

:research

What is **Effective Therapeutic Care?**



● ● **Table of Contents**

Introduction	3
Background: Why Therapeutic Care?	4
What is Therapeutic Care?	4
What Theories are Therapeutic Approaches to Care Based on?	6
What is the Evidence for Effectiveness of Therapeutic Approaches to Care?	7
What are Young People Telling us?	11
Messages from the Past	12
What are the Key Features of Therapeutic Care?	13
Summary Messages from Research: Therapeutic Care Principles	16
References	17

© 2019, Centre for Excellence in Therapeutic Care

It should be noted that reading about and engaging with material that explores the issue of self harm and suicidality may lead to experiences of distress. This should be acknowledged and support sought if required.

The Centre for Excellence in Therapeutic Care is a partnership between the Australian Childhood Foundation and Southern Cross University. The Centre integrates up to date research evidence with cultural knowledge, practice wisdom and the voices of young people in care to produce reports, practice resources and training to support the provision of high quality, evidence informed therapeutic care.

Suggested citation: Dr Lynne McPherson, Dr Kathomi Gatwiri, Dr Nadine Cameron and Natalie Parmenter. Research. Brief: What is Effective Therapeutic Care?. Centre for Excellence in Therapeutic Care: Sydney NSW.

The Centre for Excellence in Therapeutic Care is a division of the Australian Childhood Foundation.

● ● Introduction

This research briefing is an introduction to therapeutic care as a preferred response for children and young people who have experienced complex trauma and are unable to live at home. Whilst therapeutic care programs have been in existence throughout the United States of America, the United Kingdom, in the Nordic countries and other parts of Europe for many decades, they are a relatively new approach in the out of home care context in Australia. There is little agreement in the literature about what is effective therapeutic care, with strongly held views expressed against and for models of group care (Ainsworth & Hansen, 2018; Hurley, Lambert, Gross, Thompson & Farmer, 2017). What follows is an overview of the emerging research knowledge in this complex arena, messages from young people who have experienced care and a summary of messages from the research.



THIS BRIEFING COVERS EIGHT TOPICS:

1. Why Therapeutic Care?
2. What is Therapeutic Care?
3. What Theories are These Approaches Based on?
4. What is the Evidence?
5. What are Young People telling us?
6. What are the Key Features of Therapeutic Care
7. Messages from Research Summary: Universal Principles

The briefing context relates to the recent NSW government announcement:



The NSW Government has taken major steps towards replacing the states' current residential care system with a new Intensive Therapeutic Care (ITC) service system to help children and young people recover from trauma, neglect, abuse and severe adversity. The move from residential care to ITC represents an historic shift in the provision of Therapeutic Care in NSW. It introduces unprecedented quality standards relating to staff qualifications, training and rostering, and a commitment to learning, best practice and continuous improvement (FACS, NSW, 2018).

● ● **Background: Why Therapeutic Care?**

For children and young people in out of home care, responses and treatment have varied widely from large residential therapeutic communities in the UK and USA, to systems in Australia which historically, separated the provision of accommodation from therapeutic intervention. Over time, it has become increasingly apparent that for those children and young people placed in group care settings, the provision of care and accommodation alone was not enough to enable them to recover from early disadvantage and adverse experience. The development of therapeutic approaches to care has sought to better meet the needs of this group of children and young people, who are seen to be impacted by the experiences of complex trauma.



A fundamental premise of a trauma informed approach to therapeutic care is the move away from a focus on control, authority and reward and punishment as the basis of learning. The way in which children and young people are viewed shifts away from a deficit based approach which asks ‘what is wrong with you’ to an approach which implies a more nurturing response, based on the central question ‘what happened to you?’ (Bloom & Farragher, 2011).

● ● **What is Therapeutic Care?**

In Australia, one of the networks for therapeutic residential care defines this form of care as...



An intensive intervention for children and young people, which, in Australia, is a part of the out-of-home care system. It is a purposefully constructed living environment which creates a therapeutic milieu that is the basis of positive, safe, healing relationships and experiences designed to address complex needs arising from the impacts of abuse, neglect, adversity and separation from family, community and culture. Therapeutic care is informed by current understandings of trauma, attachment, socialisation and child development theories; which are translated into practice and embedded in the therapeutic care program (National Therapeutic Residential Care Alliance, 2016).

Contemporary approaches to therapeutic care frequently refer to the need to respond to the ‘**complex trauma**’ experienced by the children and young people in care.

Did you know?

Despite years of developments in this field, there is no common definition of **trauma informed care**.



MOST AGREE THAT DEFINITIONS SHOULD INCLUDE

- An awareness of the prevalence of trauma
- An understanding of the impact of trauma on physical, emotional, and mental health as well as on behaviours and engagement to services; and
- An understanding that current service systems can re-traumatize individuals

Complex Trauma



..is trauma that results from exposure to severe stressors (e.g., emotional, physical, sexual, neglect, and witnessing family violence) that most often begin in childhood or adolescence, occur repeatedly over time, and are perpetrated within the caregiving system or by other adults who typically are expected to be the source of security, protection, and stability..., many of these children and adolescents experience lifelong difficulties related to self-regulation, relationships, psychological symptoms addiction, and alterations in attention/consciousness, self-injury, identity, and cognitive distortions... (Lawson & Quinn ,2013 p.497).

