ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Specialist caregiving

Structure and effectiveness of international models

November 2023

MARTIN JENKINS

EVIDENCE CENTRE
TE POKAPŪ TAUNAKITANGA

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Contents

Glossary

Term or acronym	Definition
ACCO	Aboriginal council-controlled organisation
Attachment theory	Attachment theory is a psychological theory concerning relationships. It sets out that young children need to develop a secure, safe, and protected relationship with at least one primary caregiver for normal social and emotional development.
Behaviourism	Behaviourism focuses on the idea that all behaviours are learned through interaction with the environment, and that innate or inherited factors have very little influence on behaviour. Behaviours are acquired through conditioning processes.
CARE	Children and residential experiences model (US)
Caregiver Caregiving	Refers to adults who provide care to a tamaiti in their own home or a home leased or owned by the organisation they are approved by to care. They are assessed and approved under a caregiver assessment and approval framework and are reimbursed for costs incurred (that is, board, clothing, and other small cost payments) for the duration of the placement.
CSM	Tāne Whakapiripiri Care Support Model
Dyadic developmental psychotherapy	Dyadic developmental psychotherapy is based on a theoretical understanding of the reciprocal nature of communication and experience between two people, and the impact of developmental trauma.
EFP	British Columbia Extended Family Program (Canada)
Kaupapa Māori	Kaupapa Māori means that it is delivered or done by Māori, with Māori, and for Māori. It is informed by tikanga Māori, or Māori ways of doing things.
KEEP	Keeping Foster Parents Trained and Supported foster-parent training intervention (US)
Learning theory	Learning theory is an educational psychology theory which describes how learners receive, process, and retain knowledge during learning. Cognitive, emotional, and environmental influences, as well as prior experience, all play

Term or acronym	Definition
	a part in how understanding, or a world view, is acquired or changed, and knowledge and skills retained.
Mātauranga Māori	Mātauranga Māori means Māori knowledge, and encompasses traditional knowledge and knowing that Māori ancestors brough with them to Aotearoa New Zealand.
MIST	Multidisciplinary Intervention Service Torfaen (UK)
MTFC	Multidimensional Treatment Foster Care (US), now TFCO
NICE	The National Institute for Health and Care Excellence (UK)
PR-TFC	Pressley Ridge Treatment Foster Care Program (US)
Psychodynamic theory	Psychodynamic theory states that events in our childhood have a significant influence on our adult lives, shaping our personality. Psychodynamics focuses on the interrelationship of various parts of the mind, personality, or psyche as they relate to mental, emotional, or motivational forces, especially at the unconscious level.
Social learning theory	Social learning theory is a psychological theory which suggests that social behaviour is learned by observing, imitating, and modelling the behaviour of others.
Specialist care Specialist caregiving	Specialist care is also referred to as therapeutic foster care, enhanced foster care, treatment foster care, specialised or specialist foster care, intensive foster care, and professional foster care (Child Protection Development, 2011; Frederico et al., 2017 as cited in McPherson et al., 2018). It refers to a model of care in which foster parents have undergone training to support children who have experienced a high level of trauma and/or considerable emotional, psychological, behavioural, and social challenge.
TCF	New South Wales Therapeutic Care Framework
TFCO	Treatment Foster Care Oregon (US)
TFCP	Therapeutic Family Care Program (Canada)
TFM	Teaching-Family Model (TUS)
TFMC™	Lighthouse Foundation therapeutic family model of care (Australia)
TDCW	Training and Development for Caregiving Whānau pilot programmes

Term or acronym	Definition
TrACK	Treatment and Care for Kids Program (Australia)
Trauma-informed care	Trauma-informed care is a way of working that recognises the potential of people to heal despite traumatic experiences. It involves an understanding of the pervasive nature of trauma and how it affects people's lives. It's about building on people's strengths and relationships to support healing.
VACCA	Victorian Aboriginal Child Care Agency (Australia)
VACFSS	Vancouver Aboriginal Child and Family Services Society (Canada)

Executive summary

Aotearoa New Zealand primarily relies on a voluntary model of caregiving for children in State care. With this, caregivers receive reimbursement for some of the expenses of caring for a child but are not provided a salary or wage. In 2021, Cabinet agreed to “Establish trained specialist caregiving roles for our high and complex needs tamariki that recognise the skills required to work with our most vulnerable tamariki and enable appropriate remuneration and ongoing development and support to be provided” (Oranga Tamariki, 2021, p. 7).

Globally, the development and implementation of different models of specialist caregiving has been driven by two key trends**:** increasing complexity in the needs of children requiring care, and difficulties in recruitment and retention of volunteer carers. This evidence brief identifies and assesses a range of specialist caregiving models in Australia, Canada, the United Kingdom (UK), and the United States (US).

In assessing the models, attention was paid to:

— how the models financially support caregivers and the implications.

— the setting that the care is being delivered within.

— models of care for children with high and complex needs.

— levels of training, support, and development provided.

— how these models of care look in an indigenous context.

In identifying a model, or models, that might be applicable to the New Zealand context, Oranga Tamariki will need to make some choices and balance considerations, as no one model is the most effective (for children, and for carers, in the long term), nor have all the features that meet the need. Most notably, no indigenous-led models have been implemented in full for a significant length of time to have a conclusive evidence base supporting its adoption.

Based on the literature, particularly the empirical research and programme evaluations of various models, this evidence brief introduces a set of design principles to aid in determining a specialist caregiving model that could be implemented in New Zealand, and that could also be applied to the design of a new model for the future.

By Māori, for Māori	Systems and processes are connected to Māori philosophy and principles (Te Ao Māori), Māori tikanga and processes are followed, and Māori, whānau, iwi, and hapū lead its development and implementation. The validity and legitimacy of Māori, and the importance of Māori language, culture and values is paramount.
Evidence-based	To what extent is there the research and evaluative evidence available to back up the effectiveness of the model in achieving its intended outcomes.
Comprehensive	Applicable to the entire cycle of model implementation, that is, from recruitment to monitoring and evaluation.
Congruence and system fit	Does the model create inconsistency or questions of fairness or inequity amongst cohorts of carers? Would the model fit in well with the spectrum of care offered in New Zealand? Are there implications for the broader workforce or care system?
Value for money	*Effective* in achieving the intended outcomes desired from a specialist caregiving model *Efficient* by minimising wasted effort and expense *Economic* with costs being proportional to outputs.

Background to the evidence brief

New Zealand primarily relies on a voluntary model of caregiving for children in State care.

New Zealand primarily relies on a voluntary model of caregiving for children in State care. With this, caregivers receive reimbursement for some of the expenses of caring for a child but are not provided a salary or wage.

The term caregiver[1] or caregiving refers to adults who provide care to a tamaiti in their own home or a home leased or owned by the organisation they are approved by to care. They are assessed and approved under a caregiver assessment and approval framework and are reimbursed for costs incurred (that is, board, clothing and other small cost payments) for the duration of the placement.

Residential placements do not follow a voluntary model. Those providing care in these arrangements receive a salary or wage, are on rostered shifts, and are often required to meet specific tertiary education qualifications requirements.

The core elements of our practice approach[2] helps us work more effectively with tamariki and whānau Māori. However, the mana-enhancing paradigm and Te Ao Māori principles of oranga (wellbeing) are relational, inclusive and restorative, and therefore have benefits for all children and families.

A mana-enhancing paradigm for practice recognises that it is possible to undertake our challenging and complex mahi in a way that is respectful, relational and restorative. The mana-enhancing paradigm has a strong foundation in social work practice in Aotearoa New Zealand and embodies 5 core components:

- Te Ao Māori is valuable knowledge – it helps guide and enhance our relationships with tamariki/mokopuna, rangatahi and whānau.
- The significance of history – through which underlying and intergenerational trauma and resilience can be understood.
- Valuing narratives as cultural identity – helps to understand what tamariki/mokopuna, rangatahi and whānau experience, value, identify and connect with.
- Māori concepts of wellbeing are critical to understanding, maintaining, restoring and strengthening oranga.
- Principled practice means knowing and understanding the influence of who we are, and why we think and behave the way we do in our practice.

[1] In this report, caregivers are differentiated from those doing the caring as a member of rostered staff who are sometimes referred to as caregivers.
[2] Practice approach | Practice Centre | Oranga Tamariki

Specialist caregiving is needed for children and young people who have high and complex support needs

Within the care and protection system, and therefore in the custody of the Chief Executive of Oranga Tamariki, there are a number of tamariki and rangatahi that have been identified with high and complex support needs who require intensive and individualised care. Tamariki with high and complex needs include those with:

- disability-related care needs; including diagnosed and undiagnosed fetal alcohol spectrum disorder
- significant mental health concerns, including suicidal and self-harming behaviour
- complex trauma experiences leading to internal emotional distress being externalised to behaviours that can be high risk to themselves and/or others
- those with autism spectrum disorder, and other neurodiverse needs, can struggle to understand the world around them leading to high levels of distress.

Oranga Tamariki's first-principles review of financial assistance to caregivers concluded that the main payment model should continue to be "voluntary", but that there needs to be an appropriate mix of caregivers for children in State care who have high and complex needs (Office of the Minister for Children, 2019). It was stated that work was required to explore the effectiveness of professional caregiving approaches in addressing matters such as recruitment and retention of caregivers and meeting the high and complex needs of some children. The consequences of not having enough placement options, particularly for children with identified high and complex needs, are unacceptable levels of placement breakdowns and/or inappropriate placements.

In 2021, Cabinet agreed to "Establish trained specialist caregiving roles for our high and complex needs tamariki that recognise the skills required to work with our most vulnerable tamariki and enable appropriate remuneration and ongoing development and support to be provided" (Oranga Tamariki, 2021, p. 7).

This evidence brief is a time-limited examination that draws from a limited research base

This evidence brief is a review of models of care currently used internationally. Particular attention is paid to:

- How the models financially support caregivers and the implications
- The setting that the care is being delivered within
- Models of care for children with high and complex needs
- Levels of training, support, and development provided
- How these models of care look in an indigenous context

The literature reviewed includes journal articles and grey literature. This brief draws on international literature, and predominantly draws from literature from 2013 onwards, using the 2013 *Professional foster care: Barriers, opportunities & options*

(ACIL Allen Consulting, 2013) report to the Australian Government as the key reference point.

The following search terms were used in identifying relevant literature:

Aboriginal	Foster	Residential
Australia	Indigenous	Resource
Canada	Kinship	Therapeutic
Care	Māori	Therapy
Caregiving	Model	United Kingdom
Carer	Native	Village
Child	New Zealand	Youth

Drivers of alternative models of caregiving

A note on terminology

"Specialist care" is also referred to as therapeutic foster care, enhanced foster care, treatment foster care, specialised or specialist foster care, intensive foster care, and professional foster care (Child Protection Development, 2011; Frederico et al., 2017 as cited in McPherson et al., 2018). It refers to a model of care in which foster parents (caregivers) have undergone training to support children who have experienced a high level of trauma and/or considerable emotional, psychological, behavioural, and social challenge. In this brief, "specialist caregiving" will refer to caregiving of children with high and complex needs, while "caregiving" will be used in other instances.

The development and implementation of different models of specialist caregiving globally has been driven by two key trends (ACIL Allen Consulting, 2013):

— increasing complexity in the needs of children requiring care

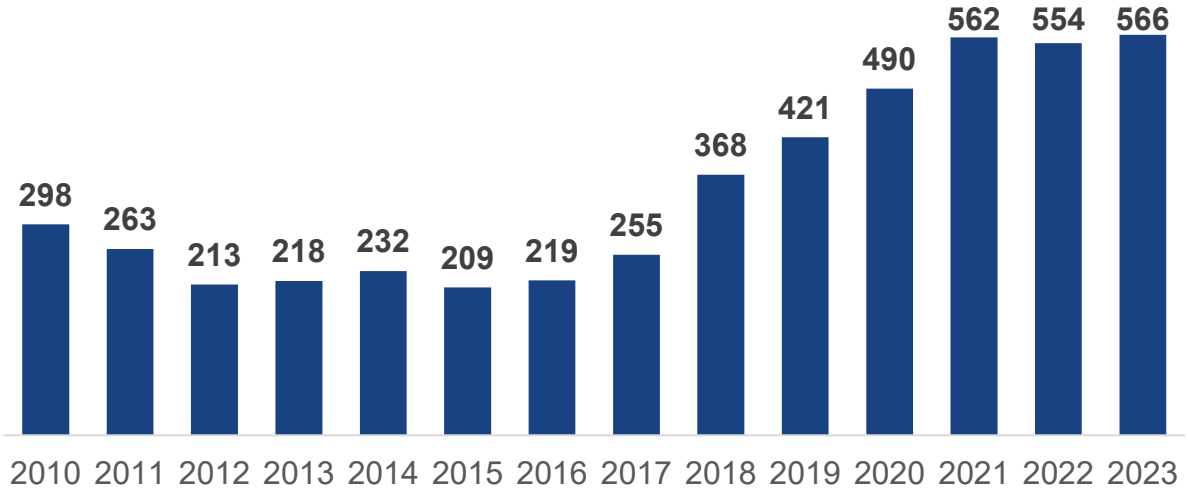
— difficulties in recruitment and retention of volunteer carers.

Oranga Tamariki Higher Foster Care Allowance payments

The number of children or youth whose carer accesses the higher foster care allowance (HFCA) provides a picture of those in care who are identified as having high needs. HFCA is a payment that supplements the standard caregiver allowance. It is paid to a caregiver where there are additional or special needs for tamariki, which are most effectively provided for through a regular higher rate of payment. The payment is reviewed regularly, at least every six months.

Figure 1 shows that the number of children receiving HFCA has been steadily growing. While there are less children coming into care, and more children being supported through other means (like the OB and UCB), there are indications that the number of children in care who are identified as having high and complex needs is rising.

Figure 1. Higher Foster Care Allowance placements by year, as at 1 June



Source: Oranga Tamariki

Recruitment and retention of caregivers is an ongoing concern

A review of the models of financial support for caregivers (Allen + Clarke, 2019) identified that work was required to explore the effectiveness of professional caregiving approaches in addressing recruitment and retention of caregivers. The consequences of not having enough placement options, particularly for children with high and complex needs, continues to lead to unacceptable levels of placement breakdowns and/or inappropriate placements.

There are few studies that focus specifically on recruitment and retention of specialist caregivers. A study of Australian tertiary students in psychology, health sciences, education, and welfare-related disciplines found that specialist caregiving models may not be more effective than general caregiving models in recruiting caregivers for children with high or complex needs (Habel et al., 2013). On the premise that students in those disciplines would have the skills to provide effective care for children with high and complex needs, the students were surveyed about their views on specialist caregiving and general caregiving. Most showed a greater interest in general caregiving than specialist caregiving.

The growing body of evidence on specialist caregiving remuneration supports additional fees or payments to improve the supply and retention of specialist caregivers, and potentially attract more highly-skilled carers (Allen + Clarke, 2019). Higher payments recognise the skilled and challenging nature of being a specialist caregiver, and provide greater financial stability, meaning that caregivers would not have to turn to supplementary employment (Allen + Clarke, 2019).

The literature is less clear on the adoption of a salary or wage, with skill-based payments remaining/being the preferred model for caregivers in the UK (Allen + Clarke, 2019). Any skill-based payment model would need to be underpinned by a comprehensive training, professional development, and certification framework.

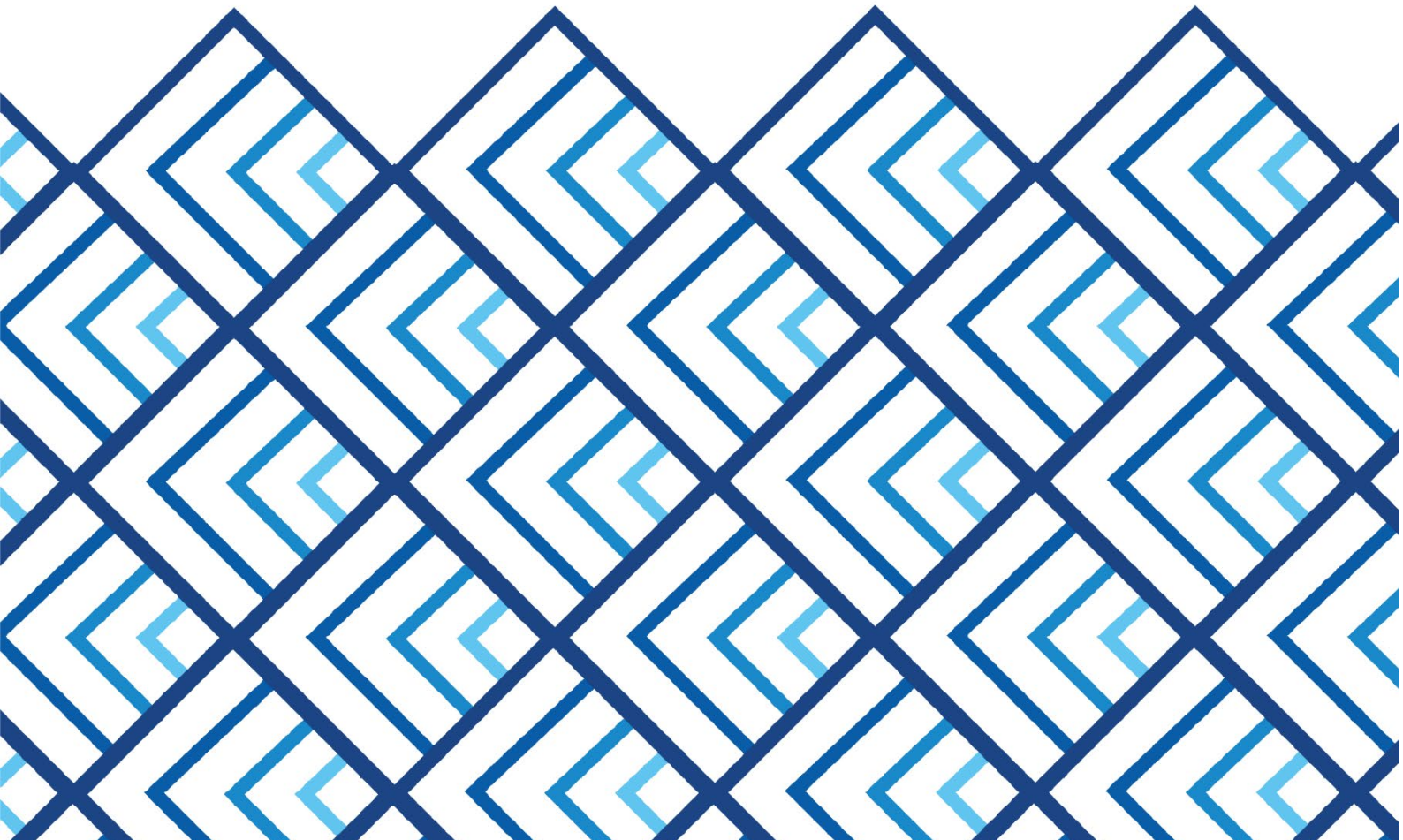
Internationally, the key factors that impact on recruitment and retention of foster carers are (ACIL Allen Consulting, 2013; Colton et al., 2006; Habel et al., 2013; Hollett et al., 2022; Randle et al., 2017):

- aging foster care workforce
- ethnic minority candidates' distrust of systems looking to recruit them
- cultural norms related to kinship care, and non-kinship care
- they are more likely to be from relatively socially and economically disadvantaged populations
- financial disruption to family and personal circumstances
- dissatisfaction with the processes associated with the assessment and quality of care
- poor peer support, networking, and advocacy
- lack of support provided by the care agency or government department
- child and young person complexity
- carer exhaustion.

The literature shows that feeling valued and respected, simple and effective administrative processes, and a strong network of support are vital in carer recruitment and retention (Colton et al., 2006; Hollett et al., 2022; Ott et al., 2023; Randle et al., 2017).

