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Submission to the

**Queensland Child Safety  
Commission of Inquiry**

**A Submission on Therapeutic Care Systems, Model  
Fidelity, and System-Wide Alignment in Residential  
Care & Child Protection**

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# Queensland Commission of Inquiry

## Residential Care & Child Protection

*A Submission on Therapeutic Care Systems, Model Fidelity, and System-Wide Alignment*

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## About the Authors: Adela Holmes & Simon Benjamin

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The authors of this submission have worked across the social services sector for 24 years and 50+ years respectively

**Simon Benjamin** brings 24 years of experience across out-of-home care, disability, and mental health — having worked as both a residential carer before progressing through management, directorship, and five years as a CEO within a Victorian community service organisation. He co-designed Victoria's system reform process from 2016 to 2021 and has four years' experience at an internationally recognised therapeutic residential care setting in the UK with over 70 years of practice heritage. He co-authored a model of foster care now funded in Victoria, has written and delivered residential care training, and contributed to the update of Queensland's Hope and Healing residential care training framework. Simon has also been a foster carer in Victoria.

**Adela Holmes** brings five decades of experience spanning direct care, frontline child protection, and senior management — including eleven years managing a large intake and response unit in Victoria's Northern Metropolitan child protection office. In the late 1990s she became an early adopter of complex trauma and neurobiological frameworks, going on to design and successfully tender for *Take Two*, Victoria's specialised trauma-informed clinical outreach service, in 2002/3. She subsequently researched and designed a pilot therapeutic residential care model for the Victorian Department of Human Services, becoming its founding manager when it opened in June 2007. Much of her expertise in trauma-grounded therapeutic care practice has been forged directly from that experience.

This breadth of experience has included direct engagement with government officers, team managers, area directors, deputy secretaries, and chief practitioners. The authors have also participated in government-led reform processes in Victoria.

The observations contained in this submission draw on the direct experience of both Ms Holmes & Mr Benjamin, including, in Mr Benjamin's case 11 years in two therapeutic care organisations in the United Kingdom and Victoria that successfully implemented genuine therapeutic care models with supporting evidence. These observations are supported by, and consistent with, the available evidence base.

The authors are willing and available to appear in person before the Commission to expand upon the content of this submission. It is the authors' firm view that there are workable, evidence-informed solutions that Queensland can adopt, and that these should be reflected in the Commission's final report.

## Executive Summary

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Residential care in Queensland, and across Australia, frequently fails to deliver the therapeutic care that children with complex trauma histories require. This is not primarily a failure of intent — the people working in this system generally care deeply about the children they serve. It is a failure of system design, definition, resourcing, and rigour.

**The central argument of this submission is this:** therapeutic care only works when every part of the system — from the frontline care worker to the government department — is

aligned to a clearly defined model of care, trained in that model, and held accountable to it. When any part of the system falls out of alignment, therapeutic intent is eroded, and children are harmed — often by the very system meant to help them.

This submission sets out:

- What therapeutic care is, and why it is difficult to define and deliver
- The essential elements of an effective therapeutic care system
- Why whole-of-system alignment and model fidelity are critical
- Practical recommendations for Queensland

## 1. The Nature of the Task: Treating Wounds You Cannot See

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To understand why residential care (and the child safety system more broadly) so often underperforms, it is necessary to understand the nature of the task. Children in residential care have almost universally experienced significant complex trauma. The wounds they carry are of neurobiological developmental compromise resulting in age/stage functional disturbances that become emotionally and psychologically symptomatic in the child's presentation. This distinction has profound consequences for how the care system must be designed and resourced.

These understandings are relatively recent in scientific terms with the largest contributions to our knowledge base coming from the research of neuropsychiatrists such as Dr Bruce Perry, psychiatrist and traumatologist Dr John Briere and trauma specialist psychiatrist Dr Bessel van der Kolk. Knowledge of their findings burgeoned in Victoria during the 1990's. A report tabled in 1999 ('When Care is not Enough' Clarke, Morton & Pead) brought this knowledge to the attention of the Victorian government. The report had been commissioned in response to concerns raised by the Victorian Children's Court magistrates regarding the continuous presentation of children before them in relation to multiple minor offences (property damage) within residential care settings following the outsourcing of residential care facilities to the Community Service sector after the deinstitutionalisation of the then Social Welfare Department's children's residential care facilities.

