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Very High Poor Mental Health Status of Young People in Out of Home Care

The Author

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Abstract

The author has led six outcome evaluations and one place-based evaluation of therapeutic residential out of home care (TRC) services in Australia over four jurisdictions over the 12 years from 2011 to 2023. The evaluations were conducted using comparable mixed methods and through the application of consistent data collection tools. This application of common evaluation methodology has enabled the capacity to document longitudinal findings.

Consistent findings from this aggregation of evaluation findings addressed in this paper are:

- Extreme poor mental health indicators of the young people entering therapeutic residential out of home care
- Evidence that majority of young people with these indicators were living with these extreme complexities in the out of home care system prior to entering TRCs
- Evidence that the poor mental health indicators are significantly higher than the indicators of young people entering specialist youth impatient mental health services
- Evidence that the application of a set of common essential elements in the TRC services reduces the poor mental health indicators

Introduction

The author has led six outcome evaluations and one place-based evaluation of therapeutic residential out of home care (TRC) services in Australia over four jurisdictions over the 12 years from 2011 to 2023. The evaluations were conducted using comparable mixed methods and through the application of consistent data collection tools. This application of common evaluation methodology has enabled the capacity to document longitudinal findings.

Aggregated results from seven evaluations has supported a capacity to increase the sample size from the original TRC pilot evaluation of 38 (plus 16 in a comparison group) to a total 259 for whom there are complete records. The aggregation of outcomes demonstrates consistent and persistent findings that result in increased reliability in relation to the findings, analysis and implications.

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- Evidence that majority of young people with these indicators were living with these extreme complexities in the out of home care system prior to entering TRCs
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- Evidence that the application of a set of common essential elements in the TRC services reduces the poor mental health indicators

TRC Pilot Evaluation

The longitudinal outcomes reported in this paper originated with the evaluation of Therapeutic Care (TRC) Pilots in the State of Victoria.[1] This evaluation commenced in 2009 and was completed in 2011. The pre-entry circumstances and progress of 38 young people in the TRC pilots were evaluated using qualitative and quantitative measures. Consistent qualitative and quantitative measures were also used to measure outcomes of 16 young people in a comparison group.

Key foci of the evaluation were the measurement and analysis of changes that occurred for the young people, the significance of the changes, and the circumstances under which the changes occurred.

The key outcome finding for the young people is that they experienced significant and positive improvements in the reduction of adverse behaviours, adoption of positive behaviours, achievement of age-appropriate milestones and reductions in indicator of poor mental health. This outcome was achieved when the essential elements of the TRC model of care were consistently applied, and the outcomes were diminished when one or more of the essential elements were compromised. Young people in the comparison group, who did not benefit from the application of the essential elements, did not experience any significant change over a 12-month period. The young people's positive experience was also compared to their previous experiences in out of home care. Other meaningful data comparisons were made to normative populations, populations in other out of home care programs and CAMHS/CYMHS[2] in Australia.

The original TRC evaluation related to services that were operated by two Aboriginal Community Controlled Organisations (ACCOs), six different community service organisations (CSOs) and one Government operated service.

The subsequent TRC evaluations (2012 to 2023) have been conducted for CSOs - with the exception of the placed-based evaluation of a Government operated service.

Other Evaluations

Building on the TRC Pilot evaluation, evaluations have been undertaken that provide the opportunity to increase the sample size and to test the findings and conclusions of the 2011 study. Accordingly, the original quantitative methods were consistently utilised in these subsequent studies complemented by similar qualitative methods. The qualitative methods were used as a counterpoint to the data and as evidence of how the consistent application of the essential elements effect outcomes.

[1] Faircloth D et al [Verso Consulting] (2011). Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report. Victorian Department of Human Services https://www.vgls.vic.gov.au/client/en_AU/search/asset/1264629/0

[2] Child and Adolescent/Youth Mental Health Services

The additional evaluations include:

Table 1: Additional Evaluations Undertaken

Evaluation	Year	Description	Publication status	Sample size	Ref[3]
TRC farm operated by the Victorian Department of Human Services	2012	Unique features included the therapeutic role of the farmer and the young people's engagement with the animals, an on-site school, two TRC homes and two independent living units.	The review has not been publicly released, however the outcomes have been used as confirming evidence by the author to provide insights into the application and efficacy of the essential elements of therapeutic care.	8	2
Salvation Army Tasmania Division TYRCS Client Outcomes Review	2014-15	The TYRCS evaluation was designed to "measure the outcomes for children and young people in the Tasmanian TRCs operated by the Salvation Army". In addition to informing continuous quality program improvement.	Findings presented at 2015 National Therapeutic Care Workshop[4] and 2019 National Therapeutic Out of Home Care Conference.[5]	12	3
MacKillop Family Services in two jurisdictions	2016-18	An evaluation of the application of the TRC data tools and an analysis of the outcomes.	Findings included in EUSARF 2016: Shaping the Future conference presentation[6,7,8]	115	4
TRC evaluation in Queensland	2019	This service predominantly supports First Nations young people.	Data insights presented at 2022 Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL) National Congress[9]	15	5
Teddington Model Outcome Review Uniting Vic.Tas	2020	This service had a focus on family reunification, with additional family worker resourcing.	Data insights included in the 2022 findings presented at the International Childhood Trauma Conference (see below)	15	6
Practice Leadership Unit Review	2022-23	The evaluation examined implementation and outcomes associated with Uniting's integrated therapeutic model of care	Findings presented at 2022 International Childhood Trauma Conference[10]	48	7

The evaluations relate to a total sample of six evaluations for 259 young people over 13 providers (17 programs) across four jurisdictions.

[3] The evaluation reference used throughout this paper; the TRC Pilot evaluation is evaluation 1

[4] Faircloth D & McNair J (2015, February 9). Therapeutic Residential Care data and practice insights from The Salvation Army Tasmania. National Therapeutic Care Workshop, Hobart

[5] Cooper J & Faircloth D (2019, June 24). Improving outcomes for vulnerable adolescents who have experienced trauma: A Tasmanian study. National Child Protection Conference, Brisbane.

[6] Faircloth D (2017, September 7-8). Measuring Change – Promoting Healing: New Perspectives for Outcome-Based Evaluation and Research on Family and Children's Services. Fondazionne E Zancan onlus and The Chinese University Hong Kong

[7] (pages 85 to 90), Faircloth D (2017). Background Paper to Eusarf 2016: Shaping the Future conference presentation "Evidence Informed Therapeutic Residential Care: Using Technology to Improve Outcomes For Children in Out-of-Home Care" pp 85-90

[8] Halfpenny N Loch E (2016). Therapeutic Care Monitoring Project: Data collection, storage and management (adapted from Verso Consulting Background Paper). Eusarf Wednesday 14th September 2016 Oviedo, Spain

[9] Faircloth D (2022, November 23-25). Residential Out of Home Care: Trauma, Complexity, Failing Up through a system that traumatises. Australian and New Zealand Association of Psychiatry, Psychology and Law (ANZAPPL) National Congress: Rights and responsibilities: challenges and opportunities for reform, Adelaide.