Models of specialist caregiving

Assessment



Different models of specialist caregiving operate around the world

To mitigate the two key trends – i) more children requiring care who have high and complex needs, ii) difficulty recruiting and retaining caregivers – specialist caregiving models have been developed and implemented. While the models may have different philosophical and therapeutic approaches, there are a few commonalities that seek to address the trends outlined above:

- to address the skills and experience required to care for children with high and complex needs,
  - specialist caregiving models elevate the role of the carer, and require specific qualifications and experience (McPherson et al., 2018). In some models the caregiver is referred to as the "parent therapist" (for example, Therapeutic Family Care program, 2023, in Canada).
  - close supervision of the young person, and setting rules and boundaries (Churches of Christ, 2023; Queensland Department of Child Safety, Youth and Women et al., 2019).
  - child-centered placements (NICE, 2022 - the National Institute of Health and Care Excellence in the UK).
- in relation to recruitment and retention,
  - specialist models tend to include intensive training and ongoing support to caregivers, as well as ensure that caregivers feel value and respected.
  - there is a care team approach with a central role for the carer in the team, the child having a therapist, and a limit of one or two children per placement (McPherson et al., 2018; Victorian Government Department of Human Services, 2009)

A set of factors were used to understand and compare the different models

In assessing the models, a set of factors were paid attention to:

- **Key features:** the philosophy of the model, and the setting in which care is delivered in – whether it is a residential programme or is in the carer's home.
- **Duration:** how long the model runs for, whether it is relatively short-term or whether it is a long-term, whole-of-organisation model.
- **Effectiveness:** what is known about the effectiveness of the model in delivering its intended outcomes for children and young people, and carers. The California Evidence-Based Clearinghouse for Child Welfare scientific rating scale ratings, and the Victoria Menu of Evidence – Children and family services assessments, were used as starting points. Independent peer-reviewed studies were given the highest priority.
- **Funder and delivery**: what is the funding model? The extent to which the model is funded by the state, and who tends to deliver the model. In some cases, models are delivered directly by government, while in other cases they are

delivered by NGOs. Some are funded wholly through private and charitable donations.

- **Indigenous-led**: how models of care look in an indigenous context was a particular area of interest for Oranga Tamariki. An assessment was made on whether the model was designed and delivered by indigenous organisations, or whether there were elements of co-design or whether the model had had success amongst indigenous populations.
- **Qualifications and training**: as discussed previously, specialist caregiving usually has a large training and learning component, differentiating it from general caregiving. This assessed the extent to which the level of learning and skills required lead to qualifications, and whether a qualification was required for the role.
- **Support services**: again, specialist caregiving tends to have a range of support services available to the carer. This might be a care team and on-demand, 24/7 specialist support.
- **Financial support**: the extent to which the model is based on a salary or wage payment, or whether it is reimbursement-based.
- **Industrial arrangements**: the status of the carer. Whether they are an employee, volunteer, or other arrangement.
- **Limitations:** Observed key limitations of the model. Particularly in terms of its evidence base, and whether the model was indigenous-led and whether it can potentially be applicable to Māori, whānau, iwi, and hapū.

How carers were reimbursed was a key area of interest for this evidence brief. This not only has fiscal implications for government, but it also flows onto the types of qualifications or certifications that may be required for carers. Legal status also has roll on effects, such as, if carers are employees receiving a salary or wage, there are employment obligations on the Crown for minimum wage, health and safety, and so on.

Table 5 provides an overview of a select number of specialist caregiving models implemented in Australia, Canada, the UK, and the US. The table provides a high-level summary of how each model fares against the factors set out above, that is, the effectiveness of the model (based on available research and evaluations), the provider model used (whether government, NGO, or private), the role of the caregiver (whether employed or a volunteer), and some of the observed limitations of the model in its application to New Zealand.

The models covered are not exhaustive. Criteria used to determine the types of models explored were:

- developed and implemented in one of the agreed jurisdictions of interest
- available independent, peer-reviewed research
- a model or programme that is manualised and able to be replicated
- where possible, had been delivered to indigenous populations
- targeted at children and young people with identified high and complex needs.

The following tables provide an overview of models assessed and included in Table 5 from Australia (Table 1), Canada (Table 2), the UK (Table 3), and the US (Table 4).

Table 1. Overview of Australian specialist caregiving models

Model	Overview
Treatment and Care for Kids (TrACK) Program	TrACK is an intensive therapeutic foster care programme. The specialised training for carers includes material on the neurobiology of trauma and brain development, and a suite of responses to trauma-based behaviours. Care teams include a therapeutic specialist, a social worker or psychologist, and a case manager, who is a foster care social worker employed by the partner agency. May include other specialists as required (for example, health, medical and educational).
Circle Therapeutic Foster Care Program or Circle Program	A therapeutic specialist supports caregivers as part of the Circle Program. 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. Brokerage funds are provided to carers as part of the programme.
NSW Therapeutic Care Framework (TCF)	Guidance on supporting children and young people, based on trauma-informed care.[3]
Children safe, family together (Northern Territory)	The model aims to transition family and kin care service delivery to Aboriginal community-controlled organisations (ACCOs). The model includes: – family finding and mapping, and assessment of carers – family-led decision making – family care team – relevant training specific to needs of placement – children have regular face-to-face contact with family and friends.

[3] Trauma-informed care is a way of working that recognises the potential of people to heal despite traumatic experiences. It involves an understanding of the pervasive nature of trauma and how it affects people's lives. It's about building on people's strengths and relationships to support healing.

Model	Overview
Hope & Healing Framework for Residential Care (Queensland)	Guidance which provides common practice principles which apply across all types of residential care and all cohorts of children and young people (Queensland Department of Child Safety, Youth and Women et al., 2019). The therapeutic approach focuses on relationships, connections, emotional know-how, and positive identity (Queensland Department of Child Safety, Youth and Women et al., 2019).
Hope & Healing Framework for foster carers (Queensland)	Adaptation of the Hope and Healing Framework for Residential Care (HHFC, above) to meet the needs of foster carers. E-learning training which is also linked to the Queensland Department of Children, Youth Justice and Multicultural Affairs mandatory training requirements for approved foster carers. The e-learning training provides carers with appropriate strategies and tools to respond to the impacts of trauma on children and young people in their care.
Lighthouse Foundation therapeutic family model of care (TFMC™) (Victoria)	Family-style environment with up to four young people and therapeutically trained carers who share the home with them. The model focuses on the young person feeling safe and secure in the Lighthouse home. The homes are near each other, with each cluster consisting of five homes in a local area. A committee of community volunteers are attached to each home, providing a sense of community support.
Hurstbridge Farm (Victoria) now statutory Therapeutic Residential Care	The original farm includes two residential houses, a school, administrative offices, farm equipment sheds, and two homes. A land and animal care worker is employed to manage the agricultural activities and to support young people's involvement in those activities. The farm can accommodate eight children and young people in total (ACT Government, 2022). The other sites generally work with four young people. Essential elements of the model include (McNamara, 2015 as cited in Oranga Tamariki, 2020): – trained staff, and consistent rostering – engagement and participation of the young people – care team meetings, and a therapeutic specialist – whole-of-organisation commitment, effective governance – physical environment – exit planning and post-exit support.

Model	Overview
Victorian Aboriginal Child Care Agency (VACCA) model	The VACCA model incorporates key elements of mainstream models of care, with connection to culture as the core focus. The model includes: – a home environment with 24/7 live-in support with residential care workers – therapeutic care – case management – education support – cultural identity support – support for children, including sibling groups.
Parkerville Our Way Home (Western Australia)	Four components of the model are (Parkerville, 2023): – personalised support – care and connection plan – Family Link worker: responsible for facilitating connection with family and children, but also with staff. – The Mundahring Baldja: A centre that undertakes the whole caregiver pathway process, from recruitment to training.

Table 2. Overview of Canadian specialist caregiving models

Model	Overview
Vancouver Aboriginal Child and Family Services Society (VACFSS) inclusive care	This model focuses on stronger cultural and relational connections. The model of care includes cultural knowledge, teachings, ceremonies, and language that are held by, and particular to, each indigenous community (Oliver, 2020).
British Columbia Extended Family Program (EFP)	It intends to fill some of the gaps identified in kinship care by: – increasing the rigor of caregiver assessment – increasing funding and support for kinship carers – increasing consistency between kinship and foster care services. Working as a team, the family and social worker develop a plan for the child or youth that outlines the services and supports that are needed. A social worker reviews the EFP agreement every three or six months.

Model	Overview
Therapeutic Family Care Program (TFCP)	Children receive services in one of three specialised, clinical programmes: – Therapeutic Foster Home Program (TFHP): Services are provided by specially trained treatment foster parents referred to as parent therapists. The child lives in a community with the parent therapist family. A multidisciplinary team wraps around family for support. – Clinical Services Support Program (CSSP): Children and caregivers are supported via direct and intensive services from a multidisciplinary clinical team. – Mixed Modality Program (MMP): A hybrid between traditional treatment foster care programmes and staff modeled settings. The treatment foster parent and child are viewed at the centre, and treatment is intensively supported by care staff.

Table 3. Overview of UK specialist caregiving models

Model	Overview
Looked-after children and young people (NICE guideline, 2022)	The recommendations in the guideline represent the view of the National Institute for Health and Care Excellence (NICE) and are based on the evidence available. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian. The guidelines emphasise therapeutic, trauma-informed parenting (covering attachment-informed, highly supportive, and responsive relational care).
Multidisciplinary Intervention Service Torfaen (MIST)	The intervention is a community and family-based alternative to residential care for children with complex mental health needs. The MIST team engages with up to 20 young people at any one time. Caregivers are termed Therapeutic Foster Carers. MIST trains, supervises, and supports foster carers, and provides 24-hour on-call support.

Model	Overview
Secure Base model	Stresses five dimensions of caregiving as important ingredients for secure attachment: – availability, which assists the child in developing trust – sensitivity, helping a child or young person manage their feelings and behaviour – acceptance, building their self-esteem – co-operation, helping young people to feel effective – family membership, helping children to belong. Originally used as a tool for analysis of a longitudinal study of growing up in foster care, it developed to become a framework for practice.
Fostering Connections: the trauma-informed foster care programme (Ireland)	Trauma-informed education for foster carers. The model is underpinned by a comprehensive manual. Training is facilitated by two trained practitioners and one trained foster carer over six weeks (six sessions of 3.5 hours each) in a community setting (Lotty et al., 2022). The training uses experiential exercises, videos, demonstration role-play, discussion, and at-home exercises. Foster carers receive a toolkit and a homework copybook.
Scotland Standard for Foster Care	The Standard for Foster Care established a framework for the learning foster carers need to undertake for the foster carer role, and to support a realistic level of standardisation and consistency in the ways learning is provided and used. The Standard is not a qualification in its own right; and the Scottish Government has made it clear that a formal qualification will not be mandatory for foster carers.

Table 4. Overview of US specialist caregiving models

Model	Overview
Treatment Foster Care Oregon (TFCO) or Multidimensional Treatment Foster Care (MTFC)	The youth is placed with a professionally trained foster family, and a clinical team is formed around the youth and their birth family. The clinical team consists of: – a case manager – a family therapist – an individual therapist – a skills trainer, and – a parent daily report (PDR) caller. The model focuses on helping youths develop positive relationships with the adults around them (NICE, 2021a).
The Sanctuary Model	The model is implemented organisation-wide and includes creating and maintaining an environment that understands how children deal with trauma. A therapeutic team is provided. The model generally places groups of four to six young people together in a residential facility (James, 2017; McNamara, 2015 as cited in Oranga Tamariki, 2020).
Keeping Foster Parents Trained and Supported (KEEP) foster-parent training intervention	A 16-week group-based parent training programme for foster and kinship parents of children (KEEP Standard) and teenagers (KEEP SAFE). KEEP aims to increase the parenting skills of foster and kinship carers. KEEP is delivered both in-person and virtually to groups of 7 to 12 foster or kin parents. It also involves weekly 10-minute phone calls to individual foster or kin parents.
CARE (Children and residential experiences) model	A whole-of-organisation approach based on six core principles, (a) relationship based, (b) trauma-informed, (c) developmentally focused, (d) family involved, (e) competence-centred, and (f) ecologically oriented (Bailey et al., 2019; CEBC, 2020b). CARE model works with 6- to 20-year-old children and youth living in group and residential care settings.
Pressley Ridge Treatment Foster Care Program (PR-TFC)	Intensive, short-term treatment of youth with emotional and behaviour problems in a home environment with the foster parent as the primary agent of change. Treatment foster parents are given advanced clinical and technical training and support.

Model	Overview
Teaching-Family Model (TFM)	The Teaching Family Model works with six to eight youths living in small group homes (Oranga Tamariki, 2020). Treatment is typically delivered by married couples in a family-style living and learning environment. The "teaching parents" are also involved with children's parents, teachers, and other support networks to help maintain progress. The model includes a set of standards and competencies that teaching parents must maintain. The standards are attained through a certification process supported by the Teaching-Family Association.
Simply Smiles Children's Village	The model supports Native American children to remain with kin and community. The Children's Village has three four-bedroom homes, a dedicated counseling building, and a garage and storage building. Foster parents are provided with extensive training and are supported by cultural programmes and mental health support workers. Foster parents are provided with housing, salary, and benefits.

Appendix 1 provides further detail on each model, by jurisdiction.

Table 5. Summary of specialist caregiving models

		Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements
KEY	●	Well supported by quality evaluations	Direct government-funding and delivery	Indigenous-led	Qualification	Care team Extensive support	Salary-based	Employed
	●	Some support	Government funded. Delivered by providers	Applied to indigenous populations, indigenous co-design	Specialised training	Some support	Additional funding sources	Contractor
	○	No evaluative evidence. Initiative in its infancy	Private funding and delivery	Untested / unknown	No training	No support services	State-based reimbursement	Volunteer

	Model	Key features	Duration	Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements	Limitations
Australia	Treatment and Care for Kids (TrACK) Program	Trauma-informed and relationship focused care. In home.	Placement	●	●	○	●	●	○	○	Not indigenous-led.
	Circle Therapeutic Foster Care Program or Circle Program	Individually tailored care teams. Training in trauma and attachment. In home.	Placement	●	●	●	●	●	●	○	Single evaluation.
	NSW Therapeutic Care Framework (TCF)	Trauma-informed care guidance. In home or residential.	System-wide	○	●	●	●	●	○	○	No evaluative evidence.
	Children safe, family together (Northern Territory)	Aboriginal-led development and delivery. In home.	Placement	○	●	●	●	●	●	○	No evaluative evidence. Model in infancy.
	Hope & Healing Framework for residential care (Queensland)	Trauma-informed, needs-based, framework. Residential care.	Placement	○	●	●	●	○	●	●	No evaluative evidence. Model in infancy.

	Model	Key features	Duration	Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements	Limitations
	Hope & Healing Framework for foster carers (Queensland)	Trauma-informed, needs-based, framework. In home.	While caregiver	○	●	●	●	○	○	○	No evaluative evidence. Model in infancy.
	Lighthouse Foundation therapeutic family model of care (TFMC™) (Victoria)	Attachment theory, trauma-informed practice, and psychodynamic psychotherapy[4]. Residential.	18 – 24 months	○	○	○	●	●	●	●	No evaluative evidence. Not indigenous-led.
	Hurstbridge Farm (Victoria) now statutory Therapeutic Residential Care	Based on theories of attachment and trauma, neurobiology of brain development, and resilience. Residential.	18 – 30 months	●	●	●	●	●	●	●	No recent evaluative evidence.
	Victorian Aboriginal Child Care Agency (VACCA) model	Trauma-informed, and strengths-based care philosophy. Cultural pillars. Residential.	Unknown	●	●	●	●	●	●	●	No evaluative evidence.
	Parkerville Our Way Home (Western Australia)	Tailored support. Relationship-based, cultural safety, values-based. Residential.	Placement	○	●	●	●	●	●	●	Model in infancy. No independent evidence.
Canada	Vancouver Aboriginal Child and Family Services Society (VACFSS) inclusive care	Strengthen kinship and culture through shared care. In the home.	While caregiver	○	●	●	●	●	○	○	No evaluative evidence. Little information available on the model.

[4] Psychodynamic theory states that events in our childhood have a significant influence on our adult lives, shaping our personality. Psychodynamics focuses on the interrelationship of various parts of the mind, personality, or psyche as they relate to mental, emotional, or motivational forces, especially at the unconscious level.

	Model	Key features	Duration	Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements	Limitations
United Kingdom	British Columbia Extended Family Program (EFP)	Planning and support for kinship carers and the child they care for. In the home.	Duration of placement	○	●	○	○	○	○	○	No training offered. Evaluation not supportive. Not indigenous-led.
	Therapeutic Family Care Program (TFCP)	Dyadic developmental psychotherapy.[5] In the home.	6 – 9 months	◐	◐	○	◐	●	○	○	Not indigenous-led. Single evaluation.
	Looked-after children and young people (NICE guideline, 2022)	Guidance. Therapeutic, trauma-informed parenting. Residential and in the home.	System-wide	○	◐	○	◐	◐	○	○	Not indigenous-led. Non-mandatory guidance.
	Multidisciplinary Intervention Service Torfaen (MIST) (Wales)	Attachment theory. Care team. In the home	While caregiver	◐	◐	○	◐	◐	○	○	Not indigenous-led.
	Secure Base model	Attachment theory. In the home.	Pre-approval training	○	◐	○	◐	○	○	○	No evaluative evidence. Not indigenous-led.
	Fostering Connections: the trauma-informed foster care programme (Ireland)	Foster carer training Trauma-informed care educational intervention	6 weeks in a community setting	◐	◐	○	◐	○	○	○	Not indigenous-led. Model in infancy. General caregiving.
	Scotland Standard for Foster Care	Trauma-informed, whole family support. In the home.	While caregiver	○	◐	○	◐	◐	○	○	Model in transition. Not indigenous-

[5] Dyadic developmental psychotherapy is based on a theoretical understanding of the reciprocal nature of communication and experience between two people, and the impact of developmental trauma.

