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Therapeutic Residential Care System Development: System Design

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1 Context

1.1 Project Purpose

This project has a clear focus on supporting the planned re-commissioning of the residential care system in NSW.

Project activities will provide FACS project teams with resources to undertake re-commissioning within the required timeframe.

1.2 Project Objectives

The project objectives are to:

- Develop a new intensive and evidence based therapeutic residential system embracing:
  - Existing residential services: Residential Care, Intensive Residential Treatment Program, Therapeutic Secure Care programs, Supported Independent Living, Supported Family Group Home
  - Entry into residential services
  - Exit pathways and programs including connection with preservation initiatives/services
  - Connections with Health, Justice and Education
- Develop an evidence guide to assist potential funded services to demonstrate capacity to deliver proposed models of care, and inform:
  - Self-assessment regarding readiness and capacity to meet the revised model structure and requirements
  - Development of a sector capacity building strategy

1.3 Definition of Therapeutic Care

FACS, ACWA and residential care providers have developed the following definition of therapeutic care:

> *Therapeutic Care for a child or young person in statutory OOHC is a planned, team based and intensive approach to the complex impacts of abuse, neglect and separation from families and significant others. This is achieved through the provision of a care environment that is evidence driven, culturally responsive and provides positive, safe and healing relationships and experiences to address the complexities of trauma, attachment and developmental needs.*

1.4 Developing a Therapeutic System

The New Zealand Ministry of Social Development provide a clear outline of why a new approach to residential care is required: “It is worth noting that many of the difficulties displayed by vulnerable children can be viewed as attempts to cope with overwhelming, traumatic events. These children must receive highest quality therapeutic intervention so they can begin to recover from these experiences. There are well-established, effective treatment and intervention options available to promote recovery from trauma, and it is now time to systemically introduce such trauma-informed approaches.”[1]

This system redesign builds on international and cross-jurisdictional evidence, sound theory and current practice. Practitioners and out of home care providers across NSW have progressively embraced therapeutic theories, practices and structures supporting a variety of distinct approaches. FACS, along with the sector, has explored current practice and has also examined how a comprehensive therapeutic system could be developed and commissioned.

The design elements addressed in this document bring these efforts together and build on the solid and sound co-design work of the sector and FACS. The authors of this paper have reviewed the co-design materials and met with the sector and representatives to tease out issues such as:

- The overall structure of the redesign
- The importance of the evidence based essential elements and how they shape the design elements
- Assessments
- The need for common outcome measures, tools and system to support evidence of program effect, organisational program management and risk management, and insights that support treatment plans and practices
- The relationship that the residential service has with the wider systems and interfacing agencies/services

The above wisdom, advice and evidence have informed the Therapeutic System Design.

[1] p.66, New Zealand Ministry of Social Development, Expert Panel Final report: Investing in New Zealand’s Children and Families, December 2015. Accessed at: https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf

2 Design Framework

2.1 Overview

The design framework has been developed to enable the evidenced based Essential Elements of therapeutic care to be practiced consistently across all components of the therapeutic residential care system. The framework also considers methodology that would support evidence based approaches that facilitate children and young people to successfully enter or transition to less intensive services. In addition the impact, the quantum and occasions for emergency placements and general placement volumes are taken into account.

The framework considers the exit pathways that are implicit in the design. These take into account the range of potential scenarios that will best match the needs and capacity of each young person.

The therapeutic residential care system sits within the broader context of out of home care and the agencies or services that are also required to achieve the outcomes that promote healing and the attainment of age appropriate milestones. The design framework embraces these essential links and connections.

2.2 Essential Elements

Therapeutic Program Essential Elements:

- Therapeutic Specialist
- Trained Staff and Consistent Rostering
- Engagement and Participation of the Young People
- Client Mix
- Care Team Meetings
- Reflective Practice
- Organisational Congruence and Commitment
- Physical Environment
- Exit Planning and Post Exit Support
- Governance and Therapeutic Practice Quality

Description and discussion regarding the Essential Elements is provided in the accompanying Evidence Guide and Other Findings and Implications paper.

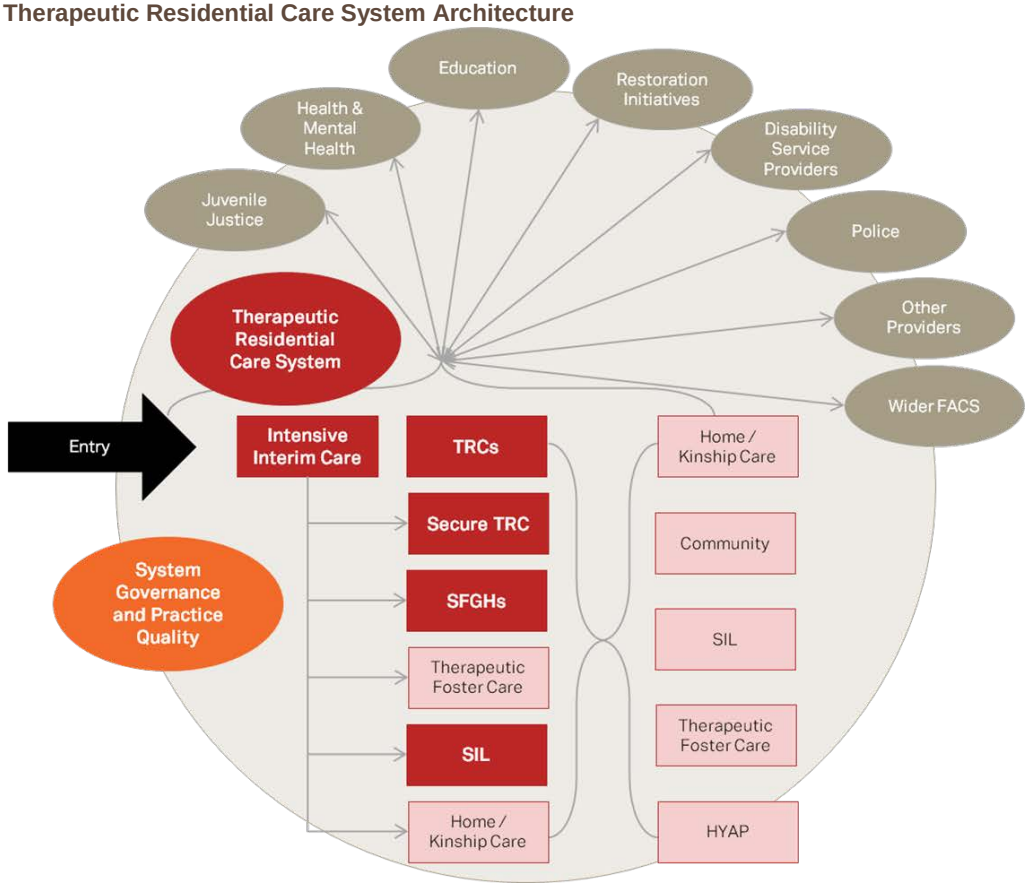
2.3 Therapeutic Residential System Architecture

Figure 1 details the broad architecture of a therapeutic residential care system, including entry and exit pathways. The pathways include residential and secure residential placements and alternate more permanent placement options as well as reunification options and exit pathways.

All aspects of the involvement of the child, young person and their families in this system is designed to be therapeutically informed. The architecture is conceived to be congruent across all parts of the system including interfacing agencies and services.

The placement type, the entry and exit pathways and the interfacing relationships are all constituent parts of the therapeutic system.

Figure 1: Therapeutic Residential Care System Architecture



Therapeutic System Architecture and the Child's Journey

Therapeutic System Architecture enables each of the components to be described and examined to understand how the practices and treatments offered at each point of the child and young person's journey through care will be supported.

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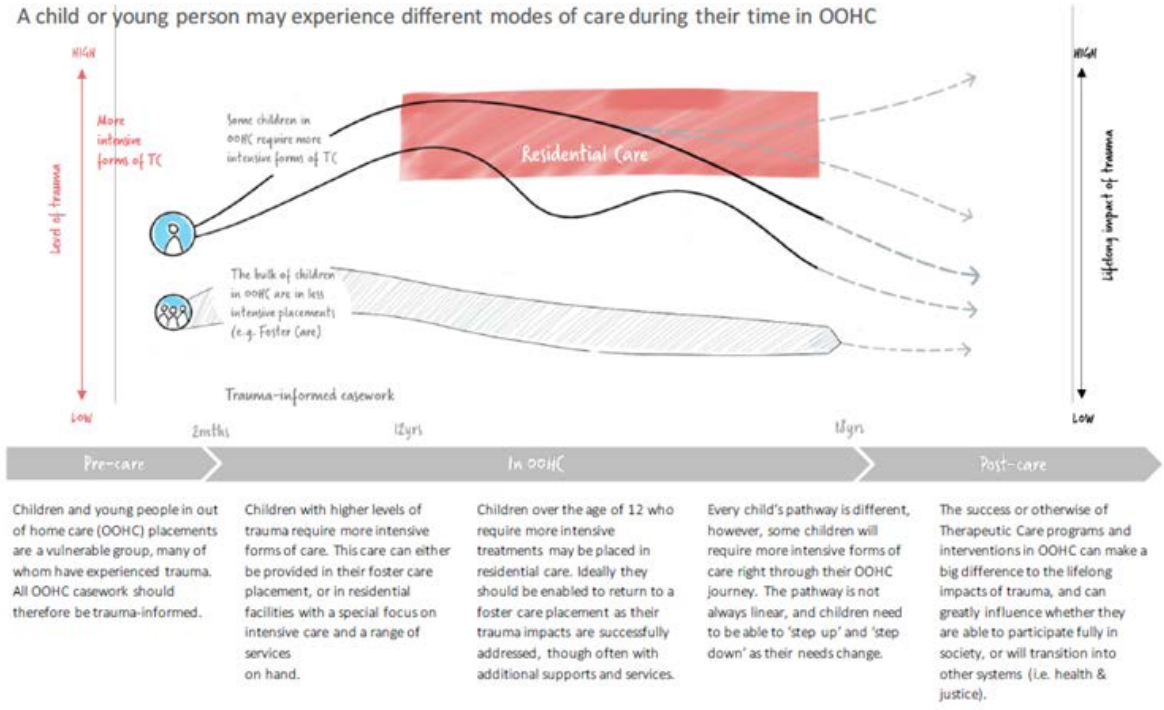
The architecture also provides insight into all of the components that will, together congruently achieve the outcomes sought by the sector and FACS.