### 1.1 The invisible wound

When a child presents with a broken leg, the nature of the injury is immediately visible. The required intervention is understood, protocols exist, trained practitioners follow them, and progress can be measured. The system is designed around the wound.

Childhood complex trauma does not present this way and unfortunately our care systems are not designed to meet the need. A caseworker, for example, can visit a child in residential care, observe that the child "looks fine," and leave without recognising the depth of the neurobiologically based psychological and emotional injury present. The 'wound' is invisible — but it is no less real, no less damaging, and no less in need of skilled, intentional treatment.

This invisibility is one of the primary reasons residential care is chronically under-resourced and under-theorised. **Decision-makers who cannot see the wound tend to underestimate the complexity of the task.** Children are placed in homes with staff who may receive as little as ten hours of initial training. Physical needs are met; trauma-related symptoms are not understood for what they represent. The high rates of children going missing from placements are, in part, evidence of this failure: children do not feel relationally or emotionally connected to the homes meant to care for them.



Figure 1: The physical wound is visible and understood; the emotional wound is invisible — yet no less real and no less in need of skilled, intentional treatment.

## 1.2 How trauma manifests

Childhood complex trauma shapes the organisation of neural pathways and causes children to develop unconscious adaptive responses that help them survive their traumatic circumstances. These adaptations — hyperarousal, hyper-vigilance, psychological and emotional dysregulation, aggression, withdrawal, difficulties with trust — are rational responses to irrational situations. But when the child is removed from the traumatic environment and placed in care, because of the neurobiological element, these adaptations persist and impair their ability to form relationships, engage with education, and function in daily life.

As van der Kolk (2014) observes in *The Body Keeps the Score*, traumatic experiences are encoded not just in cognition but in the body and nervous system. Recovery requires not merely cognitive understanding but repeated experiences of safety, attunement, and relational repair.

This has direct implications for residential care **and the child safety service system more broadly**. Healing does not occur through housing alone, or through meeting physical needs. It occurs through consistent, safe, attuned relationships with adults who understand complex trauma, who can tolerate and respond to challenging symptomatic presentation without retraumatising the child, and who remain present over time.

*“Residential care is a specialised area of work, with a strong focus on developing relationships with traumatised children and young people. It is through these relationships that healing from trauma begins.”*

— Hope & Healing Framework

### 1.3 Defining therapeutic care

The term “therapeutic care” is widely used but inconsistently understood. Many organisations describe themselves as “trauma-informed” or “therapeutic” without demonstrating it in their practice or their outcomes. This ambiguity undermines the term and contributes to systemic misunderstanding.

For the purposes of this submission, therapeutic care is defined as follows:

#### Definition: Therapeutic Care

- **Therapeutic care is intentional, relationally delivered care that promotes healing in children who have experienced complex trauma.**

Dr Bruce Perry’s definition of complex trauma is that it “provides the organising environment” for the brain. This would be the case for all children who cross the legislative thresholds to be placed in long term out of home care by the Children’s Court.

- **Intentional:** care is planned, rigorous, and consistent across all staff in the therapeutic *milieu* and all levels of the authorising organisation.
- **Relational:** healing occurs through sustained, safe, attuned relationships between the child and trained care workers who are able to respond to the underlying causal factors of symptomatic presentation in a way that does not reinforce them but gently and repetitively promotes a safe care environment where they are no longer necessary. This in turn, allows neural pathways to reshape and areas of functional brain development to alter towards less compromised operation. The process is slow to begin but once underway moves from ‘strength to strength’ as growing capacity opens the way for increasingly higher stage brain function.
- **Healing:** through the repetitive experience of functionally appropriate care neurobiological compromises are addressed and development can proceed beyond them. The goal is that the child develops a greater capacity to cognitively understand the impact of their traumatic experiences and respond to the world in healthier ways.

Healing, in this context, does not necessarily mean the complete resolution of complex trauma before a child leaves care. It means the child has begun a journey: they have experienced safe relationships, developed some capacity for trust, and have a better understanding of themselves and their history. This foundation can be built upon throughout their life.

