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ORANGA TAMARIKI
Ministry for Children

EVIDENCE CENTRE
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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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ORANGA TAMARIKI
Ministry for Children

CONTENTS

List of figures

List of tables

Glossary

Adverse childhood experiences (ACEs): are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust and bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation (Bunting *et al.*, 2019).

Evidence-based practice (EBP): the "integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (Goodheart *et al.*, 2006).

Framework: a set of therapeutic care principles and structures for describing, understanding, and guiding practice (Baron *et al.*, 2019).

Intervention: an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions (WHO, 2020b).

Model: a therapeutic care model is a multidimensional concept that defines the way in which therapeutic care services are delivered. They act as a conceptual tool that is an example or standard for comparison or replication, and combine concepts, beliefs, and intentions that are related in some way (Davidson *et al.*, 2006).

Therapeutic care: is a planned, team-based, and intensive approach to the complex impacts of abuse, neglect, and separation from families and significant others. This is achieved through the provision of a care environment that is evidence driven, culturally responsive, and provides positive, safe and healing relationships and experiences to address the complexities of trauma, attachment, and developmental needs (McAloon, 2016).

Therapeutic environment: the intangible and tangible therapeutic care space(s) supporting and surrounding children and families/whānau. These space(s) can extend across socio-ecological levels and in are particularly distinguished by capability and responsibility, for example, involving client-therapist, caregivers-staff-agencies, whānau-hapū-iwi, and individuals-groups-communities (among others).

Trauma: "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can involve "a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing" (SAMHSA, 2014). Māori perspectives of abuse, violation, and healing further focus on abuse as a violation of tapu. It should also include a focus on chronic and complex individual and collective trauma over the long-term (Ruwhiu and Eruera, 2015; Pihama *et al.*, 2017).

Trauma-informed: "an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognising that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic" (SAMHSA, 2014).

Trauma-informed care: "a strengths-based service delivery approach grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (SAMHSA, 2014). For Māori, healing must take place at individual and collective levels to prevent the intergenerational transmission of trauma (Pihama *et al.*, 2017).

SUMMARY

1. This evidence brief presents a comprehensive narrative review of the therapeutic care literature. The evidence is intended to inform the Oranga Tamariki Therapeutic Working Group. This evidence brief does not comprise an exhaustive search or systematic review. It reflects the literature available from online and library sources at the time of writing. It may be useful in due course to update this evidence brief and/or carry out more targeted research on the topics discussed, particularly as new evidence and findings emerge.
2. The therapeutic care literature is wide-ranging, and it is impossible to adequately elaborate upon all the aspects and levels of interest to the Working Group. However, this evidence brief should provide an adequate overview and depth of coverage to inform discussion and decision-making. The recommendations provide a degree of evidence-based direction for the Working Group.
3. Oranga Tamariki is going through a multi-year journey to transform how it and its partners meet the needs of those children and families/whānau involved with the system to improve their long-term outcomes. As part of that transformation, Oranga Tamariki is looking to better understand therapeutic care.

Purpose

4. The purpose of this evidence brief is to provide a description of 'therapeutic care' and outline essential aspects of the therapeutic care environment. This includes evidence and insights across several related therapeutic care levels (settings, models, and interventions). This evidence brief does not attempt to gather all the available evidence on therapeutic interventions to assess their effectiveness. Rather, it starts with a fundamental question: what is common to good practice therapeutic care?

Key findings

Background

5. There are currently 5,950 children in the care of Oranga Tamariki (as at 30 June 2020). One hundred young people were in youth justice custody. We know that many of the children in care (and in youth justice custody) suffer significant adversity and trauma. As a result, they often have high and complex needs.
6. Children's healthy development and wellbeing depends on nurturing care that ensures health, nutrition, responsive caregiving, safety and security, and learning. Oranga Tamariki is responsible for ensuring that children and young people are safe and nurtured in their families/whānau, and homes. There is also a broader endeavour and drive in government and the social sector towards a holistic focus on health and wellbeing.
7. Trauma results from an "event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual wellbeing". Child maltreatment can result in significant trauma that has immediate and long-lasting consequences. Child maltreatment can also lead to wider flow-on effects for communities and society.

8. Research shows that the children who end up doing well following adversity (and trauma) have at least one stable and responsive relationship with a parent, caregiver, or other adult. These relationships provide the scaffolding, support, and protection for children, buffering them from developmental disruption and helping to build key capabilities.

9. Māori view abuse as a violation of tapu. Māori also "experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health". Historical trauma is linked to the prevalence of violence within Indigenous communities.

10. Trauma-informed care is a widely accepted approach overseas and in Aotearoa New Zealand. It is a 'strength-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma'. Trauma-informed care recognises how trauma affects all people involved in a service response and is broadly a whole system change process that looks to embed a consistent and coherent model of trauma-informed care.

11. Trauma-informed care responses for Māori need to be critically assessed and the therapeutic and policy response appropriate. Many Western orientations are inappropriate. Other groups may also require specific trauma-informed care responses, such as disabled children and those involved with youth justice.

Therapeutic care

12. Therapeutic care incorporates a range of interventions, or 'ways of working', usually stemming from a variety of therapeutic techniques or theories presented and employed in different ways. Therapeutic care for children can be broadly defined as a:

> planned, team-based, and intensive approach to the complex impacts of abuse, neglect, and separation from families and significant others. This is achieved through the provision of a care environment that is evidence driven, culturally responsive, and provides positive, safe and healing relationships and experiences to address the complexities of trauma, attachment, and developmental needs (McAloon, 2016).

13. Further differentiation speaks to settings, models used, and interventions employed as the key areas of interest and activity for children's welfare organisations. Therapeutic care is differentiated for the purposes of this evidence brief into three categories: therapeutic care settings, therapeutic care models, and therapeutic care interventions.

14. While there are complicated distinctions between aspects of therapeutic care, what is common among definitions at different levels is the focus on healing and safe relationships with caregivers and workers at the centre of therapeutic care practice. Daily life for children in care is seen a naturally occurring opportunity for them to experience healing and safe relationships.

15. Relationships are one among several 'common factors'. Common factors are specific to therapeutic care settings and models and are present in therapeutic interventions in clinical health care, i.e. trauma-related psychotherapy.

16. Māori models of health and wellbeing are a way of conceptualising therapeutic focus. The foundations of Māori healing practices are based on interconnected relationships. The health and wellbeing of tamariki Māori is inseparable from that of their whānau.

17. A therapeutic care model is a multidimensional concept that defines the way in which therapeutic care services are delivered. There is currently insufficient evidence to support them or to support one therapeutic care model over another. Further research and evaluation

is required to get a clearer idea of 'what works for whom' and gather information on contextual factors and longer-term outcomes. There is significant common ground in these models, including the provision of a nurturing environment, building attachment to significant people, and helping children to develop critical practical, social and emotional competencies.

18. Research on therapeutic care interventions, including in residential care settings, demonstrates effectiveness if they are responsive to children's needs. These interventions include behaviour modification, family/whānau focused interventions, and specific skills training tailored to children's developmental levels.

19. The main psychotherapy approaches are commonly referred to by the 'theories' upon which they are based. These include cognitive and behavioural, psychodynamic, humanistic/experiential and integrative (common factors) approaches. This evidence brief contains a summary of predominant modalities and interventions includes cognitive and behavioural, psychodynamic therapy, and humanistic/experiential therapy, with reference to integrative (common factors) where relevant.

    19.1 Trauma Focused-Cognitive Behavioural Therapy (CBT) is the best supported and most widely used CBT intervention for treating children who have been traumatised.

    19.2 Research has also been completed that supports other types of psychotherapy, in particular psychodynamic therapy. Psychodynamic therapy is one of the most frequently used treatments for mental health difficulties.

    19.3 The humanistic therapy evidence base for the treatment of mental disorders, including depression, is less extensive than for other approaches. Some recent research from overseas suggests comparability with CBT.

20. There are demonstrated and emerging areas of understanding that require further enquiry and research. There are outstanding questions about the strength of some psychotherapy evidence, specifically for CBT, compared to other modalities and interventions. Further high-quality studies are needed.

21. Most of the therapeutic interventions used in Aotearoa New Zealand originate in part or entirely from overseas. They do not adequately address Aotearoa New Zealand's unique cultural context, specifically for Māori, and for other ethnic groups. They frequently have a mono-cultural viewpoint and are often based on evidence from a predominantly Western perspective.

22. The importance of cultural identity is found in the literature on good practice therapeutic approaches involving Indigenous populations, along with considerations of spirituality, understanding family dynamics, and crucial links to the surrounding environment. Similar themes, including a strong cultural identity for tamariki Māori and adults, are found in the Aotearoa New Zealand literature.

Conclusion

23. An important concept is that of a therapeutic care framework, which can be simply defined as *a set of therapeutic care principles and structures for describing, understanding, and guiding practice.* Common to therapeutic care frameworks overseas are congruent, whole of organisation commitments to therapeutic care and the use of trauma therapy, and trained staff.

24. A therapeutic care framework offers a promising evidence-based option for creating collective therapeutic intent and responsibility for everyone working in the child welfare

system and for best supporting children and families/whānau within a holistic therapeutic environment. Questions remain about what such a framework might look like – its appropriate design, implementation, and sustainability.

25. Developing a therapeutic care framework is an iterative process, involving the development of processes, resources, skills, and systems to reduce the gap between research evidence, manifest needs, and day-to-day and clinical practice. Collaborative approaches are the best way to pursue change and develop a suitable therapeutic care framework.

