



Family &
Community
Services



Consultation Report – Developing a Framework for Therapeutic Out of Home Care in NSW

October 2016

DRAFT

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Section 1

Introduction

About this project

Therapeutic Care is a growing field of research and practice which embeds trauma theory, child brain development, and attachment theory in service delivery, aiming to improve the well-being and outcomes for children and young people in out of home care (OOHC).

Therapeutic Care provides reparative experiences for children and young people who have experienced trauma, abuse, neglect, separation from families and significant others, and other forms of severe adversity that promotes healing and recovery.

Anecdotally, some services in NSW have been providing Therapeutic Care in both residential and foster care settings, however the sector has yet to adopt a Framework defining Therapeutic Care, nor is there an agreed Framework to evaluate the impact and outcomes for children and young people receiving such services.

In 2013, the Department of Family and Community Services (FACS) and the Association of Childrens Welfare Agencies (ACWA) formed a partnership to develop a Framework for Therapeutic OOHC in NSW. The project aimed to propose:

- an evidence informed Therapeutic Care Framework
- an agreed definition of Therapeutic Care
- a continuum of care incorporating therapeutic foster care and residential services

To guide the project a steering committee was established with representatives from five non-government (NGO) OOHC agencies (Life Without Barriers, CatholicCare Broken Bay, Key Assets, MacKillop Family Services and Allambi) and from FACS, ACWA, AbSec, Office of the Children's Guardian, NSW Ombudsman, NSW Health, Education, Juvenile Justice and University of NSW). A project working group with representatives from policy and operational units within FACS, and policy staff from ACWA also supported the project. Representatives from both Allambi and MacKillop Family Services, along with academics (Dr Marilyn McHugh and Dr Howard Bath) also provided input at the latter project stages.

Notably, the project initially intended to produce a Literature Review on Therapeutic Care and engage in comprehensive consultation with residential care providers, including the workforce (findings of this consultation process are detailed in this report). However, justly recognising that a child or young person in OOHC may need more intensive forms of trauma-informed casework and care at any given time along the continuum of care, alongside a number of reports/publications published over the last decade in Australia (i.e. reviewing and assessing foster care programs incorporating a therapeutic approach)¹ the project evolved to include Intensive Foster Care (IFC) in the project scope (refer to Section 3 of this report).

Consultation Process

To further inform the development of a Therapeutic OOHC Framework in NSW, ACWA initially undertook a survey of Residential Care Providers². The purpose of the survey was to develop an understanding of the programs and structure of organisations that provide residential care.

The survey was designed to capture the diversity of NGO agencies providing residential care services across NSW. It aimed to explore the extent to which Therapeutic OOHC is currently understood and has been implemented in the residential care sector, by investigating topics identified in close consultation with ACWA's Residential Provider's Network and on the learnings gained from the project's literature review. The design of the survey tool was also informed by a need, where possible, for consistent questions. This was to enable comparison with previous survey

¹ Refer to work by Acil Allen 2013; Frederico, Jackson and Blake 2010; Frederico et al. 2012; Hall and Robinson 2010; Lawson 2014; McAloon 2014; McClung 2007; and the Queensland Government Department of Communities 2011a, 2011b).

² ACWA acknowledges the invaluable research assistance of Ella Johnstone, who completed the fieldwork and preliminary data collation and analysis for the consultation; Pdraig Dorrigan, who provided research assistance; and Dr Robert Urquhart for supervising the analysis and compilation of the research results.

research of the residential care sector conducted by ACWA nearly a decade earlier, to understand the longer-term trend in the level of adoption of a therapeutic approach to residential programs and services.

The consultation process involved a sector consultation, which was a two-part online survey completed by Residential Care House Managers and Coordinators. The sector consultation participants were from 25 ACWA member agencies that are funded by FACS to provide OOHC residential care services. A workforce consultation was also undertaken in the form of an online survey. The participants were 110 direct care staff who responded to ACWA's invitation to give their views via the online consultation, with a good representation from all the different agencies that provide residential services. The research methodology and tools are summarised below.

Respondents were also asked to identify examples they perceived as good practice, which led to successful outcomes. Components of Therapeutic OOHC, identified by survey respondents, include flexibility; individualised care; engagement and empowerment of young people; organisational congruence; skills; trained staff and consistent rostering. With the exception of flexibility, these components are broadly consistent with some of the key program elements of therapeutic residential care models that have been identified in previous research.³ Each of these components of care overlap and are strongly linked in service provision.

The presence of these specific program elements, while essential in the articulation of a therapeutic model, are not sufficient by themselves to qualify as representing a therapeutic model of care. A therapeutic residential care program has these elements embedded in a system-wide program model that has an articulated theoretical base. Moreover, the model must also provide a logic framework that enables congruence to be achieved.⁴

The following section examines changes in practice in the identification and the level of implementation of an explicit evidence-based Therapeutic OOHC program model in NSW over the last decade.

As acknowledged above, at the onset of the Therapeutic OOHC project there was a strong focus on the OOHC residential sector, however over time the project appropriately evolved, recognising the importance to include children and young people receiving more intensive forms of casework and care (i.e. Intensive Foster Care).

Section 3 of this report details the findings of **McHugh, Marilyn, 'New South Wales Intensive Foster Care program survey findings', *Developing Practice: The Child, Youth and Family Work Journal*, Issue 41 2015.**

³ Mary McKinnon, "Life Without Barriers," Submission for the Child Protection Systems Royal Commission (Australia: Life Without Barriers, 2015), <http://www.childprotectionroyalcommission.sa.gov.au/wp-content/uploads/2015/04/Life-without-barriers.pdf>; Sara McLean, Rhys Price-Robertson, and Elly Robinson, *Therapeutic Residential Care in Australia: Taking Stock and Looking Forward* (Melbourne, Vic.: Australian Institute of Family Studies, 2011); "The California Evidence-Based Clearinghouse for Child Welfare," 2016, <http://www.cebc4cw.org/>; VERSO Consulting, "Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary and Technical Report" (Melbourne: Department of Human Services, 2011).

⁴ Frank Ainsworth, "Program: The Cornerstone of Therapeutic Residential Care," *Developing Practice: The Child, Youth and Family Work Journal* 41 (2015): 33–40; M.J. Holden et al., "Engaging the Total Therapeutic Residential Care Program in a Process of Quality Improvement: Learning from the CARE Model," in *Therapeutic Residential Care For Children and Youth: Developing Evidence-Based International Practice*, ed. James K. Whittaker, J.F. del Valle, and Lisa Holmes (London: Jessica Kingsley Publishers, 2015), 301–13.

Section 2

Snapshot of Residential Care in NSW

Methodology

Data collection methods and tools

ACWA used both survey and consultation methods in collecting and interpreting the data in this project.

An online survey tool was used to survey managers and supervisors, using the 'Residential Care Providers' two-part survey. In addition, there was a second survey of direct care providers, using the 'Residential Care Workforce Survey'. Consultation with the ACWA Residential Care Providers Network was also used to interpret, validate and explore in greater depth specific findings from the survey.

The Residential Care Providers Survey was conducted in two parts. The two parts of this survey resulted from an iterative process, as Part 2 questions were informed by the responses to Part 1. In addition, Part 2 asked participants to identify and describe case studies that managers and supervisors believed illustrated best practice in residential care. (See Selected Case Studies below). Direct care providers were also consulted using an online survey tool. Consultation with the ACWA Residential Care Providers Network was used to interpret initial findings.

The questions were developed after a Literature Review, and discussion with both the ACWA Residential Care Providers Network and the Therapeutic Care Steering Committee. Agencies agreed to participate on the basis that results would be presented only in non-identified, aggregate form. Participation was also based on the understanding that it would have no bearing on funding and would not be used in any way to evaluate the performance of services.

The tools are described below.

Residential care providers survey

ACWA conducted the Residential Care Providers Survey with ACWA member agencies that provide OOHC residential care services. Residential care house managers and supervisors were asked about their knowledge of their agencies' services and practices. It is acknowledged that for larger agencies, this may not necessarily be representative of their practice across the service but rather be indicative of only one particular residential care house.

The purpose of this survey was to develop an understanding of the programs and structure of organisations that provide residential care in NSW. The survey was designed to ensure that the project captured the diversity of non-government agencies providing residential care services across NSW.

This on-line survey was in two parts. Part I consisted of 34 questions, while Part II consisted of 14 questions and included a brief case study. Part I identified the different models and key elements of services currently being used by residential care service providers in NSW. The questions were designed with the aim of developing an understanding of the key priorities for residential care service providers. Part II gathered case studies that illustrated best practice in residential care, and was designed to capture an understanding of the major challenges currently facing the residential care sector.

The sample represented 22 out of 30 agencies, or 73% of all residential FACS-funded service providers. All respondents to the service providers' consultation survey tool, were active members of ACWA's Residential Care Providers Network.

Residential care workforce survey

In addition to the survey of managers and supervisors, a second survey (the 'Residential Care Workforce Survey') was conducted of residential care workers who were 'on the floor'. The purpose of this second survey was to capture how direct care staff understood their organisations' model of service, and how they articulated it. As such the findings provide a more complete picture of the level at which models were integrated throughout the agency. The survey also sought to gain an understanding of the priorities and barriers experienced by frontline residential workers and the supported they received to do the work (see Appendix A for copy for the worker consultation tools). This survey provides a complementary data set to the Residential Care Providers Consultation survey.

The participants were 110 direct care workers in OOHC residential care services from 13 NGO services across NSW. All variables in the consultation tool were identified in consultation with the ACWA Residential Care Providers Network and the Therapeutic Care Steering Committee. The consultation was designed as an online survey, consisting of 24 questions answered by 110 direct care workers from 13 NGO agencies. A consultation period of eight days was chosen to include staff working both regular week-day shifts and weekend staff.

Current residential care provision in NSW

The key areas explored in the residential care provider's survey included:

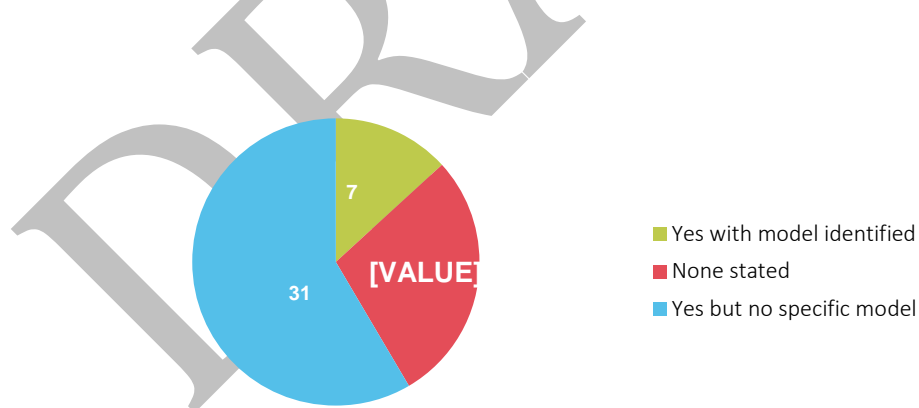
- use of trauma theory/attachment theory and brain development/neuroplasticity
- articulation of models and theoretical approaches currently in use
- core elements of the service model; and
- barriers to delivering a therapeutic care model.

Developments in approach to Therapeutic OOHC in NSW

The survey findings are significant in that they demonstrated there has been an increase in the use of therapeutic interventions in NSW residential care, in comparison to the 2005 ACWA study. However, the findings show the understanding and systematic employment of evidence based therapeutic OOHC models by agencies is not developed to the same level.

In 2005 as part of an OOHC Development Project, ACWA conducted an appraisal of residential care entitled "Residential Care in NSW". The participants were 42 NGO agencies providing residential care in NSW. Residential care program managers and coordinators participated in 109 interviews. Of interest to this report is that participating agencies were asked if they had "any specific therapeutic approach" to their programs and services.

Figure 1 demonstrates that at this time only 7 of the 42 agencies stated that they had adopted a therapeutic approach and were able to identify a specific model they were using in their residential care programs.



*Figure 1: No. of agencies nominating they have adopted a "therapeutic approach", 2005.
Source: ACWA (2005) Residential Care in NSW.*

In the 2005 study, agencies named a range of models and "therapeutic" approaches that informed their programs including Solution Focused Brief Therapy (4 agencies); Positive Peer Culture (3 agencies), Therapeutic Crisis Intervention (TCI) (3 agencies) and Windows strength-based model (1 agency) (see Figure 2).

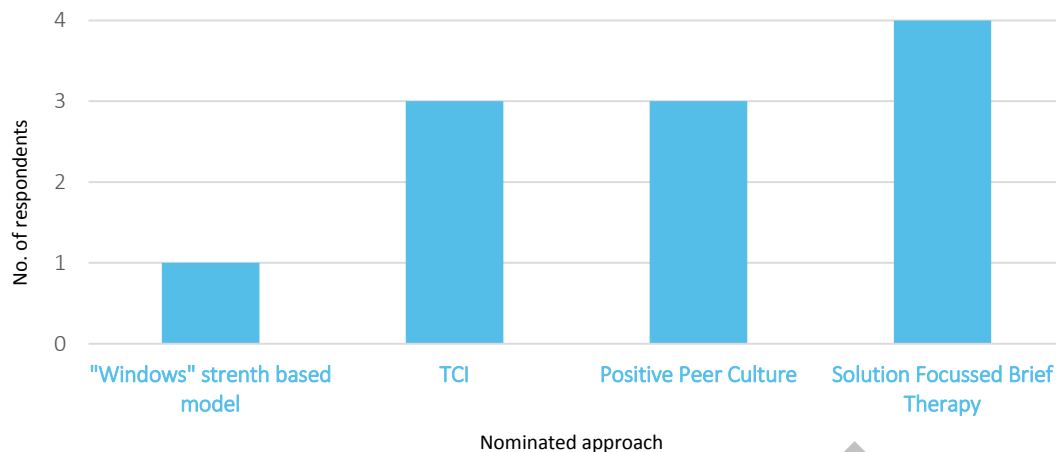


Figure 2: Specific "therapeutic approaches", nominated by service providers, 2005.
 Source: ACWA (2005). *Residential Care in NSW*.