## 2. Elements of Effective Therapeutic Care

The authors have observed, over two decades across multiple organisations and jurisdictions, that effective therapeutic care is not accidental. It is the product of deliberate design, sustained investment, and rigorous adherence to a clear model. Below are the essential elements that are manifest in numerous models of care in various jurisdictions, both in Australia and overseas.

Critically, these elements must be present not just within the care home, but across the entire organisation — and ideally across the entire care (child safety) system. **When parts**

**of the system fall out of alignment, they undermine the therapeutic work occurring at the frontline, often without those responsible understanding why.**

## **2.1 A clearly defined care task**

Organisations that deliver effective therapeutic care have a clear, shared understanding of what they are trying to achieve and the manner in which this is undertaken. They can articulate what therapeutic care is, what healing looks like for the children they serve, and how their approach achieves it.

This sounds straightforward. In practice, it is rare. Many organisations operate with vague aspirations toward “wellbeing” or “good outcomes” without defining what these mean in terms of daily practice. Without a clear definition of the task, it is impossible to train staff toward it, measure progress, or hold the organisation accountable.

## **2.2 Whole-of-organisation alignment**

The care task cannot be confined to the care home and the workers who directly support children. Every person in the organisation — from the receptionist to the maintenance worker, from the HR manager to the CEO — plays a role in either supporting or undermining the therapeutic environment.

This is not merely symbolic. **When a senior manager makes a placement decision that disrupts a child’s established relationships without therapeutic justification, they undermine months of careful work.** When an HR process treats care workers as interchangeable, it signals that the relational continuity so critical to healing is neither understood nor valued. When a funding model incentivises occupancy over outcomes, it creates structural pressure against good therapeutic practice.

Organisations that succeed in therapeutic care have recognised this. As Patrick Lencioni (2012) and others have argued in the broader organisational literature (largely targeted to the corporate world), strategic alignment — where every part of the organisation understands and works toward the same goal — is a prerequisite for organisational effectiveness. **In therapeutic care organisations, the stakes of misalignment are not just commercial: they are measured in further harm to already-traumatised children.**

The following question provides a useful diagnostic: if you asked a receptionist, a care worker, a manager, and the CEO of a residential care organisation what therapeutic care means and how the organisation delivers it, would you receive the same answer? In organisations that deliver genuine therapeutic care, the answer is yes. In most others, it is not.



Therapeutic outcomes require alignment at every level:  
from government policy to the frontline care worker.  
A gap at any level erodes the whole.

Figure 3: Therapeutic outcomes require alignment at every level — from government policy to the frontline care worker. A gap at any level erodes the whole.

## 2.3 Clearly articulated policies, procedures and practice frameworks

Healing from trauma is not a linear process. Children present differently on different days; their behaviour is often unpredictable; what works with one child may not work with another. In this environment, the risk of care workers defaulting to untrained instincts — or to the parenting approaches of their own upbringing — is high.

Effective therapeutic care organisations address this through clearly articulated, evidence-based practice policies and frameworks that translate therapeutic principles into practical guidance for daily interactions. This includes guidance on how to respond to challenging behaviour, how to structure daily routines, how to engage children around difficult topics, and how to maintain boundaries while preserving the relationship.

These frameworks are not intended to be rigid scripts. They are intended to give workers a shared understanding of the principles at stake and a common language for reflecting on their practice. Without them, the quality of care varies dramatically from worker to worker and shift to shift — and the consistency that is so essential to a child's sense of safety is lost.

## 2.4 Ongoing training at all levels

One-off induction training is not sufficient to inform the provision of therapeutic care. **The research on the transfer of learning into practice is unambiguous: without reinforcement, reflection, and application, the impact of training dissipates rapidly.** A care worker who receives ten hours of trauma training at the start of their employment and nothing thereafter will not be able to deliver therapeutic care to a level that has the capacity to effectively heal children in their care from complex trauma.

Currently in Queensland, the only requirement for residential care staff is to complete the Hope and Healing training which is approximately 10 hours to complete. While this training is of a good standard, it alone will not equip the worker for the task of bringing relational healing to children who have experienced complex trauma.