Recommendations

26. Based on this review of evidence it is recommended that consideration be given to:

    26.1 a survey of agencies and providers to assess existing therapeutic frameworks, therapeutic models, and therapeutic interventions. The survey should also consider organisational and staff 'ways of working' (among other matters).

    26.2 an Oranga Tamariki therapeutic care framework. There is strong evidence to support the development of a therapeutic care framework (as several overseas jurisdictions have done). The intent is to set clear parameters for therapeutic care based on clear evidence and values, including common factors, relationships, and te ao Māori.

    26.3 a structured evidence review process to support the systematic assessment and evidencing of therapeutic care approaches in Aotearoa New Zealand. This includes the assessment and evidencing of different modalities and interventions for effectiveness and outcomes.

INTRODUCTION

27. Oranga Tamariki—Ministry for Children was established in 2017, following the Expert Advisory Panel (EAP) report in 2015, which found the care, protection, and youth justice system did not meet the needs of those children and families/whānau involved with the system or do enough to improve their long-term outcomes.

28. Oranga Tamariki is going through a multi-year journey to transform how it and its partners meet the needs of those children and families/whānau involved with the system to improve their long-term outcomes. As part of that transformation, Oranga Tamariki is looking to better understand therapeutic care.

Purpose

29. The purpose of this evidence brief is to provide a description of 'therapeutic care' and outline essential aspects of the therapeutic care environment. This includes evidence and insights across several related therapeutic care levels (settings, models, and interventions).

30. Care Services are renewing their focus on therapeutic care amidst this transformation programme.[1] The therapeutic care project has implications across the Oranga Tamariki operating model and beyond. Specific project outputs include:

    30.1 providing a description of 'therapeutic care'

    30.2 elaborating upon the current therapeutic care environment

    30.3 proposing options for future consideration and therapeutic care service development.

31. The project considers the Oranga Tamariki and Aotearoa New Zealand 'therapeutic care' viewpoint, including current service characteristics and provision, recent care and practice changes, international, and cultural and te ao Māori perspectives.

32. This evidence brief considers what is arguably the wider therapeutic environment – the context within which therapeutic care is contextualised and functionalised. This includes the drive provided by the EAP report (2015), the subsequent establishment of Oranga Tamariki and ongoing transformation of the child welfare system, and broader contextual factors such as the development of a 'Child and Youth Wellbeing Strategy'.

33. This evidence brief touches on trauma and adversity and trauma-informed responses as a preface to the broader discussion of therapeutic care. It then approaches therapeutic care by examining key conceptual considerations. This helps elaborate upon the essential aspects of what a 'therapeutic care approach' might entail. This includes:

    33.1 Relationships: based on the premise that relationships are at the heart of what we do and the heart of effective therapeutic care.

[1] Please refer to the 'Care framework' (final version) for an early iteration of a therapeutic care response. Among the eight design principles the framework states "Care is an inherently therapeutic response to tamariki with some of the most complex needs, and should be provided in the least restrictive, most whānau-like setting as possible" (Oranga Tamariki, 2018).

33.2 Common factors: based on the premise that therapeutic care environments (including settings and interventions) share common therapeutic factors.

33.3 Māori knowledge, health, and wellbeing: based on the premise that an understanding and inclusion of these is critical to the future and success of therapeutic care in Aotearoa New Zealand.

33.4 Socio-ecological perspective: based on the premise that is important to distinguish between different levels of therapeutic level and spheres of influence. It also importantly informs broader understandings of how therapeutic approaches can be framed.

34. This evidence brief then outlines the fundamental components of therapeutic care including therapeutic setting, models, and interventions differentiating between therapeutic care elements and highlighting essential therapeutic care practices for consideration.

35. The evidence brief concludes by summarising some of the factors that support the development of a successful therapeutic care environment. Implementation is crucial to any improved therapeutic framework and environment. Therapeutic care transformation should also be multifaceted and take an integrated longer-term perspective. This evidence brief importantly also gathers and considers te ao Māori evidence and perspectives.

36. The evidence brief's aim is to provide the project with contemporary and relevant therapeutic care evidence and insights. Where appropriate, the evidence brief has sought to include innovative therapeutic care perspectives. Together they will support the deliberations of the project working group, potential next steps (design and development), and help to inform Care Services decision-making. The evidence brief is set out in a narrative style.

BACKGROUND

37. It is important to provide some additional background and context to set the scene for understanding where 'therapeutic care' is or may be positioned in what is described as the therapeutic environment, i.e. the Oranga Tamariki relational environment. This includes the wider socio-ecological environment where government and social sector changes can influence the determination and any implementation of therapeutic care.

38. By also providing a short review of trauma and trauma-informed care, this section also provides alternatives to any potential therapeutic care response. In particular, that trauma has profound implications on children and families/whānau and that trauma-informed care is commonly seen in the literature as the most appropriate response. However, it should be noted, that these conceptualisations are limited in their depth and scope, particularly in being able to sufficiently consider te ao Māori understandings and responses to trauma.[2]

The 'therapeutic environment'

39. There are currently 5,950 children in the care of Oranga Tamariki (as at 30 June 2020).[3] One hundred young people were in youth justice custody (Oranga Tamariki, 2020a). There is a lack of detailed information on children in care and what is available is often incomplete and/or fragmented (or held elsewhere). We know that many children in care suffer significant adversity and trauma and as a result have high and complex needs. There are also high numbers of children and families/whānau struggling and on the edge of care.

40. Children's healthy development and wellbeing depends on nurturing care that ensures health, nutrition, responsive caregiving, safety and security, and learning (Richter *et al.*, 2016). Their healthy development and wellbeing encompass physical, mental, intellectual, social and emotional states and is not merely the absence of disease or infirmity. The opportunities and potential for children's' healthy development and wellbeing resides within the families/whānau, communities, and environments where they live (WHO, 2020a).

41. The EAP report set out a determined challenge and series of recommendations for transforming the care and protection system in Aotearoa New Zealand with the intention of supporting the opportunities and potential of children and their families/whānau. This included the development of preventive and intensive intervention services as well as improvements to care services (when a child is unable to live at home), youth justice, and transitions (Expert Panel, 2015, p. 72).

42. The EAP recognised that children referred because of care and protection concerns frequently suffer from "high levels of adversity, often over prolonged periods, with many experiencing highly stressful traumatic events". They indicated that these "children must receive highest quality therapeutic intervention so they can begin to recover from these

[2] It is understood that work on trauma and trauma-informed care is ongoing within the Ministry. This includes te ao Māori conceptualisations and responses, i.e. mana-enhancing care. Gledhill *et al.'s* (2016) paper for the Investing in Children programme provides an earlier evidence discussion of trauma and trauma response and considers te ao Māori perspectives (Gledhill *et al.*, 2016).

[3] Who are legally in the custody of the Chief Executive. Of children living with a caregiver, 88 percent are living with family/whānau or with a caregiver of the same ethnicity.

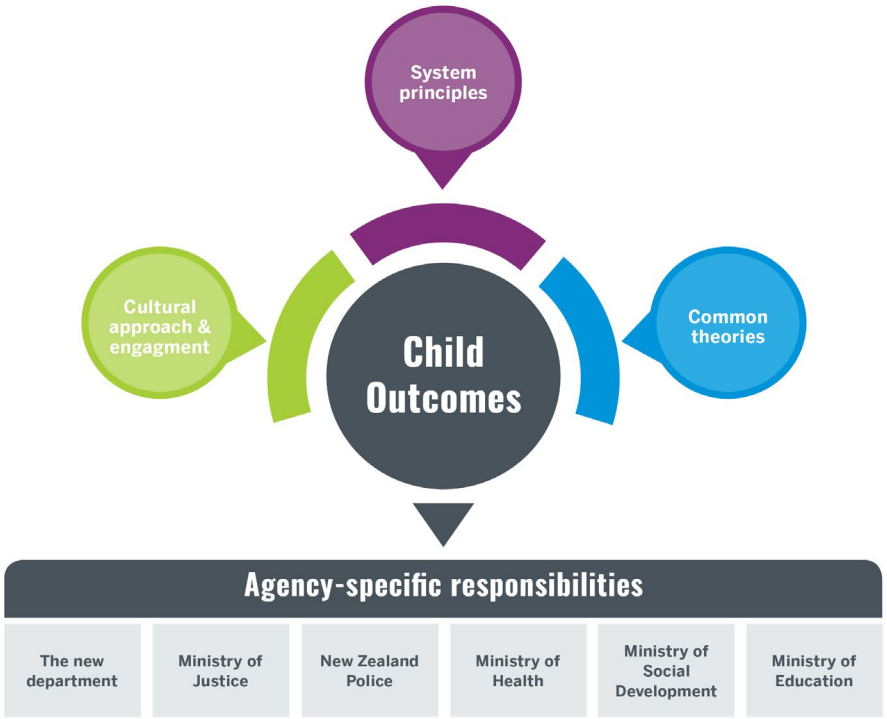
experiences" (Expert Panel, 2015, p. 66). The proposed trauma-informed framework would operate at two levels:

42.1 A system-level practice framework that underpins the engagement of all agencies and professionals with children and families. The system-level framework will ensure that a range of professionals working with children and young people, across multiple agencies, have a shared view on best practice and objectives (Figure 1 below).

42.2 A department-level practice framework that provides explicit guidance about what needs to be done, why it needs to be done, and how it needs to be done. Mandatory standards and tools for supported decision-making will ensure a focus on the needs of individual children and young people, ensure that staff are clear about the "must-do's", and that decisions and their rationale are transparent and well-evidenced (Expert Panel, 2015, p. 66).