[10] Holmes A, Melrose C & Faircloth D. Data & Practice: Closing the Loop of Understanding to Enhance Practice in a Therapeutic Model of Residential Care 3 August 2022. International Childhood Trauma Conference, Melbourne.

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Data Tools

Each of the evaluations made use of validated psychometric tools (HoNOSCA and SDQ) and an observational scale (the Brann Likert Scales) to gather outcome data. The tools are detailed in this section.

HoNOSCA

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was used in all the evaluations. Selection of this tool was based on its use by Australia's Child and Adolescent Mental Health Services (CYMHS/CAMHS) and as such it provides a comparison between the young people entering mental health services and young people in the TRCs. Gowers SG et al[11] report that 'the HoNOSCA represents a satisfactory brief outcome measure which could be used routinely in child and adolescent mental health services'. The Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP) report[12] that "the HoNOSCA has been demonstrated to have good discriminative and concurrent validity, good face validity and to be sensitive to change."

The HoNOSCA comprises thirteen core scales (rated between 'No Problem' to 'Severe Problem' over a 5 point scale) which address behaviours, symptomatology, disability, and social functioning. [13] The scales address the following areas detailed in Table 2.

Table 2: HoNOSCA Scales

• Disruptive/aggressive/antisocial behaviours	• Emotional symptoms
• Over-activity/concentration	• Peer relationships
• Non-Accidental Self-injury	• Self-care
• Substance misuse	• Family relationships
• Scholastic/language skills	• School attendance
• Non-organic somatic symptoms	

In these evaluations, the HoNOSCA scales were completed by psychologists attached to the TRCs who were trained in the use of the tool. Observations regarding the young people were collected via reflective practice meetings, care team meetings, daily/case notes and other reports such as medical and education and past case notes. In addition, retrospective HoNOSCA scales were completed to capture ratings for young people prior to their entry to the TRC using case notes, medical records and/or direct contact with clinicians, input from case managers and direct information from previous workers and insights provided by the young people.

SDQ

The Strengths and Difficulties Questionnaire (SDQ) is a 25-item screening questionnaire that exists in several versions to meet the needs of researchers, clinicians and educationalists that screens for difficulties in four areas; emotional symptoms, conduct problems, hyperactivity/ inattention and peer relationship problems in addition to strengths in prosocial behaviour. The tool's author states "The SDQ was initially tested against the Rutter Parent Questionnaire and found to have good concurrent validity. The SDQ is generally considered to have acceptable reliability and validity"[14]

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[11] Gowers SG, Harrington RC, Whitton A, Lelliott P, Beevor A, Wing J & Jezzard R (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for children and Adolescents (HoNOSCA). Br J Psychiatry, 174:413-6. doi: 10.1192/bjp.174.5.413. PMID: 10616607.

[12] Frequently Asked Questions: The Clinician's FAQ to HoNOSCA in Australia Child and Adolescent Mental Health Information Development Expert Advisory Panel (CAMHIDEAP) 2016

[13] HoNOSCA Health of the Nation Outcome Scales Child and Adolescent Mental Health Glossary for HoNOSCA Score Sheet; Authors:- S.G. Gowers, R.C. Harrington, A. Whitton, A.S. Beevor, P. Lelliott, J.K. Wing, R. Jezzard 1998

[14] Goodman, R (1997). The strengths and difficulties questionnaire: A research note. Journal of Child Psychology & Psychiatry & Allied Disciplines, 38 (5) : 581–586

and Mathai et al found that the SDQ has been found to be a useful outcome measure of Australian CAMHS services.[15]

According to Goodman and Scott "the SDQ was significantly better than the Child Behaviour Checklist (CBCL) at detecting inattention and hyperactivity and at least as at detecting internalising and externalising problems"[16] and more recently Williamson et al reported that "SDQ assessments have been found to correlate to a moderate to high level with clinician diagnoses in both a community and a clinical sample".[17]

Key reasons for the use of the SDQ in the initial TRC evaluation were:

- The SDQ has acceptable reliability and validity
- It provides a counterpoint to the HoNOSCA
- Comparative data was available for CYMHS/CAMHS in Australia as its is used alongside the HoNOSCA
- Data was available from a major Australian community service organisation regarding entry scores for all young people 12-17 years entering any of their residential and community-based services
- The SDQ reports normative population data

Unlike the HoNOSCA which is completed by a psychologist working in the TRC, the SDQ was completed by the staff (carers) who had the closest connection/relationship with the young people. The SDQs were also retrospectively completed to capture scores for young people prior to entering the TRC using case notes, input from case managers, medical records and direct information from previous workers and insights from the young people.

In the TRCs, the therapeutic specialist (psychologist attached to the TRC) routinely supported staff completing the SDQ through reflective practice meetings and their mentoring role.

Findings: Entry to TRCs

The aggregate intake score for young people entering TRCs was 34.9% higher than the aggregate intake score for young people entering CYMHS/CAMHS[18] as shown in Figure 1. The higher the HoNOSCA score, the greater the symptom severity. Symptom severity is an indicator of poor mental health.

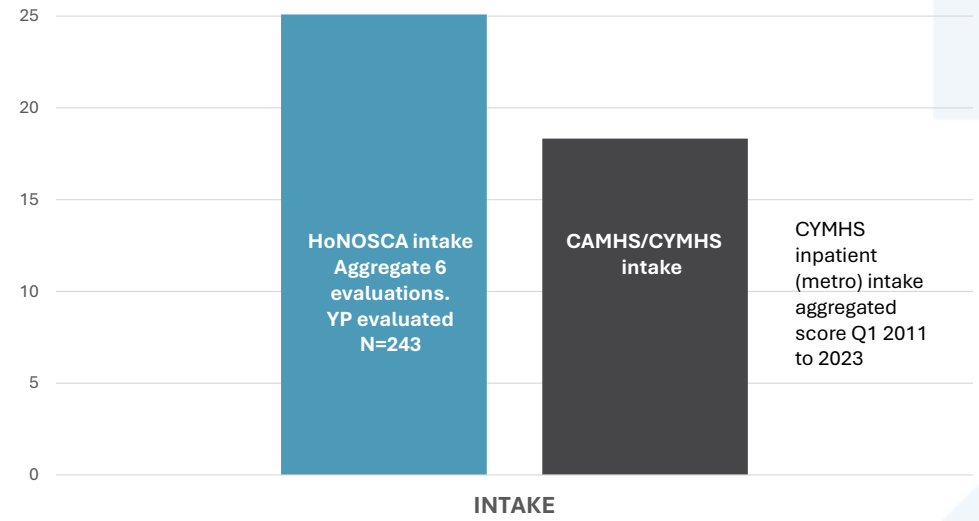
[15] Mathai J, Anderson P & Bourne A (2003). Use of the Strengths and Difficulties Questionnaire as an outcome measure in a child and adolescent mental health service. Australasian Psychiatry, 11(3), 334–337

[16] Goodman R & Scott S (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behaviour Checklist: Is Small Beautiful?. Journal of Abnormal Child Psychology, Vol 27:1, pp 17-24

