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The Essential Elements of Therapeutic Foster Care

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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.

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Introduction

As far back as 2002 in the creation of the Catalyst Program, Mitchell developed what was Australia's first therapeutic foster care program and one of a handful of pioneering programs internationally (Mitchell, 2009; Mitchell, McPherson and Gatwiri, 2020; Porges, 2020; McPherson, Gatwiri, Tucci, Mitchell and Macnamara, 2018). Translating the emerging knowledge base about the neuroscience of trauma and attachment, Catalyst and its later incarnation - Treatment and Care for Kids Program (TRACK) - introduced a comprehensive framework for understanding and responding to the needs of children placed in foster care as a result of experiences of abuse and adversity. It also invested significant effort into collective forms of decision-making that placed children, young people and their carers as experts and central participants to practice with the network of professional who are so important to the protection and well-being of children in out of home care. It was a clear early model of the Care Team function that has become widely used in modern child protection and care approaches in Australia.

Continuing this evolutionary commitment, Mitchell and her colleagues (Mitchell, Tucci and Macnamara, 2020; Tucci, Mitchell and Tronick, 2020) have recently mapped the paradigm shift that is validating the definitional significance of Therapeutic Care as an evidence informed approach to *trauma responsive in situ intervention* for children and young people living in foster, kinship and adoptive care. This analysis provides the backdrop for the current initiative that aims to integrate theoretical insights about Therapeutic Care with a scoping study describing the programs that are operating in Australia and overseas. The outcome of this project, as described in this document, is a working set of essential elements that underpin what is considered effective Therapeutic Foster Care.

Recognising the lineage of Therapeutic Foster Care in Australia

As Mitchell (2009) noted in her research at the time, Therapeutic Foster Care evolved in recognition that foster care itself needed to. For example, Mitchell cited Carter's (2002) major review of the foster care system in Victoria who concluded that

> ***…the general competency of the foster care service needs to move beyond its 150 year remit of viewing care as 'boarding out'. What the service is now required to do in addition to providing decent accommodation and family life is to reduce the risks in the life of any one child; and to build the coping and protective factors for any one child. This is why expert child development and family assessment before entering care is essential, to provide a plan to progress these two aims and to offer a logic for seeking out a carer who can meet these aims…*** (p.37).

Similar to Maluccio and Ainsworth (2006), Mitchell herself also argued that in order to address the risk of foster care becoming 'moribund and unviable', there had to be further development of theories and practice models that were sourced in acknowledging and building the capability and expertise of the foster family and the quality and effectiveness of the surrounding support system (Mitchell, 2008).

Drawing on the available literature at the time and her own experience, Mitchell (2008) began to identify the critical elements that were integrated into what was being recognised as Therapeutic Foster Care. These were:

- Therapeutic Foster Care promotes placement stability as the central focus of concern in enhancing outcomes for children in care.
- Therapeutic Foster Care recognises that children in care require a parenting approach that uses trauma and attachment frameworks.
- Therapeutic Foster Care understands that comprehensive assessment of children's past and current needs are the basis for effective matching of children to out of home care families which in turn is critical to placement success.
- Therapeutic Foster Care implements the meaningful participation of children in assessment, planning and decision-making processes.
- Therapeutic Foster Care respects carers for their role in shaping the day to day experiences of children in their care and as such are critical to the outcomes of any program.
- Therapeutic Foster Care provides carers and others in the child's network with up-to-date, evidence-based training about trauma and attachment and support to translate new knowledge into practice.
- Therapeutic Foster Care works the best when it integrates collective forms of decision making into its practices of planning to meet the ongoing needs of children in care.
- Therapeutic Foster Care recognises the involvement of birth families and kinship families in its scope of services.
- Therapeutic Foster Care involves access to specialist therapeutic support for children, carers, birth and extended family and the systems of professionals.

The success of the TRACK program (Succesworks, 2005) was instrumental in the Victorian Government implementation of an Australian first strategic reform agenda that sought to strengthen the out of home care system as more therapeutic in nature. It adopted therapeutic foster care as a cornerstone of its out of home care reform agenda with the announcement, in 2005, of $16 million in new funding for its development and implementation over the following five years. The introduction of the initiative, since named the Circle Program (Department of Human Services, 2007b), commenced in late 2006 with the funding of four pilot programs across rural Victoria and metropolitan Melbourne. This was later expanded to nine.

As articulated in the Circle Program guidelines (Department of Human Services, 2007b), one of its major aims was

> ***…in the medium to long term, to build a system of home based care in Victoria where all children receive the therapeutic response they require when they require it – which is upon entry to care in most instances - not a system where only those whose behaviours are so extreme, and who have suffered additional harm due to placement disruption or other adverse consequences of being in care, become eligible for a therapeutic response. In short, we seek to develop a therapeutic system not just a therapeutic model…***(p.6).

The Circle Program was evaluated in 2012 and found to lead to significant positive outcomes for children and carers (Frederico, et al, 2012; Frederico et al, 2014) as noted in its conclusion:

> ***…The findings of this evaluation confirm that there are positive outcomes for children and young people referred to The Circle Program. A key message from the evaluation is that The Circle Program works for children and young people. The concept of the care team surrounding the child and young person is working well. These positive outcomes are related to the overall therapeutic approach facilitated by the training of carers as well as professional staff to ensure knowledge of the theoretical basis for care of these children and young people. In addition, the role of the therapeutic specialist includes providing a therapeutic care plan and supporting the therapeutic care team and carer….***(p.13, Frederico, et al, 2012).

Similarly, the Track Program has continued to run for almost twenty years. An evaluation completed in 2018 (McPherson, Gatwiri and Cameron, 2018) concluded that

> ***There is compelling evidence to suggest that TrACK is a program worth investing in. The findings of this evaluation demonstrate that TrACK produces tangible and lasting results for children. Children who had experienced many placements and years of threat and deprivation before they entered TrACK were almost always able to achieve stability as a result of TrACK. Clearly, TrACK can prevent young people from entering residential care, or as an alternative pathway supporting young people to leave residential care, and to be looked after in family-based care. The program showed key positive outcomes in the following areas: placement stability, educational stability, emotional regulation and recovery, and caregiver relationship stability…*** (p. 3-4).

Many other Australian jurisdictions have only now begun to introduce more clearly defined Therapeutic Foster Care Programs, including the implementation of a number of pilots of Treatment Foster Care Oregon in Victoria, NSW and Queensland through OzChild and other welfare agencies. However, only limited data is currently available as to their effectiveness and longer term outcomes. The reality is that, other than the initial moves by Victoria to strengthen the foster care system as previously outlined, there has been limited reform to the way that foster care programs are delivered in Australia. This is despite the ongoing articulated need for governments to address the problems in out of home care systems including

- the demand to meet the increasingly complex needs of children and young people in care;
- the ongoing difficulties in achieving and maintaining placement stability for children and young people;
- the continuing reduction in the number of foster carers available and willing to look after children; and,
- the poor educational, cultural and developmental outcomes for children and young people arising rom their experience of being in care (Turney and Wildeman, 2017).

Whilst a number of factors have affected the extent to which therapeutic foster care has been embraced in Australia, one possible reason is a lack of understanding about what therapeutic foster is, how it works and most critically, how best to define elements which are core to the way in which it is designed and implemented. The following review and analysis provides the basis for answering these questions.

Scoping Study

The research question identified for this literature review was: What is known about approaches to therapeutic foster care, including approaches known as wrap around, treatment or enhanced foster care? For the purpose of this study, “approaches” are defined as synonymous with interventions, programs, models or frameworks informing the model of foster care.

