. The key elements of responding to trauma and promoting healing (van der Kolk 2005; Bloom 2005a; Holden 2009; Anglin 2002; Commission for Children and Young People 2013; Hodgdon, Kinniburgh, Gabowitz, Blaustein, and Spinazzola 2013; Bath, 2015) include:
- creating a sense of safety
- providing structure, routine and predictability
- building relationships and connections
- identifying and managing feelings and responses
- empowering and establishing new ways of being.

The interaction and sequential nature of these elements is also emphasised.

### 7.2 Trauma-informed therapeutic residential care

A review of the literature indicates the following key elements of trauma-informed therapeutic residential care services (DCCSDS 2014; Thomson, McArthur & Winkworth 2005; Anglin 2002; Verso Consulting 2011; National Therapeutic Residential Care Forum 2015).

#### Residential care environment

- Individualised – focused on the individual needs and situation of the young person
- Developmentally focused
- Safe and secure emotional and physical environment
- Relationship based
- Democratic and participatory – developing autonomy and competence
- Planned – based on comprehensive assessment - linking day to day interactions with programming
- A home like living environment – positive use of physical setting and space to support safety, a sense of belonging and healing
- Access to therapeutic interventions – internal/external.

#### Connections

- Inclusive of family
- Connection to community, culture and country.

#### Organisation

- Policies and procedures should support trauma-informed care
- Staffing recruitment, support, supervision and training
- Management processes - democratic and participatory.
Service system

- Access to therapeutic interventions (internal/external)
- Coordination with other services involved with the young person
- Needs based service development
- Matching need to service type – individual and population
- Integrated range and mix placement and support services
- Workforce development
- Interface with other service systems (health, education, youth justice, disability etc).

Two elements identified as relevant to the each of the dimensions are congruence (Anglin 2002) and cultural proficiency (QATSICPP 2014; Healing Foundation 2013; VACCA 2008; Williams 1999; Kaur 2014).

Implications for the proposed framework

Changing understandings of need

As understanding of need changes there can be a tendency to move from one to another, or to focus more on the emerging understanding rather than building on the previous understanding. It is therefore important that the framework reflects a holistic understanding of the care of young people including safety, nurturance, development, and healing.

Aboriginal and Torres Strait Islander children

The over representation of Aboriginal and Torres Strait Islander young people in out of home care highlights the importance of cultural understandings of safety and healing in all aspects of residential care service delivery. It is therefore critical that these understandings are embedded in the framework.

Residential care

Residential care is used for different purposes for different groups of young people and the nature and intensity of their needs may vary across these services. It is therefore important that the framework is applicable across the range of residential care services and not just focused on therapeutic residential care (as defined in the literature; McLean et al 2011).

Domains of residential care and congruence

Young people’s experience of residential care and the ‘life’ of residential care services are impacted by the residential care environment, other parts of the organisation providing residential care and the broader service system. It is therefore important that the framework identify and reflect an understanding of the domains of residential care including the residential care environment, the young person’s connections, the service provider/agency and the service system. Each of these domains contributes to the young person’s experience and therefore must be congruent to achieve the desired outcomes.
Impacts of trauma

Whilst most young people in out of home care will have experienced trauma, the impact of trauma will vary according to their age and development, history of trauma, mental and emotional strengths, and available supports (CAAB 2009). It is therefore important the framework:

- considers the impact of trauma in the context of the young person’s broader age and developmental care needs
- supports the practical application of responding to trauma, that is, what workers are expected to do
- promotes the need to develop a shared understanding across stakeholders.

Therapeutic care

The key elements of responding to trauma and promoting healing reflect requirements for a therapeutic approach to the day to day care of young people in residential care. It is therefore important that the framework identify focus areas for practice that address the impact of trauma, assist young people to make sense of how they feel and act, and strive to gradually restore functioning, support growth and improve well-being.

8 Assessment of current models in Queensland

When asked as part of the scoping survey to briefly describe their model of care, some of the 34 respondent organisations referred to application of CARE© or Sanctuary©-based models, and some outlined a therapeutic model specific to their organisation. However most of the organisations described activities, principles and/or training frameworks, rather than articulating a model of care which indicated a therapeutic approach. These were often thoughtful and well-based, reflecting effort to deliver care that responds to the needs of individual young people.