Effective training in therapeutic care has the following characteristics:

- It is ongoing, not one-off. Training is embedded in the rhythm of the organisation throughout a worker's tenure.
- It continuously connects theory to practice. Workers discuss real interactions with real children, deepening their understanding of how trauma manifests and how their responses can promote, support or hinder healing.
- It is available at all levels. Administrators, managers, and senior leaders receive training alongside frontline workers — not the same training, but training calibrated to their role's impact on therapeutic outcomes.
- It is delivered by clinically experienced and complex trauma informed practitioners who can help workers understand the child's inner world and the nature and impact of their complex trauma experience.
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The analogy with medical training is instructive. **A doctor's training does not conclude with medical school.** Residency, continuing professional development, peer review, and clinical supervision are built into the profession because the complexity of the work demands ongoing learning. Residential care workers are doing work of comparable complexity with comparable human stakes. The training investment should reflect this.

## 2.5 Reflective practice and clinical supervision

*“Without regular supervision or support from colleagues and leaders, it can be difficult to process the emotional demands of the work. This increases the risk of feeling isolated, overwhelmed, and vulnerable to vicarious trauma.”*  
— Hope & Healing Framework

### **Reflective Practice**

Reflective practice involves structured, facilitated sessions in which care workers come together to discuss their recent interactions with children, share observations, identify what is working and what is not, and refine their collective approach. It serves multiple purposes:

- It provides a psychologically safe forum for active reflection upon the felt impact of the interactions carers have with young people in their care and how to manage this.
- It builds a shared, dynamic understanding of each child’s presentation across the staff team.
- It provides a mechanism for workers to learn from each other, including from mistakes and misjudgements of response.
- It enables strategies to be adapted in response to changing presentations.
- It reduces the isolation and emotional burden that care workers carry individually.



Figure 4: Reflective practice creates a team learning loop — building shared understanding of each child and enabling strategies to be refined continuously.

A useful analogy is the conversation that occurs between parents at the end of the day — discussing how a child is presenting, what has worked, what hasn’t, and agreeing on a consistent approach. Reflective practice provides this function in the more complex environment of therapeutic residential care, where multiple workers cycle through on rotating shifts and may rarely encounter each other outside of the care home.

The evidence base for reflective practice in social care is robust. The Social Care Institute for Excellence (SCIE, 2012) found that *good supervision is consistently associated with job satisfaction, organisational commitment, and staff retention* — all of which are critical to maintaining the stable, consistent relationships that children in care need.

### ***Clinical Supervision***

Clinical supervision is distinct from reflective practice. Its primary focus is the worker, not the child. Its purpose is to support workers in understanding the emotional impact of the work on themselves — to buffer them against vicarious trauma, compassion fatigue, and burnout.

Residential care workers are routinely exposed to accounts and manifestations of severe childhood abuse. They build relationships with children who then behave in ways that are hurtful, provocative, or self-destructive. They witness suffering they cannot immediately alleviate. Without a structured space to process this, workers become emotionally depleted. Their capacity to offer the consistent, attuned care that children need diminishes. They leave.

The high turnover of residential care staff is well documented. The sector loses experienced workers at significant cost — financial and relational. Clinical supervision is not a luxury; it is a retention and quality mechanism.

## **2.6 Rigorous data collection and outcome monitoring**

If we cannot see the wound, we must be rigorous about measuring whether healing is occurring. Effective therapeutic care organisations collect data on child wellbeing and developmental progress at regular intervals, using validated measures (such as the Strengths and Difficulties Questionnaire, the Child and Youth Resilience Measure, or the Looking After Children framework). They use this data not for compliance reporting, but to adapt their care approach in response to each child's evolving needs.

Outcome data should also be aggregated to assess whether the organisation's model is working at a systemic level. Placement stability rates, rates of children missing from care, rates of involvement with the justice system, and longer-term outcomes in adulthood are all meaningful indicators of therapeutic effectiveness.

