A Literature Review – Developing a Framework for Therapeutic Out of Home Care in NSW

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Introduction

The Therapeutic Out of Home Care (OOHC) Project was established to produce an effective strategic response to the therapeutic needs of children and young people in OOHC. The project aimed to develop a body of knowledge and practice to aid children and young people in OOHC who have experienced trauma, abuse, neglect; and who face other forms of severe adversity. Therapeutic Care promotes healing and recovery from trauma, based on a trauma-informed service system. It seeks to provide trauma-informed reparative experiences to address and heal this damage.[1]

This report explores the underpinning theories that have been used to contextualise Therapeutic OOHC, and which help to create a Framework for care providers who seek to understand the philosophies and practices of this particular approach.

Therapeutic Care in Australia has grown in recent years in response to the increasing number of children and young people in residential care who have experienced developmental trauma or abuse.[2] It has also expanded due to an increase in the sophistication of Therapeutic Care interventions, both in Australia and abroad.

Recently, there have been significant changes in the delivery of services, as well as a significant increase in the number of OOHC providers. The pace and extent of this change has meant that the task of developing common definitions and common evaluation frameworks across the sector is increasingly important.

The literature review was conducted early 2014 by Dr John McAloon.

[1] *Bethany R. Lee and Ron Thompson, "Comparing Outcomes for Youth in Treatment Foster Care and Family-Style Group Care," Children and Youth Services Review 30, no. 7 (July 2008): 746–57, doi:10.1016/j.childyouth.2007.12.002; Sigrid James, "What Works in Group Care? — A Structured Review of Treatment Models for Group Homes and Residential Care," Children and Youth Services Review 33, no. 2 (February 2011): 308–21, doi:10.1016/j.childyouth.2010.09.014; James P. Anglin, Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth (New York: Haworth Press, 2002).*

[2] *Margarita Maria Frederico, Annette Jackson, and Carly Black, "More Than Words - The Language of Relationships" (Melbourne: School of Social Work and Social Policy, La Trobe University, 2009), http://www.berrystreet.org.au/Assets/825/1/TakeTwo_Evaluation_Report_3complete.pdf; "Secure Care Background Paper" (Western Australia: Department for Child Protection, 2011), https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SecureCareBackgroundPaper2011.pdf.*

What is Therapeutic Care?

Introduction

Therapeutic Care is based on the understanding that developmental trauma can have a variety of negative impacts upon a child. By addressing this trauma, in an early and informed manner, we can reduce or negate long-term issues in the life of the child or young person in care.

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

Understanding Developmental Trauma

Developmental trauma is the result of early negative life experiences that can impact upon the long-term functioning of the child. This is caused by multiple or chronic traumatic events experienced early in a child's development which are often connected to interpersonal relationships and abuse therein.[3] These events might include interpersonal conflict such as witnessing domestic violence or perceived threats of violence, sexual and physical abuse, disrupted attachment relationships, neglectful deprivation of food or deprivation of environmental and interpersonal experience, or general emotional abuse. It may also be the result of prenatal influences such as substance abuse or elevated levels of distress by a mother during pregnancy.

There is evidence for a complex range of effects that take place after a child is maltreated, which extend to neurophysiological, cognitive, social, emotional, and behavioural functioning.[4] Infants and children who have been exposed to multiple or chronic developmentally traumatic events often suffer from alterations to their biochemical stress response systems.[5] As young people, they are more likely to present with a range of chronic and complex mental health and interpersonal problems. These commonly include limitations in their ability to regulate emotion, control their behaviour, and to form and maintain relationships with others.[6]

How Can We Address Developmental Trauma?

Recent research into Developmental trauma, coupled with theoretical literature on causes and management, suggest the importance of a holistic approach to treatment. It is appropriate to consider the neurophysiological,

[3] *Christine R. Ludy-Dobson and Bruce D. Perry, "The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma," in Working with Children to Heal Interpersonal Trauma: The Power of Play, ed. Eliana Gil (New York: The Guilford Press, 2010), 26–43; Bessel van der Kolk et al., "Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V" 2009, Unpublished Manuscript, http://www.traumacenter.org/announcements/DTD_papers_Oct_09.pdf.*

[4] *van der Kolk et al., "Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V"; Bessel van der Kolk, "Developmental Trauma Disorder: Toward a Rational Diagnosis for Children with Complex Trauma Histories," Psychiatric Annals 35, no. 5 (2005): 401–8; Bruce D. Perry, "Examining Child Maltreatment Through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics," Journal of Loss and Trauma 14, no. 4 (June 25, 2009): 240–55, doi:10.1080/15325020903004350.*

[5] *Kathryn R. Wilson, David J. Hansen, and Ming Li, "The Traumatic Stress Response in Child Maltreatment and Resultant Neuropsychological Effects," Aggression and Violent Behavior 16, no. 2 (March 2011): 87–97, doi:10.1016/j.avb.2010.12.007.*

[6] *Joshua Arvidson et al., "Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model," Journal of Child & Adolescent Trauma 4, no. 1 (March 2011): 34–51, doi:10.1080/19361521.2011.545046; van der Kolk et al., "Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V."*

cognitive, social, emotional, and behavioural aspects of functioning as part of an overall system of disorganised development. If these symptoms of trauma are responded to in a holistic and trauma-informed way, this response is more likely to be more appropriate and congruent to the needs of the child than one in which these aspects of functioning are seen as discrete or unrelated characteristics.[7] Evidence also suggests that the most effective treatment occurs as part of day-to-day living, rather than in isolation from a child's everyday experiences.[8] The relationships and activities of children and young people with developmental trauma have been shown to significantly contribute to their repair and recovery following maltreatment.[9] For this reason, it is important to shape daily life in a manner that addresses Developmental trauma and encourages improved outcomes in social and emotional health.

Definitions of Therapeutic Care

There is no single agreed-upon definition of Therapeutic Care.[10] Rather, a range of definitions has been identified which varies in keeping with their focus. These differing focal points include:

- The model of care provided
- The philosophical underpinnings of the model of care
- Activities provided within the program
- The physical setting in which the care is provided
- The age and characteristics of the target population
- The size of the entity
- The length of stay
- The level of restrictiveness required
- The treatment approach utilised
- The professional and organisational mix of the staff provided.[11]

Terminology pertaining to Therapeutic Care also varied depending on the setting in which it was delivered. That is whether it was delivered in treatment foster care, specialised foster care, family-based foster treatment, intensive residential treatment, or secure care.[12] Butler and McPherson define residential treatment as any program within a therapeutic milieu, possessing a multidisciplinary core team, employing deliberate client supervisions, intense staff supervision and training, and run with consistent clinical and administrative oversight.[13] Each of these components can also be expected to exist within the context of Therapeutic Care.

[7] *Anglin, Pain, Normality and the Struggle for Congruence.*

[8] *Ludy-Dobson and Perry, "The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma"; Frederico, Jackson, and Black, "More Than Words - The Language of Relationships."*

[9] *Ludy-Dobson and Perry, "The Role of Healthy Relational Interactions in Buffering the Impact of Childhood Trauma"; Frederico, Jackson, and Black, "More Than Words - The Language of Relationships."*

[10] *James, "What Works in Group Care?"; Sara McLean et al., Therapeutic Residential Care in Australia: Taking Stock and Looking Forward (Melbourne, Vic.: Australian Institute of Family Studies, 2011); Lee and Thompson, "Comparing Outcomes for Youth in Treatment Foster Care and Family-Style Group Care"; Pauline Jivanjee, "Professional and Provider Perspectives on Family Involvement in Therapeutic Foster Care," Journal of Child and Family Studies 8, no. 3 (1999): 329–41.*

[11] *Paul Delfabbro, Alexandra Osborn, and J. Barber, "Beyond the Continuum: New Perspectives on the Future of out-of-Home Care in Australia," Children Australia 30, no. 2 (2005): 11–18; James, "What Works in Group Care?"; Linda S. Butler and Peter M. McPherson, "Is Residential Treatment Misunderstood?," Journal of Child and Family Studies 16, no. 4 (July 23, 2007): 465–72, doi:10.1007/s10826-006-9101-6; Lee and Thompson, "Comparing Outcomes for Youth in Treatment Foster Care and Family-Style Group Care."*

[12] *Jivanjee, "Professional and Provider Perspectives on Family Involvement in Therapeutic Foster Care"; Lee and Thompson, "Comparing Outcomes for Youth in Treatment Foster Care and Family-Style Group Care."*

[13] *Butler and McPherson, "Is Residential Treatment Misunderstood?"*

What are Some Primary Forms of Therapeutic Care?

Therapeutic Foster Care (TFC)

Definition of Treatment Foster Care

Provided by Romanelli, LaBarrie, Hackler, and Jensen (2008)

> "… a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centres. In Treatment Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Treatment foster programs provide, in a clinically effective and cost-effective way, individualised and intensive treatment for children and adolescents who would otherwise be placed in institutional settings."[14]

Definition of Therapeutic Foster Care

Provided by Pauline Jivanjee (1999)

> "Sometimes termed treatment foster care, specialised foster care, or family-based foster treatment, TFC is a key component of a system of care for children with serious emotional disorders who require out of home placement … [it] combines the 'normalising influence of family-based care with specialised treatment interventions, thereby creating a therapeutic environment in the context of nurturant home'. Such a definition encompasses a central tenet of therapeutic foster care: that treatment for children occurs in a family environment or essentially that the family themselves are seen as 'therapeutic'. Whilst definitions and service models of therapeutic foster care may vary, there are a number of fundamental characteristics that remain essentially the same."[15]

What is Therapeutic Foster Care? [16]

Therapeutic Foster Care (TFC) is an intensive, family-based approach based on social learning theory and an eco-systemic approach. It utilises trained foster carers who provide unrestricted support, care, and a positive relationship (known as 'alliance'). TFC is also characterised by close supervision of the child or young person, setting rules and boundaries, purposeful interventions including counselling, independent living skills, and problem-solving training, educational services, and support groups.

TFC has a set of defined characteristics:

1. It must be a home-based treatment provided by therapeutic carers with specialised training
2. Each household typically has a limit of one or two children
3. Case workers are given smaller loads so as to facilitate more intensive engagement with the children and young people they are responsible for
4. Carers are given a higher stipend
5. There is a comprehensive child assessment and matching process
6. Carers are entitled to support services including regular supervision and consultation with clinicians
7. There is also a provision of clinical services for children, carers, and their biological families
8. Crisis intervention services are available
9. Educational services are available
10. Health screenings and medical services are provided

[14] *L.H. Romanelli et al., "Implementing Evidence-Based Practice in Treatment Foster Care" (Foster Family-based Treatment Association, 2008).*

[15] *Jivanjee, "Professional and Provider Perspectives on Family Involvement in Therapeutic Foster Care," 451.*

[16] *This section of the report has been drawn from a report undertaken by Dr Marilyn McHugh (Social Policy Research Centre, University of NSW) that was commissioned by ACWA. Dr McHugh undertook an analysis of the current delivery of therapeutic foster care in NSW in 2014.*

11. There is an overall co-ordination of services, which ensures system linkages.[17]

What is Intensive Foster Care (IFC)

Intensive Foster Care (IFC) is a model currently used in NSW. It also requires a more expanded role of the carer, who provides therapeutic intervention in their daily interactions with the child. There is no articulated model specified with the provision of IFC funding. Individual care plans may specify the type of care and services to be provided.

IFC also has a set of defined characteristics:

1. Children involved are assessed as having complex and high needs
2. Care is home-based
3. Carers receive ongoing specialist training
4. Carers may receive a higher allowance than General Foster Carers
5. Carers become key members of the casework team
6. There must be a co-ordinated planning of casework and therapeutic intervention
7. There will be a higher level of scrutiny of the carer's parenting practices
8. The carer provides direct support to the child
9. Placements are generally limited to one or two foster children

Therapeutic Residential Care (TRC)

Definition of Therapeutic Residential Care

Provided by the National Therapeutic Residential Care Working Group (2011)

> "Therapeutic Residential Care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs."[18]

Definition of Therapeutic Residential Care

Provided by the Department of Human Services, Victoria (2008-2009)

> "Residential care services providing 'therapeutic' care are distinctive in their clarity and significant overarching focus on creating sustaining care environments capable of healing the traumatic impact of abuse and neglect and the disrupted attachment that ensues."[19]

Definition of Intensive Residential Care

Provided by NSW Department of Community Services (2007)

> "Broadly speaking, these terms refer to residential care programs which aim to address the behavioural, social and emotional issues of children and young people with complex and high support needs through an intensive, time limited program of integrated, individually determined interventions."[20]

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[16] *L. McClung, Therapeutic Foster Care: Integrating Mental Health and Child Welfare to Provide Care for Traumatised Children: A Literature Review (Melbourne, Vic.: Take Two, 2007).*

[18] *McLean et al., Therapeutic Residential Care in Australia, 2.*

[19] *Department of Human Services, "Essential Service Design Elements: Therapeutic Residential Care" (Victoria: Department of Human Services, Children, Youth, and Families Division, 2009 2008).*

[20] *NSW Department of Community Services, "Out of Home Care Service Model: Intensive Residential Treatment Program" (New South Wales: Out-of-home Care Policy Directorate, 2007), http://www.community.nsw.gov.au/__data/assets/pdf_file/0014/321053/oohc_model_residential_int.pdf.*

Secure Care

Secure Care for young people who have been placed in OOHC and are at risk of harming themselves is not common in Australia. However, this service does exist and is present in most states and territories.