43. The EAP noted that the care and protection system was fragmented and lacked a common set of definitions, policies, processes, tools and practices when dealing with children and their families/whānau. Its recommendations sought agreement to the implementation of a single, system-wide, trauma-informed, professional practice framework, to be characterised by a common set of definitions, behaviours, values, principles, and commitment to evidence from all professionals working with children and their families/whānau across the social sector (Expert Panel, 2015, p. 67).

Figure 1: Expert panel system-level framework for practice



Source: (Expert Panel, 2015, p. 67).

44. Oranga Tamariki is now responsible for ensuring that children and young people are safe and nurtured in their families/whānau, and homes. The Ministry's purpose is to ensure that all tamariki are in loving families/whānau and communities where oranga tamariki can be realised. To achieve this responsibility and vision the Ministry is going through a significant programme of transformation that will change the way care and protection is provided to children and families/whānau in need (Oranga Tamariki, 2019).

45. The Ministry is placing increased emphasis on prevention and targeted support (early intervention and intensive intervention). It is also striving to improve the care of children who are unable to live at home. The goal is to ensure children are safe and to promote their wellbeing. This includes the provision of stable and loving care that enables them to be safe, recover, and flourish (Oranga Tamariki, 2019).

46. The Government has also recently begun implementing the 'Child and Youth Wellbeing Strategy', which outlines an aspirational vision that 'New Zealand is the best place in the world for children and young people'. The Strategy sets out a framework for improving child and youth wellbeing that can be used by anyone. It provides a shared understanding of what children and young people want and need for good wellbeing and what we can all do to support them to have good lives (DPMC, 2019).

47. The Strategy has a Current Programme of Action that focuses on six identified wellbeing outcomes of the Strategy. It draws on evidence about what works, focusing on urgent needs and longer-term systems and services transformation to improve the wellbeing of children and young people. The Government has given initial priority to actions that will:

    47.1 Reduce child poverty and mitigate the impacts of poverty and socio-economic disadvantage.

    47.2 Better support children and young people of interest to Oranga Tamariki and address family and sexual violence.

    47.3 Better support children and young people with greater needs, with an initial focus on learning support and mental wellbeing.

Childhood adversity and trauma

48. Most children suffer some form of adversity in their lives. Some adversity can be traumatic and can have a long-lasting impact on children's development, health, and wellbeing.[4] Oranga Tamariki is particularly concerned about child maltreatment (and its traumatic impacts). Child maltreatment specifically refers to the physical and emotional mistreatment, sexual

[4] Adversity is described as "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust and bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation" (Bunting *et al.*, 2019).

abuse, neglect, and negligent treatment of children, as well as to their commercial or other exploitation and can occur in many different settings (WHO, 2006; Bailey *et al.*, 2019).[5][6]

49. Child maltreatment has immediate and long-lasting consequences for children and their families/whānau.[7] Such major adversity, along with other precipitating factors, can cause disruption to early brain development and put the body's stress response system permanently on high alert.[8] The negative outcomes for children and adults can include mental and health problems, diminished social functioning, and decreased life expectancy (Center on the Developing Child, 2007; WHO, 2016; Australian Institute of Family Studies, 2017).

50. Child maltreatment can lead to wider flow-on effects for communities and society, including costs of hospitalisation, mental health treatment, child welfare, and longer-term health costs with implications for workforce, social and economic development (Center on the Developing Child, 2007; WHO, 2016; Australian Institute of Family Studies, 2017)

51. Māori conceptualisation of trauma is a holistic one that includes physical, mental, and emotional health and wellbeing. Traditional Māori wellbeing systems are being redefined for the contemporary period. They remain critical to Māori health and wellbeing. Whānau and hapū are central to these interdependent wellbeing systems:

> The whānau and hapū base of traditional Māori life ensured that traumatic events were not isolating events. Through whakapapa, no individual was a disconnected entity and the stresses associated with traumatic events were always shared experiences, through whanaungatanga. Coping strategies and healing pathways could always be activated through these familial linkages. Beyond the affected individual or group were relatives or allies who could provide resources and support. Distanced from the trauma, these relatives provided coping strategies and means of recovery through the shared values of rangatiratanga, manaakitanga, aroha and whanaungatanga (Smith, Tinirau and Smith, 2019).

52. Māori have a worldview that has its own "valid and legitimate understandings about both the protection and abuse of the human person and as such of mokopuna" (Ruwhiu and Eruera, 2015). Māori perspectives of abuse, violation, and healing focus on abuse as a violation of tapu.

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[5] The WHO further describes child maltreatment as "abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment" (see: www.who.int/news-room/fact-sheets/detail/child-maltreatment).

[6] Another commonly cited trauma definition comes from the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States, which describes trauma as resulting from an "event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. xix).

[7] The terms "maltreatment" and "abuse" are often used interchangeably in the literature. However, in this document, "maltreatment" is a general term that includes both abuse and neglect; "abuse" refers explicitly to acts of commission; and "neglect" refers explicitly to acts of omission (see: Leeb RT, Paulozzi L, Melanson C, Simon T, Arias I. (2008). Child maltreatment surveillance: uniform definitions for public health and recommended data elements, Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control).

[8] The terms 'adversity' and 'trauma' are sometimes used interchangeably. However, there is a difference – 'adversity' describes the situation or experience; 'trauma' more often describes the impact of the situation or experience (Brennan *et al.*, 2019).

> Abuse is a violation of one's tapu. It is a perpetration or an act of violence, referred to in Māori as 'hara', which subjects the victim to a state of 'noa' or tapu restriction. The concept of noa depicts a person being in the state or the absence of mana, that is, having the power to effect change.... Abuse is a violation against the victim, the perpetrator and both of their whānau collectives... the effects of the violation and prolonged state of noa makes them vulnerable to further abuse and violent behaviour themselves... the prolonged state of noa is called 'whakamā'.... In this sense whakamā refers to the symptoms of prolonged unaddressed abuse (an externalisation of the victim's hurt emotions and a subconscious plea for help to be cleansed from the violation or the transgression of their tapu) (citing Peri (2006) Ruwhiu and Eruera, 2015).

53. Trauma in the Western sense is often framed narrowly with a focus on individuals over the short-term – lacking a focus on chronic and complex individual and collective trauma over the long-term. Māori "experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health" (Pihama *et al.*, 2017). Phillips (2008) writes there are three different trauma areas experienced by Indigenous people and these are relevant to Māori:

    53.1 Situational trauma: that occurs as a result of a specific or discrete event

    53.2 Cumulative trauma: subtle feelings that build up over time, such as discrimination or racism

    53.3 Inter-generational trauma: if trauma is not dealt with in one generation, it often gets passed down unwittingly in behaviours and thought systems (Phillips, 2008).

54. Pihama et al. (2017) writes that historical trauma – the collective complex trauma as a result of colonisation and its repercussions – is linked to the prevalence of violence within Indigenous communities. This viewpoint acknowledges the ripple effect that colonisation has had across generations including inherited grief and trauma, land dispossession and loss of traditional language and cultural practices, damage to traditional roles within culturally defined social structures, economic exclusion related to high poverty rates, and difficulties confronting issues. Pihama et al. (2017) relays that contemporary colonisation for Māori is seen in systemic, institutional, and interpersonal racism including the ongoing negative stereotyping of Māori. Historical colonisation is marked by land alienation, a breakdown of social structures, disruption of gender relationships, violence at the hands of colonial forces, and extreme depopulation (Pihama *et al.*, 2017).

Trauma-informed responses

55. Child maltreatment and resulting trauma can have profound developmental consequences (McPherson *et al.*, 2019a). It is important to understand childhood development and the impacts of early experiences on the brain, given the influence on subsequent patterns of behaviour, health, and wellbeing. Children who have experienced significant adversity and trauma will have likely experienced disruptions to their maturational process (McAloon, 2016), and disruptions in the context of their early caregiving and later relationships with adults (McLean, 2018). This can lead to significant difficulties later in life with implications for the treatment of children and adults. For example, research clearly shows childhood trauma is significantly associated with the later development of depression (Negele *et al.*, 2015).

56. Children in care are more likely to have experienced significant adversity and resulting complex trauma (McLean, 2016). Even in safe settings, where adaptations to adversity are no longer needed, traumatised children may continue to react in challenging ways (Furnivall and Grant, 2014). They are likely to have difficulty with their internal regulatory skills without the

buffering support of competent adults to help them recover. As early development is embedded in caregiving relationships, and to ensure opportunities to foster a supportive setting for recovery are not missed, understanding the impact of trauma on children is particularly important in the out-of-home care (OOHC) setting (Taylor and Siegfried, 2005; Bailey *et al.*, 2019).[9] It is also important to be aware of other adversities facing children who have experienced maltreatment, for example, antenatal alcohol exposure, placement instability, poverty, neglect and pervasive developmental issues. Therapeutic care focusing on complex trauma, may be necessary in such cases, but not sufficient to meet the overall developmental needs of particular children (McLean, 2016).

57. Trauma-informed care (TIC) is a widely accepted approach to policy and practice overseas (McLean, 2018).[10] The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States describes TIC as:

> A strengths-based service delivery approach 'that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment'. It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services (SAMHSA, 2014).

58. SAMHSA identified three key elements that underpin TIC: (1) realising the prevalence of trauma; (2) recognising how trauma affects all individuals involved with the programme, organisation, or system, including its own workforce; and (3) responding by putting this knowledge into practice (SAMHSA, 2014). Hanson and Lang (2016) set out key elements that contribute to TIC operationalisation: workforce development (training, awareness, secondary traumatic stress); trauma-focused services (use of standardised screening measures and evidence-based practices); and organisational environment and practices (collaboration, service coordination, safe physical environment, written policies, defined leadership) (Hanson and Lang, 2016).