Discussion with some of the organisations that use CARE© and Sanctuary©-based models indicated that each of these organisations has added agency-generated additional elements and/or external supports to supplement and/or tailor the model to their organisation’s needs.

Responses to the scoping survey which requested organisations to briefly outline their model of care were thematically analysed to ascertain whether it could be inferred that the organisation adhered to a model of care and, if so, whether the model was underpinned by a therapeutic approach to care. Figure 6 summarises the results of this thematic analysis, giving the predominant ‘model’ description provided by each organisation.
Note that the above figure includes 44 categorised responses (for 34 organisations). This is due to respondents for 10 organisations providing quite different responses for various residential care services within the same organisation. For example, within the one organisation, the respondent for one service stated that ‘TCI’ is the model used, while another respondent stated that ‘Transforming Care’ is the model. It is likely that the organisation accesses training in both. However these responses illustrate that the concept of a model of care is not held strongly by some organisations.

As noted, in response to the request to briefly outline their model of care, only 10 (26%) of the 34 organisations outlined a model which had a clear trauma-informed and/or therapeutic basis. This included 4 organisations implementing CARE© and Sanctuary© or Sanctuary©-based models, and 6 organisations that outlined agency-specific models.

Others referred primarily to TCI (Therapeutic Crisis Intervention) as their model, in some cases supported by other trauma-informed training:

We adopt Therapeutic Crisis Intervention and the Three Pillars of Transforming Care. Children are supported behaviourally in the home and then in the school, through sport, through family interaction and through the community.

Some organisations quoted sources from the trauma-informed care literature as the basis of their model:

Our program aims to provide care that is person centred, outcome focused, culturally responsive and collaborative. Our service does not currently prescribe to a specific model however principles of practice include elements of Sanctuary and CARE models with a focus on non-violence, participation, connectedness, attachment building, developmental focus, ecological orientation and building resilience.

Others primarily quoted a set of principles and gave general descriptions of what the service does in supporting young people:

We use a holistic strengths-based approach that is child/young person focused and family centred. We assist and advocate for each child/young person to reach the best possible outcomes and in respecting each child’s/young person’s right to self-determination we help each child/young person to make their own choices.
Our framework is inclusive of aspects such as safety in their environment, safe and reliable relationships with workers, establishment of healthy family, community and social connections, building capability and confidence, links to clinical support for young people, positive behaviour support including use of logical consequences.

Overall, the responses to the question about model of care indicated that some organisations have put considerable effort into developing a model, or a practice framework, which does include a focus on being aware of and responding to young people’s trauma-based needs. However the responses of the majority focused upon a combination of:

- the training provided to staff to respond to the trauma-based behaviour of young people (e.g. TCI and Transforming Care)
- statements of principles such as being child-focused and strengths-based
- statements about the focus of work done in supporting young people, such as supporting connections
- in some cases, references to working to departmental requirements and adopting the new Strengthening Families Protecting Children Framework for Practice.

One organisation mentioned culture, and in particular maintaining cultural connections, as an important element of their model.

In summary, it is clear from consultation and the input to the scoping study that:

- some organisations have developed and implemented models for the provision of therapeutic care and/or care which responds to young people’s individual trauma-based needs, which are well-grounded and supported by in-house training and processes
- the majority of organisations providing residential care services do so on the basis of good principles, relevant programs, and training in understanding trauma and providing therapeutic crisis intervention to challenging behaviour.

There is considerable variation in the stated approach underpinning practice across Queensland residential care services. As the majority of respondents to the scoping survey did not articulate a coherent framework or a model of care, the service system would benefit from a consistent framework which could provide guidance where needed and reinforce a therapeutic approach to practice where this is already in place.

9 Rationale for the proposed framework

This section summarises the reasons, as discussed in this and the previous section, for the proposal of a specific framework for a trauma-informed therapeutic approach for Queensland. The proposed framework is detailed in the following section of the report.

