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Therapeutic Residential Care System Development: Evidence Guide

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Context

Project Purpose

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

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

Project Objectives

The project objectives are to:

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

Definition of Therapeutic Care

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

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

Evidence Guide

Purpose

The initial purpose of this Evidence Guide is to assist potential funded services to demonstrate capacity to deliver the proposed model of therapeutic care. The Evidence Guide has been set out in such a way as to allow potential funded services (typically NGOs) to identify where and how their therapeutic practices align with the best practice Essential Elements. Where gaps exist, this tool should also assist NGOs to develop action plans and strategies to enhance their practice accordingly. There may be some cases where existing practice in a particular area may exceed the practice statements in this document.

It should be noted that the focus of this Evidence Guide is "therapeutic practice" – it is expected that the basic elements of good residential care are in place as per current program definitions and contractual requirements.

Additional demonstration of evidence is relevant post OOHC recommissioning. These future indicators are included in the following tables, but are greyed out. They are included to inform potential funded services of the level of detail required for ongoing self/peer assessment.

Structure

This Evidence Guide aligns the Essential Elements of therapeutic residential care and NSW Core Therapeutic Care Principles, provides a description that defines each Essential Element and outlines possible sources of evidence to demonstrate the presence of the respective Essential Elements in a service model.

Case vignettes illustrating best practice examples are provided as an Appendix. These are intended to be indicative, and are not exhaustive.

Essential Elements

Internationally, two key studies inform understanding of the "in program" effect of therapeutic residential care:

- Therapeutic approaches to social work in residential child care settings (Northern Ireland)[1]
- Evaluation of the Therapeutic Residential Care Pilot Programs (Victoria)[2]

These studies both examined therapeutic residential care programs informed by a range of theoretical approaches (five programs in Northern Ireland, twelve in Victoria). The Northern Ireland study "…highlighted a number of similarities across the models in terms of core concepts and essential skills. Apart from the differences in language, there were more similarities than differences…"[3], while the scope and methodology of the Victorian evaluation enabled further

[1] Macdonald G, Millen S, et al (2012), Therapeutic approaches to social work in residential child care settings, Social Care Institute for Excellence, London, available at http://socialwelfare.bl.uk/subject-areas/services-client-groups/children-young-people/scie/133315report58.pdf, accessed 22/6/16

[2] Faircloth D, Brann P, et al (2011), Evaluation of the Therapeutic Residential Care Pilot Programs, Department of Human Services, Melbourne, available at http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/712868/therapeutic-residential-care-report.pdf, accessed 22/6/16

[3] Macdonald G, Millen S, et al (2012), Therapeutic approaches to social work in residential child care settings, Social Care Institute for Excellence, London, p 55

investigation and confirmation that "There is one model of therapeutic residential care" and "Staff training in the theory and practice of working therapeutically is a program priority."[4]

Each of the Essential Elements identified in the Victorian report are referenced (implicitly or explicitly) in the Northern Ireland study. The authors of the Victorian evaluation, in their further work in the field of therapeutic residential care, have identified an additional Essential Element (Governance and Therapeutic Practice Improvement), and have clarified the definition of several others. This reflects a growing knowledge and understanding of therapeutic care as it is deployed in diverse settings and jurisdictions.

The Essential Elements as outlined in this Evidence Guide are:

Table 1: Essential Elements

Essential Elements of Therapeutic Residential Care	
• Therapeutic Specialist	• Reflective Practice
• Trained Staff and Consistent Rostering	• Organisational Congruence and Commitment
• Engagement and Participation of Young People	• Physical Environment
• Client Mix	• Transition Planning, Exit planning and Post Exit Support
• Care Team Meetings	• Governance and Therapeutic Practice Improvement

Core Therapeutic Care Principles

NSW residential care providers have recently developed an Out of Home Care Therapeutic Framework in conjunction with FACS and ACWA. This work has included articulation of a core set of Therapeutic Care principles:

Table 2: NSW Core Therapeutic Care Principles

Ref	Therapeutic Care Principles
Children and young people focused	
1	Children and young people will be active participants in the development of their care and case plans be integrated with all. These plans should be in-depth assessments that are trauma-informed and respond to complex needs.
2	Entering and exiting from a Therapeutic Care program needs to be planned and based on appropriate assessments of children and young people, taking into account their own views and preferences.
3	In residential care, the mix of children and young people in a service maximises the opportunity to address shared client needs.
4	Children and young people should be encouraged to engage with their family, and maintain social, community, and cultural connections. This is a particular priority for Aboriginal children.
5	Therapeutic care should address aspects of the child or young person's life including community, education, recreation and health.
Environment	