The NSW Department of Family and Community Services provided a definition of Therapeutic Secure Care in 2010 as part of their OOHC Model for Therapeutic Secure Care. It reads:

> "… secure accommodation used in exceptional circumstances for children and young people in OOHC who are at significant risk of harm to themselves because of their extreme risk taking and life threatening behaviour. Therapeutic secure care in this context refers to the compulsory confinement of a child or young person in group residence that aims to protect the child or young person from imminent risk and danger arising from their behaviour through 24 hour supervision, intensive case management and access to specialist services. The program involves confining the child or young person safely in a secure therapeutic environment guided by a comprehensive therapeutic philosophy while their behavioural, emotional and mental health needs are assessed, their case plan is reviewed, and linkages to appropriate support services and treatment are established or enhanced. The goal of the placement is to reduce the risk the child or young person poses to themself so that they can exit the placement as quickly and safely as possible and continue to access intervention services in a community setting."[21]

The Northern Territory Department of Children and Families identified a second definition. It reads:

> "Residential care services providing "therapeutic" care are distinctive in their clarity and significant overarching focus on creating and sustaining care environments capable of healing the traumatic impact of abuse and neglect and the disrupted attachment that ensues."[22]

United Nations Rules and Conventions

The United Nations Rules and Conventions are an important reference point for Secure Care services. The following account of these rules was developed by PeakCare Queensland in 2013, and pertains specifically to the treatment of children in secure care.[23] This has led to the formulation of five key elements contained within the Convention on the Rights of the Child, the Beijing Rules, and the Rules for the Protection of Juveniles Deprived of their Liberty.

1. The deprivation of a child's liberty and their detention for whatever reason must be a measure of last resort
2. The deprivation of a child's liberty and their detention must be for the shortest appropriate period of time
3. No child shall be detained unlawfully or arbitrarily
4. Every detained child has the right to challenge the legality of their detention before a court or other competent, independent and impartial authority, and to a prompt decision on any such action

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[21] *NSW Department of Community Services, 'Out of Home Care Service Model: Therapeutic Secure Care Programs' (New South Wales: Out-of-home Care Policy Directorate, 2010), 4, http://www.community.nsw.gov.au/__data/assets/pdf_file/0018/321057/oohc_service_model.pdf.*

[22] *Northern Territory Government, 'Secure Care Therapeutic Framework: Appendix B' (Department of Children and Families, n.d.), http://www.childrenandfamilies.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/72/38.pdf.*

[23] *PeakCare Queensland, 'Secure Care – Needed or Not?' (Queensland: PeakCare Queensland, 2013), http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0009/177408/PeakCare-Wegener,-Lindsay-Response-to-Discussion-Paper.pdf.*

5. The best interests of the child must be the primary consideration and over-ride all other considerations that may be relevant to the deprivation of their liberty and detention.

The above principles stating that detention of a child should be a last resort option, used for the shortest appropriate period of time, when read with the 'best interests of the child' principle indicates an obligation to explore all possible alternatives to Secure Care prior to depriving a child of their liberty. This must only occur where the best interests of the child are paramount.

This serves as a useful framework for considering if children should be contained within Secure Care and under what circumstances, if any, this detention should occur. Beyond this question, the specific articles and rules contained within the Convention on the Rights of the Child, the Beijing Rules, and the Rules for the Protection of Juveniles Deprived of their Liberty also establish the manner and conditions under which Secure Care should be established.[24]

Common Characteristics of all Therapeutic Care

There are many commonalities that can be drawn from the above literature. These common characteristics include:

- The complexity of the young people involved
- The time-limited nature of the service response
- The presence of an intensive or therapeutic or treatment-based response
- Acknowledgement of the disrupted early attachment experienced by young people
- Acknowledgement of the Developmental trauma experienced by young people
- The relational focus of the service response
- The goal of providing a reparative or healing service response
- The focus on behavioural, emotional, and social characteristics of young people.

By considering these shared fundamentals of Therapeutic Care, service providers can tailor their models to the specific sets of needs presented by their clients and operate within their set funding, whilst maintaining congruence with the overall Therapeutic Care Framework.

Who benefits from Therapeutic Care?

A recent study in Queensland, titled the Continuum of Therapeutic Care Project (2007) assessed characteristics of 50 young people, and developed a comprehensive account of:

- The behavioural indicators they displayed
- Their family background and child protection history
- Their placement history and length of time in care
- The complexity of their multiple support needs

Of the sample, almost half (48%) of the children had been exposed to every form of abuse. More than 80% had been exposed to physical abuse, more than 80% to emotional abuse, and more than 80% to neglect. 48% reported exposure to sexual abuse. Osborn and Delfabbro have reported similar rates.[25] In comparable samples, children

[24] *Alexandra Osborn and Paul Delfabbro, "National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care" (Adelaide: School of Psychology, University of Adelaide, 2006), Protecting Australia's Children: Research and Evaluation Register.*

[25] *Alexandra Osborn and Paul Delfabbro, "National Comparative Study of Children and Young People with High Support Needs in Australian Out-of-Home Care" (Adelaide: School of Psychology, University of Adelaide, 2006), Protecting Australia's Children: Research and Evaluation Register.*

have reported experiences of domestic violence, parental substance misuse, and parental mental illness.[26] As a result, these children are more likely to display complex behavioural and emotional difficulties including conduct disorders, difficulties with peers, and difficulties in regulating and controlling emotions in a manner that is conducive to sustaining healthy relationships.[27] Therapeutic Care is designed to comprehensively address the above issues, thus creating a trauma-aware environment of healing.

While behavioural difficulties are commonly cited as the reason children in OOHC are hard to place, this behaviour is often the culmination of traumatic early experiences in their families of origin, coupled with the resulting emotional and attachment problems.[28]

Osborn and Delfabbro reviewed data about young people with complex or extreme needs in five Australian states.[29] They found a high level of similarity in presenting behaviours, family backgrounds, and placement histories. The children in the cohort analysed:

- Are 12 to 13 years of age
- Have experienced 10 or more placements in their lifetime
- First came in to contact with the statutory child protection system at around the age of 3
- Usually do not enter care until approximately 4 years later at around the age of 7
- On average, have spent around 5 years in the care system
- Have experienced few attempts to reunify with family
- Are generally male
- Are generally not Aboriginal
- Have been subjected to traumatic, abusive, and highly-unstable family backgrounds
- Have experienced domestic violence, physical abuse, and parental substance abuse
- Have a one-in-three chance of having been exposed to every form of abuse: physical, emotional, sexual, and neglect
- Have a 50% chance of being exposed to parental mental health problems coupled with neglect
- Come from social and family backgrounds with four or more noted 'problems'
- Are likely to have high levels of conduct disorder, difficulty with peers, and other behaviours associated with disruptions to early attachment experiences
- Have a one-in-two chance of suffering from clinical depression or anxiety
- Have considerable difficulty in regulating and expressing their emotions in a way that promotes healthy peer relationships and the formation of attachment with the adults who provide them with their primary care.

Osborn and Delfabbro noted that Aboriginal and Torres Straight Islander children differed significantly from non-Aboriginal children. They experienced higher levels of exposure to domestic violence, parental substance abuse, homelessness or inadequate housing, and parental imprisonment. The cultural background of children needs to be considered and respected when formulating their ideal progression through the care system.

What goals can guide work with young people in Therapeutic Care?

[26] *James G. Barber and Paul H. Delfabbro, Children in Foster Care (London ; New York: Routledge, 2004).*

[27] *Osborn and Delfabbro, "An Analysis of the Social Background and Placement History of Children with Multiple and Complex Needs in Australian Out-of-Home Care."*

[28] *Barber and Delfabbro, Children in Foster Care.*

[29] *Osborn and Delfabbro, "An Analysis of the Social Background and Placement History of Children with Multiple and Complex Needs in Australian Out-of-Home Care."*

The journey through the care system can be complex. Understating the symptoms and implications of Developmental trauma will allow agencies to enact a model of care that has congruence with the needs of the child or young person, their stated wishes, and the core elements of the Therapeutic Care framework.

An understanding of the impact of Developmental trauma has the potential to guide service responses for children and young people in Therapeutic Care. It is clear that the experience of disrupted attachment, abuse and/or neglect has the potential to result in "developmental injuries."[30] These injuries have also been demonstrated to impact upon social, emotional, cognitive, and behavioural functioning in such a way that requires a specialised and informed treatment response.

In addition to providing an account of the consequences of developmental trauma, the discussion above can also inform broad areas of intervention appropriate to Therapeutic Care. While these would be appropriately considered within the context of individual treatment plans, they provide an outline for the basis of a model of Therapeutic Care, and may help enable the young person to:

- Develop a strong sense of safety
- Develop and maintain effective interpersonal relationships
- Develop and/or practice empathy
- Regulate their emotions
- Process traumatic memories
- Change or control their behaviour consistent with context
- Perceive congruence between their thoughts, emotions and behaviours
- Experience a sense of acceptance, comfort or positivity about themselves 'in their own skin'
- Develop a strong sense of identity
- Model more positive and helpful interpersonal relationships
- Master new skills that they may not have had an opportunity to engage with prior
- Develop a resilience to difficult experiences
- Develop a sense of calmness.

[30] *Robert Abramovitz and Sandra L. Bloom, "Creating Sanctuary in Residential Treatment for Youth: From the 'Well-Ordered Asylum' to a 'Living-Learning Environment.,'" The Psychiatric Quarterly 74, no. 2 (2003): 131.*

What are the Underpinning Theories of Therapeutic Care?

Theories of Attachment

Attachment refers to the functional bond between an infant and his or her carers. It is a species-wide, biologically based behavioural system. One may observe attachment in both the child's behaviour and the behaviour of the carer. Attachment helps to maintain the carers physical and emotional proximity to the child, and helps to develop their interpersonal connectedness. This grants the child exposure to appropriate interpersonal behaviour and regulation of emotion. This becomes the blueprint for future interpersonal relationships, and subsequent cognitive, emotional, and behavioural control. This relationship also forms the basis for the child's self image as a social being. Beyond this initial attachment relationship, other attachment relationships occur as the child develops. The quality of these relationships appears to be strongly influenced by the quality of early attachment and the experiences of this fundamental relationship.[31]

Attachment is believed to contribute to the development of 'soft' systems (behavioural, emotional, and interpersonal) and also 'hard' systems (neurophysiological).

Due to the ongoing impact of early attachment relationships, the quality of attachment experienced by a child is a significant predictor of mental health and social, behavioural, and cognitive wellbeing. This does not mean that all patterns of attachment are the same, or that they need to be identical in order to foster good overall health for the child. Attachment systems are determined by cultural context, and the expression of attachment varies across different communities. In any cultural group, attachment has the potential to go right or to go wrong.

The three main attachment theorists considered in the development of Therapeutic OOHC are John Bowlby, Mary Ainsworth and Pat Crittenden.

John Bowlby's Theory of Attachment

John Bowlby shaped the notion of attachment by describing its two core systems:

- The system controlling attachment to attachment figures
- The system controlling the exploration of an environment and information seeking within this space.

Bowlby suggests that these systems are mutually dependent. For example, if an infant decides that the demands of their environment are too great and cannot explore or master them, that infant will seek safety and guidance with their attachment figure. This act is refined through practice by the infant and productive modelling by their caregiver. If this early attachment relationship is performed well, it results in the reduction of stress and the promotion of good safety habits in infants.[32] Both of these concepts are fundamental to the needs of many young people in OOHC,[33] meaning that service systems should be developed with an awareness of this theoretical underpinning.

Bowlby also introduced the idea of a child developing an estimation of self worth from their early attachment relationships.[34] Children develop Internal Working Models as a result of these attachment relationships. In a positive attachment relationship, the carer acknowledges the infant's need for comfort and protection, whilst balancing this against their need to develop through an independent exploration of their environment. If the child is

[31] *S. A. Cole, "Infants in Foster Care: Relational and Environmental Factors Affecting Attachment," Journal of Reproductive and Infant Psychology 23, no. 1 (February 2005): 43–61, doi:10.1080/02646830512331330947; Mary Dozier et al., "Attachment for Infants in Foster Care: The Role of Caregiver State of Mind," Child Development 72, no. 5 (September 2001): 1467–77, doi:10.1111/1467-8624.00360.*

[32] *John Bowlby, Attachment and Loss, 2nd ed, vol. 1, 3 vols. (New York: Basic Books, 1999).*

[33] *Wilson, Hansen, and Li, "The Traumatic Stress Response in Child Maltreatment and Resultant Neuropsychological Effects"; Arvidson et al., "Treatment of Complex Trauma in Young Children."*

[34] *Bowlby, Attachment and Loss.*

afforded all of these needs, they are likely to develop an internal working model of themselves as both valued and reliable. Conversely, if the attachment figure frequently rejects the infant's bids for comfort and protection and does not afford them a healthy exploration of their environment, the child is likely to develop an internal working model of themselves as unworthy or incompetent.