Scoping Review Framework

This literature review was guided by a scoping framework to explore the extent of existing approaches that were documented publicly. The scope spanned international English-speaking jurisdictions over a fifteen-year period from 2005 to 2020. Publications were sourced based on their relevance the research question.

Search Strategy

The search strategy involved the identification of the research question, inclusion and exclusion criteria, data charting and collation and a descriptive presentation of results (Arksey and O’Malley, 2005). The strategy was to identify and to explain approaches rather than evaluate them.

The research team consulted the following eight recommended databases for inclusion in the search: InfoRMIT, Cinahl, Medline, ProQuest, PsycInfo, Scopus, expanded Academic complete and Academic Search Premier. A team of two researchers independently examined the abstracts and in a second round, the remaining manuscripts and reports utilizing the agreed upon inclusion/exclusion criteria. Researchers then met to discuss and reach agreement in relation to the analysis of approaches. Further details in relation to search terms, inclusion and exclusion criteria, the data extraction and analysis process are available from the Centre for Excellence in Therapeutic Care on request.

Findings

Eleven international and six Australian approaches met the inclusion criteria and are reported on here. Approaches varied in terms of the eligibility of children and young people for therapeutic foster care and the type of support that foster carers reported that they needed or were offered (Ottoman and McLean, 2014). Australian programs could also be distinguished on the basis of their philosophies and models of care, categories of professionals offering care and those in care support; their staffing arrangements and the contents of training provided to staff (McAloon, 2014). What follows is an overview approaches that are identified in the literature as enhanced, treatment or therapeutic foster care. Where evaluation outcomes are evident these are also reported.

International Therapeutic Care Approaches

‘Wrap Around’ Models of foster care

In the USA, ‘Wraparound’ is described as a team-based planning process intended to provide coordinated, holistic, family-driven care to meet the complex needs of youth who are involved with multiple systems (e.g. mental health, child welfare, juvenile justice, special education), at risk of placement in institutional settings, and/or experiencing serious emotional or behavioural difficulties (Walker, Bruns and Penn, 2008). Wraparound provides an “on the ground” mechanism for ensuring that system of care values will guide planning and produce individualized, family-driven and youth-guided support that is community based and culturally competent.

A major survey found that 91% of U.S. States have some type of wraparound initiative, with 62% implementing some type of state-wide initiative (Bruns et al, 2015). Over 100,000 youth nationally were estimated to be engaged in a well-defined wraparound process, which was, according to the developers, increasingly backed by outcomes research (Bruns et al, 2015).

In the United Kingdom, the Multi-disciplinary Intervention Service Torfaen (MIST), was established in 2004 by Action for Children in Torfaen (Wales) for young people aged 11-21 to implement the wrap around concept in Wales (Street, Hill and Welham, 2009). The program, like other therapeutic foster care programs, provides training and subsequent 24-hour support for carers and multidisciplinary support for young people placed in care. As well as supporting the main relationship between foster carer and young person, the program draws on therapies that are based in drama, music and art and provides ‘practical, befriending and learning support’ (Street et al, 2009 p. 13). The program is said to be underpinned by three theoretical orientations including humanistic psychology, child development theories and ecological theory. It is the ecological orientation that promotes the sense of a team around the child or young person, working systematically to support them.

Team Parenting Model

Core Assets in the United Kingdom have developed and implemented a model known as Team Parenting as a model of foster care. Whilst no scholarly articles identifying an evaluation of the model were identified, the model is the subject of a book (Caw and Sebba, 2014) which identifies the key elements of team parenting as;

- An integrated approach where there is an identified key worker for each child in care
- foster carers are seen as the primary agent of change
- a core goal is for the child to experience stability in their placement (Caw and Sebba, 2014).

Multi-professional working is seen as fundamental to improving outcomes for foster children. The authors suggest that Team Parenting is ‘an integrative approach to working with young people, aiming to engender collaborative and co-operative practice to ensure that their needs are met in a coherent and seamless manner’ (Caw and Sebba, 2014, p. 24). The book elaborates on the model with detailed case

studies demonstrating a range of therapeutic interventions involving children and carers. The Team Parenting model is informed by and draws upon a range of ideas, but predominately those associated with systemic theory, psychoanalytic ideas and attachment theory and some behavioural interventions. The model is presented as a holistic therapeutic approach, which takes account of the contexts for both foster child and carer.

The Secure Base Model

Therapeutic models of foster care are not homogenous, however a common theme is that they conceptualise the relationship between the carer and the child as being of central importance to the recovery and growth of the child. One such model is the Secure Base model. The model was developed in England in the early 2000s and has been adopted by agencies from Spain to the Ukraine and Iraq.

The model is based on attachment and resilience theories (Schofield, et al 2019) and relies on the creation of a sense of a child belonging to a family for its therapeutic effect. It stresses five dimensions of caregiving as important ingredients for secure attachment. They are: availability, which assists the child in developing trust; sensitivity, which pertains to helping a child or young person to manage their feelings; acceptance, a core criterion for helping a child build their self-esteem; co-operation, which allows the child to feel they are contributing, that they are efficacious, and family membership, which provides a child a sense of identity and stability. This model of therapeutic care was developed on the basis of theory and research and has been the subject of much evaluation and research studies (Schofield, et al 2019; Schofield and Beek, 2014).

The Triple A Model of Therapeutic Foster Care (Attachment, Arousal, and Accessibility)

This model was implemented in Ireland in 2015 although it was conceptualised and developed in Australia (Pearce, 2010; Pearce and Gibson, 2016). Central to the model is the development of a healthy, nurturing relationship between carer and child, who consciously uses relational techniques to help the child to recover from trauma. The aim of the model is to create a self-perpetuating therapeutic system for the child to experience. The model theorises that children in out of home care have experienced negative and disrupted attachments leading to an inability to form trusting relationships. The Triple A approach seeks to promote and support the development of positive attachment representations by enabling carer practices that manage the child's arousal and offers consistent, nurturing and containing care.

Preliminary findings following the initial implementation of the program were reported to be promising. Using a case study approach to reporting initial evaluation findings, reports by carers who had completed the AAA training course, indicated a reduction in attention seeking behaviours and an increase in independent play (Pearce and Gibson, 2016).

Parkes' Parenting Program

Parkes' Parenting Program based in the UK suggests that it is influenced by both learning and attachment theory. In this program, foster carers are 'encouraged to think about challenging behaviour as a result of patterns of learning and reinforcement' (Davies, Webber and Briskman 2015, p.6) Foster carers are encouraged to keep a diary detailing the behaviour and progression of the young person in their care whilst reflecting on 'how to describe the antecedents of this behaviour' (Davies, et al, p.6). The carer training appears to have a behavioural focus with an emphasis on managing behaviours and positive reinforcement. Carers are asked to think about young people's

behaviours as resulting from previous learning and unhelpful reinforcement, and to keep daily records of their child's behaviours. They are encouraged to apply practical skills such as positive praise and rewards for positive behaviours and to apply consequences for 'misbehaviour'. An evaluation of the foster carer training program indicated that on completion of the program, carer confidence in understanding their child's behaviour had enhanced and child behaviour problems had reduced (Davies, et al 2015). No evaluation of outcomes for children were identified.