● What Theories are Therapeutic Approaches to Care Based on?

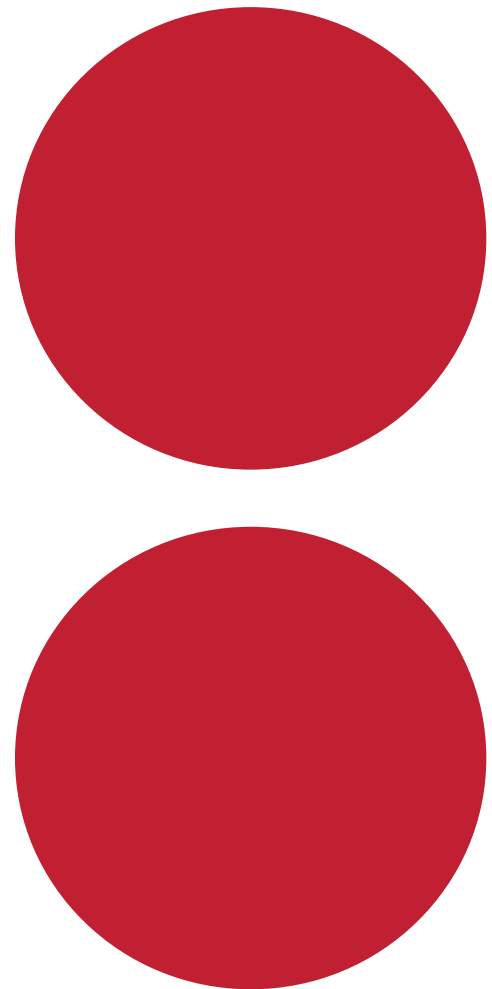
In a recent literature review, twenty two distinct approaches to therapeutic care were identified drawing upon a range of theories in their design (McPherson et al 2019). This was not an exhaustive list, however it clearly demonstrates that there are many different models that are currently operating as therapeutic approaches to care.

Three broad theoretical frameworks that influenced approaches to care were: behaviour modification, social learning and trauma theory.

Behaviour modification describes a system of token economy and levels of intervention (McCurdy & McIntyre, 2004). This approach was designed more than four decades ago and used in group care settings for children and young people the theory assumes that token reward and punishment techniques can address presenting behavioural problems and lead to lasting change. Use of these systems are contested as potentially harmful, with a suggestion that they can be 'provocative and punitive- thus inadvertently increasing children's high risk behaviours (Mohr, Martin, Olson, Pimariaga & Branca, 2009).

Social learning theory suggests that the everyday lived experience of children and young people offer opportunities to learn and to integrate new knowledge into their world view and capabilities (Gharabaghi & Groskleg, 2010). This theory takes a European approach to learning as holistic and inclusive of all aspects of social and emotional development. The theory does not seek to address any underlying concerns that children may bring to group care, including experiences of early adversity and complex trauma.

Trauma informed approaches dominated the landscape in the recent review, with twenty one of the twenty four approaches articulating the development of their therapeutic approach as founded on or influenced by trauma theory (McPherson et al, 2019; Mitchell, Tucci and Tronick, 2019). This dominant approach does appear to reflect and acceptance of the proposition that there was a need to shift the response from one of control and coercion to caring, reducing the need for intrusive and potentially re-traumatising practices such as seclusion and restraint (Hambrick et al, 2018). Trauma informed approaches are not, however a homogenous group, with approaches to care variously emphasising the role of **attachment** (Hunt, Moretti, Booth & Reyda, 2018), the significance of a whole of organisation approach to healing (Bloom & Farragher, 2011), versus **cognitive behavioural** treatment responses with an individualised treatment plan based on theories of **traumatology and neurobiology** (Hambrick et al, 2018).



● What is the Evidence for Effectiveness of ● Therapeutic Approaches to Care?

There is limited evidence that unequivocally demonstrates the effectiveness of approaches to the provision of therapeutic care. Whilst a number of approaches describe themselves as ‘evidence informed’ what they often refer to is the incorporation of research informed practices that have been built into the design of their approach (Hunt et al, 2018).

‘Hierarchies of evidence’, used frequently in research associated with public health, are one way of assessing the suitability of programs in terms of the quality and outcomes of the research that has been undertaken, and provide one measure of effectiveness.

We suggest that ‘hierarchies of evidence’ do little to demonstrate the actual value of therapeutic approaches to group care. Used inflexibly, hierarchies of evidence may underestimate the value of ‘evidence’ obtained in a different cultural, socio political and historical contexts. Hierarchies of evidence may fail to appreciate the value of the rich narrative that local communities and service users, including children and young people in residential care, may offer. Whilst well designed, rigorous programs of research in relation to client outcomes are important, a more flexible approach to an evidence hierarchy is proposed. What follows is a snapshot of twelve promising approaches to therapeutic care, based on a review of evaluation and implementation documentation.

