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THERAPEUTIC RESIDENTIAL CARE

Evidence Brief

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ORANGA TAMARIKI
Ministry for Children

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The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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BACKGROUND

This evidence brief was written to inform understanding of therapeutic residential care for children and young people with high and complex needs. It seeks evidence in a number of specific areas, including the use of seclusion rooms.

The purpose of this document is to provide evidence in the specific areas requested, grounded in the wider context of Therapeutic Residential Care (TRC), as it is referred to internationally. This brief is indicative only, as it draws on a time-limited search that was not comprehensive or exhaustive and further examination might be required.

Key findings

Therapeutic residential care (TRC) is an important part of the care continuum and requires effective collaboration between professionals

- While residential care for children and young people has been the topic of polarised debate, research and experience from practice show that residential care is an important part of the care continuum, necessary for a small number of the most vulnerable children with complex needs, for whom a family placement is not currently appropriate.
- Children in need of TRC should be able to access this care when appropriate, and not as a last resort after having experienced multiple placement breakdowns. Children assessed as needing therapeutic care, and who receive this level of care sooner, have better outcomes.
- Effective inter-professional collaboration is required to effect positive change in TRC, supported by strong communication based on mutual respect between professionals and agencies.

TRC should be tailored to the communities and cultures of the children they serve, and allow meaningful connections with families

- There are many models of care that fall under TRC with varying degrees of evidence base. However, the emerging consensus is that TRC should be tailored to the communities, cultures and social relationships of the children and families that they serve.
- There are overarching effective elements of TRC, including a shared understanding of young people's history and needs; placement based on shared needs; therapeutic input tailored to needs; connection to family, community, and culture; and prioritising relationship-based work.
- Indigenous models of TRC place heavy emphasis on cultural safety, promoting connection with culture, participation in local communities, and meaningful connection with families.
- The involvement of family in a TRC placement, from visits to shared decision making and active partnership, improves overall care outcomes.
- Family-centred TRC requires the development of policies and practice guidelines that promote true and meaningful partnership between families and residential staff. This can be facilitated through comprehensive assessment and ongoing monitoring of policies and practice.

TRC should be tailored to children's needs

- The outcomes for children in TRC should fall within broad categories of safety, happiness, stability and development. The outcomes should be set specifically for individual children and be measurable, achievable and relevant.

- The length of time spent in TRC should reflect the individual needs of each child. A longer period of time might be required, considering the severity of problems that these children experience.
- Careful planning and monitoring of step-down placements are required for those children who exit TRC to less-intensive placements.
- Treatment fidelity and development of therapeutic rapport are key facilitators of good mental health outcomes for children and young people in TRC.

Living environments should be developmentally enriching, responsive and therapeutic

- Living environments in residences have a large impact on the effectiveness and safety of TRC. As such, living environments in residences should be developmentally enriching, responsive, and therapeutic for children and young people in care.
- Trauma-informed environments and models of care in TRC also help to prevent rates of absconding and violent behaviour.
- There is evidence supporting small groups as appropriate for TRC, however there is no agreement on exact group size, and practice varies across services and jurisdictions.

Seclusion has a negative impact on children and staff

- Seclusion has a negative impact on children, who report experiencing feelings of fear, anger, abandonment, confusion, and punishment. For children with trauma-related histories, the experience of seclusion is re-traumatising, making therapeutic goals more difficult to attain.
- Staff experience of seclusion is also negative, causing stress, psychological trauma, and spiritual trauma among Māori practitioners.
- Seclusion is not effective in reducing either the frequency or intensity of challenging behaviour with children and adolescents. Rather, seclusion has been shown to increase the risk of serious physical harm, and even death, with children.
- The use of seclusion can be significantly reduced, and even eliminated, through programmes that address staff management and training in alternative methods of behavioural management for challenging behaviours with young people.
- New Zealand's mental health inpatient services are currently working towards reducing and eliminating the use of seclusion practices by 2020 due to its harmful impact on patients and staff. This goal signifies New Zealand's adoption of wider international agreements such as the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and recommendations of its monitoring committee to prohibit the use of seclusion in healthcare institutions, and notably for Oranga Tamariki, its use with young people.

INTRODUCTION

Out-of-home care for children involving specialist support is referred to in the literature as Therapeutic Residential Care (TRC). The International Working Group for Therapeutic Residential Care issued a consensus statement defining this type of care:

> *"Therapeutic residential care' involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community based formal and informal helping resources"* (Whittaker, Del Valle, & Holmes, 2014, p. 24).

TRC is typically delivered through community-based centres (eg, children's homes) or through campus-based programmes. While sharing common characteristics, the services vary greatly in treatment philosophies programmes and practices including their purposes and the intensity and duration of interventions provided (Whittaker et al., 2016).

The international working group concluded that TRC should build on shared values and principles and that specific treatment models and practices would differ according to different cultural and political contexts.

Principles of Therapeutic Residential Care

The following five principles have been adapted from Whittaker et al., 2016:

1. "Safety first" is the guiding principle in the design and implementation of all TRC programmes.
2. TRC programmes should strive constantly to forge and maintain strong and vital family linkages.
3. Services should be fully anchored in the communities, cultures, and web of social relationships that define and inform the children and families they serve. TRC programmes should not be isolated and self-contained islands, but in every sense contextually grounded.
4. TRC should, at its core, be informed by a culture that stresses learning through living, and where the heart of teaching occurs in a series of deeply personal, human relationships.
5. The working group views an ultimate epistemological goal for therapeutic residential care as the identification of a group of evidence-based models or strategies for practice that are effective in achieving desired outcomes for youth and families, replicable from one site to another, and scalable, ie, sufficiently clear in procedures, structures, and protocols to provide for full access to service in a given locality, region, or jurisdiction.

There is limited research into practice elements of this type of care. Currently, there are several treatment models used internationally under an umbrella of TRC, with varying practices. There is emerging consensus about the effective elements of TRC, including a shared understanding of young people's (often trauma-related) history and needs; placement based on shared needs; therapeutic input tailored to needs; best possible connection to family, community, and culture; and prioritising relationship-based work.

Despite emerging characteristics that might inform a framework for TRC, the operational features of TRC services still need to be better understood. (McLean, 2018). The delivery of TRC is influenced by different care systems across countries. In North America, TRC services differ in that they serve a wider population of children, not only those with complex needs. TRC is delivered in larger facilities or clusters of satellite homes, is supported by multidisciplinary services, and is guided by programme intervention often with a forensic or mental health focus. In Australia, TRC is aimed at children with complex needs and the approach is more needs-based and holistic (McLean, 2016). In the Nordic countries, what unites TRC across a range of interventions, is "the will to work purposefully and strategically with theories of change for the positive development of children in care with pronounced and well-described difficulties" (Jakobsen, 2014, p. 93).

There is a complex relationship between residential care and children's outcomes

Residential care has over time become a less preferred option due to historical reasons, policy imperatives and research showing children's negative outcomes associated with residential care. Research also underlines the importance of attachment for healthy development of children, which can be difficult to address in larger institutional, sometimes called residential, settings. As a result, there have been increased efforts to place children in family-based care (Delap 2011; European Commission, 2013; UN General Assembly, 2010; Berens & Nelson, 2015; Ainsworth & Holden, 2005).

However, some researchers note that research on residential care has failed to differentiate between the many various forms of residential care, and often does not consider the wider context in which a form of residential care exists (Whittaker, Del Valle & Holmes, 2014); residential care can mean many different things in different contexts.

Interpreting the relationship between children's outcomes and residential placement is also more complex than may seem from the outset when we consider the typical pathway that leads to placement in a residential setting. Numerous reviews report that residential care continues to be used as a 'placement of last resort' for children who have experienced multiple placement breakdowns, and only after all other alternatives have been exhausted. It becomes difficult, then, to attribute the mental health and behavioural challenges, and long-term outcomes of these children to the residential care setting, when it is known that multiple placement breakdowns themselves are a source of trauma and contribute to poor outcomes for children in care (Ainsworth & Holden, 2005; McLean, 2016).

Residential care remains an important part of the care continuum

As the debate surrounding residential care continues, several studies and experience from practice suggest that this type of care continues to be an important part of care continuum, especially for children with complex needs (Delap, 2011; Ainsworth & Holden, 2018; Ainsworth & Hansen, 2015).

The importance of residential care as a care placement option was illustrated when Australia attempted to remove residential services from its care continuum. "*State and Territory governments reduced their dependence on all forms of institutional care and in addition indiscriminately closed residential programmes, beginning in the 1970s. This was regardless of whether these programmes could demonstrate that they had an ethical, safe and sensible programme that was likely to generate positive outcomes, or not. Indeed, residential programmes were all viewed as unsafe places incapable of reform*." (Ainsworth and Holden, 2005, p.196). This attempt had a disastrous effect, pushing the most vulnerable children with complex needs out of the child welfare system and into other systems that cater for homeless youth, or into juvenile justice institutions. Ainsworth and Holden conclude

that a mature child welfare system will always require some residential programmes (Ainsworth & Holden, 2018).

Therapeutic Residential Care is necessary for a small number of the most vulnerable children

It has been noted that TRC serves a different population than foster care does and that it has a different purpose to standard foster care (Ainsworth & Hansen, 2015).

The availability of therapeutic residential care is necessary for a small number of children and youth with complex needs. These children often have mental health or behavioural issues, and/or experiences of trauma including abuse and neglect. Often, these children have also experienced multiple placement breakdowns, and no alternative placement can be found for them. These children are often not able to live with others in a family environment or attend school. Without a specialist intervention, they face poor outcomes in life including unemployment, homelessness, social isolation, crime and poverty. (Ainsworth & Holden, 2005; Whittaker et al., 2016; Whittaker, del Valle, & Holmes, 2014; Bath & Smith, 2015).

It may be inappropriate for these children to be placed in family settings due to their difficult behaviour, therefore having therapeutic residential programmes is also important to protect foster carers from being overburdened and leaving their role as carers. Ainsworth and Holden emphasise that foster carers cannot be expected to deal with extreme behaviour in the absence of residential programmes. They describe that these expectations led to a crisis in foster care in Australia where:

"many foster carers are exhausted and disillusioned by the placement, or more accurately misplacement, of children and youth who by virtue of unmanageable behaviour should not have been placed in a regular home environment." (Ainsworth & Holden 2005, p197).

Residential care is downsizing

Numerous reviews highlight concern over the use of large-scale dormitory-like residences, particularly due to the low staffing ratios. Fewer staff available to children impacts on the care and attention delivered, and consequently the development of personal attachment from children within those residences (Delap 2011; Berens & Nelson, 2015).

With the international shift towards caring for children and young people in a family environment, there is opportunity for residential care to move towards the specific purpose of caring for children with complex needs and children who transition from care in a more family-like environment (Delap 2011; Ainsworth, 2017; Ainsworth & Holden, 2018; Butler & McPherson, 2006; Anglin, 2004; McLoughlin & Gonzales, 2014; Whittaker et al., 2014; Whittaker et al., 2016).

Reducing the number of children within a residential placement is viewed as one way to make such a placement more family-like, allowing children and young people to form an attachment to a carer while ensuring high-quality, consistent care, and individualised support (Delap 2011, European Commission 2013; UN General Assembly 2010; Csaky 2009). There also needs to be a sufficient number of carers who are trained in mental health awareness (Delap 2011; Steels & Simpson, 2017; European Commission, 2013).

Wellbeing outcomes for children in care with high and complex needs

Outcomes should be needs-based and properly assessed

In TRC with children and young people, experts are looking to achieve outcomes that can be identified by the children as positive. In this process, there needs to be a considerable emphasis on high-quality assessment, clear arrangements for support, good communication between mental health professionals and support staff and consultation with young people about their treatment. Assessment needs to also measure where a person is currently situated in their progress towards desired outcomes (Barton et al., 2012).

It is important to note that there can be complexity with measuring success in TRC. Goals and outcomes for any one child can vary widely, from just being alive, to completing school studies; both are positive outcomes and worthy of celebration. With this in mind, measuring success in a TRC placement must have perspective on what success might mean for different children (Barton et al., 2012)

Some researchers suggest three broad outcomes categories for children in TRC: *safety, happiness and development*. These outcomes should be set specifically for individual children and be measurable, achievable and relevant. Also, when measuring outcomes it is important to consider whether the outcomes are achieved equally by different groups receiving the same service, eg, different gender and ethnic groups. It is also important to balance the focus on high-quality processes in therapeutic care with a focus on outcomes (Barton et al., 2012).

Matching care placements with assessed needs is important for long-term outcomes

Therapeutic Residential Care is best used as a purposeful choice, not as a last resort placement

For children and young people presenting with multiple needs that cannot be effectively met in family settings, it is important that they receive specialist care when appropriate, rather than as a "last resort".

The approach of 'last resort' results in children not being placed in residential care until they experience several foster placement breakdowns, which further traumatises them and worsens their problems. It is argued that children with multiple and complex needs should not have to "fail their way" into appropriate services, but rather, receive those services when assessment indicates, *as treatment of choice* (Whittaker et al., 2016).

Appropriate Therapeutic Residential Care placements lead to better outcomes for children

Where TRC is used as a treatment of choice from a range of care options, because it has been determined to be in the best interest of the child and appropriate to their needs, the outcomes for the children are much better (Delap, 2011).