Mary Ainsworth's Strange Situation

Mary Ainsworth is known to the field of attachment due to her work into the emerging interpersonal, emotional, and regulatory differences in infants as a result of their early attachment experiences. Ainsworth's Strange Situation experiment[35] saw mothers and their infants placed in a playroom. Shortly after, a female stranger would join them. The stranger would play with the baby, allowing the mother to leave and then return. Finally, both adults would leave the baby alone. The stranger would eventually return, followed by the mother. This experiment revealed that infants would play more vigorously in the presence of their mother as opposed to situations when a stranger was present or their mother was absent.[36]

The return of the mother within this experiment also heralded interesting results. Some infants became angry when their mothers returned, and cried to gain their attention and ask for contact. When contact was offered, many of these infants showed ambivalence by hitting and kicking their mothers. Others avoided or snubbed their mother once she returned, despite having searched for her while she was absent. The majority of the infants sought out proximity to their mother once she returned, and initiated interaction or contact upon reunion.[37] Subsequent analysis of this data suggested that these three different interaction styles upon reunion could be correlated with the degree of harmony present in the infants' homes.[38]

Pat Crittenden's Self Protective Strategies

Pat Crittenden extended upon these ideas by exploring attachment as a system of Self Protective Strategies.[39] These strategies are learned during interaction with attachment or protective figures. The ways in which infants behave, think, and learn to feel about themselves and their environment is functional within the context of their attachment relationships. For example, a child may find it more functional to be caring and helpful, or to act out and be oppositional. Children also learn if it is safer to be confident around other people, or if it is wiser to be anxious and distrusting. Crittenden believes these strategies that are developed in response to attachment relationships, will only change when they no longer fit the context in which the child is placed. Because of this, effective treatment of attachment-based concerns should involve teaching new strategies that fit everyday contexts in order to replace less appropriate strategies that were developed in abusive or neglectful contexts.

The Neuro-physiological Basis of Development

In order to comprehend the impact of developmental trauma it is important to understand the neurophysiological basis of development. The manner in which a child experiences attachment has serious flow-on effects for their ability to function within society and will alter the way in which their brains react to stimuli. Therapeutic Care

[35] *Mary D. Salter Ainsworth and B.A. Wittig, "Attachment and Exploratory Behaviour of 1-Year-Olds in a Strange Situation," in Determinants of Infant Behaviour, ed. B.M. Foss (London: Methuen, 1969), 111–36.*

[36] *Mary D. Salter Ainsworth and Silvia M. Bell, "Attachment, Exploration, and Separation: Illustrated by the Behavior of One-Year-Olds in a Strange Situation," Child Development 41, no. 1 (March 1970): 49, doi:10.2307/1127388.*

[37] *Ibid.*

[38] *Mary D. Salter Ainsworth, Silvia M. Bell, and D. Stayton, "Infant-Mother Attachment and Social Development," in The Introduction of the Child Into a Social World, ed. M.P. Richards (London: Cambridge University Press, 1974), 99–135.*

[39] *Patricia M. Crittenden, "A Dynamic-Maturational Model of Attachment," Australian and New Zealand Journal of Family Therapy 27, no. 2 (June 2006): 105–15, doi:10.1002/j.1467-8438.2006.tb00704.x.*

operates on the understanding that an individual can learn to change their thinking and behaviour if they are given the skills for better emotional regulation and healthier attachment relationships.

Attachment has significant implications for future brain, cognitive, social, emotional and behavioural development.[40] The quality of attachment has been associated with subsequent interpersonal[41] and intrapersonal[42] development and functioning. This includes the ability to maintain and develop relationships, the ability to regulate emotion, and the ability to control behaviour.[43] Experience is fundamental to shaping brain systems, with early experience occurring within the context of attachment relationships.[44] Experience, the quality of experience, and repetition of experience all go towards shaping and facilitating changes in the organisation of the brain. These patterns of organisation of the brain and associated systems reflect the environment the child developed in.

In order to develop programs for neurological change, it is vital to understand the manner in which brain systems operate and develop in response to stimuli. Brains are constructed from large numbers of neurons, most of which are present at birth.[45] The organisation of these neurons is built on small interactions with parents and caregivers within attachment relationships.[46] Within secure attachment, an attachment figure maintains an optimal level of arousal. For example, he or she is neither disinterested nor overly-reactive or chaotic. A secure attachment figure also shares positive affective states with the infant. The behaviour of the attachment figure has implications for both 'hard' (neuro) and 'soft' (behavioural, emotional) systems. It follows that if attachment is chaotic, interrupted, or disturbed as a result of relationships within the family of origin or as a result of placement out of the home, significant problems will arise.[47]

Disruptions to healthy brain development can result from experiences during early attachment relationships. For instance, underuse of neurological systems such as emotion regulation and language results in the underdevelopment of these systems. Overuse of neuro-physiological systems such as fear, arousal, and avoidance has been demonstrated to alter baseline levels of arousal as well as having implications for children and adolescents in terms of their responses to social, emotional, and interpersonal cues.[48]

Developmental trauma results when a developing person is repeatedly placed in a state of psychological distress or arousal. The more trauma the developing brain experiences, the more it comes to permanently resemble a brain in a state of psychological distress or arousal. This has the potential to disrupt an infant's ability to learn self-protective strategies, and strategies of emotional and behavioural regulation. This can threaten the development of healthy physiological arousal systems and disrupt an infant's ability to develop resilience to adversity.

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[40] *B.D. Perry and R. Pollard, "Homeostasis, Stress, Trauma, and Adaptation: A Neurodevelopmental View of Childhood Trauma," Child and Adolescent Psychiatric Clinics of North America 7, no. 1 (1998): 33–51.*

[41] *Dozier et al., "Attachment for Infants in Foster Care."*

[42] *Cole, "Infants in Foster Care"; Susan Vig, Susan Chinitz, and Lisa Sulman, "Young Children in Foster Care: Multiple Vulnerabilities and Complex Service Needs," Infants & Young Children 18, no. 2 (2005): 147–60.*

[43] *Daniel J. Siegel, "Toward an Interpersonal Neurobiology of the Developing Mind: Attachment Relationships, 'Mindsight', and Neural Integration," Infant Mental Health Journal 22, no. 1–2 (January 2001): 67–94, doi:10.1002/1097-0355(200101/04)22:1<67::AID-IMHJ3>3.0.CO;2-G; Cynthia L. Smith, Susan D. Calkins, and Susan P. Keane, "The Relation of Maternal Behavior and Attachment Security to Toddlers' Emotions and Emotion Regulation," Research in Human Development 3, no. 1 (2006): 21–31.*

[44] *Douglas Davies, Child Development: A Practitioner's Guide, 3rd ed, Social Work Practice with Children and Families (New York: Guilford Press, 2011); Sean Brotherson, "Understanding Attachment in Young Children" (NDSU Extension Service, 2005), https://www.ag.ndsu.edu/pubs/yf/famsci/fs617.pdf.*

[45] *Davies, Child Development.*

[46] *Ibid.; Brotherson, "Understanding Attachment in Young Children."*

[47] *Cole, "Infants in Foster Care"; Crittenden, "A Dynamic-Maturational Model of Attachment."*

[48] *Perry, "Examining Child Maltreatment Through a Neurodevelopmental Lens"; van der Kolk, "Developmental Trauma Disorder: Toward a Rational Diagnosis for Children with Complex Trauma Histories."*

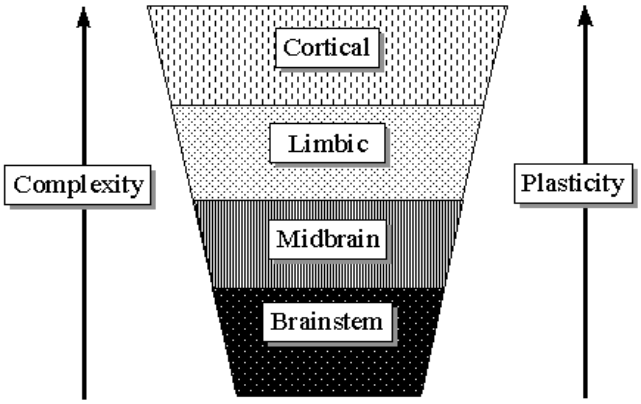

Figure 1: As areas of the brain increase in complexity, they become more plastic (Perry 2006).[49]

Assumptions of the Neuro-Sequential Model

From a neurodevelopmental perspective, the brain is seen to contain four broad and distinct systems. In the order of development and complexity these are: the Brainstem, the Midbrain, the Limbic System and the Cerebral Cortex.

The neurodevelopmental process is underlaid by a series of principles drawn from scientific evidence. These are:

- The brain systems are organised hierarchically
- Brains develop in a manner that is consistent with their use
- The brain develops sequentially
- Primary brain development happens early on in life
- Brain systems can change in keeping with the principle of neuro-plasticity.

Each of these assumptions will be briefly explained below.

The brain systems are organised hierarchically

Hierarchical organisation means that information coming into the brain enters the simplest brain systems first. Once there, this information is transferred up the hierarchy until it enters the most complex system – the Cerebral Cortex. Information from the senses that monitor external and internal stimuli enters the brain at the Brainstem. In this area of the brain there is no conscious thought, it is simply an area in which information is processed so that it can be transferred to higher levels.

For example, if information pertaining to an interpersonal situation is relayed to the Brainstem, this will result in particular patterns of activation. If interpersonal situations have been pleasurable in the past, the central nervous system will respond similarly. Heart rate and blood pressure will remain low, the pupils will remain undilated, eyes will not startle in response to movement, food will be digested normally, and the body will not need to release beta-endorphins to counteract the effects of pain. If, however, interpersonal situations in the past have been unpleasant, the central nervous system will enter a state of alarm. In this state, the heart will race, blood pressure will increase,

[49] *Bruce D. Perry, "Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics," in Working with Traumatized Youth in Child Welfare: Social Work Practice with Children and Families, ed. Nancy Boyd Webb (New York: Guilford Press, 2006), 27–52.*

and blood will travel to the muscles in a process that primes the body for further fear and alarm. The individual will quickly ready themselves to fight, flee, or freeze.

This information about experience and emotion will be pushed up to higher areas of the brain where it will be processed in more depth. In the Limbic System, this information will be compared with emotional memories from similar events. If a person repeatedly experiences alarm during interpersonal situations, this will be generalised to other relationships, including attachment relationships and social interactions. This will lead the individual to become highly aroused in these situations and to sense danger before any evidence of actual danger is available. The Limbic System will communicate this up and downstream within the brain using a range of chemical and electrical communication.

In the Cerebral Cortex another range of processes occurs, which are developed in keeping with past experience and are influenced by the systems that occur earlier in the brain hierarchy. This area of the brain is capable of conscious thought. This means that brain functions such as the control and regulation of behaviour; control of impulses for action or thought; the regulation of emotional states; the ability to reason and empathise, plan, assess risk, and make judgements are all coloured by conscious thought and are filtered through understandings of past experiences.

Brains develop in a manner that is consistent with their use

During development, the hierarchical pattern of brain organisation is relatively consistent across all people. Individual differences may be present due to individual characteristics, but overall there is stability across the species. Differences occur when repeated experiences cause certain brain systems to become activated more often or in particular ways. The more that a system is activated by experience, the more that the system as a whole will develop to reflect these experiences.

In terms of the neurological profile of a child, certain elements may become more pronounced if one of the brain systems is activated to an unusual degree. The outward expression of his or her neurological profile, that is, their behaviour, will be coloured by their developmental experience. If this person has suffered trauma during the development of their brain systems, their neurological profile and behaviour will develop consistent with the effects of this trauma.

The brain develops sequentially

Sequential development suggests that if the early building blocks of interpersonal, social and emotional development are impacted by adverse experience, then as successive and increasingly complex expressions of this development are provided, they will also reflect those early experiences. Conversely, if the early building bocks of this development are based on healthy interpersonal experiences, subsequent and more complex expressions of this development will be strong, assured and appropriate.

It is important to consider this sequential development. The only way to ensure that the complex interpersonal, social and emotional expressions of the brain that occur later in life are healthy and adaptive, is to ensure that their foundations are equally healthy and adaptive.