[17] Williamson A, Redman S, Dadds M, Daniels J, D'Este C, Raphael B, Eades S & Skinner T (2010). Acceptability of an Emotional and Behavioural Screening Tool for Children in Aboriginal Community Controlled Health Services in Urban NSW. Australian & New Zealand Journal of Psychiatry. 2010;44(10):894-900. doi:10.3109/00048674.2010.489505

[18] CYMHS/CYMHS intake Q2 FY 20/21 average Metro, CYMHS/CAMHS mental health quarterly KPI report Oct – Dec 2020 Victorian Agency for Health Information (Victorian Department of Health)

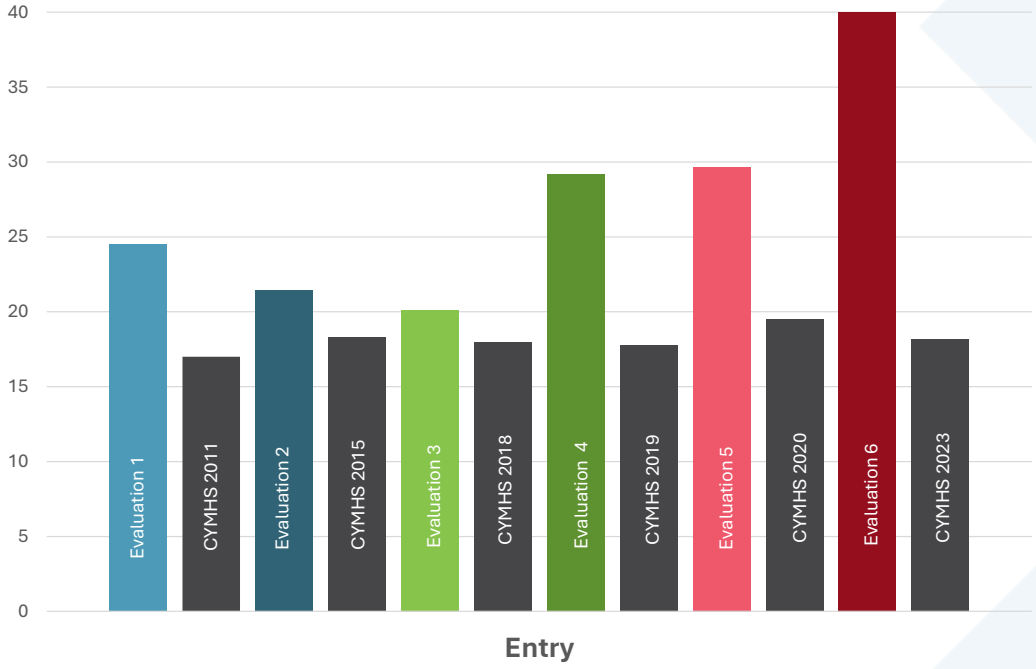
Figure 1 Aggregate HoNOSCA TRC intake scores compared to CYMHS/CAMHS intake scores



Sources: Faircloth McNair & Associates and Verso Consulting evaluations (see references) and Victorian Department of Health Child and adolescent mental health (CAMHS) performance indicator reports; Q1 2011, Q1 2015, Q1 2018, Q1 2019, Q1 2020, Q1 2023.

Figure 2 compares HoNOSCA intake scores for six evaluations of therapeutic residential care to the CYMHS intake data (metropolitan inpatient services in Victoria). The data indicates symptom severity of young people in TRCs is greater than young people entering inpatient CYMHS services over a period exceeding a span of 12 years. This suggests greater likelihood of poor mental health for the young people entering TRCs is a consistent and persistent issue.

Figure 2 HoNOSCA TRC Intake scores for each of the 6 evaluations compared to CYMHS/CAMHS

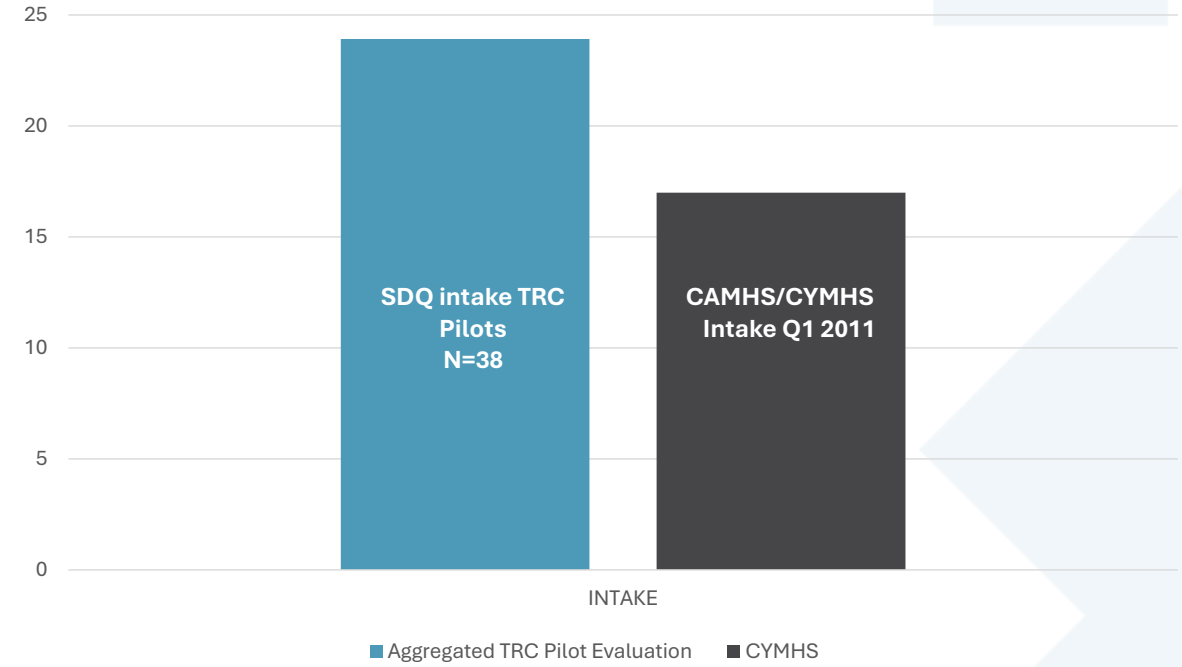


Sources: Faircloth McNair & Associates and Verso Consulting evaluations (see references) and CYMHS/CYMHS intake Q2 FY 20/21 average Metro, CYMHS/CAMHS mental health quarterly KPI report Oct – Dec 2020 Victorian Agency for Health Information.

Figure 3 provides corroborating evidence demonstrating elevated indicators of poor mental health using an alternate psychometric tool to the HoNOSCA. The data demonstrates that the young

people in the TRC pilots had indicators of poor mental health that exceed the intake scores of CYMHS services inpatients.