Children who are determined to have a need for, and are placed in a high-level therapeutic setting from the outset of entry into care, experience greater placement stability, have a shorter length of stay, and the majority of those children exit the care system and return home or to home-like

settings sooner and at lower cost compared to children who are placed in settings with a lower degree of specialist care (Sunseri, 2005).

TRC placement can also be appropriate in times of transition. For some young people who need high levels of support at a certain stage of their lives, TRC can be a preferred option as it offers a structured and supervised environment (Anglin, 2004; McLoughlin & Gonzales, 2014).

Therapeutic Residential Care group homes vary in size

As therapeutic residential care is currently guided by shared principles and values, rather than firmly defined practice elements, there is no agreement on exact group size, and practice varies across services. Small group homes were described as appropriate settings for children with complex needs (Burns, Hoagwood & Mrazek, 1999; Delap, 2011). TRC is currently typically delivered either in children's homes or through campus-based programmes (Whittaker et al., 2016).

In Australia, TRC is delivered in small group homes, with two to six young people depending on the service (McLean, 2016). In Victoria, the TRC Pilot programme worked with groups of two or four young people and showed significant improvements in placement stability, relationships and contact with family, community connection, mental and emotional health, among other outcomes (Sullivan et al., 2011). The Sanctuary model, also used in Australia, places groups of four to six young people together (James 2017; McNamara, 2015). The Lighthouse Therapeutic Family Model homes up to four young people, and has been effective in supporting traumatised young people (Barton et al., 2012).

Therapeutic residential care programmes in the United States work with bigger groups. Models include the Teaching Family Model which works with six to eight youths living in small group homes, and the Positive Peer Culture model which places eight to twelve young people together (James, 2017).

However, some argue that the number of children together is not the main determinant of successful outcomes in TRC, but rather, having stable and well-trained staff. It is also noted that larger homes may permit the full-time employment of therapeutic specialists such as psychologists and social pedagogues for the benefit of children (Ainsworth & Hansen, 2018).

Therapeutic Residential Care placements vary in duration of stay

Length of stay should be needs-based

Research suggests that the length of time spent in therapeutic residential care should be guided by an on-going assessment of needs and best interest of the child (Delap 2011; McLean 2016; Evidence In-Sight, 2012). Optimal length of stay then varies depending on a number of individual and environmental factors such as severity of symptoms at intake, family-related factors and intensity of service provided (Evidence In-Sight, 2012).

In Australia, TRC aims to stabilise a young person's living arrangements following multiple placement breakdowns, help the young person recover from trauma, and rebuild healthy attachment relationships. These therapeutic targets require longer periods of stay (McLoughlin & Gonzalez 2014).

Longer stays can also reflect the severity of children's conditions, particularly those with multiple diagnoses, or those with experience of psychiatric emergency (Evidence In-Sight, 2012). Some argue that *"years, rather than weeks or months, are needed for children and young people to heal and be supported to move forward developmentally and systemically"* (McNamara, 2015).

In Australia, periods spent in TRC range from around 18-24 months, to as long as is therapeutically necessary (Ainsworth & Hansen, 2015; McLoughlin & Gonzalez, 2014; McLean, 2016; McNamara, 2015).

Transition and exit planning, and post-exit support are essential

The transition process from one care setting to another (or to independence), is one of the major determinants of a child's outcomes. Due to attachment trauma experienced by many children in care, TRC settings must be mindful that any transition process experienced by a child has the potential to be interpreted as an event of trauma, associated with loss and grief. A trauma-informed understanding of transition events into and out of a placement, typically requires a long-term, gentle and therapeutic approach for the child (Barton et al., 2012).

Strong relationships between carers and young people in TRC play a healing role. For many of the young people in TRC, they are the only stable and trusting relationships they have ever had with adults. In the same way children who are leaving their families are experiencing gradual separation and have a "safe base" to return to, children in state care should experience similar process (Verso Consulting, 2016; Barton et al., 2012). The young person leaving care should actively participate in transition and exit planning (Verso Consulting, 2016).

There are four factors that can significantly improve a young person's experience of leaving care:

- The age at which young people leave care
- The speed of their transition
- Their access to preparation before leaving care and support after leaving care
- Maintaining stability and secure attachments after leaving care (adapted from Hannon et al., 2010, in Barton et al., 2012).

There are subsets of young people placed in TRC who do not progress during treatment, and who engage in risky behaviour after transitioning out of TRC. Specific family- and school-based support for several months following TRC exit suggests significant benefits for these young people and their families, with young people less likely to return to care, and less likely to drop out of school (Trout et al., 2013).

Addressing mental health is a core function of Therapeutic Residential Care

Poor mental health is common amongst children and young people in Therapeutic Residential Care

Research undertaken in Australia suggests that more than half of children and young people placed in out-of-home care arrangements require professional mental health assistance (Downey, Jago, & Poppi, 2015). It is likely that the proportion of children and young people in TRC experiencing mental health difficulties is even greater than this, due to the intention of TRC to care for children and young people with particularly complex needs. Some of the issues experienced by children and young people in TRC include self-harm, suicide attempts or threats, co-occurring psychiatric disorders, anger control, oppositional behaviour, and internalising behaviours (Duppong Hurley, Lambert, Gross, Thompson, & Farmer, 2017; Romani, Pecora, Harris, Jewell, & Stanley, 2019).

The prevalence of poor mental health amongst the TRC population highlights the need for therapeutic environments staffed with trained professionals who can respond sensitively and

appropriately to children and young people who have experienced trauma (Downey et al., 2015). This is particularly important given the cumulative effect that experienced trauma can have on feelings of alienation, mistrust, and rejection experienced by children and young people in TRC settings (Holden & Sellers, 2019; Leipoldt, Harder, Kayed, Grietens, & Rimehaug, 2019).

Suicidal ideation and behaviours are associated with poor mental health for children and young people in residential care

Although information on suicidal ideation and behaviours for children and young people living in TRC is limited, we know from previous research that rates of suicidal ideation and behaviour for children and young people in general residential care are approximately twice as high as their peers in the general population (Duppong Hurley, Wheaton, Mason, Schnoes, & Epstein, 2014). Children and young people at higher risk of suicide while in residential care include female youth, those with high suicide risk histories (ie, greater number of previous suicide attempts, threats, or reported ideation), and individuals with more significant mental health needs (including substance use, depression and psychotic disorders; Duppong Hurley et al., 2014). This suggests that addressing these mental health needs may help to reduce suicidal behaviour and ideation within TRC.

Given the high levels of poor mental health for children and youth in TRC mentioned above, it is important that systems and practice guidelines are in place to identify suicide risk and prevent suicidal behaviour in TRC. Again, examples of such systems and practice guidelines are available from general residential care settings rather than TRC in particular, however they are likely to have utility across both environments. Screening children and young people entering residential care for risk of suicide (based on suicidal histories) is an increasingly common practice, allowing residential staff to identify individuals who are more likely to engage in suicidal behaviour, and therefore indicating where preventative resources should be targeted (Duppong Hurley et al., 2014; Handwerk, Larzelere, Friman, & Mitchell, 1998). Paying attention to changes in mood and significant events for young people in care is also important for early detection of suicidal risk, as is immediately responding to any suicidal communication (ie., children and young people reporting suicidal thoughts or intentions to residential staff or other professionals; Handwerk et al., 1998).

One residence – Boys Town in Nebraska, USA – has reported on active suicide prevention protocols they implemented 20 years ago, with no lethal suicide attempts occurring in the residence since implementation (Duppong Hurley et al., 2014). These protocols include all direct-care staff being trained to respond to suicidal communication by: immediately reporting to senior staff; administering a risk assessment for lethal suicide attempts; and developing a safety contract with the child or young person.

Treatment fidelity and therapeutic rapport are important aspects of the effectiveness of treatment delivered within Therapeutic Residential Care

Treatment fidelity refers to the extent to which treatment and care is implemented as intended. This includes adherence to, and implementation of, the key aspects and components of treatment design, and the delivery of treatment through skilled and appropriately-trained professionals (Duppong Hurley et al., 2017). Previous research has found that treatment delivered within a TRC context is more effective, and client satisfaction higher, where there is high treatment fidelity (Duppong Hurley et al., 2017). Where treatment was delivered as intended, children and young people in TRC exhibited lower rates of internalising and externalising behaviours while in care.

A recent survey of residential care providers in the USA found that 88 percent of agencies were implementing client-specific, evidence-based interventions to address specific emotional or

behavioural need (James, Thompson, & Ringle, 2017). A majority of these interventions were client-specific interventions (eg, individual therapy sessions), delivered within either Dialectical Behaviour Therapy (DBT) or Cognitive Behavioural Therapy (CBT) frameworks. Two-thirds of residences reported that these interventions were used to address trauma responses identified in children and young people, and 75% of respondents indicated that the interventions were delivering the desired results.

Respondents indicated that the specific interventions used were primarily adopted on the basis of their research support and demonstrated effectiveness. However, it was also found that residences tended to implement these interventions with little focus on ongoing staff training and ensuring treatment integrity, threatening the fidelity of these interventions (James et al., 2017). There is a lack of research on the effectiveness of these individualised interventions within the context of TRC (James, 2017; Tregeagle, 2017), however results from the survey highlighted some factors that were associated with successful implementation of behavioural and emotional interventions in TRC (James et al., 2017):

- adequate and appropriate training, supervision and feedback
- staff ownership and shared responsibility for intervention implementation
- commitment to the intervention, and willingness to problem solve
- leadership or having a staff "champion", and administrative support
- consistency and structure
- adaptability and flexibility
- transparency and communication of expectations
- fit or congruency with the overall approach and goals of an agency
- perception of positive outcomes.

Consideration must also be given as to whether longer-term interventions will be able to be continued when or if the child or young person is transitioned out of care, particularly where a primary goal is to ensure that placement in TRC is as short as possible (Lambie, 2016).

Therapeutic rapport is another important aspect of the quality of therapy and other mental health services delivered within TRC. The relationship between children and young people and the professionals they engage with is often found to be the strongest predictor of behavioural and emotional outcomes, both while in TRC and after leaving care (Duppong Hurley et al., 2017; Holden & Sellers, 2019). These relationships provide a sense of security for children and young people, and a safe base from which children and young people can explore and test new emotional and behavioural skills and concepts while in TRC (Holden & Sellers, 2019).

Staff should be trained in the use of practical tools for responding to the emotional and behavioural needs of children and young people in Therapeutic Residential Care

Ensuring that staff are appropriately trained is consistently found to be an important factor of TRC effectiveness and responsiveness (McLean, 2016). This often includes psychoeducation on the impact of trauma on the behaviour and functioning of children and young people (Bryson et al., 2017). That said, there is some suggestion from the literature that most staff working in TRC benefit from training in specific and practical tools and strategies to respond to clients' needs, as opposed to more theoretically-based training (Downey et al., 2015). This is because the interplay between trauma, attachment, child development and mental health is complex, and it can be difficult for

anyone except the most experienced and/or educated of practitioners to work out how to respond appropriately to the inter-related mental health needs of clients. Examples of practically-based tools and strategies include Non-Violence Crisis Intervention (NVCI) and Therapeutic Crisis Intervention (TCI)[1], and having clear practice guidelines on how to respond to harmful behaviour from children and young people (eg, immediate responses to contain the situation, clear consequences for the behaviour, and restorative processes for addressing the harm caused; Downey et al., 2015).

Practically-based training should be supported by a strong clinical management team who can provide on-the-ground direction and advice as to best practice when dealing with individual cases, including individualised care plans for each child or young person (Downey et al., 2015; Huefner, 2018).

The impact of the living environment on experiences and outcomes in Therapeutic Residential Care

Living environment is a vital component of effective and safe Therapeutic Residential Care

The environment in which children and young people in TRC live and spend most of their time is a key contributor to the effectiveness and outcomes of care. To maximise gains from direct individual or group therapy, the living environment outside of these sessions should be warm, nurturing, and provide opportunities for social learning and modelling (Ainsworth & Hansen, 2018; Holden & Sellers, 2019; Hussein & Cameron, 2014; McLoughlin & Gonzalez, 2014). Without this kind of environment to support and reinforce lessons and skills developed during therapy, the relatively small amount of time that children and young people spend engaged in formal therapy or treatment within TRC is unlikely to have a large impact on psychological functioning and general wellbeing (Ainsworth & Hansen, 2018). Ensuring that TRC residences are staffed with skilled and responsive professionals, and that opportunities are provided to engage with others in meaningful and emotionally satisfying ways, are key to providing an effective therapeutic environment (Holden & Sellers, 2019).

Based on the influential Children and Residential Experiences (CARE) model, Holden and Sellers outline six evidence-informed principles that are key to providing living environments that are developmentally enriching, responsive, and stimulating for children and young people in care. TRC settings should be:

- relationship based (modelling positive relationships between adults and children)
- trauma-informed (acknowledging trauma histories and their impact on clients)
- developmentally focussed (providing opportunities for developmental experiences)
- family involved (adapting to families' cultural norms and beliefs)
- competence centred (providing opportunities to practice problem solving, coping skills etc)
- ecologically oriented (adapting the physical and social environment to support growth)

Implementation of these CARE principles in 11 residences in New York was found to significantly reduce rates of behavioural aggression toward staff, peers, property destruction and absconding (Izzo et al., 2016).