The 2005 report concluded that while most agencies did not purport to offer integrated Therapeutic OOHC programs, there was some reliance on unspecified therapeutic approaches:

"Few agencies said they provided a therapeutic program, although some used this term in their description of the agency's philosophy or service model".⁵

Agencies named a number of therapeutic approaches such as TCI, although most did not systematically apply a clinical therapeutic regime in the service. Of the approaches identified, only Positive Peer Culture (PPC) is a residential program model.⁶ The report also identified systemic problems, notably that residential care lacked a clear definition of its place in the service system:

"Residential care in NSW has drifted for a number of years without a coherent approach and without a clear or acknowledged place in the OOHC system".⁷

As part of an international move in the last decade towards trauma-informed practice, based on an increased understanding of the challenging and difficult behaviours of children in trauma-sensitive populations,⁸ there has been considerable interest in the application of findings from neuroscience and trauma-related research to programming and care planning for the cohort of children and young people using residential care.⁹

NSW service providers have been part of this trend, with an increased use of theoretical approaches based on findings in neurobiological research to guide service delivery, coupled with the systematic implementation of key principles such as the need for specialised training, coaching and supervision for residential care staff. In some cases, this has extended further to the application of evidence based therapeutic OOHC models.

⁵ C. Flynn et al., "Residential Care in NSW: OOHC Development Project" (Australia: Association of Children's Welfare Agencies (ACWA), 2005), 20, www.acwa.asn.au/downloads/publications/ResCareNov05.pdf.

⁶ Harry H. Vorrath and Larry K. Brendtro, *Positive Peer Culture* (Chicago: Aldine Pub. Co, 1974); Ainsworth, "Program: The Cornerstone of Therapeutic Residential Care."

⁷ Flynn et al., "Residential Care in NSW: OOHC Development Project," vii.

⁸ Alexandra Cook et al., "Complex Trauma in Children and Adolescents," *Psychiatric Annals* 35, no. 5 (2005): 390–98.

⁹ James K. Whittaker, Jorge Fernandez del Valle, and Lisa Holmes, eds., *Therapeutic Residential Care for Children and Youth: Developing Evidence-Based International Practice* (London; Philadelphia: Jessica Kingsley Publishers, 2015); James P Anglin, *Pain, Normality, and the Struggle for Congruence Reinterpreting Residential Care for Children and Youth* (Hoboken: Taylor and Francis, 2014), <http://public.eblib.com/choice/publicfullrecord.aspx?p=1639373>.

Use of trauma theory to inform practice

Residential care managers and supervisors were asked to nominate the theoretical approaches used to inform their service delivery and program design. As shown in Figure 3, overall respondents tended to identify current theories associated with robust empirical research that has been previously applied to programming.

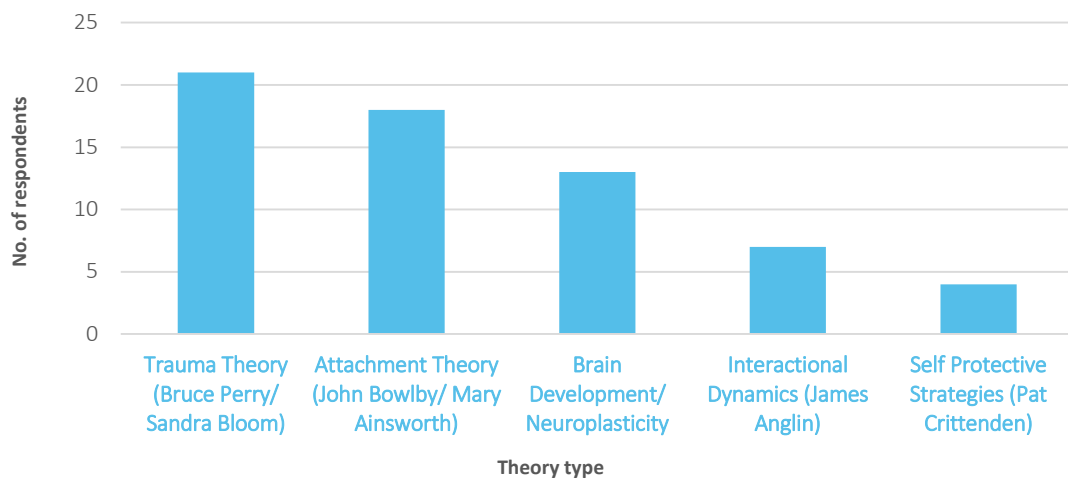


Figure 3: Theoretical approaches informing service delivery and program design.
Source: ACWA Residential Care Providers Consultation, 2014.

Trauma theory/attachment theory/brain development, neuroplasticity, interactional dynamics and self-protective strategies are all highly applicable theories to dealing with children and young people with experience of trauma and disruptions across a range of experiences resulting in complex needs.

The nomination of the newer theories, in particular trauma theory and neuroplasticity, indicates engagement with the application of new knowledge related to these areas. Additionally, it suggests a level of sophistication across the sector, in relation to a deepening understanding of the causes of behaviours of concern that is typical of populations in residential care. It also indicates access to a range of current approaches and possible interventions that are effective in developing care plans and managing day-to-day issues.

Importantly, compared to the 2005 results, this marked increase in the ability to identify explicit theoretical perspectives is evidence of a shift in the approach to planning and design of Therapeutic OOH by the sector from ad hoc approaches towards more well-conceptualised and evidence-informed programming. Interestingly this shift in thinking was not sparked by funder requirements but as agency initiatives in response to emerging research and clinical evidence in therapeutic care practice. However it should be noted that an increasing awareness of new understandings of the relationship between the effects of trauma on the brain and development and children's challenging and difficult behaviours does not necessarily indicate staff have changed their practices to be more therapeutic and trauma-sensitive.¹⁰

Models identified as currently in use

Eleven program models were identified by managers and supervisors as being currently used in NSW residential care houses. In their qualitative responses to this question, 11 respondents identified their service as using a "therapeutic

¹⁰ Holden et al., "Engaging the Total Therapeutic Residential Care Program in a Process of Quality Improvement: Learning from the CARE Model."

model” but did not specify the name of the model used by the agency they worked for. A small group of 15% of respondents reported that the agency did not have a model for their residential care services.

Researchers have highlighted the conceptual and practical need to differentiate models of therapeutic residential care from other promising frameworks or training interventions.¹¹ As in 2005, not all agencies perceived the importance of that distinction, as shown by nominations by some participants that are not considered fully-fledged models. For example, CEBCH’s data base of evidence based program models identified five of the nominations: Stop-Gap; Teaching Family Model (TFM); Positive Peer Culture (PPC); Re-Ed and Sanctuary as therapeutic care models.¹²

Indirect evidence of congruence between the program model and program policies, procedures and practices is provided by the core elements identified by service providers, as well as in the selected case studies of good practices in the following sections. However, the extent to which congruence was achieved in the best interests of young people was not specifically investigated in the consultation process. It is important to note that the range of models nominated reflect developments in the area of Therapeutic OOHC, indicating currency in the adaption of models. The high rate of nomination of TCI (16 of 23), often in conjunction with other models, is not surprising given that TCI is used as a prerequisite skill set for residential care providers (akin to first aid training). There were 11 models cited in all, with three agencies being in the process of developing a model. It is also noted that established models were nominated more frequently – such as Sanctuary (7 of 23) and Circle of Courage (5 of 23).

Of interest is the finding that all agencies either identified using a model, or were in the process of developing one. Of the agencies, 12 of 23 nominated one model, while 13 of 23 nominated the use of a hybrid model, combining elements from two or more models. In Figure 4 below, agencies selected multiple models if they were using a hybrid model (elements from two or more models used simultaneously).

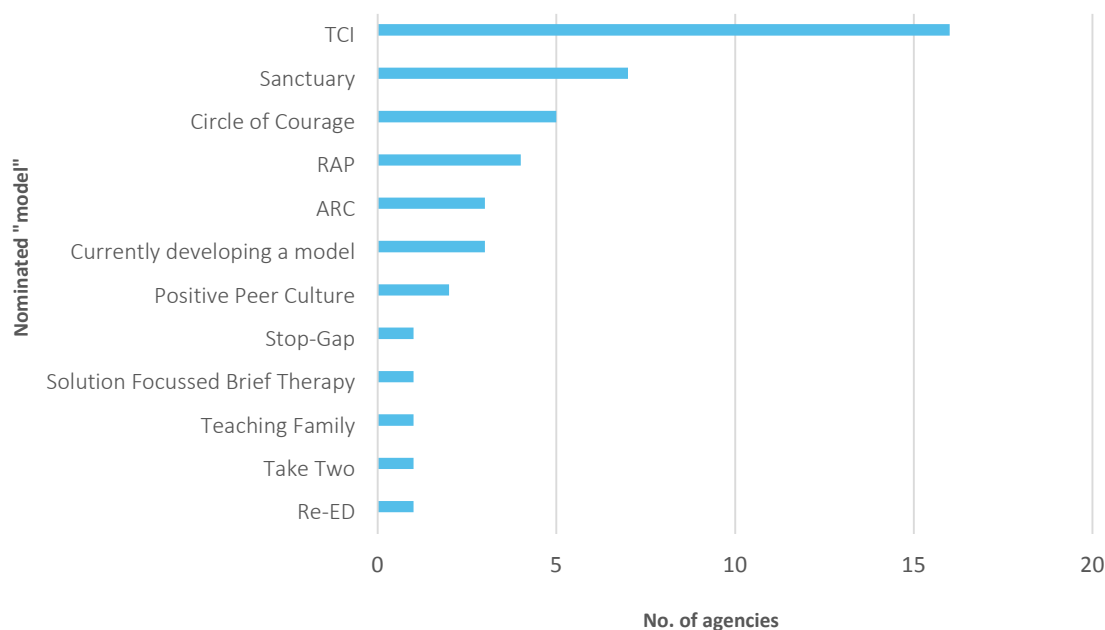


Figure 4: "Models" nominated by providers as currently in use in their agency
 Source: ACWA Residential Care Providers Consultation, 2014

¹¹ Ainsworth, "Program: The Cornerstone of Therapeutic Residential Care"; David Berridge et al., "Raising the Bar? Evaluation of the Social Pedagogy Pilot Programme in Residential Children’s Homes" (United Kingdom: Department for Education, 2011).

¹² "The California Evidence-Based Clearinghouse for Child Welfare"; Ainsworth, "Program: The Cornerstone of Therapeutic Residential Care."

It is of interest to compare the responses from managers and supervisors with that of the direct care staff.

The Residential Care Workforce Survey asked direct staff “What model does the residential care service you work for use?”

Of the 110 responses, the models mentioned in descending order were:

- TCI – 58% (64 participants)
- No model – 15% (16 participants)
- Circle of Courage – 11% (12 participants)
- RAP – 6% (7 participants)
- Sanctuary Model – 4.6% (5 participants)
- Teaching Family and DHS – TRC each 1.8% (2 participants)
- Positive Peer Culture – 1% (1 participants)

The nomination of models by direct care staff provides evidence the models are embedded within the agency to some degree, with 82% of respondents nominating a model. However, like the findings for service providers, there was some confusion about the distinction between a Therapeutic OOHC model and models of individual and group interventions with both nominated by respondents.

The results suggest that there is not a clear understanding within the residential care sector about the difference between therapeutic interventions such as TCI and Therapeutic OOHC. Comparison of the 2005 and 2014 consultation findings provides evidence of an increasing awareness of the need for a model of Therapeutic OOHC that shapes policies and practices with children and young people in care. There is also evidence of a group of providers who are already have identified and are utilizing recognised Therapeutic OOHC models. This has been achieved without FACS articulating a clear therapeutic OOHC framework, but rather by local initiatives by service providers in response to international developments in residential care research and practice.

Core elements

Respondents were asked to select core elements of their agency’s residential care model and to rank the five most important elements. The results are outlined in Figures 5 and 6.

“Creating a home like environment” was the most frequently selected element and was also ranked as the most important, while “Building rapport and relationships” ranked second in both frequency and importance. This indicates that managers and supervisors place a primacy on the physical environment of the residential care home, as well as the quality of the relationships enjoyed between staff and children and young people. This is in keeping with the emphasis placed on using staff interactions as a part of the therapeutic and reparative experience for the child or young person.

Core Element	Frequency
Creating a home-like environment	18 /25
Building rapport and relationships	15 /25
Congruence in approach by staff	14 /25
Establishing structure, routine and expectations	14 /25
Offering emotional and developmental support	14 /25

Figure 5: Core elements ranked by overall frequency
 Source: ACWA Residential Care Providers Consultation, 2014

Core Element	No. respondents
1. Creating a home-like environment	9
2. Building rapport and relationships	7
3. Ongoing training opportunities for staff	4
4. Clinical supervision available for staff	5
5. Clinical supervision available for staff	5

Figure 6: Core elements ranked in order of importance
Source: ACWA Residential Care Providers Consultation, 2014

Staffing

Stand Up Shifts

The consultations with residential care providers highlighted that “Stand Up” shifts (or active night shifts where the worker is awake) were critical in a residential care program. The Residential Care Providers Network provided feedback relating to this question including current usage (see Figure 7). It was common, for example, for critical incidents to occur in periods of transition for children and young people as they were thought to raise experiences of vulnerability and anxiety. Evenings, and preparation for bedtime could elicit experiences of fear as a result of experiences of being unsafe at these times in the past. The ability to ensure that the level of staffing was tailored to the children and young people in the residential unit at all times was considered to be crucial. When the children and young people were settled in a house, staffing numbers could be decreased, but when the stability of the children and young people fluctuated, “stand up staff” (staff who were awake the whole evening), and the availability of back up staff and/or access to a manager by phone were all considered necessary options to ensure appropriate staffing. Discussion with the network confirmed that critical incidents with a child or young persons could easily occupy one staff person’s full attention, thus leaving other children or young people without supervision. Adequate staffing was considered to result in less reliance on police in the event of a critical incident.