59. TIC is informed by seminal adverse childhood experience research in the United States and subsequent studies around the world confirming the connection between ACEs and negative outcomes across multiple domains over the life course.[11] Bunting et al. (2019) writes:

> In recognising the impact of childhood adversity on child and adult outcomes, trauma-informed services strive to build trustworthy collaborative relationships with children and the important adults in their lives, as well as improve consistency and communication across linked organisations and sectors, with the aim of mitigating the impact of adversity by supporting and enhancing child and family capacity for resilience and recovery, and reducing organisational

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[9] Out-of-home care (OOHC) refers to the alternative care circumstances for children and young people who are unable to live at home with their parents or family. There are several different OOHC options, including home-based (kin or non-kin caregivers), family-group homes, or residential care. Each of these options can provide differing support levels. For more information on OOHC care option see: https://www.orangatamariki.govt.nz/caregiving/types-of-caregiving/.

[10] For a wider discussion of trauma-informed care in relation to Aotearoa New Zealand see Donaldson, Jury, and Poole, (2018) Trauma-Informed Care: Literature Scan (Donaldson, Jury and Poole, 2018).

[11] The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from the United States, It analysed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.

practices that may inadvertently exacerbate the detrimental effects of severe adversity and constrain engagement (Bunting *et al.*, 2019).

60. TIC more broadly is a whole system change process that strives to embed a consistent and coherent model of trauma-informed care into policy and practice. This includes actions to incorporate trauma principles and understandings into organisational culture. TIC focus is evident in a number of social sector roles and settings, including care and protection, justice, mental health, and education (Bunting *et al.*, 2019).

61. There are also increasing activities overseas to better integrate children's OOHC services through the implementation of system-wide changes that incorporate organisational trauma-informed approaches. The intention is to provide an overarching strategy and common language for children, families/whānau, caregivers, and staff, among others, across all levels of the organisation. Trauma-informed organisations recognise the impact of trauma and develop an understanding of trauma in their workforces. This is intended to help reduce the overall experience of trauma (past, present, and vicarious) (Bailey *et al.*, 2019).

62. It is central to the intention of TIC that those working in the field should understand and work well with people who have experienced individual and collective trauma. It is also crucial to understand how trauma occurs within the context of culture and how culture influences the meaning attributed to trauma. Culture can affect several trauma-related areas including symptoms, treatment setting experiences, and the provision of TIC. TIC responses may need to adapt their practices to account for specific needs (Pihama *et al.*, 2017).

63. Healing can take place at individual and collective levels to prevent the intergenerational transmission of trauma. For Māori, the impact of intergenerational transmission of trauma in whānau, hapū, and iwi, and the implications on individual behaviour, needs to be critically assessed, and responded to appropriately in therapeutic and policy frameworks that determine what and how support is provided. Many Western orientations are inappropriate, as they are not informed by Māori understandings and an awareness of historical trauma and its impacts on Māori. TIC is too often only offered or provided through a clinical lens. Te ao Māori offers cultural and healing paradigms, including kaupapa Māori approaches, where te reo, tikanga, and mātauranga Māori are central (Pihama *et al.*, 2017; McClintock *et al.*, 2018; Smith, Tinirau and Smith, 2019). Numerous other cultural factors are also influential and have relevance in a multi-cultural society.[12]

Table 1: Cultural factors

Culture: Cross-cutting factors
Religion & spirituality: traditions, spiritual beliefs, and practices
Languages & styles of communication: Verbal and nonverbal
Geographic location: Rural, urban, regional
Worldview, values, & traditions: Ceremonies, ways of life, individualistic vs. collective etc.
Family & kinship: Hierarchy, roles, rules, traditions, definition of family
Gender roles & sexuality: Gender norms, attitudes towards sexuality & sexual identity, sexual expression etc.

[12] Broader reflections on indigenous child and family wellbeing in the context of social work can be found in 'Te Ao Kohatu: literature review of Indigenous theoretical and practice frameworks for mokopuna and whānau well-being', carried out to inform the development of Te Toka Tumoana: Indigenous & Bicultural Principled Framework (2013-2015) (Dobbs, 2015).

Socio-economic status & education: Access and ability to use resources and opportunities, such as healthcare, school, neighbourhood, employment etc.
Immigration & migration history/patterns: Seasonal, refugees, legal status, current generation in country etc.
Cultural identity & degree of acculturation
Heritage & history: Cultural strengths, traditions, generational wisdom, historical trauma etc.
Perspectives on health, illness & healing practices

Source: (SAMHSA, 2014).

THERAPEUTIC CARE

64. Evidence on 'therapeutic care' both as a concept and practice is wide and varied. To some degree the reader is only limited by the parameters set for defining and understanding therapeutic care. This evidence brief has taken a holistic position on its definition and understanding.

65. In order to define therapeutic care and disentangle the various interpretations, this evidence brief sets out a definition and applies it across several levels: settings, models, and interventions. The evidence brief seeks to avoid an atomised (individualised) view of therapeutic care, which can occur given that therapeutic care has many specific (narrower) inquiry areas.

66. The evidence brief sweep endeavours to account for the wider therapeutic care environment experienced by children and families/whānau, primarily in relation to their involvement with Oranga Tamariki, with reflection on the wider impactful system. It looks at more specific facets of therapeutic care that reside within operational and clinical settings, described as therapeutic care models and therapeutic interventions.

67. Oranga Tamariki will continue to question and reflect on whether it has adequately articulated a therapeutic care vision, and whether it is moving towards that vision. This evidence brief attempts to help answer these questions. It reflects on a variety of evidence from Aotearoa New Zealand and overseas. Much has been written on the narrower clinical aspects of therapeutic models and interventions; however, less has been done on conceptualising the wider therapeutic care environment. For this reason, the evidence brief begins with a definition of 'therapeutic care' before moving onto elaborating upon a foundation for understanding therapeutic care more broadly. The subsequent chapter discusses therapeutic models and interventions.

Defining therapeutic care

68. In Aotearoa New Zealand and overseas child welfare services have been challenged about the best way to address the needs of children who have been traumatised by maltreatment. Therapeutic care as part of a trauma-informed understanding is normally the recommended approach. It can incorporate a range of interventions, or 'ways of working', usually stemming from a variety of therapeutic techniques or theories presented and employed in different ways (Bailey *et al.*, 2019). Therapeutic care intent is based on the understanding that childhood trauma can have many profound impacts upon a child, and if this trauma is addressed at an early stage and in an informed way, any immediate and long-term difficulties can be reduced (McAloon, 2016).

69. There is, however, no single definition of 'therapeutic care'. In a NSW Government literature review – as part of their work towards developing and implementing a therapeutic care framework and new intensive therapeutic care service system – therapeutic care for a child or young person was broadly defined as a:

> planned, team-based, and intensive approach to the complex impacts of abuse, neglect, and separation from families and significant others. This is achieved through the provision of a care environment that is evidence driven, culturally responsive, and provides positive, safe and healing relationships and experiences to address the complexities of trauma, attachment, and developmental needs (McAloon, 2016).

70. There are complicated distinctions and at times inherent contradictions within therapeutic care descriptions. Its characterisation is context and setting dependent. Terminology associated with therapeutic care likewise differs depending on the context and setting. The specific locations that can influence therapeutic care's definitional focus include:

    70.1 The care model provided

    70.2 The care model philosophical underpinnings

    70.3 The activities within the programme

    70.4 The physical care setting

    70.5 The age and characteristics of the involved population

    70.6 The size of the organisation

    70.7 The length of stay

    70.8 The restrictiveness level required

    70.9 The treatment approach used

    70.10 The mix of professional and organisational staff (McAloon, 2016).

71. Common among definitions of therapeutic care at these different levels is the focus on healing and safe relationships with caregivers and workers at the centre of therapeutic care practice. Daily life for children in OOHC is seen as a naturally occurring opportunity for them to experience healing and safe relationships. How to practice 'therapeutically' in relationships has not been well articulated. This leaves much to be interpreted by those caregivers in direct daily contact with children (Mclean, 2016).

72. The research literature indicates that there are several factors that contribute to better therapeutic outcomes for children and in that sense the definition of therapeutic care is perhaps best understood holistically. These factors include:

    72.1 where children's needs are well understood

    72.2 where this understanding is shared by key stakeholders

    72.3 where children's needs are similar, not disparate, leading to good client 'mix' and minimising 'contagion'

    72.4 where there is specialist input and appropriate staffing

    72.5 where the therapeutic input is tailored to, and matched to, children's developmental, cognitive or socio-emotional functioning

    72.6 where there is best possible involvement with family/whānau and community

    72.7 where child-adult relationships are valued and continued post-care (McLean, 2018).

73. It is also necessary to look specifically at how therapeutic care is framed within different therapeutic care settings. This includes speaking to the evidence for different therapeutic care models and interventions. Therapeutic care terminology and its underlying theory can

be ambiguous.[13] Disentangling terminology supports a clearer picture of therapeutic care, which ultimately helps identify and improve upon the direction and the parameters of services and support for children and families/whānau. Further differentiation speaks to settings, models used, and interventions employed as the key areas of interest and activity for children's welfare organisations. Therapeutic care is differentiated for the purposes of this evidence brief (and this chapter) into three categories: therapeutic care settings, therapeutic care models, and therapeutic care interventions. Table 2 below describes these different areas.