Figure 2 'A child's journey through care' was developed by the sector in a workshop facilitated by Second Road. This diagram was provided to Verso by FACS to illustrate the aspiration of both the sector and FACS to empower and design a system that is able to respond to the particular needs of children and young people, with an emphasis on the right intervention at key moments in the child's journey. Importantly, this approach imagines children and young people being able to exit to residential care to alternate placement options that are also trauma informed and that are able to offer ongoing support to ameliorate the trauma impact experienced by the children and young people.

Figure 2: A Child's Journey through Care



Source: Family and Community Services & Associate of Child Welfare Agencies (2015). Developing a Framework for Therapeutic Out of Home Care in NSW, Sydney, p 8

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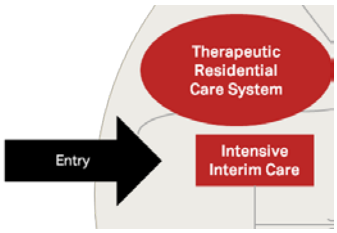
3 Design Elements

3.1 Entry



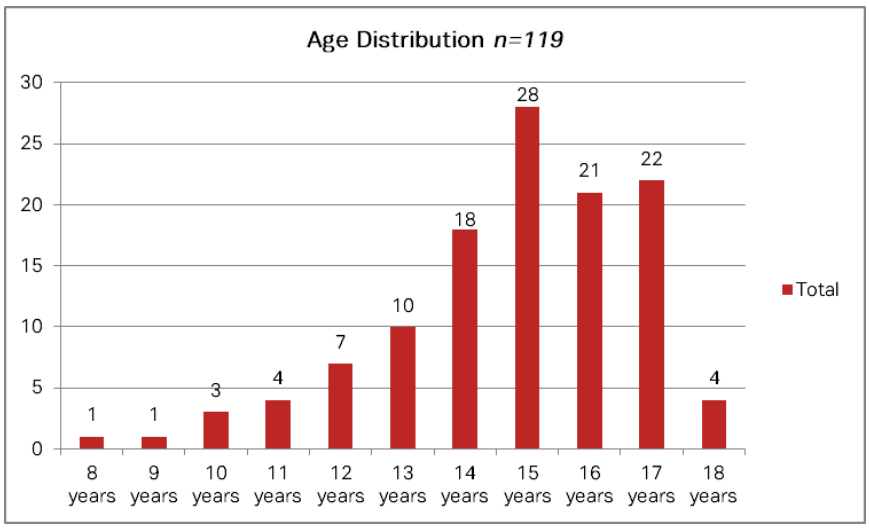
3.1.1 Context

The characteristics and circumstances of children first admitted to residential care in New South Wales in 2014 is addressed in this section. The 2014 year was selected as it is the most recently available full year of data. The data source for this analysis is data provided by FACS, relating to Residential Care as at September 2015.

3.1.2 Gender and Age of New Entrants

There were 119 children admitted to residential care in NSW in 2014. A third were female (*n=40*) and two thirds male (*n=79*). Their age distribution is shown in Figure 3. 90% of new admissions were in the 12 to 17 years age band.

Figure 3: Age Distribution of children admitted to residential care for the first time in 2014



Source: unpublished data provided by Family and Community Services

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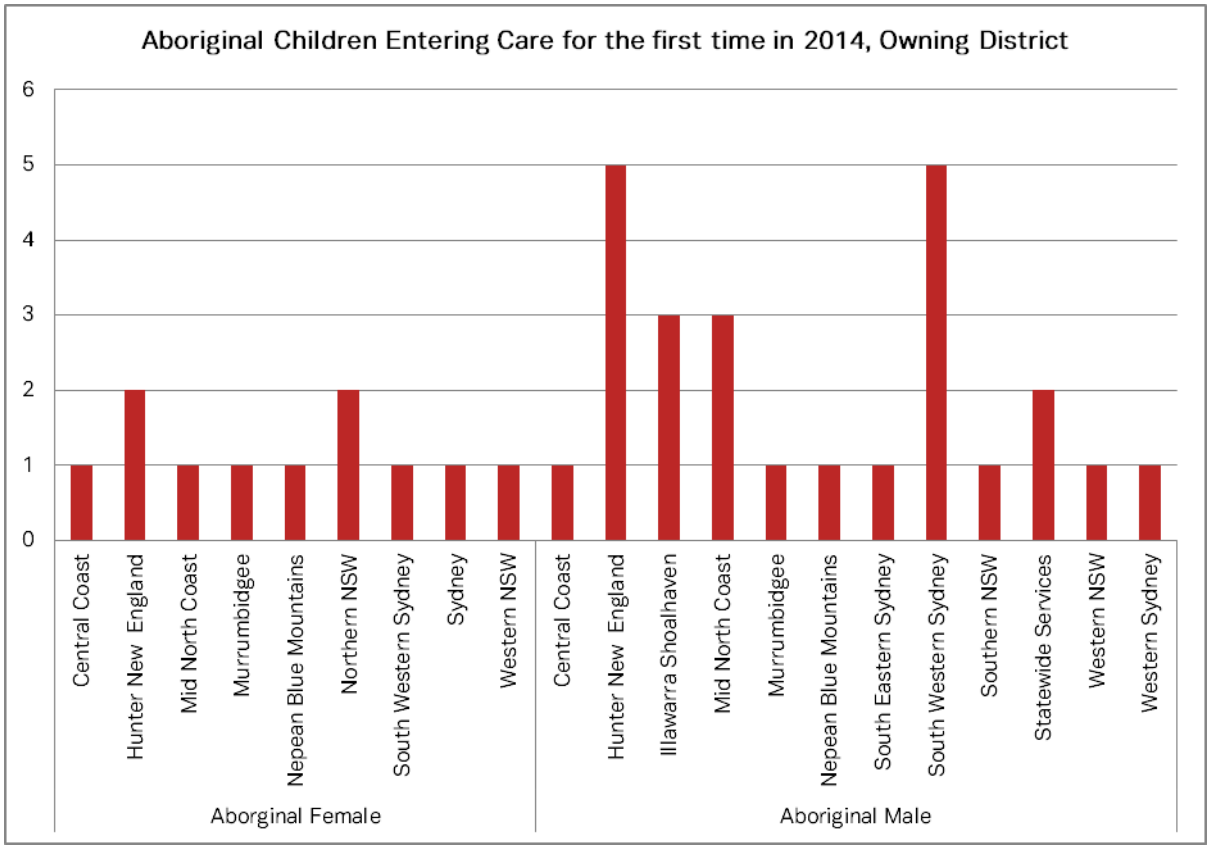
3.1.3 Aboriginal Children and Young People

30 percent *(n=36)* of the 119 placements involved Aboriginal children, of whom 11 were female and 25 male. The geographic origins of these children (Owning District) are shown in Figure 4.

14 of the children were from the Hunter New England, Illawarra Shoalhaven and Mid North Coast Districts. 11 of the children were from Sydney districts (South Western Sydney, Sydney, South Eastern Sydney and Western Sydney).

Figure 4: Aboriginal Children Entering Care for first time in 2014, Owning District



Source: unpublished data provided by Family and Community Services

3.1.4 Family Location and Placement Location

Table 1 shows the Family location (Owning District) of the 119 children entering residential care for the first time in 2014. There are two significant cohorts of children:

- Children from the Hunter New England, Illawarra and Mid North Coast areas represented 45 per cent *(n=53)* of the new entrants to residential care
- Children from the four Sydney districts represented 18 per cent *(n=21)* of the new entrants to residential care in 2014

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Table 1: Owning District of the 119 children entering residential care for the first time in 2014

Owning District	Number	Percentage
Hunter New England	35	29%
South Western Sydney	15	13%
Illawarra Shoalhaven	12	10%
Nepean Blue Mountains	11	9%
Western NSW	10	8%
Northern NSW	7	6%
Mid North Coast	6	5%
Murrumbidgee	6	5%
Statewide Services	5	4%
Western Sydney	3	3%
Central Coast	3	3%
Southern NSW	3	3%
South Eastern Sydney	2	2%
Sydney	1	1%
Total	**119**	

Source: unpublished data provided by Family and Community Services

Table 2 shows the placement location of the 119 children.

Table 2: Placement location of children admitted to residential care for the first time in 2014

Placement Location	Number	Percentage
Hunter New England	39	33%
South Western Sydney	12	10%
Illawarra Shoalhaven	16	13%
Nepean Blue Mountains	8	7%
Western NSW	6	5%
Northern NSW	9	8%
Mid North Coast	4	3%
Murrumbidgee	1	1%
Statewide Services	-	0%
Western Sydney	11	9%
Central Coast	1	1%

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Placement Location	Number	Percentage
Southern NSW	4	3%
South Eastern Sydney	1	1%
Sydney	7	6%
Total	**119**	

Source: unpublished data provided by Family and Community Services

3.1.5 Gateway Role of Metro ISS

Currently entry to residential care for most children and young people is determined and coordinated by Metro Intensive Support Services (Metro ISS). It is known that some cases (generally Exceptions – as described below) are referred directly to NGOs by the Owning District.