[1] More details on NVCI and TCI are provided in the section on seclusion and restraint in TRC below.

The physical environment should be constructed to positively contribute to children and young people's experience

Elements of the physical environment in small group homes used for TRC must be taken into consideration as they can positively contribute to children's experience (Adapted from Verso Consulting, 2016):

- Purpose-built/adapted premises that allow for private spaces
- Space for indoor recreation activities
- Design that assists with the development of personal responsibility and hygiene practices
- Opportunity for young people to personalise their bedroom, and collaboratively personalise shared areas
- Spaces for residents to safely withdraw, including sensory rooms (note there is a difference between elected withdrawal from a situation by a young person, compared to enforced restraint or seclusion. See section on seclusion below).
- A place, where staff can observe, neither intruding, nor being isolated

The mix of clients within each Therapeutic Residence should be considered

It is also beneficial to consider the right mix of clients, to maximise the opportunity for all young people to benefit from the therapeutic approach. The ability to ensure a good fit of young people within a group home requires a well-developed process, and participation of key staff who bring knowledge and understanding of the young people already resident (Verso Consulting, 2016). Consideration for compatibility may include:

- Clients already in residence (progress, background, trigger points, age, gender)
- Age and gender of the young person being considered for entry
- Particular care needs
- Willingness of the young person to participate in the therapeutic approach
- The TRC targets and outcomes defined by the service provider
- Scope to apply therapeutic approaches within a longer-term framework
- The nature of externalised behaviours and the potential impact on others

Service providers identified additional influences:

- Negotiating across varying operational interpretations of the stated eligibility criteria
- Managing differing priorities of stakeholders such as pressure to accept short-term emergency placements (adapted from Sullivan et al., 2011, p 56).

Young people placed in residential care have voiced a desire for having more say in how they were matched with their peers (Moore et al., 2016). A recent systematic review of the literature found that a positive social climate within TRC can also be promoted through a strengths-based treatment approach (eg, providing opportunities and support to repair harm and address past mistakes and negative behaviour), providing a variety of activities and daily routine, and hiring experienced and well-trained staff (Leipoldt et al., 2019). Ongoing and regular monitoring of a residence's social climate through feedback from children, young people and staff (including collective reflection on

the feedback) has also been found to significantly reduce negative aspects of the social climate in TRC (Strijbosch, Wissink, van der Helm, & Stams, 2019).

Ensuring the safety of children, young people and staff in Therapeutic Residential Care

In any type of group care, including TRC, it is important to be aware of possible dangers posed to children and staff, and to ensure the safety of all involved. The risks that may occur include physical or sexual assault, or negative group synergy due to the complex behaviours of children and young people involved. Safety needs to be the priority in the design of programmes and in making placement decisions, including the right to refuse a referral of a young person who can put current residents and staff at risk (Bath & Smith 2015; Whittaker et al., 2016). As outlined above, the living environment and culture of an organisation or residence also has a large impact on the safety of children, young people and staff. Additional considerations are discussed below.

Exposure to violence and unsafe environments is traumatising for children and young people in residential care

Interviews with 27 children and young people who had lived in any residential care (ie, not restricted to TRC) for more than three months in Australia identified that most of the children and young people reported that they were not safe and did not feel safe while in residential care (Moore, McArthur, Death, Tilbury, & Roche, 2017). Peer bullying and harassment were seen as the primary safety concerns for younger interviewees, whereas older interviewees were more aware of constant threats of violence, and sexual harassment and assault, particularly from their peers. Children and young people reported feeling angry and re-traumatised when they or their peers were not protected from harm (including self-harm) while in residences. The residences were viewed as their home, and interviewees reported that their home should be a place where they feel safe. Indeed, young people were more likely to report wanting to be in the residence where they felt that the residence was safe. Positive relationships with others in the residence was an important factor in whether they saw the residence as home (and therefore how safe they felt), as was being allowed some degree of control over decisions relating to their day-to-day care and broader placement arrangement.

Behaviour management is vital for ensuring safety in Therapeutic Residential Care

Because of the risks outlined above, a clear, purposive and effective behaviour management strategy is required within TRC settings to ensure safety for residents and staff. Children and young people in TRC typically present with risk-taking behaviour, often within the context of testing boundaries and responding to peer pressure (Tregeagle, 2017). Because of this, effective behaviour management may take some time to show effect, but consistency in response to behavioural issues is important. The involvement of police in TRC should be avoided where possible, as it is unlikely to lead to behaviour change and can instead pose more barriers in the form of a criminal record and further traumatisation (Tregeagle, 2017). Heavy use of police to manage behaviour and safety is an indicator that a residence's behaviour management strategies are inappropriately designed or being poorly implemented.

Australian-based research has found that children and young people in residences often gauge how safe a residence is based on the amount of time that their peers spend in the home, and the rate of absconding (Moore et al., 2017). The children and young people also reported that boredom and too much unstructured time was associated with higher rates of behavioural issues, whereas having high expectations and clear guidelines for responding to inappropriate behaviour was perceived by

respondents to reduce conflict and misbehaviour. The children and young people also suggested that safety in residences could be improved by: increasing placement stability; focussing on developing positive, trustworthy and appropriate relationships with peers and staff; improving the ability of staff to identify and respond to risks of abuse and harm; and independently auditing and monitoring the safety of residences.

Previous research has also explored the challenges that Australian residential staff report in managing challenging behaviour of children and young people (Mclean, 2015). Five primary themes emerged, including: balancing professionalism with "normal" parenting; ensuring a consistent approach to behavioural management; balancing control with connection to children and young people; differentiating between "normal" and "abnormal" child or teenage behaviour; and inconsistency in relationships. Notably, most of these tensions or pressures relate to organisational culture, particularly a focus on risk management, perhaps to the detriment of positive, meaningful relationships between staff and children or young people.

Trauma-informed models of practice help to prevent absconding

Absconding (or "running away") typically refers to a child or young person leaving a residential care unit without staff permission or staff knowledge of their whereabouts. Some of the factors that contribute to children and young people deciding to abscond from TRC include: feeling unsettled, alienated, bored, unsafe or not cared for in the residence; rules, expectations or restrictions placed on young people; being abused or bullied; peer pressure; desire for control, autonomy or excitement; desire to be with friends or family; and attending parties or activities (Jackson, 2014). The risk of absconding from care is highest for young people over the age of 12, although the younger the child when they first absconded, the more likely it is that they will abscond again (Courtney & Zinn, 2009, as cited in Jackson, 2014). Other organisational-level factors have also been found to predict absconding from care, including lack of leadership from senior management, low staff morale, and staff lacking confidence in their ability to safely manage client behaviour (Jackson, 2014).

TRC delivered within a trauma-informed model of care (eg, providing suitable living environment, and promoting treatment fidelity and therapeutic rapport, as outlined in the previous sections) is associated with lower rates of absconding (Jackson, 2014). Additionally, the number of psychological treatment sessions and strength of the therapeutic relationship between staff and young people in TRC has been linked to a reduced risk of absconding, after controlling for the length of care placement (Fasulo, Cross, Mosley, & Leavey, 2002, as cited in Jackson, 2014). Further, previous research has found the following strategies can reduce the rate of absconding for children and young people in care: providing daily access to someone who will listen and talk non-judgementally; providing safe engagement with family; increasing positive activities and engagement with others; engaging in active communication with schools and other supports; and ensuring young people have a voice in their placement and transition out of care (Clarke et al., 2008, in Jackson, 2014).

These findings highlight the importance of therapeutic interventions and environments in TRC, which promote the development of coping skills and behavioural strategies that children and young people can use as an alternative to absconding when challenges arise.

Seclusion in the New Zealand context

Seclusion is "*where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit*" (Standards New Zealand, 2008a, 2008b). Within New Zealand's Care and Protection and Youth Justice residences, children can be held in seclusion if it is deemed

necessary to either prevent the child or young person from absconding from the residence, or to prevent the child or young person from causing physical harm to themselves or to any other person. A review of seclusion practices in New Zealand noted that the Secure Care units in Care and Protection settings were inappropriate and indistinguishable from adult prison cells (Shalev, 2017).

New Zealand's mental health inpatient services are currently working towards reducing and eventually eliminating the use of seclusion due to its harmful impact on patients and staff (Te Pou O Te Whakaaro Nui, 2018b). The Health, Quality and Safety Commission have set a goal of zero use of seclusion by 2020 to improve the quality of care in mental health and addiction services in New Zealand[2].

The national efforts to reduce the use of seclusion are related to wider international agreements and obligations. New Zealand is a signatory to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Under this convention, the use of restrictive practices is subject to monitoring by human rights experts of the UN Committee against Torture. Following New Zealand's most recent periodic review in 2015, the Committee recommended that New Zealand prohibit the use of solitary confinement and seclusion for children[3].

This move toward a reduction in the use of seclusion and restraint follows an international trend toward reducing the use of these practices with children and young people (Caldwell et al., 2014). In particular, many international organisations are now aiming to completely eliminate the use of mechanical restraint, which is often viewed as one of the most traumatising interventions (Caldwell et al., 2014). In addition to the widely-acknowledged traumatising effects of seclusion and restraint, research has found that residences that are permissive of restraint show significantly worse child and young person outcomes (as measured by the Strengths and Difficulties Questionnaire) than those that do not allow restraint (Farmer, Murray, Ballentine, Rauktis, & Burns, 2017).

The effects of seclusion and restraint on children

Seclusion is a practice that can cause serious psychological, physical, and developmental harm to children who need age-appropriate services that promote healthy development, or who need therapeutic intervention (American Civil Liberties Union, 2014).

Children and adolescents in mental health facilities experience restraint and seclusion negatively, reporting feelings of fear, abandonment and punishment. Some felt traumatised and did not understand why staff had enforced the use of seclusion over other practices (Kerzner et al., 2004).

Similarly, young people who experienced seclusion in a juvenile detention facility reported feelings of fear, anger, and re-traumatisation. These emotional and behavioural effects persisted for a long time after removal from seclusion (Smith & Bowman, 2009).

For children with traumatic experiences, the use of restraint and seclusion poses a risk of re-traumatisation, further affecting their mental and physical health. Some point out that the use of restraint and seclusion is not therapeutic, instead turning a place of healing into a place of new trauma:

[2] www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/programme/

[3] www.hrc.co.nz/files/2814/3192/5666/CAT_Report_May_2015.pdf

> *"Rather than deterring anything, these episodes perpetuated a vicious cycle. The more I was restrained, the more humiliation I felt. The more shame and humiliation I felt, the more I dissociated, self-injured, and was restrained" (Prescott, 2000, p. 98 in Kerzner et al., 2004).*

Seclusion and restraint practices place children at risk of psychological harm, self-harming and suicide, and at levels which are greater compared to adults who have experienced seclusion or restraint (American Civil Liberties Union, 2014; Blau et al., 2014).

Overall, there is lack of evidence that restraint reduces either the frequency or intensity of challenging behaviour with children and adolescents, though there is considerable evidence for negative effects, including severe psychological and physical consequences (Blau et al., 2014; Day et al., 2010; Finke, 2001; De Hert et al., 201; Kerzner et al., 2004).

The effects of seclusion and restraint on staff

The use of seclusion and restraint is harmful to staff as well, causing stress, injury and psychological trauma (Blau et al., 2014; van der Nagel, 2009).

Staff using restraint and seclusion in a juvenile detention facility reported lingering negative emotional and behavioural post-restraint effects, experienced long after the restraint or seclusion event itself (Smith & Bowman, 2009). Staff responses to implementing restraint and seclusion on young people include anxiety, anger, distress and crying. Some staff described how they have become hardened to the experience of restraint, referring to automatic responding in which they feel no emotions (Sequeira & Halstead, 2004).

Use of restraint can have a detrimental effect on the therapeutic relationship between staff and a young person. A study examining perception of restraint with mental health patients concluded that restraint can be seen as taking advantage of considerable power imbalance in the staff-patient relationship, seen as an abusive experience and when restraint is viewed as unjust by patients, there are greater barriers to creating or maintaining therapeutic relationships with staff involved (Knowles et. al, 2015).

Seclusion from a Māori perspective

Data collected by the Ministry of Health and the Department of Corrections on the use of seclusion and restraint in New Zealand showed an over-representation of Māori in seclusion units, with Māori and Pasifika people twice as likely to be secluded than others (Te Pou o te Whakaaro Nui, 2018a).

The impact of seclusion on tāngata whai ora (Māori service users) can be traumatising on multiple levels, beyond what is typically considered in a non-Maori world view:

> *"It has the potential to trigger issues from old traumas, resurfacing feelings and thoughts from past abuse which may not have been resolved. For some tāngata whai ora, the depth of trauma was felt spiritually, at a personal wairua level that needed cultural redress" (*Te Pou o te Whakaaro Nui, 2014b, p11).

Māori mental health nurses also express concern with the use of seclusion for tāngata whai ora:

> *I don't want him locked up in there... because I know [what] they're gonna, you know [look] like the next time I [see them]... start dribbling... they... mimi [wet] themselves... and all that. Especially, if they're um young men, and like between 16-20 [years of age]..." just seeing that, it's like someone grabbing their wairua and pull[ing] it right out of them… and that's*

devastating… it's like being at their tangi" (Māori mental health professional cited in Pere, 2006 p. 179).