74. The notion of therapeutic purpose then may be best understood as relating to curing and healing within a holistic therapeutic care context. This aligns with the earlier definition and with the general direction of evidence on therapeutic care and the intent of numerous practice approaches. Wirihana and Smith (2014) write "Māori viewed wellbeing as a holistic process which emphasised the interconnected nature of spirit, body, society and the natural environment. Moreover, individual wellbeing and interpersonal relationships relied on a complex and sophisticated process founded on the basis of spiritual knowledge" (Wirihana and Smith, 2014).

Table 2: Therapeutic care settings, models, and interventions

Sites	Description
Therapeutic settings	The locations where children receive therapeutic care based on need when in OOHC, whether with whānau, non-kin care, in a group home, or residential care, or receiving particular therapeutic interventions.
Therapeutic models	The therapeutic care models that guide therapeutic care practice. All care locations have an implicit or explicit therapeutic care model. There has been more recent attention on therapeutic care models in residential care settings. Models may be elaborated upon at different levels.
Therapeutic interventions	Therapeutic care interventions directed at individuals or groups for assessed and identified needs. These are usually thought of as being clinical health treatments, however, they may also include directed non-clinical treatment activities.

Therapeutic care foundations

75. This section attempts to describe a foundation for understanding therapeutic care. It builds on the previous discussion defining therapeutic care, which elaborated upon the different levels of therapeutic care, inclusive of therapeutic interventions. This section discusses the importance of child health and wellbeing, the centrality of relationships to therapeutic care and the existence of 'common factors' in therapeutic care. It also discusses Māori health and wellbeing perspectives.

[13] This evidence brief endeavours to use clear and consistent terminology, included throughout and described in the following pages. The term 'therapeutic framework' is frequently used in the literature, however, is only used in later chapters with specific reference to the development and implementation of therapeutic care frameworks, i.e. scaffolding setting out clear therapeutic care principles and guidance.

Nurturing care

76. We know that children need nurturing care from the very beginning. Their development starts at conception. Evidence clearly demonstrates that childhood is a time of greater susceptibility to risk factors and a time when the benefits of early supportive involvement can be most useful, and any negative effect more easily reduced. The most formative experiences of children are shaped by the nurturing care provide by parents, wider family/whānau, caregivers, and community services. Nurturing care is characterised by a "stable environment that promotes children's health and nutrition, protects children from threats, and gives them opportunities for early learning, through affectionate interactions and relationships". Nurturing care provides lifelong benefits, including improved health and wellbeing, and the capability to learn and prosper (Richter *et al.*, 2016).

77. It is recognised that families/whānau often need support to provide nurturing care for children and that empowering them to do so can be an important first step. This support comes from wider family/whānau, community and iwi-based services, and from a wide range of health and wellbeing providers in sectors such as health, nutrition, education and child and social protection. It is also important that local circumstances and national policies best support families/whānau to provide nurturing care (Richter *et al.*, 2016).

78. Recognising the importance of nurturing care, and based on 'effectiveness factors' evidence, the Center on the Developing Child at Harvard University (2016) outlines a core set of principles to guide programmes and policies across childhood, describing them as current 'best practice'.

    78.1 *Build caregiver skills:* all adults who care for children need a critical mass of capabilities and knowledge to support the healthy development of children. This includes parents, wider family/whānau, foster caregivers, social workers, and educators.

    78.2 *Match interventions to sources of significant stress:* support to reduce or remove serious adversities in the lives of children and families/whānau is one of the best ways to lessen the negative effects of stress on the development and wellbeing of children. This can include targeted efforts at the community or societal level, mitigating the effects of poverty and violence for example, or on an individual level addressing identified needs and building on existing strengths to support nurturing care.

    78.3 *Support the health and wellbeing of children and caregivers throughout*: lifelong health begins with the wellbeing of caregivers (most often, mothers). In this respect preventive health care for women and their children is essential for supporting long-term physical, emotional, and cognitive development.

    78.4 *Improve the quality of the broader caregiving environment*: whether home or community-based, the features of the regular, non-parental care received by children can also help to assure their healthy development.

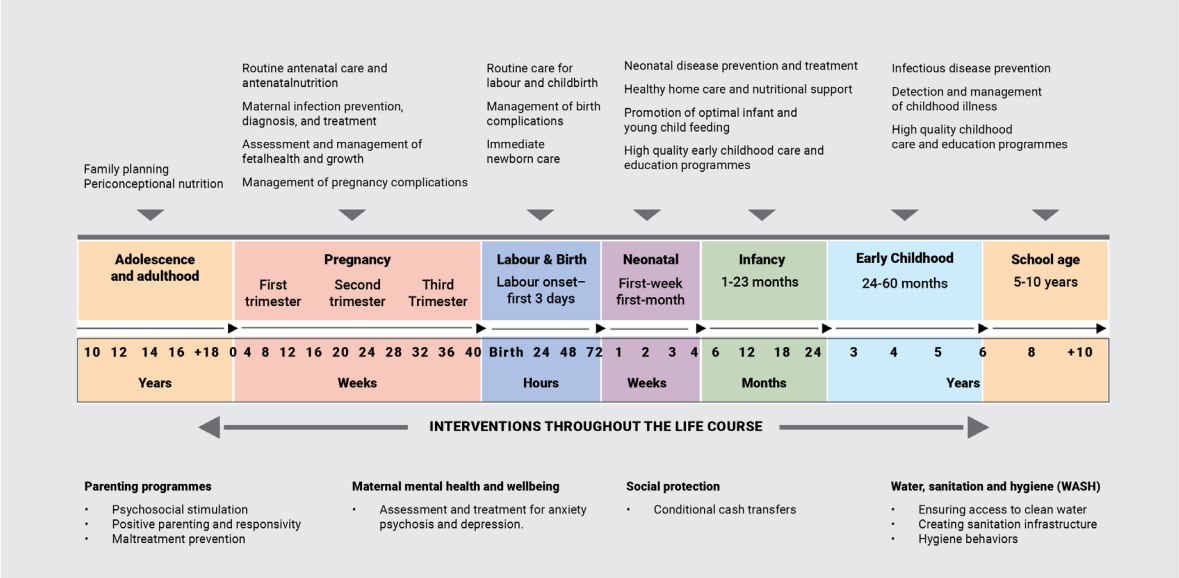
    78.5 *Establish clear goals and appropriately targeted curricula*: programmes for children, parents, or other caregivers are all most effective when they specify clearly defined goals and implement a curriculum or intervention plan that is designed to achieve those goals (Center on the Developing Child, 2016).

79. These five core principles can guide improvements in a wide range of childhood policies and programmes, particularly in the early childhood years, although it is noteworthy that they

largely draw on research and evidence from the United States. The programmes that have informed this research have typically fallen within one of four tiers: universal programmes for all children and their families; broad-based programmes serving families across the socioeconomic spectrum; targeted supports for families with low levels of education and income; and intensive interventions for young children and families at high risk of experiencing difficulties (Center on the Developing Child, 2016).

80. The 2016 Lancet Early Childhood Development Series highlights the criticality of nurturing care and new scientific evidence for 'best practice' multi-sectoral interventions that support children's health and wellbeing. Several programme areas have been shown to benefit childhood development: family support and strengthening programmes, caring for the caregiver programmes, early learning and protection programmes, and parent support programmes, which encourage nurturing care (Richter *et al.*, 2016).

Figure 2: Evidence-based interventions that affect aspects of nurturing care



Source: (Richter *et al.*, 2016)

Relationships

81. Relationships are fundamental to nurturing care and to the work of children's welfare organisations. Relationships affect virtually all aspects of a child's development – intellectual, social, emotional, physical, and behavioural. They affect long-term outcomes, including sound mental health and self-confidence; the motivation to learn and achieve in school and the workplace; the ability to manage behaviour and deal with conflict non-violently; and the capacity to develop friendships and close connections, and ultimately become a good parent (Center on the Developing Child, 2016).

82. Children's relationships with the people in their lives have a profound influence on children's brain architecture and developmental process. This process is driven by affirming and reciprocal 'serve and return' interactions between children and the adults who care for them. Relationships build resilience and improve outcomes. Relationships between children and their caregivers are therefore critical – whether they are parents, wider family/whānau, foster caregivers, social workers, or educators. Child maltreatment, adversity and other

family/whānau difficulties and stresses can disrupt positive relationship processes and in turn significantly impact children's health and wellbeing (Center on the Developing Child, 2016).

83. When children are in OOHC, research indicates that they will have better outcomes where their caregivers are present for them – physically, psychologically, and emotionally. Difficulties providing care for traumatised children can mean that trauma is recreated in their OOHC setting. Children in such settings can find it hard to develop meaningful relationships with their caregivers and despite best intentions there is often a high turnover of caregiving staff (Bailey *et al.*, 2019).

84. Research shows that continuity, stability, and secure relationships are key foundations for the development of resilience. However, children in OOHC often face difficulties building resilience, especially if their time in OOHC has been characterised by disruption and multiple placements. The concept of 'felt security' suggests that feeling secure and stable in the care setting in turn supports children to develop meaningful and trusting relationships with caregivers who play an important part in their lives. There is growing interest in reaffirming relationship-based practice in residential care and beyond (Welch *et al.*, 2018).

85. Optimal care should involve a consistently therapeutic environment, where trauma experienced in a relationship setting can be treated within a reparative and trusting relationship setting – relationships are the vehicle for healing (McPherson *et al.*, 2019a). Bath (2015) highlights that much of the healing from trauma occurs in non-clinical settings and emphasises the importance of supportive relationships in responding to trauma (Bath, 2015). Positive and supportive relationships with caregivers and staff for children in OOHC are foundational to their recovery and provide an alternative relationship model. A particular challenge is ensuring that 'relational models' of care can co-exist and complement clinical health therapeutic interventions (McLean, 2018).