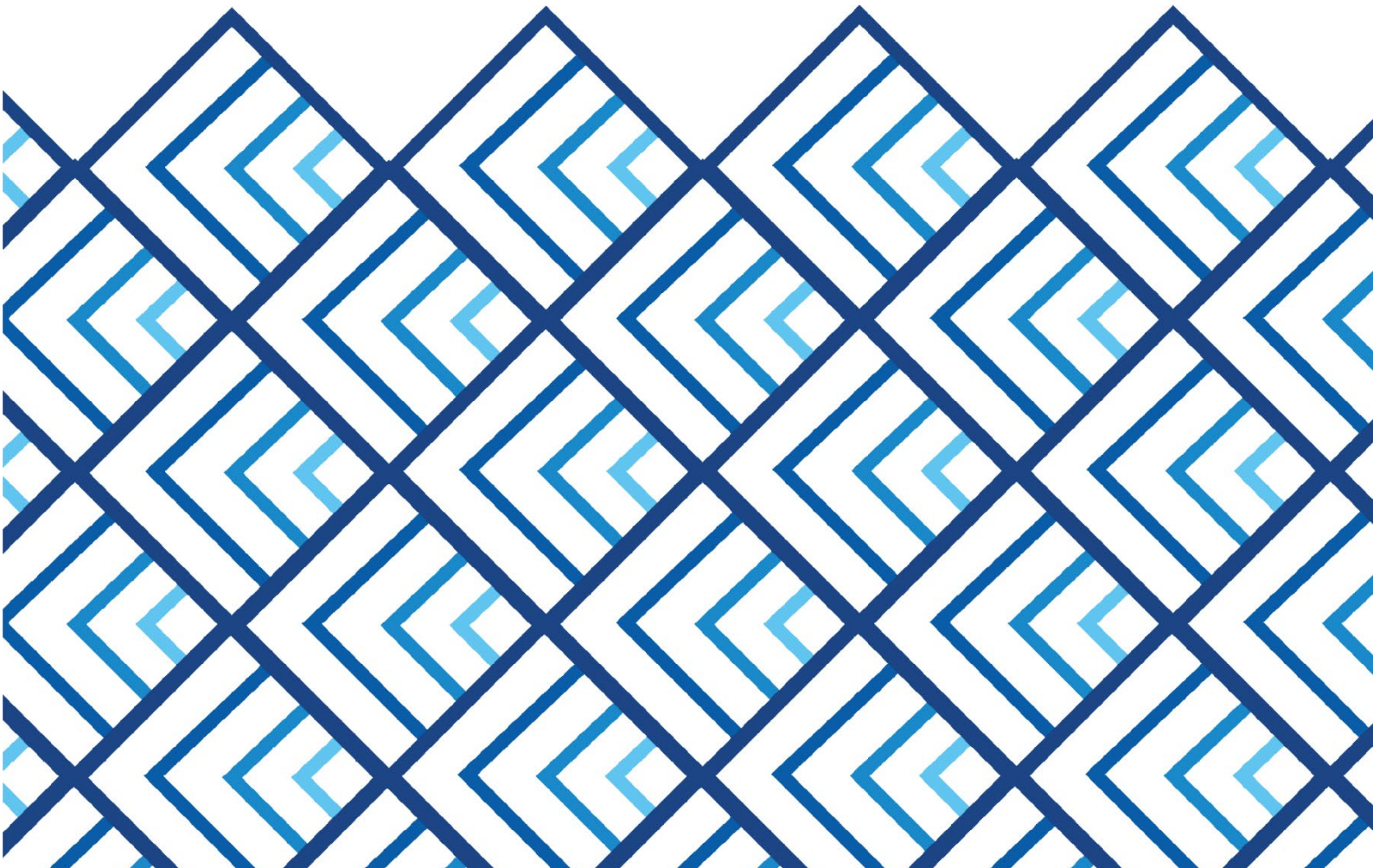
	Model	Key features	Duration	Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements	Limitations
											led. General caregiving.
United States	Treatment Foster Care Oregon (TFCO) or Multidimensional Treatment Foster Care (MTFC)	Based on learning theory, the need for structure and routine, and reinforcement of positive behaviours. In the home.	6 – 9 months	●	●	○	●	●	◑	○	Not indigenous-led. Financial support depends on service provider.
	The Sanctuary Model	Trauma-informed organisational change model. Residential care.	Ongoing	●	●	●	●	●	●	●	Not indigenous-led. Australian model includes cultural safety pillar.
	Keeping Foster Parents Trained and Supported (KEEP) foster-parent training intervention	16-week group-based parent training programme. In the home.	16-week training programme	●	●	○	●	○	○	○	Not indigenous-led.
	CARE (Children and residential experiences) model	Organisation-wide: trauma-informed, developmentally focused, family-involved, competence-centred. Residential.	3 years to establish	●	●	○	●	●	●	●	Training provider in US. Not indigenous-led.
	Pressley Ridge Treatment Foster Care Program (PR-TFC) pre-service curriculum	Training based on social learning theory[6], behaviourism,[7] and trauma-informed care. In the home.	6 to 8-week training programme	●	●	○	●	○	○	○	Not indigenous-led. Pre-service curriculum effective, but overall model

[6] Social learning theory is a psychological theory which suggests that social behaviour is learned by observing, imitating, and modelling the behaviour of others.
[7] Behaviourism focuses on the idea that all behaviours are learned through interaction with the environment, and that innate or inherited factors have very little influence on behaviour. Behaviours are acquired through conditioning processes.

	Model	Key features	Duration	Effectiveness	Funder and delivery	Indigenous-led	Qualifications and training	Support services	Financial support	Industrial arrangements	Limitations
											unable to be rated.
	Teaching-Family Model (TFM)	Proactive teaching interactions focused on positive prevention and youth skill acquisition. In the home or residential.	While caregiver	●	●	○	●	●	○	○	Not indigenous-led.
	Simply Smiles Children's Villages	Trauma-informed approach. Purpose built village. Residential in family-like home.	While caregiver	○	●	●	●	●	●	●	Model in infancy. No evaluative evidence.

Design principles for specialist caregiving

For Aotearoa New Zealand



Design principles for a specialist caregiving model for Aotearoa New Zealand

Design principles provide a way of comparing various factors to ensure the preferred option(s) meet the objectives or outcomes that are intended to be achieved. Ultimately it is necessary to consider options in the round, balancing the different elements and perspectives to find an option that best achieves the design principles and the intended outcomes.

The literature suggests that there could be a set of design principles to apply to determine a specialist caregiving model that would be effective and efficient in New Zealand (Figure 5). Design principles include considerations that are context specific and demonstrate good practice.

The following discussion introduces each design principle and applies them to some of the models presented in this evidence brief. The design principles could also be applied to the design of a new specialist caregiving model for the future.

Figure 2. Design principles for a specialist caregiving model for New Zealand

By Māori, for Māori	Systems and processes are connected to Māori philosophy and principles (Te Ao Māori), Māori tikanga and processes are followed, and Māori, whānau, iwi, and hapū lead its development and implementation. The validity and legitimacy of Māori, and the importance of Māori language, culture and values is paramount.
Evidence-based	To what extent is there the research and evaluative evidence available to back up the effectiveness of the model in achieving its intended outcomes.
Comprehensive	Applicable to the entire cycle of model implementation, that is, from recruitment to monitoring and evaluation.
Congruence and system fit	Does the model create inconsistency or questions of fairness or inequity amongst cohorts of carers? Would the model fit in well with the spectrum of care offered in New Zealand? Are there implications for the broader workforce or care system?
Value for money	*Effective* in achieving the intended outcomes desired from a specialist caregiving model *Efficient* by minimising wasted effort and expense *Economic* with costs being proportional to outputs.

By Māori, for Māori: does the model enable rangatiratanga and whanaungatanga?

Over the past decade, tamariki Māori have accounted for more than half of all children entering care (Oranga Tamariki Evidence Centre, 2021). Oranga Tamariki recognises that in order to reverse these trends, it will need to be "an enabler and coordinator for Māori and communities, to put in place the support, the solutions, and the services they know will work for their people" – as set out in the Oranga Tamariki (2022a) *Child and youth wellbeing strategy*. The Oranga Tamariki *Future direction plan* also accepts that in order for this role to be performed, resources and service delivery will be need to be transferred to partners/communities (Oranga Tamariki, 2022a).

A significant limitation of many of the models explored in this evidence brief is that they are not indigenous-led, or indigenous communities have not been a significant part of the creation or delivery of the models. Only three models have been developed from an indigenous lens: Children Safe, Family Together in Northern Territory, Victorian Aboriginal Child Care Agency (VACCA) model, and Vancouver Aboriginal Child and Family Services Society (VACFSS) inclusive care. These models have not been assessed for effectiveness through a Western or indigenous evaluation framework. However, there are elements of the models which are instructive for Aotearoa.

Children Safe, Family Together was developed by an Aboriginal community-controlled organisation. Children Safe, Family Together seeks to do for the Northern Territory, much of what is sought in New Zealand for Māori (TCAC, 2019):

- transform out-of-home care
- reverse the over-representation of Aboriginal and Torres Strait Islander children in the care and protection system
- honour the primacy of family and kin
- ensure the continued connection of Aboriginal and Torres Strait Islander children to language, land, and culture
- transition family and kin care service delivery to Aboriginal community-controlled organisations
- increase the decision-making power of Aboriginal children, families, communities, and organisations in relation to the care and protection of Aboriginal children.

Children Safe, Family Together was developed by the Tangentyere Council Aboriginal Corporation (TCAC), an Aboriginal community-controlled organisation (ACCO), with the advice and support of the Victorian Aboriginal Child Care Agency (VACCA). The model arose from:

- Data from consultations with Northern Territory-wide stakeholders in the out-of-home care sector, including on the principles and elements that should underpin the model.
- A literature review.
- Three family and kin care pilot programmes.
- Data from the voices of children in care collected by CREATE Foundation (an association which represents the voices of children and young people with an out-of-home care experience.
- Data from informal readings and the expertise of the project team.

A key focus for the model is increasing Aboriginal and Torres Strait Islander self-determination and community control, which are reflected in the stated anticipated outcomes of the model (TCAC, 2019) (Example 1). This has parallels with Māori and the value of rangatiratanga.

Example 1. Anticipated outcomes from Children Safe, Family Together

- A significant increase in the number of placements in line with the Aboriginal and Torres Strait Islander Child Placement Principle[8]
- A significant increase in the number of Aboriginal and Torres Strait Islander children in OOHC that are placed locally with family, and have a safe and stable placement
- A significantly increased level of retention of Aboriginal family and kin carers over time
- Increased community control of all decision-making processes related to potential and actual family and kin care placements
- Increased availability of targeted and tailored on-community support for Aboriginal and Torres Strait Islander carers in the Northern Territory to improve their effectiveness in providing care
- An increased knowledge and awareness in the community about family and kin care and the child protection system
- Strengthened relationships between TF and ACCOs
- Increased pool of Aboriginal general carers.

Source: Tangentyere Council Aboriginal Corporation (2019)

The Intensive Response (IR) approach, developed by Oranga Tamariki with Māori and Pacific organisations and the wider community sector in 2020, is an example of an indigenous-led approach to service delivery development and implementation. IR is currently delivered in four locations, with more coming online: Otāhuhu, Tokoroa, Horowhenua, and Ōtautahi (Christchurch East) (The Knowledge Institute, 2022a). IR seeks to:

- Develop partnerships with iwi, Māori and Pacific organisations and the wider community sector to design, develop and implement wraparound support for tamariki and their whānau.
- Support locally led solutions that reflect the needs and contexts of local whānau, hapū, iwi and community.
- Further develop and strengthen the relationships of local Oranga Tamariki offices with local Māori, Pacific, and community agencies.

[8] The Aboriginal and Torres Strait Islander Child Placement Principle aims to keep children connected to their families, communities, cultures, and country, and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children's care and protection. It centres on five elements: prevention, partnership, participation, placement, and connection.

Though in its infancy, specific models have not yet arisen from the IR approach. However, it is likely to lead to specialist caregiving models that are "by Māori, for Māori". Evaluative work to date has identified six principles of partnering that may be a valuable guide for Oranga Tamariki in future partnerships with Māori, iwi, and community organisations (The Knowledge Institute, 2022b), and in developing and implementing specialist caregiving models:

– build and strengthen the foundations of relationships; this is fundamental to ongoing partnering
– acknowledge and respond to the context and whakapapa of relationships
– resource the aspirations of your partner
– don't make assumptions
– take the time it needs
– partnering is a relationship process rather than a destination. Long term commitment and sustainable organisational structures are required to maintain these relationships over time.

Whakapapa and relational connections are valued and foundational to the IR approach (Goodwin et al., 2022). For Māori, particularly Māori working within Oranga Tamariki, IR has become an opportunity to support tamariki and whānau in the way they have wanted to for a long time but were unable to because of system constraints (Goodwin et al., 2022). Cultural connectedness, cultural safety, and cultural humility have been identified as key foundations of any programme with indigenous communities (Oliver, 2020; Rides At The Door & Trautman, 2019).

Māori have responded to IR through Māori ways of working that are relational, culturally bound, and whānau-centred. Additionally, IR has created space for Oranga Tamariki staff to bring their mātauranga and tikanga to the fore, in the interests of tamariki and whānau Māori (Goodwin et al., 2022).

A family finding and mapping service is a key element of locating and recruiting appropriate carers

There are 15 elements to the Children Safe, Family Together model that are necessary to ensure a sustainable, self-determined, and culturally strong family and kin care service can be provided to Aboriginal children and Aboriginal carers. There are four elements, in particular, that are worth considering in the New Zealand context: child family finding and carer recruitment, carer assessment, carer approval, and carer support and training.

In the model, the family finding and mapping process ideally starts when a child is at risk of entering out-of-home care. The process is largely performed by care workers within an ACCO in collaboration with children, their families, and local cultural authorities or elders as appropriate. In some cases, local cultural authorities may be best placed to provide direction on who is best placed to provide care for a child or have possible leads for potential carers (TCAC, 2019).

This approach has also been replicated in Victoria, which has an Aboriginal Kinship Finding Service, delivered by VACCA in partnership with the First Nations Legal and Research Services and the Koorie Heritage Trust (ACT Government, 2022). The service establishes a genealogical database to support early kinship carer

identification, as well as connections to family, community, and culture for children in care.

Oranga Tamariki's existing Whānau Care partnerships follow a similar approach. Through 15 Whānau Care partnerships, Oranga Tamariki assigns responsibility for day-to-day care and support of tamariki to a Whānau Care partner, which includes facilitating connection to their whakapapa and whānau. Whānau Care partners are iwi-mandated or kaupapa Māori organisations. By 30 June 2022, these partnerships had recruited over 200 caregivers (approved or in the process of approval). According to iwi affiliation data, 71% of the current tamariki Māori in care will have whakapapa connections to these Whānau Care partners, once fully operational (Oranga Tamariki, 2022b).

Evidence-based: Is there consistent research that supports the effectiveness of the model?

The Oranga Tamariki evidence brief on therapeutic care models concluded there is currently insufficient evidence to support one particular model over another (Oranga Tamariki Evidence Centre, 2020). However, therapeutic resident models tend to draw on evidence-informed models that are effective, articulated in policy and practice, and are replicable (McLean, 2018, 2019). Further research is required of models in different contexts and jurisdictions, the extent to which they achieve long-term outcomes, and what specific aspects of models are critical to success.

The models of specialist caregiving reviewed in this brief shows that there is more evidence for some models over others in terms of achieving long-term outcomes like placement stability, attachment to family and friends, and behaviour improvements. The following models had the most evidence of achieving medium- and longer-term outcomes, for children and caregivers:

- Delivered in the home:
  - the Treatment and Care for Kids (TrACK) Program
  - Treatment Foster Care Oregon (TFCO)
  - Pressley Ridge Treatment Foster Care Program (PR-TFC) pre-service curriculum
  - Teaching-Family Model (TFM).
- Residential:
  - CARE (Children and residential experiences) model
  - Teaching-Family Model (TFM).

However, none of these models have been indigenous-led. Nor do they have documented evaluations in the context of indigenous families and children. TrACK, TFCO, and TFM are all currently available in Australia. However, further research and evaluation is required on the extent to which they can be implemented successfully and lead to long-term outcomes, particularly for indigenous children and carers.

Moore et al (2016, as cited in Oranga Tamariki, 2020) reminds us that while models and interventions need to be evidence-based, the way that environments are formed, and the context in which they are delivered, are just as important. Effective relationships between all (children/young people, carers, care team, and so on)

should be a focus of service system design, organisational structures, job descriptions, recruitment and selection, and professional development.

Indigenous-led specialist caregiving models are in their infancy; the evidence-base for their effectiveness is not yet available

In general, indigenous-led models have mostly been developed or implemented in the last few years, so evaluative evidence of their effectiveness – for children, and for carers – is not yet available. For example, the Simply Smiles Children's Villages only began in South Dakota, US, in 2020 and is currently in an operational pause while it seeks to transition to an indigenous-led approach (Simply Smiles, 2023). However, some of the models that have been co-designed with the indigenous community are showing promising results. In New Zealand, both Training and Development for Caregiving Whānau (TDCW) pilot programmes and Tāne Whakapiripiri Care Support Model (CSM) have undergone early evaluations which support their continued delivery (Rowland et al., 2020; SHORE & Whāriki Research Centre, 2020).

While the models are co-designed with indigenous communities, they have also been developed based on existing research about what works. For example, TDCW follows many of the critical success factors identified for successful kinship navigator programmes (Rodriguez-JenKins et al., 2021). That is, cultural and linguistic flexibility, trauma-informed approaches, opportunities for peer support and connection, and help accessing financial, physical, legal, education, and health resources.

When considering the design principle of "evidence-based" it is also important to consider what types of evidence are used and valued – particularly evidence, evaluation, and research from an indigenous values lens such as kaupapa Māori research and mātauranga Māori.

Comprehensive: The model covers all parts of the implementation and monitoring of a successful specialist caregiving programme

The ideal model(s) should be comprehensive, able to be implemented based on available documentation or manuals, and provide a framework for its delivery, as well as monitoring and evaluation. A review of the evidence for general foster care programme design highlights the following components for quality foster care programming (Keshavarzian, 2015):

- Support for, and contact with, family of origin.
- Recruitment and assessment of carers.
- Matching and placement procedures.
- Building capacity through training, supportive supervision, and mentorship.
- Support services for children in care.
- Support services for carers.
- Monitoring care placements and evaluating care programmes.
- Supporting children and young adults leaving care.

Identification and assessment of carers is a key part of a specialist caregiving model

In the New Zealand context, having an established process of recruitment and retention of carers is particularly important. The Children Safe, Family Together model as discussed previously, sets out family mapping and finding as a key part of recruiting carers, an approach shared by Oranga Tamariki's Whānau Care partnerships.

The Children Safe, Family Together model appears to be a comprehensive approach to identifying, assessing, recruiting, and supporting Aboriginal family and kin carers. Current assessment processes in the Northern Territory were considered to be culturally inappropriate and created multiple barriers to carers being approved (TCAC, 2019). It is envisaged that the model would eventually lead to ACCOs taking responsibility for the assessment process to ensure a culturally sensitive approach to assessing carers is adopted. The assessment approach would focus on what support might need to be put in place to enable potential carers to provide care, rather than focusing on current government-developed carer capacity and capability measures. Culturally appropriate and strengths-based assessment tools and approaches are to be developed and the approach will likely be more relational, storytelling-focussed, strengths-based, and flexible but thorough. Assessments would also be undertaken using the first language of the carer, and with support people or interpreters, if required.

ACCOs would be provided with training and support to develop assessment capacity, and risk mitigation, and safety and support planning would also be a key part of the assessment process. This would be state government funded and may mean the secondment of Oranga Tamariki-equivalent staff, and/or employing senior staff to drive the assessment process and build capacity and capability of other ACCO staff.

The model recommends the implementation of an assessment tool derived from the Signs of Safety Framework (TCAC, 2019). Signs of Safety is a collaborative, relational approach, and incorporates family-level decision making. It assesses relative risk levels with an aim to draw on existing strengths and protective features whilst also building in support for families and children. It also works to enable children to have a clear voice in decision-making. It is flexible and conversational, but considered to also be thorough in its risk assessment (TCAC, 2019).

The model proposes that all assessment forms including the Home Environment Safety Check assessments be reviewed and redeveloped jointly by the Department of Territory Families, Housing and Communities (TF) and ACCOs to ensure they are relevant and accessible. Currently the formal "authorisation" of carers rests with TF. The model proposes that as capacity is built, delegation of this responsibility will be transitioned across to sit with ACCOs.

Intensive, ongoing training, and minimum qualifications for residential care workers, are two trends in the specialist caregiving landscape

Specialist caregiving models tend to be more "manualised" (and evidence-based) and set out specific competencies that caregivers must achieve. Achievement is part of the overall certification and approval process, allowing the specialist caregiver to take on children –often who have had placement instability and high and complex needs. The TFCO model states that specialised foster carers must complete 16 hours of compulsory foster care training (OzChild, 2023). The training prepares carers for the day-to-day responsibilities and challenges and provides parenting techniques. Once approved and a placement has been made, daily calls, weekly team meetings, and 24/7 access to specialists complement the training.

Other specialist caregiving models require even more training, for example, the Pressley Ridge (PR-TFC) pre-service curriculum has 30 hours of training, with 12 units in the curriculum. Integrated multimedia resources within the curriculum include slides, video vignettes demonstrating therapeutic skills taught during training, and role plays (CEBC, 2022). There are also homework and reading assignments.

More and more intensive training has been developed for general caregiving. For example, the Oranga Tamariki Training and Development for Caregiving Whānau (TDCW) programme delivery has a kaupapa Māori and te ao Māori focus but is delivered within a general caregiving model. Providers deliver this training programme through a variety of modes and frequency (SHORE & Whāriki Research Centre, 2020):

– training modules run over 4 weeks (one 6-hour day)
– a 5-week, 4 hours per week programme; or a 10-week, 3 hours per week programme (evening and morning sessions); or a 2-day intensive training
– 10 sessions, 1 morning per week for 10 weeks.
– training modules over 5 weeks (one 6-hour day).
– structured, 5-weekend wānanga
– 11 modules, over 8 wānanga (2 one-day training), as well as online learning.