Thirteen Promising Therapeutic Care Approaches

Based on implementation documentation and evaluation outcomes, Table one summarises twelve approaches to Therapeutic Care which were identified as ‘promising’ (McPherson et al, 2019). One approach is based on social learning theory and one other is based on behaviour modification and cognitive behavioural theory. Overwhelmingly, these approaches are informed by trauma theory with the remaining ten of the twelve explicitly ‘trauma informed’. Two of the approaches in Australian, others were developed in the United Kingdom, the USA or across Europe. Whilst the two Australian approaches articulate the attention to culture, there was limited documentation in international models in relation to culture or context. In light of this it is not possible to assess the transnational relevance of models developed in a particular socio-political, historic and cultural context.

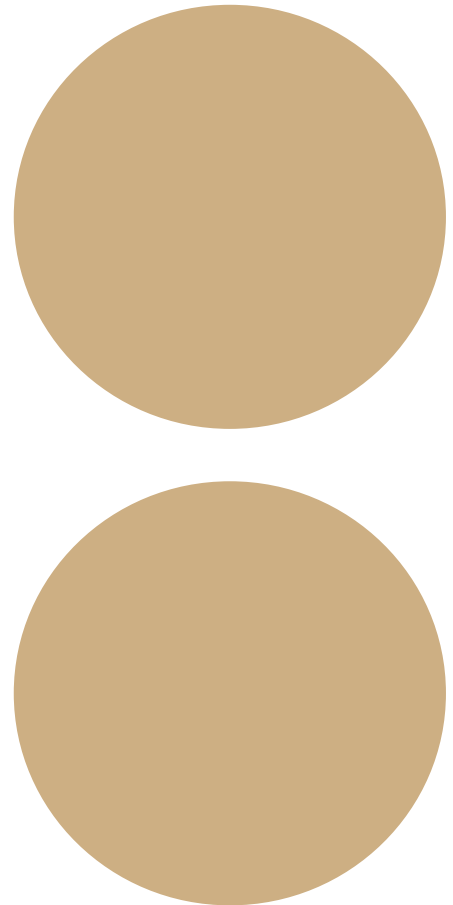


Table 1. Thirteen Promising Therapeutic Care Approaches

APPROACH	OVERVIEW OF IMPLEMENTATION	EVALUATION
<p>Bunjil Burri: an Indigenous Australian Model of Therapeutic Care.</p>	<p>Bunjil Burri: an Indigenous Australian Model of Therapeutic Care. This program documents models of planning and consultation with the local indigenous community with a view to developing a culturally specific model of therapeutic care. The core components of the approach are documented and integrate knowledge that the essence of healing for indigenous children is founded on cultural safety and comprehensive culturally informed assessments and planning. Frontline staff and managers are described as all committed to and trained in culturally safe trauma-informed practice (Bamblett et al 2014).</p>	<p>This review did not identify published evaluation outcomes in relation to this recently developed model.</p>
<p>The Sanctuary Model</p>	<p>The Sanctuary Model is also a whole of agency approach with a commitment to democratic behaviour required by all staff and managers. Opportunities for and an expectation of reflective practice are built in to the approach as is a clear rationale and theoretical base, as opposed an identified theory change.</p>	<p>Most studies identified were conducted in the USA and were of mixed method design, with results demonstrating a reduction in the use of restraint and seclusion practices long with positive progress made by young people in problem solving and resolving conflict (Rivard et al 2004).</p>
<p>ARC</p>	<p>The Attachment, Self-Regulation and Competency (ARC) approach has a clear attachment focussed theoretical basis and extensive program documentation outlining targets for treatment. It seeks to closely 'fit' the individual child's needs and includes a focus on the child's family and community. ARC is a culturally sensitive model.</p>	<p>One small scale study showed promising results in terms of permanency outcomes post treatment (Arvidson, et al 2011).</p>

APPROACH	OVERVIEW OF IMPLEMENTATION	EVALUATION
BCC	Building Communities of Care (BCC) is an approach that is holistic and ecological in design with a clear theoretical foundation. Consistency of the therapeutic experience across multiple domains is a core objective.	Evaluations indicate reductions in the need to use restraint and a reduction in staff injury (Forest et al 2018).
PCC	Positive Peer Culture (PCC) . This approach draws on the power of the group as a vehicle for change and in doing so involves the whole organisation. A well documented plan is transparent and available to all staff who are required to commit to the group work process.	Recent studies show promising outcomes for young people in group care in terms of increased pro-social behaviours however are mixed in relation to juvenile justice outcomes, where group processes are not always found to be positive (Ryan, 2006 cited in James 2011).
DDP	Dyadic Developmental Psychotherapy was implemented as an approach to care in Illinois, USA, where it was implemented via a detailed staff training program with an explicit theoretical basis and a requirement that all staff adopt the P.A.C.E approach to working with young people (Clarke, 2011).	A small scale program evaluation found that on completion of the program that children had statically significant, positive changes in behaviour, mental health, capacity to resolve conflict and socialise (Blackwell & McGill, 2008).
DBT	Dialectical Behaviour Therapy has been adapted for use in group care as part of a 12 month residential care program in the USA (McCredie, Quinn & Covington, 2017). The approach is manualised and has extensively documented the four core modules offered over 4 stages of treatment.	Extensively researched with reference to adult populations, there is now emerging evidence in respect of adolescent group care, indicating reduced clinical symptoms and a greater capacity to use skills learnt, for young people who completed the program (McCredie, Quinn & Covington, 2017).
NMT	The Neuro sequential Model of Therapeutics (NMT) is an approach to the assessment and treatment of children that has been adapted to group care settings in the USA and the United Kingdom (Hambrick et al 2018). Training in the approach is certified, thoroughly planned, documented and based on emerging research and theory in neurobiology, traumatology and neuroscience.	Evaluations indicate reductions in the need to use restraint and a reduction in staff injury (Forest et al 2018).