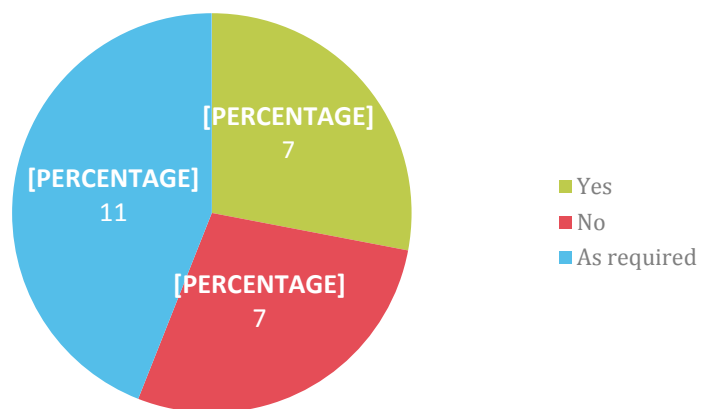


Figure 7: No. of providers that incorporated stand up shifts within their program
Source: ACWA Residential Care Providers Consultation, 2014

Qualifications and Experience

As James has highlighted, historically low wages and consequently a workforce with poor qualifications and higher turnover rates has been an impediment to the implementation of high quality therapeutic residential care.¹³ In order to successfully introduce and sustain promising Therapeutic OOHC models, the recruitment, training and retention of suitably qualified and experienced direct care staff and managers is essential.¹⁴

Service providers were asked “If your organisation sets a minimum qualification or experience level for residential care staff, what is it?” Figure 8 shows that service providers listed a range of level of minimum qualifications for direct care staff, with most service providers requiring Certificate IV or equivalent qualifications. Only one respondent mentioned that there was no minimum requirement for a direct care worker at their agency.

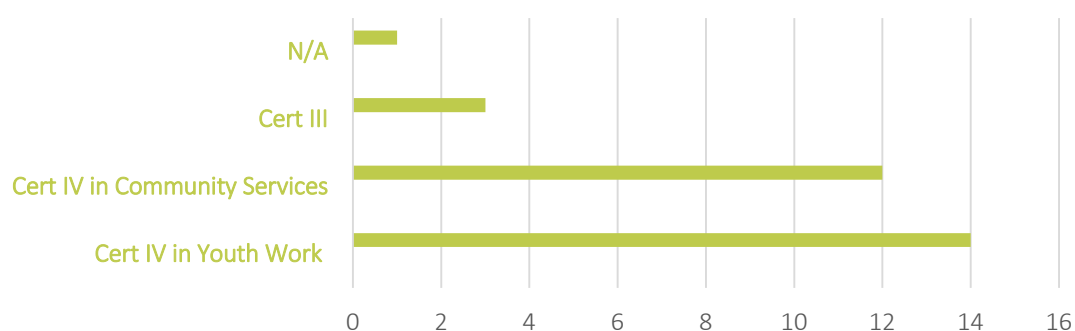


Figure 8: Direct care staff minimum qualifications
Source: ACWA Residential Care Providers Consultation, 2014

The Certificate IV qualification in Community Services is typically undertaken over a 6 month to 2 year period while the student is employed as a direct care worker in residential care. Respondents commented that a Certificate IV in Community Services or Youth Work represents a solid base of learning for entry-level residential care workers who may go on to do further training and qualifications, and it was the most frequently held qualification by staff, followed closely by a degree in Social Work (or equivalent field) (see Figure 10). Some respondents commented that the provision of specialist Certificate IV qualification in residential care would be highly useful in terms of creating a pool of suitable job applicants.

Prior residential care experience was not considered mandatory by most service providers for direct care staff. Only 7 agencies stipulated that previous experience working in residential care was a prerequisite for direct care staff in addition to their formal qualifications. Respondents commented that an even temperament, flexibility, excellent professional judgement and the ability to think critically and make quick decisions in the face of inappropriate and challenging behaviour by children were more important to them in selecting staff, who could then be offered on-the-job training, rather than prior experience.

Figure 9 shows a similar pattern of minimal qualifications for managers, with most service providers required Certificate IV, and given the managerial nature of the role, some required a higher qualification of a degree or diploma equivalent. Of agencies surveyed, only 10 stipulated that previous experience working in residential care was

¹³ Sigrid James, “Commentary: Engaging the Total Therapeutic Residential Care Program in a Process of Quality Improvement. Learning from the CARE Model,” in *Therapeutic Residential Care For Children and Youth: Developing Evidence-Based International Practice*, ed. James K. Whittaker, J.F. del Valle, and Lisa Holmes (London: Jessica Kingsley Publishers, 2015), 315; Matthew Colton and Susan Roberts, “Factors That Contribute to High Turnover among Residential Child Care Staff,” *Child & Family Social Work* 12, no. 2 (May 2007): 133–42, doi:10.1111/j.1365-2206.2006.00451.x.

¹⁴ Holden et al., “Engaging the Total Therapeutic Residential Care Program in a Process of Quality Improvement: Learning from the CARE Model”; James, “Commentary: Engaging the Total Therapeutic Residential Care Program in a Process of Quality Improvement. Learning from the CARE Model.”

a prerequisite in addition to formal qualifications for those working as house managers or coordinators. One respondent answered that there was no minimum requirements for a house manager or supervisor at their agency.

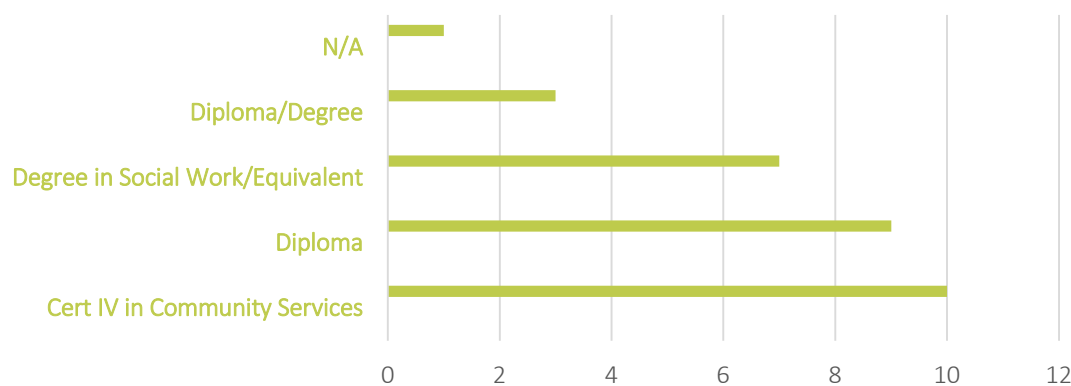


Figure 9: Residential house managers/coordinators minimum qualifications
Source: ACWA Residential Care Providers Consultation, 2014

Participants in the direct care workforce survey were also asked about their educational qualifications (Figure 10). This shows that many workers exceeded the minimum qualifications reported by service providers and held degree (43 respondents) and diploma equivalent qualifications (15 respondents).

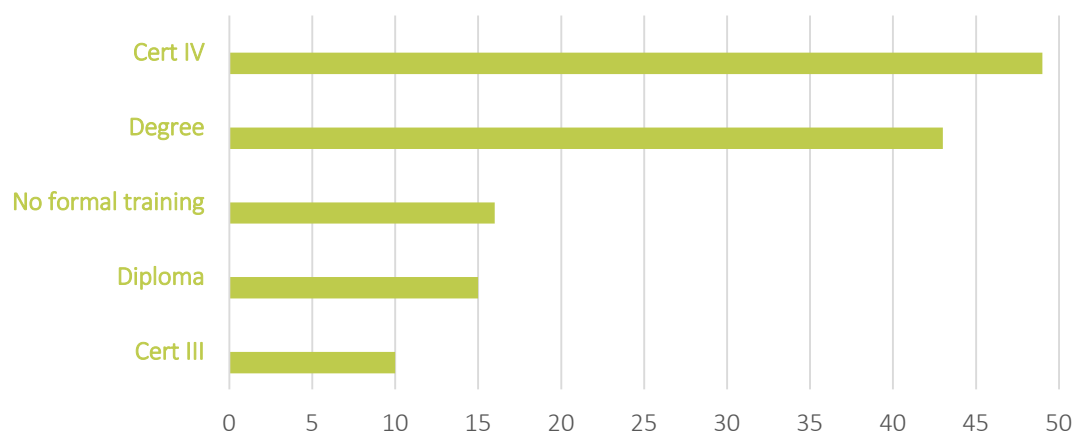


Figure 10: Direct care staff educational qualifications
Source: ACWA, Direct Care Workforce Survey, 2014

Staff supervision

It appears that there is a range of supervision provided to direct care staff from across the agencies involved in the survey. In most cases, it was experienced as helpful and adequate.

Figure 11 shows professional support reported by direct care staff. The Residential Care Workforce Survey asked direct staff “Do you currently get professional support to help you do your job?” 94 respondents said yes). Of these, 82 per cent said they had supervision with the house manager, 75 per cent at all staff meeting, 65 per cent with the house manager on call, 55 per cent in Care Team Meeting, and 43 per cent with a clinical supervisor. In being asked if the supervision was adequate and helpful for the type of work they undertook with young people, 85 per cent replied

'yes'. Eighty-seven per cent of direct care workers also said that they had access to specialist support services to assist young people.

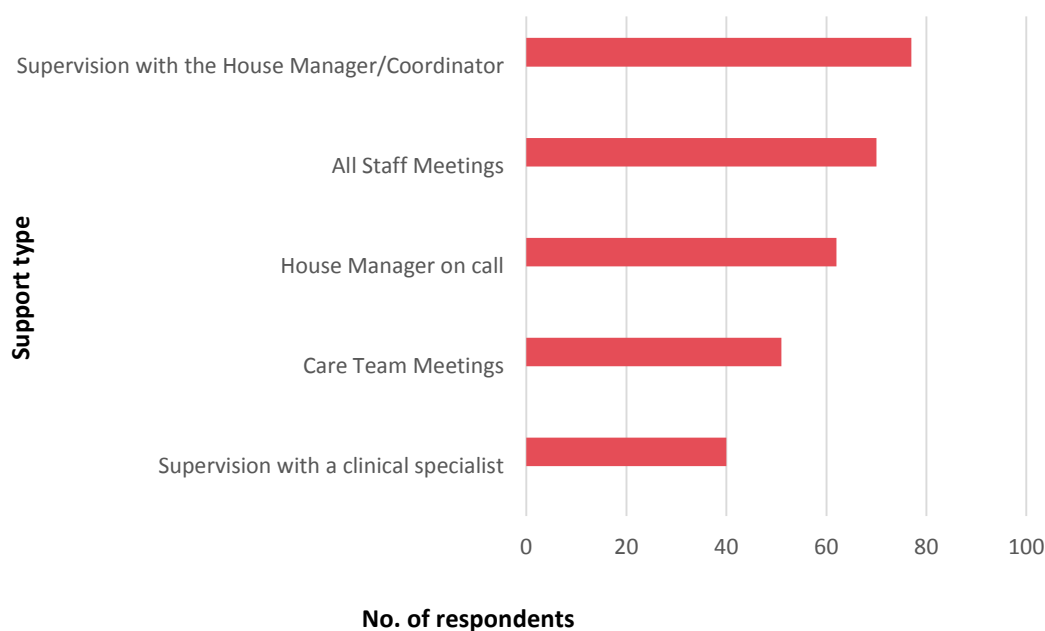


Figure 11: Professional support for staff
Source: ACWA Residential Care Providers Consultation, 2014

Residential care service providers described a pattern of supervision that was both frequent and multilayered (see Figure 12). All of the sample provided supervision with the residential care house manager at least monthly, and in the care team or all staff meetings on a weekly or monthly basis. In addition, the majority provided and on-call manager (only 2 did not) and most provided this on a weekly or monthly basis, and 17 of 23 also provided supervision by a clinical specialist most of whom provided this on a monthly basis.

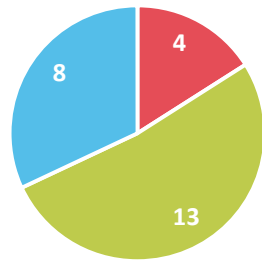
As already discussed, direct care staff reported in the Residential Care Workforce Survey that these arrangements were helpful and adequate.

In the consultation with the Residential Care Providers Network, it was noted that each of these types of supervision had different purposes. "Supervision with the Care Team/All Staff meetings" ensured that there was a co-ordinated, shared approach and understanding in relation to the child or young person and provided a place for regular check-ins with how young people were managing.

Supervision by the house manager reflected their familiarity with the dynamics of the children and young people who were currently in the house, as well as their knowledge of the direct care staff (Figure 12b).