Primary brain development happens early on in life

Most brain development happens early. In utero and following birth, a child's brain develops at the fastest possible rate. By the time that school begins, a child's brain is over 90% developed. This means that the quality of the early environment experienced by this child has huge implications for the formation of the brain systems and their behaviour. The emotional and behavioural development that occurs in school and beyond is generally limited when compared to the developmental significance of what is learned and experienced early in life.

The brain organises itself in keeping with qualities present in its environment. If a child is exposed to talking, then the brain will learn to talk. If reading is also present, then the brain will learn to associate reading and talking, and thus organise itself accordingly. If there is a co-occurrence of regulated emotional expression and talking, then the brain will organise itself to regulate emotional expression within interpersonal communication. Because this development primarily occurs in the early stages of life, a child who is exposed to these things at an appropriate stage of development will be able to capitalise on these windows of opportunity and learn adaptive abilities and skills. These will be vital for constructive social relationships and communication.

Brain systems can change in keeping with the principle of Neuroplasticity

An assumption that underlies all work in Therapeutic Care is the notion that people can change. Behaviour can be seen to alter in response to effective therapeutic systems. Because behaviour is an outward expression of the neurological systems that underlie it, successful therapy has been taken to mean that the brain systems, including thinking and the regulation of emotion and behaviour, can be changed.

The term neuroplasticity has been coined to describe the brain's ability to change and adapt based on new circumstances and stimuli. There are two primary factors that determine the brain's ability to respond to changes in function and organisation. These are the stage of development that the brain is in, and the part of the brain that is being asked to change. Because the brain develops in a hierarchical fashion, different systems are developed and organised at different times. Once these systems have developed in a manner that is consistent with their environmental influences, their ability to display plasticity reduces.

Some systems and their component parts are more able to display plasticity than others. Higher-level structures retain a degree of plasticity throughout life. If the systems in the Cerebral Cortex are built upon foundations of good attachment and beneficial social and emotional experiences, then there is a good chance of this system benefitting from intervention later on in life. Other systems lose plasticity at an earlier age. The Brainstem, Midbrain and, to some extent, the Limbic System are well organised by three to four years of age. Once these systems are established in a particular form, change is far more difficult to effect. More time and more intensive intervention will be needed.

Summary

When developing models for effective Therapeutic Care, it is important to understand the impact of early experience on the development of the brain and subsequent patterns of behaviour and emotion. Children who have developed in traumatic environments will have likely experienced chronic abuse and neglect. This has many negative implications for brain development. Such children are likely to display poor attachment relationships and difficulties in interpersonal relationships generally, limitations in biological, physical and cognitive development, difficulties in emotional regulation and behavioural control, and low value of self.

Protective strategies developed to help survival in an earlier environment may not be appropriate for the current environment in which the young person resides. Therapy can help to address these problems and encourage as much behavioural and emotional change as is possible. New experiences can have a positive impact on the young person or adult brain. Interpersonal therapeutic strategies can be engaged in order to address early experiences and assist children or young people who have suffered abuse.

The neurodevelopmental perspectives discussed above have been important tools in collating and developing a coherent range of knowledge that explains the detrimental impact of Developmental trauma, as well as showing how effective treatment responses may be developed in order to deal with the consequences of developmental trauma.

What are the Elements of Practice in Residential Care?

James Anglin's Model of Therapeutic Care

James Anglin's theoretical model of Therapeutic Care centres on the notion that there should be congruence between a child's best interests and the services provided to them in response.[50] Pragmatically, Anglin saw full congruence between these two as an ideal that was unlikely to be achieved. Group homes could, however, aspire to develop congruence between their services and the best interests of children in their care. To this end, Anglin grouped significant processes and interactions into the three categories of: Basic Psychosocial Processes, Interactional Dynamics, and Levels of Group Home Operation.

Basic Psychosocial Processes

There are three dominant psychosocial processes related to the struggle for congruence in the service of a child's best interests. Each process can be viewed as a category in its own right within group home life and work. Each results from numerous moment-to-moment interactions between individuals within the context of interpersonal interactions inside group homes. These psychosocial processes are:

1. The extra-familial living environment:

As its name implies, a group home strives to offer a home-like environment whilst removing the intensity often present in dysfunctional family environments.

2. Responding to pain and pain-based behaviour:

Drawing on dynamic theory, Anglin coined the term 'pain-based behaviour' to describe what he saw as a primary challenge in group homes.[51] For Anglin, the externalising and internalising behaviours in group homes are driven by the internalised pain that results from the experience of developmental trauma. One of the characteristics of staff in a well functioning home is their ability to respond to behaviour in a trauma-informed way. In reality, workers in group homes often struggle to maintain non-reactive and non-judgemental trauma-informed responses to the behaviour of young people.

3. Developing a sense of normality:

One significant function of group homes is to develop a sense of normality for the residents. To achieve this, young people are often assisted in engaging with normative environments outside the group home, following internal arrangements to facilitate this.

Interactional Dynamics

Anglin's analysis of group homes identified 11 influential interactional dynamics (that is, interpersonal interactions) that contribute to the Therapeutic Care and repair of young people who have dealt with trauma. Anglin also details how these dynamics can be used as therapeutic behaviours by staff in order to help children and young people in care.

[50] *Anglin, Pain, Normality and the Struggle for Congruence, 52.*

[51] *Ibid., 55.*

These interactional dynamics are:

1	Listening and responding with respect – This helps the child to develop a sense of dignity, the idea that they are valued as a person, and a sense of self worth.
2	Communicating a clear framework for understanding – This helps to create a sense of meaning and rationality within daily life.
3	Building a relationship and rapport – This helps young people to develop a sense of belonging and the skills to connect with others.
4	Establishing structure, routines and expectations – This creates a sense of order and predictability in the world, as well as a sense of trust in the reliability of other people.
5	Inspiring commitment – This assists young people in the development of a sense of value, loyalty and continuity.
6	Offering emotional and developmental support – This helps young people to enhance their skills of caring and the mastery of life tasks.
7	Challenging problematic styles of thinking and action – This encourages new behavioural patterns to increase potential and capability.
8	Sharing power and decision-making – This helps young people to feel a sense of personal power and discernment.
9	Respecting personal space and time – This helps to foster feelings of independence.
10	Discovering potential and talents – This provides hope and opportunity, which will be beneficial in the future.
11	Providing resources for betterment – This helps young people to appreciate generosity and have a sense of gratitude.

When these interactional dynamics are coupled with key staff behaviours, they can help to create a sense of safety and the facilitation of repair within group homes.

Each of these interactional dynamics can be used in a single moment or as part of a broader interaction in order to develop a group home where the resident's best interests are considered at all times. This development of a positive environment is largely a matter of combining these interactional ingredients in a congruent manner, whilst sensitively addressing the creation of an extra-familial living environment, responding to pain and pain-based behaviour and developing a sense of normality.

Levels of Group Home Operation

Organisations bring together a range of processes involving their necessary operations, roles, functions and responsibilities. In the group home context, Anglin has identified five levels of operation:

1. Extra-agency level (contracting, funding, liaising with other organisations)
2. Management level (administration, HR, budgeting, resource allocation)
3. Supervision level (overseeing care workers, team development, programming, resident care)

4. Carework and teamwork level (working individually and collectively with youth and family members, completing reports, linking with community agencies)
5. Youth resident and family level (daily living and visitations)

Anglin believes that a "flow of congruence" from the higher levels to the lower levels of service is in the best interest of the child.

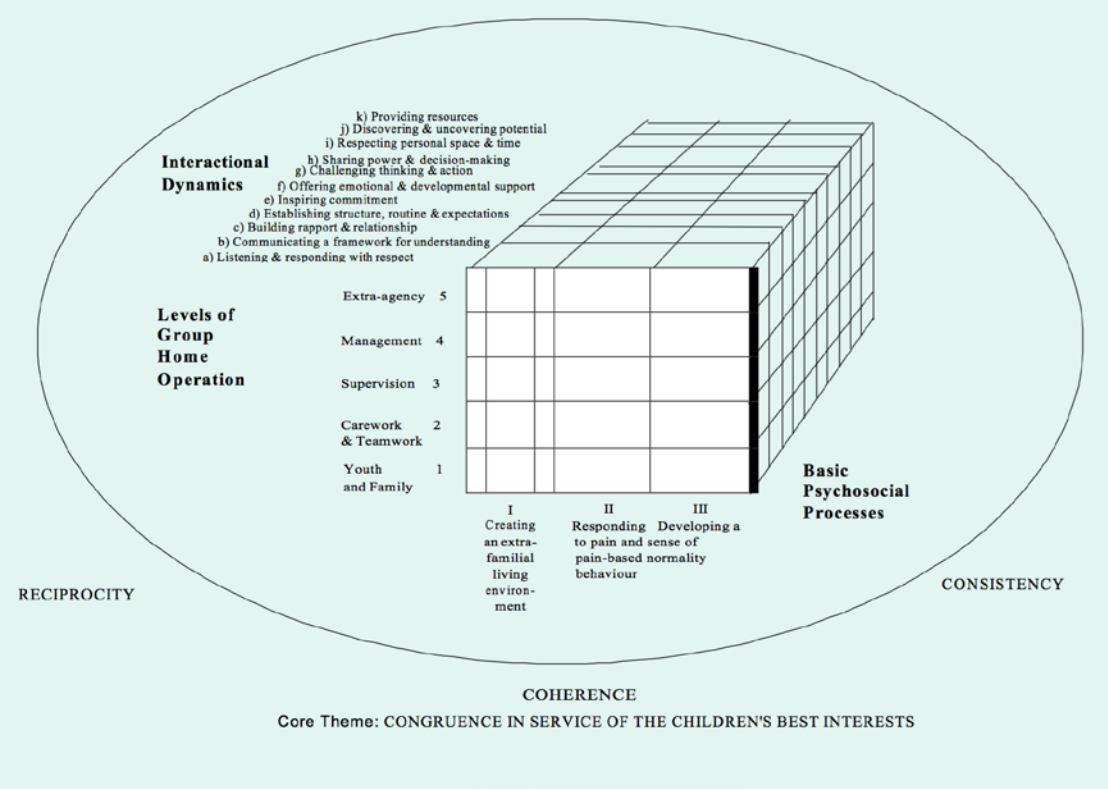

Figure 2: Framework Matric for Understanding Group Home Life and Work (Anglin, 2012)[52]

The Sanctuary Model

The Sanctuary Model is a format devised by Sandra L. Bloom and indexed online at http://sanctuaryweb.com/. This model has similarities with the model developed by Anglin, as it also provides a framework and language for organisational behaviour, which is undertaken in order to allow reparative responses to trauma. The Sanctuary Model proposes that it is impossible for a trauma-saturated organisation to work effectively or to address the needs of young people who have experienced developmental trauma. Bloom argues that an inherent risk in the development of systems that respond to trauma is the possibility for that organisation to become "trauma organised".[53] An organisation in this condition may fail to challenge the assumptions, behaviour, thinking and emotions that have developed in response to the children's early trauma history. In the worst-case scenario, such an organisation can even inadvertently support these negative adaptations from early environments.

[52] *Anglin, James P. Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth. New York: Haworth Press, 2002.*

[53] *Sandra L. Bloom, "The Sanctuary Model of Organizational Change for Children's Residential Treatment," Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26, no. 1 (2005): 6.*

To avoid these issues, Bloom's model provides a non-hierarchical, highly participatory system for organisational behaviour that is trauma- and evidence-informed. For trauma to be addressed in an organisational context, the Sanctuary Model emphasises the importance of shared goals and the creation of a philosophical framework in which these goals can be achieved. This helps to create a system in which understanding and awareness can be used to guide behaviour, decision making, problem solving and conflict resolution. Bloom assumes that individuals recovering from trauma and the organisations that support them need to learn better skills for communication and active listening. These skills will result in increased democracy, transparency, and participation. They can also underpin conflict resolution strategies in order to support a non-crisis based and non-reactive service of care.

To develop an organisational culture that is committed to addressing this trauma, seven dominant cultural characteristics are engaged:

1. Culture of non-violence: building safety skills
2. Culture of emotional intelligence: helping to teach effective management skills
3. Culture of inquiry and social learning: building cognitive skills
4. Culture of shared ownership: helping to develop skills of self-control, self-discipline, and the administration of healthy authority.
5. Culture of open communication: helping to overcome barriers towards healthy communication, the reduction of 'acting-out' behaviours, the improvement of self-protection and self-correcting skills, and the creation of healthy boundaries.
6. Culture of social responsibility: rebuilding social connections, establishing healthy attachment relationships.
7. Culture of growth and change: restoring hope, meaning, and purpose to empower positive change.

In order to define and maintain culture change, residential care staff need to be supported in their engagement with a reflective practice. The Sanctuary Model offers the S.E.L.F. framework, which is a trauma-informed tool to help staff and young people move through four critical stages of recovery. It incorporates the following elements:

S Safety – Attaining safety for oneself, for others and the creation of a safe environment overall
E Emotional – Examining personal experiences and developing impact management skills
L Loss – Feeling grief and dealing with personal loss
F Future – Bettering future outcomes by trying out new roles and practicing ways of relating in order to ensure personal safety and to help others.