APPROACH	OVERVIEW OF IMPLEMENTATION	EVALUATION
Stop-Gap	Stop-Gap is a short term therapeutic approach intensively delivered across within the care setting the wider environment and in preparation for discharge. The token economy behavioural modification approach seeks to reward positive behaviours across three tiers of intervention which clearly document a learning program for young people.	One evaluation noted a reduction in the use of restraint practices following a one year period of implementation (McCurdy & McIntyre, 2004).
Teaching Family Model	Teaching Family Model is an approach which has been widely implemented across the USA, Canada and in the Netherlands and as a manualised model has clear planning and implementation documentation which includes annual reaccreditation processes and training programs for professional carers.	Evaluations over time are promising and indicate reduction in problem behaviours and mental illness symptomology (Lazselere, et al 2004 cited in James 2011).
The Australian Spiral Model	Spiral is described as an 'evidence informed framework for therapeutic residential care (TRC) and is a model of care developed in Queensland, Australia by a non-government organisation, Catalyst Child and Family Services. Recognising that an extremely high proportion of children in out of home care in Fra North Queensland are Indigenous, the model explicitly focuses on cultural safety, 'including the recruitment and support of indigenous staff'. The model involves the whole organisation, with effective leadership an essential component (Downey, Jago & Poppi, 2015)	Only one publication was identified in relation to this recently developed model which does not include evaluation or research findings.
The Circle of Courage Model	The Circle of Courage , is based on traditional Native American beliefs and philosophy. In a residential care setting it promotes a sense of belonging, the development of mastery independence and a sense of generosity for First Nations children and young people (Lee & Perales, 2005). It is described as a model for promoting resiliency and empowerment that 'originated from Native American culture' (Lee & Perales, 2005, p.2).	One study involving 29 youth in a mixed method assessment of the extent to which young people in residential care programs had integrated the four key components of the Circle of Courage components was conducted over an eight month period, yielding positive results.
CARE	The CARE approach involves all levels within the organisation, drawing on trauma and attachment theory with a clearly articulated theory of change. Planning and implementation is well documented and transparent. Leadership commitment is required and supported and reflective practice valued.	Multi-site studies have been completed and have involved non randomised control groups. Findings indicated significant declines for 3 types of problem behaviour in studies located in the USA (Holden & Izzo, 2016).

● ● What are Young People Telling us?

Before we turn to the core elements of therapeutic care, it is important to hear from young people who have experienced out of home care. Two recent Australian studies have revealed that most young people have positive things to say about their experiences in care. At the same time, a number reported that they did not feel safe, and that physical, psychological and sexual violence were perceived to be real risks for them, both between young people in care and between young people and workers and other adults (Moore, McArthur, Roche, Death & Tilbury, 2016). This study concluded that children and young people living in residential care were at risk of being pressured into having sex, being sexually manipulated or physically assaulted and were at greater risk of sexual exploitation compared to their peers living in other forms of care (Moore et al, 2016 pp. 79-81).

In another Australian study, young people currently living in residential care, aged 15 to 17 years, were surveyed about their current experience in care. Of the 321 young people who responded (a response rate of 67%), about a quarter responded negatively. (Robertson, Laing, Butler & Soliman, 2017). Concerns included not have a lot of say in decisions affecting them; more than a quarter reported not feeling safe and settled (28%) and almost a quarter were not satisfied with the level of contact they have with their family (23%).

● ● RESEARCH TELLS US THAT YOUNG PEOPLE VALUE:

- positive and lasting relationships,
- an experience of stability and predictability whilst in residential care
- the facilitation of an emotionally and physically safe environment
- participation in decision making about their lives
- to be listened to and respected
- understanding that their connection to their siblings and friends is important
- a desire for normality is highlighted
- flexible carers who respect young people's cultural heritage whilst offering a genuine and caring relationship (Mason, 2007; Sinclair 2005).
- opportunities to have a positive future where they can identify and strive toward their personal goals (Berridge, 2005; Chapman, Wall & Barth, 2004; Mason, 2007; Moore et al 2016; Sinclair 2005).



Messages from the Past

Forty years ago, Henry Maier's paper, *The Core of Care: Essential Ingredients for the Development of Children at Home and Away from Home* (1979, cited in Mitchell, 2015) identified seven vital components in the core of care.

Bodily Comfort

As a child's bodily comforts are met, they feel treated with care. Throughout life a sense of well-being and care is experienced when one's body is free of stress. The experience of discomfort makes people feel unwelcome, worthless and isolated. Young people need to have private spaces that are unconditional.

Differentiations

Individual children all have different temperaments. This requires that caregivers differentiate in the way they respond to them. Temperamental differences impinge on development. Some young people require bodily contact as part of close personal interactions while others need some distance and rely on eye and marginal body contacts.