As part of the proposed system design, it is recommended that Metro ISS provide a statewide assessment and coordination gateway. It is also recommended that the name of this service be more reflective of a "statewide" rather than "metro" service.

3.1.6 CAT Scores

Entry into a residential placement is currently determined through the use of the CAT assessment. The CAT tool has been adapted from guidelines developed for Needs-Based Service Planning in Child Welfare in the US. The CAT is designed to identify the most appropriate level of care, ranging from General Foster Care to Intensive Residential Care, for a specific child or young person, based on an assessment of their behaviour and health and development. The CAT is administered by Child and Family District Units Caseworkers. The CAT supports the decision making process caseworkers undertake when placing children and young people in OOHC. The tool:

- Determines the level of care that will best meet the needs of a child or young person including support from a carer
- Enhances the transparency and consistency of placement decisions
- Creates a common framework for placement decisions between FACS and NGOs.

The CAT is not a diagnostic tool and does not identify the underlying reason or cause for particular behavioural issues or health and development issues. It does not replace casework and should not take the place of a full assessment of a child or young person's strengths and needs. The CAT is completed based on the information available about the child or young person at the time of placement. The administrators of the CAT are instructed: "The completion of the CAT should not be delayed in order to source additional information about the child or young person".

Consultations suggest that the CAT is not administered in a consistent manner. Many respondents propose that the skills and qualifications of the administrators of the CAT tool should be consistent with the requirement to assess the potential complexity of behaviours stemming from trauma and its pervasive impact particularly on psychological and emotional health. There have also been concerns that the information relied on to use the CAT ratings is insufficient to triage placements. This observation promotes the need for comprehensive information regarding the young people and their placement history to be readily available in an electronic file.

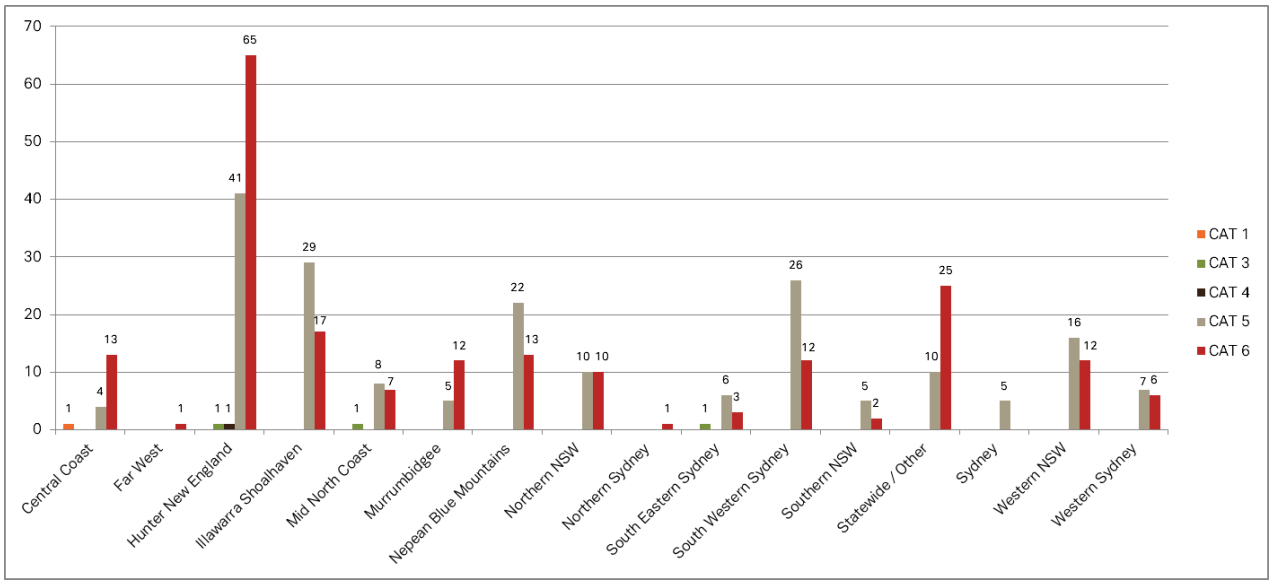
We understand that a review of the tool is currently being conducted by Ernst & Young. The findings of that review should be considered and dovetailed with the requirement for the initial entry into a therapeutic system to be more nuanced than is being achieved through the current process.

CAT scores on entry to residential care are shown in Figure 5. 55 per cent of the 119 admitted children had a CAT 5 score (*n=65*) and 45 per cent (*n=54*) a CAT 6 score. One child had CAT 3 score.

All children with a CAT score of five were placed in care type Residential Care (RC). Similarly all children with a CAT score of six were placed in care type Intensive Residential Care (IRC). The child with a CAT 3 score was placed in IRC.

These scores suggest the policy intent of restricting entry to residential care to children with scores of CAT 5 or CAT 6 was generally met in 2014.

Figure 5: Number of children admitted to residential care for the first time in 2014, by CAT Score and Owning District



Source: unpublished data provided by Family and Community Services

Note: no children with a CAT Score of 2 were admitted to residential care for the first time in 2014

3.1.7 Exception Placements

11 per cent (*n=13*) of the 119 placements were made on an Exceptions basis. Eight of the exceptions placements resulted in placement in IRC and five in RC. Consultations identify that this had 'blown out' over the ensuing period to 23% of placements (2015/16).

Current exception category entrant increases are attributed:

- Age being below the threshold (12 years) - this may include being part of a sibling group
- Lack of alternate placement options
- A CAT rating below the entry score for residential care while having complex behaviours that are best supported in a residential setting

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3.1.8 Prior Placement

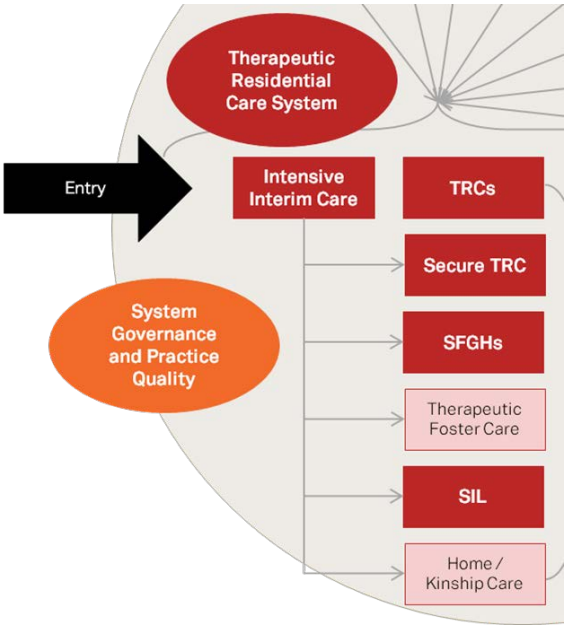
Table 3 shows the prior placement of children admitted to residential care for the first time in 2014. For 34 per cent *(n=41)* of the children in the cohort of 119 children entering residential care for the first time in 2014 their prior placement was in foster care. Significantly, 32 per cent of the children *(n=38)* had already experienced at least one residential care placement. 13 per cent *(n=15)* of the children had entered care directly from their parent's care or kinship care.

Table 3: Prior placement of children admitted to residential care for the first time in 2014.

Previous placement	Number
Birth Parents	4
Father	1
Foster Care	41
Juvenile Justice	5
Kinship	8
Motel	4
Mother	1
Refuge	9
Residential Care	38
Special Care	8
Total	**119**

Source: unpublished data provided by Family and Community Services

3.2 Intensive Interim Care



3.2.1 Context

The concept of a consolidated system entry point is not new. It has been used across multiple jurisdictions as a short term placement option. These units typically facilitate emergency placements and provide the time required to identify alternate placement options when the child or young person's placement breaks down in foster or kinship care or when they are newly placed in residential out of home care from the community or from a juvenile justice placement.

Such options have been problematic in the past as they have become another 'blockage point' in an overstretched system. The blockages have become unmanageable as governments have commonly been the operators of entry units and the providers have been in a position to cherry pick or refuse placements resulting in these units becoming pseudo residential houses and thereby losing the capacity to operate as intended.

3.2.2 Intensive Interim Care

Acknowledging the previous poor outcomes, the design of the NSW therapeutic residential system has been developed learning from past experience.

It is proposed that through the recommissioning, a number of residential units whose sole purpose is to conduct comprehensive assessments of children likely to enter residential care be established. Such placements would need to be time-limited (8 to 13 weeks), based on clear therapeutic principles and focussed on assessing the child's future placement needs. It is proposed that these would be titled Intensive Interim Care units. These units would be tied to geographic areas where they would be integral to the overall residential services being contracted and delivered in that geographic area.

If the provision of Intensive Interim Care was managed as proposed it would necessitate a milieu of related therapeutic residential services to be provided by the same provider in the defined geographic area. The provider would through this design element own the need to manage throughput and would also have to resolve how to develop ongoing solutions to ensure that the Intensive Interim Care units remain a short term placement option and is able to manage the planned and predicable flow of placements including emergency placements.