A literature review of general out-of-home care training in Australia found that foster carers were provided with the most comprehensive and quality training of all types of carers, and standards decreased for kinship carers, lower again for adoptive parents, to almost none for guardians (Institute of Open Adoption Studies, 2019). In adopting models to the New Zealand context, it will be important to ensure both kin and non-kin carers receive the same training and support.

In Scotland, care standards have been established for all foster carers (SSSC, 2017). In England, the National Institute for Health and Care Excellence (NICE) looked-after children and young people guidelines recommend that agencies and departments provide a schedule of mandatory training for carers and recommended topics that should be covered (NICE, 2022). While the care standards and guidelines do not call for mandatory qualifications (and the Scottish Government has explicitly stated that qualifications will not be a requirement to be a caregiver), they are aligned with the qualification skills frameworks, should carers decide to pursue a qualification (SSSC, 2017). The Scottish Independent Care Review has stated that the care system should not require qualifications in order for carers to receive caregiver (financial) support (Independent Care Review, 2020b).

Carers in specialist caregiving models often have relevant experience and qualifications, but, in general, qualifications are helpful but not mandatory. For example, TFCO carers often have experience, and related qualifications, in dealing with children or young people with complex behaviours (Kirkham, 2023; OzChild, 2023). In some cases, specialist caregiving models elevate carers to a higher status, for example, making sure they are integral to the care team and have similar training support as other staff members. Carers reported feeling more empowered and felt that this approach professionalised their role, without necessarily having specific qualifications attached (see for example, the Circle Program (Frederico et al., 2017), and MIST (Smallman et al., 2017; Street et al., 2009).

At Children's Wisconsin in the US, an independent health care and social services system for children, specialist caregivers are required to have a minimum of a high school diploma or the equivalent, but a college, vocational, technical, or advanced degree in the area of a child's treatment needs, such as nursing, medicine, social work, or psychology, can be used as one of at least four qualifiers (Example 2).

Example 2. Treatment foster care licensing requirements

… if you are applying for a Level 3 license (moderate treatment foster care) you must possess at least three of the following, Level 4 (specialized treatment foster care) applicants must possess at least four):

a) A minimum of one year of experience as a foster parent or kinship care provider with a child placed in his or her home for at least one year.
b) A minimum 5 years of experience working with or parenting children.
c) A minimum of 500 hours of experience as a respite care provider for children under the supervision of a human services agency.
d) A high school diploma or the equivalent.
e) A college, vocational, technical, or advanced degree in the area of a child's treatment needs, such as nursing, medicine, social work, or psychology.
f) A substantial relationship with the child to be placed through previous professional or personal experience.
g) Work or personal experience for which the applicant has demonstrated the knowledge, skill, ability, and motivation to meet the needs of a child with a level of need of 3.

*Note: If an applicant for certification to operate a Level 3 or 4 foster home relies on experience that meets the requirements of b. or f. as one of the required criteria above, the applicant shall also meet one of the criteria in a., c., e., or g.

Source: Children's Hospital of Wisconsin (2023)

Some Australian states have moved towards minimum qualifications for residential care workers (ACT Government, 2022):

– Since 1 July 2018, the Department of Children, Youth Justice and Multicultural Affairs have worked with PeakCare Queensland to begin phasing in new standards outlining the minimum qualification expectation for all residential care staff working in Queensland. The minimum qualifications standards require that

residential care workers obtain a minimum qualification of Certificate IV level from an approved list (PeakCare Queensland, 2023a).
– In 2018, Victoria instituted minimum qualifications for residential care workers, requiring a Certificate IV in Youth and Family Intervention and including a mandatory unit on trauma, or holding a recognised equivalent qualification in combination with a short top-up skills course (ACT Government, 2022; McNamara, 2023).

Cross-agency wraparound support services for carers, and children in care, are needed

Support for those in care usually requires funding and services from multiple government agencies – child wellbeing, health, education, housing, social development, and justice. For carers, this means that they may have to interact with many different agencies. Responsibilities between agencies may be blurred and it can be difficult to navigate the support available to those in their care, as well as support for themselves.

Some of the specialist caregiving models reviewed have sought to streamline interactions through formalised agreements. For example, the Children Safe, Families Together model has (TCAC, 2019):

– formalised agreements between ACCOs, Department of Territory Families, Housing and Communities (TF) and Department of Housing and Community Development to fast track any necessary repairs, home modifications or new housing arrangements necessary for the approval of family and kin carers
– memoranda of understand that will formalise caveats between TF, the Police and ACCOs which allow for the preliminary screening checks to be fast-tracked.

In Victoria, Australia, an education partnering agreement, *Out-of-home care education commitment*, between health, education, and child welfare agencies and organisations (including VACCA) targets better outcomes for children in care, including therapeutic residential care (Department of Health and Human Services et al., 2018; McNamara, 2023).

However, in general, there are few specialist caregiving models that specifically consider support from a cross-government perspective, or has research which comments on the success, or not, of these types of initiatives. One model, which is not specifically a caregiving model, shows how information sharing protocols and close working relationships between government agencies can support residential and educational care and outcomes – Wiltja Boarding.

Wiltja Boarding is a programme initiated and governed by Aṉangu for the benefit of their children and communities (Wiltja Boarding, 2022). The Aṉangu Pitjantjatjara Yankunytjatjara Lands (APY) cover over 100,000 square kilometres in north-western South Australia and extend over the Northern Territory boarder. The APY Lands is home to approximately 2,500 people from a variety of communities (Seymour & Guerin, 2018). Wiltja (the Pitjantjatjara word for shelter) Boarding is a product of Aṉangu elders who in the 1970s saw that relocation of students from the lands to Adelaide as a potential solution to some of the problems with remote education. The

education programme itself was officially established in 1990 at an Adelaide high school.

Wiltja Boarding is resourced by the South Australian Department for Education (DfE), and the Commonwealth supports students' boarding costs via the ABSTUDY programme administered by Services Australia (Wiltja Boarding, 2022). Operational control of education in APY was provided to Aṉangu by the DfE in the 1980s. In addition, the Pitjantjatjara Yankunytjatjara Education Committee (PYEC) was formed to represent all communities and determine the educational directions/plans for the Aṉangu Lands Partnerships schools. Anangu Lands Partnership is an educational region within DfE. Wiltja Boarding, although metropolitan based, is a formal part of Aṉangu Lands Partnerships. The PYEC is Wiltja's Governing Council.

The staff at Wiltja Boarding are youth workers and educators. The school campus and the residential campus work closely together, providing education, health and therapeutic programmes, social programmes, sports, and life skills as a holistic package. There is a close working relationship, formalised by information sharing protocols, with government agencies, such as Child and Adolescent Mental Health Services, Women's and Children's Hospital, and Families South Australia, to ensure that the children's physical and psychosocial needs are consistently addressed (Office of the Guardian for Children and Young People, 2015).

Tailored, 24-7 support for carers are features of high performing specialist caregiving models

The models outlined in this evidence brief sit across the spectrum of caregiver and care team support. Some offer no additional support, while others include a comprehensive system of peer support, 24-7 services, and intensive training. The Children Safe, Family Together model goes so far as to recommending the establishment of a bespoke service, a new Aboriginal Controlled Family and Kin Carer Support and Advocacy service (TCAC, 2019). It is intended that this service would specifically cater to the needs of Aboriginal and Torres Strait Islander carers using a cultural perspective, as well as provide culturally appropriate advocacy, support, and training to carers from diverse cultural backgrounds who are providing out-of-home care to Aboriginal and Torres Strait Islander children. This part of the model has not yet been implemented.

Key functions of this new service are to include (TCAC, 2019):
- development of a family and kin carers' network across the Northern Territory
- development and maintenance of online apps and portals which carers can access for information and resources
- development of culturally appropriate relevant training and educational resources
- development of peer-to-peer support groups, meetings, presentations, and award ceremonies
- collaboration with ACCOs delivering family and kin care services and TF to inform regional resource development
- advocacy services including virtual advocacy.

The following models include on-demand 24-7 carer support services: The Circle Program, Therapeutic Family Care Program (TFCP), Multidisciplinary Intervention Service Torfaen (MIST), and Treatment Foster Care Oregon (TFCO).

Congruence and system fit: Would the model perpetuate or create inconsistency? Is it in line with the principles of New Zealand's system of care?

The Scottish Government recently supported an Independent Care Review which resulted in a system-wide call to action, *The promise* (Independent Care Review, 2020b). A key finding from the review was the inequities encountered by kin caregivers, compared to foster caregivers, in accessing appropriate (financial) support. As mentioned previously, a review of caregiver training in Australia found disparities between training quantity and quality between foster and kin carers (Institute of Open Adoption Studies, 2019).

Does professionalisation of caregiving give rise to "deemed employment"?

Specialist caregiving models are being trialled in Australia where caregivers are required to meet a consistent set of skills. They are reimbursed for this expertise and for caring for, usually, children and young people with high and complex needs. OzChild offers the TFCO model in Victoria, Queensland, New South Wales, and South Australia. TFCO carers are provided with a carer allowance of $75,000 per annum pro rata in Victoria and NSW, and $65,000 per annum pro rata in Queensland and South Australia (OzChild, 2023). As at 2018, foster carers received an allowance of between $500 and $750 a fortnight, but the TFCO payment would mean an increase of $2,880 a fortnight ('NSW Government Plans to Recruit More Foster Carers for Vulnerable Children', 2018).

This tax-free payment is clearly stated as an "allowance". Various reviews and commentaries have identified that professional foster care models have come across issues related to tax, and health and safety at work (for example, ACT Government, 2022). In England, carers have called for more certainty as to their status. Carers are currently classified as self-employed for tax purposes, but do not have freedom of association or the ability to negotiate payment (Kirton, 2022). Other employment law concerns include the lack of employment rights; ability to receive pensions, sick, and holiday pay; are not subject to the national minimum wage; and do not have access to employment disputes pathways such as whistleblower mechanisms or reporting of exploitative employment practices.

In New Zealand, health and safety laws apply to both employees and contractors. Oranga Tamariki would need to consider how allowances and other financial arrangements, if included in a future specialist caregiving model, would give rise to obligations related to employment, or as contractors. The courts have developed some legal tests to determine whether, in this case caregivers who are provided with a generous allowance, are an employee or contractor (Employment New Zealand, 2023). While legal opinion will need to be sought, it is likely that such arrangements would effectively be "deemed employment", presenting Oranga Tamariki with significant legal considerations.

In England, a 2006 Green Paper, *Care Matters*, proposed fee payments to foster carers via a tiered structure, underpinned by a qualifications framework (including possible progression to higher education) and mandatory registration, with foster carers clearly incorporated into the children's workforce (Kirton, 2022). However, this was never implemented. There have been attempts to unionise foster carers, and to

seek worker or employee status (unsuccessfully) through the courts (Kirton, 2022). Kirton (2022) concludes that foster care policy in England has had an increasingly "anti-professionalism" stance.

In 2018, *Fostering Better Outcomes* was released by the Government in England's response to two reports on foster care and its submissions. *Fostering Better Outcomes* argued for fostering not to be professionalised due to the implications related to being employed, and that those in care felt like they were treated like a job. In Kirton's (2022) analysis of these documents, he finds no evidence to support either of these conclusions.

In Ohio, US, there have been recent discussions on the professionalisation of specialist caregiving through a tiered system with associated per diem ranges (Mighty Crow Media et al., 2020b, 2020a). Additionally, specialist caregivers are legally considered to be independent contractors who work with both public and private agencies. It has been recommended that contracting organisations consider what types of support and benefits should apply to specialist caregivers, such as, access to employee assistance programmes (EAP), and appropriate liability insurance coverage (Mighty Crow Media et al., 2020a).

The monetisation of care is a significant concern related to specialist caregiving models

There are concerns that the professional foster care model would potentially complicate the relationship between a foster carer and a child (Queensland Family & Child Commission, 2017 as cited in ACT Government, 2022; Independent Care Review, 2020b; Kirton, 2022). Indeed, even in the absence of a professional caregiving model, the Review Panel in Scotland heard from many who had been, or are, in foster care who that felt like their care was monetised (Independent Care Review, 2020b). Children felt excluded from parts of the foster family's lives, that advertising for foster carers was too commercialised and treated like a business, and that foster carers only fostered to make money out of them (Independent Care Review, 2020a, 2020b).

Previous literature reviews on financial support for carers, and its role in recruitment and retention, are mixed. While most studies find that financial support is not the most important motivator for deciding to become a caregiver, many have found that financial reimbursement is a factor in caregiver satisfaction and retention (Allen + Clarke, 2019). But other studies have failed to find a relationship between financial support and caregiver recruitment and retention (Allen + Clarke, 2019). However, studies have suggested that the low level of remuneration for caregiving is a potential barrier for new recruits (Daniel, 2011; De Wilde et al., 2019 as cited in Allen + Clarke, 2019).

In most jurisdictions reviewed, there tends to be government-run and funded caregiving – in New Zealand, this is through Oranga Tamariki, and in the UK local authorities are the delivery agency – but also a system of independent care agencies (an example in New Zealand is Key Assets). Studies have found that carers from independent care agencies are more likely to rate their payments as "much better than most", but again there was no association between satisfaction with remuneration and recruitment and retention (Kirton et al., 2006).

The Circle Program introduces a hybrid model where specialist carers are provided with state allowances as with general carers, but the programme provides "brokerage funds". These discretionary and flexible funds enabled specialist carers to support children to connect with their community – for example, through community dance classes or organised support. Where a child requires a specialist assessment (for example, speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. Focus group participants in the evaluation indicated that access to flexible funds to obtain services influenced carer retention (Frederico et al., 2017). Carers stated that it was important to be able to access discretionary funds to meet a child's needs in a timely way (Frederico et al., 2017).

Value for money: A number of specialist caregiving models have demonstrated positive social and economic benefits

With recruitment and retention of carers being a key driver of specialist caregiving models, the cost and availability of specialist carers is a significant consideration (ACT Government, 2022). Some cost benefit analyses of various models have been conducted and generally find good social and economic benefits. In general, residential care placements are considerably more costly than in-home care placements – in Wales it was found that residential placements cost at least four times as much per placement as foster care (Smallman et al., 2017). The following outlines cost benefit analysis of various specialist caregiving models.

Lighthouse Foundation therapeutic family model of care (TFMC™)

While there is no formal evaluation of the programme, a return-on-investment analysis concluded that for every individual that passes through the Lighthouse Foundation model, the state typically saves $667,836 over 35 years. Additionally, survey participants who were taken care of under the model reported positive developments in their mental, physical, and financial health, as well as improved relationships with others, with most attributing it to the Lighthouse Foundation model (EY, 2018). This would equate to significant social benefits that are not included in the cost savings.

Treatment Foster Care Oregon (TFCO)

The cost analysis showed that TFCO is likely to be cost saving compared to general group care, given that it appears to be effective in reducing the number of days that a youth is placed in a locked setting (Åström et al., 2020). However, the researchers suggest that more studies, in various contexts, linking costs and effects of TFCO compared to general group care would be needed to be more conclusive.

In Australia, a complete TFCO placement has been estimated to cost approximately $240,000 per child, including carer reimbursement rates (OzChild, 2020).

Teaching-Family Model (TFM)

A cost benefit analysis found that for every participant in a TFM group home (rather than another type of group home) there was a $21,355 net benefit. There was also a high chance that the programme would produce benefits that are greater than the costs (Washington State Institute for Public Policy, 2019).

Pressley Ridge Treatment Foster Care Program (PR-TFC) pre-service curriculum

Basic pre-service training was compared with Pressley Ridge pre-service training. Analyses found that participants in the PR-TFC group were four times more likely to become licensed than those in the basic training group (Strickler et al., 2018). It was suggested that PR-TFC may increase parent's feelings of efficacy in being a treatment parent. Interestingly, most of those in the PR-TFC group who didn't become licensed were not considered as suitable candidates for licensing by the relevant agency. It was suggested that the PR-TFC may be a useful tool in reducing the financial and resource cost of recruiting, training, and certifying foster parents (Strickler et al., 2018), by potential carers self-selecting themselves in or out of the role.

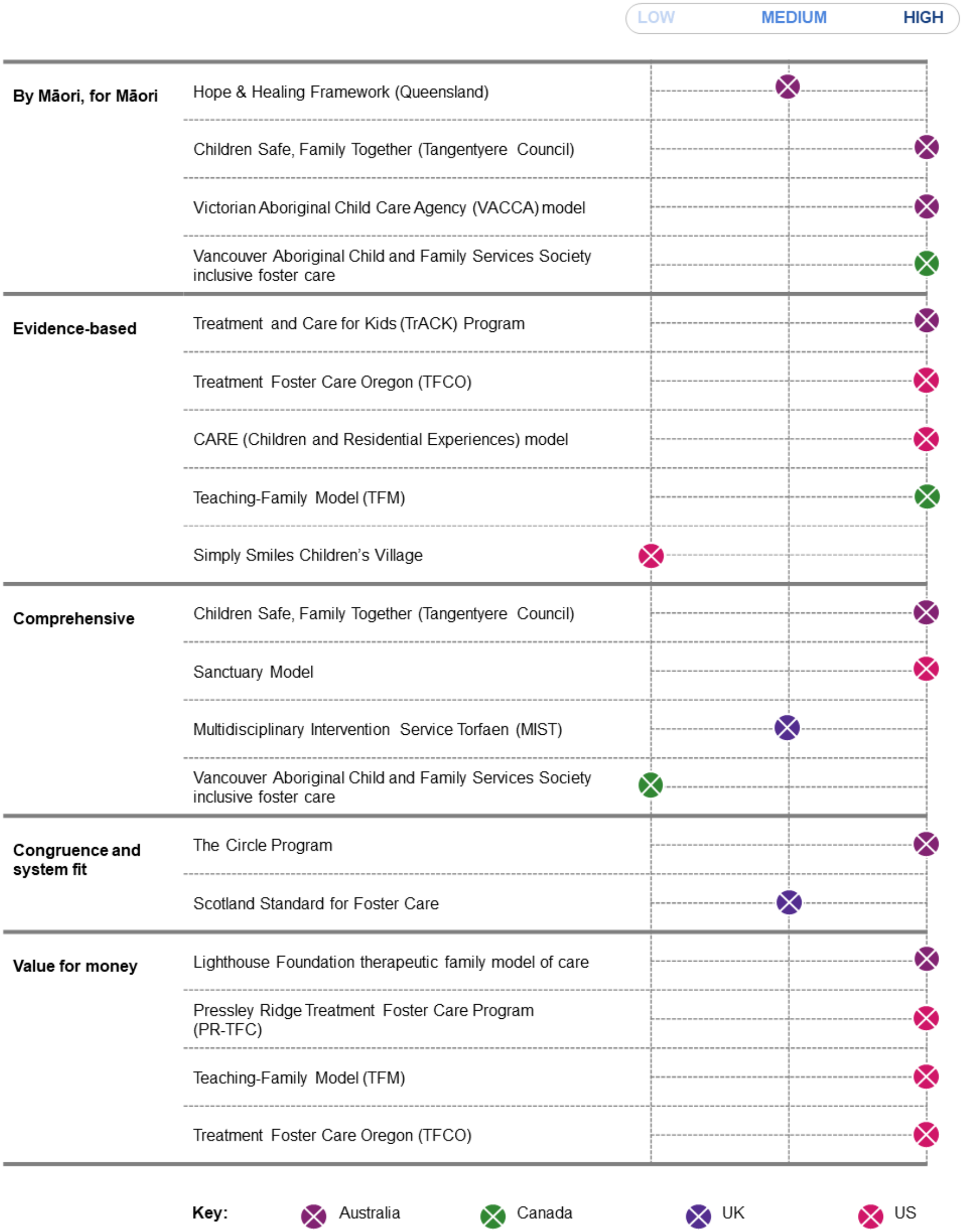
Parkerville Our Way Home

An internal review has calculated that outcomes to date from the model are likely to result in direct future savings of at least $6.46 million from total expenditure of $1.44 million to set up and deliver the model (Parkerville & Innovation Unit, 2022).