[4] Faircloth D, Brann P, et al (2011), Evaluation of the Therapeutic Residential Care Pilot Programs, Department of Human Services, Victoria, Melbourne, p 5

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6	The physical environment provided must be safe, nurturing, and predictable to enable effective reparative care.
7	Care teams should aim to create a "homelike" environment, which creates positive, healing relationships and experiences.
Organisations	
8	Organisations should have a clearly articulated statement that outlines the values and culture behind their Therapeutic Care program, informed by relevant trauma and attachment theories. This statement should be understood and agreed to throughout the organisation.
9	All care team members should have relevant experience and qualifications, or be working toward those relevant qualifications. They should also receive therapeutic training that addresses the rationale and therapeutic underpinning of practice.
10	Therapeutic Foster Carers should be trained, supported and assessed to ensure their capacity for providing a consistent, healing response to children and young people.[5]
11	Therapeutic Specialists will support staff and carers in providing a safe, healing environment for children and young people.
12	For residential care, appropriate staff-to-child ratios coupled with consistent rostering of staff should be used to create a stable environment for children and young people.
System	
13	A shared understanding of Therapeutic Care helps organisations and their external stakeholders to act congruently and with a shared purpose.
14	Congruent action should also be taken across agencies and government bodies – such as child protection, health, and education – to provide children and young people with an integrated response to their needs.
15	A good system requires robust central-level and district-level governance. The roles and responsibilities of all stakeholders, including government, should be clearly articulated and understood to enable agencies to fulfil program requirements.
16	Outcomes for children and young people need to be measured and evaluated.

The following Evidence Guide table identifies the significant alignment between the NSW Therapeutic Principles and the Essential Elements which form the framework of the Evidence Guide.

[5] In the context of this Evidence Guide, this Principle has been extended to include Therapeutic Residential Care workers

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
Therapeutic Specialist [5, 10, 11, 16]	The Therapeutic Specialist role is an essential, funded element of Therapeutic Residential Care. It is significant that the importance of this role is described not only in relation to specialist knowledge, but equally in terms of the quality of their relationships with staff, clients, families and interfacing agencies and organisations. The Therapeutic Specialist will not generally work directly (clinically) with the child or young person, but rather will have a focus on equipping and supporting staff in their caring role, including facilitating Reflective Practice sessions, and collating and reviewing outcomes measures. The Therapeutic Specialist provides an important contribution to assessing appropriate placements, and considering the optimal client mix in each unit to best support maintenance of a safe, healing environment for all residents. Therapeutic Specialists carry a primary responsibility for developing Treatment Plans and informing Care Plans, and where required facilitating other targeted plans such as Behaviour Management Plans and Medication Plans. Community of Practice Evidence suggests that Therapeutic Specialists from a range of disciplines or with multiple qualifications will enhance therapeutic capability. Development of a Therapeutic Community of Practice will maintain consistent and continuous improvement of Therapeutic Specialist practice. This Community of Practice would jointly be the holders and developers of the 'knowledge of therapeutic care' and of the definition of what constitutes 'therapeutic care', and it is anticipated that the membership will include a range of disciplines. The Community of Practice would manage professional development, supervision and registration of Therapeutic Specialists in NSW.	• Consistent engagement of a registered Therapeutic Specialist as part of therapeutic care program team • Documented and distinct professional/clinical and management supervision structures for Therapeutic Specialist • Therapeutic Specialist developing Treatment Plans for young people in care and facilitating development of other plans • Therapeutic Specialists linking and referring young people to other services including Health, Education, Mental Health, Behavioural Management specialists consistent with Treatment and other plans • Therapeutic Specialist/s contributing to placement decisions as part of Client Mix panel (see below) • Therapeutic Specialist utilising staff observations and reflections to collate, report and analyse Outcomes Measures relating to young people • Therapeutic Specialist supporting staff to consistently provide practice responses that have been developed to bring healing or to mitigate behaviours that are damaging to the young person and/or others • Therapeutic Specialist supporting staff to problem solve through continual (daily) Reflective Practice enabling development of alternate approaches to achieve desired outcomes • Therapeutic Specialist supporting staff to reflect on the progress the young person is making, and the need for new approaches to be adopted and the development of agreed practices • Therapeutic Specialist supporting staff to self-manage (including the tendency to respond in a punitive manner under