## **3. Why Model Fidelity Is Non-Negotiable**

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The elements described above are not independent variables that can be partially adopted to partial effect. They are interdependent. An organisation that invests in reflective practice but does not have a clearly articulated practice framework will find reflective practice sessions directionless. An organisation with excellent frontline training but whose senior managers make decisions that undermine therapeutic relationships will see the benefits of that training eroded. An organisation that defines therapeutic care clearly but does not resource the supervision and training needed to maintain it will see its culture drift.

This principle — **that therapeutic care requires whole-system alignment and rigorous model fidelity — is one of the most important and least understood aspects of effective therapeutic residential care.** It is also one of the most frequently violated.

### **3.1 How misalignment causes harm**

The harm caused by systemic misalignment is not always dramatic or visible. It accumulates in small erosions of the therapeutic environment: the placement decision that disrupts an established relationship, the manager who overrides a care plan without therapeutic justification, the government guideline that creates perverse incentives around placement duration, the training that is mandated once and never followed up.

**Each erosion, in isolation, may seem minor. Cumulatively, they ensure that the care system falls far short of what is needed.** And for children who have already experienced significant harm, each additional adverse experience — each disrupted relationship, each failed placement, each system that did not hold together — compounds the impact of the original trauma in a way that may be difficult to see but is profound.

The most harmful form of misalignment is when well-intentioned people in the system — case workers, managers, government officers — make decisions that are understandable from their own frame of reference but are therapeutically counterproductive. This is not a failure of intent. It is a failure of training and system design.

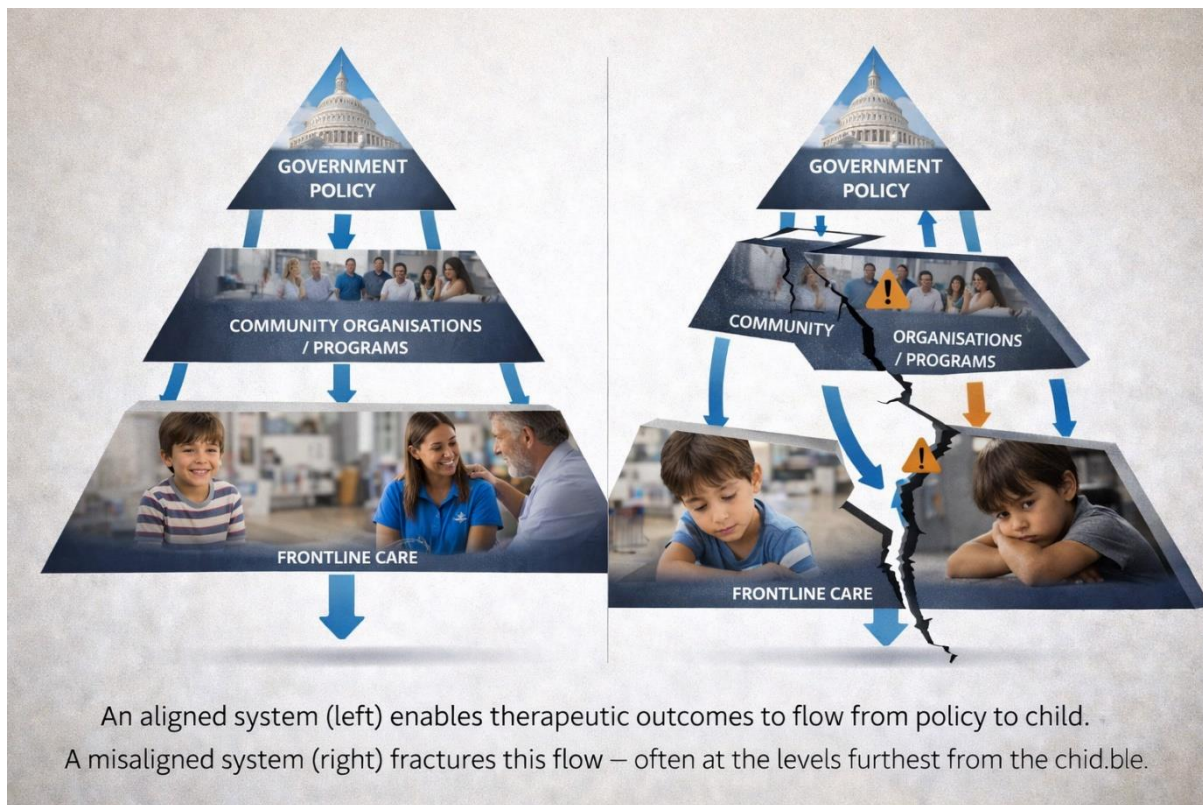


Figure 5: An aligned system (left) enables therapeutic outcomes to flow from policy to child. A misaligned system (right) fractures this flow — often at the levels furthest from the child, where the damage is least visible.