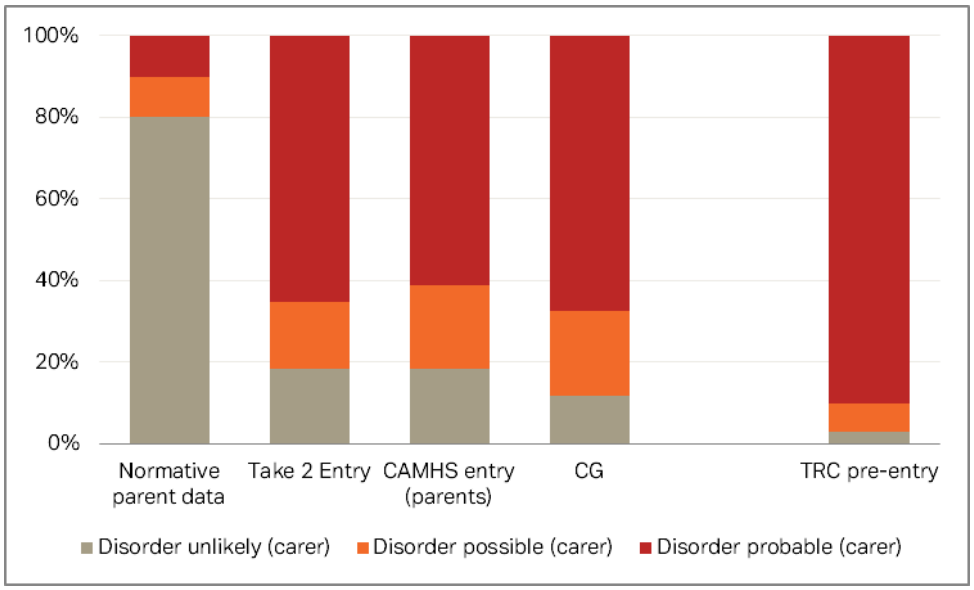
Conceptually this approach requires the provider to have sufficient scale of services within their milieu of therapeutic residential care to manage the planned throughput. The implication is that this design requires fewer providers delivering services for a greater number of young people. The alternate approach is that smaller providers are commissioned to provide services in consortia or partnership arrangements. To manage the scale and the need, Intensive Interim Care units will be strategically geographically located along with the therapeutic residential services serving that geographic area. In Sydney there may be far greater room for a range of competing providers. The throughputs are discussed in point 3.2.7.

3.2.3 Therapeutic Activities of the Intensive Interim Care units

Intensive Interim Care units will support a comprehensive therapeutic assessment and intervention, for up to three months, to determine the child's needs and most suitable exit pathway from interim care.

Data collected in the Evaluation of the Therapeutic Care Pilots in Victoria (2009-11) identify the high probability of a disorder being present in the population of children and young people entering residential care. The data references the Therapeutic Residential Care population (TRC) to Normative data, an aggregation of the entry level scores of young people to Take 2's foster care, kinship care and residential care, entry level to specialist child and adolescent mental health services (CAMHS) and a control group (CG) of young people in residential care set up as a comparator to the TRC. The comparison supports an understanding that young people entering residential care are likely to have a disorder. This finding is confirmed by the findings of the Victorian and Tasmanian TRC Evaluations conducted by Verso using the Health of the Nation Outcomes Score for Children and Adolescents (HoNOSCA), a psychometric tool used to identify the probability of a disorder. This tool mirrors the findings using the Strengths and Difficulties Questionnaire (SDQ).

Figure 6: Likelihood of a disorder (SDQ Measurements)



Assessments

Assessments will include:

- Physical and dental health needs
- Educational needs
- Cultural needs
- Developmental needs
- Mental health needs
- Trauma and healing needs
- Future placement requirements

The therapeutic intervention will commence immediately through the practices of the trained and stable care staff supported by a Therapeutic Specialist and other professional services required to undertake the assessments and develop plans. The range of services and specialists accessed may include mental health, behavioural, family therapy,

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general practice, learning needs assessment. Where possible, Intensive Interim Care staff will engage with the child's family of origin and/or previous carers to support the assessment and jointly plan the exit pathway.

Evidence from Allambi Care's model of intensive therapeutic engagement and assessments demonstrates significant levels of undiagnosed and untreated conditions (autism, ADHD, developmental disorders) that may be amenable to alternate interventions other than the treatment in a therapeutic residential placement. These undiagnosed issues may contribute to placement breakdown and/or in combination with other stressors in the life of the family of origin may have contributed to the intervention. There is mounting evidence that intensive and well-focused wraparound services focused on the family can be effective in reducing the multiple stressors that lead to placement and that when mitigated can facilitate reunification. Allambi Care have operationalised this model building on the evidence and exemplar of Wraparound Milwaukee. The Stronger Families Evaluation conducted by KPMG in Victoria also demonstrates how over a three year period multiple stressors were able to be significantly mitigated thus reducing placements into out of home care. This was achieved by long-term intensive case management support a wide range of responses focused on the family.

3.2.4 Throughput

An estimate of the throughputs of the Intensive Interim Care units has been developed considering:

- An estimated 220 new entrants into residential out of home care in 2016/17
- 75% or 85% occupancy rates
- A 3 month maximum stay with an average of 11 weeks

Using these considerations the following estimates demonstrates the number of homes required:

Table 4: Houses required matching throughput

Details	@ 75% Occupancy	@ 85% Occupancy
Actual episodes of care	220	220
Available capacity at varied rates	293	259
Average episode of care length of stay	11 weeks	11 weeks
Number of units with 4 beds[2]	7	6
Contingency	25%	15%

The throughputs are predicated on the availability of alternate placements. It will be essential therefore geographic, cultural and numeric growth estimates are developed and used as an essential planning instrument to respond to growing demand for residential units. This will be required even if initiatives such as an Intensive Interim Care unit and the improved care outcomes achieve reduced lengths of stay or alternate placements. These initiatives may take 2 to 3 years to demonstrate evidence of program effect.

It should be noted that these figures are indicative and it is recommended that a thorough analysis be undertaken to inform resource and budget allocation.

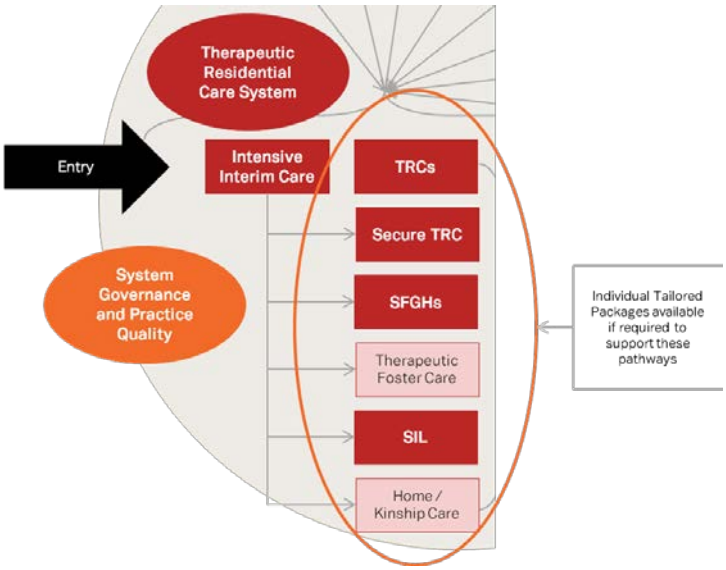
[2] Greater flexibility of unit size and bed configuration may need to be considered

3.2.5 Exit Pathways from Intensive Interim Care Units

The quality and comprehensive nature of the assessments and sufficient time to validate and modify assessments will contribute to the identification of multiple alternate options and pathways. It is expected that some children and young people will not need to go into a longer-term or intensive therapeutic residential placement.

To facilitate return to foster care, to home, or other less intensive approaches an individual package of support with intensive case management and brokerage funds is proposed. This will ensure that the alternate placements are afforded every opportunity of success. The packages would be part of the milieu of therapeutic services delivered by the successful provider as a result of the recommissioning.

Figure 7: Exit Pathways Intensive Interim Care Units



The packages are proposed to ensure that the plans developed in the Intensive Interim Care units are embedded in the alternate placement including access to the required services and material support that will aid the stability and effectiveness of the placement.

The proposed Individual Tailored Packages are discussed in the accompanying Other Findings and Implications paper.

3.2.6 Facilitating Essential Elements of Therapeutic Care

This design element supports evidence based practices that lead to significantly improved outcomes for young people in residential out of home care. In particular the two elements that this supports are:

- Engagement and participation of the young people in particular:
  - Engaging with the young person prior to their entry to the residential placement to understand/frame their expectations
  - Engaging with existing residents of the residential home prior to new young person entering to understand/frame their expectations
  - Supporting both the new and existing young people to prepare for the transition, and through the transition

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- Engaging young people in developing and implementing their own Care and Treatment Plans

- Client Mix:
  - An established internal (NGO) panel that is convened to consider referrals and their potential fit with existing residents
  - A documented process to consider referrals, including best interests of existing residents
  - Reflective processes to review decisions and enhance operation of internal panel

Unplanned placements have been identified as scenarios that reduce or significantly disrupt the therapeutic effect experienced by existing residents and damages the benefit that the young person being placed could otherwise experience. The engagement of the young people and the appropriate matching of young people in residence will be facilitated by developing Intensive Interim Care units and at the same time the vexed issue of emergency placements can be adequately addressed.

In-depth consultations conducted with young people (*n=18*) who were residents of therapeutic units in Victoria and Tasmania expressed broadly consistent opinions that 'having the right combination of other residents in their TRC was very important for them'.

3.2.7 Challenging Issues to be Managed

A range of challenging issues in the Intensive Interim Care units client mix will include:

- The gender and age mix
- Aggression
- Sexual dysfunction or predatory behaviour
- Risk taking.

Managing this risk and safety will require Intensive Interim Care units across the state to work together to:

- manage the mix as necessitated by the presenting risk management and safety issues
- The intensity of supervision including one on one care and support.