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
		pressure, vicarious trauma and/or become reactive to their own history) so they can remain consistent in their application of responses that have been developed to bring healing or to mitigate behaviours that are damaging to the young person and/or others • Therapeutic Specialist supporting staff to respond to crisis situations (incidents) in relation to the young person and to reflect on the triggers and other dynamics associated with the incident
Trained Staff and Consistent Rostering [6, 7, 8, 9, 10, 12]	Training for staff working in Therapeutic Residential Care comprises two equally important strands: • Training in the theoretical principles of Therapeutic Care • Training in competency based requirements, including cultural competency These strands are supported by annual refresher training in the theoretical underpinning of Therapeutic Care as well as ongoing professional development, both in terms of the theoretical base and skill/competency components of the role. Consistent staffing and team members are core features of Therapeutic Care that provide the predictability and stability that residents require. Tactics that enable NGOs to provide the predictability required to achieve the desired outcomes include : • rostering a mix of part-time and full-time team members • including NGO case managers in weekly staff roster to facilitate good connection and understanding of residents' changing needs • rostering at appropriate staffing levels (ratios) to respond to care and treatment plan goals of all residents, including accommodating 1:1 care needs • maintaining a bank of skilled and trained staff (known to residents) who can backfill planned and unplanned absences • managing handovers in a manner that increases communication and reduces associated	• Mandatory sector-wide training course based in theoretical principles of Therapeutic Care • NGO prescribed training in therapeutic practice, consistent with theoretical base adopted • Completion of (or progression toward) relevant competency based training, including cultural competency, by all residential care workers • Completion of mandatory sector-wide training course based in theoretical principles of Therapeutic Care by all residential care workers • Annual refresher training in theoretical principles of Therapeutic Care • Documented supervision and support processes for residential care workers • Ongoing theory and competency based professional development • Reduced staff turnover • Consistent rostering – same staff on same shifts • Inclusion of NGO case managers on weekly rosters

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
	stress • managing handovers in a manner that enables reflections from the shift to be captured and facilitates the documentation of information about each young person. Consistent staff and rostering will also facilitate development of predictable and reliable daily routines and planned activities.	• Adequate staffing levels (ratios) to support care and treatment plans goals of all residents • Adequate trained staff levels to backfill leave and other absences • An absence of untrained and unknown staff, including staff employed on a casual basis being rostered (agency/brokered) • Consistent daily/weekly routines and activities and meet the needs of young people as individuals and foster positive peer relationships • Consistent handover notes/records
Engagement and Participation of the Young People [1, 2]	When a child or young person comes into care, an initial assessment will be undertaken, and the child or young person will then be referred to an NGO, identified as providing a service that best matches the assessed needs of the young person. On receiving the referral, staff will review the provided history and assessments, and engage with the young person to explore their expectations regarding Therapeutic Residential Care. The discussion may reflect on the young person's goals and how they may benefit from being in the unit. The discussion may include supporting the young person to imagine what it would be like to live in the therapeutic unit. Children and young people already resident in the Therapeutic Residential Care units will be engaged in democratic processes regarding 'their home'. This will often be in the form of a community meeting. These meetings assist in developing pro-social behaviours and also provide a forum to develop and maintain consistent boundaries, to help name feelings and to underline the availability of help and support. Participation in community meetings and other democratic processes related to everyday life (potentially including Care Team meetings) are a characteristic of Therapeutic Residential Care. Children and young people are also engaged in developing and implement their own Care and Treatment Plans, including Exit and Post Exit Plans.	• Engaging with the young person prior to their entry to the unit to understand/frame their expectations • Engaging with existing residents prior to new young person entering to understand/frame their expectations • Supporting both the new and existing young people to prepare for the transition, and through the transition • Engaging young people in developing and implementing their own Care and Treatment Plans • Engaging young people in discussions and decisions relating to everyday life • Evidence of young people participating in house/community meetings • Engaging young people in developing and implementing their own Exit and Post Exit Plans
Client Mix	The objective of client group matching is to create a mix that maximises the opportunities for all young people (current residents and the new young person) to benefit from the	• Evidence of NGO ability to be responsive to Intensive Interim Care referrals, and adhere to agreed/contracted timeframes