Sanctuary Within a Residential Setting

To effect change, develop more democratic participatory process and maintain positive changes in a therapeutic community, Bloom outlines a number of necessary transformations.[54] These include:

- **Leadership commitment:** All key organisational leaders must become actively involved in the process of change and participate in the core change team. The responsibility of this core team is to actively represent and communicate with their work colleagues and to become change agents for the whole department.
- **Adoption of an evaluation framework:** This allows staff to deal with problems that arise between staff and young people, amongst staff, and between staff and administration or management within a treatment setting. The final question must always be 'are we safe?'.
- **The creation of shared assumptions, beliefs and values:** The core team must identify the most important organisational values and identify instances in which the organisation is not compliant with them.
- **Increased presence of democratic principles:** The core team must learn what it means for leaders, staff, children and young people to engage in more democratic processes.

[54] *Bloom, "The Sanctuary Model of Organizational Change for Children's Residential Treatment."*

- **Team work and collaboration:** The core team needs to develop a vision of how groups and teams function together to produce an integrated system. They can then plan steps for the improvement of vision, teamwork and collaboration.
- **Understanding trauma and its impact:** An understanding of the impact of trauma of individuals, families and systems needs to occur. This knowledge must be integrated into policy and procedures.
- **Establishment of care community meetings:** The core team should develop a format for regular meetings that will disseminate information and allow an open process for decision-making.
- **Creation of safety plans and individual contracts:** Simple and straightforward safety plans should be developed by young people for themselves, in collaboration with staff members. These plans must identify the immediate steps that an individual can take as soon as they find themselves in a stressful, challenging, or dangerous situation. These plans should be reviewed regularly, and may be carried by the staff and young people for use as a cognitive-behavioural tool.
- **Ongoing staff learning and development:** The creation of a staff learning and development program should incorporate an understanding of the elements of trauma-based behaviour, an evaluation framework, and safety planning. This program should begin at orientation, and be ongoing for the duration of their contract.
- **Client participation:** Children and young people should be given multiple opportunities to participate in the planning around their care and the outcomes expected of them.
- **Ongoing evaluation:** The core team should develop indicators that allow for an ongoing evaluation of the program, which should be observable, measurable, and consistent with the agreed standards. [55]

Monitoring Success

Bloom emphasises the importance of evaluation in order to demonstrate an organisations ability (or inability) to make positive changes. To this end, she has outlined nine indicators to guide the evaluation of progress:

1. Less violence (physical, verbal and emotional)
2. A greater understanding of the impact of trauma within the system
3. Less victim blaming, including fewer punitive or judgemental responses to behaviour
4. Clearer and more consistent boundaries with higher expectations (linked to rights and responsibilities)
5. Earlier identification of perpetrator behaviour, plus appropriate strategies to deal with this
6. Enhanced ability to state clear goals, create strategies for change, and to justify the need for a holistic approach
7. Better understanding of repeat behaviours and resistance to change
8. A more democratic environment at all levels
9. Better overall outcomes for children and young people, staff, and the organisation.

The Attachment, Self-Regulation and Competency (ARC) Model

ARC is a framework based on cognitive behaviour strategies, which helps in the intervention of young people who have experienced developmental trauma. This framework draws on attachment, trauma, and resilience literature, and is underpinned by the philosophy that systematic changes can lead to effective and sustainable outcomes – both for the individuals and the systems they inhabit. ARC provides a framework that seeks to recognise factors derailing normative development. It seeks to rebuild healthy developmental pathways by working with children, families and systems. ARC addresses vulnerabilities created by exposure to significant trauma in development, which interferes with future healthy development.

[55] *Ibid.*

The goals of ARC are to decrease internal distress; increase a child's ability to identify, access, and regulate emotion; and to build the skills necessary for healthy development and resilience.[56] ARC acknowledges the importance of intervening locally to target contextual and systemic factors, in an effort to develop sustainable individual change. It is thus a useful guiding framework for intervention, and helps to assist children and young people within their caregiving systems.

The ARC framework addresses three primary domains of attachment, self-regulation and developmental competence. These domains are broken down to ten foundational building blocks, which form the basis for intervention across individual, familial and systemic contexts.

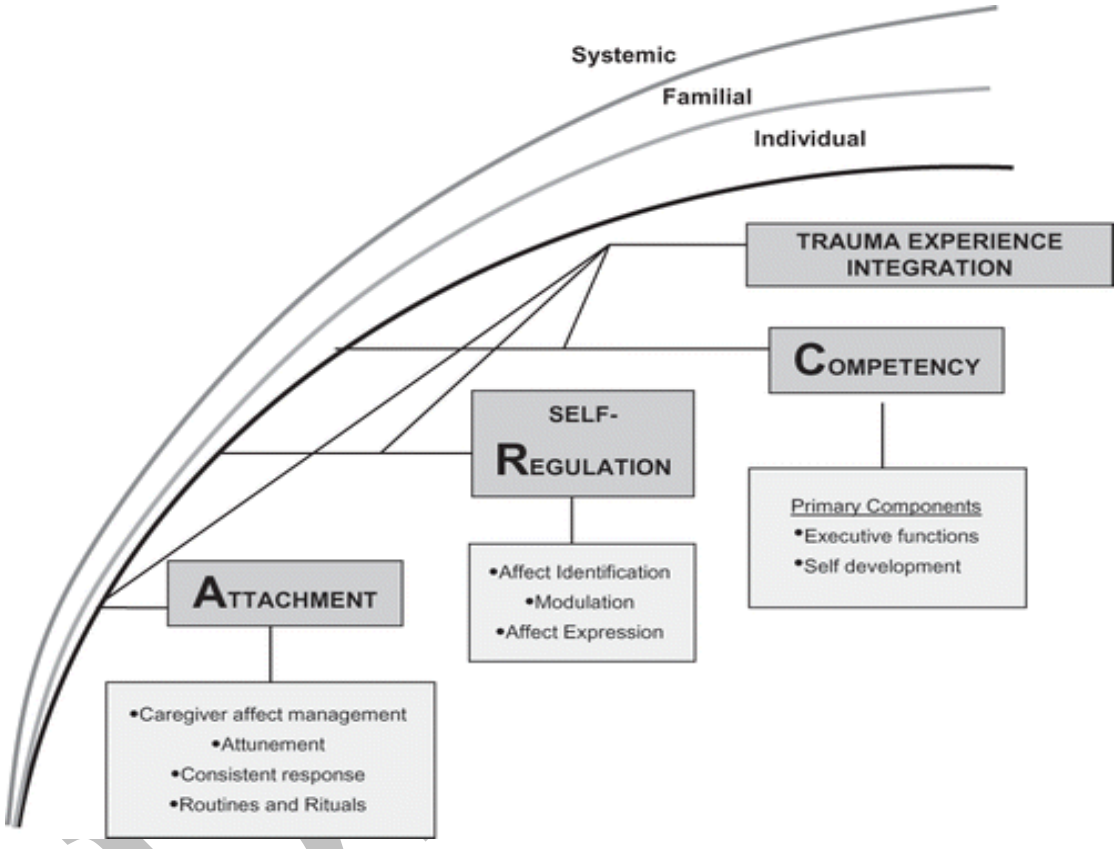

Figure 3: Attachment, Self-Regulation, and Competency: a framework for intervention with complexity traumatised youth

Attachment

In order to address experiences of poor attachment or the severe implications of damaged attachment relationships, ARC helps caregivers to create an environment that is safe and able to support a child in meeting their developmental, emotional and relational needs. This is achieved through:

- Caregiver Affect Management: Developing the capacity of caregivers to manage and regulate their own emotional responses, both to a traumatised young person as well as within their own lives.

[56] *Kristine Kinniburgh et al., "Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatised Youth," Psychiatric Annals 35, no. 5 (2005): 424–30.*

- **Attunement:** Building caregiver-child attunement by improving their ability to accurately read cues and respond to underlying emotion.
- **Consistent Response:** Fostering consistency in caregiver responses to child behaviours by developing the skills and ability to respond consistently and safely when dealing with both positive, desired behaviours and negative or dangerous behaviours.
- **Routines and Rituals:** Working with caregivers to build routine and create rituals (both child-specific and family-specific) that establish familiarity and connectedness with context, and which target high-risk situations and settings.

Self-Regulation

A common impact of developmental trauma is a disconnection from aspects of emotional experience. This could, for example, mean that a person lacks awareness of emotion-related body states or does not understand the relationship between experience and emotional response. Difficulty expressing emotion may lead children and young people who have suffered developmental trauma to be emotionally blunted or constricted, or to be excessively emotional and show trouble regulating emotional responses or limiting their expression. Difficulties can also be experienced when attempting to calm after periods of emotional liability. This can lead to unhelpful emotion management strategies such as self-harm or substance abuse. The overarching goal of self-regulation is to work with children and young people to help them develop the capacity to safely and effectively identify, access, regulate, and share their emotional experiences. This is achieved by:

Affect Identification: The development of an awareness of internal experience as distinct from shared or public experience. This emotional understanding should include:

- A connection and contextualisation provided for emotional experience, such as the affect to physiology, experience, thoughts, behaviours *et cetera*.
- Accurate identification of emotions in others.

Affect Modulation: Building a child's capacity to regulate emotional experience and maintain optimal levels of arousal regardless of emotional experience. These building blocks may include:

- Identification, labelling, and mapping emotions and emotional states.
- Identification and connection to subtle changes in emotional state.
- Identification of the skills and strategies that can lead to change.
- Skills for working through the aftermath of intense affect.
- The ability to modulate emotion in a multi-directional manner with down-regulation used to calm after an explosive state, and up-regulation used to expand constricted emotive patterns.

Affect Expression: Supporting children and young people to learn ways of sharing their emotional experience with others:

- In functionally appropriate terms.
- In order to meet emotional or practical needs.

Competency

Trauma derails developmental competencies across domains of functioning and across developmental stages. Kinniburgh *et al* identify four major domains of competency that are likely to be affected by developmental trauma.[57]

[57] *Ibid.*

These are:

- Interpersonal competencies such as building secure attachment relationships, positive peer relationships and mature relationships in adulthood.
- Intrapersonal competencies such as the development of positive self-concept, awareness of internal states, realistic assessment of self-competencies and the capacity to integrate self-states.
- Cognitive competencies such as language development, school performance and academic achievement, and the growth of executive functioning skills such as problem-solving, frustration tolerance, sustained attention and abstract reasoning.
- Emotional competencies such as the ability to be calm and curious, rather than reactive, and the skills to read the emotional cues of others.

By developing these forms of competency, a child or young person will be able to gain foundational skills needed for their ongoing progress and resilience. The key principles of competency should be addressed in the following ways:

- **Executive Function Skills:** Executive skills are developed when a child or young person is able to practice their ability to evaluate situations, inhibit impulsive responses and actively make choices.
- **Self-Development and Identity:** The development of the self and a sense of self-identity targets four key domains. These are: the development of a Unique Self where the child or young person is assisted to identify their personal attributes such as likes and dislikes, values, talents, and opinions; the development of a Positive Self where a child or young person has the ability to develop their internal resources and is able to identify positive aspects of their character such as esteem or efficacy; the development of a Cohesive Self where the child or young person builds a sense of self that integrates the multiple aspects of their experience; and the development of a Future Self where a child or young person is taught to imagine their preferred future identity and to draw connections between current activities and future outcomes.
- **Integrating Trauma Experience:** In the ARC framework, the integration of trauma experiences involves working with children and young people to develop their abilities in exploring and reflecting on their past experience. This reflection should be active and curious, rather than reactive. This helps the child or young person to gain a realistic understanding of their trauma experiences, and helps them to engage in age-appropriate meaning-making activities to aid in processing and contextualising past events. A child or young person is thus assisted in engaging with their present life and harnessing experiences in order to move from a reactive state into a mode of thoughtful action and connectivity.

Assessing the Needs of Individual Children and Young People in Therapeutic Care

Generally, the needs of children and young people entering Therapeutic Care reflect the consequences of their disrupted attachment relationships and developmental trauma.[58] While evidence does suggest that the development of strong attachment relationships early in life can contribute to resilience, which buffers against the effects of later trauma,[59] this evidence applies largely to the sort of trauma that is characterised by one-off or PTSD-type experiences.