Māori mental health nurses prefer to use traditional approaches such as whanaungatanga to foster therapeutic relationships that negate the need for seclusion (Te Pou o te Whakaaro Nui, 2014b).

Strategies for reducing seclusion and restraint use

The use of seclusion can be influenced by staff factors and practice approaches

The use of seclusion can be significantly reduced by interventions that are aimed at staff and organisational factors. By addressing issues such as low staff morale, staff conflict, and unsupportive management, the use of seclusion in a child psychiatric hospital was reduced by 50 percent. Strategies included utilisation of practice-based research, assessment of the level of aggression within the agency, change in staff perception about the use of coercive interventions to manage behaviour, revision of behaviour management programmes and policies relating to crisis events, and increased involvement of families (Goren et al., 1996).

Another study with psychiatric staff found that use of restraint and seclusion was higher when staff perceived greater expression of anger and aggression among team members and when they perceived the safety measures in the workplace were insufficient, suggesting that staff perception of security should be targeted in order to reduce the use of these practices (De Benedictis et al., 2011).

Analysis of New Zealand adult mental health seclusion data from district health boards showed that variation between seclusion rates across health boards could not be attributed to the socio-demographic or clinical factors of people who were secluded. Instead, differences across health boards, where health boards with the highest rates of seclusion were 11 times more likely to seclude than the lowest, may be explained by differences in service delivery models and approaches to practice. This suggests system changes can reduce the need for and use of seclusion (Lai et al., 2019).

There are also some examples of changes in practice that have been found useful in attempts to reduce seclusion and restraint in residences. These include: having individualised care plans that include triggers and risk warnings for children and young people; sensory integration prevention techniques such as "comfort rooms" that youth can retreat to when elevated or distressed; and including young people in the development of training resources (eg, role plays) for crisis intervention (Caldwell et al., 2014).

Local research has indicated that seclusion reduction initiatives do not increase risk to staff safety (Te Pou o te Whakaaro Nui, 2014a). Instead, international research suggests that implementing interventions to reduce seclusion and restraint can reduce aggression toward staff and peers, particularly where the intervention involves organisational-level strengths-based change rather than behaviour management strategies alone (Forrest et al., 2018; Izzo et al., 2016).

Implementing seclusion and restraint reduction strategies requires ongoing commitment to changes in organisational culture and practice

Effectively reducing seclusion and restraint in TRC generally requires meaningful and comprehensive changes to organisational culture, strategic vision and practice guidelines, championed by senior leadership within organisations (Caldwell et al., 2014; Forrest et al., 2018). A recent systematic review of the literature identified five critical factors that contribute to successful

implementation of trauma-informed care in residences, including a reduction in the use of seclusion and restraint (Bryson et al., 2017). The five factors were:

1. Senior leaders visibly committed to change and prioritising trauma-informed care.
2. Delivering ongoing staff training which includes psychoeducation on the neurological and behavioural impacts of trauma, as well as support through supervision and coaching.
3. Listening to clients and families about their treatment needs, priorities and goals.
4. Reviewing data and outcome indicators (including targets) to inform continuous improvement.
5. Aligning policy, guidelines and practice with the philosophy of trauma-informed care.

The review also identified that larger-scale cultural changes within organisations tended to result in longer-term and deeper organisational change in a positive direction. This involves a greater initial resource investment, including allocating dedicated staff time to training and purposeful implementation of the new care approach, and recognising that trauma-informed interventions often take more time and skill than "traditional" seclusion and restraint approaches.

The Six Core Strategies© is a promising framework for reducing use of seclusion and restraint in Therapeutic Residential Care

The current best practice in New Zealand and internationally is the whole system approach of *The Six Core Strategies for Reducing Seclusion and Restraint Use* (Adapted from Te Pou o te Whakaaro Nui, 2018b)*:*

1. Leadership towards organisational change
   Committed and supportive leadership that is applying and resourcing seclusion and restraint reduction initiatives
2. Using data to inform practice
   In depth analyses and examination of seclusion data, regular review and critical reflection on practice
3. Workforce development of competency and capability
   Training in trauma-informed care
4. Use of seclusion and restraint reduction tools and assessment
   Including individual assessment and treatment plan, identifying risk factors, de-escalation techniques and use of sensory rooms
5. Development of the peer workforce
   Increase the presence and advocacy roles for people with lived experience of healing
6. Use of debriefing techniques
   Opportunity for reflection and practice development

It is notable that these strategies largely overlap with the key success factors identified in Bryson et al.'s (2017) systematic review of the literature looking at how to reduce seclusion and restraint in residential care. An evaluation of the implementation of the Six Core Strategies in 29 residential facilities in Texas found that 55 percent of facilities rated the framework as very effective at identifying and promoting solutions to reduce the rate of seclusion and restraint, and 45 percent as being somewhat effective; no facilities rated the framework as "not effective" (Hogg Foundation for Mental Health, 2013). Facilities reported that debriefing and inclusion of clients and family members were the most difficult strategies to implement. Leadership and workforce development were seen as the most important strategies for successful reductions in seclusion and restraint. Policy and resource constraints, as well as high staff turnover, were seen as particular challenges to effective

implementation of the strategies, however it was noted that local innovation and tailoring of the strategies facilitated implementation and effectiveness. The Six Core Strategies framework has also been approved as an evidence-based practice according to the National Registry of Effective Programs and Practices in the USA (Caldwell et al., 2014).

The Six Core Strategies© for reducing seclusion and restraint checklist has been adapted for the New Zealand context. Implementation of these strategies in a 32-bed adult inpatient mental health service was found to reduce the use of seclusion from 40 percent of people admitted, to 9.8 percent in the first year following implementation. These reductions continued in the second year, to being used with only 0.4 percent of people admitted (Wolfaardt, 2013).

Cultural approaches for reducing seclusion

As discussed earlier, the effects of seclusion may be worse for Māori. Key cultural approaches for reducing seclusion for tangata whai ora include enhancing Māori leadership, increasing tangata whai ora participation and whānau participation, increasing Māori support staff and cultural competency training for the workforce (Te Pou o te Whakaaro Nui, 2018b).

The Māori adaptation of Six Core Strategies© for reducing seclusion and restraint was developed in collaboration with Māori mental health professionals (adapted from Wharewera-Mika et al., 2013):

1. Leadership and rangatiratanga
    - Oversight exists over seclusion and restraint practices.
    - Māori leadership and participation exists across all service levels.
    - A commitment to Te Tiriti o Waitangi is evident.
    - Organisational culture focuses on recovery, tāngata whai ora and whānau-centred, holistic and trauma-informed care.
    - A commitment to the Māori model of care and principles.

2. Better use of data to inform best practice
    - Improved collection and use of relevant information.
    - Accurate recording of ethnicity.
    - In-depth analyses and examination of seclusion data (in relation to Māori).
    - Regular review and audit to encourage critical reflection on practice.

3. Workforce development
    - A culturally competent workforce.
    - Increase Māori staff at all levels of intervention.
    - Trauma-informed interventions, care and practitioners.
    - Improved supervision and support for Māori and non-Māori.
    - Awareness of the impact of organisational regulations upon cultural differences.

4. Seclusion and restraint prevention tools
    - Culturally-informed processes for Māori across the care continuum.
    - Inclusion of cultural practices in care, including healing.
    - Increased use of Te Reo me ona tikanga.
    - Increased awareness about and promotion of wairuatanga.
    - Whānau-centred care.
    - Emphasis on Māori cultural identity for recovery.
    - Environments conducive to Māori.

5. Tangata whai ora roles
    - Increased tangata whai ora presence and advocacy roles in units.
    - Increased Māori peer support resource.

6. Debriefing techniques
    - Debriefing techniques and opportunities in both Māori and mainstream.
    - Encouragement for critical reflection on practice and ongoing development.
    - Purposeful evaluation of practice in response to working with Māori.
    - Debriefing opportunities for tāngata whai ora and whānau.

A qualitative study with Māori mental health nurses explored their experience working with tangata whai ora and effective strategies for reducing seclusion which identified Whanaungatanga as an appropriate model of practice. This model is adapted according to Māori customary principles and involves four elements:

1. Recognition (kanohi kitea).

2. Māori therapeutic relationship.

3. Focused engagement (using te reo Māori, karakia, waiata and deliberate linking).

4. Relational-centred interventions which include working closely with whānau.

Further, areas for improvements included increasing the number of Māori mental health staff, especially in cultural roles, professional support for Māori mental health nurses, implementing a non-Māori workforce development programme provided by Māori mental health professionals with elements such as:

- Understanding Māori worldviews, including the history of New Zealand and impact of colonisation
- A paradigm shift from a clinical model of practice to a holistic health model
- Communication strategies for working with Māori
- Challenging the bias and stereotyping regarding the use of seclusion of Māori men
- Acceptance of the Māori mental health professional's model of practice and working relationships with tangata whai ora and whānau

(Adapted from Te Pou o te Whakaaro Nui, 2014b.)

Workforce and practice implications for reducing or eliminating seclusion and restraint

Summarising the information outlined above, reducing or eliminating the use of seclusion and restraint in TRC requires the implementation of purposeful changes to care practices and workforce structure and training. Workforce considerations include:

- Addressing staff morale, cohesion, and aggression.
- Ensuring senior management are visibly committed to, and supportive of, the move to reduce or eliminate seclusion and restraint.
- Providing ongoing staff training in:

    - non-violent behavioural management techniques
    - debriefing and professional reflection practices
    - psychoeduction on the impacts of trauma
    - cultural models of trauma-informed care.
- Training should include input from children and young people, and be supported by ongoing clinical supervision from expert professionals.
- Allowing for dedicated staff resource and time for training and ongoing supervision or coaching, and implementation of new policies or practices.

In addition to addressing workforce factors, implementing seclusion and restraint elimination or reduction strategies requires amendment of policies and practice guidelines to emphasise non-violent behaviour management programmes, the needs of children, young people and their family or whānau, and the philosophy of trauma-informed care. Importantly, these amendments should highlight how the safety of staff, children and young people can be maintained without the use of seclusion and restraint. This can include the use of individualised care plans that outline triggers and patterns of escalation for individual youth.

Successful implementation of seclusion and restraint elimination or restraint strategies also requires a practice and living environment that supports the use of non-violent alternatives. This can include "comfort rooms" available to elevated children and young people, and appropriate data collection frameworks and systems to allow for continuous monitoring of implementation and outcomes.

Alternatives to seclusion and restraint

Non-Violent Crisis Intervention (NVCI)

Non-Violent Crisis Intervention (NVCI) is a non-harmful behaviour management framework for prevention and de-escalation of challenging behaviours (Lambie, 2016). NVCI training involves the development of skills to safely and effectively engage in early intervention, including understanding how behaviour can escalate, the effect of non-verbal behaviour on others, how to effectively use communication to de-escalate situations, and personal safety strategies for staff. Physical intervention is used as a last resort where other preventative and early intervention strategies have not worked, and where the child or young person poses a safety risk to themselves or others. Comprehensive debriefing is also required after any physical intervention is used, including the use of restorative justice practices where appropriate.

Previous research has found an association between the use of NVCI and reductions in safety holds or physical restraints in residences (Lambie, 2016).

Therapeutic Crisis Intervention (TCI)

Therapeutic Crisis Intervention (TCI) is similar to NVCI in that it promotes the prevention of harmful behaviour through de-escalation and early intervention (Lambie, 2016). In TCI, aggressive and violent behaviours are viewed and treated as expression of needs; teaching children and young people more adaptive strategies to managing distress and meeting emotional or physical needs is therefore a core focus of TCI. Staff training involves learning how to interpret the function of the child or young person's behaviour (ie, the need being met by the behaviour), and how to reduce the tendency to respond with similarly aggressive behaviour. As with NVCI, TCI also places a heavy emphasis on the

use of communication (verbal and non-verbal) to de-escalate situation, and physical restraint is limited to instances where the child or young person poses a safety risk to themselves or others.

Previous research suggests that the implementation of TCI in therapeutic residential settings is associated with a decrease in rates of restraints, assaults, absconding, and verbal threats, and increased staff confidence in their ability to deal with acute crisis situations (adapted from Lambie, 2016).

The involvement of families and community in Therapeutic Residential Care programmes

Family-centred practice makes a difference to overall care outcomes

A review of outcomes from quasi-experimental studies of residential child and youth care found that those programmes using therapeutic behavioural methods, and with a focus on family involvement, show the most promising short-term outcomes (Knorth et al., 2008). While in residential care, children who receive visits from family were more likely to complete the residential treatment programme compared with children who had no family visits. This effect increased with the frequency of family visits (Sunseri, 2001). Children whose families attend therapy with them while in residential placement, were eight times more likely to be discharged to less restrictive settings (Stage, 1998). Because of this body of evidence, involving families in care and treatment decisions of children and young people in TRC is one of the most widely-recognised indicators of quality TRC services (Cocks, 2016; Huefner, 2018).