The out of home care service system is complex. Residential care is one of a range of flexible, responsive out of home care and support interventions available to meet the diverse needs of young people who are unable to live with their families at a point in time. The use of residential care is both purposeful and planned in response to young people’s needs, with particular attention given to their transitions into and out of the service.

In Queensland, residential care is used for a range of purposes including:

- meeting young people’s needs for intensive support services, where these services are unable to be provided within family-based care
- maintaining young people’s connections with family, community and culture where family-based care is unavailable
- keeping siblings together when this is not possible within family-based care
• providing emergency or short-term care facilitating initial assessment and planning
• preparing young people for reunification, transition to family-based out of home care, or transition to independent living
• supporting semi-independent living.

Residential care services must be part of a coordinated and integrated range of in home and out of home care and support services that share responsibility for meeting the needs of young people and their families. In considering the ‘best fit trauma based practice framework for the Queensland context’, it has been important to take account of key issues within the current context. In addition to the above, these include:

• the number of young people being placed in residential care and the rapid growth over a short period of time
• the high proportion of Aboriginal and Torres Strait Islander children in residential care, yet the low proportion of Aboriginal and Torres Strait Islander staff employed in residential care and the low number of community-controlled organisations providing residential care
• the range of purposes and cohorts of young people for which residential care is used
• the types of residential care services currently being provided
• the rapid growth in the number of organisations providing residential care and the number of residential care services being provided. Issues include:
  – different capabilities
  – variation in stages of development of in-scope services
  – current variable use of models and/or frameworks
  – significant geographic spread
• the roles of other (non-residential) government and non-government service providers within the wider service system for residential care
• the place of residential care as part of the wider out of home care system and the wider child protection system – as noted, residential care is in a period of ‘transition’ as its role is strategically considered.

In considering this context and the information gathered about models of care in use in Queensland, these observations have been made:

• There is widespread variation, with some organisations implementing a service-wide therapeutic care model and other organisations not articulating a model of care but describing good practice principles that underpin their service provision
• The scoping survey results indicate that across many of the organisations providing residential care, there is currently limited understanding of what it means in practice to work from a trauma-informed therapeutic perspective
• Some organisations in Queensland have made significant investments in commercially available trauma-informed models of care or in developing their own models – an overarching framework would be consistent with (not replacing) such models while providing foundational support for other organisations
• Some larger organisations have adopted the CARE© model and some are using Sanctuary© or a Sanctuary©-based composite model. Discussion with some of these service providers indicated that:
  – these models do not reflect an understanding of Aboriginal and Torres Strait Islander cultures and traditions, and the legacies of dispossession. A framework for Queensland must embed cultural proficiency and culturally-informed responses at every level
  – the experiences of these organisations have demonstrated that successfully adopting one of the recognised models requires whole-of-organisation readiness and commitment to the specific model, and significant ongoing resourcing
Given the range of service types to be included in the framework, and the range of cohorts of young people, any framework which applies across all services needs to be foundational and flexible. It must apply to young people who do not have significant trauma-based therapeutic needs, as well as those who do.

In particular, a framework for Queensland must embed cultural proficiency and culturally-informed responses at every level.

The existing literature largely addresses the provision of purposeful therapeutic care for young people with significant therapeutic needs. In terms of the state of the evidence:

- there is insufficient evidence to support one therapeutic model or intervention over another
- there is a gap in the literature in considering the application of a trauma-informed therapeutic approach across all types of residential care services provided to all cohorts of young people.

Consideration of these issues has led to the conclusion that adopting one of the commercially-available existing models of therapeutic care is not a solution for a trauma-informed therapeutic framework to be applied across all Queensland residential care services. A framework specifically designed for Queensland will be more effective in improving service delivery across the state to our young people in residential care.

The small number of Queensland organisations that have implemented the CARE® or Sanctuary® models or another organisationally-specific model of therapeutic care will continue to provide care consistent with these models. The proposed overarching framework does not dictate a model of care. It is consistent with such models, while providing foundational guidance for all residential care organisations and promoting consistent principles, practice and outcomes.