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
[3, 7, 14, 15]	Therapeutic Approach, informed by the needs of the young people. Consideration of Client Mix requires a well-developed process, and participation of key staff who bring knowledge and understanding of the young people already resident (including their vulnerabilities and triggers). The introduction of Intensive Interim Care units will create opportunity for the care and treatment needs of children/young people entering residential care to be more fully assessed and understood. Establishing a Client Mix panel, comprising the Therapeutic Specialist, House Manager/Team Leader, Program Manager and in some cases other key workers will ensure a consistent approach to placing children and young people across the NGO's units or other appropriate alternative (including other providers).	• Evidence of planned transitions of young people out of Intensive Interim Care unit within 13 weeks • Evidence of effective protocols and links with other providers to offer the most appropriate type of care for children and young people (including transition to less intensive placements) • An established Client Mix panel that is convened to consider children/young people and their potential fit with existing residents • A documented process to consider placements and Client Mix, including best interests of existing residents • Reflective processes to review decisions and enhance operation of Client Mix panel
Care Team Meetings [7, 11, 13, 14]	Care Team Meetings are facilitated on a regular basis (one to four weeks) with contributions being made to the individual cases of young people by relevant stakeholders. The review process for each young person may take between half an hour and an hour depending on the complexity of the young person's background and current issues. Stakeholders involved in these meetings may include: • Therapeutic Specialist • House Manager/Team Leader • Internal (NGO) Case Manager • Child Protection Case Manager • Teacher/education support • Parent/Family • Drug and Alcohol worker • Mental Health Support Worker • Police • Young Person It should be recognised that the needs of the child or young person will change over time, and therefore the composition of the Care Team will change accordingly.	• Regular Care Team meetings (at least monthly) • Considered construction of Care Team (see adjacent sample list) • Regular review (at least annually) of Care Team composition • Constructive engagement with members of each young person's broader Care Team – between Care Team meetings if required • Evidence of improved outcomes for each young person
Reflective Practice	Reflective Practice is a process by which Therapeutic Residential Care staff develop their skills and practices through becoming aware of their actions and responses, and their	• Regular Reflective Practice meetings (at least fortnightly)

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
[8, 10, 11, 16]	impact on the young people while they are working (practicing). Staff also reflect on the young people's actions, interactions and triggers within a framework that attributes meaning to the young person's behaviour. Within this practice framework, staff take dedicated time to evaluate their observations/learnings by talking and asking their colleagues and the Therapeutic Specialist to contribute to their observations and reflections. Staff are coached and supported to develop this approach as a consistent practice and way of thinking; participating in team meetings is central to this process. Other team members participate in these meetings through Reflective Practice thus creating an environment where day to day reflective practice thrives. In Reflective Practice meetings, the Therapeutic Specialist uses their expertise to create an egalitarian and an informed learning environment that reinforces the value of each team member's reflections and contribution. In this way what is learnt through practice is strengthened and reinforced and new ideas can be proposed for the benefit of the individual staff member, the team as a whole, the young person and the residents as whole. It is important to note that Reflective Practice should be given its own regular planned time and be differentiated from other team/staff meetings. Staff use the Reflective Practice meeting and its processes to reflect on questions provided through daily observations and information collected through previous Reflective Practice meetings to aid their understanding of the young person's progress and to accurately determine what interventions are effective and those that are not. The data also provides insights into the symptom severity of the young person at the centre of the Reflective Practice meeting, which in turn informs Outcome Measure reporting, analysis and subsequent practice refinement.	• Primarily focus on one child/young person per Reflective Practice session • Evidence of data collection and analysis • Therapeutic Specialist prepared summary of current and longitudinal information and Outcome Measures on focus child/young person • Reflective discussion facilitated by Therapeutic Specialist • Reflective Practice meetings informing collation of Outcome Measures for young people
Organisational Congruence and Commitment [4, 5, 7, 8, 10, 11, 12, 13, 16]	Organisational congruence and commitment to a therapeutic approach - from care worker through to board member - provides a range of wider benefits. While these benefits go "beyond" the wellbeing of the children and young people in care, they materially contribute to wellbeing, through stability and consistency. Reported benefits of organisational congruence include: • A higher level of staff satisfaction – staff feel empowered to operate in a therapeutic	• Evidence of organisational Therapeutic Statement • High level of job satisfaction among Therapeutic Care Program staff demonstrated by reduced turnover • Evidence of management and board active support for therapeutic approach • Inclusion of organisational therapeutic statement in all position