### 3.2 The whole-of-system imperative

For the Queensland out of home care system to deliver genuine therapeutic outcomes, the alignment required is not just within individual organisations. It must extend across the entire system: government departments, funding bodies, regulatory agencies, placement services, training providers, courts, and schools.

In practical terms, system-wide alignment in Queensland would require:

- A shared, clearly defined and fully understood therapeutic care framework adopted across government and non-government providers.
- Training and ongoing professional development requirements that apply to government (child protection) caseworkers and managers, not just non-government therapeutic care providers and staff.
- Funding and placement system models that reflect the **actual cost** of delivering genuine therapeutic care.

- Regulatory and oversight mechanisms that assess actual therapeutic practice, not just compliance with administrative requirements.
- Government decision-making processes — including placement decisions — that are informed by therapeutic principles and reviewed accordingly.

## 4. Caring for the Care Worker

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A residential care system cannot deliver therapeutic outcomes for children if it does not invest in the wellbeing of the people delivering that care. This is not a secondary concern. It is a foundational one.

Care workers who are under-trained, under-supervised, and under-supported will not be able to sustain the consistent, attuned relationships that children in care need. They will burn out. They will leave. And the high turnover that results will directly undermine placement stability — one of the most important protective factors for children in care.

There is also a values dimension to this. What we ask of care workers — to remain regulated and attuned in the face of provocative, distressing, or aggressive symptomatic presentations — is precisely what we are trying to model for the children. If the organisation cannot create the conditions for workers to experience safety, reflection, and genuine support, it cannot expect workers to create those conditions for children.

*“If you care for the care worker, they can care for the children.”*  
**— Practice wisdom from the field**

Investments in reflective practice, clinical supervision, ongoing training, and proactively psychologically safe workplace cultures and systems are therefore **not optional enhancements**. They are the conditions for the system to function as intended.

## 5. Accountability and Oversight

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Queensland requires a strengthened accountability framework that is capable of distinguishing genuine therapeutic care from care that merely describes itself as therapeutic.

### 5.1 What effective oversight looks like

The UK’s Ofsted model for residential care inspection provides a useful reference point. Key features include:

- Unannounced inspections that assess actual practice, not prepared documentation.
- Direct consultation with children about their experience of care.
- Scrutiny of whether policies are actually followed in practice — not just whether they exist.
- Public reporting of inspection outcomes.
- Review of incident data and placement disruption rates as indicators of therapeutic effectiveness.

Queensland’s current oversight framework does not adequately perform these functions. The Commission should consider what structural reforms are needed to enable genuine accountability for therapeutic outcomes.

### 5.2 Commissioning and funding

Funding models are not therapeutically neutral. A funding model that pays per occupied bed creates incentives that can work directly against therapeutic practice — for example, by discouraging the admission of children whose complex needs may make placement more difficult, or by dis-incentivising investment in the staffing and supervision infrastructure that therapeutic care requires.

The Commission should consider whether Queensland’s commissioning and funding frameworks adequately support, or inadvertently undermine, genuine therapeutic care.

## 6. The Economic Case

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Investing in genuine therapeutic care is not only the right thing to do for children — it is economically rational.

**The economic argument for investing in genuine therapeutic residential care is straightforward: it costs more upfront, but generates measurable near-term savings to government that substantially offset the additional investment — before any long-term benefits are counted.**

**The Victorian TRC Pilot evaluation (Verso Consulting, 2011) provides the most rigorous Australian cost-benefit analysis available.** The pilots were funded at an additional \$65,000 per child per year above standard residential care costs (at that time). Against this, the evaluation identified \$44,243 in quantifiable avoided costs per child per year, drawn from three sources: reduced police, hospital and secure welfare costs (\$787,147 across the program annually — with secure welfare admissions alone falling from \$619,400 to \$136,658 per year for the same cohort); improved placement stability (\$164,160); and planned, stable exits from care (\$730,000). Total identified savings: \$1,681,307 per year across 38 young people.