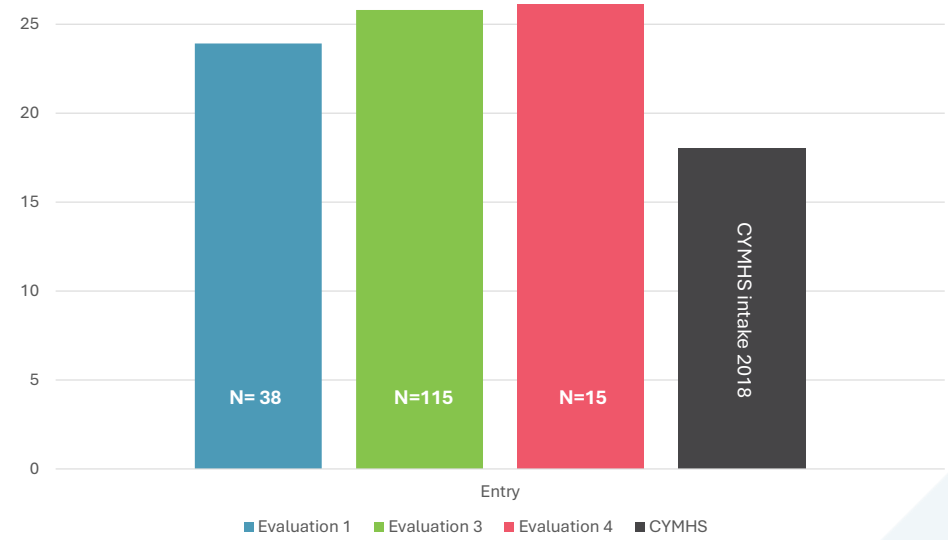
Figure 3: Intake scores SDQ TRC Pilots compared to CYMHS intake scores



Sources: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report Nov 2011

Figure 4 corroborates consistent and persistent indicators of poor mental health for young people entering TRCs. The indicators are consistently higher than those of young people entering CYMHS inpatient services. This evidence is also consistent with the findings from the application and analysis of the HoNOSCA.

Figure 4: Intake Scores SDQ compared to three evaluations and CYMHS (2011-2018)



Sources: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report Nov 2011, and Australian Mental Health Outcomes and Classification Network, AMHOCN - NOCC Standard Reports (SDQ at intake for inpatient services)

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CYMHS - TRC Comparisons

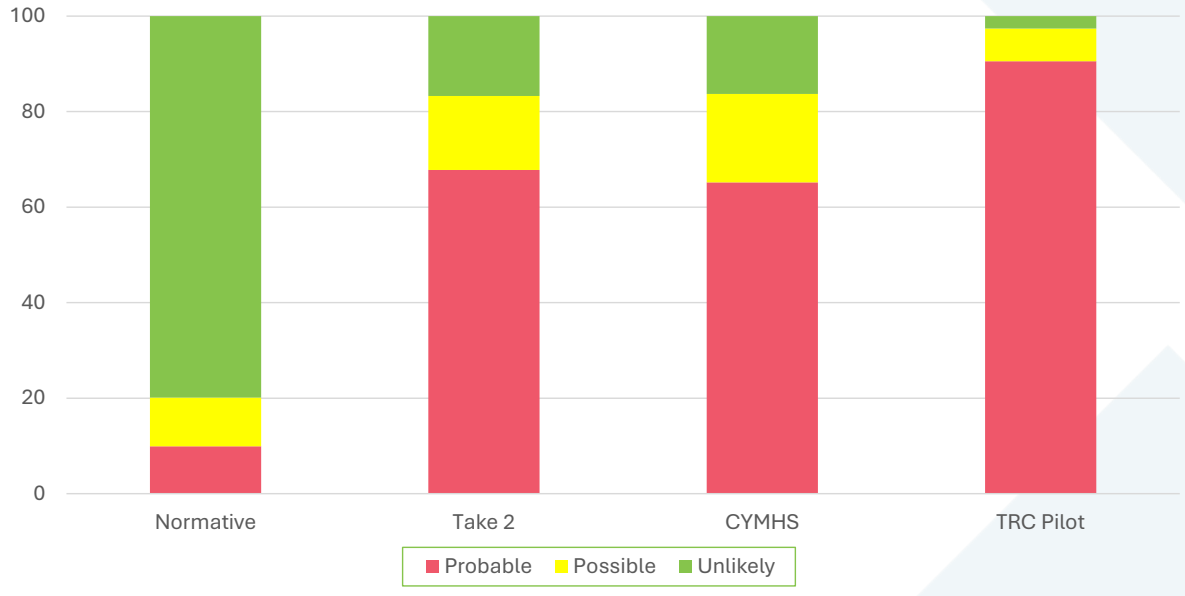
The Victorian Government's mental health system target population guidance for CAMHS/CAMHS[19] details the range of presenting problems that the young person may be experiencing. The description supports insights as to the severity of problems appropriate to referral to CAMHS/CYMHS and therefore the contrast to the higher and persistent HoNOSCA and SDQ ratings in the TRCs is significant and concerning. The Victorian Government advices the following problems are considered appropriate for referral to CAMHS/CYMHS in Victoria:

- 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
- Conduct disorder is the most severe type of disruptive behaviour in children and young people, with such behaviours as extreme aggression, truancy, lying, stealing, lack of empathy, or running away

Corroborating Comparisons

Figure 5 details the high probability of a disorder for young people entering the TRC pilots and provides comparisons to support insight into the significance of ratings and the finding that young people entering the TRC have very high indicators of poor mental health.

Figure 5: SDQ Comparative Data TRC Pilot Evaluation – Likelihood of a disorder



Source: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report Nov 2011

The three comparisons provided in Figure 5 inform the following key findings:

[19] http://www3.health.vic.gov.au/mentalhealthservices/child/index.htm (accessed 12/07/2025)

- Young people at intake to the TRC have a likelihood of a disorder 9 times greater than the normative population
- Young people at intake into the TRC are 33.6% more likely to have a disorder than young people entering Take 2 out of home (community and residential) care placements
- Young people at intake into the TRC are 38.8% more likely to have a disorder than young people entering CYMHS/CAMHS metropolitan inpatient services
- Young people entering Take 2 out of home care are more likely to have a disorder than the young people entering CYMHS/CAMHS metropolitan inpatient services

Ineffective treatment or untreated complex care needs prior to TRC

Years in out of home care prior to TRC entry

The average number of years spent in out of home care prior to entry into the TRC pilots (Evaluation 1) was 72 months.[20]

Information regarding the time spent in out of home care is difficult to obtain, as it is held across multiple departmental databases. For Evaluation 1, this data was accessed and extracted by an authorised Departmental officer in line with research ethics approval. Successive evaluations did not benefit from this level of investigation of departmental databases, and information about the history of the young person was often unavailable, not known by the Case Manager, and on occasion deliberately obscured by the relevant department.

However, evaluations 1, 3, 5 and 6 detail placement changes (Table 3). Using the placement change and age of entry data a calculation has been made suggesting that across Evaluations 3, 5 and 6 that the average number of months in OoHC prior to entering the TRCs can be estimated to be 69 months.