Attachment 1 to this report outlines the proposed hope and Healing Framework for Residential Care.
REFERENCES


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Department for Education (2014) Rethinking support for adolescents in or on the edge of care.
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National Therapeutic Residential Care Forum (2015) *TRC definitions and principles*.


Queensland Aboriginal and Torres Strait Islander Child Protection Peak (2014) *Practice Standards: Working with Aboriginal and Torres Strait Islander children and families*. QATSICPP: Brisbane.


APPENDIX A

List of government agencies consulted

- Department of Communities, Child Safety and Disability Services, Child Safety Services – Child and Family Services
- Department of Communities, Child Safety and Disability Services, Child Safety Services – Indigenous Practice Leaders
- Department of Education and Training
- Queensland Family and Child Commission
- Department of Health
- Department of Health (Evolve Therapeutic Services)
- Department of Justice and Attorney-General (Youth Justice)
- Office of the Public Guardian

In addition to the government agencies listed above, contact occurred with the following:

- Evolve Behaviour Support Services, Department of Communities, Child Safety and Disability Services
- Queensland Police Service
- Department of Aboriginal and Torres Strait Islander Partnerships.

Health and Community Services Workforce Council

Contact also occurred with the Health and Community Services Workforce Council.
APPENDIX B

Expert Advisory Group

The membership of the Expert Advisory Group is:

- Rachel Atkinson (Palm Island Community Company)
- Noeleen Lopes (Gallang Place)
- Sandy Wilson (North Coast Region, DCCSDS)
- Toni Cash (Practice Leadership Unit, DCCSDS)
- Gregory Nicolau (Consultant Psychologist, Psychotherapist and Family Therapist)
- Ian Nussey (Psychologist)
- Lucas Moore (CREATE Foundation Queensland Coordinator)
- Howard Bath (researcher and academic)
- Michael Dawbney (Queensland Health)
- Laurel Downey (Catalyst Child and Family Services)
- Lisa Hillan (Healing Foundation).
List of organisations (residential care service providers) that participated in the scoping survey for this project

Ablecare
Act for Kids
Alternate Care Pty Ltd
Anglicare Central Queensland
Anglicare North Queensland Limited
Anglicare Southern Queensland
Anniez Plaze Pty Ltd
Carinity
Catalyst child and family services Ltd
Cerebral Palsy League of QLD
Churches of Christ Care
Co-Ordinated Support Services
Endeavour Foundation
Excelcare Australia Inc
Foundations Care
FSG Australia
GSL: a Good Start to Life
House with No Steps
Integrated Family and Youth Services
Life Without Barriers
Lifestyle Solutions
Mercy Community Services – Family Services
Mission Australia
Northern Peninsula Area (NPA) Family and Community Services
Palm Island Community Company
Reddy Respite Services Pty Ltd
Safe Places for Children
Silky Oaks Children’s Haven
South Burnett CTC
Southern Cross Support Services
United Synergies
UnitingCare Community
Youth Lifestyle Options (Residential Care Services)
Youth Care Support Services
APPENDIX D

Summary of young people’s views and experiences of residential care

What works well in residential care?

The two most common things identified as working well were relationships with other young people and staff.

Living and interacting with other young people was good in terms of meeting different types of young people, sharing experiences with and learning with each other, getting along together, and stopping isolation.

Relationships with staff were good in terms of having staff who care and look after you, interacting with staff, staff providing support, being rewarded for positive behaviour and buying you things without being asked.

Other things identified as working well included:
- staffing including mixed gender contributing to making it feel like a family and the importance of longer shifts for consistency
- learning in terms of relationships, being trustworthy, working as part of a team, taking responsibility and life skills
- planned entry and exit of residential care services
- living with siblings in terms of being together and having fun
- involvement with activities
- safety and privacy in terms of locks on bathrooms and separate bathrooms for males and females
- access to food and providing a family environment.

What can be improved in residential care?

Relationships with staff was identified as needing improvement in terms of worker attitudes towards them, wanting to be treated as an individual and with respect, the need for space and freedom, and worker accessibility. Others identified the need for more understanding in adjusting to residential care, support in terms of transport and cleaning their rooms, and understanding that ‘their workplace is my home’ and to act accordingly.