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
	mode and are confident that they have management support • Strong relationships with external stakeholders/agencies are fostered through deliberate, consistent and constructive engagement at all levels (management, Therapeutic Specialist, staff) • Positive and collaborative relationships with District FACS (Placement & Support, and Child Protection)	descriptions • Inclusion of organisational therapeutic statement and approach in induction and orientation processes for all staff and board members – not only those directly involved in the Therapeutic Care Program • Inclusion of outcomes and risk analysis in management and board standard reports • Active and constructive engagement with interfacing agencies and organisations in relation to creating a consistently therapeutic environment for young people
Physical Environment [6, 7]	Identification of "physical environment" as an essential element goes beyond the limitations of the facility, and more broadly encompasses how the young people experience the physical environment. Characteristics that facilitate positive experience of the physical environment include: • Purpose built/adapted premises that allow for private spaces • Space for indoor recreation activities • Design that assists in 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 • A place where staff can observe, neither intruding nor being isolated The physical environment and the physical arrangements contribute significantly to the creation of a home-like environment that provides a sense of normality and ensures physical and emotional safety.	• A safe physical environment • A "home-like" environment • Client's own personalised space • At least two indoor shared recreational spaces • A place where staff can observe, neither intruding nor being isolated
Transition Planning, Exit Planning and	There are different approaches and circumstances that drive the timeframe for transitioning out of a Therapeutic Residential Care program – whether to an alternate care type, family	• Early commencement and implementation of Transition/ Exit Planning to manage related anxiety

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
Post Exit Support [2, 14, 15]	restoration or exiting care. In any of these scenarios, a plan to exit Therapeutic Residential Care should be developed in collaboration with the child or young person. Of particular importance is consideration of the ongoing impact of historical trauma and poor attachment and the healing role played by strong relationships with residential carers. While these relationships are not familial, for many of the young people they are the only stable and trusting relationship that they have ever had with an adult. Specifically in relation to exiting care, the impact of exiting into an environment without supports and the absence of attached relationships is cause for careful Exit and Post Exit planning. It should also be noted that age is not always a good indicator for Exit Planning as chronological age may not be an indicator of emotional age.	• Engagement of young person in developing their Transition, Exit and Post Exit Plans • Post Exit support (formal or informal) including transition to other programs

Governance and Quality Therapeutic Practice
 	
[6, 13, 14, 15, 16]
	Therapeutic Residential Care programs sit within a complex array of statutory and contractual responsibilities, as well as practice and philosophical alignment to a therapeutic approach.
	
	Structures around governance and ongoing therapeutic practice improvement are required to maintain consistent practice and congruence between NGOs and all aspects of interaction with FACS and other interfacing agencies (eg Health, Justice, Education and others related to care and treatment plans).
	
	Governance sessions should be characterised by a Reflective approach.
		• Active program support from FACS Placement & Support and Child Protection
		
		• NGO willingness to actively participate in regular Governance and Quality Practice sessions (at least six monthly)
		
		• Active engagement of relevant interfacing agencies to participate in Governance and Therapeutic Practice Improvement sessions (at least six monthly)
		
		• Regular self-assessment against this Evidence Guide (at least six monthly)
		
		• Adherence to statutory and contract requirements, including maintaining OCG accreditation and Outcome Measurement processes
		
		• Outcome Measurement collected and reviewed to inform:
		  ◦ outcomes for children and young people
		  ◦ organisational performance

Essential Element [Corresponding TC Principles]	Descriptions	Possible Sources for Evidence of Achievement: There is evidence of…
		• benchmarking • measuring program effect

Appendix 1: Case Vignettes

The following case vignettes provide practical examples of the application of therapeutically informed care principles in residential care settings.

Rory

Rory is a twelve year old boy who was placed in residential care after his foster care placement ended.

Rory has been diagnosed with multiple and complex needs and the initial referral indicated a diagnosis of autism spectrum disorder and challenging behaviours including aggression and self-harm. He has very poor sleep patterns and difficulty forming relationships. He has limited, sporadic contact with his mother and with Ben, his younger brother, placed in a foster care placement in a nearby town.