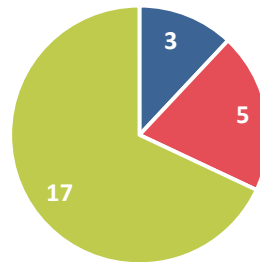
By comparison, supervision by a clinical specialist resulted in the development and application of clinical strategies to respond to each young person's needs in a therapeutic way, taking into consideration their individual needs. Clinical supervisors assisted with developing plans for point of crisis. Having a Residential Manager on call provided back up to staff who were managing on-the-ground issues, including crisis events.

Figure a. Supervision with a Clinical Specialist



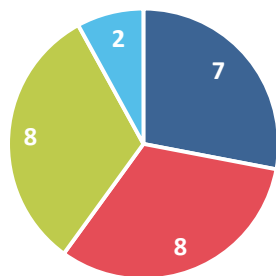
■ Daily ■ Weekly ■ monthly ■ N/A

Figure b. Supervision with the Residential Care Household Manager



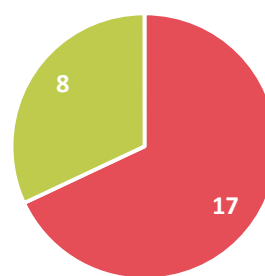
■ Daily ■ Weekly ■ monthly ■ N/A

Figure c. Residential Care Household Manager



■ Daily ■ Weekly ■ monthly ■ N/A

Figure d. Care Team / All Staff Meetings



■ Daily ■ Weekly ■ monthly ■ N/A

Figure 12: Staff supervision. Note: N/A indicates that this supervision type was not available to staff. (N=25)
Source: ACWA Residential Care Providers Consultation, 2014.

Barriers to achieving positive outcomes for children and young people

Barriers ranked by respondents as most critical: (Q: Are there any barriers that prevent you from achieving positive outcomes for young people? "Difficult" behaviours = violence, withdrawing, trust issues, hard to engage).

- Funding limitations
- "Difficult" client behaviours
- Mental health/trauma issues
- Lack of skilled staff
- Drug and alcohol problems
- Inadequate matching processes
- FACS case worker involvement
- Lack of parental understanding and support

Funding issues were exacerbated by additional costs born by agencies in relation to a lack of access to universal services including education and mental health services.

Evaluations

Figure 13 shows that of the 25 service providers who participated in the consultations 60 per cent had had an evaluation of their RC program, but of those only 20 per cent had been carried out by an external evaluator. Of the agencies surveyed, 40 per cent had not had any evaluation conducted. Further consultations with the ACWA Residential Care Providers Network identified that there are currently a variety of outcome measures being used across the sector and also differing perceptions of what an “outcome measure” is. This suggests that strategies to foster a more outcomes-focussed culture in the sector, for example, developing outcomes measurement training strategies and resources, and the adoption of a common framework by RC providers across NSW with agreed evidence-based outcome measures may be positive steps towards delivering high quality therapeutic OOHC to children and young people.

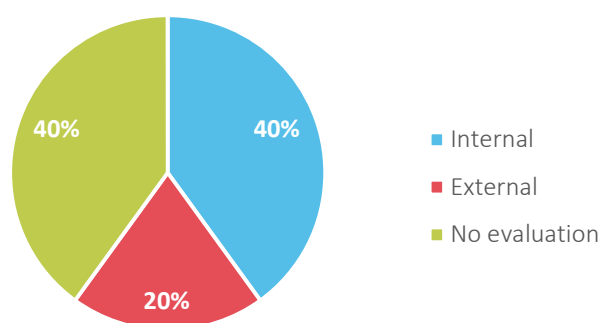


Figure 13: Agency programs that have been evaluated
Source: ACWA Residential Care Providers Consultation, 2014

Therapeutic Elements Identified by Residential Care Sector

This section draws on the case examples provided in the survey. The case examples demonstrate the principles of therapeutic care as they have been applied. The discussion also draws attention to the distinction between elements of therapeutic care being implemented versus the systematic application of a model of therapeutic care.

The survey tool elicited examples of what service providers perceived as good therapeutic practices within their agencies. These case studies were thematically analysed and a number of practice elements were common, which are summarised below.

Flexibility / Step down Step up

Flexibility of service delivery is the ability of agencies to provide “step up step down” support as needed. “Step up step down” refers to young people having the ability to transition smoothly and effectively between service types of differing intensity according to their changing needs.

Flexibility of care that responds to the changing needs for the child or young person is germane to good quality residential care, so how is this different when it occurs within a therapeutic residential care environment? Agency responses to this question were that in therapeutic OOHC models planned, reparative experiences in day-to-day interactions with direct care staff as well as specialists, were necessary to facilitate healing. The ‘flexibility’ of service provision responds to the changing needs of the young person as they spend time in the program. It ensures that they continue to be supported by a therapeutic program when they move from one residential care facility to another, or to foster care, for example. One agency provided the following annotations about an example of flexibility in service provisions:

“...a young person was referred to the agency after numerous foster care breakdowns. Entered a residential program for a six-month period. Introduced to foster carers. Stayed for 3 years. Transitioned to supported independence.”

The agency perceived that this was a good outcome that was a result of therapeutic gains that were made in the residential unit that allowed the young person to move back into a foster care setting. The supported transition phase was a therapeutic element in the successful transition, and this required flexibility for the young person to use the residential facility as their safe base from which to develop confidence and trust with their new foster carers. This flexibility supported their successful transition back to foster care.

“Flexibility” in residential care also includes the ability of agencies to work outside of their standard model. For example, extending care periods past 18 years of age was expressed as important, with one service reporting that a young person,

“...was able to stay in [the residential] unit after turning 18 until accommodation [was] found for him”. In another example of flexibility, one service said “[we] provided comprehensive contact with family on a daily basis which the young person reported to enjoy”.

This is considerably more frequent contact than most agencies reported providing for the children and young people in their care and was client-centred practice in providing a critical service to assist young people to move into independent living. Several services provided ongoing support after self-placement with family, including, “*Young person self placed with family and our service then began ‘delivering’ OOHC support in the family home*”. This agency reported that the young person and the family felt positive about the outreach support. Finally, another agency stated,

“There was a strong commitment to the young person, even after the young person self placed with family. We advocated to remain involved and to keep the funding available for the young person so that supports could remain even though it meant delivering the service off site.”

Flexibility is an important factor in the care of young people for agencies. To highlight, 76% of respondents said there were occasions when they accepted children or young people who did not fall within their stated service target group. One of the respondents indicated this was due to lack of information or human error. However, most made informed decisions based on what they felt were in the best interest of the child or young person and in several cases their siblings. Over the past year most services had made over two exceptions placements providing services for children ranging to twelve. It was a finding of this survey that most agencies reported and gave examples of providing flexible care to children and young people in their programs.

Individualised/tailored care

Strongly linked to flexibility is the component of individualised or tailored care within Therapeutic OOHC. Individualised or tailored care is care that meets the specific needs of different children and young people. Again, like the element of flexibility, *individualised/tailored care* is present in good quality care – however its expression in a therapeutic program is in its application within the holistic Therapeutic OOHC model of an intensive, planned, reparative experiences and interventions planned around the individual child or young person and their own trauma. Planning these interventions requires clinical knowledge and skill, as well as congruence, and for the direct care staff to be supported and supervised in implementing them with the young person.

Individualised/tailored care contributes to empowerment, by giving children and young people input into their own lives and the services working with/for them. Nearly all (96 per cent) of the agencies reported that young people were directly involved, formally and informally, in decision making processes. Several agencies reported that giving children and young people a say in their care helped to achieve positive outcomes. For example, one agency said, “*We found giving the young person real choice and participation during their time in care helped to achieve the goals of the young person.*”

Agencies gave examples of tailoring care in relation to more specific needs. One agency reported,

“Hoarding [food] was a major issue”. The agency resolved this “by giving the young person some control over food selection and purchasing and by providing a hygienic alternative for storage [in her room]”.

The agency reported that by doing this the young person started to feel safe and engaged better with the staff. In another instance a young person did not feel comfortable with eye contact so the agency “*purchased a PlayStation and began ‘in house’ competitions while playing these games we began to use these opportunities to ‘touch base’ and*

get a sense of where he was, what he needed and began to build from this initial strategy". Several respondents saw thinking creatively and responsively as integral to good quality Therapeutic OOHC.

Clearly tailoring care and empowering young people is important to many agencies. The above examples highlight that empowerment of young people to make decisions and having some control over their care was important for agencies and young people alike. However, only three agencies indicated this as part of their top five priorities of care, indicating that other priorities may be receiving more attention.

Congruence

An example of congruence agencies gave is having a whole of service appreciation for Therapeutic OOHC. That is, ensuring all staff from care workers to CEOs all work consistently in a therapeutic manner. As one agency explained it, *"all parts of the organisation are connected to the outcomes of the young person. Congruence is also about ensuring external agencies work therapeutically."*

Interagency Collaboration

One agency demonstrated the importance of working with schools stating, "Education settings that are prepared to 'walk the extra mile' and have wider corridors of tolerance re trauma and resultant behaviour". The agency felt that this partnership was integral for a Therapeutic OOHC model to work. Other agencies gave more general statements regarding congruence, but felt that collaboration was important. For example, statements like "There was police involvement, coordination with school, mental health and legal services" were common to many agencies.

In relation to providing specialist service provision agencies reported that "referrals to appropriate external agencies" such as psychologist, psychiatrists, legal services were an important part of Therapeutic OOHC. Nearly all agencies reported that they provided access to specialist services daily or weekly. Agencies reported positive outcomes from these interventions such as "[young person's] anxiety issues decreased from seeing a psychologist fortnightly". One agency reported that referrals contributed significantly to a young person's good outcomes stating that, "services' ability to refer young person to many different agencies that could assist her i.e. "Adolescent Mental Health Service, School, PCYC, Doctors" was instrumental in providing adequate care. Internal specialist services were also important in providing quality outcomes for young people, when agencies had the resources to provide them. For example, one agency stated, "The young person was highly supported by our clinical team so upon leaving was able to self soothe and safely work through any problems she was experiencing, while also knowing how to access support when unsure."

Consistency

For many organisations consistency was needed over time to yield positive results. As one agency observed, that after 12 months consistent practice *"We started to make progress."* Many agencies reported consistency as an important factor in outcomes with statements like, "The consistency and predictability of staff on shift allowed the young person the opportunity to build meaningful relationships with staff" were common. Ensuring that young people have the opportunity to continue relationships even when moving to different care settings is important. When a young person moved from foster care to residential care, one agency felt *"support to maintain existing contacts with foster family and other social activities"* was an important part of Therapeutic OOHC and *"collaboration of all stakeholders"* was needed to adequately facilitate this outcome.

Skills (level of qualification and access to training) / Specialist input

Skills and training is an important factor and is essential to ensure quality flexible, congruent and tailored care. Five agencies indicated that training for staff is a top five priority. However, many agencies mentioned a *"commitment to training and development"* in their descriptions of good practices. The majority of services indicated that a Certificate IV in Youth Work or similar was a requirement for a Residential Care Worker job. Some said that relevant experience was as valuable and did not always expect a tertiary qualification. For managers or team leaders a Certificate IV and experience was generally expected with degrees in Social Work or similar looked upon favourably.

One agency expressed concerns when staff are not trained to an adequate level and felt that their agency was letting down a young person. *"[Young person's] engagement is very limited as we have not provided the type of training for*

staff to ensure meaningful engagement". This open and honest account shows the importance of appropriate training when agencies endeavour to work therapeutically. Another agency felt that *"training and development of care staff"* and *"clinical intervention and supports"* were primary aspects of their service that drove positive outcomes for young people. One agency reported they provided *"Training through [their] internal clinical team to enhance staff consistency in interactions and interventions"*. These examples show the importance of quality training, both internally and externally, to ensure quality therapeutic outcomes for young people.

Environment

One additional agency reported the environment of the care setting was important. Creating a "home-like" environment was seen by over 70% of respondents as being important for Therapeutic OOHC.

Family contact

"Promotion of natural family contact over an extended period" was also reported by some agencies as contributing to this component of Therapeutic OOHC. However, no agencies reported that Cultural Care Plans were one of the five most important elements of residential care work. This may be a gap in current Residential Care work, in particular around contributing to a "home-like environment" within care settings.

Leaving and Aftercare

Finally, leaving and Aftercare were also important aspects of Therapeutic OOHC that many agencies felt, due to funding constraints/guidelines they were not able to adequately provide.

Section 2 Summary

The findings from this snap shot provide important new information about the current residential service sector in NSW as of 2014. It is clear that there has been a substantial development in the field since the last survey in 2005. This development is captured most clearly in the data relating to the increased level of awareness of models of Therapeutic OOHC across the residential care workforce. This included evidence of the application of specific elements in the provision of care as illustrated in case examples, and in the arrangements being made for supervision, training and specialist support.

The survey was not designed to establish if agencies were or were not achieving therapeutic OOHC, however, it did provide details of a range of practices that provide affirmation that elements of a therapeutic model are being implemented. It should be noted that the adoption of therapeutic models and their associated elements has been initiated by the service sector itself – rather than being the result of the being a requirement of funding contracts. This development has also taken place in the absence of a NSW definition of Therapeutic OOHC. Taking this policy vacuum into consideration, the development indicates a strong intrinsic commitment to a therapeutic approach.

The workforce responded consistently in relation to the provision of supervision, access to clinical specialists, and support.

The case examples provided by agencies illustrated the use of therapeutic elements in caring for children and young people and what was particularly apparent was the influence of the adaptation of the newly developing knowledge base related to neuro-plasticity and an understanding of the impact of trauma and its management.