Placement Instability

Placement data (Table 3) indicates very high levels of placement instability prior to TRC entry. This instability should have been understood to be an indicator of the potential for complex trauma and related poor mental health as shown by research conducted by Osborn & Bromfield[21] and Wise et al. 2010[22] which establish that placement instability is a fundamental problem experienced by children and young people in the out of home care system, particularly among groups with complex care needs. Placement instability, or drift, is shown to be strongly linked to worse outcomes including schooling and subsequent life chances for young people. Several studies support the contention that placement instability lasting for more than 12 months is more strongly linked with a higher prevalence of psychological, social, and educational difficulties.[23,24,25]

[20] Faircloth D et al [Verso Consulting] (2011). Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report. Victorian Department of Human Services www.vgls.vic.gov.au/client/en_AU/search/asset/1264629/0

[21] Bromfield L & Osborn A (2008). 'Getting the big picture': A synopsis and critique of Australian out-of-home care research. Australian Institute of Family Studies. www.aifs.gov.au/nch/pubs/issues/issues26/issues26.html

[22] Wise S et al (2010). Care system impacts on academic outcomes, Anglicare Victoria and Wesley Mission Victoria. Available at: www.anglicarevic.org.au.

[23] Cashmore J & Paxman M (2006). Predicting after-care outcomes: The importance of 'felt' security. Child & Family Social Work, 11(3):232-241

[24] Bromfield L & Osborn A (2008). 'Getting the big picture': A synopsis and critique of Australian out-of-home care research. Australian Institute of Family Studies. www.aifs.gov.au/nch/pubs/issues/issues26/issues26.html

[25] Stone S (2006). Child maltreatment, out-of-home placement and academic vulnerability: A fifteen-year review of evidence and future directions. Children and Youth Services Review, Vol 29:2, pp 139-61

Table 3: Placement Stability

Placement Changes Prior to TRC	Evaluation 1	Evaluation 3	Evaluation 5	Evaluation 6	Aggregate
More than 10	40%	33%	19%	14%	27%
5 to 9	20%	35%	26%	5%	25%
1 to 4	40%	33%	52%	58%	42%
Zero	0%	0%	4%	23%	6%

Source: Data reports Evaluations 1, 3, 5 and 6

Estimates and administrative data reveal that young people have typically been in care for significant period of time prior to entry into the TRC (estimate 69 months). In this time (while in care) the opportunity to address their very poor mental health has either been disregarded or (at best) ineffectively managed. The following qualitative data supports insights into poor or non-existent health management, including mental health. It provides further insight into escalation of symptoms and difficulties due to lack of effective action.

Poor health management – meeting outcomes

Early in the evaluation of the TRC pilots, when data relating to the very poor and poor health outcomes was first analysed by the evaluators, the author convened an urgent meeting of the senior bureaucrats responsible for the care of the young people. The evaluators considered that the outcome data revealed that there was critical safety and duty of care issues that warranted immediate interventions.

The response to the concerns uncovered from the data was a casual disregard. The author was stunned and sought further insight from the bureaucrats who indicated that the poor health management and related action was 'just normal'.

The author finds it very difficult to understand how this neglect can be an appropriate response for an agency tasked with responsibility to protect children and young people from abuse and neglect.

Consultations – access and support of psychologists

While undertaking the out of home care system redesign for the NSW Department of Families and Community Services, consultations with clinicians suggested that effectively the mental health care needs of young people in out of home care could not be clinically addressed as there were insufficient practitioners.

Jurisdictional consultations

In one Australian jurisdiction, a senior child protection bureaucrat stated that it was policy that young people in out of home care could not access state-funded psychology services.

The lack of responses to the mental health needs of young people in out of home care is discussed in a submission to the Royal Commission into Victoria's Mental Health System, pertinent observations regarding knowledge include:

> *...it (the mental health system) has not kept apace adequately with emerging knowledge regarding the underlying causes of certain diagnostic categories. As a consequence of this it fails both its real target population because of unavailability and other individuals struggling with psychological distress that could be dealt with more effectively by being understood and provided with service in other more well targeted and therefore more effective, ways.*

> *...emergent knowledge frameworks over the past twenty years of complex trauma/Post Traumatic Stress Disorder as it arises from extreme developmental adversity, its impacts on neurobiological organisation and development and consequently its manifestations in the form of a range of symptomatic presentations. These include states of extreme psychological and existential distress, many childhood/adolescent behavioural disorders, the regular criminalisation of these within a system that is required to heal & provide care, the metamorphosis of these into later more complex and troubling social, emotional and psychological states and the common trajectory into tertiary mental health/psychiatric, drug and alcohol, homelessness and criminal justice systems.*[26]

Reinforcing the findings that there is a lack of attention to health

In this section, discussion regarding another data collection tool (the Brann Likert Scales) used in the evaluation In the TRC Pilot Evaluation is introduced to corroborate the finding that the young people's health needs including mental health have not been effectively and appropriately managed while in out of home care (prior to entry to the TRC). This insight supports the often repeated claim made by therapeutic specialists that young people in out of home care are left to "fail up through the system".[27] Consultations undertaken as part of the TRC evaluations and other work in out of home care settings demonstrate that, for many young people, their experience in out of home care settings is traumatising. Further, the Principal Commissioner for Children and Young People in Victoria reported that

> *Data [shows] that since July 2021 until the end of March 2023, 423 incidents of sexual exploitation in residential care were reported to the Commission, involving a total of 165 children. Of these, 64 per cent, or 241 incidents, involved sexual exploitation and abuse of children under 16, and 11 incidents involved nine children under 12.*
>
> *Behind these figures are 165 of Victoria's most vulnerable and victimised children – children who have already suffered trauma, been removed from their families and are now in the care of the state.*[28]

Data relating to physical health was measured using the Brann Likert Scales, an observational tool developed by Dr Peter Brann[29] for the TRC Pilot evaluation. This tool was also applied to three of the other evaluations. Nine domains were observed and were documented in concert with the application of the HoNOSCA and SDQ. The health domains are documented medical status; documented dental status; documented nutritional status; documented sleep status; documented hygiene status; recreational patterns; frequency of recreation; improvements in exercise; and frequency of exercise.

Table 4 details an aggregation of the poor and very poor ratings for five health domains (physical health, dental, nutrition, sleep and hygiene) status 15-18 months and 3-6 months pre-entry to the TRC. The data was drawn from case files, health records, case manager knowledge, interviews with people providing care prior to their entry to the TRC Pilots. The young people's insights were also sought where this was possible/appropriate. These records supported the house manager and therapeutic specialist to collaboratively populate the scales. The data collection proforma for the Brann Likert Scales was accompanied by guidance notes to support the retrospective data

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[26] Holmes A, Faircloth D & Streatfeild K (2019). Joint Submission to the Victorian Royal Commission into Mental Health. Individual submissions (Faircloth D) https://rcvmhs.archive.royalcommission.vic.gov.au/submissions.html (Accessed 20/07/2025)

[27] Interviews with Uniting's therapeutic specialists and associated clinicians 2021/22

[28] https://ccyp.vic.gov.au/news/statewide-action-overdue-amid-new-data-showing-continuing-sexual-exploitation-of-children-in-residential-care/

[29] See bio at www.easternhealth.org.au/institute/research-programs/mental-health-research/

collection. Further support was provided by evaluators facilitating 'clean' and complete data for 38 young people.