Concluding summary

Figure 6 provides an overview of a sample of specialist models discussed in this evidence brief and whether they meet the design principles.

Figure 3. Assessment of specialist caregiving models using the five design principles



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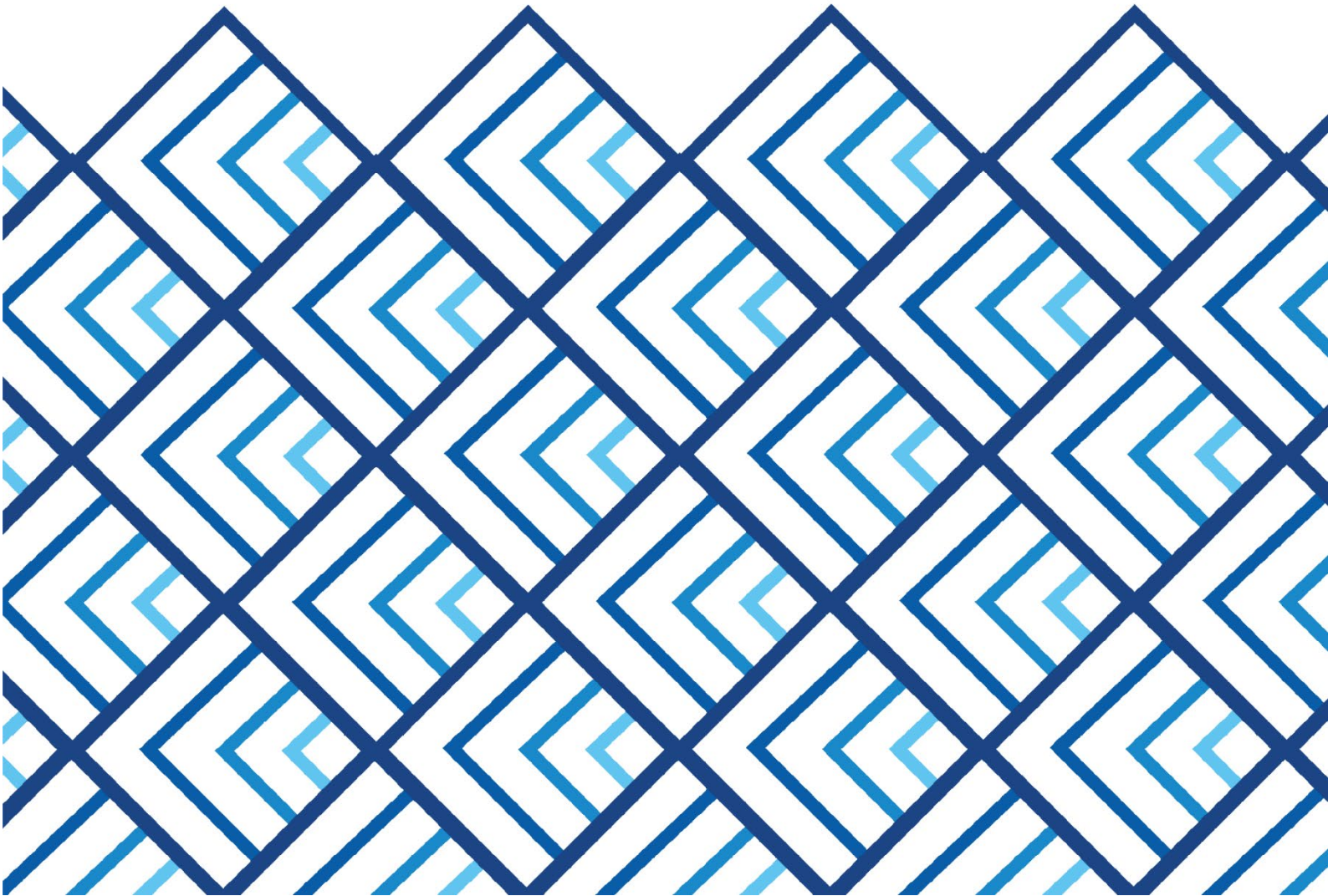
Appendix 1: Specialist caregiving models



Australia

Model	Treatment and Care for Kids (TrACK) Program
Key features	Developed in 2002, TrACK is an intensive therapeutic foster care programme for significantly traumatised children and young people who present with a range of complex needs and challenging behaviours. Trauma-informed and relationship focused care.
Effectiveness	Recent evaluation has found that children had more stability in their lives as a result of the programme (Gatwiri et al., 2019; McPherson et al., 2018). This included placement stability, improved engagement with education, better peer relationships, and improved self-regulation.
Funder and delivery	Developed and delivered in partnership by the Australian Childhood Foundation and Anglicare Victoria. Funded by the Eastern Division of the Department of Health and Human Services, Victoria since its commencement (2002).
Indigenous elements	Evaluation (Gatwiri et al., 2019; McPherson et al., 2018) included two indigenous children.
Qualifications and training	As required by the state for all foster carers, applications are through the Department of Communities and carers must complete a Department training module. The specialised training for carers includes material on the neurobiology of trauma and brain development, and a suite of helpful responses to trauma-based behaviours.
Support services	Care Team creates a shared approach to the care of the child. Care Teams include a therapeutic specialist, a social worker or psychologist, and a case manager, who is a foster care social worker employed by the partner agency. May include other specialists as required (for example, health, medical and educational).
Financial support	Reimbursement as per federal caregiver arrangements.
Industrial arrangements	Voluntary

Model	The Circle Program
Key features	The Circle Program was developed by the government in Victoria in 2007. It was a therapeutic foster care programme designed to provide a care environment that could contribute to healing the traumatic impacts of child maltreatment. It was part of ongoing reform efforts to improve outcomes for children who had experienced maltreatment and were placed in out-of-home care. A therapeutic specialist supports caregivers as part of the Circle Program. The model leans on trauma-informed care, and resilience theory, and positions the child in care at the centre of the programme. 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 programme are: – training in trauma and attachment theory – 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. Programme guidelines are available on the Department of Families, Fairness and Housing website (Victorian Government Department of Human Services, 2009).
Effectiveness	An evaluation found that the Circle Program lessened the number of unplanned exits compared to a matched dataset of children in generalist foster care (Frederico et al., 2017). Additionally, the Circle Program positively influenced foster carers' decisions to stay in the carer role. Key components perceived as contributing to outcomes of the Circle Program included enhanced training of foster carers, intensive carer support, specialist therapeutic support to the child and carer, therapeutic service to family members, brokerage funds, and a network of services to provide support to the child (Frederico et al., 2017).

Model	The Circle Program
Funder and delivery	Funded by the Department of Families, Fairness and Housing (DFFH). Delivered by various organisations, including Anglicare Victoria, Berry Street, Mallee Family Care, and OzChild.
Indigenous elements	The evaluation included 31 children (16.6%) in generalist foster care and 34 (16.7%) in the Circle Program who were Aboriginal and Torres Strait Islander. Included in the provision of care for Aboriginal children in Victoria is the requirement that cultural support plans are developed that strengthen the children's relationship to their culture. Placement of Aboriginal children in out-of-home care is also governed by adherence to the Aboriginal Child Placement Principle that privileges placement within the Aboriginal community.
Qualifications and training	– Pre-placement and ongoing structured training as part of a group. – Specific, individualised training relating to the care of a child to assist in translating broad principles and individual care plans into practical reality. – Provision of a peer support system for carers. – Professional development opportunities for the carer to gain recognised qualifications in the areas of counselling and child development. A professional development approach is consistent with a model that conceptualises carers as valued members of a professional care team (Victorian Government Department of Human Services, 2009). The evaluation found that carers felt that the programme elevated the role of the foster carer to one that is equal to the other professionals on the care team. This, combined with the Circle Program training, was deemed to professionalise the role of the foster carer, and some carers reported increased levels of confidence in their competence (Frederico et al., 2017). Focus groups participants in the evaluation indicated that the support, training, ongoing education, and access to flexible funds to obtain services influenced carer retention (Frederico et al., 2017).

Model	The Circle Program
Support services	Support services include (Victorian Government Department of Human Services, 2009): – the carer support group – support by the placement worker and the therapeutic specialist on a planned, regular, and intensive basis – visits by the foster care worker and the therapeutic specialist are supplemented by more intensive joint discussions/meetings/training sessions as needed – professional supervision for the carer and family, focused on their needs – carer reviews that focus on carer satisfaction, support needs and provide opportunities to identify issues of concern – access to 24 hour “on call” crisis support, via phone to the placement agency in the first instance. Respite care is included as an important consideration and ideally should be provided from someone within the support system; the primary consideration should be that respite care is provided by extended family members in an effort to build an ongoing relationship between the child and a significant adult.
Financial support	Brokerage funds are provided as a part of the programme. The evaluation found that access to flexible brokerage funds was critical (Frederico et al., 2017). These funds were described by carers as supporting children to participate in community activities, for example a dance class or organised sport. Where a child required a specialist assessment (for example, speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. Carers stated that it was important to be able to access discretionary funds to meet a child’s needs in a timely way (Frederico et al., 2017).
Industrial arrangements	Voluntary. Part 3.4 of the Children Youth and Families Act 2005 establishes the regulatory framework for the registration, reporting, investigation, and disqualification of out-of-home carers. The Victorian Carer Register is a web-based application established to enable the Secretary of the Department of Families, Fairness and Housing to keep a register of out-of-home carers as required under section 80 of the Act.

Model	NSW Therapeutic Care Framework (TCF)
Key features	Guidance on supporting children and young people, based on trauma-informed care. Intends to focus on recovery from trauma so that children and young people spend less time in intensive out-of-home care (OOHC) services and achieve permanent homes where they can thrive. Therapeutic care is defined as "holistic, individualized, team-based approach to the complex impacts of trauma, abuse, neglect, separation from families and significant others, and other forms of severe adversity" (Oranga Tamariki Evidence Centre, 2020).
Effectiveness	Documentation states that "The TCF focuses on evidence-informed, culturally respectful and responsive Therapeutic Care practice" (Department of Communities and Justice, 2019). Intends to be measure outcomes through the Quality Assurance Framework (QAF). The QAF is to capture information across the 3 key outcome domains of: Safety, Permanency and Wellbeing. The QAF is one element of the broader Human Services Outcomes Framework (Department of Communities and Justice, 2019).
Funder and delivery	NSW Department of Communities and Justice. Delivered by service providers.
Indigenous elements	The framework was developed in partnership between Family and Community Services (FACS) and the Association of Children's Welfare Agencies (ACWA), The Aboriginal Child, Family and Community Care State Secretariat (AbSec), OOHC sector representatives and academics in the field of child protection (Oranga Tamariki Evidence Centre, 2020). In taking a holistic approach to Therapeutic Care, consideration of the cultural context of children and young people is extremely important. Cultural connection is critical to identity and wellbeing. The TCF highlights the importance of promoting safe, healing relationships between children and young people and their family, kin and community, noting that these relationships are important for family, social, community and cultural connections. The TCF recognises culture as an integral aspect of a child or young person's wellbeing. Children and young people will be active participants (where appropriate) in the development of their care and case plans, and this includes cultural plans.

Model	NSW Therapeutic Care Framework (TCF)
Qualifications and training	Training and education across the OOHC sector is part of the new Intensive Therapeutic Care service system (Department of Communities and Justice, 2019).
Support services	The TCF is not prescriptive, but rather outlines a consistent framework for delivering evidence-informed Therapeutic Care programs and practice in NSW that can lead to change, growth and healing. The TCF guides quality practice by encouraging: – a consistent understanding of Therapeutic Care for the OOHC sector (definition) – NSW Therapeutic Care Framework core principles defining requirements across the domains of children and young people, organisations, environment, and system.
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Children safe, family together (Northern Territory)
Key features	A comprehensive, culturally safe, Aboriginal family care service model developed and implemented by Tangentyere Council Aboriginal Corporation (TCAC) for Aboriginal family and kin care services in the Northern Territory (TCAC, 2019). The model aims to transition family and kin care service delivery to Aboriginal community-controlled organisations (ACCOs) and increase the decision-making power of Aboriginal children, families, communities and organisations in relation to the care and protection of Aboriginal children. This is a fundamental step towards increasing community control and self-determination for Aboriginal people and communities. The model focuses on providing safe, stable, and best possible placements for Aboriginal children in those instances where removal is a necessity and reunification, despite best efforts, has not yet been achievable: – family finding and mapping, potential family and kin carers identified and capacity to provide care is assessed – family-led decision making – family care team – relevant training specific to needs of placement

Model	Children safe, family together (Northern Territory)
	– children have regular face to face contact with family and friends.
Effectiveness	A literature review of existing family and kin care programmes was undertaken to understand how those programmes supported child wellbeing, permanency, child safety, and cultural connectedness (Centre for Evidence and Implementation, 2019). No evaluations as yet. As at 2020, 42 Aboriginal children had been placed with Aboriginal carers (an increase of 18% since the previous year) (SNAICC, 2020).
Funder and delivery	Model has been formally adopted by the Northern Territory Government, who have committed to implementing it in full over the next five years. TCAC is an Aboriginal community-controlled organisation that works with every household in the Alice Springs Town Camps and more than 10,000 Aboriginal people from across Central Australia. In 2020, the Department of Territory Families, Housing and Communities committed $2.2 million for six ACCOs to recruit and support Aboriginal foster and kinship carers over two years: Yalu Aboriginal Corporation, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, NT Stolen Generations Aboriginal Corporation, Kalano Community Association Incorporated, Tangentyere Council Aboriginal Corporation, and Larrakia Nation Aboriginal Corporation (SNAICC, 2021).
Indigenous elements	The model was developed by TCAC with the advice and support of the Victorian Aboriginal Child Care Agency (VACCA). It was based on wide consultation, findings from three pilot programmes, and literature review (including a survey of views of children in out of home care).The model functions to provide better practices related to the provision of safe and sustainable care for Aboriginal and Torres Strait Islander children through the identification, recruitment, and support of family and kin carers. The model suggests new ways of engaging and working with Aboriginal and Torres Strait Islander families and communities, ensuring they are empowered and supported in all aspects of the provision of family and kin care placements (TCAC, 2019).
Qualifications and training	Currently the formal “authorisation” of carers remains the responsibility of Northern Territory’s Department of Territory Families, Housing and Communities (TF). The model proposes that as capacity is built, delegation of this responsibility will be

Model	Children safe, family together (Northern Territory)
	transitioned to ACCOs. The overall guardianship of the child will continue to be held by TF. Provided with culturally appropriate relevant training and educational resources. Training resources are developed in Aboriginal and Torres Strait Islander first languages, and training sessions and workshops are supported by interpreters, and delivered in short segments. The model proposes that training resources are developed by TF in collaboration with ACCOs and the new Aboriginal Family and Kin Carer Support and Advocacy Service.
Support services	The creation of a new Aboriginal Controlled Family and Kin Carer Support and Advocacy service is a critical part of this model. This new service would function to specifically cater to the needs of Aboriginal and Torres Strait Islander carers using a cultural perspective, as well as provide culturally appropriate advocacy, support and training to carers from diverse cultural backgrounds that are providing OOHC to Aboriginal and Torres Strait Islander children. Some key functions of this new service would include: – development of a family and kin carers' network across the Northern Territories – development and maintenance of online apps and portals which carers can access for information and resources – development of culturally appropriate relevant training and educational resources – development of peer-to-peer support groups, meetings, presentations, and award ceremonies – collaboration with ACCOs delivering family and kin care services and TF to inform regional resource development, and – advocacy services including virtual advocacy. The local family and kin care workers will provide face-to-face support for carers during the initial establishment of a placement. The model recognizes the importance of emergency and respite care as a factor in reducing crisis-driven responses, ensuring children are placed with a 'best fit' family and kin placement. The model suggests that multiple family members are assessed and 'authorised' to provide care, enabling more respite opportunities.
Financial support	Family and kin carers are currently eligible for the same level of financial assistance as foster carers. For both cohorts, allowance rates are variable depending on the complexity of children's needs, the child's age, and where the child lives (TCAC, 2019).

Model	Children safe, family together (Northern Territory)
	This model recommends that TF remains responsible for the provision of payments for family and kin carers. The model calls for an increase to the additional one-off payment to carers prior to or on commencement of placement to assist carers to purchase the material items necessary to accommodate the placement. This increase should be in line with payments levels of other jurisdictions in Australia. Material items which may be required at the time of placement set up include but are not limited to items, such as, bedding, clothes, necessary safety items such as car seats, and age-appropriate toys and play equipment. ACCOs should take the primary responsibility for assisting carers to access and receive all payments they are entitled to. Consultations on broader financial supports indicated that some carers will also benefit from and should be offered budgeting and financial counselling. This type of support should be provided through ACCOs. On financial support, the literature review concluded that Aboriginal caregivers are more likely to be older, single, in poorer health, and caring for more children than non-Aboriginal caregivers of Aboriginal children, and therefore commensurate reimbursement should be provided (Kiraly & Humphreys, 2011 as cited by Centre for Evidence and Implementation, 2019).
Industrial arrangements	Voluntary.

Model	Hope & healing framework for residential care (Queensland)
Key features	A trauma-informed, needs informed, therapeutic framework underpinned by common practice principles which apply across all types of residential care and all cohorts of children and young people (Queensland Department of Child Safety, Youth and Women et al., 2019). Developed in 2015 through a partnership between the then-Queensland Department of Child Safety, Youth and Women, PeakCare Queensland Inc, Encompass Family and Community Pty Ltd, and Paul Testro Consulting. Residential care attends to the fundamental needs of children and young people for safety, nurturance, development, and healing. The therapeutic approach focuses on relationship, connections,

Model	Hope & healing framework for residential care (Queensland)
	emotional know-how, and positive identity (Queensland Department of Child Safety, Youth and Women et al., 2019).
Effectiveness	Not yet available. But an evaluation framework and programme logic appears to have been developed (PeakCare Queensland & Encompass Family and Community, 2021)
Funder and delivery	Funded by Queensland Department of Children, Youth Justice and Multicultural Affairs. Delivered by residential care service providers.
Indigenous elements	Three of the common principles are: – care occurs within the context of family – care supports links with community – care is culturally safe and proficient, supporting Aboriginal and Torres Strait Islander identity, and culturally and linguistically diverse identities. Cultural safety requires that workers interacting with children and young people move beyond awareness to become responsive to the needs of children and young people of diverse cultures and, in particular, Aboriginal and Torres Strait Islander children and young people, to create a physical and inter-personal environment which is welcoming and respectful of each person's culture. Key to cultural safety is connection to family, kin, community and country (Queensland Department of Child Safety, Youth and Women et al., 2019).
Qualifications and training	10 e-learning modules for residential care workers and their direct supervisors via the e-learning platform, Clui (PeakCare Queensland, 2023a). There are also a Masterclass Series, and Hope & Healing podcasts. Prior to the wider implementation of the hope and healing framework for residential care across Queensland, there was no standard training programme available to workers in trauma-informed therapeutic care (PeakCare Queensland & Encompass Family and Community, 2021). Since 1 July 2018, the Department of Children, Youth Justice and Multicultural Affairs have worked with PeakCare Queensland to begin phasing in new standards outlining the minimum qualification expectation for all residential care staff working in Queensland. The minimum qualifications standards require that residential care workers obtain a minimum qualification of Certificate IV level from an approved list (PeakCare Queensland, 2023a).

Model	Hope & healing framework for residential care (Queensland)
Support services	"It is important that governance and management actions reflect an understanding of care and he delivery of residential care services to children and young people, value the role of residential care workers in providing care and working with children and young people, and ensure congruence at all levels of the organisation" (Queensland Department of Child Safety, Youth and Women et al., 2019, p. 13). This was a particular issue noted in the implementation report. The implementation report concluded that valuing of the residential care role was directly related to difficulties in retaining staff (PeakCare Queensland & Encompass Family and Community, 2021).
Financial support	Salary.
Industrial arrangements	Employee.