As well as providing evidence of a trend towards the adoption of therapeutic models and elements, the snap shot also tells a story related to a sector in transition, and where there are differences in training and skill level. In addition, it must be remembered that not all residential care units are striving toward a Therapeutic OOHC model. They may instead be seeking to fulfil the niche of 'good residential care'. For these services, while some elements of Therapeutic OOHC may be utilised, they will not have the full suite of elements within their service.

Section 3

Snapshot of Intensive Foster Care Services

Background

In nexus with the aforementioned work conducted, in 2014 the Association of Children's Welfare Agencies (ACWA) commissioned the Social Policy Research Centre (SPRC) to conduct a study of Intensive Foster Care (IFC) in NSW.

The aim of the study was to contribute information on IFC to a larger project being conducted, jointly between ACWA and the Department of Family and Community Services (FACS) on the development of a Framework for Therapeutic Care in NSW. The shared project sought to establish a strategic response to the therapeutic needs of children and young people in out-of-home care (OOHC), promoting healing and recovery from exposure to trauma (and other forms of severe adversity) through the development of a consistent sector wide trauma-informed service system for NSW.

Resultantly, Dr. Marilyn McHugh produced a developing practice article which provided a brief explanation of OOHC in Australia, and an outline of IFC services in NSW. A survey was conducted with non-government agencies providing IFC services, and the survey findings discussed. Specific focus in the paper was also given to one agency providing a small pilot program of Therapeutic Foster Care in NSW. The use of published material and other research studies to discuss certain aspects of Therapeutic Foster Care (TFC) services, in relation to NSW, were also included.

The paper's summary identified the links existing between IFC services and therapeutic foster care more generally, and also recommended attention be paid to carer recruitment, assessment, training and reimbursement for IFC; availability of carer respite; the matching process of carer/s to the child or young person; and the importance of model coherence when developing a Therapeutic Framework for Foster Care.

Notably the information outlined below has been extracted from the works of above-mentioned SPRC study of IFC in NSW, and practice papers written by Dr Marilyn McHugh, M. Refer also to the '*New South Wales Intensive Foster Care program survey findings*', *Developing Practice: The Child, Youth and Family Work Journal*, Issue 41 2015.

General Foster Care

General Foster Care (GFC) is provided by volunteer carers who receive initial training before being approved. On placement of a child or young person with an approved carer, the carer is entitled to receive reimbursement (i.e. fortnightly care allowance) for expenses incurred in the day-to-day care of the child or young person.

In relation to allowances, there is great variability between jurisdictions in relation to: how children are grouped into age categories; the number of groups used to set allowance levels; and the levels of allowances provided to Foster Carers. For GFC carers, the level of care allowance is usually based on the age of the child or young person. Most jurisdictions provide increased levels of care allowance for children or young people with special needs (McHugh & Pell 2013).

In NSW, Foster Carers are eligible for an age-based Statutory Care Allowance, and Relative/Kinship Carers may be eligible to receive an age-based Supported Care Allowance. The level of both allowance types is the same, and carers of children or young people with special needs may be entitled to receive a higher age-based allowance (e.g. for Foster Carers Statutory Care +1 Allowance or Statutory Care +2 Allowance). The same principle applies to Relative/Kinship Carers who may be eligible to receive either Supported Care Allowance +1 or +2 (NSW FACS 2014).

Across jurisdictions, all GFC carers are expected to attend ongoing training and though not mandatory, some jurisdictions require that they attend further standard training within their first 12 months. In most jurisdictions, Relative/Kinship Carers are encouraged, but not required, to attend Foster Carer training. Despite the assessment of special needs of some children in OOHC, there is no research based evidence that suggests GFC carers or Relative/Kinship Carers, who are receiving higher age-based allowances, are required to attend additional carer training to meet these special needs.

All Australian jurisdictions providing statutory Foster and Relative/Kinship Care also have a small number of specialist/therapeutic Foster Care programs. Despite the increasing number of children and young people placed in Relative/Kinship Care there is little, if any mention, in the literature of specialist/therapeutic care provided by Relative/Kinship carers¹⁵. There is no national data available on the number of specialist/therapeutic Foster Care programs, nor the characteristics and numbers of children and young people receiving these services. At August 2014 in NSW, there was provision for 947 IFC placements through non-government agencies providing OOHC services

¹⁵ Queensland has provision for Intensive Foster Care placements with kinship carers (QLD Department of Communities 2012).

(Carlisle 2014). More recently, at 31 March 2016 in NSW, 812 children and young people were receiving IFC (FACS preliminary data March 2016: OOHCA Actuals placement report 2 May 2016).

Therapeutic approach to Foster Care

In the last decade in Australia, a number of reports/publications reviewing and assessing foster care programs incorporating a therapeutic approach have been published. They include work by Acil Allen 2013; Frederico, Jackson and Blake 2010; Frederico et al. 2012; Hall and Robinson 2010; Lawson 2014; McAloon 2014; McClung 2007; and the Queensland Government Department of Communities 2011a, 2011b.

Fundamental characteristics defining Therapeutic Foster Care (TFC), similar to those described by McClung (2007) in the Victorian context, are outlined in the nuanced step-by-step overview by the Substance Abuse and Mental Health Services Administration of how TFC operates in practice in the United States (SAMHSA 2012, p. viii):

- a) Place a child singly, or at most in pairs, with a foster parent who is carefully selected, trained, and supervised and matched with the child's needs.
- b) Create, through a team approach, an individualized treatment plan that builds on the child's strengths
- c) Empower the therapeutic foster parent to act as a central agent in implementing the child's treatment plan.
- d) Provide intensive oversight of the child's treatment, often through daily contact with the foster parent.
- e) Make available an array of therapeutic interventions to the child, the child's family, and the foster family (including behavioural support services, crisis planning and intervention, coaching and education for the foster parent and child's family, and medication monitoring).
- f) Enable the child to successfully transition from TFC to placement with the child's family or alternative placement by continuing to provide therapeutic interventions.

An overview by SAMSHA on studies of services (e.g. mental health) for children or young people in TFC found that little is known about this type of care in the United States (US). Similar to Australia, there is no national data on the characteristics or numbers of children in TFC in the US. In the US, a wide range of approaches/frameworks were found to be used by agencies providing TFC (SAMSHA 2012). Similar to Australia, SAMSHA notes that TFC functions in a number of ways, as a 'step up' from regular (or general) family Foster Care or a 'step down' from residential care (or group home). Depending on the initial assessment of a child or young person coming into care, it may be the first placement option.

Intensive Foster Care in NSW

Until recently little was known about the NSW Intensive Foster Care (IFC) program. The program, introduced in 2007, followed a literature review of Therapeutic Foster Care (Schmied, Brownhill and Walsh, 2006: 5). This therapeutic approach was seen as 'promising and probably efficacious' and components of the programs reviewed informed the development of the IFC model for children and young people, aged 10-17 years with high and complex needs.

Review of available literature on specialist foster care (conducted by NSW researchers in 2006) found this care was defined as:

An intensive, family-based therapeutic approach based on social learning theory and an eco-systemic approach. Specially trained foster carers provide unrestricted support, care and a positive relationship (alliance) with a mentoring adult. The program involves close supervision of the child or young person, setting rules and boundaries ... interventions include counselling, independent living skills and problem-solving training, educational services and support groups (Schmied, Brownhill & Walsh 2006, p. 9).

Implemented by a number of non-government agencies, the NSW IFC program uses professional/experienced Foster Carers who receive approximately three times the level of the standard care allowance (McHugh and Pell, 2013). The focus of the program is on supporting children and young people in OOHCA who were:

Assessed as having high support needs and for particular groups of children (like siblings) that together require a more complex caring role. Intensive foster care provides for a coordinated plan of casework and therapeutic intervention within a community-based environment for children and young people with high support needs (NSW FACS, 2012, p. 4).

Understanding how IFC operates, and identifying the links between IFC services and other types of out-of-home care, especially Residential Care (RC) and Intensive Residential Care (IRC) services, is important in the context of the aforementioned ACWA and FACS joint project on Developing a Framework for Therapeutic OOHCA in NSW.

IFC functions in a number of ways – as a ‘step up’ from regular/ general foster care (GFC) or a ‘step down’ from a group home or RC/IRC. Depending on the initial assessment of a child or young person coming into care, IFC may be the first placement option.

In NSW, there are several key components of IFC services. Placements are characterised by the following:

- Carers are specifically recruited and provided with comprehensive training to equip them to effectively respond to the needs, and manage the behaviour of children and young people placed with them.
- Carers either retain the status of volunteers or engage as self-employed contractors (both options are current practice).
- Carers agree that they will have only one child placed with them at any one time¹⁶
- Carers agree that they will be available to provide direct support and supervision to the child or young person on a daily basis, and to attend case planning and other meetings/appointments related to the child/young person.
- Carers are actively involved in the development and implementation of the case plan, so that they become, in effect, key members of the casework team for the child/young person.
- Intensive caseworker support is offered to carers by way of frequent and regular home visits and telephone contact.
- There is the availability of after hours on call and call out support in the event of crises.
- There is regular, planned respite care for carers and children/young people.
- There is intensive case management of a child or young person in placement (NSW DOCS 2007, p. 4).

Difference between General Foster Care and Intensive Foster Care

McClung (2007) states that the key difference between General Foster Carers (GFC) and those providing Intensive Foster Care (IFC) is the expanded role of the carer and the more complex needs of the children in IFC:

Treatment foster care is based on the premise that foster parents can serve as a major provider of therapy in their daily interactions with the child, and that therapy need not be practised by the clinician alone (Redding et al., 2000, p. 426 cited in McClung, 2007, p. 13).

One of the key elements in IFC is the critical role/relationship of carers to children in IFC. The NSW IFC program emphasises this aspect stating that carers are to:

- receive comprehensive training
- provide direct support to the child
- attend case planning and other child-related meetings
- be actively involved in case plan development and implementation
- be key members of the casework team
- receive intensive case-worker support, including frequent home visits and telephone contact
- have access to after-hours on-call and call-out support
- have regular, planned respite
- all placements are to receive intensive case management (DOCS 2007, p. 4).

Although it is stated that the program is to provide ‘therapeutic intervention’, it is not clear what approach/model (e.g. trauma-attachment) a non-government provider should utilise in providing IFC services and in training their IFC carers. When recruiting an ‘adequately trained and supported pool of specialists carers’ it is also not clear whether agencies are to utilise their existing pool of experienced GFC carers, or whether carers are to be specifically recruited to the IFC program using a more sophisticated assessment tool and training process. This is an important point as whilst IFC is ‘family-based’ care that shares certain obvious similarities to general Foster Care including trust in the benefits of such care, one researcher suggests that:

¹⁶ There may be occasions when siblings may be placed together in an intensive foster care placement, but there would need to be a careful assessment of the capacity of the carer to adequately meet the needs of **all** the children in the sibling group, not just the child or young person identified as having the most significant problems. There may also need to be flexibility around this requirement for Aboriginal intensive foster carers due to the fluid and sometimes informal living and support arrangements in many Aboriginal families and communities.

... the differences between the models far outweigh the similarities and warrant recognition that they are not simply variations on a theme (Berreika, 1992 cited in SAMHSA 2012, p. xi).

The difference between a GFC carer and an IFC carer is substantial, and it is useful to delineate these differences. Clarifying the terminology used in a Queensland report, where a 'traditional' (i.e. general) Foster Carer was compared to a carer who provides IFC (i.e. 'enhanced' care), the differences were described as follows:

Carers of traditional Foster Care programs enjoy a greater level of autonomy than those of enhanced Foster Care programs. In a traditional foster placement, the child is placed with a family with minimal ongoing supervision and monitoring of the carers' parenting abilities. The child is expected to share the everyday life experiences of the family, and accept the responsibilities associated with that family. In contrast, a placement in enhanced Foster Care is subject to a higher degree of intrusion into the family home and scrutiny of the carers' parenting practices. There are also increased expectations upon the carers: that they accept these intrusive supports, embrace critical self-reflection, and put aside many of their natural parenting strategies in favour of those built into the program (QLD Department of Communities 2011a, p. 26).

Other characteristics of carers who are providing IFC include:

- willingness and ability to work as part of team
- commitment to ongoing learning
- resilience, patience and capacity to deal with a child's extreme and complex needs
- acceptance of a greater intensity of supports and intrusion upon the home life
- willingness to accept new and different ways of doing things, and acceptance of advice that can be challenging or confronting (for example in the form of constructive criticism) (Hall & Robinson 2010; QLD Department of Communities 2012, p. 11).

A further key difference between TFC and GFC is that the role of the TFC carer includes being part of the professional treatment team (i.e. 'care team'). TFC organisations define this difference as:

While all treatment parents are foster parents, not all foster parents are treatment parents. Treatment parents serve both as caregivers of children with treatment needs (the fostering role) and as active agents of planned change (the treatment role) (FFTA 2004, p. 19 as cited in McClung 2007, p. 11).

Children in TFC programs are assessed as being more traumatised, having more challenging behaviours (and/or complex needs) than those in GFC. This is reflected in the provision of increased caregiver reimbursements, staffing intensity and the multiple treatment services provided (McClung 2007).

A further difference between GFC and IFC carers is that a GFC carer can foster several children (related and/or non-related) at the one time. Generally the intent of carers in IFC is to provide care for one child only, except if the child is part of a sibling group, a decision has been made to place siblings together, and the carer is able to provide appropriate care for the group (DOCS 2007). In addition, the less intensive caring provided in most GFC placements means a carer may well participate in part- or full-time employment as well as fostering. This is generally not the case for carers providing IFC, where the complexity of the caring role usually prevents paid employment for at least one member of a carer couple/family.