The reality of disrupted attachment and developmental trauma is that they co-occur to a significant extent, and disrupted attachment may be taken as contributing to a broader syndrome of developmental trauma. With the assistance of strong and functional attachment relationships, the brain develops through infancy in a sequential and hierarchal way, with the ability to develop higher brain functions dependent on the successful development and

[58] *Perry, "Examining Child Maltreatment Through a Neurodevelopmental Lens"; Allan N. Schore, "Effects of a Secure Attachment Relationship on Right Brain Development, Affect Regulation, and Infant Mental Health," Infant Mental Health Journal 22, no. 1–2 (January 2001): 7–66, doi:10.1002/1097-0355(200101/04)22:1<7::AID-IMHJ2>3.0.CO;2-N.*

[59] *Nicola Atwool, "Attachment and Resilience: Implications for Children in Care," Child Care in Practice 12, no. 4 (October 2006): 315–30, doi:10.1080/13575270600863226.*

organisation of the structures that underpin them.[60] Being in a chronic state of distress or fear, such as that which occurs when children or young people are traumatised, or have poor models of appropriate emotion regulation or stress response, has the potential to compromise the brain development commonly associated with normal childhood development.[61]

Drawing on a range of literature,[62] a broad account of the domains of functioning that may be affected by developmental trauma have been provided already in this document. It is important to note that a range of multiple potential outcomes can result from relativity similar beginnings, and that the outcomes listed below are also known to result from developmental contexts that may not have included disrupted attachment, abuse or neglect. For instance, children and young people who have experienced developmental trauma frequently have trouble at school. Yet, in some cases, they may not. In addition, children and young people who have not experienced developmental trauma may struggle at school, but for different reasons.

Domain	**Characteristics**
Attachment	Poor interpersonal boundaries Distrust Suspiciousness Social isolation Interpersonal difficulties Excessive compliance Poor empathy
Biology	Sensorimotor developmental problems Hypersensitivity to physical contact Problems with coordination, balance, body tone Difficulties locating skin contact Increased range of medical problems
Emotion Regulation	Poor emotion regulation Poor ability in describing internal experience Poor ability in describing internal states

[60] *Bruce D. Perry, "Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics," in Working with Traumatized Youth in Child Welfare: Social Work Practice with Children and Families, ed. Nancy Boyd Webb (New York: Guilford Press, 2006), 27–52.*

[61] *Ibid.; Bruce D. Perry et al., "Childhood Trauma, the Neurobiology of Adaptation, and 'Use-Dependent' Development of the Brain: How 'States' Become 'Traits,'" Infant Mental Health Journal 16, no. 4 (1995): 271–91.*

[62] *Alexandra Cook et al., "Complex Trauma in Children and Adolescents," Psychiatric Annals 35, no. 5 (2005): 390–98; van der Kolk, "Developmental Trauma Disorder: Toward a Rational Diagnosis for Children with Complex Trauma Histories"; Perry, "Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics"; Perry et al., "Childhood Trauma, the Neurobiology of Adaptation, and 'Use-Dependent' Development of the Brain: How 'States' Become 'Traits'"; Schore, "Effects of a Secure Attachment Relationship on Right Brain Development, Affect Regulation, and Infant Mental Health"; Phyllis T. Stien and Joshua C. Kendall, Psychological Trauma and the Developing Brain: Neurologically Based Interventions for Troubled Children (New York: Haworth Maltreatment and Trauma Press, 2004); A. Streeck-Fischer and B. A. van der Kolk, "Down Will Come Baby, Cradle and All: Diagnostic and Therapeutic Implications of Chronic Trauma on Child Development," The Australian and New Zealand Journal of Psychiatry 34, no. 6 (December 2000): 903–18; Jane Morton, Robin Clark, and John Pead, When Care Is Not Enough (Melbourne: Department of Human Services, 1999); Barber and Delfabbro, Children in Foster Care.*

Dissociation	Distinct alterations in states of consciousness Shutting down or demonstrating 'Absence'
Behavioural Control	Poor ability to regulate impulses Self-destructive behaviour Aggression Problematic self-soothing behaviours Sleep disturbances Eating disorders Substance abuse Oppositional behaviour Difficulty understanding and complying with rules
Cognition	Problems with processing novel information Problems focusing on and completing tasks Difficulty planning and anticipating Learning difficulties Problems with language development Acoustic and visual perceptual problems Poor ability to articulate wishes and desires
Self-Concept	Lack of a continuous, predictable sense of self Poor sense of separateness Disturbances of body image Low self-esteem Shame and guilt

Table 2: Domains and Characteristics reported to be demonstrated to be effected following experience of developmental trauma. (Cook et all 2005).[63]

It is also important to consider the best format in which this care can be given. In TFC, a child or young person is placed in a family setting where they are encouraged to form a primary relationship with one carer. This format is too intimate for some young people who have expressed discomfort with this style of Therapeutic Care. Therapeutic Residential Care provides 24-hour support for young people who experience high levels of distress and need intensive therapeutic responses after hours. These young people are likely to burn out Foster Carers and should not be placed in a family unit until they have developed some strategies to manage their own behaviour.

Evaluating the Outcomes of Therapeutic Care Programs

The overall aim of an evaluation of Therapeutic Care programs is to "evaluate the effectiveness and efficiency of the Therapeutic Residential Care services that form part of the OOHC system."[64] The inclusion of appropriate evaluation has however been missing from many models of Therapeutic Care. As a result, "[r]igorous evaluation, including cost-

[63] *Cook, Alexandra, Joseph Spinazzola, Julian D. Ford, Cheryl Lanktree, Margaret E. Blaustein, Marylene Cloitre, Ruth DeRosa, et al. "Complex Trauma in Children and Adolescents." Psychiatric Annals 35, no. 5 (2005): 390–98.*

[64] *VERSO Consulting, "Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary and Technical Report" (Melbourne: Department of Human Services, 2011), 23.*

benefit analysis, is needed to determine the effective components of intensive support services and care models to examine what types of children and young people are more likely to benefit from certain types of services."[65]

This section on the evaluation of models of Therapeutic Care will focus on two studies: the review undertaken by James that draws on the California Evidence Based Clearinghouse rating criteria,[66] and the VERSO Consulting evaluation of eleven therapeutic residential care entities in Victoria, Australia.

California Evidence Based Clearinghouse Rating Criteria

James provided a review of the effectiveness of group homes and residential care settings. She concluded that the evaluation of Therapeutic Care has not been comprehensively studied. The studies that have been conducted lack controls and standardised measures.[67] They each measure symptoms reduction,[68] behaviour,[69] or academic achievement.[70]

Research suggests that better outcomes for children and young people in Therapeutic Care would be achieved if they demonstrated:

- Less severe symptoms
- Less comorbidity
- Good interpersonal ability
- Acute, as opposed to chronic, symptoms.

Other protective factors during this journey include:

- Families involved during care
- Access to step-down or after care services
- Shorter stays in therapeutic facilities
- Families involved during group care placements
- Low(er) levels of abuse.[71]

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[65] *Northern Territory Government, "Growing Them Strong, Together: Promoting the Safety and Wellbeing of the Northern Territory's Children," Summary Report of the Board of Inquiry into the Child Protection System in the Northern Territory (Darwin: Northern Territory Government, 2010), 7.*

[66] *James, "What Works in Group Care?"*

[67] *P. Bean, L. White, and P. Lake, "Is Residential Care an Effective Approach for Treating Adolescents with Co-Occuring Substance Abuse and Mental Health Diagnoses?," Best Practices in Mental Health 1, no. 2 (2005): 50–60; Joanna E. Bettmann and Rachael A. Jasperson, "Adolescents in Residential and Inpatient Treatment: A Review of the Outcome Literature," Child & Youth Care Forum 38, no. 4 (August 2009): 161–83, doi:10.1007/s10566-009-9073-y.*

[68] *John S. Lyons et al., "Outcome Trajectories for Adolescents in Residential Treatment: A Statewide Evaluation," Journal of Child and Family Studies 10, no. 3 (2001): 333–45; Robert Weis, Nicole L. Wilson, and Savannah M. Whitemarsh, "Evaluation of a Voluntary, Military-Style Residential Treatment Program for Adolescents with Academic and Conduct Problems," Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53 34, no. 4 (December 2005): 692–705, doi:10.1207/s15374424jccp3404_11.*

[69] *M. Leichtman et al., "Effectiveness of Intensive Short-Term Residential Treatment with Severely Disturbed Adolescents," The American Journal of Orthopsychiatry 71, no. 2 (April 2001): 227–35; John S. Lyons and Katherine Schaefer, "Mental Health and Dangerousness: Characteristics and Outcomes of Children and Adolescents in Residential Placements," Journal of Child and Family Studies 9, no. 1 (2000): 67–73; Weis, Wilson, and Whitemarsh, "Evaluation of a Voluntary, Military-Style Residential Treatment Program for Adolescents with Academic and Conduct Problems."*

[70] *S. R. Hooper et al., "Ecological Outcomes of Adolescents in a Psychoeducational Residential Treatment Facility," The American Journal of Orthopsychiatry 70, no. 4 (October 2000): 491–500.*

[71] *M. J. Landsman et al., "Outcomes of Family-Centered Residential Treatment," Child Welfare 80, no. 3 (June 2001): 351–79; Linda A. Wilmshurst, "Treatment Programs for Youth with Emotional and Behavioral Disorders: An Outcome Study of Two Alternate*

Another limitation of existing research is the treatment of group care as a uniform construct. Most studies do not report on specific group care models, and provide limited information on the type of group care received by the cohort studied.[72] A notable exception to this is the structured review initiated and guided by the California Evidence-Based Clearinghouse for Child Welfare (CEBC), which explores group care treatment models relevant to children and young people in the child welfare system. The CEBC was created through collaboration between the California Department of Social Services, the Chadwick Center for Children and Families (based in Rady Children's Hospital, San Diego) and the Child and Adolescent Services Research Center. The CEBC was set up to help identify, select and implement evidence-based child welfare practices in order to improve the safety, permanency and well-being of children and families in the care of the child welfare system.[73]

In exploring these possibilities, James identified five treatment models, which are relevant to group care for children and young people in the child welfare system. These were Positive Peer Culture,[74] the Teaching Family model,[75] the Sanctuary Model,[76] the Stop Gap model,[77] and the Re-ED model.[78] Four of the models were rated as either supported by research evidence (PPC) or as being promising (TFM, Sanctuary Model, Stop-Gap). One model (Re-ED) could not be rated due to a lack of data that met CEBC rating criteria. The models were generally considered to be of 'medium' relevance to the child welfare population. All studies included in the review primarily targeted child and family well-being outcomes rather than outcomes of safety or permanency.

Verso Evaluation of the Therapeutic Residential Care Pilot Programs

In 2009, VERSO Consulting was asked to evaluate relevant entities in Victoria that were providing Therapeutic Residential Care. The full study was completed and published in November 2011.[79] All of the entities were developed consistent with the DHS Essential Service Design Elements, which were required if entities were to receive DHS funding. The progress of 38 young people in Therapeutic Residential Care was tracked, with 16 young people in 'general' residential care also tracked as a comparison group.

VERSO provided the following evaluation objectives:

- Identify best practice approaches for the planning, development and implementation of Therapeutic Residential Care programs
- Develop an understanding of the effectiveness and efficiency of each element of the programs

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Approaches," Mental Health Services Research 4, no. 2 (June 2002): 85–96; Kimberly Hoagwood and Mary Cunningham, "Outcomes of Children with Emotional Disturbance in Residential Treatment for Educational Purposes," Journal of Child and Family Studies 1, no. 2 (June 1992): 129–40, doi:10.1007/BF01321281; Robert Larzelere et al., "Outcomes of Residential Treatment: A Study of the Adolescent Clients of Girls and Boys Town," Child and Youth Care Forum 30, no. 3 (2001): 175–85; Mary Peterson and Mark Scanlan, "Diagnosis and Placement Variables Affecting the Outcome of Adolescents with Behavioral Disorders," Residential Treatment For Children & Youth 20, no. 2 (December 2002): 15–23, doi:10.1300/J007v20n02_02.

[72] *James, "What Works in Group Care?"*

[73] *Ibid.*

[74] *Harry H. Vorrath and Larry K. Brendtro, Positive Peer Culture (Chicago: Aldine Pub. Co, 1974).*

[75] *E.L. Phillips et al., The Teaching-Family Handbook, 2nd ed. (Lawrence: University of Kentucky Press, n.d.).*

[76] *Bloom, "The Sanctuary Model of Organizational Change for Children's Residential Treatment."*

[77] *Barry L. McCurdy and E. K. McIntyre, "'And What about Residential…?' Re-Conceptualizing Residential Treatment as a Stop-Gap Service for Youth with Emotional and Behavioral Disorders," Behavioral Interventions 19, no. 3 (July 2004): 137–58, doi:10.1002/bin.151.*

[78] *Robert P. Cantrell and Mary Lynn Cantrell, eds., Helping Troubled Children and Youth: Continuing Evidence for the Re-Ed Approach, The Troubled and Troubling Child Series (Memphis, TN: American Re-Education Association, 2007); Nicholas Hobbs, "Helping Disturbed Children: Psychological and Ecological Strategies.," American Psychologist 21, no. 12 (1966): 1105–15, doi:10.1037/h0021115.*

[79] *VERSO Consulting, "Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary and Technical Report."*

- Clarify the specific client outcomes that should be measured
- Confirm that the client measurement tools currently in use are the best possible tools to contribute to an understanding of the clients' progress
- Develop an appreciation of how well each Therapeutic Residential Care program has performed against stated objectives
- Build an appreciation of key lessons from Therapeutic Residential Care to apply to generalist residential settings
- Develop an evaluation framework for the Therapeutic Residential Care suite of initiatives.