86. Children value positive and lasting relationships with their social worker (and caregivers when in OOHC). There are several qualities that children look for in a good relationship with their social worker, which are also important for other caregiving relationships. They value people who are reliable, honest, available, interested, and effective listeners. They also appreciate people who take them and their views seriously, accept and respect them, are ambitious for them, and who are committed to them (Welch *et al.*, 2018; McPherson *et al.*, 2019a).

87. Relationships are critical to social work (and other caregiving relationships). Social work is carried out within a network of human relationships – it is the medium through which social work is conducted. (Hennessey, 2011). According to Ingram and Smith (2018) there are convincing philosophical, policy, and practice reasons for putting relationships at the heart of social work, not least that effective relationships are central to successful outcomes. Fewster (2004) suggests that within the caring role, the relationship *is* the intervention. The concept of relationship-based practice (RBP) is a way of articulating the centrality of the relationship between social workers and the people in their care. It is argued that RBP is not a social work approach that offers a menu of alternatives; rather, it should be central to social work care across different client groups and domains of practice (Ingram and Smith, 2018).

88. While engaging in helping relationships is traditionally a core function of social work and social care, the skills can be difficult to develop and exercise effectively, particularly when working with children and families/whānau who have very difficult backgrounds. There is renewed interest in ensuring that relationships should be a central focus. The Care Inquiry (2013) in the United Kingdom (UK) elaborated that 'relationships are the golden thread in

children's lives […] the quality of a child's relationships is the lens through which we should view what we do and plan to do'. The Barnardo's report 'Someone to Care', also from the UK, which included 62 interviews with young care leavers, said that young people felt they needed someone to care about them, someone to talk to, someone to be with, someone to set standards, and someone to show them the way (Welch *et al.*, 2018).[14]

89. The importance of relationships is also highlighted at the point of transition for young care leavers. Relationships feature strongly as important areas of experience and yardsticks for measuring happiness. Where supportive relationships are in place, they are central to the transition for young care leavers. Research highlights the key role of managers and practitioners in facilitating important relationships for children, particularly where they may lack family/whānau or community-based networks (Welch *et al.*, 2018).

90. Some commentators have suggested that the ascendance of managerialism in some places – with its increased focus on targets and outcomes that seek to define and control boundaries between social workers, care staff, and children in OOHC – has often meant that the importance of nurturing and trusted relationships has been downplayed. It is argued that managerialism in broader organisational and structural forms can impede on the ability of children to develop relationships with social workers and care staff members that are safe, trustworthy, and reliable (Welch *et al.*, 2018).

Common factors

91. Relationships are central to nurturing care. They are also central to understanding the foundations of formal therapeutic care models and interventions in OOHC and clinical health care. Relationships are one of several 'common factors'. Identifying these 'common factors' helps to provide a deeper understanding of therapeutic care (and its components).

92. The theory of congruence in residential care was proposed by James Anglin (2002) and centred on a two-year study of residential care in North America. Anglin (2002) based his research on the question: 'What makes a well-functioning residential service?' Anglin discerned that while all the residences sampled had different approaches, strategies, theoretical foundations, staff, organisational profiles, and client groups, the residential services that had successful outcomes for children all shared one common factor. All had a high-level of congruence across 11 interactional dynamics within their organisations (contractual level, managerial, supervisory, carework/team, youth and family). The 11 interactional dynamics are:

    92.1 listening and responding with respect

    92.2 communicating a framework for understanding

    92.3 building rapport and relationship

    92.4 establishing structure, routine and expectations

    92.5 inspiring commitment

    92.6 offering emotional and developmental support

    92.7 challenging thinking and action

[14] The follow-up report to 'What makes a good life' surveys the views of children and young people in care on wellbeing in Aotearoa New Zealand (Oranga Tamariki and Office of the Children's Commissioner, 2019).

92.8 sharing power and decision-making

92.9 respecting personal space and time

92.10 discovering and uncovering potential

92.11 providing resources (Anglin, 2002, cited in Clarke, 2011).

93. A number of therapeutic care models, including many used in residential care, correlate strongly with the theory of congruence, which includes aspects consistently found in successful residential care settings, e.g. Sanctuary Model (Clarke, 2011). Similarly, many of these therapeutic care models also display a high-level of convergence. A review carried out for the Social Care Institute for Excellence (SCIE) in the UK looked at six therapeutic care models in residential settings. They found underlying similarities between the approaches. All provided a way of thinking about the challenges of working with children who have various social, emotional, and behavioural difficulties. And each provided a framework with fundamental theories intended to help staff understand:

93.1 How trauma impacts on children and young people.

93.2 How and why their ways of coping might be maladaptive.

93.3 How and why agencies and staff respond in ways that are not always helpful.

93.4 How they might change. Each emphasises the importance of helping staff develop the knowledge and skills necessary to help those they care for (Macdonald and Millen, 2012).

94. These residential care model's convergence raises the question of whether it matters which residential care model (or care models) is used if successful examples are so similar. The SCIE review acknowledges that models provide a framework within which caregiving staff can think about work that matters, better understand children's behaviour, and critically appraise their own actions. This can support job satisfaction and job effectiveness. It also encourages consistency, something which children are known to value. However, the question of one therapeutic care model over another is an empirical question. Although research demonstrates the importance of these common factors there is less empirical data to support one care model over another (Macdonald and Millen, 2012).

95. The NSW Government conducted a literature review as part of its work towards developing and implementing a therapeutic care framework and new intensive therapeutic care service system. This review highlighted the shared fundamentals of therapeutic care (inclusive of therapeutic foster care and therapeutic residential care) as a basis for congruence within an overall therapeutic care framework. These common characteristics include:

95.1 the complexity of the young people involved

95.2 the time-limited nature of the service response

95.3 the presence of an intensive or therapeutic or treatment-based response

95.4 acknowledgement of the disrupted early attachment experienced by young people

95.5 acknowledgement of the developmental trauma experienced by young people

95.6 the relational focus of the service response

95.7 the goal of providing a reparative or healing service response

95.8 the focus on behavioural, emotional, and social characteristics of young people (McAloon, 2016).

96. In addition to therapeutic care models specific to OOHC and other settings, common factors are also present in therapeutic interventions in clinical health care, i.e. trauma-related psychotherapy. The common factors approach conceives psychotherapy as socially constructed and mediated healing practice. The common factors perspective focuses on several elements that are necessary to bring about change:

    96.1 a bond between the therapist and patient (therapeutic alliance also includes therapy goals and tasks agreement)

    96.2 a confiding healing setting in which therapy takes place

    96.3 a therapist who provides a psychologically derived and culturally embedded explanation for emotional distress

    96.4 an explanation that is adaptive (i.e., provides viable and believable options for overcoming specific difficulties) and is accepted by the patient

    96.5 a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is positive, helpful, or adaptive (Laska, Gurman and Wampold, 2014).

97. The common factors approach predicts several things: that any therapy containing all the common factors will be effective for the problems being treated and that relationship elements such as empathy, goal consensus and collaboration, the therapeutic alliance, and positive regard, should predict the outcome of psychotherapy. Some therapists will be more skilful at providing these common factors and therefore more effective. Finally, the common factors approach predicts that treatments designed to be therapeutic will be superior to 'supportive control' or psychological placebo options. In these respects, the common factors approach is focused on improving therapist competence and practice outcomes (Laska, Gurman and Wampold, 2014).

98. These common factors are more than a set of therapeutic elements common to all or most psychotherapies. They collectively form a theoretical model about psychotherapy change mechanisms. Wampold (2015) outlines the 'contextual model of psychotherapy'. It advances three pathways through which psychotherapy produces benefits: a) the real relationship, b) the creation of expectations through explanation of disorder and the treatment involved, and c) the enactment of health promoting actions. Wampold (2015) writes that before these can be activated, an initial therapeutic relationship must be established. He cites Bordin (1979) who said "some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (Wampold, 2015).

99. Common factors are recognised as a therapeutic process and the common factors approach has received sizable empirical attention in psychotherapy research. The therapeutic working alliance particularly has received considerable attention. There is a strong correlation between the working alliance and patient outcomes across different therapy types, including cognitive behavioural therapy (CBT). Other relationship variables that span therapeutic intervention orientations and have received empirical support include empathy and positive regard. Other non-relational common factors, such as therapist intervention focus, exposure, client procedures to foster a new perspective of self, and those that facilitate corrective experiences, play a role. Common factors related to learning (e.g. feedback) and action (e.g. modelling) have also been identified as important (Castonguay *et al.*, 2015).

100. Although the common factors approach and its corollary in the psychotherapy integration movement have been influential, Castonguay et al. (2015) identifies four primary psychotherapy traditions – CBT, psychodynamic, humanistic/experiential, and systemic – and writes that they are likely to remain and continue to grow. These traditions represent a "contemporary manifestation of longstanding ways of accumulating and using knowledge". Castonguay et al. (2015) argues that one way for the four primary psychotherapy traditions to grow is through an assimilative process – adapting and utilising concepts and techniques from other therapeutic intervention orientations in a cohesive way (Castonguay *et al.*, 2015).

Māori models of health and wellbeing

101. The health and wellbeing of tamariki Māori is inseparable from that of their whānau. This points to the importance of taking whānau-centred approaches. And crucial for the health and wellbeing of whānau, although not the only determinant, is the emphasis on identity, culture, and language. Whakapapa, connections to whānau, hapū, and iwi, and whanaungatanga and manaakitanga, are important values that support tamariki Māori wellbeing, fostering health, safety, and security in the home, and supportive environments in the community. The Māori Select Committee (2013) for example, writes: "In seeking to empower whānau, we favour means that enhance the ability of whānau and communities to practice whanaungatanga and manaakitanga because these frame responsibilities towards tamariki Māori, and for tamariki Māori, in meaningful ways" (Māori Select Committee, 2013; Wirihana and Smith, 2014).