Rhythmic Interactions

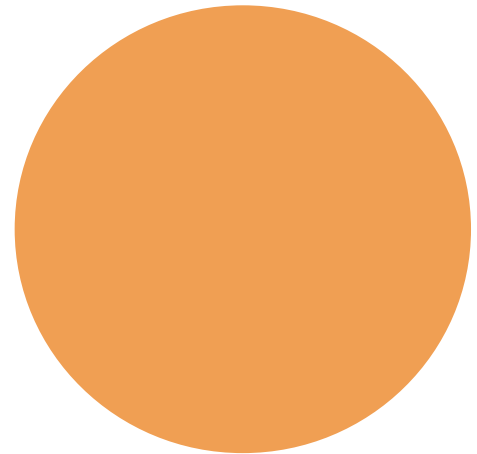
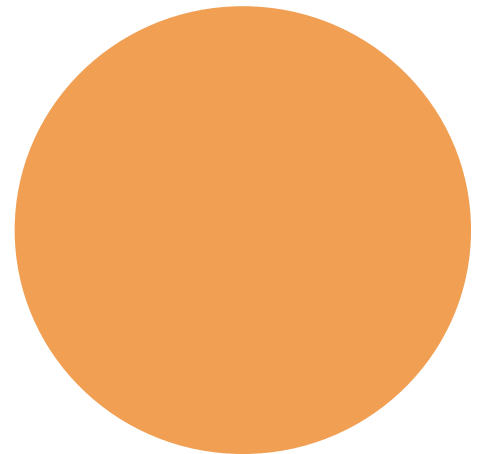
Rhythmic experiences promote feelings of belonging and continuity. These can be simple things like walking, laughing or clapping together. Playing ball games can also create these rhythms. Rituals are the social counterpart to psychological rhythmicity. Formal rituals might be the kind of things that happen on birthdays.

The Element of Predictability

To know what is likely to happen in the future lends a sense of order and power to people's lives. Predictability can be encouraged by engaging with young people in activities. The young person accomplishing a new task requires recognition for their mastery of this rather than an evaluation in terms of good and bad. Maier (1979) however cautions that a healthy sense of order does not come from a book of house rules but needs to grow out of the lived experience of those who live and work in a centre.

Dependability

When repetition, rhythmicity and predictability are combined, the child will feel good and cared for because these experiences establish a sense of certainty. The feeling of dependence creates attachments and intimacy which are pleasurable and safe.



Personalised Behavioural Training

It is only when a trusting relationship has been established with caregivers that effective behaviour training starts. This is because behaviour is moulded largely by the caring person who the young person perceives as being on his or her side.

Care for the Caregivers

It is essential that the caregivers are nurtured and given caring support to enable them to transmit this quality of care to others. Caregivers are enriched or limited as agents of care according to the care they receive.

Traumatised children have a limited capacity to manage change and new experiences in a constructive way, often triggering hyper-arousal responses that challenge the care and other environments. As such, therapeutic residential care must introduce structures and routines that seek to promote safety and predictability for children. Changes, where possible, should be carefully planned for and implemented, taking into account the needs and abilities of individual children to tolerate such change. Where change is unplanned or unexpected, the responses of staff must be sensitive to the impact of such change on the child/people involved. As we examine the key features of Therapeutic Care, below we can see that Henry Maier's work remains relevant to a contemporary understanding of this important work.

● What are the Key Features ● of Therapeutic Care?

According to the contemporary research, 'Therapeutic Care' is not a single approach. There is now a multiplicity of documented approaches across the world that each identify as both trauma informed and therapeutic. In Australia, Howard Bath proposed 'The Three Pillars' as an orientation to healing from complex trauma (Bath, 2015). Challenging traditional mental health treatment paradigms, Bath suggests that 'Healing starts with creating an atmosphere of safety: formal therapy is unlikely to be successful unless this critical element is in place' (Bath, 2015, p.6).



THE 'THREE PILLARS' FOR DEVELOPING AND MAINTAINING AN ENVIRONMENT THAT FACILITATES HEALING ARE:

1. **Safety** entails an environment where one can feel secure, calm and attend to normal developmental tasks
2. **Connections** involve trusting relationships with caring adults as well as normative community support such as sports teams, youth groups and recreational programs. Building connections fosters resilience by meeting growth needs for belonging and generosity.
3. **Coping** enables the individual to meet life challenges as well as to manage emotions and impulses underlying traumatic stress. In resilience terms, successful coping strengthens growth needs for mastery and independence (Bath, 2015, p.6).

The Centrality of Relationship



The general premise underpinning the therapeutic dimension of residential child care is that all interactions in the environment have the potential to be a corrective emotional experience for children with insecure attachments. Such supportive relationships create a milieu where young people feel safe, secure and have the potential to grow (Moses, 2006).

Children and young people suffering from complex trauma often have difficulties related to attachment, regulation, physiology, dissociation, behavioural control, cognition, and self-concept (Cook, Blaustein, Spinazolla, & van der Kolk, 2003). The significance of meaningful relationships for children and young people in residential care has been widely acknowledged (Harder, Soenen, D'Oosterlinck, & Broekaert, 2013) in terms of: promoting resilience, supporting the young person with challenging behaviour ensuring active participation in decisions affecting young people (Cahill et al., 2016); and as pre conditions for effective interventions (Berridge et al., 2011). **The traumas that were experienced in relationship, can be treated in and through the use of a trusting, reparative relationship** (Spinazolla, et al 2018). Therapeutic presence is not simply a question of engagement of the young person. It is premised on a deep understanding of complex trauma and an awareness of the implications for this particular child. Carers and practitioners can then respond in a way that will promote recovery. Thus a focus of the establishment of therapeutic care programs is the centrality of relationships as a vehicle for healing.