Social Pedagogy: The Head, Hands Heart Model – United Kingdom

The Head, Heart and Hands model (Mc Dermid et al, 2016) was introduced as a therapeutic social pedagogy approach to foster care across seven demonstration sites across England and Scotland in 2010. The objectives of the approach were to:

- develop a professional, confident group of foster carers who demonstrate that by using a social pedagogic approach, they will develop the capacity to significantly improve the lives of the children in their care.
- develop social pedagogic characteristics in foster carers. Foster carers will have an integration of 'head, hands and heart' to develop strong relationships with the children they look after.

Early implementation results of the UK implementation were reported to be mixed. A small number of carers made changes to the way they cared for children and reported a big impact. Many carers reported that they were more reflective and thoughtful as a result of training and implementation. The findings suggest that systemic change is needed to support social pedagogic practice which recognises the central role played by foster carers (McDermid, et al, 2016).

Social Pedagogy in Continental Europe

One study looked at the experiences of foster carers in Sweden, France, Norway and Denmark (Petrie, 2007) exploring whether the understanding of social pedagogy in foster care in Europe might extend to the United Kingdom. Petrie identifies pedagogy as both a theoretical field and an area for social policy in continental Europe. The pedagogic approach is said to take a holistic view of the child as a person with mind, body, feelings, sociability and creativity. The approach proceeds on the basis of the relationship between the pedagogue and child. Pedagogic practice aims to support children's overall development, their 'education' in the broadest sense of that term. From a social pedagogic perspective, both personal and professional characteristics in foster carers are highly important for working with children. Critical reflection on personal capacities, motivations and abilities is included within pedagogic education, which is typically a three-year degree course. This research found that generally, foster carers were not qualified pedagogues in any of the four countries identified. That said, the principles of pedagogy were apparent in the foster care agency training and support systems. With the exception of Sweden, the training for carers was often delivered by people who identified themselves as qualified social pedagogues.
A number of research participants identified the strengths of this orientation, when applied to foster care, includes a valuing of the child's strengths, an orientation to action and a continuous focus on developing knowledge whilst actively engaging in relationship with the child or young person in care. Findings suggest, as identified in the earlier evaluation (McDermid, et al, 2016), that there would need to be significant cultural change across the UK in order for social pedagogy to be experienced as valuable in foster care (Petrie, 2007).

Treatment Foster Care

Whilst much of the documentation identified outlining program models is descriptive rather than reportioning evaluation outcomes, the research literature is dominated by one model of treatment foster care; Treatment Foster Care, Oregon (TFCO). TFCO is a foster care family based model that seeks to provide young people with a tailored program developed to help them to make positive life changes. TFCO was originally designed to help young people who has particularly challenging behaviours and were at risk of being placed in a secure setting. The TFCO model has been extensively researched and evaluated, often by the authors of the program (Chamberlain 1990; Chamberlain et al, 2007; Chamberlain and Mihalic 1998; Chamberlain and Reid, 1998). In one review however, involving independent researchers, a meta- analysis of five studies examining TFCO was undertaken to assess the impact of Treatment Foster Care on a range of outcomes for young people (MacDonald and Turner, 2007). These authors identified five studies that met their inclusion criteria (MacDonald and Turner, 2007), all conducted in the USA. Findings from this review suggest that TFCO care may be an appropriate intervention to help place these more difficult to place young people in family settings. Some decreases were reported in antisocial behaviours, absconding and involvement in crime. The authors of this review issue a cautionary note in respect of the findings, noting that program developers were members of the research teams conducting the outcomes studies and suggesting that future studies might be more able to be generalised if they involved independent research teams, were conducted in different locations, with different groups of young people, of different ages and more diverse ethnicity (MacDonald and Turner, 2007).

A very recent, independent systematic review of TFCO outcomes research (Astrom, et al 2020) was also identified. It found that there was a moderate level of certainty that TFCO reduces future criminality according to police or self-report, compared to when adolescents are placed in group care. Of interest, it also found that there was low certainty of evidence that TFCO enhances young people's mental health and decreases delinquent peer associations and drug use in the longer term. The evidence was considered to be of very low certainty for alcohol use and sexually risky behaviour (Astrom, et al 2020). The findings of this recent review by Alstrom and colleagues may indicate that whilst behavioural change may be evident when the young person is in placement in the TFCO program, that these changes may not be sustained.

The Early Intervention Foster Care Program

The Early Intervention Foster Care Program (EIFC) targets the spectrum of challenges that preschool-aged foster children face via a team approach delivered in home and community settings (Fisher, Burraston and Pears 2005). Both EIFC and TFCO were developed in Oregon, USA and delivered through a team approach in which foster parents receive extensive training and ongoing support from program staff, children engage in individual therapy, and birth parents receive parent training. Both EIFC and TFCO interventions emphasize the following;

- encouragement for prosocial behaviour;
- consistent limit setting to respond to difficult behaviour
- close supervision of the child.

The EIFC intervention also follows a developmental framework in which the challenges of younger foster children are viewed from the perspective of delayed maturation, rather than as strictly behavioural and emotional problems. The intervention aims to create enhanced conditions to facilitate developmental progress. These conditions include a responsive, consistent caregiver, a daily routine which is predictable, with preparation for transitions between activities.

One study reports on permanent placement outcomes from the EIFC randomized clinical trial (Fisher, Burraston and Pears 2005). Children in EIFC had significantly fewer failed permanent placements than children in the regular foster care comparison condition. The child's abuse history did not predict permanent placement outcomes. These results are said to provide the foundation of an evidence base for the EIFC program as an intervention to improve permanent placement outcomes for preschool-aged foster children (Fisher, Burraston and Pears 2005).

Trauma systems therapy foster care

Trauma-systems Therapy-Foster Care (TST-FC) is said to be a system wide model of trauma-informed care focused on meeting the emotional needs of children in foster care who have experienced traumatic events (Bartlett and Rushovich, 2018). One study evaluated the implementation of TSTFC in two state child welfare agencies in the USA, that included training for staff (n = 123) and resource parents (n = 111TST-FC was associated with significant increases in trauma-informed parenting and tolerance of children's challenging behaviour by resource parents, as well as more trauma-informed policies and practices in the child welfare agencies. Training participants reported that TST-FC provided useful tools and a common language about trauma that enhanced their capacity to collaborate with one another and manage children's difficult behaviour. An exploratory study of resource home retention and children's placement stability revealed fewer foster home closures and placement disruptions when resource parents were trained in TST-FC compared to homes not trained in the model. The results of this study suggest that TST-FC is a said to be a promising model for increasing the capacity of child welfare agencies to provide trauma-informed care to children and families in the foster care system (Bartlett and Rushovich, 2018).

The Mockingbird Program

This model is reported to have originally been developed by the Mockingbird Society in the USA in 2004 and is now implemented in the United Kingdom and Australia. The extent to which this model is a therapeutic program is unclear. What is of interest is that the model centres on a group of foster families with one family acting as a 'Hub' home offering 'planned and emergency short breaks, advice, training and support for six to ten satellite households….." (Mockingbird Program 2020, p.1). The program was piloted in the UK in 2015 and by 2020 there were a reported 13 services as Mocking Bird partners implementing the program. Interim evaluation findings are promising in terms of enhanced placement stability as a result of fewer placement breakdowns (Mockingbird 2020).

Australian models

Whilst each state and territory may well be implementing models of therapeutic foster care in some form, research and evaluation publications in respect of these approaches are few. What follows are Australian foster care initiatives that were identified as a result of available documentation.

