Summary: Evaluation of the Therapeutic Residential Care Pilot Programs in Victoria

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Abstract

This paper summarises the *Evaluation of the Therapeutic Residential Care (TRC) Pilot Programs* conducted in Victoria between 2009 and 2011. The evaluation assessed the effectiveness and efficiency of twelve TRC pilot programs established within Victoria's out-of-home care (OoHC) system to support children and young people with complex trauma histories. Using a mixed-methods design, the evaluation combined longitudinal quantitative outcome measurement with extensive qualitative inquiry. Results indicate that TRC produces significantly better outcomes than general residential care across multiple domains, including placement stability, mental and emotional health, relationships, education engagement, community connection, and reductions in risk-taking behaviour. Although TRC entails higher upfront costs, the evaluation demonstrates substantial cost avoidance through reduced use of crisis services, health, police, youth justice, and placement breakdown. The report concludes that there is a single, clearly identifiable TRC model underpinned by trauma-informed and attachment-based theory and recommends the transition from pilot status to system-wide implementation.

Introduction

Children and young people entering Victoria's out-of-home care (OoHC) system commonly present with complex needs arising from chronic abuse, neglect, disrupted attachments and repeated placement instability. Prior to the introduction of TRC, generalist residential care models were widely understood to provide safety and accommodation but lacked the therapeutic intensity required to address trauma-related developmental, emotional and behavioural difficulties.

In response to these systemic concerns, the Victorian Department of Human Services (DHS) initiated the first TRC pilot at Hurstbridge Farm in 2007. Drawing on international trauma-informed practice, particularly the Sanctuary Model, the pilot sought to embed therapeutic treatment within a residential care environment. Following early evidence of positive outcomes, an additional eleven TRC pilots were established across Victoria with varying client cohorts, including Aboriginal children, sibling groups, young people with intellectual disability and adolescents with high-risk behaviours.

The evaluation conducted by Verso Consulting aimed to determine whether TRC was more effective and efficient than general residential care, to identify the essential elements of the TRC model, and to establish whether this model should be expanded across the OoHC system.

Methods

Evaluation Design

The evaluation employed a multi-layered mixed-methods design comprising both formative and outcomes-focused components. This design aligned with a program logic framework and enabled triangulation across qualitative and quantitative data sources.

Quantitative Methods

A longitudinal, time-series design was used to track outcomes for 38 children and young people placed in TRC. Data were collected at up to seven time points: two pre-entry periods, entry, and multiple post-entry intervals extending to 24-27 months (with limited data beyond this point). A comparison group of 16 young people in general residential care was also assessed.

Outcome measurement tools included:

- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
- Strengths and Difficulties Questionnaire (SDQ)
- Brann Likert Scales, developed for the evaluation to align with the Child Protection, Placement and Family Services Outcomes Framework.

Qualitative Methods

Qualitative data were gathered through:

- Service modelling workshops (n≈158 participants),
- Focus groups and forums (n≈95),
- Workforce surveys (n≈73),
- Interviews with nine young people residing in TRCs,
- Stakeholder consultations with interfacing agencies (n≈26),
- Site visits and case studies,
- Review of service documentation and original funding proposals.

Ethics approval was obtained through the DHS Human Research Ethics Committee.

Results

Client Outcomes

Across nearly all domains measured, children and young people in TRC demonstrated marked and sustained improvement over time, significantly outperforming the comparison group in general residential care.

Placement stability improved substantially, with an average length of stay of approximately 30 months in TRC compared with an average of seven months in previous placements. TRC placements represented the most stable care experience many young people had ever experienced.

Relationships with residential carers and family members improved both in quality and consistency. Secure, attachment-promoting relationships with carers increased steadily, while poor or very poor relationship ratings declined sharply.

Mental and emotional health showed statistically significant improvement. HoNOSCA data indicated reductions in symptom severity across 13 of 15 domains, including aggression, emotional symptoms, peer relationships, self-care, and school attendance. SDQ scores similarly demonstrated reductions in emotional distress, conduct problems, and hyperactivity, alongside increases in pro-social behaviour.

Risk-taking behaviours decreased over time. Ratings of high or very high risk reduced from approximately two-thirds of young people pre-entry to under 40 per cent by 18 months post-entry. Secure welfare admissions dropped dramatically, from a median of 16 prior to TRC placement to zero by 24-27 months.

Education and community engagement improved, with higher school attendance, better peer functioning, and increased participation in recreational and community activities compared to the comparison group.

Program Costs and Benefits

TRC placements incurred an additional average cost of approximately $65,000 per child per annum relative to general residential care. However, the evaluation identified significant cost avoidance, including reduced secure welfare use, fewer placement breakdowns, and lower justice system involvement. The estimated annual financial benefit was approximately $44,000 per child, generating a net positive return when broader system impacts were considered.