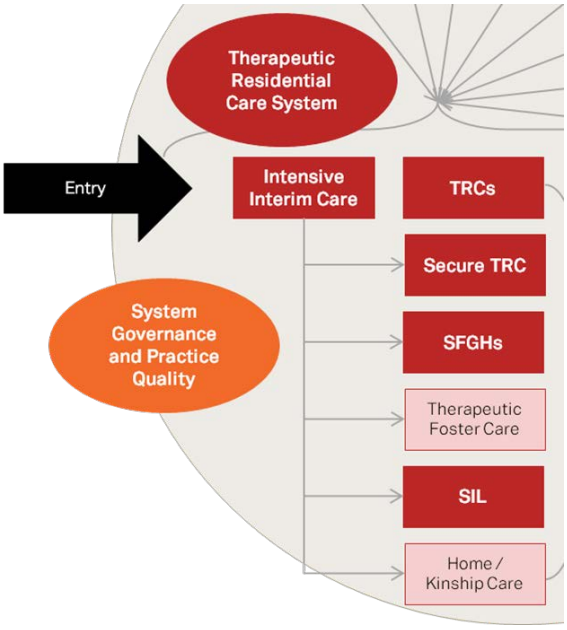
3.2.8 Geographic Considerations

In determining appropriate geographic locations of Intensive Interim Care units across the state, three threshold criteria are proposed:

- Projected demand – distribution of Intensive Interim Care (and residential care units) should be aligned to projected referral patterns across the state
- Access to services – as children and young people entering Intensive Interim Care units will be engaged in comprehensive assessments, it is important that relevant mainstream and specialist services be accessible. This implies that in regional areas the Intensive Interim Care will be proximate to significant service centres

- Access to country and culture – connection to country and culture is an important consideration for Aboriginal children and young people. Intensive Interim Care unit teams should have an understanding of the traditional land on which the unit is located, and be able to develop a relationship with Aboriginal communities and groups which relate to that land

3.3 Therapeutic Placements Options



3.3.1 Referrals and Transitions to Therapeutic Options

Referrals/transition processes will be managed by the Provider from the Intensive Interim Care unit to a milieu of therapeutic residential or less intensive therapeutic options. Referrals and transitions may also be managed from one form of therapeutic placement to alternate to match the progress that the young person is making within their particular care arrangement in line with their treatment plans. Ideally this would be managed in a continuum that supports the young person's attachment needs.

This design element would therefore ideally suit service provision where the provider was able to deliver the continuum through internal service transitions or through formal partnerships/collaborations that facilitate and guarantee this capability through to major programs such as foster and kinship care.

3.3.2 Residential Options

The residential care options will all demonstrate practices and structures as defined in the Essential Elements (section 2.2). Governance processes will ensure barriers to consistent practice are addressed. Residential options include:

- Therapeutic Residential Care Houses
- Secure Therapeutic Residential Care Houses
- Supported Independent Living
- Supported Family Group Homes

Therapeutic Residential Care Homes

In sections 3.3.3 and 3.3.4 there is a discussion relating to geographic coverage and the physical environment for the Therapeutic Residential Care Homes.

The overall number of therapeutic residential homes required will be calculated considering:

- The population in residential out of home care and the historical growth rates

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- The impact of redirecting children and young people from Intensive Interim Care to non-residential placements
- The impact of improved cultural planning and targeted geographic placements of the homes on reunification rates
- The impact of evidence based placement preventions initiatives on the number of children and young people entering residential care
- The vacancy rates (proposed at 85%)
- The effectiveness and resources applied to exit programs/pathways

Within the provision of residential homes consideration will need to be given to the need to have home that support a particular cohort such as:

- Aboriginal status (30% of new entrants)
- Age less than 12 years (7.6% of new entrants)

Secure Therapeutic Residential Care Homes

Currently the only secure therapeutic residential home is Sherwood House, which is government-operated. At present, Sherwood House is only able to support females, and there is an identified need for a comparable service for young men.

In the recommissioning it would be appropriate to consider the expansion of this service option.

Supported Independent Living

Different approaches and circumstances drive the timeframe for transitioning out of a Therapeutic Residential Care program – whether family restoration, exiting care or to an alternate care type such as Supported Independent Living (SIL).

Data prepared as part of the FACS Recontracting project indicates that as at March 2015 there were 49 SIL placements, provided by seven NGOs, allocated as indicated in Table 5, and distributed across seven FACS Districts (Central Coast, Hunter, New England, Illawarra Shoalhaven, Nepean Blue Mountains, South Eastern Sydney, Sydney and Western Sydney).

Table 5: SIL Provision, March 2015

SIL Providers	Number	SIL Providers	Number
Allambi Care	12	Marist	14
Care South	4	Pathfinders	1
Caretaker's Cottage	4	SYFS	4
CatholicCare Hunter Manning	10		

Source: Family and Community Services (2015). Residential Care Delivery Models and Contracted Care: The Current Systems, Service System Recommissioning, Out of Home Care Contracting, Sydney, p 11

The March 2015 review also identified at least 264 young people in residential care aged 16 to 19 who could potentially transition successfully to SIL if this step down/less intensive option were available to them. Expanding the availability of SIL would also include broadening the geographic spread of services to provide options in all/most FACS Districts.

A 2014 review of SIL services identified a series of recommendations, categorised under the following themes:

- Client needs
- Referrals
- Gaps in continuum of care
- NGO innovation
- Cost
- Cross-government service response

Some recommendations are addressed in the system architecture outlined in this document (such as “OOHC Directorate to review the SIL program including investigating the development of an indicator/assessment tool for SIL suitability” and “Improve monitoring and reporting of outcomes across FACS for young people leaving OOHC”).

Focus on developing system congruence would also respond to recommendations such as “Circulate good practice examples including partnerships with local real estate agents and private landlords, Housing Pathways, Community Housing and other NGOs enabling more flexible and affordable exit points for young people, trial programs such as This Way Home Project, Youth Private Rental Subsidy and Shared Supported Student Accommodation” and “Identify opportunities for improvement of SIL presented by the FACS localisation strategy, alignment of NSW Health Districts and the joining up of Community Services, Housing and ADHC under one department.” [3]

Supported Family Group Homes

The current definition of Supported Family Group Homes (SFGHs) describes them as “medium to long term care and accommodation options for groups of children or young people aged 0-17 years who have low to moderate support needs but cannot be placed in relative, kinship or foster care. Children and young people live in regular houses in the community in a family-like setting and are cared for by authorised foster carers living in the home seven days a week. The target groups are sibling groups and adolescents.”[4]

In the proposed system architecture, SFGHs are positioned as tailored therapeutic residential care responses to sibling groups, and may include children aged 0-12 years, although it is conceivable that this approach may be appropriate for other groups of children with common assessed needs. SFGHs would be established as the need arises, and would encompass the same Essential Elements and therapeutic practices as other therapeutic residential care options. Depending on the age of the children, the staffing model may orient more toward foster carers, however the principles of the “Trained Staff and Consistent Rostering” remain, as do “Care Team Meetings” and “Reflective Practice”.

As identified in the associated Evidence Guide, staffing/rostering profiles are likely to be different across therapeutic residential care units, in line with the assessed needs and treatment plans of the resident children and young people. It is anticipated that in Supported Family Group Homes the therapeutic intensity will flexibly respond to the changing needs of the young people, keeping in mind the maintenance and preventative roles that may be embedded in care and treatment plans.

In assessing the needs of a sibling group and consideration of establishing a SFGH, the Essential Element “Client Mix” prevails as it relates to the safety and wellbeing of the children as individuals.

3.3.3 Essential Element: Physical Environment

A distinguishing feature of the residential therapeutic care options is the residential setting. In this context it is important that the essential element of the physical environment is appreciated in regard to the design of the system. The physical

[3] Family and Community Services (2015). Residential Care Delivery Models and Contracted Care: The Current Systems, Service System Recommissioning, Out of Home Care Contracting, Sydney, p 13

[4] Family and Community Services (2015). Residential Care Delivery Models and Contracted Care: The Current Systems, Service System Recommissioning, Out of Home Care Contracting, Sydney, p 13

environment is an essential element that goes beyond the limitations of the building it also includes how the young people express their experience of the physical environment.

James Anglin states that "The private spaces, personal items and preferred furnishings contribute to the home-like environment and they have therapeutic intent particularly creating 'a safe place.'" Anglin's research demonstrates the importance of 'offering a safer environment while they (the young people) work out their problems.'[5]

Prior to young people entering the therapeutic residential setting (while they are living in the Intensive Interim Care unit) their preferences for personalising their room will be discussed. Arrangements will be made to respond to requests and preferences within reasonable limits and implemented prior to entering their new home; this is part of the process of honouring young person's voice and 'recruitment' process.

The physical environment and the physical arrangements contribute significantly to the creation of a home-like environment that provides a sense of normality and ensures physical and emotional safety.

Observing the Elements that Support Therapeutic Care

The NGOs delivering the TRC pilots in Victoria identified the following key issues:

- Purpose built/adapted premises that allow for private spaces
- Indoor recreation activities
- Design that assist in development of personal responsibility and hygiene
- The opportunity for young people to personalise their room
- Space for a client to safely withdraw
- A place where staff can observe without intruding
- Somewhere (safe) to use up energy in bad weather

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

Other features of homes that ensure that the therapeutic fidelity include:

- Attention to minor maintenance issues
- None of the units had obvious damage
- Furnishings were home-like and coordinated
- The homes were spacious
- Young people spoke positively about the arrangements

Young People's Perspective

In the interviews conducted with the young people in the Victorian Pilots, they consistently called the TRC 'home' and described other Residential Units they have lived as a 'unit'. When they were asked to explain this distinction, the young people talked about issues such as "it doesn't have that little window that they look through" and "you can have your own

[5] Anglin, J (2002). Pain, normality and the struggle for congruence: Reinterpreting residential care for children and youth. Birmingham, NY: Haworth Press

stuff". One of the young people talked about how they "acted out" and "wrecked some of their stuff in their bedroom (including a TV)". The young person stoically described how they needed to take responsibility for their action and how they would have to save money to replace the items they had wrecked.