102. Māori models that focus on the health and wellbeing of tamariki Māori and whānau are crucial ways of framing and helping to determine success. They are also ways of conceptualising therapeutic focus. Te Whare Tapa Whā is often referenced as improving understanding of Māori health and wellbeing. It points to the foundations of Māori healing practices based on interconnected relationships. It has four dimensions, representing the four basic tenets of life, taha tinana (physical wellbeing) taha hinengaro (mental wellbeing) taha wairua (spiritual wellbeing) (Durie, 1985; Wirihana and Smith, 2014).

103. Durie (1999) also put forward 'Te Pae Māhutonga: a model for Māori health promotion'. Te Pae Māhutonga refers to the Southern Cross. It offers a way of conceptualising therapeutic focus. The model has six elements of modern health promotion comprising the four central stars (key health promotion tasks reflecting particular goals): Mauri ora (cultural identity), Waiora (environmental protection), Toiora (healthy lifestyles) and Te Oranga (participation in society). And the two pointer stars (prerequisites for effectiveness): Te Mana Whakahaere (autonomy) and Ngā Manukura (leadership) (Durie, 1999).

The socio-ecological perspective

104. It is useful then to elaborate key distinctions identifying different aspects of therapeutic care.[15] The socio-ecological perspective is a helpful analytic tool. Understanding therapeutic care across different levels – including te ao Māori – helps consolidate the focus beyond individual level therapeutic care to include broader relationship, community and societal perspectives. It acknowledges the pervasive influences of interactions between these levels;

[15] The topic of therapeutic care **settings, models, and interventions** is discussed later in this section and goes into some detail about therapeutic care levels, which in reading and discussion are often easily conflated, and require some disentangling.

the existence of specific therapeutic interventions and models within different therapeutic care settings and the wider therapeutic care environment (containing day-to-day and clinical therapeutic care).

105. The complicated and complex interactions between these different socio-ecological levels are described by the World Health Organization (WHO) in the following way:

105.1 Individual factors address biological variables such as age and sex, together with factors of personal history that can influence an individual's susceptibility to child maltreatment.

105.2 Relationship factors examine an individual's close social relationships, in particular family members or friends, which influence the individual's risk of both perpetrating and/or suffering child maltreatment.

105.3 Community factors relate to the settings in which social relationships take place – such as neighbourhoods, workplaces and schools – and the particular characteristics of those settings that can contribute to child maltreatment.

105.4 Societal factors involve the underlying conditions of society that influence maltreatment – such as social norms that encourage the physical punishment of children, economic inequalities and the absence of social welfare safety nets (WHO, 2006).

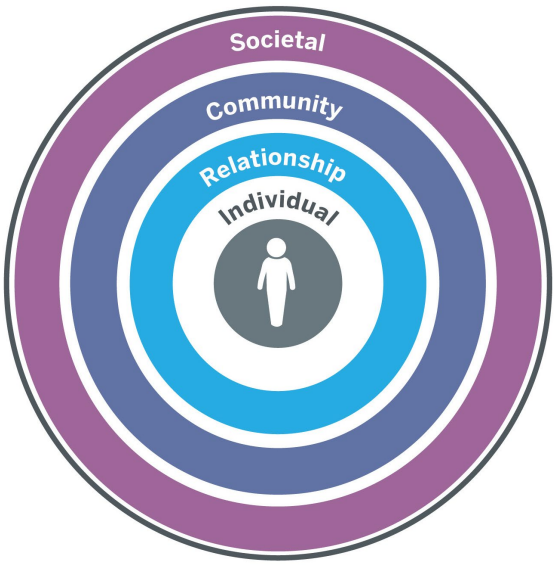
106. Child maltreatment (and any responses) can be understood by looking at the complex interactions of different factors across multiple levels. This helps address the problems of adversity and trauma more effectively. The socio-ecological perspective demonstrates how these factors increase or decrease the likelihood of child maltreatment (individual, family/relationship, and community/society). Examples of commonly understood risk and protective factors across multiple levels include:

106.1 Risk factors, child disability and child temperament or behaviour (individual); parental substance abuse and family conflict or violence (family/relationship); and socio-economic disadvantage and parental unemployment (community/society).

106.2 Protective factors, social and emotional competence and attachment to parent/s (individual); family cohesion and parental resilience (family/relationship); and positive social connection and support and employment (community/society) (WHO, 2006).[16]

[16] The risk and protective factors listed are examples only. An expanded list is provided in the main text of a summary evidence brief, on which this section draws, compiled by the Evidence Centre for the Early Intervention Programme.

Figure 3: The socio-ecological perspective



Source: (WHO, 2006)

107. A range of therapeutic care approaches has emerged over recent decades to cater for different socio-ecological levels, i.e. individuals, relationships, communities, and society. The approaches vary based on theoretical orientation as well as context and setting. And as previously discussed, they also frequently share commonalities. Arguably, what has changed is the conceptual breadth imagined for therapeutic care. Where 'care models' once offered care, containment and support, and the therapeutic needs of children were seen as the domain of specialist mental health clinicians, there is now a greater awareness and support for a holistic therapeutic environment based on children's and families/whānau needs and an understanding of complex trauma, nurturing care, and relationships (McPherson *et al.*, 2019a).

108. Many overseas jurisdictions recognise that 'care is not enough' to meet the needs of children who experience complex trauma (and are in OOHC). These children require consistent and effective therapeutic interventions within a therapeutic environment that systematically fosters healing and positive relationships (throughout their days and not simply in formal therapeutic sessions once a week). This has given momentum to the development of more integrated therapeutic services and overall therapeutic care system.

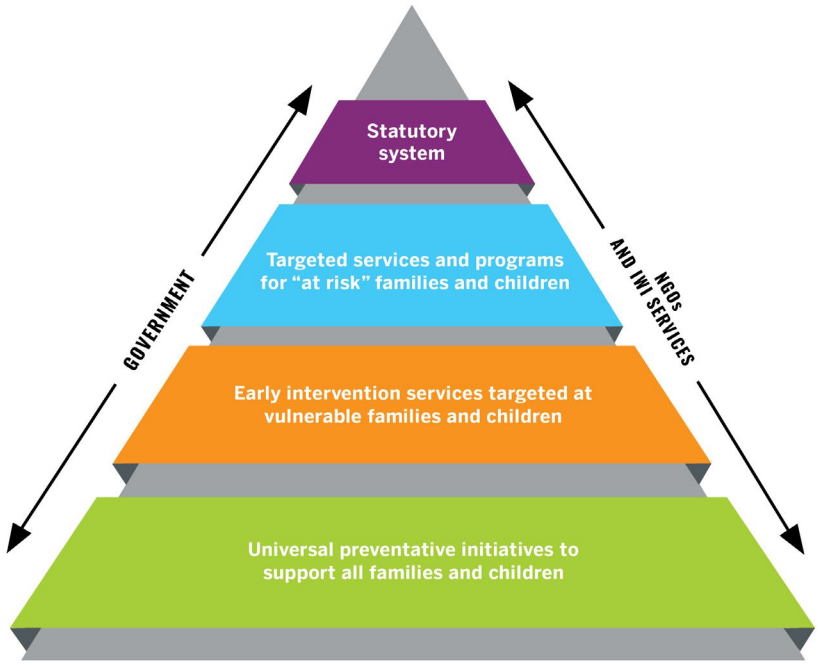
109. There are diverse groups within the wider therapeutic milieu. In child welfare this includes disabled children, children from culturally and linguistically diverse (CALD) backgrounds, and children and young people in the youth justice population, among others. Each has different characteristics and therapeutic needs. This means individuals from these groups may require specific support in the form of different settings, models, and/or interventions. This might be considered support that is 'additional' to that generally outlined (e.g. relationships and common factors) to appropriately meet their therapeutic needs. Therapeutic care for disabled children in OOHC for example should emphasise their perspective and strive to address equity problems and barriers to participation (Kelly, Dowling and Winter, 2016).

110. A children's welfare 'system' can be described as group of services designed to prevent harm and promote the health and wellbeing of children by helping to ensure they are safe and flourishing. It is comprised of the organisations, people, and resources involved in delivering care to children and families/whānau. It can be represented across the primary (universal),

secondary, and tertiary levels, see Figure 4 below, and is closely allied with the socio-ecological perspective (individuals, relationships, communities, and society). A successful therapeutic care environment requires system commitment, coordination, and integration. The policy and practice systems of organisations tend to be highly compartmentalised and composed of multiple layers of different programme delivery models. They frequently function as systems within systems (Center on the Developing Child, 2016).

111. Different service responses are provided across these different system levels. While care and protection responses typically fall within the tertiary level, we are mindful that the current Oranga Tamariki transformation is also focusing further efforts within the secondary level. The degree to which the therapeutic care environment for children and families/whānau should extend remains an open question. Research supports their creation within the context of trusting relationships, which are seen as the primary source of healing for children in OOHC. 'Therapeutic care' organisations also ensure non-violence and emotional safety, focus on stability, predictability, and opportunities for learning (rather than compliance and control) (McPherson *et al.*, 2019b).

Figure 4: Public health levels and population focuses



Adapted from: (Australian Institute of Family Studies, 2017)

112. The fragmentation of child welfare services efforts has a corresponding effect on therapeutic care coordination and coherency. Research indicates that there are common aspects to therapeutic care that can be adopted throughout the child welfare system – from the focus on effective and supportive therapeutic interventions to healing and positive relationships in the wider therapeutic environment. This includes discerning where organisational boundaries are in respect of child and family/whānau health and wellbeing, particularly where organisations are advocating and supporting families/whānau in the wider therapeutic milieu. Commentary on the potential system of care is important.