Discussion

The evaluation provides compelling evidence that TRC constitutes a distinct and effective treatment-oriented model, rather than a variation of general residential care. While pilot sites differed in target groups and operational details, outcomes were consistently linked to the presence of a common set of program elements.

The evaluation identified a single, cohesive model of TRC comprising therapeutic specialist leadership, trained and stable staff, reflective practice, intentional client matching, young person participation, organisational congruence, a therapeutic environment and robust exit planning, all of which are necessary to achieve improved outcomes for children and young people with complex trauma histories.

Essential Elements of Therapeutic Residential Care	
Therapeutic Specialist	• Embedded specialist role (e.g. psychologist, social worker, mental health clinician). • Primarily works through staff, not by providing direct therapy to young people. • Leads assessment, formulation, therapeutic planning and reflective practice. • Continuity and accessibility of this role is critical; gaps significantly reduce effectiveness.
Trained and Therapeutically Skilled Staff	• Residential care workers trained in trauma, attachment and therapeutic care (e.g. With Care training). • Staff capable of responding non-punitively, reflectively and consistently. • Ability to recognise and manage their own triggers and vicarious trauma is essential.
Consistent Staffing and Rostering	• Stable staff teams with minimal use of untrained or brokered staff. • Rosters designed to maximise predictability, continuity and relationship building. • Adequate staffing levels allow flexibility, one-to-one support and crisis response.
Reflective Practice	• Regular, structured reflective practice sessions facilitated by the Therapeutic Specialist. • Enables staff to understand behaviour through a trauma lens rather than a control lens. • Central to learning, emotional containment, team cohesion and therapeutic consistency.
Engagement and Participation of Young People	• Young people actively involved in decisions about placement, daily living, goals and exit planning. • Emphasis on dignity, voice, agency and relational safety. • Use of democratic processes (e.g. community meetings) informed by the Sanctuary Model.
Careful Client Mix and Matching	• Intentional matching of residents based on age, gender, trauma history and behavioural presentation. • Focus on maximising safety and therapeutic benefit for all children in the home. • Avoidance of emergency placements that disrupt therapeutic integrity.
Regular Multidisciplinary Care Team Meetings	• Involvement of carers, Therapeutic Specialist, case managers, education and other key services. • Ensures shared understanding, coordinated responses and system congruence. • Supports problem-solving, monitoring progress and managing risk therapeutically.
Organisational Congruence and Commitment	• Whole-of-organisation alignment with trauma-informed and therapeutic principles. • Leadership actively supports the therapeutic model and protects model integrity. • Incongruent practices (e.g. punitive responses, bypassed intake processes) undermine outcomes.
Therapeutic Physical Environment	• Home-like, non-institutional residential settings. • Private spaces, opportunities for personalisation, and a sense of normality. • Environment contributes to emotional safety, regulation and attachment.
Planned Exit and Post-Exit Support	• Exit planning begins early and is based on developmental readiness, not age alone. • Recognition that emotional recovery lags behind behavioural change. • Ongoing post-exit support and relationship continuity are critical to sustaining gains.

Central to the model is the Therapeutic Specialist, whose role is to embed therapeutic thinking through staff practice rather than deliver therapy directly to children. Evidence showed that gaps in access to this role significantly diminished program effectiveness, underscoring its indispensability.

Training and workforce development were also critical. Nearly all staff had completed core trauma-informed training, facilitating consistent, non-punitive responses to behaviour and supporting relationship-based care. These practices contributed to high staff satisfaction and lower turnover.

The findings highlight the importance of organisational congruence and system integration. TRCs were most effective where child protection, education, mental health services, and justice agencies aligned their practices with trauma-informed principles. Conversely, incongruence-such as emergency placements or court-ordered exits contrary to therapeutic advice-was associated with poorer outcomes.

Persistent challenges were identified in exit planning and post-exit support. Although behavioural improvements often occurred relatively early, mental health recovery progressed more slowly, suggesting that premature exits risk undermining gains. The report argues for longer TRC stays and structured post-exit therapeutic support.

Conclusion

The evaluation concludes that TRC delivers significantly superior outcomes for highly vulnerable children and young people compared with general residential care. Despite higher upfront costs, TRC generates substantial social and economic benefits through improved wellbeing, reduced system burden, and enhanced life trajectories.

The report recommends removing TRC's pilot status, expanding the model across Victoria's residential care system, and embedding therapeutic principles throughout OoHC. Fundamental to this expansion are workforce development, consistent therapeutic leadership, robust data systems, and coordinated cross-agency practice. TRC is positioned not as an optional enhancement, but as an evidence-based standard of care for children and young people with complex trauma histories.

This summary has been AI-generated and subsequently reviewed by the report authors to ensure accuracy, completeness, and faithful representation of the original report.