With the assistance of the therapeutic care specialist a comprehensive assessment and treatment plan was developed based on Rory's developmental age and his trauma history. Psychological tools (HoNOSCA and Brann Likert scales) were used to inform the initial assessment through daily observations of Rory's behaviour and affect and continue in daily use throughout the placement.

All members of the care team met on several occasions to discuss the results from the psychological tools, the rationale for the plan, and to agree on the need for all care team members to commit to implementing the plan through consistent responses to Rory.

Professional development opportunities were made available to the care team in relation to working with young people with autism spectrum disorder

Members of the care team were able to integrate the recommendations of the treatment plan. For example, carers worked on Rory's aggression and self-harm by designing a range of positive activities for him to participate in. He had shown some interest in fishing and through a local community contact a staff member regularly accompanied Rory to local fishing club outings at a nearby lake.

Care team staff attempted to regularise Rory's contact with his mother, however this proved difficult due to her own trauma history. It was, however, possible to set up a regular pattern of contact with Rory's younger brother Ben, who now also participates in the fishing activities.

Three months into the placement, daily observations of his care team (entered electronically into his care file) demonstrate Rory is showing positive improvements in his behaviours, self-regulation and sleep patterns. The incidence of aggression and self-harm has significantly reduced. He has a much more established sleep pattern and this has assisted his capacity to self-regulate and form relationships. Rory has very positive relationships with members of his care team (psychologist, case manager, carers) as well as with his peers within the care setting.

His care team has worked from a shared understanding of Rory's needs and his goals, and integration of validated psychological tools into the daily care work has enhanced Rory's treatment and care. Reports across various outcome domains continue to provide good evidence of Rory's progress and improvement.

Juliet

Juliet is a 15 year old girl who has been in out of home care since the age of 11. She has experienced multiple foster care placements and recently was placed in a therapeutic residential care setting. Juliet was admitted to care due to a long history of sexual abuse by her mother's partner (her step father). Her biological father was killed in a road accident soon after her birth.

Juliet has been rejected by her mother and has no current connections with her family. She exhibits many characteristics of serious trauma including self-harm, suicide ideation, eating disorder, poor sleep patterns, poor school attendance, frequent running away and is highly susceptible to older male peer group pressure. It is suspected that Juliet has sex worked in recent times.

Upon admission to the therapeutic residential care setting a comprehensive assessment was undertaken. The care team considered that many of Juliet's behaviours could be traced back to unresolved issues prior to sexual abuse and rejection by her mother. For several years Juliet has refused to receive counselling about these matters.

One female team member had developed a good relationship with Juliet and the treatment plan included a strong focus on building up this relationship through a range of activities that Juliet had shown interest in including photography and art. The staff member

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met on a number of occasions with a local art therapist to discuss and plan her work with Juliet. Some two months later Juliet agreed to participate in some art therapy sessions with the local art therapist. Through these sessions Juliet was able to put in pictures her sadness and anger about what had happened to her.

Attendance at the art therapy sessions coincided with a slow but gradual improvement in Juliet's wellbeing and behaviour. Some risk taking behaviour has continued but at a much lower frequency.

Through the art therapy Juliet has revealed a wish to try to establish contact with the paternal side of her family and the care team is now seeking out further information through the department.

The care team continue to monitor Juliet's progress carefully and recognise she is very early in her recovery from a deeply traumatic past. Application of psychological instruments show that Juliet is exhibiting improvements across a number of domains.

Appendix 2: Local Governance and Quality Practice Session Checklist

The following checklist provides an outline for local governance and quality practice sessions. These sessions should be characterised by a Reflective approach.

Item	Yes	No	Don't Know
Organisational Level			
Have contractual requirements been met?			
Has a self-assessment against the Therapeutic Residential Care Evidence Guide been undertaken by each organisation?			
Have action plans been developed to address identified evidence/practice gaps?			
Have previous action plans been implemented/completed?			
Do outcome measure reports indicate improved outcomes for children/young people at house/unit level?			
Do outcome measure reports indicate improved outcomes for children/young people at organisation level?			
District Level			
Do outcome measure reports indicate improved outcomes for children/young people at District level?			
Has constructive communication been maintained with/between interfacing agencies?			
What is the average length of time in Intensive Interim Care for current children/young people?			
What is the maximum length of time in Intensive Interim Care for current children/young people?			
What are current gaps/barriers to congruent system responses to children/young people in residential care?			
Have joint action plans been developed to address identified gaps/barriers?			
Have previous action plans been implemented/completed?			

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