Team Parenting Model

Key Assets, as the Australian division of the UK based Core Assets have implemented the 'team parenting' model of foster care as a 12-month intensive model of home-based therapeutic care in Australia. This intensive model is based on the design outlined above (Team Parenting Core Assets) with detail elaborated on by Caw and Sebba (2014). Central to this model is the concept of a specialist team surrounding the child and carers to ensure that therapeutic and/or educational interventions support the developing young person in home-based care. Key Assets offer this model of care to young people who are transitioning out of a residential Care setting and are preparing for a permanent and stable arrangement, either via reunification, longer term foster care or independent living.

THE PROGRAM IS OFFERED AS A FOUR PHASED APPROACH WHICH INCLUDES:

1. **Matching and planning**
2. **Settlement**
3. **Stabilisation**
4. **Maintenance**

Whilst evaluation outcomes were not identified, the key Assets website suggests that an anticipated outcome of the maintenance phase (26 weeks) is for young people to be 'emotionally and mentally healthy, feel confident and have social skills, possess coping skills and ability to manage adversity and display positive and appropriate behaviour' (Key Assets 2020).

Treatment and Care for Kids (TrACK).

The Australian Treatment and Care for Kids (TrACK) program is an intensive therapeutic foster care program for traumatised children and young people who present with complex needs and challenging behaviours. Delivered in a partnership by two charitable organisations, the program sought to provide an alternative for children and young people living in residential care who were otherwise considered too 'difficult' or 'challenging' to be successfully accommodated in foster care. Elements of the program include: a focus on the caregiver–child relationship as the primary site of therapeutic intervention, supported by educative and support professionals known as therapeutic specialists and foster care workers. In turn they are surrounded by a multidisciplinary Care Team supporting the carer–child dyad a trauma-informed system with a focus on creating nurturing and healing relationships, for traumatised children and young people.

Core elements of the program model include (and are not limited to):

- Services and systems existing to meet young people's needs
- A trauma informed system focusing on creating nurturing and healing relationships for traumatised children and young people
- The primary task of carers is to create physical and emotional safety for children (stability and security) and then to help them to reduce anxiety through co-regulation
- Support and training for carers are provided on a frequent basis to ensure that they are able to maintain their capacity to be reflective about children rather than reactive to their behaviour
- A Care Team of skilled trained and supported foster care staff and therapeutic specialists support the placement
- Regular access to specialised consultation and training
- Improved access to required therapeutic/mental health/educational supports (Australian Childhood Foundation 2017).

In summary, the TrACK program seeks to create and maintain a trauma-informed system with a focus on creating nurturing and healing relationships for traumatised children and young people. The foundation of the TrACK program is relationships. In a recent evaluation investigating service user outcomes, findings suggest that TrACK is achieving relational connection and placement stability for most of the young people. (McPherson et al, 2018).

Special Youth Carer Program (SYC)

The focus of the Special Youth Carer Program is to enable young people to experience stability in their placement, whilst reportedly incorporating other core features of specialised foster care programs including 'specially trained and recruited carers, higher than standard carer remuneration, intensive placement support and wraparound services' (Gilbertson et al, 2005, p.76). Developed and implemented in South Australia, and based primarily upon the Treatment Foster Care (TFC) model (Gilbertson et al, 2005), SYC is said to incorporate an additional defining feature: in the event of a placement breakdown, it is the carer and not the young person who leaves the home. The program itself appears to combine the concepts from Lead Tenant models where young people have a degree of independence with treatment foster care (Gilbertson et al, 2005). Defining features of the SYC include;

- there is never more than one adolescent and one carer per home;
- the home is owned by the Agency rather than the carer;
- where the carer and young person relationships break down and cannot be reconciled, the carer will be replaced
- the program is not time-limited; -
- the young person may have the option of remaining in the home when they turn 18 years and assuming legal responsibility for the tenancy.

By offering the young person security of tenure, this model overcomes a flaw in specialist programs which, until now, have offered time limited placements and have thus perpetuated one of the main problems they seek to reduce or eliminate—that is, instability. Initial findings of an early evaluation were reported to be promising, however more recent publications evaluating the program were not identified. Positive behavioural change was reported for most young people in the initial evaluation and there were some noteworthy improvements in placement stability (Gilbertson, Richardson and Barber, 2005).

Mockingbird Family

This model has recently been implemented in Australia under licence by Life Without Barriers as partners. The model is described as being like "extended family and the Hub Home is like a grandparent's house that is familiar and comfortable. Each child in the Constellation is welcomed by the Hub Home Provider for sleep overs and social events…" (Mockingbird Family 2020. p.1). There were no evaluation reports identified for the program in Australia, however initial findings in the UK (see above) indicated greater placement stability.

Professional and Individualised Care (PIC)

The PIC model of care is an individualised model where one child or young person only is placed in a family with a therapeutic foster carer. The focus is on the development of a secure relationship with a 'professional therapeutic carer' and that the relationship will enable the young person to overcome the adverse impact of complex trauma. Limited information about the program as it is implemented in NSW was identified, however an overview of the relational nature of the program is available online (PIC, 2020).

The Circle Program

The Circle Program, introduced in Victoria in 2009 and based on the key elements of the Treatment and Care for Kids (TrACK) Therapeutic Foster Care Program described above, aimed to ensure that 'all children receive the therapeutic response they require when they require it…' (Department of Human Services, 2009, p. 6). The conceptual framework was informed by trauma-informed principles and resilience theory. The care environment is defined as 'relationships, home, family, school and networks created by the primary carer; and engagement of the child and the family of origin where possible to promote family reunification, or long term stable care for the child' (Department of Human Services, 2009, p. 7).

The care team members include: the foster care worker, the therapeutic specialist, the child protection practitioner, foster carer and the birth family. Additional roles are added as needed to match each child's requirements. The core elements of the program include:

- Training in trauma and attachment.
- Assessment of the child and an intervention plan led and coordinated by a therapeutic specialist.
- Individually tailored Care Teams designed to meet the specific needs of every child and young person entering The Circle Program.
- As far as possible the family of origin were to be involved in the assessment process

An evaluation of the Circle program found that children placed with the program were significantly less likely to experience an unplanned exit compared to those who were in a comparative general foster care program. They were also more likely to reunify with their families or enter kinship care. (Frederico et al 2014).

Professional Foster Care

> ***…Professional foster care refers to a model of home-based foster care whereby carers are employed in a professional capacity to care for children and young people with complex needs, who are unable to be placed in more traditional, less intensive forms of Out-of-Home Care. Under professional care models, carers would be paid a salary that is commensurate with their level of skill; would be required to hold a relevant qualification and / or undertake ongoing competency-based learning and development; and would provide, or have access to, therapeutic clinical support and other specialist supports…*** (ACIL Allen Consulting, 2013, p. 1).

Across the world, including Australia, foster care is becoming more professionalised, with requirements for standardised training and foster care standards (McHugh and Smyth, 2006). However, in Australia, models of professional foster care that fulfil the requirements of the above have not been fully implemented (ACIL Allen Consulting, 2013). ACIL Allen Consulting's report to the Department of Family Services and Indigenous Affairs about issues involved in implementing a professional model of foster care, provides a useful table outlining this variety (ACIL Allen Consulting, 2013, p. 24). ACIL Allen's report also notes some of the issues in designing a professional model of foster care including: employment and taxation status, qualification requirements; how remuneration is to be calculated; and how 'normal' working conditions can be built in appropriately to the fostering situation, for example holidays, time off and superannuation.

The Core Elements of Therapeutic Foster Care

The outcomes of the scoping study highlight that there is no single definition of therapeutic foster care. Different knowledge traditions, policy contexts and practice histories have led to different approaches being developed and implemented.