Organisational Culture and Commitment

Put simply, this is about managers and leaders 'walking the talk' of a trauma informed, therapeutic approach. Some suggest that a 'whole of organisation approach' to the provision of therapeutic care is required, in order to ensure that staff at all levels of the agency experience support and safety in their practice (Bloom & Farragher, 2017). A central concept for the organization of therapeutic residential care has been trauma informed and trauma sensitive care. Bloom's (2005) and Anglin's (2002) work in describing the importance of having an organizational culture that is trauma-informed and that provides both safety and an environment in which trauma can be explicitly acknowledged (Rivard, Bloom, McCorkle, & Abramowitz, 2005). Perry (2006) and Van der Kolk's (2014) work in the neurobiology of childhood trauma and abuse and how trauma has a different impact at different stages of development, and that disruptions in care-giving systems have additional deleterious effects that need to be addressed for effective intervention.

The Therapeutic Environment

The therapeutic environment or milieu, created in the context of trusting relationships, is seen as the primary source of healing for young people in care. The environment experienced by children and young people is one which creates and maintains a climate of non-violence and emotional safety, focusing on stability, predictability and opportunities for learning rather than compliance and control.



THERAPEUTIC CARE ENVIRONMENTS ARE DESCRIBED AS 'HOLDING ENVIRONMENTS' CONSISTING OF A NUMBER OF KEY ELEMENTS:

- 1. providing suitable boundaries for behaviour and the expression of emotion so that strong feelings can be expressed but do not get 'out of hand';**
- 2. providing an element of 'giving' and tolerance in relationships, so that people felt genuinely cared for and looked after;**
- 3. the appropriate containment of anxiety; and,**
- 4. Working towards clarity in communication, thus avoiding or dealing promptly with misunderstandings or confusion (Ward, 2003 cited in Mitchell 2015).**

● Summary Messages from Research: ● Therapeutic Care Principles

The 'NSW Core Therapeutic Care Principles' are documented elsewhere (Verso, 2016). They support the 'ten essential elements' and outline principles in relation to young people, the care environment, organisations and the wider system. These principles are congruent with the key messages from international and national research.

Drawing from the research, we propose the following **seven universal principles** as those that have implications for individual carer/young person relational practice, intra and interagency communication and organizational culture and climate:



- 1. Attachment:** a culture of belonging
- 2. Containment:** a culture of safety
- 3. Communication:** a culture of openness and transparency
- 4. Connectedness:** belonging to one's community and an identity grounded in cultural knowledge and connection
- 5. Involvement:** a culture of participation and citizenship which listens to and hears from young people
- 6. Continuous learning:** founded on a belief in personal and professional growth and development
- 7. Agency:** a culture of empowerment (Bambllett, 2014; Hewitt, 2007 cited in Mitchell 2015)

The briefing provides a summary overview of the research in what is a highly complex area of practice. The development of therapeutic approaches to care has sought to better meet the needs of the group of children and young people who have been impacted by the experiences of complex trauma. Thirteen 'promising approaches' to therapeutic care are reported on, the majority using trauma theory as the basis of their approach. Further research is required in order to learn more about 'what works' in this important and complex area of practice.



References

Ainsworth, F., & Hansen, P. (2008). Programs for high needs children and young people: group homes are not enough. *Children Australia*, 33(2), 41-47.

Anglin, J. P. (2002). *Pain, Normality, and the Struggle for Congruence: Reinterpreting Residential Care for Children and Youth*. Binghamton, NY: Haworth Press.

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H, Evans, M., Andres, B., Cohen, C., & Blaustein M.E. (2011). Treatment of Complex Trauma in Young Children; Developmental and Cultural Considerations in Application of the ARC Intervention Model. *Journal of Child and Adolescent Trauma*, 4(1), 34–5.

Bamblett, M., & Lewis, P. (2007). Detoxifying the child and family welfare system for Australian Indigenous Peoples: Self-determination, rights and culture as the critical tools. *First Peoples Child & Family Review*, 3, 3, 43–56.

Bamblett, M., Long, M., Frederico, M., & Salamone, C., (2014). Building an Aboriginal Cultural Model of Therapeutic Residential Care: The Experience of the Victorian Aboriginal Child Care Agency. *Children Australia*, vol 39, no.4, pp 206–210 doi: 10.1017/cha.2014.28

Bath, H. (2015). The Three Pillars of TraumaWise Care: Healing in the Other 23 Hours. *Reclaiming Children and Youth*, 23, 4, 5.

Becker-Weidman, A. (2006) Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy. *Child and Adolescent Social Work Journal*, 23(2). DOI: 10.1007/s10560-005-0039-

Berridge, D., Biehal, N., Lutman, E., Henry, L., & Palomares, M. (2011). *Raising the Bar? Evaluation of the Social Pedagogy Pilot Programme in Residential Children's Homes*. Department for Education Research Report (Vol. DFE-RR148). London: Department for Education.