Model	Hope and healing for foster carers (HHFC) (Queensland)
Key features	In 2020, PeakCare commenced the adaptation of the Hope and Healing Framework for Residential Care to meet the needs of foster carers. The Hope and Healing for Foster Carers (HHFC) e-learning training was developed to capture the in-depth research that occurred in implementing the framework within residential care (PeakCare Queensland, 2023b). The training is also linked to the Queensland Department of Children, Youth Justice and Multicultural Affairs mandatory training requirements for approved foster carers. Trauma-informed e-learning package, based on the Hope and Healing Framework, provides carers with appropriate strategies and tools to respond to the impacts of trauma on children and young people in their care.
Effectiveness	Not yet available.
Funder and delivery	Funded by Queensland Department of Children, Youth Justice and Multicultural Affairs Delivered by PeakCare Queensland
Indigenous elements	The Department has a module titled Caring for Jarjums, which has been developed for non-indigenous carers caring for Indigenous children. Caring for Jarjums in not a compulsory module however completion is strongly recommended

Model	Hope and healing for foster carers (HHFC) (Queensland)
	(Queensland Department of Children, Youth Justice and Multicultural Affairs, 2022).
Qualifications and training	There are 10 modules of training. The training is self-paced and self-assessed and has an accompanying learning journal. Each module takes about 30-45 minutes to complete. There is also a reflection journal that is downloadable and should be used to complement the learning. The training platform has an in-system approvals and certificates workflow, streamlining the process for everyone. Service providers will have nominated approvers who review carers' progress with the training and learning journal and on meeting requirements, issue a completion certificate. Carers are able to log in at any time and download the certificate for their own records (PeakCare Queensland, 2023b).
Support services	PeakCare is working with partners to develop a Masterclass Series that will support, in more detail, the themes of the framework. The series will draw on the work already available in the e-learning modules, providing more detailed information and contributions from guest speakers (PeakCare Queensland, 2023b).
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Lighthouse Foundation therapeutic family model of care (TFMC™)
Key features	Holistic therapeutic treatment programme underpinned by three theoretical frameworks of attachment theory, psychodynamic psychotherapy and trauma-informed practice (EY, 2018). Serves young people (ages 15-23) by providing a family home and two key carers who provide around-the-clock tailored therapeutic care. As at 2018, there were 10 homes across Melbourne, with a community hub in Richmond. Each Lighthouse home aims to provide children and young people with an experience of a family-style environment with up to four young people and therapeutically trained carers who share the home with them. The carers are central to helping the young person to re-develop the capacity to engage in healthy

Model	Lighthouse Foundation therapeutic family model of care (TFMC™)
	relationships. The model focuses on the young person feeling safe and secure in the Lighthouse home. The homes are geographically close to each other, with each cluster consisting of five homes in a local area. The homes spend time together celebrating birthdays, Christmases and achievements, such as graduations and other events, providing an extended family (McLoughlin & Gonzalez, 2014). Volunteers are recruited, psychologically screened, and passed through appropriate checks to form a coterie of community volunteers to support the running of the homes. A committee of community volunteers are attached to each home. This can provide the young person, where appropriate, with a sense of community support, beyond the confines of the home and the individuals who care for them. The length of stay ranges from 18 to 24 months (McLoughlin & Gonzalez, 2014).
Effectiveness	While there is no formal evaluation of the programme, a return on investment analysis concluded that for every individual that passes through the Lighthouse Foundation model, the state typically saves $667,836 over 35 years. Additionally, survey participants who were taken care of under the model reported positive developments in their mental, physical, and financial health, as well as improved relationships with others, with most attributing it to the Lighthouse Foundation model (EY, 2018).
Funder and delivery	The Lighthouse Foundation is a not-for-profit organisation providing therapeutic residential care in Victoria, Australia. They are funded by government programme grants as well as through private charitable investments. The youth-focused programmes are primarily funded through philanthropic and general donations (Lighthouse Foundation, 2022).
Indigenous elements	None.
Qualifications and training	Homes are managed by an experienced, professional live-in primary carer with the assistance of a professional support carer (also live-in). Both primary and support carers are remunerated for their role, and share a 70/30 split of the care in the home, with support carers also working day shifts on the roster (McLoughlin & Gonzalez, 2014).

Model	Lighthouse Foundation therapeutic family model of care (TFMC™)
	Carers are trained and intensively supervised to be attuned to the young person's verbal and nonverbal communications, needs and to engage in therapeutic, relational care. Adding to the circle of care, young people are supported by a small pool of community members who visit the home on an as-needed basis. They provide support in a number of areas – local knowledge, mentoring for the children, financial assistance, networking opportunities, legal matters, maintenance of the home, links to employment, education and training initiatives, and various other support (Barton et al., 2012). The community committee of volunteers hold fundraising activities, organise excursions and special events, and connect the home with local businesses, sporting clubs, and community groups (Lighthouse Foundation, 2017).
Support services	Offsite, another layer of care is provided by a team of clinical and community professionals – including psychologists and community care workers, who provide specialist support (ensuring that young people's core needs are being met by their relationships with carers, and that specific health, education, psychological and emotional issues are addressed). There is a detailed manual for practising Lighthouse's TFMC™ and features case examples from over 25 years of practical application (Barton et al., 2012).
Financial support	Salary.
Industrial arrangements	Employee.

Model	Hurstbridge Farm (Victoria) now operating as statutory therapeutic residential care (TRC) across the State
Key features	Therapeutic residential care (TRC) run by the Victoria Department of Families, Fairness and Housing. It supports young people aged 12-18 years who have suffered developmental trauma. Programme requirements that service providers must adhere to are available (Victoria, Department of Health and Human Services, 2016). The original farm is located on 13 hectares in rural Victoria and includes two residential houses, a school, administrative offices, farm equipment sheds and two bungalows to assist young people

Model	Hurstbridge Farm (Victoria) now operating as statutory therapeutic residential care (TRC) across the State
	preparing for independent living. A land and animal care worker is employed to manage the agricultural activities and to support young people's involvement in those activities. The farm can accommodate eight children and young people in total (ACT Government, 2022). The other sites generally work with four young people, and the model is influenced by the Sanctuary model, based on theories of attachment and trauma, neurobiology of brain development, and resilience. Essential elements of the model include (McNamara, 2015 as cited in Oranga Tamariki, 2020): – trained staff – consistent rostering – engagement and participation of the young people – client mix – care team meetings – the therapeutic specialist – reflective practice – organisational congruence and commitment – physical environment – exit planning and post-exit support – governance, and – therapeutic practice improvement. The length of stay is between 18-30 months.
Effectiveness	An evaluation of 12 therapeutic residential care pilots, including Hurstbridge Farm as the original model, concluded that the model leads to better outcomes for children than standard residential care practice, including improvements in placement stability, better quality of relationships and contact with family and residential carers, increased community connection, improvements of sense of self, increased healthy lifestyles, reduced risk taking, enhanced mental and emotional health and improved relationship with school (Verso Consulting, 2011). The Victorian Auditor General has stated that there is a lack of outcomes monitoring and research, particularly recent research and evaluation of the longitudinal outcomes from Victorian statutory TRC (Victorian Auditor General, 2020 as cited in McNamara, 2023).
Funder and delivery	This model was developed for children and young people with complex needs in the state of Victoria, Australia. In June 2007, the then-Victorian Department of Human Services launched the first TRC pilot, referred to as Hurstbridge Farm. Since then, a

Model	Hurstbridge Farm (Victoria) now operating as statutory therapeutic residential care (TRC) across the State
	further 11 pilot sites have been established, each with a specific client focus (Verso Consulting, 2011). The model has now been expanded to provide an estimated 80 TRC homes across the state of Victoria (McNamara, 2023). Lighthouse, Sanctuary model, and Allambi Care are examples of the TRC model in action (McNamara, 2023).
Indigenous elements	Two of the original pilots were delivered by Aboriginal community services organisations: – Mildura Aboriginal Corporation (MAC), Loddon Mallee Region – Victorian Aboriginal Child Care Agency (VACCA), Statewide service An essential service element of the model is the delivery organisation's capacity to involve specialist and skilled therapeutic interventions with known family, assisting young people to identify their family of origin, and assist Aboriginal children and young people to re-connect or maintain contact with their extended family and Aboriginal community. The training includes working with Aboriginal children, young people, and their families and communities in culturally informed ways. By December 2020, the Victorian government had transferred case management responsibility for 50% of Aboriginal and Torres Strait Islander children and young people on care and protection orders to Aboriginal Community-Controlled Organisations (ACCOs). Implementation challenges have included workforce capability and working with children with a high and complex needs (ACT Government, 2022).
Qualifications and training	Trained residential care workers who can consistently and skillfully enact the therapeutic approach is essential to the success of TRC (Verso Consulting, 2011). Ninety percent of the staff and management in the TRC Pilots surveyed in 2010 had participated in the core "With Care" two- and five-day training programmes. This training was a pre-requisite to the implementation of the pilots. Specialised training assists staff to develop the required skills to work in a therapeutic, often counter-intuitive manner with children and young people in TRC. In 2018, Victoria instituted minimum qualifications for residential care workers of Certificate IV in Youth and Family Intervention, including a mandatory unit on trauma, or hold a recognised

Model	Hurstbridge Farm (Victoria) now operating as statutory therapeutic residential care (TRC) across the State
	equivalent qualification in combination with a short top-up skills course (ACT Government, 2022; McNamara, 2023). The Victorian government launched in April 2017, Carer KaFÉ, a programme of learning and development opportunities for statutory kinship and accredited foster carers, through the Foster Care Association of Victoria (ACT Government, 2022).
Support services	TRC funding provides for increased staffing. This results in more one-to-one time with children and young people (when required), greater programme flexibility, and increased opportunities to respond to client needs (Verso Consulting, 2011).
Financial support	The 2011 evaluation indicated that the then-Department of Human Services had estimated that the annual cost of a TRC placement is approximately $2.6 million per annum to support 40 young people (Verso Consulting, 2011). Salary.
Industrial arrangements	Employee.

Model	Victorian Aboriginal Child Care Agency (VACCA) model
Key features	The six “cultural pillars” providing the foundation for the model are (Oranga Tamariki, 2020): cultural safety; cultural rights and responsibilities; Aboriginal understanding of family and kinship structure; Aboriginal understandings of culture as resilience; adherence to the Best Interest principles; and adherence to the Aboriginal Child Placement principle (that is, that Aboriginal children should be placed within their own family or Aboriginal community/culture). The VACCA model incorporates key elements of mainstream models of care, including training in trauma-informed practice, and recognising the importance of staff commitment to a strengths-based care philosophy. The promotion of child and young person healing through connection to culture is the core focus of the model. The model includes: – a home environment with 24/7 live-in support with residential care workers – therapeutic care which helps to recover from trauma and overcome emotional and practical challenges in the young people’s daily lives – case management

Model	Victorian Aboriginal Child Care Agency (VACCA) model
	– education support – cultural identity support – support for children, including sibling groups.
Effectiveness	The VACCA's TRC model has yet to be evaluated, but early indications suggest that the model is supporting positive wellbeing outcomes for Aboriginal children and young people in care (Bamblett et al., 2014 as cited in Oranga Tamariki, 2020).
Funder and delivery	Developed by VACCA, supported by a working party, discussion paper and five "think tanks" who ensured that the key values and principles of an Aboriginal therapeutic approach were present in the final model (Bamblett et al., 2014 as cited in Oranga Tamariki, 2020).
Indigenous elements	Aboriginal community-controlled organisation-led. VACCA launched the Nugel programme in 2017 (ACT Government, 2022) whereby VACCA takes full responsibility for Aboriginal children and young people on Children's Court orders: – case planning and cultural planning – support for the child's out of home care arrangement – case management – relevant legal services – referral to and coordination with VACCA's and other services – support children to remain with their families or be safely reunited.
Qualifications and training	A relevant qualification, in line with residential care minimum standards, and/or be willing to undertake relevant study. Career development and training opportunities, including recognised relevant qualifications where possible.
Support services	– A positive, culturally safe, and inclusive work environment. – Ongoing training and professional development opportunities. – Paid parental leave, carers leave, Cultural Event Day leave, Christmas bonus day leave and study leave. – Flexible work options. – Comprehensive employee assistance programme. – Opportunities for career advancement and progression.
Financial support	Salary.
Industrial arrangements	Employee.

Model	Parkerville Our Way Home model of care
Key features	In November 2019, Parkerville Children and Youth Care invited social design consultancy Innovation Unit to help develop a new approach to out-of-home care. Our Way Home is the outcome of this co-design process involving over 200 stakeholders or people with experience with the out-of-home care system. It was co-designed with children and young people with a care experience, families, carers, community group representatives and survivors of the Stolen Generation. In 2021 the model was prototyped and tested, and in 2022 it moved toward implementation. Four components (Parkerville, 2023): – Personalised supports: adapt methods, plans, and environments to meet the needs of individual children and young people. – Connection planning: each child has a plan for the way that they connect with the important family or community members who are in their life, or who could be. – Family Link worker: a new role, designed to do the creative work necessary to enable deep connection of children with family, whilst mitigating risk. The role responsible for facilitating connection with family and children, but also with staff. – The Mundahring Baldja: a centre for focusing on the people doing the work from recruitment through to their successful practice. The driver for the new and traditional capabilities necessary for the realisation of Radically Personalised Shared Care. This component of the model has not yet been funded, but developing a workforce with the skills and mindsets necessary to deliver this model of care is critical.
Effectiveness	Model in infancy. Internal review has found that the model has led to (Parkerville & Innovation Unit, 2022): – more regular connections and contact for children in care and the people they care about that are natural, meaningful and fun – more individual care and attention to the desires, aspirations, and goals of children in care. Family Link Workers and Aboriginal Practice Leads were critical in making the model work. Medium and longer term outcomes identified so far include (Parkerville & Innovation Unit, 2022): – Children are more settled at school. – Children are feeling more listed to and empowered.

Model	Parkerville Our Way Home model of care
	– Family are reporting benefits. – Family are making changes in their own lives. – Children are being reunified with their families and leaving the care system. The review also calculated that outcomes to date from the model are likely to result in direct future savings of at least $6.46 million from total expenditure of $1.44 million to set up and deliver the model (Parkerville & Innovation Unit, 2022). This was based on one child moving from Family Group Home to mother's care, and one child transitioning from Family Group Home to family care placement, over the 12 months the model has been running.
Funder and delivery	Parkerville began in 1903 as a children's home on an 18-acre block in the Perth Hills, Western Australia. Parkerville is a charity funded almost 80% by the state and commonwealth government. Department of Communities is the main funder.
Indigenous elements	The model was co-designed with members of the Stolen Generation, and with community members. Aboriginal Practice Leads: The role of Aboriginal Practice Leads already ensures culturally safe practice in care settings, and in this model, their role expands to include the work of finding and maintaining connections to family, community, and culture for Aboriginal young people in care. In collaboration with the Family Link worker, the Aboriginal Practice Lead is key to connecting family with children and carers to enable successful shared care.
Qualifications and training	Induction and training at the Mundahring Baldja Learning Centre. The programme is designed to support staff carers, and volunteer careers, to emphathise with children and families, and learn what the new model of care looks like (Innovation Unit & Parkerville, 2022). Targeted coaching to enable carers to support child's needs and situation, for example, trauma, mental health, etc.
Support services	This model supports and resources carers to prioritise personalised care and creative connection work. Carers are encouraged to understand the needs and desires of the children in their care, to give children voice and choice in the home, and to participate in making connections with family that are safe and meaningful. Mentoring.

Model	Parkerville Our Way Home model of care
Financial support	Salary.
Industrial arrangements	Family Group Home carers are salaried employees.

Canada

Model	Vancouver Aboriginal Child and Family Services Society (VACFSS) inclusive foster care
Key features	An approach requiring foster parents to engage with the family, community, and cultural life of the child for whom they care. Inclusive foster care offers a path towards stronger cultural and relational connections. Based on the common theme that positive child development for Indigenous children occurs within interdependent relationships with the broader community, the ancestors, and the land. It is nourished by the cultural knowledge, teachings, ceremonies, and language that are held by, and particular to, each Indigenous community (Oliver, 2020).
Effectiveness	Unknown. No studies have been published.
Funder and delivery	In 2003, Vancouver Aboriginal Child and Family Services Society (VACFSS), one of Canada's largest urban Indigenous child welfare agencies, developed an inclusive foster care policy. VACFSS is located in the city of Vancouver on the traditional unceded territories of the Musqueam, Squamish and Tsleil-Waututh people.
Indigenous elements	Developed with a circle of staff, foster parents, birth parents, and elders. The children and families served by VACFSS come from over 50 distinct Indigenous cultures across Canada. At the time of the qualitative evaluation, 400 children were living in VACFSS foster care. Approximately one third of VACFSS foster parents are Indigenous (Oliver, 2020).
Qualifications and training	Holistic training, including a caregiver cultural camp, workshops, ceremony and access to online cultural resources (VACFSS, 2019).
Support services	– Resources programme. – Touching of our relations programme: commits to sending children home to their communities during their time in care. – Homecoming ceremony. – Honouring the journey of our youth.
Financial support	A study involving interviews with foster parents recommended that foster parents should be provided with practical, emotional, financial, and cultural support, to undertake homecoming trips to the child's territory (Oliver, 2020).

Model	Vancouver Aboriginal Child and Family Services Society (VACFSS) inclusive foster care
	Reimbursement.
Industrial arrangements	Voluntary.

Model	British Columbia Extended Family Program (EFP)
Key features	Launched in 2010, the Extended Family Program (EFP) intended to consolidate different types of kinship care options and encourage the use of collaborative practice with families and communities through the provision of voluntary, informal kinship care options (Burke et al., 2023). It was also intended to fill some of the gaps identified in kinship care by: – increasing the rigor of caregiver assessment – supporting kinship caregivers through increasing funding and supports – increasing consistency between services available through kinship care and through foster care. In 2011, the Government of British Columbia (BC) made a further major change to kinship care options when it introduced amendments to legislation that allowed for the permanent legal custody of children in kinship care. This change was intended to increase stability for children in kinship care, help indigenous children stay connected to their culture, and continue with the provision of funding and other support services. An agreement is signed with the parent, the caregiver and the Ministry of Children and Family Development or Delegated Aboriginal Agency. Working as a team, the family and social worker develop a plan for the child or youth that outlines the services and supports that are needed. Parents must agree to the plan – where possible, they also need to contribute financially to their child or youth's care. A social worker reviews the EFP agreement every three or six months.
Effectiveness	The EFP was met with mixed reviews from kinship care advocates who argued that it excluded private, informal kinship caregivers; put barriers in place regarding who could qualify; supported only temporary placements; and lacked social work resources to accommodate the additional rigor in home screening

Model	British Columbia Extended Family Program (EFP)
	(British Columbia Association of Social Workers, 2010 as cited in Burke et al., 2023). A mixed methods evaluation of the EFP focusing on caregivers concluded that caregivers found the kinship care system in BC to be overly complex, making it difficult to access services (Burke et al., 2023). Caregivers also reported feeling pressured by lawyers, social workers, and themselves, to make quick decisions without fully understanding the implications.
Funder and delivery	Government.
Indigenous elements	If the child is Indigenous, the child's Indigenous community may also be a party to the agreement to offer additional supports to the family. One of the goals of EFP has been to facilitate stable cultural and community connections for Indigenous children and youth and offer cultural supports. Participants in the evaluation felt afraid of the Ministry of Children and Family Development and its officials who facilitate kinship care placements, particularly related to being judged for asking for support (Burke et al., 2023). They also described feeling as if the government discriminates against them as kinship caregivers, exhibiting bias toward them for their family's situation. Further, Indigenous kinship caregivers described kinship policies that were racist and colonial in nature and that prevent them from caring for their children using traditional kinship structures.
Qualifications and training	None.
Support services	Kinship Care Help Line: 1-877-345-9777.
Financial support	The provincial government provides monthly financial support for the child or teen's care. Effective April 1, 2023, the financial support is as follows (Government of British Columbia, 2023): – age 11 and under, $1465.86 – age 12 and older, $1655.91. Additional supports are available based on the child's assessed needs and may include: – dental and optical coverage – child minding and respite – counselling – services for children and youth with special needs or mental health conditions

Model	British Columbia Extended Family Program (EFP)
	– training/education needs of the care provider. If a child or youth has significant functional support needs, they may also be eligible to receive enhanced supports, if these supports are not available through other sources. Additional benefits may be available through the Canada Revenue Agency – BC family benefit, BC early childhood tax benefit, Canada child benefit.
Industrial arrangements	Voluntary.