As Tucci, Mitchell and Tronick (2020) have pointed out,

> ***…Therapeutic Care increasingly finds expression in forms of programs that have evolved from a range of different starting points but all with the same purpose – to reconstruct out of home care as active intervention that seeks to deliver foundational experiences to children that apply the healing properties of safety, attunement, trust, predictability and stability…*** (p.30).

Building on her earlier work (Mitchell 2009) and in the most comprehensive effort to date, Mitchell, Tucci and Macnamara (2020) have proposed a framework of common principles that underpin the emerging paradigm of Therapeutic Care. They argue that the following 12 principles are as relevant to therapeutic approaches to foster care as they are to therapeutic approaches to kinship and adoptive care.

Principle 1. Therapeutic Care recognises that trauma related to abuse and violence has a differential impact on each child and young person, leading to a unique configuration of impact and down stream consequences.

Therapeutic Care views children from a developmental perspective, noting their challenges, and appreciating their strengths. Children are more than a cluster of symptoms which need treatment (Tucci, 2016). They are in continuous movement between the states that cripple them and those which bring them back to life. The unique configuration of strengths and needs are important to acknowledge and work with. It is, as Badenoch (2018) claims, the depth of what can occur when an individual is received with respect for the deep wisdom of their brains and bodies to resist trauma and find a way to live with its effects. Their history braids their interaction with people, the impact of events and the messages they have received about the world and themselves, into ways of understanding them and their needs. This is the starting and return point for the practice of Therapeutic Care.

Principle 2. Therapeutic Care practice privileges children's needs as the basis of all of its decisions.

In many circumstances, children's behaviour directs decisions making when they are in care. Traumatised children's behaviour can be challenging and complex. The child protection system, which is set up from inception to be reactive, responds to these behaviours quickly as a blunt instrument of care and control. Often, it fails to appreciate the subtlety of children's range of behavioural expressions.

Therapeutic Care privileges children's needs as they connect through time. It recognises that at its heart, trauma leaves children's developmental needs unfulfilled and compromised. Its intervention takes the form of supporting carers and others in the child's relational network to understand the myriad of children's communication as failures in the past to repair overwhelming intrapsychic, neurophysiological, interpersonal and cultural ruptures caused by violence and abuse. These unmet needs from the past combine into strong thematic axioms along which run powerful repetitive patterns of interaction drawing in the activated circuitry of those around them. Meeting children's

needs in the present, when they remain unmet from their past, seals the reverberating gap left in their neural networks with a new line of filler that satisfies a little of the implicit memories of those needs which are so vividly aroused in their moment by moment lived experience.

Principle 3. Therapeutic Care understands that children's behaviour communicates the efforts made by their internal systems to protect them from the traumatic experiences of violation.

Therapeutic Care holds as its central tenet that children come to heal from trauma when the relationship network around them are resourced with therapeutic intent.

Carers, teachers, siblings, friends, coaches, extended family are able to and do offer spaces in the now that respect the inherent life surging states children have experienced whenever they have occurred. These are experiences which act like a tuning fork for children in out of home care. The ways in which children are responded in their interactions with these others set off a relational resonance that is sensed by children, vibrating the implicit memory filters in an effort to align with the state they are in at the time. In the here and now experience, the interactions of the relationship invites past memories of relationships to be re-influenced by the one in the now. If that relationship in the now vibrates with pain or activated states of threat and danger, then these past relationship filters amplify and consolidate further – as a lesson to the child to expect nothing different ever.

The intentionality of Therapeutic Care does not leave healing to chance. It structures these relationships to be able to maintain a clear focus and single purpose to support the needs of children in care. It provides a shared knowledge base and language to understand children. It delivers routine methodologies for convening collaborative discussions between key figures in children's relationship networks. It titrates the decision making of child protection authorities into manageable processes so that the network can have the time and the information they need to properly consider all eventualities in their deliberations. It brings into sharp focus children's ongoing lived experiences and orients the system to become more child serving.

Principle 4. Therapeutic Care adopts a lifespan approach to planning for children and young people as they grow and change.

Therapeutic Care recognises that child protection systems are inherently oriented towards making decisions about children according to legislative and policy-based planning cycles which generally emphasise the immediate and short term needs of children. For example, the requirements to make an annual plan for children compels a focus on where children should live, whether it is safe for children to be reunified with parents, how to prevent placement breakdowns and where the child should attend school. In addition, child protection systems are frequently overburdened with high demands and inadequate resources. And as such, the system is more likely to prioritise what it must do in the time it can allocate in order to meet compliance expectations. Therapeutic Care engages the system in order to affirm its role in ensuring the here and now needs of children, but it also supports it to consider the children's relational needs over time.

Therapeutic Care allows for children to have opportunities to connect with the adults in their family who hurt them if it is possible. Therapeutic Care can resource these adults who have been abusive or neglectful to these children to make changes, prove themselves over time and be facilitated to re-join the relational network around children in an appropriate way that attempts to predictively ameliorate relational crises that may emerge in the future. Therapeutic Care holds the position that all relationships for children have the potential to offer therapeutic impact, whilst recognising that the perpetuation of abusive dynamics cannot be tolerated for children who are in the process of recalibrating their internal systems to a deep and sustained sense of relational safety and security.

Therapeutic Care ensures that the extended family of children are not lost to them. Too often, the network of children in out of home care is overly dominated by professional relationships which by definition are time limited. Extended family provide an alternative network of informal relationships which children can remain connected to that will scaffold their development and be there during major transition points in their development. Therapeutic Care treats the extended family as an undervalued resource that needs to be incorporated as an intrinsic part of the relational network of children in out of home care.

Principle 5. Therapeutic Care honours the strengths of cultural heritage as resources for children and their relationship networks.

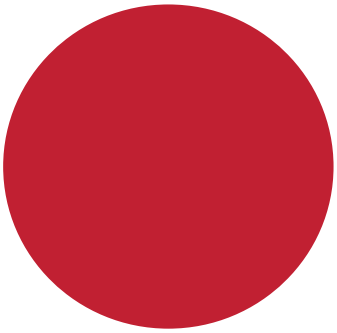
The cultural heritage of children is viewed by Therapeutic Care as integral to and foundational for the wellbeing of children in care. Children's culture is not separate to the relationships around them, their sense of belonging, or their identity. Their culture is experienced in and through their relationships with family and community, their stories, traditions and practices. It recognises the deep reservoir of cultural knowledges, practices and beliefs that innervate the life of communities and the relationships they hold. It actively seeks out individuals within the cultural communities for these children to be cared for directly, or at the very least, be connected with in some way so that they may live within rather than visit their culture, as is too commonly the case.

Principle 6. Therapeutic Care adopts the view that children's experiences of deep visceral safety is both an outcome and a form of intervention.

Therapeutic Care primarily establishes and maintains an organised interpersonal milieu which recognises that children's deep experiences of relational safety are both a major goal of intervention and a major resource in the healing process (Tucci, Weller and Mitchell, 2018). It adopts the view that the experience of safety is not the equivalent of removing threat and danger (Porges, 2014). Relationships which heal are trustworthy and enduring. They are attuned to the children's flow of implicit activated memory states. They stabilise and they help organise regulation of activated states in children.