Blackwell, S. & McGill, J., (2008). *Dyadic Developmental psychotherapy in residential treatment*. In A. Becker-Weidman & D. Shell (Eds) *Creating capacity for attachment: Dyadic Developmental psychotherapy in the treatment of traumaattachment disorders* (pp143–163) New York: Wood 'N' Barnes.

Bloom, L. (2005), The Sanctuary Model of Organisational Change for Children's Residential Treatment, Therapeutic Community. *The International Journal for Therapeutic and Supportive Organisations* 26(1): 65–81.

Bloom, S. & Farragher, B. (2011). *Destroying Sanctuary: The Crisis in Human Service Delivery System*, New York: Oxford University Press.

Cook, A., Spinazzola, J., Ford, J. D., Lanktree, C., Blaustein, M., & Cloitre, M. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390- 398.

Cahill, O., Holt, S., & Kirwan, G. (2016). Keyworking in residential child care: Lessons from research. *Children and Youth Services Review*, 65, 216–223.

Chapman, M. V., Wall, A., Barth, R. P., Biemer, P., Runyan, D., Webb, M., ... Wallace, I. (2004). Children's voices: The perceptions of children in foster care. *American Journal of Orthopsychiatry*, 74(3), 293-304.
<https://doi.org/10.1037/0002-9432.74.3.293>

Clarke, A. (2011). Three therapeutic residential care models, the Sanctuary Model, Positive Peer Culture and Dyadic Developmental Psychotherapy and their application to the theory of congruence. *Children Australia*, 36(2), 81-87.

Cook A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). *Complex trauma in children and adolescents: White paper*. Allston, MA: National Child Traumatic Stress Network, Complex Trauma (NCTSN) Task force.

Downey, L., Jago J. & Poppi, S. (2015). The Spiral to Recovery: An Australian Model for Therapeutic Residential Care. *Children Australia*, 40(4), 351-360 doi:10.1017/cha.2015.31

Family and Community Services: FACS (2018) The Intensive Therapeutic Care System in New South Wales. Retrieved from <https://www.facs.nsw.gov.au/families/permanency-support-program/intensivetherapeutic-care-system>

Frederico, M., Long, M., McPherson, L., McNamara, P., & Rose, R. (2016) Improving Outcomes for children in out of home care: the role of therapeutic foster care. *Child and Family Social Work*, doi: 10.1111/cfs.12326

Gharabaghi K. & Groskleg, G. (2010). A Social Pedagogy Approach to Residential Care: Balancing Education and Placement in the Development of an Innovative Child Welfare Residential Program in Ontario, Canada. *Child Welfare*, 89(2).

Hambrick, E., Brawner, T., Perry, B., Wang, E., Griffin, G., DeMarco, T., Capparelli, C., Grove, T., Maikoetter, M., O'Malley, D., Paxton, D., Freedle, L., Friedman, J., Mackenzie, J., Perry, K., Cudney, P., Hartman, J., Kuh, E., Morris, J., Polales, C. & Strother, M. (2018). Restraint and Critical Incident Reduction Following Introduction of the Neurosequential Model of Therapeutics (NMT). *Residential Treatment for Children & Youth*, 35(1), 2-23.

Harder, A.T., Knorth, E.J., & Kalverboer, M.E. (2013). A secure base? The adolescent-staff relationship in secure residential youth care. *Child & Family Social Work*, 18(3), 305-317.

Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J. C., & Kuhn, F. (2010). Children and Residential Experiences: A Comprehensive Strategy for Implementing a Research-Informed Program Model for Residential Care. *Child Welfare*, 89(2), 131-149.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings. *The Open Health Services and Policy Journal*, 2, 131-151.

Hunt, S., Moretti, M., Booth, C. & Reyda, N. (2018). Creating evidence-based change through trauma-informed lens: Translating principles into practice. *International Journal of Child, Youth and Family Studies*, 9, 1, 54-68 DOI: <http://dx.doi.org/10.18357/ijcyfs91201818119>

Hurley, K. D., Lambert, M. C., Gross, T. J., Thompson, R. W., & Z., E. M. (2017). The Role of Therapeutic Alliance and Fidelity in Predicting Youth Outcomes During Therapeutic Residential Care. *Journal of Emotional and Behavioral Disorders*, 25(1), 37–45.

<https://doi.org/10.1177/1063426616686756>

James, S. (2011) What Works in Group Care – A Structured Review of Treatment Models For Group Homes and Residential Care. *Children and Youth Services Review*, 33(2), 308-321.

Lawson, D.M., & Quinn, J. (2013) Complex Trauma in Children and Adolescents. Evidence Based Practice in Clinical Settings. *Journal of Clinical Psychology*, 69(5) 497.

Lee B., & Perales, K. (2007) Circle of Courage: Reaching Youth in Residential Care. *Residential Treatment for Children and Youth*, 22(4), 1-14 doi: 10.1300/JOO7v22n04 01.