Mandatory ongoing training to extend knowledge and skills is a requirement for carers in the IFC programs, but is not mandatory for GFC carers. In coping with their more complex role, the Department of Community Services (now FACS) acknowledged that a Foster Carer providing IFC requires an elevated level of support from an agency:

Levels of support and training, and remuneration that needs to be offered to carers to assist them and provide them with recognition for their role is higher than the more standard form of Foster Care (DOCS 2007, p. 3).

Differences in Intensive Foster Care and Residential Care in NSW

A Child Assessment Tool (CAT) score is assigned to children and young people when they are referred for placement. There are six levels of care, which in theory, determine which level of care a child or young person should be placed in:

Level 1: General Foster Care

Level 4: Intensive Foster Care

Level 2: General Foster Care + 1

Level 5: Residential Care

Level 3: General Foster Care + 2

Level 6: Intensive Residential Care

Where possible, children and young people are placed with an agency that can provide a placement matching their CAT level. As will be noted in the discussion below, in the findings from the survey with agencies, it is not uncommon for children or young people to be in placements that do not match their CAT score, resulting in some children and young people at Levels 4-5 being in either IFC or Residential Care (RC). Despite similarities between the needs of children assessed as Level 4-5, there are significant differences in a number of aspects of IFC and RC, which raise some concerns between equality of treatment for IFC carers compared to workers in residential settings.

The unit costs for IFC compared to RC is around half. The additional funding for RC covers costs not applicable to home-based IFC, including staff salaries and accommodation costs. The financial support for a volunteer Foster Carer (Care Allowance) covers the typical day-to-day costs of the child or young person whilst the wages/salaries for staff are their income/earnings. The unit costs for IFC include an unspecified amount for contingency payments. This is a common term used to describe the funding for services and items for children and young people in IFC that are in excess of the 'day-to-day' expenses that are included in the care allowance.¹⁷

Depending on circumstances the CAT score can be reduced or increased at the time of a case review and assessment of the child or young person. Some children or young people may move from IFC to GFC whilst others may require a RC placement. In circumstances where an IFC placement changes to a GFC, and the placement is maintained with the same carer (a desirable outcome), the level of care allowance can be reduced to a lower GFC level. This may result in some financial stress to the carer previously receiving a higher care allowance and less caseworker support due to the change in the child's CAT score.

The expectation of an IFC carer is that care will be provided on a 24/7 basis with occasional respite provided. The provision of appropriate respite as discussed below in the survey findings is problematic, and finding respite carers for children in IFC placements can be extremely difficult. Staff in residential settings would generally work to their award conditions (e.g. 7-8 hours per day, five days a week) with regulated breaks from their care work.

In relation to training, little is known about the formal qualifications of carers in IFC. The survey findings indicate that carers with professional qualifications were seen as 'more desirable' by agencies than those without them. Data from the NSW Workforce Profile of Residential Care Workers (n=110), conducted for the ACWA/FACS project, indicates that NSW residential care workers had significant qualifications. While around 15% had no formal training; 10% had a Certificate III; 15% had a Diploma; 43% had a degree; and 48% had a Certificate IV (percentages are more than 100 owing to some workers having more than one qualification).

Survey of Intensive Foster Care Services in NSW

In NSW at September 2014 (at the time the study was conducted), throughout metropolitan and regional areas, there were 23 non-government agencies providing IFC services. Twenty agencies had approximately 910 IFC placements and three Aboriginal agencies had approximately 37. Eleven agencies had 10 or less IFC placements; another 10 had between 11 and 63; and two agencies had 105 and 539 placements.

The focus of the IFC program is on supporting children and young people in OOHC who are assessed as having complex and/or high support needs, and for particular groups of children (e.g. siblings) that together require a more complex caring role. IFC provides for a coordinated plan of casework and therapeutic intervention within a community-based environment for children and young people with high or complex support needs.

¹⁷ Care Allowance covers costs incurred by the carer for an individual child or young person, including food, shelter, clothing & footwear, household provisions, daily travel & suitable car restraints, holidays, gifts, haircuts, pocket money, hobbies, music lessons, sporting activities, general education costs, school excursions, general hygiene needs, medical costs and pharmaceutical costs.

Understanding how IFC operates, and what the connections are between IFC services and other types of care, especially Intensive Residential Care (IRC) services, is seen as important in the context of this study on Therapeutic Care.

Given the time-limited nature of the smaller study conducted, both ACWA and the researcher decided to conduct a short survey. The survey with the non-government agencies providing IFC services was designed to capture specific aspects of their program. The survey contained nine open-ended questions with a number of prompts in order to elicit detailed information from each question. The survey conducted in September/October 2014 contained the following questions:

1. How are IFC carers recruited?
2. What type of training is provided to IFC carers?
3. How are IFC carers reimbursed?
4. What types of assistance best support IFC carers?
5. What are the difficulties in matching carers/children/young people in IFC?
6. What are the usual pathways for children entering IFC?
7. In general, how long do children stay in IFC?
8. What models of IFC guide an agency's practice?
9. How do agencies ensure IFC carers have a good understanding of what 'therapeutic intervention' means in their caring role?

The agencies were contacted by email explaining the purpose of the study and requesting them to complete the attached survey. Follow-up phone and email contact to agencies, who did not initially respond, was utilised to encourage agencies to complete/return the survey. Responses were received from 19 of the 23 agencies resulting in a response rate of 83%. Two organisations returned additional surveys as they had agencies located in different areas in NSW. In total, data was obtained from 21 completed surveys.

Agencies responding to the survey appeared to be at different stages of IFC provision. Some had been providing IFC for many years while others appeared to be more recent providers. Some agencies provided detailed information whilst others replied with only brief statements about their service. Some responses contained information relating to all the prompts in the questions whilst others did not. The main themes emerging from the data analysis are presented below. In 2014, one agency was implementing a therapeutic foster care pilot with 12 placements.

Responses from agencies are highlighted in Dr Marilyn McHugh's *Developing Practice* paper (refer below to Case Study heading).

Carer recruitment for Intensive Foster Carers

In relation to recruiting carers, most surveyed agencies utilised their existing pool of generalist carers for IFC. Generalist carers known by agency workers as having the additional skills and extensive fostering experience required to provide IFC were invited to consider being an IFC carer. In addition, in their general carer recruitment process, agency workers followed up recently approved carers who they thought had the potential to be IFC carers. Only one agency that had, until 2014, provided IFC services only, specifically recruited approved and trained IFC carers. In 2014, this agency also began providing GFC. Nine agencies had, or were currently using, specific marketing strategies to attract IFC carers. Acknowledging the increasing professional approach to IFC, one agency, in advertising for carers for IFC, looks for people with background skills and knowledge from working in areas such as education, health, child protection, disability care:

We treat Intensive Foster Care as a job and advertise through avenues such as SEEK (i.e. employment websites), this way we can acknowledge the level of commitment required and allows us to target people who will have a primary carer dedicated solely to the foster caring role (Regional agency).¹⁸

Assessment process for IFC carers: Eight agencies said they used the assessment tool Shared Stories Shared Lives (SSSL) for their generalist carers and initially for IFC carers as well. Agencies recruiting for IFC then conducted a more in-depth assessment of potential IFC carers. The assessment was based on findings from known characteristics of their current IFC carers and other care aspects, including:

¹⁸ The agency offers carers up to \$39,000 annual tax free allowance, advertising that it works with carers and children to provide 'true' Therapeutic Care. The indicative annual amount of carer allowance calculated by the department in the breakdown of Unit Costs for IFC services is \$41,015 (Carlisle, 2014).

- carer experience working with children with challenging behaviours
- household capacity to support children with high and complex needs
- current household composition of adults, birth children and current child placement
- therapeutic services available to children within the region
- respite options available within the region
- length of placement required.

In addition, agencies assessed IFC carers on their motivation, resilience, levels of empathy, in-depth understanding of the influence of trauma, appropriate behaviour management techniques, ability to provide consistency and routines, and a willingness to work with young people with high and complex needs. If 'gaps' were found in any area of the required skills, assessors would recommend specific training. Carer availability to attend training and their preferred method of training was also assessed. Assessors looked for a commitment from carers to participate in ongoing learning and training.

Only one agency stated they had an IFC carer who was a qualified social worker/disability worker. Another agency, who looked at the carers' previous employment (e.g. nurses, youth workers and teachers) as a guide to their experience and skill, found only a small number of people in those professions agreeing to consider IFC children. Before a long term IFC placement was made, the policy of one agency was to ensure that IFC carers were experienced at providing GFC and had previously provided IFC respite care.

Literature findings on carer recruitment: Evaluators of the Victorian Circle program, in noting the ongoing difficulties in recruiting carers, suggested that it was important that agencies used specific strategies to recruit suitable carers for IFC. A suggested recruitment strategy, which has been found elsewhere to be particularly useful, is the 'word of mouth' where current IFC carers encourage others to foster by relaying their caring experiences to friends, family and colleagues. The evaluators also noted that recruitment should be locally based and emphasis placed on the benefits of support systems attached to IFC programs. Also important was highlighting to potential carers the positive experiences of existing carers, including their ongoing development and understanding of their enhanced role. An obvious corollary of this approach, stated by the evaluators, is to involve experienced IFC carers in the recruitment and training of potential IFC carers (Frederico et al. 2012, pp. 11-12).

Similar to the Victorian evaluators, a consultant reviewing specialist Foster Care in Queensland, also found stakeholders in the consultation reporting general difficulties in carer recruitment. Most stakeholders found local-level activities more productive than state-wide recruitment campaigns. In recruiting for specialist Foster Carers, services used targeted recruitment strategies seeking people appropriate for children with complex or extreme needs. In some instances, they used targeted recruitment for a specific child with particular needs. The review highlighted the characteristics of the people 'best suited' for providing specialist care:

Services tend to look for people who are or have been parents themselves, or who may have provided foster care before; people who have specific skills for specific needs (for example working with disabilities); people who show a willingness to work as part of a team and to learn; and people who have flexible lifestyles (i.e. at least one carer has enough time available). At least one service noted that it screens out approximately 90 per cent of those who express interest throughout its recruitment activities (QLD Department of Communities 2011b, p. 8).

In addition to specific recruitment strategies, the Queensland consultant also found that in integrated services (e.g. providing various types of OOHC placements) approaches were made to experienced GFC carers to provide specialist care. In some existing placements, where additional supports were found to be required to meet a child's specific needs, then the placement could be 'upgraded' to a specialist placement with the child remaining with the carer (QLD Department of Communities 2011b).

Training for Intensive Foster Carers

Most agencies in NSW used a combination of internal and external trainers to provide specific training for carers in IFC. Trainers were agency staff and/or professionals such as psychologists, psychiatrists, therapists, social workers, counsellors and other specialists (e.g. SAL Consulting).¹⁹

One agency, a provider of IFC services for a number of years and with a large number of IFC placements, used a Carer Learning and Development Program for IFC carers. The program includes eight core areas and uses multiple pathways for ongoing carer development – electronic versions, small groups, online support, and independently in a self-directed format.

Most agencies offered training opportunities to their IFC carers through their attendance at carer conferences, forums, workshops, or with other partner organisations. One agency commented that their practice was to provide flexible training opportunities delivered in different modalities, i.e. within the home, as a part of a larger carer group, by funding attendance at conferences and workshops, or by contracting a specialist to provide specialist training on a specific topic. Another agency noted that one-on-one carer training is presented as needs arise. Agencies also mentioned using regular training sessions provided by *Connecting Carers*.

Types of carer training for IFC carers: The types of ongoing carer training offered by agencies varied significantly. Many agencies noted the importance of providing training around the influence of trauma on the developing brain for children in different age groups. As a consequence useful strategies and therapeutic tools were provided in dealing with trauma.

An Aboriginal agency conducts bi-annual training for IFC carers using a program, **Special Training for Aboriginal Carers**. Similar issues or training needs are identified by carers and then translated into training by the Foster Care Support Team. The agency has developed a partnership with the Australia Trauma Group, which delivers ongoing training in relation to children and young people's experience of trauma and associated issues.

Similar to other agencies, one agency stated that the most common form of training undertaken by IFC carers related to behaviour management whilst others spoke of providing specific carer training based on the child's needs e.g. training on autism if a child in their care is diagnosed with autism.

One agency said that it was critical to ensure the carers understood what working within a therapeutic framework involved, and how it would be possible to provide this type of care within their homes. A definition of therapeutic care needed to be discussed along with a number of other topics related to increasing the skill levels of carers.

Reflecting the diverse needs of the population of children and young people in IFC services, a number of re-occurring specialised training topics were mentioned by agencies, including:

- reactive attachment disorder
- oppositional defiance disorder
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- anxiety
- cultural and support issues for Aboriginal and Torres Strait Islander children
- meeting needs of Aboriginal and Torres Strait Islander children
- Post-traumatic Stress Disorder
- sexualised behaviours
- deep brain learning
- impact of domestic violence on CYP
- self-harm and suicide risk
- intellectual and/or physical disabilities
- restricted practices
- Therapeutic Crisis Intervention (TCI)
- Response Ability Pathways (RAP)
- therapeutic crisis intervention for foster carers
- grief and loss

¹⁹ SAL Consulting is a human services consultancy offering therapeutic service for children, adolescents and adults who have experienced complex trauma, long-term difficulties in emotional interaction, attachment difficulties, and severe behavioural disruption due to abusive and neglectful backgrounds (<http://www.salconsulting.com.au/therapeutic.html>).

- attachment
- substance abuse
- absconding; and
- reunification.

Intervals between carer training: As with training topics, there was considerable variation in intervals for IFC training. Some noted that carer training was held at irregular intervals; others said it was monthly or bi-monthly, or 2-3 times per year, or bi-annually. Other agencies provided individual training for carers with clinicians/professionals, arranged as needed, focussing on specific needs of the carers or client. A number of agencies noted that they required IFC carers to participate in regular ongoing training sessions. One agency spoke of a fortnightly online support program where carers could log on to discuss issues and gain increasing knowledge on how to work within a therapeutic manner. In other agencies, carers attended IFC carer support groups bi-monthly.