The finding from the application of the Brann Likert Scales which is, consistent with the mental indicators (HoNOSCA and SDQ), indicates that there are significant failures in the management of young people's health prior to entering the TRC. The average period of time in care prior to entry into the TRCs was upwards of 69 months (for 94% of the sample). The finding provides insight into the lack of support and focus on health including mental health in the general out of home care system.

Table 4: Documented poor and very poor health status pre-entry to the TRC

Collection Period	Quality of medical status	Quality of dental status	Quality of nutritional status	Quality of sleep status	Quality of hygiene status
15-18 months pre-entry poor or very poor rating	22%	20%	32%	39%	20%
3-6 months pre-entry poor or very poor rating	24%	28%	59%	40%	18%

Source: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4 November 2011 Department of Human Services (page 138)

Supporting Positive Change

The TRCs evaluated by the author share the conceptual underpinnings detailed in the TRC pilot evaluation including:

- Attachment theory
- Trauma theory that includes complex trauma
- The neurobiology of attachment and trauma
- Attachment, trauma and resilience.[30]

The submission to the Royal Commission into Victoria's Mental Health System referenced above[31] documents frameworks and knowledge for the therapeutic treatment of young people in out of home care. These frameworks and knowledge form the foundations for the treatments and practices in the TRC. The submission states:

> The underlying frameworks of knowledge referred to are well documented in the work of Doctors Bessel van der Kolk, Judith Herman, Sandra Bloom, Bruce Perry, Gabor Maté, Daniel Siegel; Professor Allan Schore, Dr James Anglin and others. These frameworks all speak of the role of extreme developmental/complex trauma arising from exposure to family violence, parental substance abuse, profound neglect; physical & sexual abuse and emotional abuse & neglect both in utero and in the first five years of life and the 'pain-based' behaviours (Anglin, 2014a) that arise as a result. It has long been recognised that traditional Child & Adolescent Mental Health Services do not adequately meet the needs of individuals who have complex trauma/PTSD presentations. This recognition is what led, in 2002, to the development of Take Two as a targeted outpatient service for children and young people so affected and then to the development of the model for the Victorian

[30] Faircloth D et al [Verso Consulting] (2011). Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report. Victorian Department of Human Services www.vgls.vic.gov.au/client/en_AU/search/asset/1264629/0

[31] Holmes A, Faircloth D & Streatfeild K (2019). Joint Submission to the Victorian Royal Commission into Mental Health. Individual submissions (Faircloth D) https://rcvmhs.archive.royalcommission.vic.gov.au/submissions.html (Accessed 20/07/2025)

Therapeutic Residential Care pilots in 2008, including the prototype program, Hurstbridge Farm/...

The TRCs employ common essential elements upon which consistent practices have been instituted to facilitate the application of these 'essential elements'. The essential elements and common practices have been found to produce similar positive outcomes and, over time, reduce the very high indicators of very poor mental health. The essential elements are detailed in the TRC Pilot Evaluation (2011) and also in advice that the author and his colleague provided to the New South Wales Department of Families and Community Services[32]. The essential elements, in an abridged version, as detailed in this section were reproduced from a guide produced by the Centre for Excellence in Therapeutic Care[33].

Therapeutic Specialist

Therapeutic specialists have proven to significantly affect client outcomes and are intrinsically linked to each element of a therapeutic program. Their impacts are multi-dimensional and pervasive. Their importance is not only in relation to their specialist knowledge, assessments and therapeutic planning but equally in terms of the quality of their relationships with staff, children and young people, families and other Agencies. The Therapeutic Specialist will not generally work directly (clinically) with the child or young person, but rather will have a focus on equipping and supporting staff in their provision of therapeutic care, including facilitating Reflective Practice sessions, and collating and reviewing outcomes measures and ongoing quality improvement.

Trained staff and consistent rostering

Becoming trauma-informed is a process through which we use knowledge about the prevalence and impact of trauma, abuse and neglect to re-examine how we see, interpret, and interact with children and young people. Trauma-informed care is a principle-based culture change process, and being trauma-informed requires viewing the world through a new lens. Training enables staff to gain a deeper and broader understanding of the issues affecting children and young people and the theory behind their practice

Engagement and participation of young people

Participation is a process where someone influences decisions about their lives and this leads to change. It is not just about listening to children and young people's views; it is about them influencing what is decided and how things are done.

Client mix

The importance of the overall mix of children and young people when assessing the suitability of a potential new child or young person in the therapeutic program is a critical element of the success of a therapeutic program. The objective of client group matching is to create a mix that maximises the opportunities for all children and young people to experience on-going safety and benefit from the therapeutic approach.

Care Team Meetings

When it comes to helping troubled children and young people no single practitioner, profession or service has all the answers. Where the needs are complex and challenging, a multi-system approach is necessary. Working together to remove or reduce the key risk factors, strengthen the

[32] https://dcj.nsw.gov.au/documents/service-providers/out-of-home-care-and-permanency-support-program/residential-care-placements/ITC-RFT-Volume-5-Appendix-5-Service-Overview-ITC.pdf (accessed 15/07/2025)
[33] https://www.cetc.org.au/wp-content/uploads/2022/07/10-essential-elements-practice-guide.pdf (accessed 15/07/2025)

protective factors and take a holistic approach to address the issues related to the young person's wellbeing. This is known as the 'care team'.

Reflective Practice

The delivery of a therapeutic residential service incorporates an intellectual dimension which requires staff to employ sharp analytical and reflective skills to unravel presenting complexity, uncertainty and risk. Learning from experience, and recognising that each child and young person's situation is different, necessitates that the use of reflective practice is an ongoing practice characteristic which should permeate all therapeutic practice. No two children are the same and one size does not fit all in terms of practice interventions.

Organisational congruence and commitment

The challenge for all therapeutic programs is to translate their values and principles into daily organisational practice in a manner that is accountable, professionally responsible, and in the best interests of those served. Therapeutic programs need to create the conditions for all staff, at all levels, to respond effectively to needs and complexity and ensure organisation and system cultures (policies, practices and procedures at all levels) are congruent with the children's best interests and sensitively applied in practice.

Physical environment

Identification of "physical environment" as an essential element goes beyond the limitations of the facility and more broadly encompasses how the young people experience the physical environment, their feeling and experience of safety. 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.

Transition planning, exit planning and post-exit support

To successfully support a young person's transitioning from OOHC, staff need to recognise the importance of preparing young people for leaving care. Enabling young people to actively participate and involve themselves in decision-making can help them in managing their future. Practical and emotional support throughout the process should begin early and include the young person. Most importantly, professionals need to work in strengths-based ways to support the aspirations of young people during this transitional period of their lives.

Governance and quality therapeutic practice

Governance is a system through which programs are responsible for continuously improving the quality of their service and ensuring high standards of care by creating an environment in which excellence in therapeutic care will flourish.