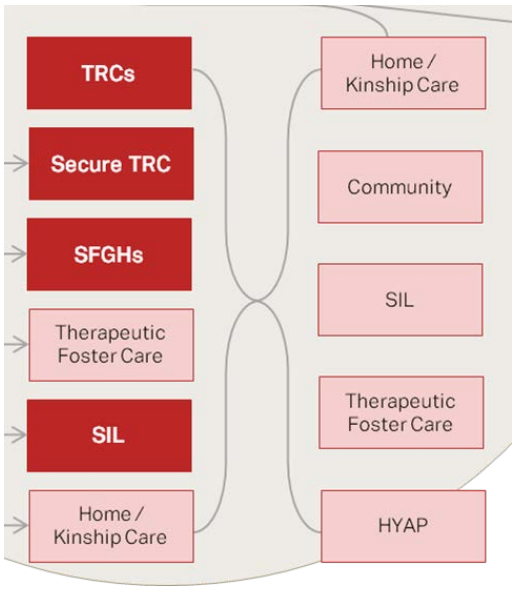
The young people would appreciate the houses being consistent from the street with the other houses a remark that typifies the young people's perspective is; "you can tell a resi unit from the street, they are too plain".

3.3.4 Geographic Locations

Therapeutic residential homes need to reflect the following regarding their location:

- Be located in the areas where the current and future demand exists
- By virtue of the geographic location:
  - facilitate increased the likelihood of reunification
  - create more feasible connections with families including opportunities for the family and the young person in care to maintain connections (where appropriate)
- Be clustered in a geographic area[6] in a manner that support the interrelationships between the options including the Intensive Interim Care units and to ensure that recruiting the young person from the Intensive Interim Care unit can be feasibly managed.

3.4 Transitions



3.4.1 A Continuum of Therapeutic Care

Figure 8 illustrates the aggregate progress made by young people in the Victorian Therapeutic Care Pilots. Interposed on the data from the pilots are visual cues to identify potential points for transition and the indicators of why it will be essential that a treatment focus is maintained beyond the more intensive residential setting and ideally within a single agency providing the continuum of services and program fidelity.

Developing an evidence base and accompanying essential elements necessary to ensure that treatment can continue in these less intense settings is critical. This system design proposes a focus on mental and emotional health as well as positive progress in reducing behaviours that are damaging to self and others.

It is proposed that intensive tailored packages, as described earlier in the context of transition from Intensive Interim Care units, will also be key in transition support at other points in the therapeutic

[6] Geographic area may encompass multiple Districts eg Mid North Coast and Northern New South Wales

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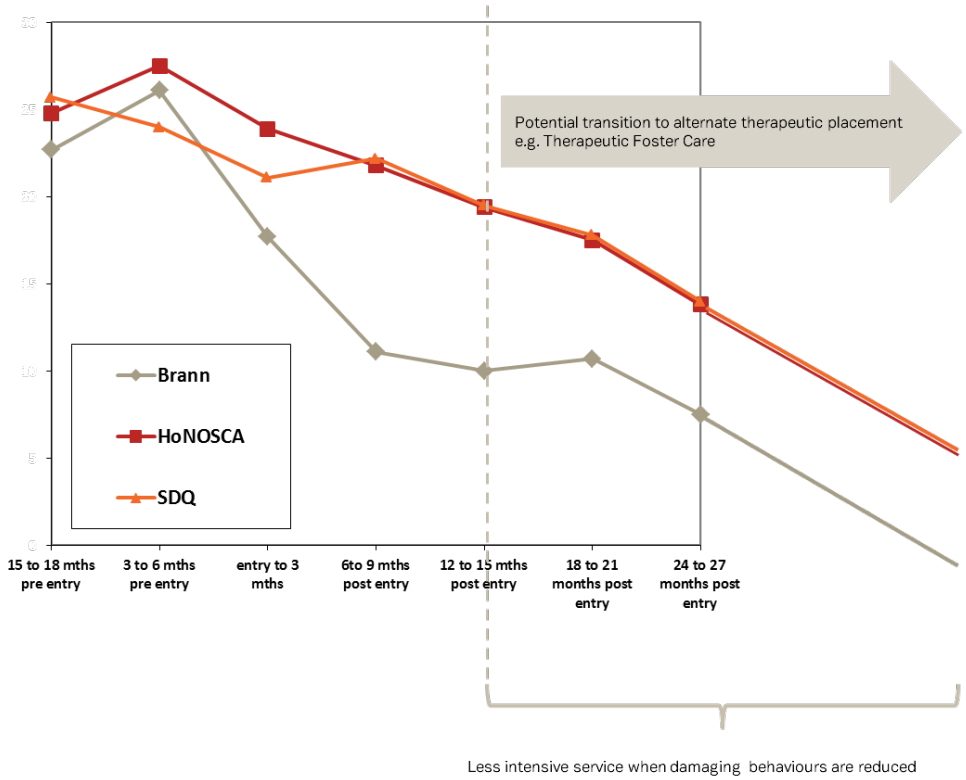
system.

The proposed Individual Tailored Packages are discussed in the accompanying Other Findings and Implications paper.

Figure 8: Potential transition point



The Victorian Therapeutic Care Pilot evaluation also compared mental and emotional status against benchmarks to appreciate the severity and complexity of the mental and emotional mental health conditions experienced by young people entering the pilots. The two psychometric tools used in the evaluation were the HoNOSCA and the SDQ. The findings highlighted the very significant and elevated rates of poor mental health. The significance of these elevated rates can be understood when they are compared to the entry scores of children and young people when they are entering specialist mental health services (CAMHS/CYMHS). The severity rates of the young people in the pilots were significantly higher, using both tools, than the rates experienced by young people entering CAMHS/CYMHS. The range of presenting problems considered appropriate for referral to CAMHS specialist mental health service in Victoria include:

- Young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development, and/or where there are substantial difficulties in the person's social or family environment
- Symptoms that may include impaired reality testing, hallucinations, depression and suicidal behaviour
- Children's emotional disturbances more often present in other ways such as hyperactivity, nightmares, fearfulness, bed-wetting, language problems, refusal to attend school, and stealing: these are among the behaviours that may indicate distress or disturbance.

The table below details the HoNOSCA scores for young people in the Victorian TRC pilots and the Tasmanian TRCs over a 12 month period from entry to the pilots and at the point in Tasmania where the provider considered that they had

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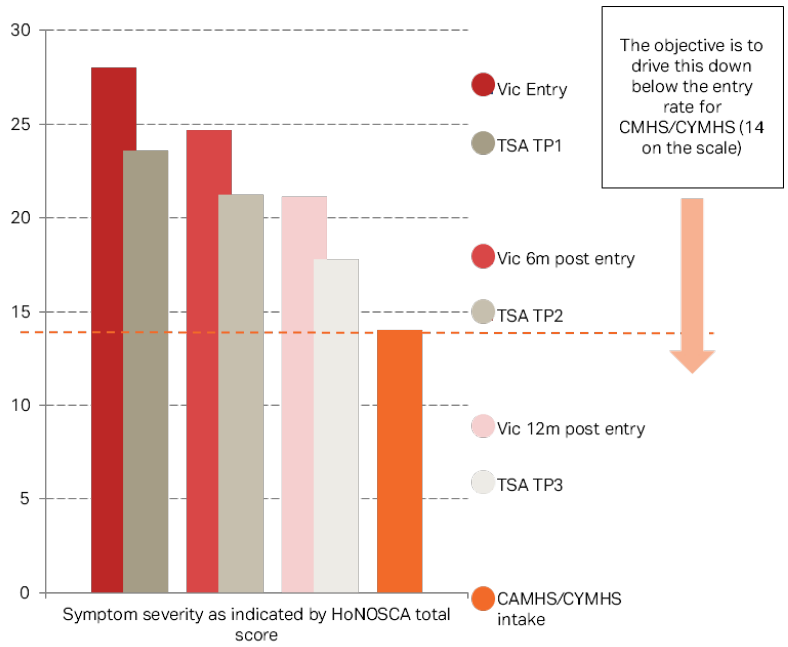
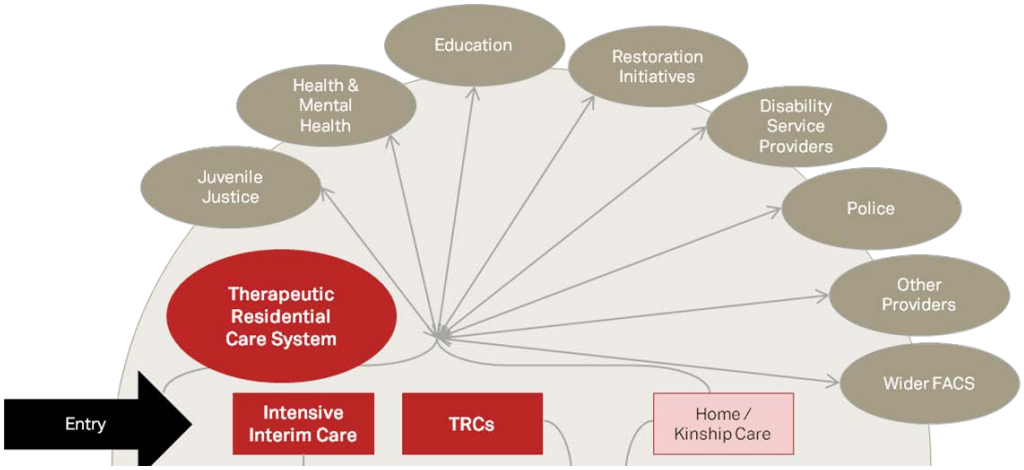
begun to consistently practice therapeutically[7]. The table details a similar rate of change for both jurisdictions however after 12 months the rating still exceed the ratings of entry into CAMHS/CYMHS.