Literature findings on carer training for IFC: Overviews of TFC suggest that enhanced or specialist training is integral for carers in the program. Specialist training has many advantages including:

- providing carers with a conceptual framework to understand children’s complex needs
- assisting in preventing placement breakdowns
- increasing carer retention rates
- developing carer skills and knowledge in implementing a treatment plan
- assisting in managing complexities of behaviour and providing effective treatment
- achieving optimum outcomes for CYP (McClung 2007).

McClung (2007) discussed a number of national and international specialist carer training programs, some based on attachment theory and/or the influence of trauma on the brain and development, though none appear to have been evaluated. Similarly, a Queensland review of specialist Foster Care found no generic training programs for specialist Foster Carers that had been ‘scrutinised by empirical study’, and while there were existing training programs, none were specifically designed for specialist foster care (QLD Department of Communities 2011a, p. 37).

Stakeholders in the Queensland review suggested a mandatory training program tailored specifically for specialist carers, though there were divergent views on what should be included in the package. Concerns were raised around practical issues in terms of when carer training should occur. The consensus was that training should be undertaken within a fixed time period after a placement was made. If specific needs were identified in a child’s case plan, targeted training should be provided to specialist carers. Benefits were seen in carers and caseworkers co-attending specific training allowing for reflective practice, discussion and shared understanding. Some specialist services thought, however, ongoing carer supervision and mentoring was more beneficial than training programs (QLD Department of Communities 2011a). In Queensland, IFC carers may be exempted from completing additional training if the carer has ‘relevant experience or training that can be recognised as prior training’ (QLD Department of Communities 2012, p. 14).

Similar to Queensland, except for two surveyed agencies (i.e. one providing Carer Learning and Development Program and the other Special Training for Aboriginal Carers), there also appeared to be no standardised training for IFC carers in NSW. A study conducted by one of the surveyed agencies on transitioning children and young people from RC to IFC recommends that training in RAP (Response Ability Pathways) and TCI (Therapeutic Crisis Intervention) be made compulsory for all IFC carers (Lawson 2014).

Best supports for carers

Surveyed agencies provided a wealth of information on what they considered to be the best support for IFC placements. As with the variety of carer training topics, types of support also varied significantly though there were a number that dominated the responses. Based on the number of agencies providing responses, included among support types were the following:

- intensive casework and case plan management (21 responses)
- regular and appropriate paid respite as part of a case plan (16)
- access to 24 hour on-call support worker (16)
- access to high-quality ongoing training (11)
- provision of adequate and appropriate allowances (7)
- access to clinical advice/consultations (6)

- non-emergency out of hours support service (6)
- carer access to qualified, experienced trauma counsellors (5)
- access to appropriate wraparound services for child or young person (4)
- frequent supervision and reflection in a non-judgemental setting (4)
- carer review (4)
- team meetings with carers (4)
- input and support on all aspects of child or young person's education (3)
- carer support groups (3)
- child or young person access to qualified and experienced trauma counsellors (2).

Other support mentioned only once included: the use of Neurosequential Model of Therapeutics²⁰; organised activities for children; ongoing/meaningful opportunities for carer participation and feedback; provision of care by agency during periods of school suspension; physical assistance such as purchase of specialist equipment, home modification; Life Story work; holiday camps for children and young people; youth worker support; and utilising Connecting Carers²¹ as an external support.

Several agencies mentioned providing more general support, including access to Agency newsletter containing information and resources, foster care stories and upcoming events. Some agencies said they recognised carers in the annual foster care week and provided them with gifts and appreciation cards. Other agencies held annual Christmas lunches and events to facilitate peer support amongst carers.

Respite: Respite for carers involved in the intensive and challenging work of IFC is an essential support service. As with the level of care allowance provided to IFC carers, the department does not prescribe how NGOs implement their respite policy, or the amount of respite to be provided to carers. The recommended benchmark level for carers of children with high needs (e.g. IFC carers) is 48 days per annum.

The limited availability of IFC respite carers was raised as an issue by one agency. The manager commented that the agency struggled to find carers for children aged 10+ as carers were unprepared to deal with teenage behaviour, let alone the level of challenging behaviour of many children in IFC. The importance of providing trained respite carers for children and young people with complex needs was noted by the evaluators of the Victorian Circle Program:

Focus group and survey respondents emphasised both the importance of access to and continuity within respite provision. Notwithstanding the fact that respite care has not been available to all Circle carers, it was highlighted by some as an essential component of carer support (Frederico et al. 2012, p. 81).

Matching carers to children and young people in Intensive Foster Care

Current practices in matching: Most agencies stated that matching is done by assessing the needs of the child with carer qualities/attributes/skills. The process is informed by the Child Information Form and CAT scores. A number of agencies provided guidelines they used to identify the type of care best suited to the child or young person, the supports and services required for the child or young person, and the particular skills and abilities required of the carer. Key factors included:

- child or young person's identified immediate and long-term needs
- effect on household members of proposed placement
- child or young person's cultural and ethnic background, needs and linkages
- ensuring Aboriginal children and young people are placed with Aboriginal carers (where available)
- knowledge of whether the child or young person is a member of a sibling group

²⁰ Bruce Perry's Neurosequential Model of Therapeutics (NMT): Forensic psychologist employed to complete NMT; all child files (affidavits, child protection report, specialist reports, case notes etc) reviewed; casework team interviewed; current and past carers interviewed; NMT brain map and report compiled; psycho-education plan developed and provided to casework team and carers; training for carers in the use of the psycho-education plan delivered; and casework staff follow up on plan.

²¹ **Connecting Carers NSW** provides support and training to foster, kinship and relative carers. It offers carers 24 hour telephone support, ongoing education, peer support and advocacy to assist carers in caring for children and young people in OOHC.

- known behaviours of the child or young person
- child or young person's views (if known)
- additional support required to meet the child or young person's needs
- carer skills, experience and ability to meet the child or young person's specific needs
- carer ability to work with the biological parents in a positive manner
- age, gender, development stage of carers' children and other children already placed
- carer age, general health, energy levels and stamina in relation to expected length of the placement
- carer preference, lifestyle and personality
- carer's current circumstances, socio-economic considerations and household dynamics
- placement location - ability to minimise disruption to the child's life by maintaining community links including school, friends and sports
- carer value conflicts, creation of barriers to child returning home
- carer ability to establish empathy
- effect of proposed placement on any existing placement
- current staff capacity and availability
- current support available
- religious views of the carer and the biological families (if applicable).

These carer-related factors are similar to those outlined in the Queensland IFC program description (QLD Department of Communities 2011, p. 15).

Barriers, difficulties and challenges with matching: As one respondent commented, in an ideal world, agencies would have a pool of carers to select the 'best' match with a child or young person requiring IFC services. The reality, however, is that many surveyed agencies, especially those in regional areas, struggle to find a carer to take a child or young person assessed for IFC. Finding appropriate Aboriginal carers for Aboriginal children and young people requiring an IFC placement is also extremely difficult. One agency stated that recruiting and maintaining IFC carers is a challenge due to the limited understanding in carer communities of the needs of children and young people assessed at this high/complex level of need. Similar challenges presented themselves in finding ongoing suitable IFC respite carers. Use was made by one agency of placing children and young people requiring IFC services with a short-term IFC carer, until the agency assessed and developed a profile that matched the child or young person with a suitable long-term carer.

The following quotes highlight the challenges faced by agencies:

The difficulty is having the range of carers to meet the complex needs of kids who are in need of IFC.

IFC foster carers generally need to invest more of their personal time to care for an IFC client. Often the clients are not able to attend school due to behaviours or excessive appointments, preventing carers from work commitments. Carers often have to choose between a career over caring for a child or young person.

We consistently have challenges in recruiting carers who have the capacity to manage the additional challenges that IFC children present. Of note is the impact of an IFC child on their own family, their social engagement and their ability to have the sufficient time to devote to this.

When we speak to carers about the needs of an IFC child we are honest and open about the child's trauma history and current challenging behaviours. There is generally not a problem in matching carers to IFC children, but the difficulty is in maintaining the placement as I don't think carers ever actually believe us when we tell them how difficult it will be.

Solution for matching: As with many OOHC, placement agencies are often asked to place a child at short notice, which can cause difficulties if there has been little time for child/carer matching. Several agencies thought that use should be made of short-term/emergency/respite carers for short periods during the transition phase, thus reducing the risk of 'crisis driven' matching and ultimate placement breakdown.

Another agency suggested that the 'ideal' solution was to have a steady stream of Foster Carers recruited into agencies, so as to have 'options' for children and young people when needed. This worked for one agency who commented that they had a large pool of carers available and could usually placement match.

Some agencies noted that client/carer matching had many issues particularly in the initial stages of transition. Providing high levels of support through the transition could increase the likely success of carer/client matching, with one manager saying that their solution was to offer intense casework support and scheduled respite. Furthermore, if IFC placement meant a change of carer and, as a consequence, a change of school, this process could commence as soon as the 'new' placement was confirmed, minimising time out of school.

It was also suggested that agencies, using their existing GFC carers to provide IFC, could benefit from implementing a specialised recruitment campaign for IFC carers. A further solution for appropriate matching of carer/child for IFC placements came from a regional agency manager:

Moving forward, I believe developing a professional foster care model is the ideal way to provide successful IFC placements. This model attracts a different calibre of carers who can provide emotional and psychological warmth and care whilst also engaging in their role from a different attitudinal position. This approach would also allow for regular formal supervision, increase wage/allowance and further 'professional development' versus simple training opportunities.

Length of time children and young people spend in Intensive Foster Care

Understanding how RC interrelates with IFC services, the 'fit' in the services system and their relationship is discussed in this section. The length of time spent in IFC varied greatly; it often depended on the age and/or needs of the child or young person. Whether the IFC placement was a 'step-up' from GFC or a 'step-down' from RC also affected the time spent in IFC.

Two agencies noted that clients transitioning from RC were likely to remain in IFC, where behaviours were managed and needs met. These clients could remain in the placement until they left care. One manager noted that all IFC children in their program were in stable placements with long-term carers and required intensive support and funding to maintain the level of services and support that were keeping the placement stable. This was echoed by another manager who said that most children in IFC placements stayed in the program because of the ongoing support required.

Children and young people with high/complex health or development needs (e.g. global developmental delays, autism or mental health needs), were likely to remain in IFC for longer periods or as a long-term placement option. Other agencies maintained children in IFC until their behaviour 'settled', they showed evidence of developing a strong carer attachment, they were able to self-regulate across different settings and had become competent in navigating social situations including school. If these children were in stable placements, then the IFC level could be reduced to GFC +2 or GFC within the same placement. This process allowed for continuity of the agency's workers in the child's life as well as ongoing connection and attachment to the carer. Agencies noted this occurred as many of their placements were long-term care arrangements.

For other agencies, some young people stayed with carers past 18 years of age, some transitioned to independent living and some transitioned home. One manager commented that in some instances, a family member (or significant other) prepared to support the young person may come forward, and this was always a good option as they could be educated and supported through a planned and gradual transition process.

One manager of an Aboriginal agency had transitioned some children and young people from IFC to family/kinship placements. Noting this took 'a very thorough transition plan' where the IFC caseworker was highly involved with the family/kin. The transition required the development of a training plan with the family/kin to ensure they could meet the child or young person's needs.

Five agencies said that they had children and young people move from IFC to RC due to an escalation in a child's behaviours/health issues, carer burnout or the carer being unable to provide adequate care. For one agency, placement stability was due to the 'strength' (resilience) of the Foster Carer, with the manager noting that this was the defining factor of a strong placement.

Some placement reviews and re-assessments indicated that care levels had increased from IFC to RC or IRC. It was the experience of one agency that children and young people with a significant history of previous IFC placement breakdowns were at increased risk of further placement breakdown, and referral to RC. The manager stated that this situation could arise if an assessed young person requiring RC was placed in IFC due to either their age, lack of an RC placement, or other factors such as costs. Age was also a factor in the breakdown of IFC placements, with some agencies noting an increase in placement breakdowns for young people in mid-late teenage years.

One agency (provider of a large number of IFC placements), indicated the ongoing tension for some agencies providing IFC services, is that:

It is not an incentive for the NGO or carer to show evidence that the young person's needs have reduced and that the carer and organisation has been able to show such positive outcomes in standards of care. The outcome will be that the amount of reimbursement ... and the subsequent organisation support as well as contingency expenditure will also be reduced.

Challenges in transitioning children from IFC: A number of challenges were noted by five agencies providing IFC services. One challenge highlighted in the quote above related to reduced carer reimbursements when a child transitioned from one level of care to another. A manager spoke of the issues for an IFC kinship carer when the young person (aged 16 years) was reassessed as requiring GFC not IFC. Although notified several months in advance of the change to the allowance, the significant change in reimbursement was a 'struggle', given the allowance reduced by approximately half per week.

For another agency, the transition to GFC from a settled IFC placement meant a change of carer. The manager noted that this raised concerns and challenges in maintaining this attachment, and supporting the child or young person to transition to yet another placement in a system that constantly seeks and promotes permanency and placement stability. This was also a concern for another manager who commented that when some children or young people change programs, and the funding and support decreases, it can result in placements destabilising.

Another agency often found it very difficult to transition a young person from IFC to RC due to lack of available RC placements. At times, this resulted in some IFC placements breaking down due to the young person's high/complex needs. Even when requests for additional support and funding were granted until a RC placement was found, finding staff to provide the increased level of care was problematic.