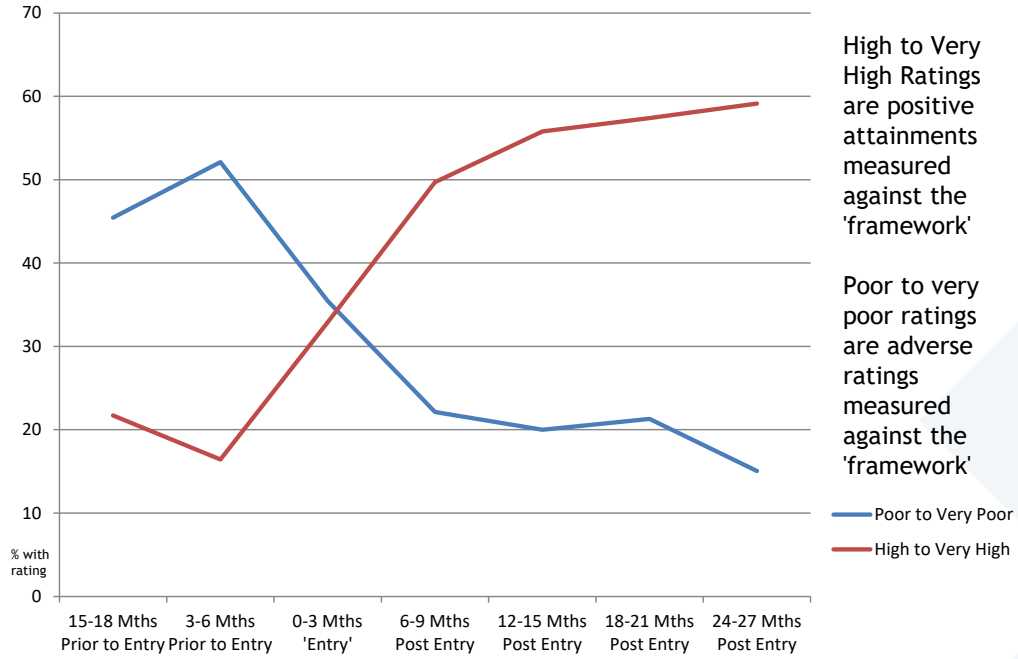
Hope: Healing and Change can be achieved

The TRC pilot evaluation supported the finding that the essential elements when practiced in concert supported a reduction in symptom severity, difficulties, negative outcomes and damaging behaviours and supported the attainment of positive outcomes. The place-based evaluation and five subsequent evaluations supported the assertion that maintaining program fidelity through the application of all of the essential elements resulted in the optimum outcomes for the young people. It was consistently observed that when one or more of these essential elements was absent that the outcomes were sub optimal.

Figure 6 details the positive outcomes experienced by children and young people in the TRC Pilots (n=38) demonstrating a de-escalation of ratings of adversity and the adoption of positive

attainments. The measures were collected from the Brann Likert Scales which were specifically developed to collect data against the National Child Protection, Placement and Family Services Outcomes Framework[34].

Figure 6: Outcomes Using the Brann Likert Scales TRC Pilot

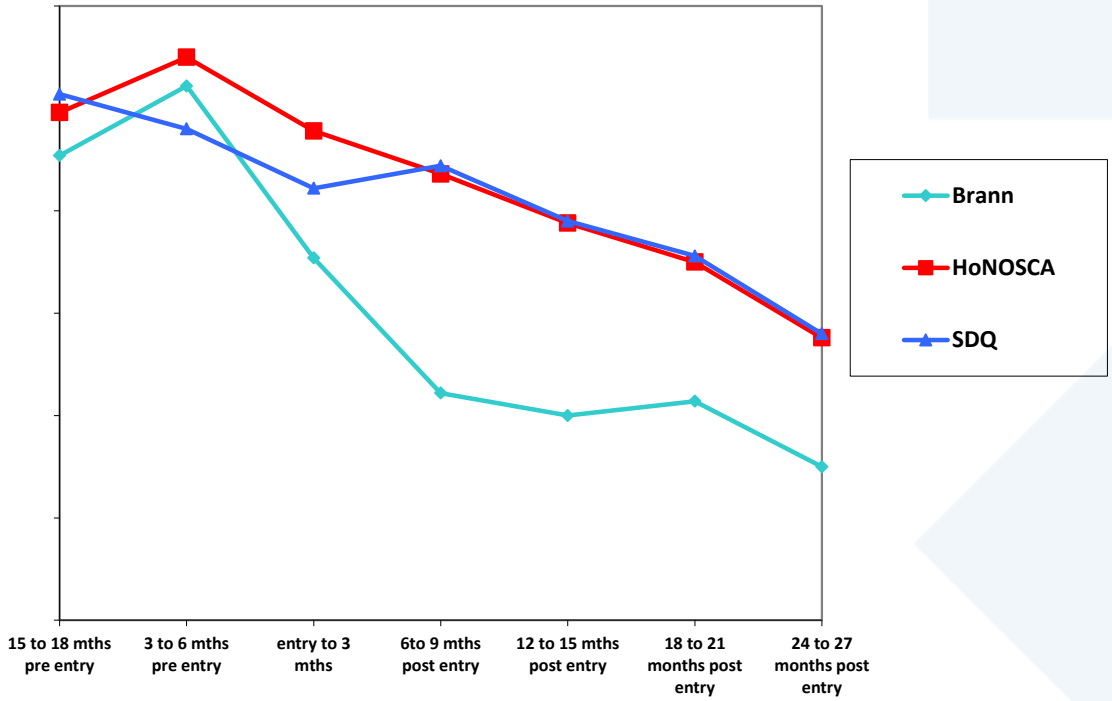


Source: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4 November 2011 Department of Human Services

Figure 7 provides insight into the how adverse outcomes and very poor mental health outcomes changed overtime in the TRC Pilot Evaluation (n=38 at commencement). The data also demonstrates how the SDQ and HoNOSCA outcomes converge. This convergence of outcomes provides confidence in the validity and sensitivity of these psychometric tools. The figure also demonstrates that overtime the rate of change as measured by the Brann Likert Scales is consistent with the improvements demonstrated using the HoNOSCA.

[34] Australian Institute of Health and Welfare 2013. National Framework for Protecting Australia's Children 2009–2020: Technical paper on operational definitions and data issues for key national indicators. Cat. no. CWS 44. Canberra: AIHW.