These evaluation activities included service modelling workshops, the collection of initial and ongoing client outcome data (plus data from a comparison group), consultation and workforce surveys, a literature review, case interviews, and the development of an ongoing evaluation framework.[80] Qualitative data was collected via interviews with care staff and management, therapeutic service providers, a sample of young people living in Therapeutic Residential Care, and representatives from relevant agencies and stakeholder groups. Quantitative data was collected at two time points prior to entry into Therapeutic Residential Care, and at regular times after entry.

Progress was measure in terms of the well-being of clients, considered from two perspectives:

- Improvement over time
- Improvement in relation to a comparison group.

Quantitative tools used to collect data included the Health of the Nation Outcomes Scale (HoNOSCA) and the Strengths and Difficulties Questionnaire (SDQ). The VERSO report concluded:

- The practice of Therapeutic Residential Care leads to better outcomes for children and young people in comparison to standard residential care practice
- Therapeutic specialists are essential
- Staff training in the theory and practice of working therapeutically is a priority
- There are significant improvements in placement stability
- There are significant improvements to the quality of relationships and contact with family
- Over time, there were significant improvements to the quality of contact with residential carer during the pilots
- There is an increased community connection
- There are significant improvements to sense of self
- There are increased healthy lifestyle choices and reduced risk taking
- Mental and emotional health is enhanced
- Optimal physical health is improved
- Improvements in relationships with schools are evident across multiple measures.

The VERSO report concluded that "Therapeutic residential care practice leads to better outcomes for children and young people than standard residential care practice."[81] It noted that Therapeutic Residential Care was more expensive than general residential care, however the immediate, medium-term, and long-term benefits for children and young people resulted in net benefits from "reduced demand for crisis services and intensive intervention services such as secure welfare, youth justice, policy and the courts." The evaluation concluded that there was an avoided cost per child and young person of $44,243.[82]

[80] *Ibid.*

[81] *Ibid., 4.*

[82] *Ibid., 5–6.*

What is Happening in Other Australian Jurisdictions?

Out of Home Care services in Australia – General Trends

In 2012-2013, recurrent expenditure on services for child protection and OOHC services in Australia was approximately $3 billion, an increase of $100.8 million (3.5%) from 2011-2012.

There is a series of general trends that have emerged in Therapeutic Care in Australia. These trends are described below, followed by a focus on the states and relevant practice examples where they are identified.

In some cases, characteristics of a child or young person mean that other options of care are not appropriate. These characteristics include:

- A history of disrupted attachment
- A history of abuse (physical, psychological, emotional)
- A history of neglect
- A history of developmentally-based trauma
- Developmental or cognitive challenges
- Poor response to residential settings
- Demonstrated degree of risk to oneself or others
- Mental health difficulties characterised by internalising or externalising characteristics
- Ongoing social, emotional, cognitive or behavioural challenges.

Despite these core similarities, there are many differences across the models of Therapeutic Care employed in Australia. These differences can be found in terms of:

- Models of care
- Philosophies of care
- The age of targeted children and young people
- Staffing arrangements
- The contributions of different professional and service streams
- The training provided to staff (such as attachment, trauma informed, or neuro-physiologically informed)
- The degree to which models of care are informed by evidence, and the quality or source of that evidence
- The involvement of government and private sector partners, and the degree of involvement of each.

Overview of Therapeutic Residential Care in Australian States and Territories

Information on Therapeutic Residential Care in Australia has been collated separately under each State and Territory below.

At the time this report was assembled, only limited information could be identified for the Northern Territory, South Australia and Tasmania, for inclusion in the Literature Review.

Queensland

Program Target
Children and young people aged 12 to 17 years. Children younger than 12 years may only be considered for placement if comprehensive assessment indicates they have therapeutic needs best met by Therapeutic Residential Care and/or they are one of a sibling group, who all have complex or extreme support needs and would benefit from being placed together.

Parental Responsibility
Chief Executive

Program Purpose
Therapeutic Residential Care services will:

- assist children and young people to build relational, behavioural and emotional capacity;
- assist children and young people to develop skills and behaviours to transition to a less intensive form of out-of-home care, and decrease the risk of future placement instability; and
- support reconnection with family and community (where appropriate and consistent with the case plan).

Referral into program
Placements in Therapeutic Residential Care may be made for children and young people aged 12 to 17, who are subject to an order granting custody or guardianship to the Chief Executive under the Act, including a temporary custody or a transition order; and who have been assessed as having complex or extreme needs; and who are unable to be placed in family-based care or other forms of residential care, but have capacity to live in a small-group (i.e. co-tenanted) setting.

Program Duration
Placement of a child or young person in Therapeutic Residential Care will be for a period of up to 18 months.

Program Authority
A child or young person may be placed in Therapeutic Residential Care under the authority of the Child Protection Act 1999, section 82(1)(d) for licensed services or section 82(1)(f) for services yet to be licensed; with the approval of the delegated officer and in accordance with Child Safety Services financial delegations. Placement of a child or young person in Therapeutic Residential Care will be made in accordance with placement-matching procedures in the Child Safety Practice Manual.

Placements of a child or young person in Therapeutic Residential Care will be made in consideration of the child or young person's own views, strengths and needs, individual abuse and trauma history, culture, disability and developmental needs (including any diagnosed mental health conditions), the views and wishes of the child or young person's family, continuity of relationships, and the needs of other children and young people already residing with the service; as outlined in the Child Safety Practice Manual.

Recognised Entities will be given opportunity to participate in the decision to place an Aboriginal or Torres Strait Islander child or young person in Therapeutic Residential Care. Placements of Aboriginal or Torres Strait Islander children will be made in accordance with the Indigenous Child Placement Principle (Child Protection Act 1999, section 83).

Additional Information
Therapeutic Residential Care: offers enhanced levels of residential care and support for children and young people with extreme to complex support needs, as assessed on the Needs Assessment Structured Decision Making tool (CRC, 2009).

The department maintains responsibility for the case management of children and young people in residential care. The development of residential service responses and their review are supported by information generated from:

- the Child Strengths and Needs Assessment
- the Child Health Passport
- the Education Support Plan
- the Cultural Support Plan for Aboriginal and Torres Strait Islander children and, where appropriate, children from culturally and linguistically diverse backgrounds

- the Transition from Care case plan, for young people who are aged 15-17 years old; and specialist assessments, such as those conducted by Evolve Interagency Services and disability services, and any behaviour support and/or treatment plans.

The department and the residential care service providers involved are involved in development and review, and also in facilitating the participation of the child or young person, their family, relevant support services, Aboriginal and Torres Strait Islander Recognised Entities, and other relevant persons or significant others (such as school staff, support workers and previous carers) in these processes.

Queensland Practice Example: Evolve

Evolve was developed on the basis of partnerships between the Department of Child Safety, Queensland Health, Disability Services Queensland and the Department of Education, Training and the Arts. Principles of the interagency model include:

- Service responses based on the goal of the best outcomes for the child or young person rather than the capacity or responsibility of each service system or department;
- The team embrace a culture of shared responsibility and 'owning' solutions through the development of networks and relationships, not just systems and processes;
- A balance of 'ground-up' expertise regarding the particular needs and situations of the child or young person, with 'top-down' authority and expertise to consider and implement options and strategies;
- Effective communication between service providers across all departments/agencies and all levels, the child or young person and their support system is essential;
- Children who have been maltreated require specialised, sensitive and consistent care;
- The child or young person is considered in their social and cultural context and, whenever possible, interventions will focus on developing supportive social environments rather than on the child or young person in isolation; and
- The views of the child or young person and their support system must be considered (including obtaining consent for information sharing and participation in care or treatment planning wherever possible).

Evolve has been established in seven locations in Queensland and was introduced specifically to support the therapeutic and behavioural needs of children and young people in the care of the Department of Child Safety. The needs of the children and young people were assessed against the Child Strengths and Needs Assessment Structured Decision Making tool (CRC, 2009), and responses to their needs are coordinated across services as follows:

Queensland Health: through the Evolve Therapeutic Services teams, provide intensive mental health therapeutic assessment and interventions to children and young people who experience trauma related psychological and behavioural problems as a result of abuse and neglect. This may include crisis response, short-term intervention, and medium to long-term therapy aimed at: reducing the child or young person's maladaptive emotional and behavioural responses; carer support and specialist consultation services.

Disability Services Queensland: through the Evolve Behaviour Support teams, provide behaviour support services (through a multi-disciplinary team of psychologists, speech and language pathologists and occupational therapists) to children and young people with a disability who have psychological and behavioural problems resultant of trauma from abuse and neglect and/or from having a disability. Positive behaviour support strategies are presented within the context of a behaviour support plan and are developed on the following basis:

- **The Department of Education, Training and the Arts:** supports the collaborative model of service through linking therapeutic and behaviour support services with the Education Support Planning services and providing school based support and educational services appropriate to the needs of children and young people in care.
- **Local Evolve Steering Committees:** are comprised of members from the four key agencies (Department of Child Safety, Queensland Health, Disability Services Queensland and the Department of Education,

Training and the Arts), and oversee the implementation of the initiative at the local level. Their role includes ensuring services are being delivered to the target group, identification of issues in service delivery and the development of local solutions to address these issues, in particular problems that occur in relation to interagency collaboration for the delivery of services to individual children and young people referred to Evolve.

Victoria

Program Target
Residential Care - Complex: Provides short, medium and long term out-of-home care in residential facilities for young people aged 12 to 17 years who display multiple and complex needs and whose behaviours place them at extreme risk of harm. Specialist therapeutic and support services are available to these young people and staff who work with them.

Parental Responsibility
Minister

Program Purpose
Residential care services specifically respond to the trauma and attachment disruption arising from prior abuse and neglect that has been experienced by a significant number of children and young people in residential care. It is necessary for residential care to provide a care system grounded in Therapeutic Care.

Referral Into Program
A formal agreement between the Community Service Organisations (CSOs) and the Victorian Department of Human Services (DHS) region (signed off by the Child Protection Manager, Placement and Support Manager, and CSO Residential Services Program Manager) regarding the referral, selection and admission for all clients into the Therapeutic Care facility.

Program Duration
Not specified.

Program Authority
Legislative requirements of the Child Wellbeing and Safety Act 2005 and the Children Youth and Families Act 2005 together provide "a consistent and unifying philosophical platform to guide the practice across the Child and Family Services Sector, the Children's Court, Child Protection and Placement Services, by specifying a common set of principles. The principles give guidance under the administration of the Children Youth and Families Act 2005 and include:

- Best Interest Principles (best interest of the young person)
- Decision Making principles Additional Decision making principles for Aboriginal children and Aboriginal Child Placement Principle
- Adopting a cumulative harm approach (in respect of the impact of chronic developmental trauma)
- Performance standards for Community Service Organisations The Charter for Children in Out of Home Care.

Other
In Victoria, Residential Care is a care placement service for children in the child protection service system. Residential units are operated by CSOs and Residential Care is classified as General, Intermediate or Complex depending on the characteristics of the children and young people referred.

Residential Care - General: Provides short, medium and long term out-of-home care in community-based residential facilities for children and young people aged mainly 12 to 17 years who are unable to be placed in home based care (such as Foster Care or Kinship Care). These placements are delivered with a range of support services.

Residential Care - Intermediate: Provides short, medium and long term out-of-home care in residential facilities for children and young people aged 12 to 17 years who have challenging behaviours.

Residential Care - Complex: Provides short, medium and long term out-of-home care in residential facilities for young people aged 12 to 17 years who display multiple and complex needs and whose behaviours place them at extreme risk of harm. Specialist therapeutic and support services are available to these children and young people, and staff who work with them.

CSOs funded by the department to operate a therapeutic residential care unit must comply with the Therapeutic residential care essential service design elements. CSOs providing Therapeutic Residential Care (TRC) will employ a therapeutic specialist who will work across the organisation and in the residential care home to advise and promote the therapeutic approach. Residential carers working in a therapeutic residential care unit must undergo mandatory staff training in trauma and the theory and practice of working therapeutically. CSOs delivering therapeutic residential care placements must also comply with broader residential care program requirements.

Victorian Practice Example: Hurstbridge Farm

The Victorian Department of Human Services commenced the first TRC program in 2007 and this expanded to a further ten TRC units, operated by CSOs as four-year pilot programs. The pilots trialled and assessed an approach to residential care that focused on understanding and responding in a therapeutic manner to the impact of trauma and was informed by Attachment theory, Trauma theory and the Neurophysiology. A two-year independent evaluation of the TRC (DHS, 2011) found that that the TRC model achieved better outcomes for children and young people than standard residential care.