**Critically, these figures capture only what could be monetised in the short term.** The evaluation explicitly notes that no calculation was possible for youth justice system costs, court costs, or the direct costs of offending — meaning the true offset is likely considerably higher. The longer-term economic benefits — reduced criminal justice involvement, improved workforce participation, reduced homelessness, and reduced intergenerational transmission of abuse and neglect — were identified but could not be quantified without longitudinal data.

**The starkest economic argument lies in the comparison group.** Young people in standard residential care showed virtually no measurable improvement over the same period that TRC young people showed a 73.8% reduction in poor wellbeing ratings and a 237.9% increase in high wellbeing ratings. The costs of failing to invest in therapeutic care do not disappear — they accumulate in continued placements, crisis interventions, and the downstream burden of poor adult outcomes on health, justice, and welfare systems.

**The current system’s failure to invest adequately in therapeutic care does not save money. It displaces costs** — into emergency departments, mental health crisis services, youth justice, homelessness services, and the next generation of child protection cases.

## 7. Recommendations

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The Commission is invited to consider the following recommendations in its final report.

- **Point 1:** Urgently review out-of-home care placement processes to ensure decision-making is clinically informed and reflects each child's therapeutic needs, including formal clinical oversight and needs assessment at the point of placement — rather than placement availability being the primary determining factor.
- **Point 2:** As part of that review, examine the assumption that foster care is the most therapeutically appropriate placement for all children upon entry to care. Research suggests that this is not always the best option. Delfabbro and Barber's 2005 research (*Children in Foster Care*, University of Adelaide), for example, documented children cycling through repeated placement breakdowns — coining the term "*homeless in care*" — **suggesting that for some children, the psychological demands of foster care may compound rather than address early trauma**. This pattern may also be a contributing, and underexplored, factor in the difficulty of recruiting and retaining foster carers. North Yorkshire's No Wrong Door programme, independently evaluated by Professor Lisa Holmes (University of Sussex, 2025), provides strong evidence that matching children to the right placement type from the outset produces significantly better outcomes and warrants serious consideration by the Commission.
- **Point 3:** Adopt a clear, shared definition of therapeutic care both residential and home-based across the Queensland out of home care system, applicable to both government and non-government providers.
- **Point 4:** Require whole-of-organisation training in therapeutic care principles for all staff — including administrative, management, and government staff — not only frontline care workers but at all levels.
- **Point 5:** Mandate and resource ongoing reflective practice and clinical supervision for all residential care workers.
- **Point 6:** Require residential care organisations to implement and maintain clearly articulated, evidence-based complex trauma grounded, therapeutic practice frameworks, and to demonstrate adherence in practice.
- **Point 7:** Reform funding and commissioning models to reflect the genuine cost of therapeutic care and to incentivise therapeutic outcomes rather than occupancy.
- **Point 8:** Strengthen oversight and accountability mechanisms to assess actual therapeutic practice — including unannounced inspections, child consultation, and outcome data review.
- **Point 9:** Ensure that all relevant senior government decision-makers, government caseworkers, team managers, and decision-makers receive ongoing training in therapeutic care principles, so that government decision-making is therapeutically and complex trauma informed.

- **Point 10:** Establish a system-wide outcome monitoring and evaluation framework using validated measures to assess therapeutic progress across Queensland’s residential care system.

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## Closing Statement

The children who come into residential care in Queensland have already experienced significant harm. They deserve a system that is designed — with rigour, investment, and genuine understanding — to help them heal. Such a system is not beyond reach. It exists in pockets, in organisations that have done the work of building genuine therapeutic cultures. The task for the Commission is to understand what those organisations do, and to recommend a system that enables this everywhere.

The authors are grateful for the opportunity to contribute to this inquiry and remain available to appear in person to expand on any aspect of this submission.

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