While there may be contention in involving a child's family, given that the family's problems contribute to a young person being taken into care, family involvement in residential care is important to consider, as the ultimate goal of state care is to reintegrate children back into their family and community. It is also important to recognise that families are the experts about their children (LeBel et al., 2018). Additionally, Article 9(3) of the UN Convention on the Rights of the Child states that children separated from one or both parents have the right to maintain personal relations and direct contact with both parents on a regular basis, unless it is contrary to the child's best interests.

Family-centred practice in TRC refers to a set of institutional structures and a range of services, supports, and professional practices designed to (Small et al., 2014):

- Maintain and strengthen connections between the young person in care and his/her extended family and community.
- Facilitate and actively support full participation of family members in the daily life of the programme.
- Promote shared responsibility for outcomes, shared decision making, and active partnership between family members and all stakeholders.

Meaningful engagement with families includes involvement, respect, agency, and support

Parents of children or young people with complex needs in residential care report that there are four key needs related to their involvement with services (Van den Steene, van West, & Glazemakers, 2018). These needs are:

- Involvement: having a partnership with residential care workers, including being involved in care planning and delivery. This can involve regular and detailed communication about the

daily functioning of children and young people, and frequent meetings, depending on the wishes of the parent.

- Respect: includes respect for parents as people, respect for their parental role, respect for their parental rights, and respect for their schedule (eg, when setting appointments).
- Agency: having adequate information and mandate for joint decision-making. This includes being meaningfully involved throughout the decision process, rather than just seeking parental approval after a decision has been made.
- Support: receiving practical advice and emotional support from residential care professionals, for parents and the wider family (including siblings).

Overall, parents report desiring an equal partnership with residential care providers, based on mutual respect and open communication (Van den Steene et al., 2018).

Because families have often experienced trauma and deprivation of their own, active support from residential staff is required to facilitate true partnerships with families (LeBel et al., 2018). This support can include greeting families warmly and making them feel welcome, actively initiating daily communication, scheduling meetings at times that respect their availability, avoiding jargon, and respecting cultural needs.

A number of barriers have been identified in facilitating partnership with, and involvement of, families in TRC (Geurts, Boddy, Noom, & Knorth, 2012). One primary barrier is distance from service providers, with children placed closer to home being more likely to have family involved in their care. Families are also more likely to be involved in the care of their children where they are provided opportunities to be involved, their participation is valued by residential staff, they feel welcomed, and they are treated with dignity and respect.

Family-centred Therapeutic Residential Care requires purposeful changes in practice

The Building Bridges Initiative (BBI) model of family-centred TRC provides some guidance as to how family-centred values can be implemented in practice (Blau et al., 2010; Building Bridges Initiative, 2012; Small et al. 2014). Some examples include:

- Allowing 24/7 family access to children and young people in the residence, which is not contingent on the progress of the child or young person.
- Employing “family partners” or family advocates in services whose role is to support family engagement efforts and ensure the family voice is present in agency practice, policies and activities.
- Allowing families to select the care team for their children.
- Developing clear protocols for communication with families, including content and frequency of communication.
- Using consensus between families and professionals to make decisions and formulate care plans.

Allowing families to have more flexible access to children and young people in care is becoming an increasingly common shift in residential practice, particularly in indigenous models of TRC (Ainsworth & Hansen, 2017; Bamblett, Long, Frederico, & Salamone, 2014). More flexible family time allows parents and other family members to be more engaged in the day-to-day care of children while they are in the residence, such as helping with mealtimes, homework or putting children to bed. This promotes parental skill development and empowerment to assist with successful

transition from care (Huscroft-D'Angelo, Trout, Lambert, & Thompson, 2017). In this way, focus is shifting from family *contact* to family *involvement* in the care of their children as true partners with service providers (Geurts et al., 2012; Gillen, 2018; Palmer, Durham, & Osmond, 2014). This is a radical shift from more traditional models of TRC, whereby contact hours and frequency were typically tightly controlled by residential staff, and contact was typically held in agency rooms that were not child-friendly and made families feel uncomfortable (Cocks, 2016).

Successfully implementing family-centred practice in TRC requires ongoing commitment from agency management and senior leadership, supported by clear policies and practice guidelines (LeBel et al., 2018). Previous research has found that residential care staff are more supportive of family engagement where it involves provision of guidance or skill development, and less supportive of activities that empower families, such as joint decision-making or families being involved in the daily care of children and young people (Geurts et al., 2012). However, staff were increasingly more likely to see families as equal partners as they became more involved in daily care, decisions and planning for their children.

Self-assessment and ongoing monitoring are key to family involvement in Therapeutic Residential Care

Two influential models of family involvement in TRC – the Residential Child Care Project (CARE) model and the Building Bridges Initiative (BBI) – place heavy emphasis on initial self-assessment by service providers and ongoing structured monitoring to support meaningful engagement with families (Small et al., 2014; Blau et al., 2010).

The purpose of the initial assessment is to assess readiness for, and commitment to, family-centred practice, and to provide some ideas about how to incorporate family-centred practice into the service. This includes evaluating the transparency and availability of outcome data to families, how family-friendly admissions and intake procedures are, and developing clear practice guidelines to facilitate family involvement in care.

Agencies are also strongly encouraged to collect and monitor data on outcomes that are important to families, to inform continuous improvement. Examples include educational outcomes, medication rates, use of restraint and seclusion, length of stay and progress toward individual treatment goals. Indicators should also be included that measure the extent to which families are meaningfully involved in the care process, from assessment and intake to post-transition from care.

Multi-disciplinary teams and inter-agency collaboration in Therapeutic Residential Care

Effective inter-professional collaboration care requires strong communication

Providing responsive and effective care within a TRC setting requires collaboration and integration of services from a variety of clinical and child welfare professionals, including education, mental health, physical health and social work service providers. Effective inter-professional collaboration is therefore crucial for ensuring that children and young people have their varied and often complex needs met within TRC. Previous research suggests that effective inter-professional and inter-agency collaboration in TRC relies heavily on shared language and expectations for collaboration between professionals, to serve as a foundation for meaningful communication (Timonen-Kallio, Hämäläinen, & Laukkanen, 2017). This creates an initial relationship through which professionals and service providers can determine a clear division of responsibility and tasks amongst themselves, as well as develop mutual respect for the expertise that each professional brings to the table.

Previous international research suggests that one of the largest barriers to effective inter-professional collaboration in TRC is a lack of understanding or acknowledgement of the contributions of different professionals or agencies, including expectations around roles or responsibilities in given cases (Timonen-Kallio, 2019; Timonen-Kallio et al., 2017). In particular, mental health practitioners in residential child care reported having a clear understanding of their role (eg, assessment and therapy), whereas residential youth workers were less clear about the boundaries of their role, how their role interfaced with the work of mental health professionals, and whether their role was acknowledged or respected to the same extent as that of mental health professionals. It was also felt that knowledge could be more effectively shared between professionals to provide support for more holistic and integrated care for children and young people.

Some examples of innovation in the delivery of multi-disciplinary care exist internationally

The No Wrong Door model

The No Wrong Door (NWD) model is an innovative model of inter-disciplinary care in TRC. Implemented as two "hubs" in North Yorkshire, UK, NWD provides wraparound services to at-risk children and young people with complex needs, both at home and in out-of-home placements (Bellonci, Holmes, & Whittaker, 2019). Each hub houses an embedded specialist multi-disciplinary team including a clinical psychologist, speech language therapist, and police liaison officer. Because of the embedded nature of these teams, children and young people in care are able to build close, trusting and consistent relationships with professionals delivering support services. A core feature of the model is a proactive response to at-risk children and young people, with targeted support being provided to identified families to prevent out-of-home placements. In this way, the NWD model provides targeted services as a first, rather than last, resort.

An initial independent evaluation of the NWD model concluded that substantial progress had been made toward intended objectives within a relatively short time (April 2015 – March 2017; Lushey, Hyde-Dryden, Holmes, & Blackmore, 2017, as cited in Bellonci et al., 2019). In particular, young people in TRC who were engaged in the NWD service experienced greater placement stability and overall absconding incidents were halved.

German practices of multi-disciplinary residential care

A recent report on multi-disciplinary care in general residential care settings (ie, not limited to TRC) in Europe provided some promising practices supporting inter-professional collaboration in Germany (Timonen-Kallio, Pivoriene, Smith, & del Valle, 2015). These include psychiatric liaison services, cooperation agreements, and inter-professional exchange.

Psychiatric liaison services provide regular mental health assessment, diagnosis, and treatment within care residences, including TRC settings. This includes screening for mental disorders for children and young people entering the residence. Importantly, the treatment delivered within residences as part of the service includes residential care workers, to support continuity of care and therapeutic relationships outside of direct treatment. Research suggests that the use of psychiatric liaison services reduced the number of days children and young people remained in care, but that limited staff and time resources was a barrier to successfully completing routine mental health assessments.

Cooperation agreements focus on the implementation of inter-professional collaboration at the practice level, to support ongoing dialogue and working relationships between professionals. The agreements outline shared values and clear demarcation of professional roles and responsibilities. Guiding principles for working with challenging or harmful behaviours and frameworks for conflict

resolution can also be included in agreements. Additionally, quality standards and methods for evaluating the implementation of the agreement are clearly outlined as part of the agreement. The overall purpose of these agreements is to streamline services and efforts to provide improved experiences and outcomes for children and young people in residential care.

Finally, inter-professional exchange involves bringing professionals together in formal (eg, joint case conferences) and informal contexts to strengthen relationships, build trust and address conflict. Inter-professional educational opportunities, such as joint workshops, have also been found to help facilitate knowledge exchange and networking. Important facilitators of successful inter-professional exchange include appropriate resources to support learning, staff who moderate engagement, a neutral location, and professionals' motivation and willingness to participate in multi-disciplinary activities.

Numerous models of Therapeutic Residential Care exist, with varying degrees of evidence

Positive Peer Culture

The Positive Peer Culture (PPC) model was developed to tackle negative peer pressure among troubled youth. It is grounded in theories of social psychology and emphasises social context as a key determinant of thoughts and behaviours. As such, PPC aims to build a positive peer culture, which reinforces mutual responsibility, pro-social attitudes, development of trust and respect, and positive involvement in the community.

PPC has been applied in residential settings, outpatient facilities and schools. It is usually delivered in groups of eight to twelve youth in 90-minute structured group meetings, five times per week over a six- to nine-month period. PPC is manualised and training is available.

There are four essential treatment features:

- Building group responsibility
- Group meetings – structured as a problem solving arena
- Service learning – involvement in community projects
- Teamwork primacy – staff teams are organised around groups of children.

PPC is considered to be supported by research evidence using established California Evidence-Based Clearinghouse for Child Welfare (CEBC) criteria, based on one randomised and two quasi-experimental studies with delinquent youth (James, 2011, 2017; Pecora & English, 2016). (For more information on review methodology and model outcomes refer to James, 2011.)

Teaching Family Model

The Teaching Family Model (TFM) was first implemented in 1967 in a group home for delinquent children. Adaptation of this model is known as Boys Town. Treatment is typically delivered by married couples in a family-style living and learning environment and is realised by proactive teaching interactions focused on positive prevention and youth skill acquisition. The model also uses a client-peer leadership / self-government system. The "teaching parents" are also involved with children's parents, teachers and other support networks to help maintain progress. TFM is manualised and training is provided.

The TFM was rated as “promising” according to CEBC criteria based on seven peer-reviewed articles (James, 2011, 2017; Pecora & English, 2016).

Sanctuary model

The Sanctuary model represents a trauma-informed method for creating an organisational culture, where healing from trauma can take place. This model was developed within a context of an inpatient psychiatric clinic and since then has been modified in range of settings including group care. The model is based on non-violence, emotional intelligence, inquiry and social learning, shared governance, open communication, social responsibility and growth and change.

The Sanctuary model sets four stages of recovery from trauma – Safety, Emotional Management, Loss and Future (SELF). In addition, it employs cognitive-behavioural strategies and coping skills acquisition. The model is not manualised but training is available. In Australia, young people stay as long as is therapeutically necessary.

The Sanctuary model is considered to be “promising” according to CEBC criteria, studied with groups of youths with histories of maltreatment (James, 2011, 2017; Pecora & English, 2016). Additionally, a recent systematic review of the literature found the model had a medium positive effect in promoting a positive social climate within TRC residences (Leipoldt et al., 2019).

Stop-Gap model

The Stop Gap model conceptualises group care as a short-term arrangement aimed at stabilising youth enough for discharge to lower-level community-based treatment. It uses a three-tiered approach with goals to reduce problematic behaviour and prepare the post-discharge environment for reintegration.

The focus of Tier 1 is on the immediate reduction of problem behaviours through intensive interventions such as a token economy, academic interventions, social skills training, problem-solving and anger management skills training. Tier 2 is focused on discharge-related interventions such as intensive case management, parent management training and community integration activities. Tier 3 includes behaviour support planning. The duration of the service ranges from 90 days to one year, depending on needs of the individual young person.

The Stop-Gap model was rated as “promising” based on CEBC criteria, studied in residential treatment centres (James, 2011, 2017; Pecora & English, 2016).