Model	Therapeutic Family Care Program (TFCP)
Key features	Community adaptation of treatment foster care (TFC) among children and youth with long-term child welfare involvement (Browne et al., 2019). Grounded in dyadic developmental psychotherapy (DDP) (TFC Therapeutic Family Care Program, 2022). Children receive services in one of three specialised, clinical programmes: – Therapeutic Foster Home Program (TFHP): Children are supported through services delivered by specially trained treatment foster parents referred to as parent therapists. The child lives in a community with the parent therapist family and permanency for the child is the prime objective. Also, a multidisciplinary team wraps around family for support. – Clinical Services Support Program (CSSP): Children are supported via direct and intensive services from a multidisciplinary clinical team. To facilitate placement stability and preservation of families, clinical strategies to effectively meet the child's and caregiver's needs are implemented within the child's living arrangement. – Mixed Modality Program (MMP): Children are supported in a setting that is a hybrid between traditional treatment foster care programmes and staff modeled settings. The treatment foster parent and child are viewed at the centre of treatment that is also intensively supported by child and youth care staff.
Effectiveness	No control group of "usual foster care services", but 10-year longitudinal study found that the model was associated with clinical improvements and increases in placement permanence (Browne et al., 2019). For each additional year of involvement

Model	Therapeutic Family Care Program (TFCP)
	with the programme, the child or adolescent had improved clinical outcomes.
Funder and delivery	Delivered in Cobourg, Ontario. Funded by Durham Children's Aid Society, Highland Shores Children's Aid, Kawartha Haliburton Children's Aid Society (Child protection agencies in Ontario)
Indigenous elements	None.
Qualifications and training	TFHP: Monthly formal training, foster parent therapists are certified/licensed with experience working with children in care. CSSP: Not certified foster parent therapists. Clinical case consultants are trained in Level 1 & Level 2 Dyadic Developmental Psychotherapy (DDP) (Therapeutic Family Care program, 2023). The organisation is working towards being certified in DDP (Therapeutic Family Care program, 2023).
Support services	TFHP: Clinical case consultant, weekly supervision, and a 24-hour clinical on call system. CSSP: Clinical case consultant provides weekly support to the caregiver to assist in implementation of the clinical intervention plan. Phone or home visits. MMP: Clinical case consultant, up to 55 hours of clinical support per week by a child and youth worker.
Financial support	Financial reimbursement that covers the daily cost to care for a child ($1250 – $1800 a month). Financial compensation for mileage, seasonal allowances, medical/dental coverage, and recreational allotment.
Industrial arrangements	Voluntary.

United Kingdom

Model	Looked-after children and young people (NICE guideline, 2022)
Key features	The recommendations in the guideline represent the view of the National Institute for Health and Care Excellence (NICE) and are based on the evidence available. Professionals and practitioners are expected to take the guideline fully into account, alongside the individual needs, preferences, and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian. The guidelines emphasise therapeutic, trauma-informed parenting (covering attachment-informed, highly supportive, and responsive relational care).
Jurisdiction	Public Health England published the National Institute for Health and Care's guideline for "Looked-after children and young people" in October 2021. **Context** As of 31 March 2020, there were 80,080 looked-after children and young people in England, with the total number of children being looked after increasing yearly since 2010. Most of the looked-after children are cared for in foster placements (72%), with 14% in connected care[9], and 13% in residential care, secure units, or semi-independent living accommodation. In addition to these, 7% of looked-after children are placed with birth parents (NICE, 2022). All looked-after children and young people will have experienced trauma in some way.
Effectiveness	The guidelines and recommendations are based on an extensive evidence review (NICE, 2021a, 2021b, 2021c, 2021d, 2021e, 2021f, 2021g).
Funder and delivery	Existing care delivery mechanisms: – Social care, health and education practitioners working with looked-after children and young people and care leavers.

[9] Connected care is a type of family and friends care. It is when a child or young person is fostered by someone they already have a positive relationship with. The connected carer could be: a member of their family (grandparent, aunt, uncle, cousin), a family friend, a neighbour.

Model	Looked-after children and young people (NICE guideline, 2022)
	– Commissioners and managers, policy makers and providers in the NHS, health and social care, public health and local authorities, and third-sector organisations. – Commissioners, managers and providers of residential accommodation and housing for looked-after children and young people and care leavers. – Birth parents, carers and prospective adoptive parents of looked-after children and young people.
Indigenous elements	**Diversity** – Be aware that many looked-after children and young people are from groups that may face additional disadvantage. Ensure that their needs are met and that they do not face further marginalisation. These groups include those from black, Asian, and other minority ethnic groups, Gypsy, Roma and Traveller communities, and those from different religious backgrounds, as well as other groups such as refugees and unaccompanied asylum-seeking children, disabled people with complex needs, autistic children and young people, children and young people with a learning disability or neurodevelopmental disability, lower socioeconomic groups and people who identify as LGBTQ+.
Qualifications and training	**Training for carers** – Plan training for carers so that it is delivered before it is needed. Think about the need for multiagency involvement in training programmes and ensure that the organisations involved agree the source of funding between them. – Supervising social workers should work with carers to assess the needs of the looked-after child or young person, to inform and tailor training and development needs for the carers. – Provide a schedule of mandatory training for carers, excluding birth parents. Ensure that this training covers: o therapeutic, trauma-informed parenting (covering attachment-informed, highly supportive, and responsive relational care) o safeguarding procedures o how to communicate effectively and sensitively (for example, using de-escalation techniques) o life story work to promote a positive self-identity, which has a consistent, child-focused and planned approach o how to be an educational advocate o identifying problems with, and supporting, good oral health, diet and personal hygiene (particularly among those coming into care)

Model	Looked-after children and young people (NICE guideline, 2022)
	○ encouraging positive relationships and sexual identity (covering issues such as consent, encouraging healthy intimate relationships, 'coming out' and transitioning) ○ self-care for carers, preventing burnout and coping with placements ending ○ the importance of health assessments, supporting attendance and issues of consent for medical treatment ○ record keeping and sharing the information in the record with the looked-after child or young person in a constructive and positive way, considering the need for confidentiality, and the impact the record may have on the looked-after child or young person. – Training can be delivered in person (for example, at home or in community group settings) or virtually. – Provide targeted support and training for birth parents if reunification is a possibility or if the child or young person is to remain in placement with the birth parent. This should be provided through transition planning with family support teams. – Think about providing tailored training for carers if there are specific needs related to race, ethnicity and culture. This could include, for example, understanding and respecting cultural and religious identity (including dietary requirements or preferences), and understanding specific hair and skin care needs. – Provide tailored training for carers if there are specific needs relating to special educational needs, long-term health conditions and disabilities, for example sensory and communication needs. Training could be provided through specialist healthcare teams and voluntary organisations. – Based on the individual needs and developmental age of the looked-after child or young person, consider more intensive training methods for carers to support the delivery of therapeutic, trauma-informed caregiving. These methods should use video feedback, coaching and observation, role play, and follow-up booster sessions and be delivered by trained facilitators. – Ensure that trauma-informed training covers: ○ understanding behaviour as a form of communication and as a response to trauma ○ understanding, recognising and processing triggers for trauma responses ○ understanding attachment and loss. – Ensure that trainers for carers are trauma informed and have a good understanding of attachment issues and therapeutic approaches.

Model	Looked-after children and young people (NICE guideline, 2022)
	– Ensure that new permanent or long-term carers are trained and prepared so that there is continuity of care and support, including therapeutic support if needed, between placements.
Support services	**Supporting and involving carers** – Involve and value the carer's input in decision making in the broader care team, and keep carers fully informed about a looked-after child or young person's care plan. – Provide out-of-hours support services for carers to help resolve urgent problems, for example through social workers working 'on call', emergency duty teams or out-of-hours service, voluntary or independent agency helplines, or carer peer support associations. – Ensure that carers log any help sought outside of usual operational hours as part of their routine and urgent reports. – Facilitate peer support for carers at accessible times and places, including online if people may find it difficult to attend a physical meeting. – As part of the care plan, think about the need for planned respite care (or 'support care') for carers. – Ensure that respite (or support) care is used in the looked-after child or young person's best interests and explain this to the looked-after child or young person. For example, make use of short breaks that are fun for the child or young person, such as staying with relatives or extended carer family. – Use a respite (or support care) carer who the child or young person is familiar with if possible and account for the skills or training needed to meet the looked-after child or young person's assessed need. – Keep carers fully informed and updated about the support services available to carers and looked-after children and young people in their local authority. – Inform the looked-after child or young person's carers about any interventions used to support the looked-after child or young person, including the purpose of these interventions. Studies showed that carers could feel “left alone” to deal with severe problems on evenings or weekends, and lack of out-of-hours support can make them feel isolated. The committee agreed that out-of-hours support services are important but recognised that employing an on-call social worker may need substantial changes to contracts and expenses. So, they agreed that various alternatives might be used to fill this gap (NICE, 2022). Using alternatives to on-call social workers will mitigate the cost of increasing out-of-hours support. A range of possible ways in

Model	Looked-after children and young people (NICE guideline, 2022)
	which out-of-hours support could be offered was included in the recommendation to allow local authorities to use a system that works best for them, both logistically and financially. Some of the options listed would be more affordable, such as the use of volunteer-operated helplines or peer support or advocacy groups. Local foster carer associations may have people working on-call or provide round the clock access to a peer support network. The use of generic emergency duty teams may also reduce funding pressures (NICE, 2022).
Financial support	The Guardian's Allowance rate is £20.40 a week and is tax free. This is on top of the Child Benefit (GOV.UK, 2023).
Industrial arrangements	Volunteer

Model	Multidisciplinary Intervention Service Torfaen (MIST)
Key features	Therapeutic wraparound support alongside mental health interventions which focus on the lived experience of children and young people and aims to impact a child's development and resilience. It is underpinned by a number of theoretical orientations: attachment theory, systems theory, and dyadic developmental psychotherapy (Smallman et al., 2017). Works with children and young people aged between 5-21 years old. Community and family-based alternative to residential care for children with complex mental health needs. The MIST team engages with up to 20 young people at any one time and works intensively, adopting a psychotherapeutic approach as a way of working with such complexity. Caregivers are termed Therapeutic Foster Carers. In partnership with the local authority's family placement team, MIST jointly selects and manages four therapeutic foster care placements. It trains, supervises, and supports these foster carers and provides 24-hour on-call support. In addition to therapeutic foster care placements, and intensive kinship placements, MIST also supports a small number of general foster care placements (Street et al., 2009).
Jurisdiction	Established in 2004 by Action for Children in Torfaen, Wales. It is also delivered in Caerphilly in South Wales, and Hereford, England.

Model	Multidisciplinary Intervention Service Torfaen (MIST)
Effectiveness	A small-scale qualitative evaluation concluded that MIST is working well in reaching its broader outcomes (Street, 2008). Interviews with carers indicated high support and satisfaction for the MIST teams. Carers thought the MIST team's advice was consistent, and they felt empowered by the way they were included in the MIST process and decision making, in contrast to the usual way they interacted with social workers and other professionals (Street, 2008; Street et al., 2009).
Funder and delivery	In 2017, MIST was jointly funded by Social Services, Education, and the Local Health Board in Torfaen. Contracted KPIs were: – reducing the number of young people in care – reducing the number of residential bed nights annually – increasing participation in education and training – improving placement stability. At the time, residential placements cost at least four times as much per placement as foster care (Smallman et al., 2017).
Indigenous elements	None.
Qualifications and training	As well as regularly attending local authority training along with mainstream foster carers, MIST carers are provided with separate training opportunities. This training specialises in issues relating to: – long-term work with high-risk behaviours, such as self-harm and suicide attempts, – management of escalating behavioural crises – attachment theory and practice – motivational interviewing.
Support services	– 24-hour support for carers after training – ongoing supervision – live guidance – support group meetings.
Financial support	Reimbursement through local authority.
Industrial arrangements	Voluntary.

Model	Secure Base model
Key features	Based on attachment and resilience theories (Schofield & Beek, 2009), and relies on the creation of a sense of a child belonging to a family. Stresses five dimensions of caregiving as important ingredients for secure attachment: – availability, which assists the child in developing trust – sensitivity, helping a child or young person manage their feelings and behaviour – acceptance, build their self-esteem – co-operation, helping young people to feel effective – family membership, heling children to belong. Originally used as a tool for analysis of a longitudinal study of growing up in foster care, it developed to become a framework for practice.
Jurisdiction	Developed in England in the early 2000s, by the Head of the School of Social Work and Professor of Child and Family Social Work at the University of East Anglia (UEA), and a fostering and adoption practitioner and researcher for Norfolk County Council and the Centre for Research on Children and Families. It has been adopted by agencies in Spain, Mexico, Ukraine, and Iraq.
Effectiveness	Has been used as a framework for analysis – for example, in a recent small scale qualitative study of LGBTQ young people in foster care and their carers (Schofield et al., 2019), and in a longitudinal foster care study (Schofield & Beek, 2009), but no evaluative studies of the model itself.
Funder and delivery	Government. Delivered by service providers, for example, The Fostering Network.
Indigenous elements	None.
Qualifications and training	The model is introduced to new foster carers in the UK as part of their preapproval training on attachment and caregiving and is widely used in practice for supporting foster carers (Schofield et al., 2019). Also covered in The Fostering Network's Fostering Excellence Masterclasses.
Support services	None.

Model	Secure Base model
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Fostering Connections: the trauma-informed foster care programme (Ireland)
Key features	Fostering Connections aims to develop foster carers' understanding of trauma impact and to develop effective strategies to promote restorative relationships with children. Manualised, trauma-informed psychoeducational intervention. It is facilitated by two trained practitioners and one trained foster carer over six weeks (six sessions of 3.5 hours each) in a community setting (Lotty et al., 2022). Content is cumulative, based on information on trauma, attachment, fostering resilience, and collaborative working. The training uses experiential exercises, videos, demonstration role-play, discussion, and at-home exercises with limited slides. Foster carers receive a toolkit and a homework copybook.
Effectiveness	Process and early outcomes evaluations suggest that caregivers had more knowledge of trauma-informed fostering after attending Fostering Connections, and that it leads to improved child emotional and behavioural difficulties (Lotty et al., 2022). Evaluation employed quasi-experimental design with 79 foster carers divided into an intervention group and a control group. Foster carers also report high levels of satisfaction with the training (Lotty et al., 2020, 2021, 2022). The evaluation found that foster carers thought they should have received the training earlier in their fostering career, that is, after the approval stage, and felt it should be compulsory for all foster carers (Lotty et al., 2021, 2022).
Funder and delivery	Tulsa – Child and Family Agency is the national agency responsible for child care services. Fostering Connections is the output of a research collaboration between Tulsa and University College Cork in 2016. The programme was first delivered in 2017.

Model	Fostering Connections: the trauma-informed foster care programme (Ireland)
Indigenous elements	None.
Qualifications and training	Six weeks of training (6 sessions of 3.5 hours each).
Support services	A toolkit which is a resource for foster carers to refer to during and beyond the programme. It contains information presented in each session, practical tools to support the foster carer, links to videos used, and resources (for example, websites, book lists) to support ongoing learning. The homework copybook was a reflection journal that carers were asked to complete after each session with guided exercises to reflect on their learning in relation to the child or children they were caring for. Foster carers indicated that they needed follow-up training and ongoing support to sustain their learning (Lotty et al., 2020, 2022).
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Scotland
Key features	A dual system of kinship and foster carers. Foster care is monitored and delivered by local authorities, and independent and voluntary providers. A kinship arrangement can be informal or can be organised through Social Work and The Children's Hearing System.
Effectiveness	An Independent Care Review was undertaken between 2017 and 2020 which raised a number of challenges in the overall care system (Independent Care Review, 2020b). Seven reports were published, and *The Promise* laid out five foundations and over 80 calls to action.
Funder and delivery	Funded by Scottish Government. Delivery through local authorities, and private and charitable providers.

Model	Scotland
	The Care Inspectorate registers around 14,000 registered care services in Scotland and inspectors visit each one. Note that this extends to adult and aged care services.
Indigenous elements	None.
Qualifications and training	The Standard for Foster Care issued by the Scottish Social Services Council (2017) in response to the 2013 National Foster Care Review. It establishes a framework for the learning foster carers need to undertake for the foster carer role, and to support a realistic level of standardisation and consistency in the ways learning is provided and used. The Standard is not a qualification in its own right; and the Scottish Government has made it clear that a formal qualification will not be mandatory for foster carers. While the Standard is not a qualification in itself, it is linked to the Scottish Credit and Qualifications Framework level 7 characteristics and has shared ground with the NOS for SVQ Awards, such as Social Services (Children and Young People) at SCQF level 7 (which includes a foster carer skill set) and the HNC Qualification Social Services at SCQF level 7. Due to the links between the Standard and formal qualifications, foster carers who are able to show they have met the Standard may be able to use their learning in ways that can contribute towards gaining a formal qualification (if desired) through recognition of prior learning. The Independent Care Review (2020b, p. 74) stated that "Kinship carers should not feel the need to professionalise their role in order to access support".
Support services	The government: – funds The Fostering Network to help recruit new foster carers and provide support for existing foster carers, including a confidential support service "Fosterline Scotland". – sets out parameters in the Looked After Children (Scotland) Regulations 2009 for fostering allowances that local authorities provide to cover the needs of children living with foster families. – implements improvements to foster care recommended by the foster care review and the Independent Care Review.
Financial support	A 2014 survey of providers found large disparities between rates of regular allowance provided by fostering agencies: ranging from around £109 per week to £400 per week for local authorities,

Model	Scotland
	and from around £134 per week to around £215 per week for independent and voluntary providers (Button, 2014). The subsequent National Review of Care Allowances recommended a Scottish Recommended Allowance (Scottish Government, 2018). This was later rolled into the Independent Care Review. The Independent Care Review (2020b, p. 74) stated that "financial support to kinship carers must match that of foster carers. However, there must also be recognition of the tension and complications that money can add to decision making about children, particularly when wider family groups are living in poverty. Decisions about where children live must follow their best interests". The Review Panel also heard from many who had been, or are, in foster care who that felt like their care was monetised (Independent Care Review, 2020b).
Industrial arrangements	Voluntary.

United States

Model	Treatment Foster Care Oregon (TFCO) Multidimensional Treatment Foster Care (MTFC)
Key features	Based on learning theory and emphasises the need for structure and routine in the lives of the young people in care and reinforcement of positive behaviours. The youth is placed with a professionally trained foster family, and a clinical team is formed around the youth and his or her birth family. The clinical team consists of: – a case manager (who supervises and coordinates the treatment) – a family therapist (who conducts weekly therapy sessions with the youth and her or his family) – an individual therapist (who supports the youth to achieve daily progress) – a skills trainer (who practises new skills in the youth's daily activities and everyday life) – a parent daily report (PDR) caller (who telephones the foster family every day to monitor progress) and – the foster family (which provides the youth with a structured, therapeutic living environment).