Significantly, only one agency mentioned that they sought the young person's opinion on how best to transition them to another placement/program.

Models of Intensive Foster Care currently used by non-government agencies in NSW

Twenty-two respondents answered this question. Two respondents in discussing their practice said they did not use a specific model. The model used by the other 17 agencies varied considerably. Some respondents named a specific model while others spoke of a 'Framework of Practice' and others referred to using a model with a 'Therapeutic focus'. Notably, some agencies provided very detailed information on numerous aspects of their practice whilst others provided a minimal answer as simple as 'Therapeutic Model'.

The various models used by agencies in NSW included:

- Therapeutic model (7)
- Trauma-informed model of care (4)
- Bruce Perry's Neurosequential Model of Therapeutics (NMT) (1)
- CARE Framework (1)
- Strengths-based/solutions-focused approach plus Circle of Courage²² (1)
- ARC (attachment, regulation and competency) (1)
- Team Parenting Framework (1)
- Agency practice/framework guided by research on attachment, resilience and provision of safe, secure and nurturing relationships (1).

Foster Carer practice in Intensive Foster Care

An important aspect of IFC is in understanding the day-to-day practice of therapeutic intervention as provided by Foster Carers in IFC, and how carers are sustained in their role. There are no research studies outlining how therapeutic interventions are implemented in practice by Foster Carers in an IFC program. This is understandable

²² Circle of Courage Brendtro, Brokenleg & Van Bockern, 1990.

given the children or young person's specific needs and complex behaviours in IFC programs. As noted by McClung (2007, p. 34):

Chronic childhood trauma interferes with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole ... trauma affects the whole person: their mind, brain, body, spirit and relationships with others.

While there may be some similarities or common features in carer practices in IFC, there is unlikely to be any specificity in the approach taken by an individual carer. This is supported by researchers' findings of therapeutic care who suggest that:

...attunement, attachment theory, and understanding of trauma dictate how to interact with a child rather than a specific set of rules or a predetermined structure (Shell & Becker-Weidman 2005, p. 141 as cited in McClung, 2007, p. 26).

Fundamentals principles involved in therapeutic parenting are discussed by McClung (2007). They include IFC parents being attentive, friendly, empathic, playful, loving, accepting and curious about the child whilst providing the child with a secure attachment relationship that promotes stability.

In Queensland, where the carer is the key figure in the therapeutic milieu, the aim of therapeutic intervention is towards healing, recovery, rehabilitation and growth, particularly:

- healing damage caused by broken attachments (often multiple)
- promoting the development of positive attachment styles
- promoting positive behaviour strategies
- reducing maladaptive problem behaviours learnt through traumatic childhood experiences
- fostering growth and development to age-appropriate milestones
- building the capacity of children to manage enduring challenges such as disability and chronic illness
- restoring and rebuilding broken relationships with family, friends and community
- developing children's capacity to form and maintain positive relationships with others;
- diminishing negative and unconstructive self-schemata (QLD Department of Communities 2011, p. 20).

Evident from the analysis above and findings from research studies indicate that agencies have high expectations of carers who take on the difficult task of caring for children and young people in IFC placements. A Victorian overview of TFC noted the role of the care team in assisting/supporting the carer as fundamental in TFC in retaining carers and avoiding placement breakdown. McClung (2007, p. 29) notes that 'living and caring for traumatised children is a challenging task that may evoke intense emotions in the care giver'. Good support, supervision, reflective practice and respite are essential components of practice to assist the carer in maintaining the placement.

Circle Program and Therapeutic Foster Care

One jurisdiction in Australia, Victoria utilises a specific model in providing a Therapeutic Foster Care approach and it has proved to be highly successful. The evidence comes from an evaluation of the Circle Program, a Victorian TFC program introduced in 2007. In 2012 the program provided placements for 97 children (7% of all children in foster care) across Victoria. The program is based on a strong theoretical foundation, providing therapeutic training for all key individuals in the care relationship. All foster parents (existing and new) in the program must undertake the program's training package and be assessed as suitable carers (VDHS, 2009). Central to the program 'is the primacy of the carer/child therapeutic relationship. The focus becomes the carer's ability to provide **skilled therapeutic parenting**' (authors' emphasis). (Frederico et al., 2012: 17)

In discussing what TFC carers achieve with children and young people in the program the evaluators found carers were well trained, well supported and highly committed to their role. In addition carers were highly satisfied with their role as valued members of the team, their opinions were heard and their expertise valued.

Maintaining the health and well-being of carers and their families was also a constant point of focus of the care team and carer retention in the program was high. Availability of respite for the carer was central to the success of the program as was higher financial reimbursement for carers. The provision of high financial reimbursement enabled carers to provide the best care for their foster children, allowing one carer (usually the mother) to give up fulltime employment to support the fostered child or young person. The evaluators found that carers described their role as 'equal' with other professionals in the care team:

This, combined with The Circle Program training, has professionalised the role of foster carer, and some carers reported increased levels of confidence in their competence. (Frederico et al., 2012: 10)

Aspects of care which appeared to influence the outcomes for children and young people included the fact that with competent, confident and well trained and supported carers placement stability was enhanced, allowing children and young people to 'progress forward', especially with developmental gains. An example of this progress was indicated by the evaluators:

The timeliness of responses to a child's need was frequently mentioned as a core component of The Circle Program. Dramatic stories involved children who had experienced such severe neglect that they were unable to sit, crawl or walk, where these milestones were well overdue. Infants have been described as having to receive intensive support and input to learn how to chew food to communicate with adults and to establish normative sleeping patterns. (Frederico, et al., 2012: 80)

Specialised training received by carers was seen as essential as it helped carers translate the theoretical model into practice. The evaluators found that:

The theme of a planned and thoughtful response to challenging behaviours was consistent among carers in all of the focus groups ... Furthermore, in addition to the initial training, the ongoing opportunity to review, reflect and to deepen one's understanding of the child's needs in the context of a trauma-based theoretical framework was frequently mentioned by carers as a key benefit to them. (Frederico, et al., 2012: 38-39)

Agency Case Study

One surveyed agency in NSW, contacted to take part in the study's survey, was implementing a TFC pilot program (12 placements). The agency's model based on Victoria's Circle Program uses the **Sanctuary Model** as its overarching Practice Framework. Sanctuary is a clinical and organisational change model that promotes safety and recovery from adversity through the active creation of a trauma-informed community. It operates from a therapeutic framework grounded in trauma, attachment, child/adolescent development, and reflective and evidence-based practice. The framework underpins all service delivery, organisational systems and corporate support services, and engagement with partners and stakeholders.

A specific carer recruiting strategy of awareness raising, word of mouth and targeted recruitment for specific children is being used. The strategy is designed to attract applicants (e.g. teachers, doctors, nurses and social workers) with particular skills, knowledge and characteristics necessary for providing TFC. Prospective carers complete Shared Stories Shared Lives (SSSL) and Step by Step (SxS) and an additional three-day therapeutic foster care training program. The training is multi-faceted and is based on current research and practice in the field of trauma and attachment; the Sanctuary model; the Circle Program; and therapeutic parenting concepts.

Applicants are then assessed by a therapeutic specialist to assess their competency, attitudes, values, abilities and commitment to provided TFC. The robust assessment process means that only applicants able to provide TFC and meet children and young people's complex needs are recruited for the therapeutic foster care pilot. Regardless of the child's CAT score all carers are reimbursed at the GFC+2 rate (age-based fortnightly levels range i.e. 0-4 year old to 16-17 years). The level of allowance is seen as an important element of the agency's carer recruitment strategy.

The agency places a strong emphasis on matching carers to children and young people, as good matching increases placement success and stability. This may mean that some children and young people are placed in short-term bridging placements while information about the child or young person's needs and trauma history is gathered, a suitable match with a Therapeutic Foster Carer is made, the care team and birth family are engaged and an individual transition plan is developed.

Whilst the agency has committed significant resources to carer recruitment the biggest challenge for the agency is finding carers with the qualities and attitudes required to provide TFC. The agency only places sibling groups of 2-3 children and places no more than 1-2 children with a carer at a time, to ensure that carers are able to provide a therapeutic environment and an appropriate level of therapeutic care.

Section 3 Summary

Links between IFC and Therapeutic Care

Except for the specific case study noted above on a TFC pilot program, the findings from this brief analysis of survey respondents suggests that a number of aspects of Therapeutic Foster Care, as described by McClung, 2007 and SAMSA, 2013, are being implemented by some agencies providing IFC in NSW. Overall however, it appears that there are other agencies, possibly due to their size (i.e. small), lack of appropriately skilled staff, and/or access to appropriate resources (e.g. carers, services/specialists and funding) are struggling to meet the essential elements required for Therapeutic Foster Care to be implemented. This section outlines some of the good practices emerging from the findings and the literature, offering some suggestions for a more coherent approach to IFC.

Review of IFC Model

If therapeutic intervention is to be provided in an IFC program, the department should suggest a small number of evidence-based models/approaches to be utilised in providing IFC. These models/approaches must be appropriate in informing the recruitment, assessment and training (initial and ongoing) of IFC carers, whether they are specifically recruited, or drawn from an agency's pool of experienced and skilled GFC carers. In achieving stability and continuity of relationships between the child/ young person and agency staff (including carers), ideally, agencies providing IFC services should be providers of integrated OOHC services, where flexibility exists for a smooth transitioning process of children and young people, based on their needs, from one type of care to another within the agency. Integrated service providers are also best placed to have a range of qualified and experienced staff and more flexible funding options when transitioning of a child or young person is required.

Carer recruitment/assessment/training for IFC

The data analysis indicates that the sector faces ongoing challenges in recruiting, retaining and developing quality Foster Carers for IFC and TFC. Whilst SSSL and SxS may be suitable tools for GFC recruitment and training, there is a need for a more thorough carer assessment tool, such as the one used in the case study, based on the Circle Program. A more robust assessment would focus on people's strengths (e.g. commitment, perseverance and tenacity) and competencies (gained through experience and training) which are essential for therapeutic work. A number of agencies used a more in-depth assessment for finding potential IFC carers though, except in the case study, none mentioned utilising the 'word of mouth' strategy favoured in the literature for specialised carer recruitment.

Linked to recruitment is the initial and ongoing training required for a more therapeutic approach to fostering by IFC carers. Only one agency had a program (Carer Learning and Development Program) for IFC carers, and an Aboriginal agency used Special Training for Aboriginal Carers for its IFC carers. There is strong evidence that the specialised training model used in the Victorian Circle Program (Federico et al. 2012) and in the case study agency assists carers in helping them translate and implement the theoretical model embedded in the program into their practice. This would appear to be an absolutely critical component for any successful program offering a therapeutic approach.

Higher rates of carer reimbursement for IFC

The breakdown of unit costs in the NSW funding model for IFC services suggests a fortnightly carer allowance with no age-based criteria. Many agencies, including the case study agency, however, were not providing this amount and were also using the age of the child or young person in determining an amount. At a time when incentives to attract potential carers to provide the level of intensity required for IFC are important, 'prescribing' rather than 'suggesting' that the higher rate of carer reimbursement alongside other forms of support (financial and non-financial) be provided, could be an important policy initiative to consider.

Agencies providing IFC or TFC services would need to explain why any deviation in the level of carer reimbursement was made and in what circumstances a lesser amount was deemed appropriate. From the analysis it did appear that larger agencies were able to provide more substantial amounts for their carers, and also had the capacity/flexibility to offer additional financial support to maintain the placement.

Agencies indicated that many families providing Foster Care are 'working households' and cannot afford to have a carer at home full-time, providing the intensity of care required for IFC. Providing the maximum amount of carer reimbursement may assist in alleviating the financial constraints on some working households and may also be useful as a motivating factor in recruiting better quality carers for IFC placements. This approach recognises that IFC carers are an increasingly professional component of the care team.

Respite

Many agencies were providing the types of additional support required to maintain IFC placements. Carer respite, an essential component of carer support, was provided in a variety of innovative ways by agencies. For some agencies, however, finding trained respite carers was not always easy, especially for smaller regional agencies.

Matching process

An agency's use of appropriate guidelines in the matching process of a child or young person with a carer was evident from the analysis. Inhibiting the process for some agencies was a lack of large carer pool to draw from, or when a child or young person's needs were not always known. Offering intense casework support with short-term/emergency/respite carers for short periods was seen as an appropriate option to reduce the risk of 'crisis driven' matching and ultimate placement breakdown in IFC placements. As with other forms of OOHC, IFC can be a 'step up' or a 'step down' within the care system, supporting the case for IFC services to be provided, wherever possible, by larger agencies offering a range of integrated services. Stability and continuity for a child or young person would appear to be more satisfactory when transitioning can occur within an agency where relationships and attachments with staff and other professionals can be maintained as required, and agency workers 'know' the carers with whom the child or young person are to be placed. Levels of placement support can also more easily be monitored and maintained, depending on the length of the transition process.

Model coherence for IFC

The variety of models used by agencies in providing IFC services again highlights the importance of the department providing guidance to agencies on utilising a small number of evidence-based models/approaches in providing IFC. What constitutes 'therapeutic intervention' by carers would also be clearer to agencies if use was made of specific models.

Limitation of the research

A limitation of this research into IFC is that it only provides the perspective of agencies and does not include the voices of carers or any of the characteristics of children and young people in IFC programs. Without carer input, little can be said about the actual practice of carers in IFC and TFC programs in NSW. The best research evidence on what foster carers have achieved, by using a therapeutic approach in the Australian context, is indicated in the Victorian Circle Program evaluation (Frederico et al. 2012). This is the model currently being trialled in the pilot TFC program.

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