Therapeutic Residential Care pilot model (Hurstbridge farm)

This model was developed for children and young people with complex needs in the state of Victoria, Australia. Most TRC residences work with four young people aged 12-18 years. The TRC model was influenced by the Sanctuary model and uses theories of attachment and trauma, neurobiology of brain development and resilience. Essential elements of this model include trained staff, consistent rostering, engagement and participation of the young people, client mix, care team meetings, the therapeutic specialist, reflective practice, organisational congruence and commitment, physical environment, exit planning and post-exit support and governance and therapeutic practice improvement. The length of stay is between 18-30 months (McNamara, 2015).

An evaluation concluded that this model leads to better outcomes for children than standard residential care practice including improvements in placement stability, better quality of relationships and contact with family and residential carers, increased community connection,

improvements of sense of self, increased healthy lifestyles, reduced risk taking, enhanced mental and emotional health and improved relationship with school (Sullivan et al., 2011).

The Lighthouse Therapeutic Family Model of Care

The Lighthouse Foundation is a not-for-profit organisation providing therapeutic residential care in Victoria and has developed its own Therapeutic Family Model of Care. It aims to help young people who have experienced trauma with healing and rebuilding their lives.

The model is based on attachment theory, is trauma-informed and addresses the psychological need of young people to bond with primary caregivers, which is considered fundamental to their healthy development. It offers support with learning, therapy and personal development from within the home and on an outreach basis, ensuring a sense of belonging within a community. The model offers a safe and consistent family-like living environment with positive and consistent parental role models so the young people can rebuild their sense of self, learn new ways of trusting and relating to others and develop pro-social connections with their communities, There is also good support for young people transitioning from the programme and the participants are encouraged to stay connected with the organisation for life.

The Therapeutic outcomes assessment tool assesses young person's progress across eight domains:

- learning
- physical development
- emotional development
- attachment
- identity
- social development
- autonomy/life skills
- relational and community connectedness

The Lighthouse model works with youth from 15-22 years of age. There are four young people in a house and the length of stay ranges from 18 to 24 months (McNamara, 2015). While there is no formal evaluation of the programme, a Social Return on Investment Analysis[4] concluded that the programme leads to a holistic transformation of young people's lives, the changes are sustainable and the investment into the programme generates significant social returns.

Indigenous models of Therapeutic Residential Care

Victorian Aboriginal Child Care Agency (VACCA) model

This model was developed by the Victorian Aboriginal Child Care Agency (VACCA) in Australia, supported by a working party, discussion paper and five "think tanks" who ensured that the key values and principles of an Aboriginal therapeutic approach were present in the final model (Bamblett et al., 2014). The six "cultural pillars" providing the foundation for the model are: cultural

[4] http://lighthouseinstitute.org.au/wp-content/uploads/sites/2/2013/09/sroireport.pdf

safety; cultural rights and responsibilities; Aboriginal understanding of family and kinship structure; Aboriginal understandings of culture as resilience; adherence to the Best Interest principles; and adherence to the Aboriginal Child Placement principle (ie, that Aboriginal children should be placed within their own family or Aboriginal community/culture).

The VACCA model incorporates key elements of mainstream models of care, including training in trauma-informed practice, and recognising the importance of staff commitment to a strengths-based care philosophy. However, the promotion of child and young person healing through connection to culture is the core focus of the model. Key practice components of the model include:

- Comprehensive, culturally-informed assessments and planning: assessments involving engagement with the child or young person, siblings, parents, wider family, and previous carers or service providers are conducted to inform individualised treatment planning.
- Social network mapping: social networks with peers are mapped in conjunction with cultural planning tools to support the development of Aboriginal friendships and monitoring of key relationships.
- Men's and women's business: key developmental milestones related to "girls' business" and "boys' business" are addressed and managed in accordance with Aboriginal cultural practices.
- Return to country: Aboriginal children and young people are taken to visit their country (ie, traditional lands) to experience their land and meet Elders and members of their cultural community.
- Cultural support plans: developmentally-appropriate cultural support plans are created to assist children and young people, and adults in their life, understand who they are, who their family is, and what cultural connection means to them.
- Community and cultural participation: children and young people are actively involved in the normal life of the community, including participating in Aboriginal children's community and sporting events.

The VACCA's TRC model has yet to be evaluated, but early indications suggest that the model is supporting positive wellbeing outcomes for Aboriginal children and young people in care (adapted from Bamblett et al., 2014).

Halls Creek model

The "Halls Creek way" of residential care was developed in response to the high levels of sexual and physical abuse of indigenous children in Western Australia, resulting from colonisation and past government practices and policies relating to Aboriginal communities (Hodgkins, Crawford, & Budiselik, 2013).

The resultant residence (Yurang-Man-Gu Taam-Purru, which translates to "a good place for kids") operates according to seven overarching strategies:

- A commitment to recruiting local staff
- Maintaining links to culture
- Staying connected to family
- Staff are learning too
- Keeping kids strong

- Learning through play
- Celebrating milestones and our identity.

These strategies inform practice within the residence, with the first four strategies listed above being seen as of central importance. For example, "staying connected to family" is implemented through an open-door policy with family (ie, families are able to visit at any time) and by holding relationship-building events such as weekend barbeques with families and local community members. Staff also engage with family to support their learning eg, feeding techniques for children with foetal alcohol syndrome.

At times conflict arises between the Halls Creek way and existing policies or guidelines based on mainstream approaches to TRC. Open lines of communication with monitoring and funding agencies are maintained to ensure that such tensions are addressed. For example, the manager and staff of Yurang-Man-Gu Taam-Purru may detail the rationale of their practices and the local input that led to them; key to this process is other agencies being open to hearing and considering alternative models of practice.

The expected key enablers of successful implementation of the Halls Creek way of residential care have been identified as:

- Support, resources and funding from the relevant government agency
- Integration of community values, knowledge and skills
- Long-term engagement and consultation between key stakeholders
- Careful translation and negotiation of meaning, knowledge and solutions between the local and state level
- Local management and ownership (adapted from Hodgkins et al., 2013).

An overarching framework for Therapeutic Residential Care

TRC looks to move away from model-based delivery, to overarching principles of care that can be applied to any socio-political context. With much variation in the way that TRC is delivered, and acknowledgement that variation in treatment models is unavoidable due to differing cultural and political contexts across care systems, the development of TRC looks to establish guiding principles in practice, and to examine current practices to determine the essential elements of therapeutic care.

What is said to underlie models or programmes of TRC, what makes them therapeutic, is the willingness to work purposefully and strategically with "theories of change" for the positive development of children in care who have significant difficulties (Jakobsen, 2014). Building in this principle of working with theories of change, as opposed to a particular model, will allow for greater flexibility in the delivery of TRC, and greater capacity to cater for the uniqueness of each child for whom TRC is intended.

Common features and quality standards for Therapeutic Residential Care

Building on the basis of the international consensus statement (see Introduction), studies of the effectiveness of current TRC models and practices, and a public/private partnership involving providers, lead agencies, research leaders and state agencies, the development of quality standards for TRC (Daly et al., 2018) aims to improve the quality of individual TRC programmes:

Standard 1: Assessment, admission, and service planning/treatment planning • *Emphasis on trauma-informed, strengths-based, and need-based interventions* • *Use of evidence-based tools to conduct pre and during programme assessment* • *Emphasis on measurable goals*
Standard 2: Positive, safe living environment • *Policies and operations in place to strive for a restraint-free setting* • *Measurable safety from other youth problem behaviours*
Standard 3: Effectively monitor and report problems • *Staff are systematically trained in reporting and monitoring methods* • *Programmes must have a system to externally assess programme satisfaction of key stakeholders such as parents, youth, and placement agents* • *Consumer satisfaction surveys are used as an element in a continuous quality improvement system*
Standard 4: Promote family, culture, and spirituality • *Policies, training, and programme structures promote family reunification as the preferred outcome* • *Active encouragement of family and home visits, and community/cultural contact* • *Promotion of personal religious participation and moral development*
Standard 5: Develop and maintain a professional, competent staff • *All staff are appropriately trained* • *New staff receive pre-service training in evidence-based/evidence-informed models of interventions* • *Competency measures occur for all training*
Standard 6: Programme elements • *Use of evidence-based/evidence-informed practices* • *Support for implementation of theoretically sound programmes* • *Psychotropic medication utilisation is overseen by the appropriate professional*

Standard 7: Promote education, skills, and positive outcomes

- *Youth educational progress should be routinely monitored using standardised, criterion-referenced assessments*
- *Educational outcomes should show 1 year of growth for 1 year of education*
- *Programmes must reduce symptoms in youth with psychological problems as assessed by credentialed clinical evaluators or standardised assessments*
- *Programmes should regularly measure individual youth outcomes as well as programme-wide outcomes*
- *Programmes should demonstrate a functional relationship between the methods employed and the outcomes achieved*

Standard 8: Pre-discharge/Post-discharge processes

- *Programmes need to utilise discharge plans for each youth according to their needs*
- *Aftercare/After programme outcomes should be measured to assess educational, functional, legal/citizenship, and adult functioning outcomes*

Core therapeutic imperatives include safety, connections and adaptive coping

In their recent review, Bath and Smith (2015) identified core therapeutic imperatives for working with traumatised children in therapeutic residential care services and implications for practice:

Safety

Establishment of a context of safety is the most important aspect for the healing of children who have experienced trauma. The children need to be safe, but they also need to *feel* safe – physically, emotionally, socially, culturally and spiritually – to be able to relax and to attend to normal developmental tasks.

In practice, this means that TRC programmes need long-term, stable and well-trained staff, including experienced clinicians. Also, the need for safety should guide programme design and placement decisions, including the right of services to refuse referrals of people who may pose a risk to current clients and staff.

Healthy connections

The experience of childhood trauma is characterised by the failing of normally supportive connections from caregivers who either could not provide safety and protection, or were themselves the source of trauma (Bath & Smith, 2015).

From this experience, children often develop a lack of trust and a sense of disconnection from adults. Therapeutic care needs to offer caring adults that are available, reliable, capable and trustworthy, so the healthy connections can be established and healing can take place.

In practice there needs to be an emphasis on the continuity of service, and positive connections need to be a priority, including connections between former carers and young people.

Adaptive coping

The focus of TRC should be to help children to manage their overwhelming emotions and impulses in a healthy and adaptive way. In practice, this means teaching self-regulation skills rather than using

coercive responses such as seclusion or restraint, which further distress young people and cause a disconnection from adults.

Common features of TRC programmes

Some additional common features of programmes have been identified in reviews of TRC (McLean, 2018; Farmer et al., 2017; James, 2017; Grietens et al., 2014):

- providing treatment, education, socialisation, and protection
- trauma-informed treatment, including focus on building caring and nurturing relationships
- shared understanding of young people's (often trauma-related) history and needs
- placement based on shared needs of children within a residence
- therapeutic input tailored to needs of a child and family
- prioritising relationship-based work
- eliminating the use of restraint and seclusion
- evidence-based or evidence-informed practice
- supportive, safe environment during care
- carefully managed transition from care
- inclusion of after-care services
- the basic therapeutic milieu in residential care should be completed with specific treatment that is aimed at the particular needs of every individual child
- support for residential staff – training, coaching, supervision, working with treatment protocols; focus on prevention of incidents and dealing with crises.

CONCLUSION

This brief outlines key principles of TRC and provides answers to specific questions around operational aspects of this type of care. The findings indicate that TRC is an important part of a care continuum, that should be accessible for children when appropriate. While there are many models of TRC, it should be tailored to the communities, cultures and social relationships of the children and families that they serve. Indigenous models of TRC emphasise cultural safety, promoting connection with culture, participation in local communities, and meaningful connection with families.

The outcomes for children in TRC should fall within broad categories of safety, happiness, stability and development. These outcomes should be set specifically for individual children and be measurable, achievable and relevant. The involvement of families in TRC placements improves overall care outcomes, and trauma-informed environments and models of care in TRC also help to reduce rates of absconding and violent behaviour.

Seclusion is not effective in reducing either the frequency or intensity of challenging behaviour with children and adolescents. Rather, seclusion has been shown to increase the risk of serious physical harm, and even death, with children. For children with trauma-related histories, the experience of seclusion is re-traumatising, making therapeutic goals more difficult to attain. Staff experience of seclusion is also negative, causing stress, psychological trauma, and spiritual trauma among Māori practitioners.

The use of seclusion can be significantly reduced, and even eliminated, through programmes that address staff management, and provide staff training in alternative methods of behavioural management for young people with challenging behaviours.

REFERENCES

Ainsworth, F. (2017). For the few not the many: An Australian perspective on the use of therapeutic residential care for children and young people. Residential Treatment for Children & Youth, 34(3-4), 325-338.

Ainsworth, F., & Hansen, P. (2005). A dream come true–no more residential care. A corrective note. International Journal of Social Welfare, 14(3), 195-199.

Ainsworth, F., & Hansen, P. (2015). Therapeutic residential care: Different population, different purpose, different costs. Children Australia, 40(4), 342-347.

Ainsworth, F., & Hansen, P. (2017). Understanding the behaviour of children in care before and after parental contact. Children Australia, 42(1), 5–8. https://doi.org/10.1017/cha.2016.50

Ainsworth, F., & Hansen, P. (2018). Group homes for children and young people: The problem not the solution. Children Australia, 43(1), 42–46. https://doi.org/10.1017/cha.2018.4

Ainsworth, F., & Holden, M. J. (2018). A Response to 'Weighing Up the Evidence and Local Experience of Residential Care'. Children Australia, 43(3), 169-172.