Figure 9: Treating Mental Health symptoms[8]



3.5 Linkages



[7] When all of the essential elements were in place

[8] "Vic" relates to Victorian Therapeutic Residential Care Pilots; "TSA" relates to The Salvation Army therapeutic residential care units in Southern Region; "TP1" means Time Point 1, "TP2" means Time Point 2, "TP3" means Time Point 3 – these timepoints were at six monthly intervals, and align with the "Entry", "6m post entry" and "12m post entry" time points.

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3.5.1 Critical Partners

The system design identifies the critical role of partners who by virtue of the services they provide are essential to supporting healing and the attainment of age appropriate milestones, and to system integrity.

Effective cross-government coordination is required to support children and young people to access the services that they require. Solving the issues that deny these young people access are often place based and therefore they will be complex to solve. Achieving congruence is essential to achieve the outcomes required and the timeframe to achieve this is unknown.

Key partners are detailed in the table below.

Table 6: Critical Partners

Critical Partners	Current connectivity or issues	Identified opportunities for improvements
Juvenile Justice	The referral protocols and transition planning are critical.	Improved protocols for communication (file sharing). Shared therapeutic training and systems to support congruence.
Health	Inconsistent access to the range of health services required.	Development of place based agreements. Improved when a Therapeutic Specialist is an embedded in the unit. High level interdepartmental agreements.
Mental Health	Inconsistent access to the range of mental services required. Improved access if the Provider has well developed therapeutic assessments and a therapeutic practitioner embedded in the program.	Development of place based agreements. Improved when a Therapeutic Specialist is an embedded in the unit. High level interdepartmental agreements.
Education	Significant dissatisfaction amongst providers; the Department of Education also suggests that failures in communication and planning are contributing to poor outcomes. A recent consultation initiated by the Department with OoHC providers may yielded practical opportunities for improvement.	Examine the outcomes from the Department of Education and Provider's consultation – build on positive opportunities for improvement. Development of place based agreements. Improved when therapeutic units incorporate teachers in the care team meetings and Therapeutic Specialist support the teacher to have shared development goals; congruence. High level interdepartmental agreements.
Restoration Initiatives	Children and young people in out of home care are remaining in residential placements for a longer period of time. This may point to opportunities to improve restorations.	Emerging evidence identified in Victorian programs and evaluations and in international experience identifies ways to improve restorations particularly for Aboriginal children and young people. It will essential that development and operationalisation of cultural and care plans are developed using the findings from these evaluations. Therapeutic specialists have been demonstrated to develop effective responses for families supporting opportunities for restoration. Development of residential services located closer to where people live, particularly Aboriginal people.

Critical Partners	Current connectivity or issues	Identified opportunities for improvements
Disability Service Providers		Include providers/workers in care team meetings
Police	Reports from providers identify varying relationships and partnerships.	Develop place based agreements Include police in care team meetings
Other Providers	Examples: • Red Cross Young Parents Program • Youth Off the Streets school services • Restoration initiatives	Develop agreements to cooperate, share information, set up protocols for transitions. In some situations set up formalised consortia or partnerships with the express intent of providing a congruent system response for children, young people and their families - avoiding cultivation of service silos.
Wider FACS	Including but not limited to Cluster/District Child Protection and Disability Services	While this reform is being led by Program and Service Design, it is critical that wider FACS be fully engaged to achieve the shared departmental commitment to better outcomes for vulnerable children and young people.

It is essential that the system be developed as a statewide service, leveraging the strengths and capabilities of each participant. This may include recognition of particular specialist capacity such as culture, disability, young mothers and babies.

3.5.2 Essential Design Elements: Congruence with Interfacing Agencies

An observed essential element of the Victorian Therapeutic care pilots was care team meetings and congruence. The following details support an appreciation of how this design element could be developed and to what benefit.

Congruence with Interfacing Agencies

Interviews with 26 interfacing agencies and feedback from workshops with Community Service Organisations (CSOs) as part of the Victorian Pilot Evaluation provided the insights discussed below.

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

- Student Wellbeing Coordinator (or similar role)
- Principal and/or Vice Principal of schools attended by young people in the program
- School Year Level Coordinator
- Police Youth Liaison Officer/ Police Officers (where the young person has had ongoing contact with police)
- Youth Justice Worker (if relevant)
- DHHS Case Contracting Team Leader
- Team Leader of programs such as ‘Leaps and Bounds’ and Education Support Program

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

- DHHS Refugee Minor Program - Case Manager
- Youth alcohol and other drug consultant

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

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

However, five interfacing agencies (20%) (mostly schools and police representatives) indicated that they had 'no idea' of the underpinning theories or key elements of the TRC program and some said that they had little or no contact with the residential team and not much more than an occasional phone call or email. Police considered that they could have a more positive role in supporting the outcomes for young people, however it was their impression that this was not welcomed or sought.

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

- There is an atmosphere of collaboration and mutual support between many services that was not there previously. The regular Care Team meetings and case management meetings are providing a platform for reflective care of the child while allowing for information to be shared in a systematic and professional manner
- With an increase in understanding the overarching theory and training in strategies and responses, many of the interfacing agencies have found that they have a much better working relationship with the residential unit than previously
- Of the schools spoken to, many have greatly appreciated the "Calmer Classrooms" program and training, and have implemented the program throughout the whole school with positive results

Calmer Classrooms: A guide to working with traumatised children[9]

"Both research and wisdom show us that regardless of the adversity they face, if a child can develop and maintain a positive attachment to school, and gain an enthusiasm for learning, they will do so much better in their lives. The role of teachers in the lives of traumatised children cannot be underestimated.

"This booklet encourages teachers and other school personnel to forge those attachments through two key mechanisms: understanding traumatised children and developing relationship based skills to help them.

"Teachers who understand the effects of trauma on children's education, who are able to develop teaching practices to help them, and who are able to participate actively and collaboratively in the systems designed to support traumatised children will not only improve their educational outcomes but will assist in their healing and recovery." (p iv)

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

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

- Those who believed that there had been no change in the way services worked together also felt they had no voice regarding the care of the child and were unsure of both their role and the role of other interfacing agencies with regard to the child in question. These interfacing agencies believed clearer definition of roles would facilitate a smoother, timelier exchange of information and client history which would in turn maintain consistency of care and response to incidents.
- The interfacing agency was unsure of the theory and practices of the Therapeutic Care Model.
- Schools and Police identified difficulties regarding sharing information with relevant parties; they found privacy requirements were often stated as the reason for lack of information but found this to be inconsistent as the therapeutic approach is based on knowledge and understanding of the child's history. This issue persisted as a theme in workshops with the CSOs and with DHHS Managers
- Youth Justice stated that they considered engagement with the evaluators as a possible breach of privacy. CSOs were unanimous that engagement with, and obtaining information from Youth Justice was generally problematic
- A lack of regular and informative meetings to the extent needed by the interfacing agencies in order for them to feel that they have an integral role in the care of the child/young person.
- Two CSOs raised concerns regarding congruence with the courts typified by the following remark, "Children's Court needs to be well educated in the process used in the therapeutic setting." Consultations indicated that the legal profession is interested in the advances being made and would welcome briefings.

3.5.3 Care Team Meetings

One of the essential elements of the Therapeutic program is regular 'Care Team Meetings', designed to produce optimal service integration and coordination, continuity of care for clients and timely and appropriate information exchange. Care Team or Case Management meetings were conducted once per month. Most respondents in the Victorian TRC evaluation reported that most have a vibrant working relationship with the TRC Unit and care workers with 'lots of informal contact by phone or email' as well as other more formal/structured meetings.

The regular meetings (including staff, parents, teachers and other interface agencies) are recognised as an essential element of the program and maintain a consistent approach. Consistency was cited as a mainstay of the therapeutic approach and with that in mind a schedule of regular meetings with clients, teachers, care workers, case managers, staff and interfacing agencies was seen as critical to the child's emotional, physical and mental wellbeing.

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

- Therapeutic Specialist
- Unit Manager
- Case Manager / Intensive Case Management Service (ICMS)
- Child Protection Case Manager (if relevant)

- Teacher/education support (depending on the circumstances)
- Parent/Family (in a few cases)
- Drug and Alcohol worker (if relevant)
- Mental Health Support Worker (if relevant)
- Police (if relevant)
- Young Person (in a few cases)

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

- Enhanced communication supporting congruence and consistent approaches and measures
- Ongoing education and learning regarding therapeutic practice across multiple agencies
- The identification of alternate strategies to support the young person's progress towards the identified goals and outcomes
- Problem solving regarding externalised behaviours (understanding the need/s which underlie the behaviours)
- Discussions regarding other young people who may be suitable for the TRC program (matched to the existing client group, within the targets for the individual TRC Pilots)

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

- Focus on clients as individuals, not as collective groups
- Appropriate referrals and information sharing
- Proactive planning for each client
- Transition planning for entry and exit of clients
- Ensuring safety of clients and staff via safety plans and other strategies
- Culturally appropriate responses
- Measurement of client progress
- Clear and appropriate communication – amongst staff and between TRC and external agencies such as the Department, schools and Regional Reference Groups Governance Group
- Partnerships with schools to assist/encourage adoption of therapeutic practice

Contribution to Client Outcomes

Care Team meetings contribute to the goal of providing unconditional high quality therapeutically focused care and a disposition to 'never give up'. Through the meetings there are multiple inputs and in particular they support collaboration and up-to-date information about the young person. This supports a consistent approach and facilitates problem solving and solution development that would otherwise be unlikely. This results in an approach that reinforces/supports the

therapeutic impact on the young person and supports problem solving when the approach is not producing positive outcomes for the young person.