Figure 7: Reduction in adverse outcomes, symptom severity and difficulties over time

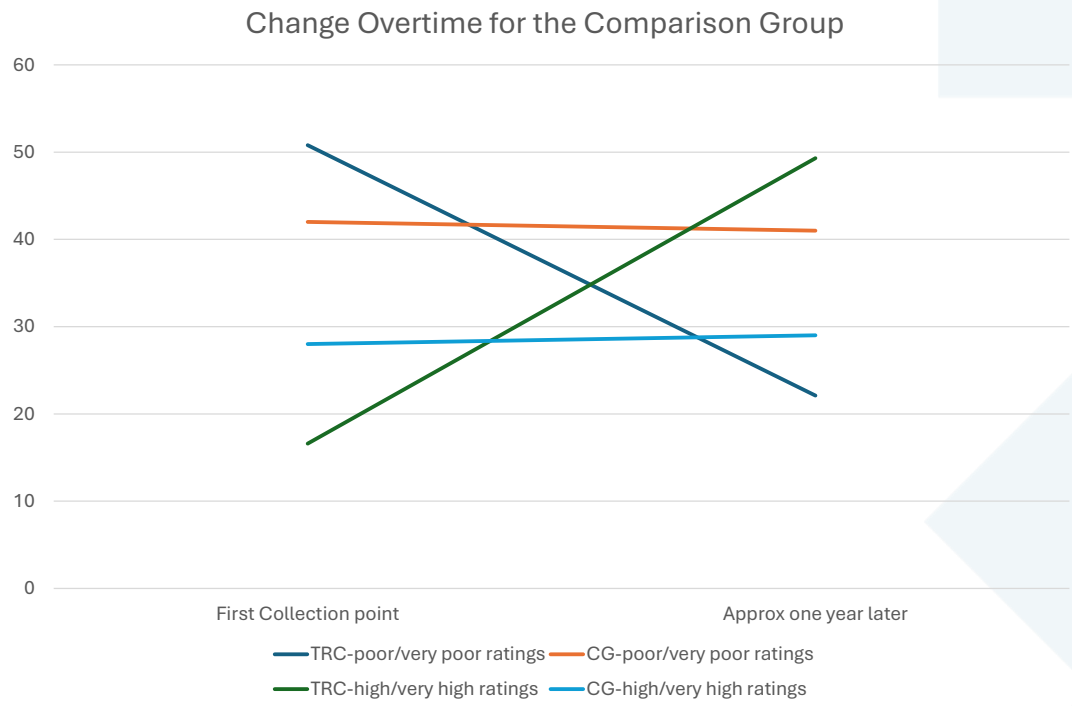


Source: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4 November 2011 Department of Human Services

In the TRC Pilot Program a matched comparison group (n=16) living in standard[35] residential out of home care outcomes were documented. The data (in Figure 8) for the comparison group was collected through the application of the Brann Likert Scales that measured change overtime. The change related to the reduction in adverse behaviours and the adoption of positive behaviours. The comparison group data was compared and contrasted to the data collected for the TRC pilot group (n=38). The outcome from this contrast it can be demonstrated that the comparison group achieved minimal reductions and improvements whereas the TRC pilot population achieve significant change.

[35] Standard refers to the residential out of home care operated in Victoria (RP3) that did not include the additional resources and service model available to young people in the TRC pilots.

Figure 8: TRC Pilot outcomes contrasted to Comparison Group



Source: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4 November 2011 Department of Human Services

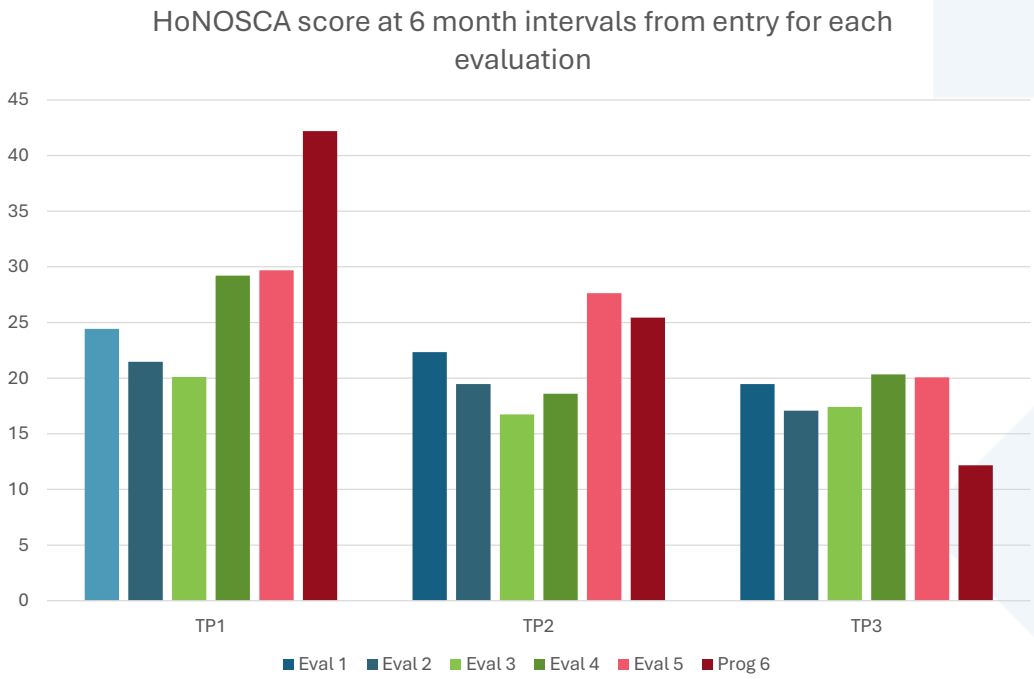
Figure 9 provides insight into the outcomes achieved for young people in Therapeutic Residential Out of Home Care at three time points. The figure demonstrates change over time in each of the evaluations (which are labelled and colour coded).

The data demonstrates that improvements to very poor mental health was achieved over 12 months. As discussed in this paper the young people's experience prior to entry was that of increasing escalation. The outcomes in the TRCs supports an understanding that clinically significant improvements are achieved in Therapeutic Residential Out of Home Care. The following summary statement made in multiple sector and conference presentations regarding the TRC has been corroborated in 5 successive evaluations.

> *"The application of particular set of therapeutic resources applied consistently for children and young people in Therapeutic Residential Care settings is achieving outcomes for those clients that are superior in comparison to outcomes experienced by clients in residential care settings where those resources are not applied."*

FAIRCLOTH McNAIR
& ASSOCIATES

Figure 9: HoNOSCA Change over time



Sources: Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report 4 November 2011 Department of Human Services and page 2 & 3 details of the evaluations

Discussion Very High Poor Mental Health Indicators

This finding of Very High Poor Mental Health Indicators is both consistent and persistent.

The combination of the use of; two psychometric tools, six evaluations (completed between 2011 and 2023), other evaluation data, and comparators provides evidence that the young people entering TRC's have very high indicators of poor mental health.

The finding that the young people in the TRC have very high of indicators of poor mental health is supported by the comparison to the young people entering inpatient mental health services and through the comparison made to the normative population.

The severity of the indicators is substantiated by the comparison to the entry of young people into inpatient mental health services. Guidelines for clinicians detail the elevated symptoms and problems that may warrant a clinically necessary intervention, an admission to an inpatient service.

The evaluation evidence demonstrates that young people in a Therapeutic Out of Home Care setting can be supported to experience healing and improved outcomes. The comparison group in the TRCs did not achieve the positive outcomes experienced by young people who benefited from treatment focused care and support.

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