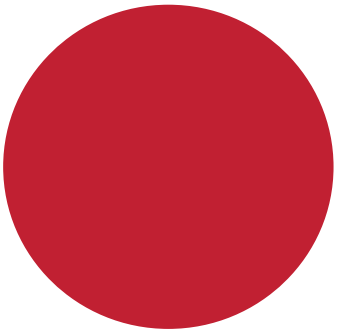
Principle 7. Therapeutic Care is active in ensuring that children and young people who have experienced abuse and neglect are not further disempowered by the way practice is implemented.

Therapeutic Care is fundamentally a form of practice that seeks to enact the basic human rights of children and young people as articulated in the UN Convention on the Rights of the Child (United Nations, 1990). Nationally, in Australia, government and non-government organisations have also adopted a set of rights for children and young people living in Out of Home Care. These frameworks make explicit the core entitlements of children and young people to protection, family, culture, privacy and to participate in decision making which affect their lives.



Therapeutic Care translates these rights into meaningful actions that support its intended outcomes. It resists diagnostic criteria that defines children and young people's identity on the basis of the trouble they cause or experience. It recognises that sensitivity to the developmental capacities and stages of young people is in itself a respectful orientation to practices of assessment and intervention.

Principle 8. Therapeutic Care fosters the authentic participation of children and young people in decision making processes that are about them.



Through its practice, Therapeutic Care communicates to children and young people that their views, beliefs and ideas hold an intrinsic value. They are provided with ways to rehearse sharing in problem solving and decision making processes in supported contexts. Then, when it comes time for them to be more independently responsible for these decisions, they are more likely to be better prepared. This is what all families do for and with their children.

Principle 9. Therapeutic Care empowers relationships to be therapeutic.

Therapeutic Care practice renders the opaque nature of the internal states of the child, the carer, the others in the child's relational network more transparent. It achieves this through a sequence of strategies that start with training carers and the relational network around the child about the neurobiology of trauma, attachment and child development. This knowledge base lays the foundation for the adults to understand the internal systems of traumatised children in out of home care. It integrates their own intuition and experience with children in their own family or in their community with the outcomes of research that builds an orientation to undertaking more of a therapeutic parenting role (Cairns, 2002; Hughes, 2007; Hughes and Baylin, 2012). It also softens the terrain of expectations aiming to dislodge set views that may have developed about how children should behave, what they need, how to respond to them and how children should respond in return.

Training of course is not enough on its own. Access to knowledge does not necessarily translate into changed behaviour. Therapeutic Care then support carers in real time to apply this knowledge into practice in day to day moments of care. Therapeutic Specialists utilise patterns of trauma enactments as opportunities to reflect on their meaning with carers and resource them to intentionally respond with sensitivity, openness and care. These experiences offer children's activated circuitry the repair and re-attunement they need. Often the support is provided at the time when children come home from school, get ready for bed, wake up in the morning – many of the transition points in a normal day when the change of state is likely to occur because of the nature of the routine itself. Therapeutic Care recognises how the flux of a normal day can it and of itself prompt activation of implicit memory systems that awaken in children and need a response.

Therapeutic Care spreads the approach to supporting carers to as many of the adult relationships in the network of the children as can be reached. Empowered relationships ripple in concentric circles around the child, reinforcing and amplifying the safety and comfort that are now the primary qualities of the child's experience in relational exchanges. The therapeutic impact takes hold as the child stops needing the threat activated circuitry in favour of safety satiated internal systems that are oriented towards mind and body restoration and resuming their developmental progression.

Principle 10. Therapeutic Care conceptualises the physical and sensory environments that children inhabit as therapeutic.

Therapeutic Care acknowledges that traumatised children have a fundamental need to experience safety not only within their relationships, but also in their environments. It appreciates that the physical space through which children can interact can support children if it is structured and clearly marked. Practitioners in Therapeutic Care, as do early childhood educators, appreciate how marking out zones in a room or a home for different functions allows children to orient themselves to what to do where. The arranging of space also physical boundaries to be experienced which can also act as tangible replicas of interpersonal boundaries, exposing them to experiences of negotiation, flexibility and co-organisation.

Therapeutic Care also invests effort into evaluating and strengthening the predictability of children's day to day experiences in particular eating, sleeping, school and play routines. Temporal maps enable children to know what to expect when, when their transition points are in a day or week or month, who will be involved and how they will be supported throughout. Plans about time, just as diaries resource adults, make the world a little easier for children to navigate. Conversely, for these children where predictability is a theme anchored in tension, changing or ignoring a routine after it has been established without warning and support can unearth activated internal states that terrify them or cause distress.

Therapeutic Care holds a focus on optimising the environments that foster for children a felt experience of safety.

Principle 11. Therapeutic Care expands the role of therapists to become relational brokers, network enablers and system advocates for children in out of home care.

The role of the therapist is extended beyond the traditional scope of dyadic or family engagement in the practice of Therapeutic Care. It invites therapists to take on functions as facilitators of safety, relationship and resource brokers, network enablers and system advocates. As mentioned in the first chapter, this is the reason for their role title being changed to Therapeutic Specialists – a term that was first introduced into the lexicon of our broader field in 2000 by Mitchell (SuccessWorks, 2005; Mitchell, 2009) in the formulation of the original TRACK Therapeutic Foster Care Program in Melbourne, Australia.

First and foremost, Therapeutic Specialists provide therapeutic leadership across all the critical relationships around the child in order to develop a shared understanding of the needs of children as the basis for developing congruent and collaborative trauma-informed responses which are consistent across the settings that children live, learn and play. They broker these relationships moulding them into a collective that works to keep the whole child in perspective. They help to establish trust and open lines of communication between these relationships and deal with the dynamics that can arise between individuals, organisations and systems. They support safety in these networks to emerge as qualities between people who engage each other for children. They develop the good will that will allow tension or immobilisation to be addressed and dissipate.

Therapeutic Specialists also walk alongside the carers and other really close relationships to the child. They offer carers the intersubjective resource (Hughes, 2007, 2015, 2017; Hughes and Baylin, 2012) that enables them to stay open to the relationships with children, which can in themselves be stressful if not traumatising to the carer. Therapeutic Specialists undertake a comprehensive gathering of information about the history of experiences of specific children in out of home care and compile it into a formal assessment that is used as the basis for therapeutic plans involving the children, the carers and the relationship network around children. In this assessment process,

children, carers, family members (where possible) and professionals in the network around children are provided with the opportunity to provide input. Therapeutic Specialists ensure that the narrative that is retold about children which includes their strengths, their wishes, their descriptions of their lived experiences. The assessment and documentation process is a meaning making endeavour that generates deep insight into the needs of children that remain unattended to because of their violation or neglect. It also enables children to be viewed compassionately in ways that inject delight and hope into the relational experiences that children and others have of each other.

Therapeutic Specialists use this integrated narrative about children to interpret their behaviour so that the impact of their history is always incorporated into explanations and descriptions about them. Therapeutic Specialists use their knowledge about trauma and evidence informed intervention to offer the necessary adjustments to relational exchanges and the environmental routines that facilitate children's capacity to use these relationships to shift their re-occurring patterns of activated states.

When it is warranted, Therapeutic Specialists engage directly with children to enable them to have another relationship which offers opportunities for the co-organisation of regulated states, co-construction of meaning about past experiences and shared activities which awaken developmental momentum.

Principle 12. Therapeutic Care is resourced by coordinated collective decision making that serves the needs and interests of children.