Allen, J. J. (2000). Seclusion and restraint of children: A literature review. Journal of Child and Adolescent Psychiatric Nursing, 13(4), 159-167.

American Civil Liberties Union. (2014). Alone & afraid: Children held in solitary confinement and isolation in juvenile detention and correctional facilities.

Anglin, J. (2004). Creating "well-functioning" residential care and defining its place in a system of care. Child and Youth Care Forum, 33(3), 175-192.

Bamblett, M., Long, M., Frederico, M., & Salamone, C. (2014). Building an Aboriginal cultural model of therapeutic residential care: The experience of the Victorian Aboriginal child care agency. Children Australia, 39(4), 206–210. https://doi.org/10.1017/cha.2014.28

Barton, S., Gonzalez, R., & Tomlinson, P. (2012). Therapeutic residential care for children and young people: An attachment and trauma-informed model for practice. London, UK: Jessica Kingsley Publishers

Bath, H., & Smith, B. (2015). Practice challenges in the shift to therapeutic residential care. Developing Practice: The Child, Youth and Family Work Journal, (41), 62.

Bellonci, C., Holmes, L., & Whittaker, J. (2019). Re-thinking Therapeutic Residential Care (TRC) as a preventive service: Examining developments in the US and England. Residential Treatment for Children and Youth, 36(1), 35–53. https://doi.org/10.1080/0886571X.2018.1536495

Berens, A. E., & Nelson, C. A. (2015). The science of early adversity: is there a role for large institutions in the care of vulnerable children? The Lancet, 386(9991), 388-398.

Blau, J. G. M., Caldwell, B., Fisher, S. K., Kuppinger, A., Levison-Johnson, J., & Lieberman, R. (2010). The Building Bridges Initiative: Residential and community-based providers, families, and youth coming together to improve outcomes. Child Welfare, 89(2), 21–38.

Blau, G. M., Caldwell, B., & Lieberman, R. E. (Eds.). (2014). Residential interventions for children, adolescents, and families: A best practice guide. Routledge.

Bryson, S. A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., … Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. International Journal of Mental Health Systems, 11(1), 1–16. https://doi.org/10.1186/s13033-017-0137-3

Building Bridges Initiative. (2012). *Engage us: A guide written by families for residential providers*. United States: Author.

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical child and family psychology review*, *2*(4), 199-254.

Butler, L. S., & McPherson, P. M. (2007). Is Residential Treatment Misunderstood? *Journal of Child and Family Studies*, *16*(4), 465.

Caldwell, B., Albert, C., Azeem, M. W., Beck, S., Cocoros, D., Cocoros, T., … Reddy, B. (2014). Successful seclusion and restraint prevention efforts in child and adolescent programs. *Journal of Psychosocial Nursing and Mental Health Services*, *52*(11), 30–38. https://doi.org/10.1017/CBO9781107415324.004

Cocks, J. (2016). *Family inclusion initiatives in child welfare*. Canberra: The Winston Churchill Memorial Trust.

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.

Csáky, C. (2009). *Keeping children out of harmful institutions: Why we should be investing in family-based care*. Save the Children.

De Benedictis, L., Dumais, A., Sieu, N., Mailhot, M. P., Létourneau, G., Tran, M. A. M., ... & Lesage, A. D. (2011). Staff perceptions and organizational factors as predictors of seclusion and restraint on psychiatric wards. *Psychiatric Services*, *62*(5), 484-491.

De Hert, M., Dirix, N., Demunter, H., & Correll, C. U. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: a systematic review. *European Child & Adolescent Psychiatry*, *20*(5), 221-230.

Daly, D. L., Huefner, J. C., Bender, K. R., Davis, J. L., Whittaker, J. K., & Thompson, R. W. (2018). Quality care in therapeutic residential programs: definition, evidence for effectiveness, and quality standards. *Residential Treatment for Children & Youth*, *35*(3), 242-262.

Day, A., Daffern, M., & Simmons, P. (2010). Use of restraint in residential care settings for children and young people. *Psychiatry, psychology and law*, *17*(2), 230-244.

Delap, E. (2011). *Scaling down: Reducing and reshaping and improving residential care around the world*. London: Every Child.

Downey, L., Jago, J., & Poppi, S. (2015). The Spiral to Recovery: An Australian model for therapeutic residential care. *Children Australia*, *40*(4), 351–360. https://doi.org/10.1017/cha.2015.31

Duppong Hurley, K., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. Z. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care. *Journal of Emotional and Behavioral Disorders*, *25*(1), 37–45. https://doi.org/10.1177/1063426616686756

Duppong Hurley, K., Wheaton, R. L., Mason, W. A., Schnoes, C. J., & Epstein, M. H. (2014). Exploring suicide risk history among youth in residential care. *Residential Treatment for Children & Youth, 31*(4), 316-327. https://doi.org/10.1080/0886571X.2014.958377

El-Badri, S. M., & Mellsop, G. (2002). A study of the use of seclusion in an acute psychiatric service. *Australian and New Zealand Journal of Psychiatry*, *36*(3), 399-403.

European Commission. (2013). Recommendation of 20 February 2013. Investing in children: breaking the cycle of disadvantage (2013/112/EU). *Official Journal of the European Union.* L 59/5. Retrieved from: www.bettercarenetwork.org/library/social-welfare-systems/cost-of-care-and-redirection-of-resources/eu-commission-recommendation-2013112eu-on-investing-in-children

Evidence In-Sight. (2012). *Optimal Length of Stay in Residential Treatment for High Risk Youth.* Ontario Centre of Excellence for Child and Youth Mental Health.

Farmer, E. M. Z., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017). Would we know it if we saw it? Assessing quality of care in group homes for youth. *Journal of Emotional and Behavioral Disorders*, *25*(1), 28–36. https://doi.org/10.1177/1063426616687363

Finke, L. M. (2001). The use of seclusion is not evidence-based practice. *Journal of Child and Adolescent Psychiatric Nursing*, *14*(4), 186.

Forrest, S., Gervais, R., Lord, K. A., Sposato, A., Martin, L., Beserra, K., & Spinazzola, J. (2018). Building communities of care: A comprehensive model for trauma-informed youth capacity building and behavior management in residential services. *Residential Treatment for Children and Youth*, *35*(4), 265–285. https://doi.org/10.1080/0886571X.2018.1497930

Geurts, E. M. W., Boddy, J., Noom, M. J., & Knorth, E. J. (2012). Family-centred residential care: The new reality? *Child and Family Social Work*, *17*(2), 170–179. https://doi.org/10.1111/j.1365-2206.2012.00838.x

Gillen, P. (2018). Therapeutic residential care: Partnering with families for improved outcomes. *Brown University Child & Adolescent Behavior Letter*, *34*(9), 1–7. https://doi.org/10.1002/cbl

Goren, S., & Curtis, W. J. (1996). Staff members' beliefs about seclusion and restraint in child psychiatric hospitals. Journal of child and adolescent psychiatric nursing: official publication of the Association of Child and Adolescent Psychiatric Nurses, Inc, 9(4), 7-14.

Goren, S., Abraham, I., & Doyle, N. (1996). Reducing violence in a child psychiatric hospital through planned organizational change. *Journal of Child and Adolescent Psychiatric Nursing*, *9*(2), 27-36.

Grietens, H., Knorth, E., Barth, R., Cummings, M., Stein, M., Courtney, M., ... & McNamara, P. (2014). *Therapeutic residential care for children and youth: Developing evidence-based international practice*. Jessica Kingsley Publishers.

Handwerk, M. L., Larzelere, R. E., Friman, P. C., & Mitchell, A. M. (1998). The relationship between lethality of attempted suicide and prior suicidal communications in a sample of residential youth. *Journal of Adolescence*, *21*(4), 407-414. https://doi.org/10.1006/jado.1998.0160

Hodgkins, K. A., Crawford, F. R., & Budiselik, W. R. (2013). The Halls Creek way of residential child care: Protecting children is everyone's business. *Children Australia*, *38*(2), 61–69. https://doi.org/10.1017/cha.2013.5

Hogg Foundation for Mental Health. (2013). *Seclusion and Restraint Reduction Initiative: Evaluation executive summary*. Austin, Texas.

Holden, M. J., & Sellers, D. (2019). An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care. *International Journal of Child, Youth and Family Studies*, *10*(2–3), 63–80. https://doi.org/10.18357/ijcyfs102-3201918853

Huefner, J. C. (2018). Crosswalk of published quality standards for residential care for children and adolescents. *Children and Youth Services Review*, *88*(December 2017), 267–273. https://doi.org/10.1016/j.childyouth.2018.03.022

Huscroft-D'Angelo, J., Trout, A. L., Lambert, M. C., & Thompson, R. (2017). Caregiver perceptions of empowerment and self-efficacy following youths' discharge from residential care. *Journal of Family Social Work*, *20*(5), 433–456. https://doi.org/10.1080/10522158.2017.1350893

Hussein, T., & Cameron, C. (2014). Lighthouse Foundation therapeutic family model of care: Stages of recovery

and their application to young people in out-of-home care. *Children Australia*, *39*(4), 237–242. https://doi.org/10.1017/cha.2014.35

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. *Prevention Science*, *17*(5), 554–564. https://doi.org/10.1007/s11121-016-0649-0

Jackson, A. (2014). From where to where - Running away from care. *Children Australia*, *40*(1), 16–19. https://doi.org/10.1017/cha.2014.46

Jakobsen, T. B. (2014). Varieties of Nordic Residential Care: A Way Forward for Institutionalized Therapeutic Interventions? In *Therapeutic Residential Care for Children and Youth* (pp. 87-99). Jessica Kingsley Publishers.

James, S. (2017). Implementing evidence-based practice in residential care: How far have we come? *Residential Treatment for Children & Youth*, *34*(2), 155-175.

James, S., Thompson, R. W., & Ringle, J. L. (2017). The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers. *Journal of Emotional and Behavioral Disorders*, *25*(1), 4–18. https://doi.org/10.1177/1063426616687083

Kerzner, J. M. S. P. A., Goldstein, R., & Weeks, M. (2004). Child and Adolescent Inpatient Restraint Reduction: A State Initiative to Promote Strength-Based Care. *Adolescent Psychiatry*, *43*(1)

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. Children and youth services review, 30(2), 123-140.

Knowles, S. F., Hearne, J., & Smith, I. (2015). Physical restraint and the therapeutic relationship. *The Journal of Forensic Psychiatry & Psychology*, *26*(4), 461-475.

Lai, J., Jury, A., Long, J., Fergusson, D., Smith, M., Baxendine, S., & Gruar, A. (2019). Variation in seclusion rates across New Zealand's specialist mental health services: Are sociodemographic and clinical factors influencing this? *International journal of mental health nursing*, *28*(1), 288-296.

Lambie, I. (2016). *Care and protection secure residences: A report on the international evidence to guide best practice and service delivery*. Wellington.

LeBel, J. L., Galyean, L., Nickell, M., Caldwell, B., Johnson, K. A., Rushlo, K., & Blau, G. M. (2018). The changing role of residential intervention. *Residential Treatment for Children and Youth*, *35*(3), 225–241. https://doi.org/10.1080/0886571X.2018.1437376

Leipoldt, J. D., Harder, A. T., Kayed, N. S., Grietens, H., & Rimehaug, T. (2019). Determinants and outcomes of social climate in therapeutic residential youth care: A systematic review. *Children and Youth Services Review*, *99*(November 2018), 429–440. https://doi.org/10.1016/j.childyouth.2019.02.010

Mclean, S. (2015). Managing behaviour in child residential group care: Unique tensions. *Child and Family Social Work*, *20*(3), 344–353. https://doi.org/10.1111/cfs.12083

McLean, S. (2016). *Report on therapeutic residential care. Report to the SA Child Protection Systems Royal Commission*. Canberra: Australian Centre for Child Protection.

McLean, S. (2018). *Therapeutic residential care: An update on current issues in Australia*. Australian Institute of Family Studies.

McLoughlin, P. J., & Gonzalez, R. (2014). Healing complex trauma through therapeutic residential care: The Lighthouse Foundation therapeutic family model of care. *Children Australia*, *39*(3), 169-176. https://doi.org/10.1017/cha.2014.22

McNamara, P. (2015). A new era in the development of therapeutic residential care in the state of Victoria. In Whittaker J. K., del Valle, J. F., & Holmes, L. (Eds), (2014). *Therapeutic residential care for children and youth. Developing evidence-based international practice (pp. 126-141).* London: Jessica Kingsley.

Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C. (2016). Safe and sound: Exploring the safety of young people in residential care. Melbourne: Institute of Child Protection Studies, Australian Catholic University. Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Moore, T., McArthur, M., Death, J., Tilbury, C., & Roche, S. (2017). Young people's views on safety and preventing abuse and harm in residential care: "It's got to be better than home." *Children and Youth Services Review*, *81*(August), 212–219. https://doi.org/10.1016/j.childyouth.2017.08.010

Palmer, S., Durham, D., & Osmond, M. (2014). Therapeutic visiting in treatment foster care. *Child Welfare*, *93*(4), 25–52.

Pecora, P. J., & English, D. J. (2016). Elements of effective practice for children and youth served by therapeutic residential care: Research brief. Seattle, WA: Casey Family Programs.