Safety and privacy within the residential was identified as needing improvement in terms of keeping young people out of each other’s bedrooms and the bathroom, stopping bullying, responding to risk of harm and other incidents, workers constantly entering young people’s rooms, and listening in to family phone calls.

Some young people felt that workers could improve listening to and hearing young people including really listening to what they are thinking and feeling, letting them have their own say and opinions, answering their questions, and listening to their complaints and telling them the outcomes of complaints.

Rules, decisions and fairness were highlighted by a number of young people as needing improvement. Some young people felt that the rules were too strict and restrictive, that consequences for behaviour were not clearly communicated before being applied, and that carers are punitive towards them. Other young people highlighted the differences in rules for some young people than for others and from one residential to another. Young people wanted to be treated fairly.
Other things identified as needing improvement included:

- staffing of the residential including screening and training workers, putting workers on longer shifts, reducing turnover, and considering the gender of staff and impacts on the emotional safety of some young people.
- living with other young people who could be disruptive and feed off each other, and better matching is required
- more support when transitioning from residential care to supported independent living
- not saying ‘yes’ to young people so often
- prioritising access to activities, better linking of case plans and care plans and placing siblings together

**Safety**

The most common factor identified by young people as making the feel safe was staff and actions they take. The actions identified included being protective and looking after young people, leaving the office door open, being confident and strong, responding well to young people who are getting upset, making time to talk with young people, building relationships, having carers around and staying close to them, having fun, checking on them when they were out and when they were staying with someone, and teaching safety.

Other factors identified as important to safety included:

- privacy within the residential including being able to lock bedroom and bathroom doors
- having your own space and time to yourself
- the development and use of safety plans
- staff awareness of young people’s cultural background, having a worker on shift from the same cultural background as the young person and offering access to cultural activities
- living with siblings.

**Relationships**

The most common ways young people identified staff could build positive relationships with young people was how they communicate with young people including talking with young people one on one, being able to relate to different situations, talking positive, getting to know young people and taking them at face value.

Other ways included:

- openness and honesty in discussing young people’s situations
- staying calm when responding to young people
- being fair in their interactions with young people
- having fun with young people and doing things with them
- showing respect and caring for young people
- giving hugs and showing affection to young people
- maintaining confidentiality.

**Connections**

Young people’s views on whether enough was being done to keep young people in touch with family, siblings and other adults in their lives were mixed.

Those who said that not enough was being done stated that:

- not enough effort was put in to finding out family contact details, building up contact and supporting contact
• practical difficulties got in the way including availability of transport, easy access to a phone and availability of staff
• there was a lack of trust in young people as indicated by staff monitoring phone calls
• organisations had different policies about whether staff could stay in contact with a young person when they left a service.

Those who thought enough was being done said that they are supported to keep in contact with their siblings and parents including being reminded about contact, being given access to the phone, being transported, being encouraged to keep contact and having siblings sleep over.

**Managing how they feel and react**

The most common way young people thought staff could help young people to manage how they feel and react was to give them space to calm down. Ways of giving young people space included leaving them alone, providing access to ways of being alone, and being present but not talk.

Other ways of assisting included:
• developing, following and updating a safety plan – young people stressed the importance of staff following the plan
• one on one time including acknowledging, talking, assisting and guiding and working on issues
• developing relationships with young people that make it safe for young people to talk with staff about issues
• having rules and boundaries that are fair, make sense and are flexible
• accessing external assistance when necessary
• having an understanding of mental health.

**Characteristics of a good worker**

Young people identified that a good worker is one who is kind, understanding, honest, strong and protective, non-racist, healthy and fit, has a sense of humour, is patient, confident, has empathy, is smart, friendly, open minded, resilient and generous.

Caring for young people and acting as a ‘parent’ was a significant factor in a good worker.

Other factors included:
• worker skills, knowledge and experience to be able to understand and respond to young people
• assisting young people through teaching skills, engaging in activities and providing day to day care.