Therapeutic Care uses vehicles such as Care Teams, to organise important relationships to co-ordinate the actions and responses of services and individuals in the here and now. Often led by Therapeutic Specialists, Care Teams work by enlisting a shared view and understanding of children's needs. They use the understanding about children that has been informed by the comprehensive assessment of Therapeutic Specialists to co-opt and use a common language to explain and interpret children's behaviour and needs. Care Teams allow agreement between individuals who engage children in different contexts about strategies for these children that are replicated or at least consistent across those contexts. In so doing, children are given the experiences of safety that are built into predictable structures and routines applied consistently at home, school, during their involvement in recreation or other similar activities.

Care Teams keep the child in the centre of their frame. They look for the successes that occur with children, even when they are almost imperceptible, and celebrate them with children and others in the relational network around them. They also reflect on how those successes were born and examine how these lessons may be able to be applied into a different setting or with a different relationship. The change that occurs within relationships that lead to improvements in children's lived experiences are amplified. Care Teams also work to find and involve relationships of significance in children's lives even when they are in out of home care. It facilitates adults, who are family and safe for children to move closer and become a resource in the here and now and/or as children's development seeks them out.

Analysis

The emergent properties of Therapeutic Care approaches integrate knowledge and practice traditions that aim to reset the experience of relationships that children in care need. Therapeutic Care acknowledges as Tucci, Mitchell and Tronick (2020) have noted that children who have experienced abuse and violation have been

> ***…doubly betrayed. Not only have their relationships in the past hurt them, but they have also ill-prepared them to be able to use the resources offered by safe relationships to heal. The very relational safety their systems crave can be beyond their reach. These children are not waiting for relationships to work in the future for them. Their needs are so severe that they cannot afford to only be supported within one therapeutic dyad. They depend on relationships across the multiple contexts in which they inhabit. They need relationships to work for them in real time. …***(p.28).

The importance of this conceptual work so far exists in its acts of consilience – recognising and distilling the common findings from different schools or disciplines of knowledge building. It has unearthed the beginning of a critical blueprint for what can be made in the future. Some of it is already in place. Other elements are more complicated to implement and therefore more aspirational in nature. It also resists the temptation to pit one model against another in an artificial race to be the best - the one that attracts the most funding, the one that can prove its claims the most convincingly, the one that has the greatest impact. The reality is that not all models will work equally for all children. Children in different contexts with different needs will be supported by different approaches. The service sector needs adequate funding to ensure that the right models are available and accessible.

Therapeutic Foster Care in practice

Building on these principles, the scoping study highlighted a number of important core considerations in the implementation of Therapeutic Foster Care approaches as programs or initiatives. In practice, Therapeutic Foster Care programs

- utilise a defined theoretical framework that articulates a clear theory of change;
- hold a focus on the relationship between carers and children as a primary vehicle through which children's needs are addressed;

- allocate smaller caseloads for foster care workers so as to facilitate more sustainable and intensive relationships with and around children and carers;
- make available higher rates of financial support to carers to support them to be available as needed for the children in their care;
- involve a specialist needs assessment of children;
- actively match children to carers in relation to a specified range of qualities and experience;
- employ therapeutic specialists to support therapeutic responses being provided to children across contexts and times;
- provide specialist training to carers and the network of relationships involved in day to day interactions with children in care;
- are based on collective planning and decision making usually involving an approach to Care Teams.

Conclusion

Eleven international and six Australian approaches are briefly described, and evaluation outcomes indicated where they were analysed. In addition, the most up to date conceptualisation of therapeutic care principles were reviewed and discussed. The critical or essential elements of Therapeutic Foster Care distilled from the findings of this initiative are documented. They should be viewed as a series of integrated components that when implemented together form the basis of almost all current therapeutic foster care programs in Australia and overseas.

It is clear that further research investigating the long-term outcomes for children and young people who have experienced therapeutic foster care is needed. However, it is clear that the core elements of Therapeutic Foster Care approaches in and of themselves offer the resources that can support the much needed reforms to out of home care that many governments in Australian jurisdictions are seeking.

Empowering relationships to support the healing and development of children in care is the organising principle that will effect real change for children, carers, families and the professional networks that come into contact with and interact about and with children in care every day.

Therapeutic Foster Care has the configuration of elements that can make reform work.

References

ACIL Allen Consulting (2013). *Professional Foster Care, Barriers Opportunities and Options,* Melbourne Australia.

Arksey H., and O'Malley L. (2005). Scoping studies: towards a methodological framework, *International Journal of Social Research Methodology,* 8:1, 19- 22, DOI: 10.1080/1364557032000119616.

Astrom, T., Bergstrom, M., Hakansson K., Jonsson A., Munthe C., Wirtberg I., Wess, J., and Sundell, K (2020). Treatment Foster Care Oregon for Delinquent Adolescents: A Systematic Review and Meta-Analysis. *Research on Social Work Practice, Vol.* 30(4) 355-367.

Australian Childhood Foundation (2017). *Treatment and Care for Kids Program*. Program document (unpublished). Melbourne Australia.

Badenoch, B. (2018). *The Heart Of Trauma: Healing the Embodied Brain in the Context of Relationships.* New York: W.W. Norton and Co.

Bartlett J.D. and Rushovich, B. (2018). Implementation of Trauma Systems Therapy-Foster Care in child welfare. *Children and Youth Services Review*, 91. 30-38.

Bergstro M, Cederblad M., Kickan H., Jonsson A., Munthe, C., Vinnerljung, B., Wirtberg I., Stlund V. and Sundell K. (2020). Interventions in Foster Family Care: A Systematic Review. *Research on Social Work Practice,* Vol. 30(1) 3-18.

Bruns, E. J., Pullmann, M. D., Sather, A., Denby Brinson, R., and Ramey, M. (2015). Effectiveness of wraparound versus case management for children and adolescents: results of a randomized study. *Administration and policy in mental health,* 42(3), 309–322.

Cairns, K. (2002). *Attachment, trauma and resilience. Therapeutic caring for children.* BAAF Adoption and Fostering. London.

Cairns, B. (2004). *Fostering Attachments: Long-term outcomes in family group care.* London, BAAF.

Carter, J. (2002). *….towards better foster care…reducing the risks,* Melbourne: The Children's Foundation.

Caw J. and Sebba J. (2014). *Team Parenting for Children in Foster Care.* Jessica Kingsley, London, UK.

Chamberlain, P. (1990). Comparative evaluation of specialized foster care for seriously delinquent youths. A first step. Community alternatives. *International Journal of Family Care,* 2, 21–36.

Chamberlain, P., Leve, L. D., and DeGarmo, D. S. (2007). Multidimensional treatment foster care for girls in the juvenile justice system: 2-year follow-up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology,* 75, 187–193.

Chamberlain, P., and Mihalic, S. F. (1998). *Blueprints for violence prevention, multidimensional treatment foster care.* Boulder, CO: Center for the Study and Prevention of Violence. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/204274.pdf2017-01-15

Chamberlain, P. and Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology,* 66, 624–633.

Davies, P., Webber, M. and Briskman, J. A . (2015). Evaluation of a Training Programme for Foster Carers in an Independent Fostering Agency, *Practice*, 27:1, 35-49, DOI: 10.1080/09503153.2014.983434

Department of Human Services. (2009). *The Circle Program- A therapeutic approach to foster care program guidelines.* May, Melbourne, Victorian Government.

Fisher, P., Burraston, B. and Pears, K. (2005). The early intervention foster care program: permanent placement outcomes from a randomized trial. *Child Maltreatment. 10(1):61-71*.

Frederico, M., Long M., McNamara, P., McPherson, L., Rose, R., and Gilbert, K. (2012). *The Circle Program: an Evaluation of a therapeutic approach to Foster Care.* Centre for Excellence in Child and Family Welfare, Melbourne, Australia.