Maier, H.W. (1979). The Core of Care: Essential Ingredients for the Development of Children at Home and Away from Home. *Child Youth Care Forum*. 8, 161 <https://doi.org/10.1007/BF01554603>

McCredie, M. N., Quinn C.A. & Covington, M (2017) Dialectical Behaviour Therapy on Adolescent Residential Treatment: Outcomes and Effectiveness. *Residential Treatment for Children and Youth*, 34(2), 84-106, doi:10.1080/0886571X.2016.1271291

McCurdy, B.L & McIntyre, E.K, (2004). And what about the residential.....? Reconceptualising residential treatment as a stop gap service for youth with emotional and behavioural disorders. *Behavioural Interventions*, 19, 137-158.

Mitchell, G. (2013). Children with Disabilities using Child and Family Welfare Services, Melbourne, OzChild. Retrieved from https://www.ozchild.org.au/wpcontent/uploads/2015/03/OzChild_DisabilityResearchReport_2014.pdf

Mitchell, J., Tucci, J. and Tronick, E. (2019). *The Handbook of Therapeutic Care for Children – Evidence Informed Approaches to Working with Traumatised Children and Adolescents in Foster, Kinship and Adoptive Care*. Jessica Kingsley, London.

Mohr, W.K., Martin, A., Olson, J.N., Pimariaga A.J., & Branca, N. (2009). Beyond point and level systems: Moving toward child-centred programming. *American Journal of Orthopsychiatry*, 79(1), 8-18.

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

National Therapeutic Residential Care Alliance. (2016). *Therapeutic residential care: Australian consensus definition and agenda*. Presentation at EUSARF Conference, Oviedo, Spain.

Perry, B.D., (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical Application of the Neuro-sequential Model of Therapeutics. *Journal of Loss and Trauma*, 14(4), 240-255.

Rivard, J.C., Bloom, S.L., McCorkle, D. Abramovitz, R. (2005) Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. Therapeutic Community. *The International Journal for Therapeutic and Supportive Organizations* 26(1): 83-96.

Rivard, J.C., McCorkle, D., Duncan, M., Pasquale, L., Bloom, S., & Abramovitz, R. (2004). Implementing a trauma recovery framework for youths in residential treatment. *Child and Adolescent Social Work Journal*, 21(5), 529-550.

Robertson, C., Laing, K., Butler, M., & Soliman, R. (2017). *The views of NSW children and young people in out-of-home care: NSW results from the National Out-of-Home Care and NSW Residential Care surveys*. NSW Dept. of Family and Community Services, FACS Analysis and Research, Ashfield, NSW.

Ryan, J.P. (2006). Dependent youth in juvenile justice: Do Positive Peer Culture programs work for victims of child maltreatment? *Research on Social Work Practice*, 16(5), 511–519.

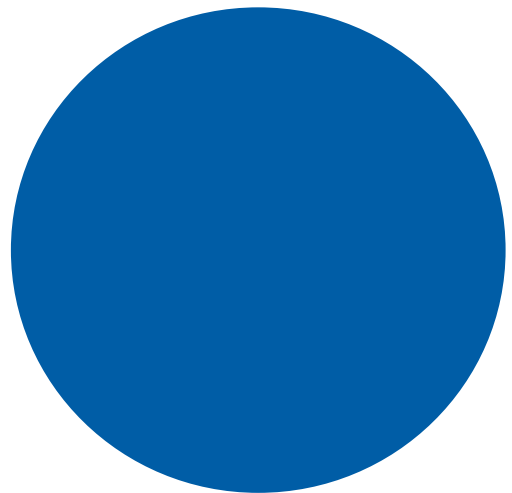
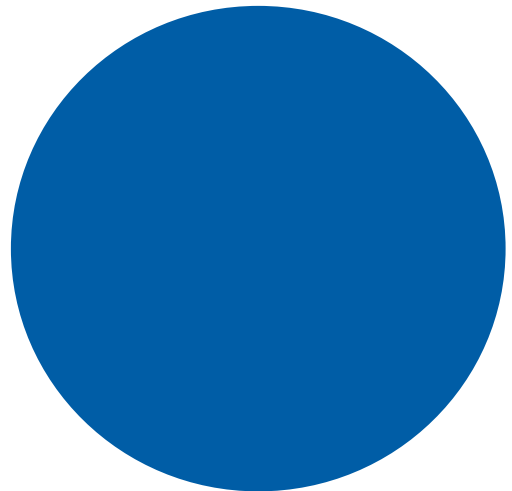
Sinclair, I. (2005). *Fostering Now: Messages from Research*, Jessica Kingsley, London.

Spinazzola, J., van der Kolk & Ford, J.D. (2018). When Nowhere Is Safe: Interpersonal Trauma and Attachment Adversity as Antecedents of Posttraumatic Stress Disorder and Developmental Trauma Disorder. *Journal of Trauma and Stress*, 31(5), 631-642.

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY, US: Viking.

Verso Consulting (2011). *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*. Clifton Hill, Victoria, Australia.

Verso Consulting (2016). *Therapeutic Residential Care System Development: Evidence Guide*. Clifton Hill, Victoria, Australia. Verso 1



cetc ● centre for
● excellence in
therapeutic care

cetc@childhood.org.au
www.cetc.org.au



**Australian
Childhood
Foundation**

The Centre for Excellence in Therapeutic Care
is a division of the Australian Childhood Foundation.