3.5.4 Governance

It has been observed that program drift began as soon as the Victorian TRC pilots were mainstreamed. In the TRC Pilot evaluation the probability of program drift was addressed and approaches to mitigating this possibility put forward.

Local Governance

While a series of factors contributed to program drift, the importance of robust local governance arrangements cannot be underestimated. During the pilot period, key DHHS Central staff met regularly (at least quarterly) with pilot providers and other key stakeholders in each region, including regional DHHS. This not only provided a contract adherence and quality assurance check, but also ensured that the therapeutic approach remained front of mind – for all parties involved. These sessions were a vehicle for providers and agencies to voice the challenges they were experiencing as new scenarios were encountered, and a collaborative, reflective, problem solving perspective was adopted by all stakeholders.

Learning from this experience, Governance and Therapeutic Practice Quality has been identified as an Essential Element of therapeutic residential care. As stated in the Evidence Guide:

> *Therapeutic Residential Care programs sit within a complex array of statutory and contractual responsibilities, as well as practice and philosophical alignment to a therapeutic approach.*
>
> *Structures around governance and ongoing therapeutic practice improvement are required to maintain consistent practice and congruence between NGOs and all aspects of interaction with FACS and other interfacing agencies (eg Health, Justice, Education and others related to care and treatment plans).*
>
> *Governance sessions should be characterised by a Reflective approach.*

Consultations in NSW suggest that interfacing agencies, such as Education and Juvenile Justice, would be open to participating in grassroots/local governance processes that contribute to improved outcomes for children and young people.

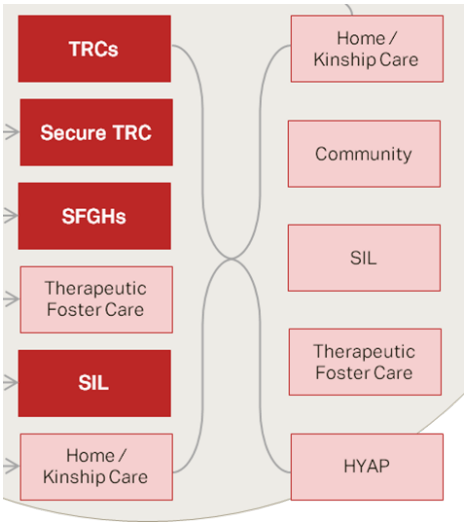
Program Governance

At a program governance level, factors contributing to program drift in the Victorian experience included:

- Organisational memory of the TRC evaluation was lost due to high turnover of key DHHS staff along with a major organisational restructure
- Key recommendations that would mitigate program drift were not implemented
- Outcome measures and embedded ongoing evaluation recommendations were not adopted

Embedding program governance into internal FACS structures and processes, including involvement in local governance activities, will assist in ensuring strong program fidelity. Other mechanisms proposed as part of this suite of recommendations (such as Therapeutic Community of Practice and FACS sponsorship of mandatory sector-wide training in theoretical principles of therapeutic care) will also contribute to strong governance and accountability, as will outcome measures and reporting.

3.6 Exit Pathways



3.6.1 System Architecture Exit Pathways

The system architecture supports a range of transition points consistent with the co-design detailed in Figure 2: 'A child's journey through care'.

Consultations undertaken to develop this architecture confirm that there is a lack of system congruence that has particular impacts on developing effective exit pathways that are able to support ongoing treatment. This element of the architecture is reliant on reshaping the service design and developing congruent practices in non-residential programs.

3.6.2 Towards Better Practice

The therapeutic residential care system is designed to interface with a continuum of therapeutic practices in less intensive settings and to prioritise approaches that support safe restorations. The wider out-of-home care will require redesign to facilitate this vision and to realise the envisaged exit pathways.

As the architecture promotes exit pathways as an essential part of the design several exit alternatives are explored to highlight feasible options for enhancing and or securing the long-term therapeutic outcomes.

Supporting the Journey into Adulthood

The consultants met with senior management of Stepping Stone House as part of the background investigation for this redesign. The model developed by Stepping Stone House includes options that build independence and resilience while having the support required as the young person matures into independent adulthood.

Stepping Stone House use a variety of mechanisms to promote a successful journey into adulthood that include housing options supported by ongoing case work and life-skills coaching, housing with support as required and an alumni capable of providing a community of peer support.

Reunification - Restoration

Verso recently completed a review of placement prevention and reunification services for Aboriginal children, young people and their families in Victoria. The evidence gathered through the review identifies that significant progress could be made to support restoration. Some elements of the review that support how or where improved rates of restoration can be realised are:

- Options for restoration that have not been adequately investigated particularly in the wider family and community
- Wraparound service responses that intensively support families demonstrate improved rates of restoration
- Cultural plans that are developed in collaboration with appropriate Aboriginal people

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- Cultural safe and component practices
- Therapeutic foster care and kinship care

3.6.3 Exit Pathways and Exit Planning - an Essential Element

Exit pathways and exit planning is an essential element of effective therapeutic residential care. The Victorian TRC Evaluation provided insights that have been embedded in this design. The insights are:

- There are different approaches and circumstances that drive the timeframe for transitioning out of a Therapeutic Residential Care program – whether to an alternate care type, family restoration or exiting care. In any of these scenarios, a plan to exit Therapeutic Residential Care should be developed in collaboration with the child or young person.
- Of particular importance is consideration of the ongoing impact of historical trauma and poor attachment and the healing role played by strong relationships with residential carers. While these relationships are not familial, for many of the young people they are the only stable and trusting relationship that they have ever had with an adult.
- Specifically in relation to exiting care, the impact of exiting into an environment without supports and the absence of attached relationships is cause for careful Exit and Post Exit planning. It should also be noted that age is not always a good indicator for Exit Planning as chronological age may not be an indicator of emotional age.

Key actions supporting this Essential Element are:

- Early commencement and implementation of Transition/ Exit Planning to manage related anxiety
- Engagement of young person in developing their Transition, Exit and Post Exit Plans
- Post Exit support (formal or informal).

3.7 Structured Observations, Reflections and Reporting

Evaluation and outcomes measurement are embedded within the proposed system design. This has historically been a challenge across the community and social service sectors. Within the current residential care system, there is no evidence this has been achieved. There is good evidence that individual providers have developed processes however most of these processes are focused on assessment and treatment rather than outcomes measures. The current approaches will provide learnings that will be of great value in the assessment processes to be undertaken within the Intensive Interim Care units.

In relation to evaluation and outcomes, a consistent new approach will be required. This differs from the current approach identified in Section 3 of the QAF

> *The QAF is an organising framework or structure setting out what 'should' be attended to in order to improve outcomes for children in OOHC… The QAF does not define the 'how' – the specific way this will be achieved. Instead, the QAF will allow each individual agency to map its own pathway to achieving these goals in response in response to the particular needs of the children and young people they care for.*[10]

[10] Parenting Resource Centre and University of Melbourne (2015). NSW statutory out-of-home care: Quality Assurance Framework–Section 3: The quality assurance framework, Melbourne, p 2

The new system requires that providers comply with a standard and consistent approach to gathering and reporting data. Current and past practices demonstrate that this has not been achieved for a range of reasons. However, software and system developments present an opportunity to radically rethink what can be achieved.

Verso has been working with a large provider of therapeutic residential care in Victoria (10 TRCs, up to 40 young people in care at any time) in relation to linking structured observations, reflections and outcomes reporting. Two psychometric tools (HoNOSCA and Brann Likert Scales) are being utilised, and since March 2016, over 100 care staff have been recording daily observations for all children and young people.

Consistent collection of relevant data that inform outcome measurement and reporting was the primary goal of the project. The provider has been able to review progress at child/young person level, house/unit level and whole of program level. Further, information is collected in a manner that ensures that data is 'clean' and can be aggregated and/or presented for:

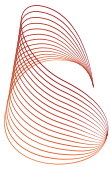
- Clinical and practice significance
- Managing program outcomes in the provider e.g. how many young people were in the unit as expected or absent in an unauthorised manner or how many young people were involved in education as expected
- Managing risk including providing a direct 'line of sight from the provider's board to each unit
- Reporting program effect – critical to justifying the case for funding and to be ensuring the best opportunities are being provided
- Benchmarking and expert data analysis and reporting on the significance of outcomes

Therapeutic Specialists analyse the data, and use the information in reflective practice meetings to discuss behavioural patterns and triggers and support staff to develop appropriate responses for a range of scenarios.

In addition to the primary goal, it has been identified that this process could feasibly replace daily notes entirely. This is being contemplated due to the following factors:

- The comprehensive and structured reflective questions are more reliable than daily notes due to the reflective nature of the questions and the broad scope of considerations e.g. not focused on the most difficult or challenging behaviour
- The information is collected in a manner that remains accessible and usable (there is a reliable audit trail) within the organisation for continual therapeutic practice and for risk management
- There is an observable educative and practice improvements that result from being asked to consider the critical and structured questions at each shift change
- Structured observations supports and prompts ongoing therapeutic practice and provides insights into interrelated patterns that have not been considered in previous practice
- There are considerable cost savings through reducing the time required to complete daily notes at handovers due to the efficient reporting method (up to 15 questions at each shift change per young person)

As noted above, the proposed system provides data that supports treatments and measures outcomes for young people, as well as the program as a whole. The outcomes data will also enable ongoing monitoring and evaluation of FACS' therapeutic residential care system.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