Frederico, M., Long, M., McNamara, P. and McPherson, L. (2014). The way all foster care should be The Experience of Therapeutic Foster Carers in the Victorian Circle Program. *Children Australia*, 39(4), 211-215.

Kinsey, D., and Schlösser A. (2012). Interventions in foster and kinship care: A systematic review. *Clinical Child Psychology and Psychiatry.* doi.org/10.1177/1359104512458204

Gilbertson, R., Richardson, D., and Barber, J. G. (2005). The Special Youth Carer program: An innovative program for at-risk adolescents in foster care. *Child and Youth Care Forum,* doi.org/10.1007/s10566-004-0883-7

Hughes, D.A. (2007). *Attachment Focused Family Therapy.* New York: Norton.

Hughes, D.A. (2015). The Complex Journey of Traumatised Children: Discovering Safety in Order to Experience Comfort, Joy and Self-discovery. *Children Australia,* 40(2), 147–151.

Hughes, D.A. (2017). Dyadic Developmental Psychotherapy (DDP): An Attachment-focused Family Treatment for Developmental Trauma, *Australian and New Zealand Journal of Family Therapy,* 38, 595–605.

Hughes, D. and Baylin, J. (2012). *Brain-based Parenting: The Neuroscience of Caregiving for Healthy Attachment.* New York: W.W. Norton.

Key Assets (2020). *Pathways to Stability.* Retrieved from https://keyassets.com.au/pathways-to-stability/ on 30/11/2020

MacDonald, G. M. and Turner W. (2007). Treatment foster care for improving outcomes in children and young people. Campbell Systematic Reviews. https://doi.org/10.4073/csr.2007.9

McAloon, J (2014). *A Literature Review – Developing a Framework for Therapeutic Out of Home Care in NSW.* Unpublished draft, NSW.

McDermid, S., Holmes, L., Ghate, D., Trivedi, H., Blackmore, J. and Baker, C. (2016). *Evaluation of head, heart, hands: Introducing social pedagogy into UK foster care. Final report.* Loughborough University. Report. Retrieved from https://hdl.handle.net/2134/24091

McPherson, L., Gatwiri, K. and Cameron, N. (2018). *An evaluation of the Treatment and Care for Kids Program.* Australian Childhood Foundation, Melbourne.

McPherson, L. Gatwiri, K., Tucci, J. Mitchell, J. and Macnamara, N. (2018). A paradigm shift in responding to children who have experienced trauma: The Australian treatment and care for kids program. *Children and Youth Services Review,* https://doi.org/10.1016/j.childyouth.2018.08.031 The Mockingbird program (2020). Retrieved from. https://www.thefosteringnetwork.org.uk/policy-practice/projects-and-programmes/mockingbird-programme

Maluccio, A. and Ainsworth, F. (2006). Family foster care: development or decline. *Adoption and Fostering,* 30, 20 – 25.

Mitchell, J. (2009). *A Case Study in Attempted Reform in Out of Home Care: A Preliminary Examination of the Introduction of the Circle Therapeutic Foster Care Program in Victoria* – MSW (Research) Thesis, Monash University, Melbourne.

Mitchell, J., McPherson, L. and Gatwiri, K. (2020). "Support and love and all that stuff": Evidence of impact in the Treatment and Care for Kids Program. In Mitchell, J., Tucci, J. and Tronick, E. (Eds). *The Handbook of Therapeutic Care for Children – Evidence Informed Approaches to Working with Traumatised Children and Adolescents in Foster, Kinship and Adoptive Care,* pp 35-58. Jessica Kingsley, London.

Mitchell, J., Tucci, J. and Macnamara, N. (2020). What are the Key Elements of Therapeutic Care? In Mitchell, J., Tucci, J. and Tronick, E. (Eds). *The Handbook of Therapeutic Care for Children – Evidence Informed Approaches to Working with Traumatised Children and Adolescents in Foster, Kinship and Adoptive Care,* pp 35-58. Jessica Kingsley, London.

Mocking Bird Family (2020). Retrieved from. https://www.lwb.org.au/our-approach/child-youth-and-family/mockingbird-family/

Octoman O. and McLean S. (2014). Challenging behaviour in foster care: what supports do foster carers want? *Adoption and Fostering,* https://doi.org/10.1177/0308575914532404

Pearce, C. and Gibson, J. (2016). A preliminary evaluation of the Triple-A Model of Therapeutic Care in Donegal. *Foster* Issue 2, 95-104

Pearce, C. (2010). An integration of theory, science and reflective clinical practice in the care and management of attachment –disordered children: A Triple-A approach. *Educational and Child Psychology,* 27(3), 73-86

Petrie, P. (2007). Foster care A role for social pedagogy? *Adoption and Fostering,* https://doi.org/10.1177/030857590703100111

PIC. (2020). Program Manual. retrieved from https://pic.care/about-pic

Porges, S.W. (2020). Feeling Safe is the Treatment. In Mitchell, J., Tucci, J. and Tronick, E. (Eds). *The Handbook of Therapeutic Care for Children – Evidence Informed Approaches to Working with Traumatised Children and Adolescents in Foster, Kinship and Adoptive Care*, pp 11-18. Jessica Kingsley, London.

Saldana, L Campbell, M., Leve, L., Chamberlain, P. (2019). Long-Term Economic Benefit of Treatment Foster Care Oregon (TFCO) for Adolescent Females Referred to Congregate Care for Delinquency *Child Welfare*, 97 (5) 179-195

Schofield, G., Cossar, J., Ward, E., Larsson, B., and Belderson, P. (2019). Providing a secure base for LGBTQ young people in foster care: the role of foster carers. *Child and Family Social Work,* 24(3), 372-381. https://doi.org/10.1111/cfs.12657

Schofield, G., and Beek, M. (2014). *The Secure Base Model: Promoting attachment and resilience in foster care and adoption.* UK. BAAF.

Street, E., Hill, J., and Welham, J. (2009). Delivering a therapeutic wraparound service for troubled adolescents in care. *Adoption and Fostering,* https://doi.org/10.1177/030857590903300204

Success Works (2005). *Evaluation of the Treatment and Care for Kids (TrACK) Program.* Melbourne: Success Works.

Tucci, J. (2016). What comes after trauma-informed practice?, *Prosody,* 12 December, https://professionals.childhood.org.au/prosody/2016/12/what-next/.

Tucci, J., Mitchell, J. and Tronick, E. (2020). The Need for a New Paradigm in the Care and Support of Children in Foster, Relative and Adoptive Care. In Mitchell, J., Tucci, J. and Tronick, E. (Eds). *The Handbook of Therapeutic Care for Children – Evidence Informed Approaches to Working with Traumatised Children and Adolescents in Foster, Kinship and Adoptive Care,* pp 21-34. Jessica Kingsley, London.

Tucci, J., Weller, A. and Mitchell, J. (2018). "Deep" safety for children who have experienced abuse: Application of Polyvagal theory in therapeutic work with traumatised children and young people. In S.W. Porges and D. Dana (Eds.) *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies,* (pp.89-105). New York: W.W. Norton and Company.

Walker, J. S., Bruns, E. J., and Penn, M. (2008). Individualized services in systems of care: The wraparound process. In B. A. Stroul and G. M. Blau (Eds.), *The system of care handbook: Transforming mental health services for children, youth, and families* (p. 127–153). Paul H. Brookes Publishing Co.

cetc: centre for excellence in therapeutic care

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

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