In Victoria, DHS investigated alternative approaches to out-of-home care and recommended that the Sanctuary Model best informed the framework of organisational change required to support therapeutic approaches to care. The Sanctuary Model is outlined earlier in this document.

In 2008, Sanctuary training was provided to CSOs that delivered residential care. The theoretical underpinnings of Sanctuary were tested at the TRC pilot site at Hurstbridge Farm, and results from this evaluation encouraged DHS to expand delivery of the TRC programs across Victoria.

Development of the program was also driven by demand, concern about outcomes from existing models, the increasing complexity of the children and young people utilising the service, and ongoing concern about service costs.

The Hurstbridge Farm pilot was opened in 2007 and was the first in a series of TRC sites in Victoria. Hurstbridge Farm was run as a farm with the agricultural activities undertaken on the farm undertaken in support of children and young people's development and recovery. Hurstbridge Farm also provided the opportunity to develop the Victorian Therapeutic Care model and demonstrated how theory could be realised in practice. This was an important first step that gave the children and young people, staff and DHS insight into the challenges and benefits of working in a trauma informed environment. The knowledge gained from the implementation shaped is accounted for in the VERSO report into residential programs in Victoria (DHS, 2011) as follows:

Policy

- The importance of developing a good residential framework as well as the therapeutic model
- The importance of organisational congruence
- Ensuring funding levels are appropriate to realise the model.

Service management

- Good management structures
- Staffing models with a particular emphasis on shifts (length) and to the self care of staff
- Attention to managing the cohort or mix of residents
- The importance of reflective practice and ensuring that it is embedded in practice.

System interface

- Building the whole system to support children and young people in a congruent manner
- Case management needed to be congruent and consistent e.g. It was noted that a "Critical flaw of the initial Hurstbridge Farm model was that staff had to liaise with six different case managers which over-complicated everything"
- Congruent and well coordinated approaches with education providers i.e. this has been an effective and highly integrated element of 'the farm'.

Research and education

- Research helped inform new services and put a framework around the implementation of the new legislation
- The evaluation of 'the Farm' and other programs helps inform what 'not to do' and 'what works best'
- The results from 'the Farm' generally helped offer enthusiasm and motivation for staff at the other sites (DHS, 2011, P34).

Victorian Practice Example: Berry Street Take Two

Berry Street has a long history of providing a range of social, hospital, care and educational services in Melbourne and now across Victoria. The Berry Street name originated from a premises on the corner of Vale and Berry Streets in East Melbourne and the entity now provides a range of community, education, training and employment, family, domestic violence, foster and kinship care, residential and therapeutic services across sites in five Victorian regions.

The Take Two program is an intensive therapeutic service for children and young people who are substantiated child protection clients who have experienced trauma, neglect and/or disrupted attachment and if they are judged to be demonstrating, or at risk of demonstrating, behavioural or emotional disturbance. Take Two is funded by the Victorian Department of Human Services to provide intensive therapeutic services to referred children, young people and their families, as well as undertaking research and training to build and disseminate knowledge and to contribute to the responses of service systems to the needs of this client group. Take Two is a partnership of child and family services, mental health, academic, and Indigenous services as follows:

- Berry Street
- Austin Child and Adolescent Mental Health Services (CAMHS)
- La Trobe University School of Social Work and Social Policy
- Mindful; and
- Victorian Aboriginal Child Care Agency (VACCA).

Take Two staff are based in every DHS region. They are deployed on a regional basis in both rural and urban settings and some teams offer coverage on a state wide basis (i.e. the Aboriginal team). Take Two offices are located in Richmond, Scoresby, Flemington, Eaglemont, Bendigo, Ballarat, Geelong, Morwell, Shepparton, and La Trobe University - Bundoora and Mindful. Staff are also co-located in facilities in Warrnambool, Horsham, Mildura, Wangaratta, the DHS Hurstbridge Farm, and DHS Secure Welfare Facilities.

Take Two is an intensive therapeutic service, providing counselling and therapy for children and young people who have suffered from physical or sexual abuse, neglect or family violence. Take Two works intensively with people who may be significantly distressed or who may have experienced significant distress previously, as well as their families, carers and other services. The aim is to facilitate recovery from the negative impacts of disrupted attachment, abuse, neglect, violence and/or trauma.

Western Australia

Program Target
Children and young people up to the age of 18 years, who are in the care of the Chief Executive.

Parental Responsibility
Chief Executive

Program Purpose
Individual Therapeutic Plans. The purpose of individual therapeutic plans is to use the information and priorities identified within the Residential Care Plan to further identify specific objectives and to develop and implement agreed strategies for all staff to consistently apply when engaging with the child or young person.

Referral Into Program
District office completes an assessment of the child or young person's needs to determine the tier of service. Case Manager completes the standard Referral Form (signed by the Senior Child Protection Worker- Placement Services and District Director). Completed and signed Referral Forms are forwarded (with appropriate support information) to Agency Referral Officers (AROs) at the Central Referral Team for review and potential placement. Consultation with the Manager to confirm the suitability of the placement being considered, and ARO will confirm placement options (or otherwise) as soon as practicable with the Senior Child Protection Worker- Placement Services.

Engagement Duration
Until leaving care arrangements are fulfilled.

Program Authority
Children and Community Services Act 2004; and

Other
The Residential Care Conceptual and Operational Framework accounts for all children and young people in out-of-home care. It has not been developed in response to a particular sub set of these children or young people. The residential care Manager is responsible for ensuring the development, implementation and review of Individual Therapeutic Plans for all children or young people in their care. Individual Therapeutic Plans are developed collaboratively by the care team. The implementation of an Individual Therapeutic Plan is the responsibility of all staff. The Psychologist has a key role in developing and supporting the implementation of the Individual Therapeutic Plan and in providing 'hands on' support to staff. An Individual Therapeutic Plan will clearly identify a child or young person's specific behaviour and/or need that staff will manage in an agreed and consistent manner. Individual Therapeutic Plans are reviewed at least every week, or more frequently if necessary, by the residential care team and adjusted as required. Usually not more than one behaviour and/or need is targeted within an Individual Therapeutic Plan at any one time. Progress made is reported back through the Residential Care Plan.

In Western Australia, the Department for Child Protection (DCP) has adopted a model of residential care that draws both on Sandra Bloom's (2005) Sanctuary Model and James Anglin's (2004) study into residential care.
The DCP Residential Care (Sanctuary) Framework 2012 accounts for an overarching model of care as well as relationships between its constituent parts. The model offers a therapeutic approach to care as well as an organisational roadmap of how to develop a trauma informed culture that can support the delivery of care. DCP is in the process of undertaking a major expansion and reform of residential care across the State.

Western Australia has transformed its residential care services of larger hostel like accommodation into smaller houses located throughout urban areas and regional locations characterised by houses with a larger capacity. These residences are established both within government and also in partnership with the non-government sector. In addition, a Secure Care facility for up to six young people aged 12 to 16 years has been established. This Centre provides for stays of up to twenty-one days with the option of one extension (Department for Child Protection, Residential Care Sanctuary Framework 2012, P2).

Australian Capital Territory (ACT)

Therapeutic Residential Care

The ACT has recently commissioned services for out of home care under a Continuum of Care. Services are provided by a lead agency responsible for provision of Therapeutic Residential Care, Intensive Support Options, Kinship Care and Foster Care. Under this model, children and young people in care will have the one agency responsible for their case management throughout their journey in care once long term orders have been made.

Residential Care is not the preferred option for children and young people, but the ACT recognises there are times when intensive, therapeutic support in a residential facility that is goal orientated and time limited may be beneficial. The Lead Agency of the Continuum of Care will be responsible for developing alternative, family based, intensive support options for children and young people to prevent children entering residential care or exit children from residential care to appropriate family based care arrangements as soon as possible.

Therapeutic Assessments and Plans

ACT Community Services Directorate recognises the impact of trauma for children and young people in care, and the importance of receiving the right therapeutic support, at the right time. Under the ACT Government's 5 year out of home care strategy; A Step Up for Our Kids, Therapeutic Assessments and Plans will be undertaken with every child and young person in care. In the future Therapeutic Assessments will also be offered to children and young people in placement prevention services in order to ensure that any trauma related issues are identified and addressed as early as possible. Therapeutic assessments will also assist in identifying needs of children and young people who may be eligible for the National Disability Insurance Scheme (NDIS).

Purpose

Therapeutic plans will be developed with the child and young person so they have a voice and in consultation with their carer and significant others. The plan will focus on supporting their development, building self-regulation of emotions, establishing healthy relationships, identifying appropriate cultural responses to trauma, addressing any trauma-related behaviours and developing social skills. It will form a component of the care or case plan for the child.

Identified benefits:

- More targeted focus on outcomes for children and young people;
- Development of a specialist team with experience and knowledge of the complex needs of children and young people who have experienced trauma and attachment difficulties;
- Developmental and behavioural needs identified and managed earlier so parents and carers are better able to manage the child's behaviour and families can continue to care for children long term;
- Regular review of therapeutic plans and increased carer input;
- Funds earmarked for therapeutic purposes; and
- Objective time series evidence about improvements to a child or young person's well-being.

Duration of Therapeutic Plan

The Therapeutic plan will be reviewed and updated annually or in the event of changed circumstances including a placement change.

Northern Territory

In the Northern Territory Government Strategic Plan 2012-2015, Supporting Children in Care is listed as a strategic priority. This includes developing out-of-home care to better reflect available evidence and cultural appropriateness, and to facilitate access to therapeutic support in response to emerging needs of children and young people and their families. Currently, fee-for-service placements are provided by either private (for-profit organisations) or non-government agencies who supply residential care for children with complex and extreme

behaviours. These placements are established on an as-needs basis for as long as required and are negotiated individually. The Northern Territory Community Services High Risk Audit recommended, as part of an overall response to the needs of children and young people with high and complex needs, that a small number of secure care beds be offered to provide temporary containment during which assessment, treatment and longer-term planning could begin where significant risk meant that maintenance in the community could not be considered an option (Northern Territory Department of Health and Community Services, 2007).

The Northern Territory Government, Growing them strong, together (2010) report recommended that the Northern Territory Families and Children develops and appropriately funds specifically therapeutic options for children and young people with high needs such as therapeutic residential care, secure care, therapeutic foster care and a range of therapeutic counselling and treatment services (including Tier 3 services) (Rec 66, P76).

South Australia

With the exception of committing to a reduction in violence against women and children, child protection and the implications of disrupted attachment and development trauma are not specifically mentioned in the South Australian Government's 2012 strategic plan. Similarly, the South Australian Government's Office of the Guardian for Children and Young People was unable to identify Therapeutic Care among the range of OOHC services responses in its 2012-12013 report. The report suggested that the state government spent about two thirds of its "child maltreatment" (Office of the Guardian for Children and Young People, 2012-2013, P6) money on out-of-home care as a result of increased demand in the sector. It also reported that five per cent of this budget was spent on family restoration or preservation type services for families where children and young people had already been or may be removed, and who received intensive support in the expectation that their children would be returned to them as a result of their engagement with those services.

It was reported by the Office of the Guardian for Children and Young People that demand in the sector meant that an average of 56 children in OOHC were cared for in motel or other rental accommodation including rented rooms, cabins, caravans or apartments. These situations were staffed by commercially based carers who were rostered on eight hour shifts. The report suggested that these children had an average age of 11 years, included infants, and commonly involved arrangements lasting months or even years.

In June 2013, developments in the South Australian context were reported by the ABC that have seen the state government commit to developing a Therapeutic Care service stream designed to provide Therapeutic Care and repair that the state government has argued has not been provided to date. Press material suggested that the Child Development Minister had reported that the Government had built new housing for caring for young people for whom foster care was not an option and were now in a position to recruit 360 professional carers to staff them. This development is directed at young people who have experienced a range of developmental trauma, and is designed to avoid the need to use casual carers to provide care in temporary situations (i.e. motel room), where Therapeutic Care based on relational repair cannot realistically be provided. Following time in the Therapeutic Care service stream it is envisaged that these young people will be able to engage foster care more successfully than may otherwise have been the case. It was also suggested that in developing this service stream and staffing it as outlined, the government would save a significant amount of money that could be used to deliver therapeutically effective care to children and young people in need of therapeutically based residential care.

Tasmania

A current or recent Tasmanian Government strategic plan was not identified in the current review. The Department of Health and Human Services (2012) final report in Response to the Select Committee on Child Protection included in Action Area 5: Reforming Out of Home Care. "This action area is about ensuring the OOHC system best meets the needs of children and young people". Recommendation 52 was "The need for specially trained therapeutic foster carers for children who are unable to be placed in therapeutic residential care settings be investigated" (Department of Health and Human Services, 2012, P 18).

Other than this, and some NGO documentation, little information was identified on the subject of Therapeutic Care in Tasmania.

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