Model	Treatment Foster Care Oregon (TFCO) Multidimensional Treatment Foster Care (MTFC)
	Members of the foster family help the youth to develop pro-social skills by being role models and providing clear sets of rules with predictable privileges and consequences for specified target behaviours. The programme provides youth with tight supervision but also focuses on helping youths develop positive relationships with the adults around them (NICE, 2021a). TFCO has a placement duration of 6 to 9 months. The child or young person's treatment consists of a one hour weekly individual therapy session and 2-hour weekly individual skills training session. Three comparable programmes have been developed under this model for those of different age groups: – TFCO for pre-schoolers (TFCO-P) serves children aged 3 to 6 – TFCO for middle childhood (TFCO-C) serves children aged 7 to 11 – TFCO for adolescents (TFCO-A) serves youth aged 12 to 173–6 years, 7–11 years and 12–16 years.
Jurisdiction	Developed in the US, but has been implemented in Australia, the UK, Sweden, Norway (Hukkelberg & Ervik-Jeannin, 2022), Ireland, and Germany.
Effectiveness	As at February 2023, the California Evidence-Based Clearinghouse for Child Welfare (CEBC) has rated the adolescent programme (TFCO-A) a 1 – Well supported by research evidence, and the preschool programme (TFCO) a 2 – Supported by research evidence (CEBC, 2023). A recent meta-analysis, not included in the CEBC's review, of TFCO-A found that there was a moderate certainty of evidence that TFCO reduces the risk of future criminal behaviour and the number of days in locked settings (Åström et al., 2020). The systematic review concluded that TFCO was preferred to group care for youth with serious behavior problems. The meta-analysis relied on eight medium-to-high quality studies – six were randomised control trials and two were concurrent prospective studies with nonequivalent comparison groups. Five of the eight studies included were conducted in the US, two in UK, and one in Sweden. In the NICE evidence base, one Swedish study was included and it was concluded that it provided low quality evidence that TFCO-A improves placement stability (NICE, 2021a).

Model	Treatment Foster Care Oregon (TFCO) Multidimensional Treatment Foster Care (MTFC)
	The systematic review and meta-analysis included economic aspects of the TFCO. The cost analysis showed that TFCO is likely to be cost saving compared to group care, given that it appears to be effective in reducing the number of days that a youth is placed in a locked setting (Åström et al., 2020). However, the researchers suggest that more studies, in various contexts, linking costs and effects of TFCO compared to group care would be needed to be more conclusive.
Funder and delivery	In Victoria, Australia, TFCO-C is delivered by OzChild to children aged 7 to 12 years old, and TFCO-A is delivered by Anglicare Victoria to young people aged 12 to 17 years old. Both programmes are delivered in conjunction with VACCA and are supported by the Victorian Government (Department of Families, Fairness and Housing Victoria, 2022b).
Indigenous elements	Available studies have not examined effects on indigenous children or youth, Aboriginal children and families (Department of Families, Fairness and Housing Victoria, 2022b), or on minority populations.
Qualifications and training	TFCO carers are required to be over 21 years of age and must follow the exact instructions in the programme over a short-term period of 6 to 9 months under close supervision. TFCO carers need to be available for their foster child when needed at any time of the day/night (Department of Families, Fairness and Housing Victoria, 2022b). Foster parents are trained at the site during a 2-day training.
Support services	TFCO carers are supported 24/7 by a team of 6 professionals, daily calls, and a respite carer as needed.
Financial support	Financial reimbursement. A complete TFCO placement costs approximately AUD240,000 per child, including carer reimbursement rates (OzChild, 2020). OzChild offers TFCO in Victoria, Queensland, New South Wales, and South Australia. TFCO carers are provided with a carer allowance/reimbursement of up to $75,000 per annum, tax-free ($75,000 per annum pro rata in Victoria and NSW, and $65,000 per annum pro rata in Queensland and South Australia) to help with the costs associated with supporting the child or young person in care (OzChild, 2023).

Model	Treatment Foster Care Oregon (TFCO) Multidimensional Treatment Foster Care (MTFC)
Industrial arrangements	Voluntary.

Model	Sanctuary Model
Key features	The Sanctuary Model represents a trauma-informed method for creating an organisational culture, where healing from trauma can take place. This model was developed within a context of an inpatient psychiatric clinic and since then has been modified in range of settings, including group care. The model is informed by four knowledge areas: the psychobiology of trauma, actively creating nonviolent environments, social learning principles, and understanding complex system change. The Sanctuary Model sets four stages of recovery from trauma – Safety, Emotional Management, Loss and Future (SELF). In addition, it employs cognitive-behavioural strategies and coping skills acquisition. The model is implemented organisation-wide and includes creating and maintaining an environment that understands how children deal with trauma. A therapeutic team is provided. The model generally places groups of four to six young people together in a residential facility (James, 2017; McNamara, 2015 as cited in Oranga Tamariki, 2020). The Sanctuary Model originated in the Philadelphia area in the early 1980s. A team of clinicians working in a small inpatient adult hospital unit, led by Dr Sandra Bloom, combined their clinical knowledge and experiences to create Sanctuary (ANDRUS & The Sanctuary Institute, 2022).
Effectiveness	**CEBC rates it as 3 – Promising research evidence** A systematic review concluded that promising information was provided on the effectiveness of the Sanctuary Model, but that further research is required (Bailey et al., 2019). However, the evidence did suggest that trauma-informed care models may have significantly positive outcomes for children in out-of-home care.
Funder and delivery	The model was developed and implemented in the US, but is also delivered in Australia, and in Scotland (Henderson, 2020). Churches of Christ Care Pathways have been delivering the Sanctuary Model in Queensland since 2010 (Churches of Christ,

	2023; Clarke, 2012), funded by the Department of Children, Youth Justice and Multicultural Affairs. MacKillop Family Services is a community service organisation providing services across Victoria, Western Australia, Australian Capital Territory, and New South Wales. The Sanctuary Model has been implemented across MacKillop since 2012 (Galvin et al., 2022).
Indigenous elements	The Sanctuary Model was originally structured across four pillars, however, a fifth pillar of Cultural Safety has since been developed and is an important feature of the model in Australia (Galvin et al., 2022). The other pillars are trauma theory, SELF, seven sanctuary commitments, and the Sanctuary Toolkit.
Qualifications and training	A set of practical tools, known as the Sanctuary Toolkit which includes individual and community practices to build emotion regulation skills of individuals and build protective factors into the community. Sanctuary psychoeducation curricula for parents/caregivers (Teaching Families about Sanctuary and the Sanctuary Multi-Family Group Curriculum) are offered as part of the implementation process. At the organisational level, there are implementation standards that have to be achieved (The Sanctuary Institute, 2021).
Support services	Toolkit and manuals, certification, information, and resources. The Sanctuary Training: Considered too theory-based, too much information, and not sure how to implement, by staff at MacKillop (Galvin et al., 2022). The initial training was also considered to lack context for a residential care setting.
Financial support	Salary.
Industrial arrangements	Employee.

Model	**Keeping Foster Parents Trained and Supported (KEEP) foster-parent training intervention**
Key features	KEEP intervention represents a modified version of the MTFC/TFCO intervention developed at the Oregon Social Learning Center and is designed to provide training and support for children ages 5–11 in regular foster care.

Model	Keeping Foster Parents Trained and Supported (KEEP) foster-parent training intervention
	It is a 16-week group-based parent training programme for foster and kinship parents of children (KEEP Standard) and teenagers (KEEP SAFE). KEEP aims to increase the parenting skills of foster and kinship carers in responding to children's difficulties and supports foster families by promoting child wellbeing and preventing placement breakdowns. KEEP is delivered both in-person and virtually, to groups of 7 to 12 foster or kin parents. It also involves weekly 10-minute phone calls to individual foster or kin parents. The programme is typically conducted in a range of settings including the adoptive home, birth family home, foster/kinship home, outpatient clinic, provider, or residential care.
Jurisdiction	Implemented in the US and in England. Has not been available, or implemented, in Australia (Department of Families, Fairness and Housing Victoria, 2022a).
Effectiveness	**CEBC rates it as 3 – Promising research evidence** **Victoria, Australia's Child and Family Services Menu of Evidence rates it as Supported[10]** Studies suggest that it is effective in reducing child behaviour problems and that the effects of the intervention are mediated through changes in parenting behaviour (Price et al., 2009). There is also evidence that the KEEP foster-parent training intervention increases the chances of a positive change of placement (such as being reunited with biological parents) and mitigates the effect of multiple placements. Subsequent studies suggest the programme improves child behaviour and parenting style of the carer (Greeno, Lee, et al.,

[10] The Menu has 5 ratings:
Very well-supported – Evidence from an independent source that shows positive effects from a rigorous systematic review with meta-analysis of studies with similar results.
Well-supported – Evidence of positive effects from at least two randomised controlled trials or quasi-experimental studies on at least one child or family outcome.
Supported – Evidence of positive effects from at least one randomised controlled trial or quasi-experimental study on at least one child or family outcome.
Emerging – A programme or practice has a planned or underway evaluation using a randomised controlled trial or quasi-experimental design.
Logic-informed – A programme or practice has a logic model that explains why and how the approach should have positive effects on child and family outcomes.
Programmes with outcomes sustained 12 months and beyond, are indicated with a plus rating. For example, Supported+, Well-supported + or Very well-supported+.

Model	Keeping Foster Parents Trained and Supported (KEEP) foster-parent training intervention
	2016; Greeno, Uretsky, et al., 2016; Roberts et al., 2016), reduces carer stress (Roberts et al., 2016) and improves placement stability (Greeno, Lee, et al., 2016).
Funder and delivery	KEEP has been available in the UK since 2009 with more than 2,000 carers completing groups and the behaviours of 1,300 children tracked (National Implementation Service, 2018). KEEP Safe, KEEP Standard and KEEP Prevention (3-6) are delivered by facilitators around the UK. The implementation and operation of the programme is overseen by the National Implementation Service who has a business partnership agreement with KEEP developers in Oregon. It is funded by the NHS.
Indigenous elements	None.
Qualifications and training	KEEP is delivered over 16 weekly sessions of 90 minutes duration.
Support services	Unknown.
Financial support	None.
Industrial arrangements	Voluntary.

Model	Children and residential experiences (CARE) model
Key features	The Children and Residential Experiences (CARE) model aims to development an organisational climate that is therapeutically beneficial and supports and attends to the needs of each child within the organisation. This process was termed “creating a therapeutic milieu,” and involved staff from all levels of the organisation incorporating CARE principles into daily practice. Inherent in the attention on the whole-of-organisation approach is the assumption that a positive organisational climate and positive staff interactions will lead to better services, as well as improved child outcomes and wellbeing. The model was based on systemic practices oriented around six core principles, being (a) relationship based, (b) trauma-

Model	Children and residential experiences (CARE) model
	informed, (c) developmentally focused, (d) family involved, (e) competence-centred, and (f) ecologically oriented (Bailey et al., 2019; CEBC, 2020b). CARE model works with 6- to 20-year-old children and youth living in group and residential care settings.
Jurisdiction	CARE model was developed by Cornell University.
Effectiveness	**CEBC rates it as 3 – Promising research evidence** A systematic review of specialist care models found only one paper on the CARE model that met the threshold for inclusion. That study found that implementation of the model led to significant reduction in aggression towards staff, property destruction, and runaways. Inconclusive results were found for aggression towards peers and self-harm. The evaluation found that a more positive organisational climate predicted less aggression towards peers and less property destruction (Bailey et al., 2019; Izzo et al., 2016). A subsequent study employing quasi-experimental design found that child perceptions of relationship quality with care providers increased significantly in the three years after implementation of CARE. The effect was stronger with those who had several previous placements (Izzo et al., 2020 as cited in CEBC, 2020b).
Funder and delivery	Delivered by group or residential care organisations. Usually state-funded.
Indigenous elements	None.
Qualifications and training	There are no educational requirements to become a CARE educator. Anyone interested in becoming one must attend a training of educators' course offered by Cornell University and pass the written test to be certified. Onsite training is provided as part of an implementation agreement and contract with Cornell University. During the implementation period, Cornell consultants collaborate with agency leadership to assist the agency in fully implementing the CARE model. Consultation includes leadership retreats during which agency leaders are trained in the CARE model and principles. In addition, Cornell consultants conduct a 5-day training-of-educators event during which CARE Educators are prepared to train other agency staff in the CARE model (CEBC, 2020b).

Model	Children and residential experiences (CARE) model
Support services	Technical assistance visits include: – observation and feedback – training and coaching for frontline supervisors – developing routines for reflective practice – assistance with survey administration and data analysis – addressing organisational barriers to create a more therapeutic milieu. After implementation is complete, there is a 3-year sustainability agreement that includes 6-8 days of onsite visits and continued email communication, teleconferences, video conferences and access to annual regional, national, and international events. Agencies can apply for CARE Agency Certification once CARE is fully implemented. Support during the sustainability agreement includes continued support through onsite visits, training, on-going data collection and survey analysis, certification assessment visit, and on-going certification of agency staff to deliver CARE training throughout their organisation. There are implementation guides and manuals for the CARE model.
Financial support	Salary.
Industrial arrangements	Employee.

Model	Pressley Ridge Treatment Foster Care Program (PR-TFC)
Key features	Intensive, short-term treatment to youth with emotional and behaviour problems in a home environment with the foster parent as the primary agent of change. The model uses treatment foster parents who are given advanced clinical and technical training and support in order to best serve the youth placed in their home. Within the family setting, the treatment approach used by the programme is behavioural, based on measurable treatment goals which are monitored frequently. Treatment is guided by a treatment plan implemented by the treatment parents and consists of a set of specific goals which are tailored to each individual youth's needs and problems.

Model	Pressley Ridge Treatment Foster Care Program (PR-TFC)
	Three basic tenets underlie the PR-TFC model: 1) youth's troubled behaviour can change, 2) foster parents can learn to change youth's behaviour, and 3) treatment is teaching skills for effective living (CEBC, 2020a).
Jurisdiction	Evaluations were conducted in North Carolina and Virginia, with research participants from service provider Easterseals UCP.
Effectiveness	**CEBC rates the programme as NR – not able to be rated** **CEBC rates the pre-service curriculum as 3 – Promising research evidence** Basic pre-service training was compared with Pressley Ridge pre-service training. Analyses found that participants in the PR-TFC group were four times more likely to become licensed than those in the basic training group (Strickler et al., 2018). It was suggested that PR-TFC may increase parent's feelings of efficacy in being a treatment parent. Interestingly, most of those in the PR-TFC group who didn't become licensed were not considered as suitable candidates for licensing by the relevant agency. It was suggested that the PR-TFC may be a useful tool in reducing the financial and resource cost of recruiting, training, and certifying foster parents (Strickler et al., 2018). There are some studies that find that the model appears to lead to children and youth with improved day-to-day functioning (for example, Bishop-Fitzpatrick et al., 2015). But the California Evidence-based Clearinghouse for Child Welfare concludes that the overall programme is "not able to be rated" (CEBC, 2020a).
Funder and delivery	Funded by the state or NGOs. Pressley Ridge is based in Pittsburgh, Pennsylvania and is a service provider focusing on diverse communities and the needs of the most complex youth and families.
Indigenous elements	None.
Qualifications and training	PR-TFC Pre-Service Curriculum is designed to be used by agencies to provide 30 hours of training to incoming treatment foster care (TFC) parents by going through all 12 units in the curriculum. Integrated multimedia resources within the curriculum include slides, video vignettes demonstrating therapeutic skills taught during training, and role plays (CEBC, 2022). All trainers use the PR-TFC Pre-Service Curriculum training manual and parents also receive a manual with training content,

Model	Pressley Ridge Treatment Foster Care Program (PR-TFC)
	homework, and reading assignments. The PR-TFC Pre-Service Curriculum is a competency-based programme rooted in social learning theory, behaviourism, working alliance, and trauma-informed care. Recommended that carers train for 2.5 - 3 hours for each unit, maximum of 2 units per training session each week, for 6 - 8 weeks. Training is typically conducted in foster/kinship care, or through a provider.
Support services	Formal support is optional. Pressley Ridge's training department provides implementation support through teleconferencing or e-mail on an as-needed basis up to 6 months for an additional cost. Pressley Ridge can provide support for fidelity monitoring and programme effectiveness evaluation on an as-needed basis through teleconferencing or e-mail up to 6 months for an additional cost.
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Teaching-Family Model (TFM)
Key features	Teaching Family Model works with six to eight youths living in small group homes (Oranga Tamariki, 2020). Treatment is typically delivered by married couples in a family-style living and learning environment and is realised by proactive teaching interactions focused on positive prevention and youth skill acquisition. The model also uses a client-peer leadership / self-government system. The “teaching parents” are also involved with children’s parents, teachers, and other support networks to help maintain progress. There are seven essential elements: teaching systems, self-determination, client advocacy, relationships, family-sensitive approach, diversity, and professionalism. Each element is supported by standards and competencies. The Teaching-Family Association assesses carers in these standards and competencies, leading to certification.

Model	Teaching-Family Model (TFM)
Jurisdiction	TFM was first implemented in 1967 in a group home for delinquent children. Adaptation of this model is known as Boys Town. Model is used by Berry Street in Australia for residential care.
Effectiveness	**CEBC rates the programme as 3 – Promising research evidence** The TFM was rated as “promising” according to CEBC criteria based on 10 peer-reviewed articles (CEBC, 2021). A cost benefit analysis found that for every participant in a TFM group home (rather than another type of group home) there was a $21,355 net benefit. There was also a high chance that the programme would produce benefits that are greater than the costs (Washington State Institute for Public Policy, 2019).
Funder and delivery	Funded by the state or NGOs. The Teaching-Family Association is based in Anderson, South Carolina.
Indigenous elements	None.
Qualifications and training	For all residential settings, it is a 24/7 arrangement. Ideally for nine months. Qualifications required are those set by the service provider. For home-based interventions, it is a 10-15 sessions per week arrangement. For 6-10 weeks. Training is competency-based and involves theory, practice, demonstration, and implementation. TFM is manualised.
Support services	TFM has a written set of standards and ethics. TFM standards include goals, systems, and elements. There are 78 indicators across the standards, each one measuring the fidelity of implementation at the agency, across its programmes, and of staff. First-hand observations, training, supervision, staff development, evaluation, consumer satisfaction records, interviews with external consumers (clients, families, partners, stakeholders, and other involved persons/agencies) and internal consumers (agency-wide staff, Boards, others) are all required. Demonstration of all standards to criteria (using a 4-point rating scale) is required (CEBC, 2021).

Model	Teaching-Family Model (TFM)
Financial support	Reimbursement.
Industrial arrangements	Voluntary.

Model	Simply Smiles Children's Village
Key features	In partnership with the Reservation community, Native activists, elders, child welfare professionals, and the state of South Dakota Child Protective Services, Simply Smiles (an NGO) built and piloted the Simply Smiles Children's Village—a community of foster families offering a child placement option that fulfills the spirit of the Indian Child Welfare Act (ICWA) by ensuring that Native children who have been removed from their homes can remain with kin and community (Simply Smiles, 2023). Construction began in 2019 and by 2022 the Children's Village had three four-bedroom homes, a dedicated counseling building, and a 5,200-square-foot garage and storage building. The model is currently in an operational pause while it seeks to transition to a model that will, ideally, be fully Native-led and operated (Simply Smiles, 2023).
Jurisdiction	The Children's Village is situated on the Cheyenne River Reservation in South Dakota.
Effectiveness	No evaluations or research available. Model in infancy.
Funder and delivery	Simply Smiles is an NGO and funds the Children's Village through donations, grants, and the State (when children in State care are referred to the Children's Village) (Zoints, 2023). The Children's Village is licensed by the state of South Dakota's Department of Social Services as a Therapeutic Foster Placement Agency (John and Daria Barry Foundation, 2020).
Indigenous elements	Co-developed with Native tribes. Tribal council voted to support the model, and Simply Smiles has advisors including other leaders of the Cheyeen River Sioux and other tribes (Zoints, 2023). Seeking to move to Native-led in the future.

Model	Simply Smiles Children's Village
Qualifications and training	The programme's foster parents receive 70 more hours of training than required by the state, including education about Lakota culture (Zoints, 2023). Simply Smiles have had difficulty recruiting, with burnout experienced by one foster parent during the COVID-19 pandemic, and another found it difficult due to the remoteness of the location (Zoints, 2023).
Support services	On-site resources and staff members. The Children's Village also offers telehealth therapy, evaluations, and medication management to the foster parents, children, and birth parents (Zoints, 2023).
Financial support	Housing, salary, and benefits (Heemstra, 2021).
Industrial arrangements	Unclear but likely an employee.