Pere, L. M. (2006). *Oho mauri: cultural identity, wellbeing and tāngata whai ora/motuhake*. (Unpublished Doctor of Philosophy thesis, Massey University, Palmerston North, New Zealand).

Romani, E., Pecora, P. J., Harris, B., Jewell, C., & Stanley, A. (2019). A systems analysis of youth in acute and subacute therapeutic residential care. *Journal of Public Child Welfare*, *13*(2), 196–213. https://doi.org/10.1080/15548732.2018.1498429

Sequeira, H., & Halstead, S. (2004). The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: 'When I go home, it's then that I think about it'. *The British Journal of Forensic Practice*, *6*(1), 3-15.

Small, R. W., Bellonci, C., & Ramsey, S. (2014). Creating and maintaining family partnerships in residential treatment programs: Shared decisions, full participation, mutual responsibility. In J. K. Whittaker, J. F. del Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Developing evidence-based international practice* (pp. 156–171). London: Jessica Kingsley Publishers.

Stage, S. A. (1998). Predicting adolescents' discharge status following residential treatment. *Residential Treatment for Children & Youth, 16*(3), 37-56.

Standards New Zealand. (2008a). *Health and Disability Services (General) Standards: NZS 8134.0:2008.* Wellington, New Zealand: Ministry of Health.

Standards New Zealand. (2008b). *Health and Disability Services (Restrain Minimisation and Safe Practice) Standards: NZS 8134.2:2008.* Wellington, New Zealand: Ministry of Health

Steels, S., & Simpson, H. (2017). Perceptions of children in residential care homes: A critical review of the literature. *The British Journal of Social Work*, *47*(6), 1704-1722.

Strijbosch, E. L. L., Wissink, I. B., van der Helm, G. H. P., & Stams, G. J. J. M. (2019). Building a positive group climate together: How monitoring instruments are part of an improvement process in residential care for children. *Children and Youth Services Review*, *96*, 266–277. https://doi.org/10.1016/j.childyouth.2018.11.051

Sullivan, M., Falrcloth, D., McNair, J., Southern, D., Brann, P., & Starbuck, L. (2011). Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary & Technical Report. *Clifton Hill: Verso Consulting*. Summary & Technical Report. Melbourne: Department of Human Services.

Sunseri, P. A. (2005). Children referred to residential care: Reducing multiple placements, managing costs and improving treatment outcomes. *Residential Treatment for Children & Youth*, *22*(3), 55-66.

Sunseri, P. A. (2001). The prediction of unplanned discharge from residential treatment. In *Child and youth care forum* (Vol. 30, No. 5, pp. 283-303). Kluwer Academic Publishers-Plenum Publishers.

Te Pou o te Whakaaro Nui. (2014a). *Do seclusion initiatives increase risk to staff safety? An integrative review of evidence of association and causality from 2004-2014, with recommendation from for practice.* Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Te Pou o te Whakaaro Nui. (2014b). Supporting seclusion reduction for Māori: "Taiheretia tātou kia puta te hua". Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Te Pou O Te Whakaaro Nui. (2018a). *Evidence update for reducing seclusion in New Zealand.* Auckland, New Zealand: Te Pou O Te Whakaaro Nui. (www.tepou.co.nz/uploads/files/resource-assets/Seclusion%20evidence%20FINAL%20november%202018.pdf)

Te Pou O Te Whakaaro Nui. (2018b). *Reducing and Eliminating Seclusion in Mental Health Inpatient Services: An Evidence Review for the Health, Quality & Safety Commission New Zealand.* Auckland, New Zealand: Te Pou O Te Whakaaro Nui.

Timonen-Kallio, E. (2019). Interprofessional collaboration between residential child care and mental care practitioners: a cross-country study in six European countries. *European Journal of Social Work*, *22*(6), 947–960. https://doi.org/10.1080/13691457.2018.1441135

Timonen-Kallio, E., Hämäläinen, J., & Laukkanen, E. (2017). Interprofessional collaboration in Finnish residential child care: Challenges in incorporating and sharing expertise between the child protection and health care systems. *Child Care in Practice*, *23*(4), 389–403. https://doi.org/10.1080/13575279.2016.1158153

Timonen-Kallio, E., Pivoriene, J., Smith, M., & del Valle (2015). *On the borders between residential child care and mental health treatment in Europe*. Turku: Turku University of Applied Sciences.

Tregeagle, S. (2017). Weighing up the evidence and local experience of residential care. *Children Australia*, *42*(4), 240–247. https://doi.org/10.1017/cha.2017.36

Trout, A. L., Lambert, M. C., Epstein, M. H., Tyler, P., Thompson, R. W., Stewart, M., & Daly, D. L. (2013). Comparison of On the Way Home aftercare supports to traditional care following discharge from a residential setting: a pilot randomized controlled trial. Child Welfare, 92(3).

UN General Assembly. (24 February 2010). Guidelines for the Alternative Care of Children: resolution adopted by the General Assembly (A/RES/64/142). www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/64/142

Van den Steene, H., van West, D., & Glazemakers, I. (2018). Needs and preferences of parents of adolescents with multiple and complex needs in residential care. *Child and Family Social Work*, *23*(4), 693–700. https://doi.org/10.1111/cfs.12465.

Van Der Nagel, J. E. L., Tuts, K. P., Hoekstra, T., & Noorthoorn, E. O. (2009). Seclusion: the perspective of nurses. *International Journal of law and Psychiatry*, *32*(6), 408-412.

Verso Consulting. (2016). *Therapeutic Residential Care System Development: Evidence Guide*. Family & Community Services NSW.

Wharewera-Mika, J., Cooper, E., McKenna, B., Wiki, N., Field, T., Haitana, J., Toko, M., & Edwards, E. (2013). *Strategies to reduce the use of seclusion and restraint with tāngata whai ora.* Auckland, New Zealand: Te Pou o te Whakaaro Nui.

Whittaker, J.W, Del Valle, J.F., & Holmes, L. (Eds.). (2014). Therapeutic residential care with children and youth: Developing evidence-based international practice. London and Philadelphia: Jessica Kingsley Publishers.

Whittaker, J. K., Holmes, L., del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., ... & Courtney, M. (2016). Therapeutic residential care for children and youth: A consensus statement of the international work group on therapeutic residential care. *Residential Treatment for Children & Youth*, *33*(2), 89-106.

APPENDIX ONE:

Methodology for the evidence brief

Scope

The brief was completed in two stages. Stage one provided evidence in the following areas:

- Principles, common features and quality standards for therapeutic residential care
- Wellbeing outcomes for children in TRC
- Size of homes for TRC and duration of stay for children
- Features of therapeutic physical environment
- Placement decisions and mix of clients
- Effects of restraint and seclusion on children and staff and strategies for reducing the use of these practices
- Evidence of some models of TRC

Stage two included literature that addresses the following research areas related to Therapeutic Residential Care:

1. Safety management for young people, for staff/caregivers in group homes, and for the community (eg, (but not limited to) managing risks of housing tamariki with complex needs together; managing absconding in the absence of secure/restricted housing).
2. Best practice for dealing with acute mental health situations (including the interplay of relevant agencies).
3. Behaviour management approaches in group homes, particularly where seclusion and restraint are not available, including:
    a. alternatives for moving towards eliminating seclusion and restraint practices (eg, expansion on current evidence brief section that touches on the Six Core Strategies© to Prevent Conflict, Violence and the Use of Seclusion and Restraint model, and its implementation in NZ).
    b. workforce implications of eliminating seclusion and restraint.
    c. implementation considerations for eliminating seclusion and restraint.
4. How to best bring in services from external agencies such as Education, Primary health, Mental health.
5. Examples of effective inter-agency collaboration in the Therapeutic Residential Care context.
6. Indigenous models or approaches to Therapeutic Residential Care, including indigenous approaches to behaviour management and safety.
7. How to allow for, or include family/whānau participation (eg, Building Bridges Initiative).

For the purposes of the evidence brief, the following areas were considered out of scope:

- youth justice-related residences

- non-specialised residential care (eg, residential homes that do not provide complex or high-needs care)
- contracting/financial models for delivery of Therapeutic Residential Care services.

The search was limited to peer-reviewed articles published within the past five years (ie, since 2014), or grey literature from reputable sources (eg, government departments or prominent NGOs) from any time period, published in English.

Literature search for stage two

In total, information from 44 articles, reports or books was used to provide an overview of the evidence related to each key research question. The following databases were searched between 4 and 8 November 2019:

- Cochrane Library
- CINAHL
- ProQuest
- PsycINFO
- PubMed
- ScienceDirect
- Scopus
- Web of Science.

A search for grey literature was also conducted using Google Scholar, as well as targeted searches of The Hub (a research depository maintained by the Social Investment Agency) and GOV.UK (a research depository maintained by the UK government).

To conduct the search combinations of subject/index terms were used where appropriate, in combination with key words. All search terms used in the evidence brief search are provided in the table below.

Search term 1	Search term 2	Search term 3
Search One: Research areas one and two (safety management and acute crisis response)		
Therapeutic residential care	Safety manage*	
Institution* therapeutic intervention*	Risk manage*	
	Security	
	Behaviour/behavior manage*[5]	
	Crisis response	
	Acute mental health	
	Mental health manage*	

[5] Also applicable to Search Two

	Physical environment/features	
	Client mix	
	Abscond*	
Search Two: Research area three (behaviour management alternatives to seclusion and restraint)		
Therapeutic residential care	Seclusion	Alternative*
Institution* therapeutic intervention*	Restraint	Eliminat*
		Reduc*
		Remove
		Non-violent
		Therapeutic
		Safety
		Prevention
Search Three: Research areas four and five (inter-agency collaboration)		
Therapeutic residential care	External	Collaborat*
Institution* therapeutic intervention*	Agency	Cooperat*/co-operat*
	Department	Multi-*
	Service	Inter-*
	Government	Integrate
	Education	
	Health	
Search Four: Research area six (indigenous models)		
Therapeutic residential care	Indigenous	Model
Institution* therapeutic intervention*	Māori	Framework
	Pacific/Pasifika	Approach
	Aboriginal	Kaupapa
	First Nations	Provi*
	Native American	
Search Five: Research area seven (including family/whānau participation)		
Therapeutic residential care	Famil*	Inclu*
Institution* therapeutic intervention*	Whānau	Incorporat*
	Caregiver	Participat*
	Parent*	Communicat*
		Connect*

Searches were conducted using all possible combinations from each of the three columns, with the terms in the first column being used as subject/index terms.

The title and abstracts of initial returns were reviewed for relevance to the key research areas. The references used in articles or reports that passed this initial review, as well as lists of documents that had cited these articles or reports (generated by the databases searched), were also checked for any further relevant information sources.

From this first sweep, full text for all potential inclusions (61 documents) were reviewed for relevance to the key research areas. Further documents were excluded because they did not specifically address residential foster care (eg, they instead discussed care being provided by foster parents in private homes), or because they related to the post-care transition period. In total, 14 documents were excluded from the evidence brief after reviewing the full text.

This left a total of 47 articles, reports and books included in the final evidence brief.

Limitations

When considering the information provided in this evidence brief, it is important to recognise that, although the search of the literature was relatively detailed and extensive, it is likely that some research or reports that address the key research areas were not identified in the search (and therefore not included in this report).

Furthermore, the quality of each study or report was not formally assessed in the evidence brief. As a result, this report includes information from reviews that provided useful information but lacked some important components such as clear eligibility criteria, search strategies, study selection processes, and assessment of methodology and bias in individual studies. We have also included information sourced from individual studies, which may be more subject to bias than research that collates findings across several studies and analyses the results as a whole. It is important that the information presented in the evidence brief is therefore interpreted within this context.

Although a relatively large number of relevant articles were identified for this evidence brief, there were some important gaps in the literature. These included information on how to effectively facilitate inter-agency service delivery in TRC, indigenous models of TRC, and how to appropriately respond to acute mental health crises in TRC residences (ie, where prevention is no longer appropriate and direct intervention is required). It is recommended that more research is conducted in these areas to better understand these important aspects of TRC.

A final limitation of the evidence brief is that most of the evidence included has been sourced from outside New Zealand, primarily from Australia and the USA. Although the child welfare systems in these jurisdictions are broadly similar to New Zealand's, care needs to be taken when generalising the findings to the unique cultural and environmental context of New Zealand. In particular, no information was identified relating to TRC with Māori and Pasifika children and young people for the key research questions guiding the evidence brief. Further New Zealand-based research is required to identify whether the learnings and evidence found overseas are also applicable here. Also, the majority of the literature, particularly relating to trauma and mental health, was drawn from a western/clinical perspective on trauma and mental health. In New Zealand context, we need to consider te ao Māori conceptualisation of trauma and its effects, and the impacts of colonisation and intergenerational trauma on Māori, to avoid the risk of developing inappropriate support services.[6] Therefore the applicability of some of the recommendations around therapeutic approaches for dealing with trauma is limited.

[6] For further information about conceptualisation of trauma and healing in te ao Māori see "Historical trauma, healing and wellbeing in Maori communities" at www.teatawhai.maori.nz/images/downloads/He_Rau_Murimuri-Aroha_web.pdf#page=11.

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