> Preventing child maltreatment and strengthening parental capacity requires more than a single public agency and service strategy, or even a series of targeted prevention services. It requires a *system of care* that recognizes that all parents face common challenges and that these

> challenges require both a collective and individual response. A universal commitment to help all parents care for their children establishes the foundation necessary to efficiently allocate scare public resources and create a social context that is more respectful of parental autonomy and more responsive to child safety and wellbeing. Waiting for parents to fail before justifying offers of collective support becomes unacceptable [italics added] (Daro, 2019).

113. This also speaks to the need to improve social policy and equity generally, rather than focusing solely on improving preventive and care activities, i.e. taking a broader view of therapeutic intent and practice. Increasing rates of child maltreatment have been described as a downstream consequence of political and socio-economic difficulties. Child maltreatment in this context services as a proxy for overall community wellbeing. Research demonstrates that social policies that provide a social good, such as paid family leave, high-quality childcare, and income support, have a secondary effect on reducing child maltreatment. This insight emphasises the importance of integrated systems and linking therapeutic care and outcomes with broader interactions and goals for children and families/whānau (Campbell, 2019).

Therapeutic care settings

114. This section looks at the therapeutic setting – where therapeutic care takes place for children and families/whānau involved with the child welfare (care and protection) system. In particular, OOHC settings with day-to-day caregivers and clinical staff, where therapeutic care models guide practice and children receive therapeutic interventions. It considers what makes a therapeutic setting 'therapeutic in nature' – therapeutic care models as part of children's daily life, i.e. reparative and stable relationships as well as clinical therapeutic interventions.

115. When children and families/whānau are struggling and there are safety concerns, children are sometimes placed in OOHC. They may be the subject of a substantiated care and protection finding and need a safer protective setting. Children may also be placed in OOHC when their families/whānau are unable to provide adequate care for them or when alterative care is needed during times of family/whānau crisis. OOHC is seen as a last recourse. There is a strong emphasis on supporting families/whānau to keep children safely at home. And where that is not possible, to place them with wider family/whānau, and in time if appropriate, reunite them with their immediate family/whānau (McPherson *et al.*, 2019a).

116. There are several locations where children in OOHC can be placed, some of which are more obviously associated with therapeutic interventions, i.e. clinical health care. These placement types include emergency, respite, transitional, family home care with professional caregivers or staff, permanent care (home for life), and adoption. There are also care and protection (and youth justice) residences. 'Therapeutic care' is present in these different settings to various degrees.(Oranga Tamariki, 2020b).[17]

117. Therapeutic care settings differ for each child in OOHC depending on their location and needs. The therapeutic care setting may refer to situations including but not limited to:

[17] Lambie et al. (2016) provides a comprehensive review of evidence-based literature on best practice and optimal service delivery in relation to secure residences in New Zealand with implications for the child welfare population (See Lambie *et al.*, 2016).

117.1 The provision of individual therapy for a child, or group therapy for several children, by a professional therapist, to address a specific need or range of needs;

117.2 An individualised programme for a child to attain a stated and agreed outcome, which may include different therapy models;

117.3 The day-to-day interactions between children and caregivers that are specifically organised to achieve therapeutic objectives and defined outcomes for children;

117.4 An evidenced-based therapeutic model that informs the philosophy and purpose and function of a residential centre/service or an aspect of the service;

117.5 The use of wider programmes, models, and services to support parenting and families/whānau to effect change and support identified outcomes for children and families/whānau (Children Acts Advisory Board, 2009).

118. These setting considerations highlight the distinctions between different levels within the therapeutic care environment (incorporating day-to-day and clinical therapeutic care). Children in OOHC may receive specific therapeutic interventions to improve their health and wellbeing. However, they also live in a landscape that offers the potential for improved holistic therapeutic care (the other 23 hours) (Bath, 2015). This includes the day-to-day interactions children have with caregivers, including social workers and staff (depending on their placement setting), and the therapeutic care impact of the care and protection system, i.e. organisation, community, and societal therapeutic care.

119. This evidence brief specifically looks at therapeutic care information with reference to therapies and programmes (interventions) and day-to-day interactions and evidence-based therapeutic models (models). It is useful to note that in this evidence brief we specifically refer to these levels, given the often confusing and overlapping use of the terminology. The use of wider programmes, models, and services to support parenting and families/whānau is largely outside the scope of this evidence brief.

Therapeutic care models

120. There is significant ambiguity in the research literature and general inconsistency in practice about the use of the term therapeutic care 'models'. A therapeutic care model is a multidimensional concept that defines the way in which therapeutic care services are delivered. They act as a conceptual tool that is an example or standard for comparison or replication, and combine concepts, beliefs, and intentions that are related in some way. A therapeutic care model includes the following critical elements:

120.1 is evidence-based and/or grounded in theoretical propositions;

120.2 is based on assessment of children's and care providers' needs;

120.3 incorporates evaluation of therapeutic care-related and intervention outcomes;

120.4 consultation with key stakeholders;

120.5 consideration of the safety and wellbeing of caregivers and staff;

120.6 involves a multidisciplinary approach where applicable;

120.7 considers the optimal and equitable utilisation of therapeutic care resources;

120.8 optimises equity of access for all OOHC children (and families/whānau); and

120.9 includes interventions that are culturally sensitive and appropriate (Davidson *et al.*, 2006).

121. In child welfare specifically, therapeutic care models are a way of conceptualising and organising services, referring to the "package of principles, target group and goals, policies and procedures, services provided, and staffing, which together describe the programme logic for how therapeutic care is provided by a particular therapeutic care provider within a particular service or programme (Queensland Government, 2015).

122. Having a clearly articulated therapeutic care model helps ensure caregivers and care professionals are all seeing the same picture – working towards the same common goals and are able to evaluate performance on an agreed basis (Davidson *et al.*, 2006). Therapeutic care models incorporate a range of therapeutic interventions and can provide an overarching approach and common language for staff across all levels of an organisation or system (Bailey *et al.*, 2019).

123. A considerable amount of residential care research focuses on 'therapeutic residential care' (TRC), which in turn informs the foundations of, or is informed by, different therapeutic models of care (Queensland Government, 2015).[18] TRC is usually seen as being for children with particularly complex needs who are placed in OOHC. TRC is described as residentially-based treatment and accommodation services designed to meet these children's complex needs, including experiences of child maltreatment and separation from family/whānau, by actively facilitating therapeutic healing and recovery. It typically provides therapeutic care based on guiding principles such as a) understanding and responding to young people's needs; b) adopting clear models of practice; and c) the recruiting and staffing of TRC homes. It is distinct from standard residential care (Mclean, 2016; McLean, 2018).

124. TRC can be considered part of the wider therapeutic environment. However, clear differentiation is often not made between types of TRC services and it can be difficult to discern why some children are receiving TRC services, i.e. need for a placement, for mental health concerns, or other risks. This means practitioners and policy-makers frequently talk about residential care as if it were a uniform concept, although there can be wide variation in, for example, placement goals, the target population, length of stay, restrictiveness, and treatment rationale (Mclean, 2016).

125. TRC has gained increased attention and research interest over the past decade in response to the recognition that therapeutic care in a residential setting offers the potential to improve children's lives by addressing multiple health and wellbeing domains. The following TRC 'international consensus' definition focuses on different aspects of care, emphasising especially the intentional and goal-oriented nature of TRC, and placing particular weight on partnerships with family and community.

> Therapeutic Residential Care involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources (Whittaker, Del Valle, & Holmes, 2014, cited in McLean, 2018).

[18] Further information on TRC can be found in a recently completed Oranga Tamariki Evidence Centre evidence brief (see Evidence Centre, 2020).

126. In Australia, the peak body for TRC, the National Therapeutic Residential Care Alliance, provided an alternative more pragmatic TRC (practice) definition.

> Therapeutic residential care is an intensive intervention for children and young people, which, in Australia, is a part of the out-of-home care system. It is a purposefully constructed living environment which creates a therapeutic milieu that is the basis of positive, safe, healing relationships and experiences designed to address complex needs arising from the impacts of abuse, neglect, adversity and separation from family, community and culture. Therapeutic care is informed by current understandings of trauma, attachment, socialisation and child development theories; which are translated into practice and embedded in the therapeutic care program (National Therapeutic Residential Care Alliance, 2016, cited in McLean, 2018)

127. The pragmatic Australian definition reflects their TRC 'philosophy of care', in particular its unique role in their OOHC landscape and the view that supportive relationships with children promote their psychosocial development. It also suggests TRC is one of several potential services for children in need – rather than a placement of last resort – provided under an organisation's overarching therapeutic care practice framework. It is however worth noting that many still favour the international definition, particularly because it accommodates a broader range of developmental issues beyond relational trauma (McLean, 2018).

128. There is a growing focus on TRC in Australia, where a number of states have developed and/or implemented TRC. A therapeutic care programme has been established and evaluated in Victoria and they have recently extended their therapeutic approach to all residential services, including setting out specifications for the commissioning of new services. NSW implemented a Therapeutic Care Framework (TCF) to guide trauma-informed therapeutic care and has established an Intensive Therapeutic Care (ITC) residential care service system. Queensland has taken significant steps towards implementing a therapeutic framework for residential care (congregate and non-family-based care). The Hope and Healing Framework (2016) sets out a vision, principles and theory for offering trauma-informed care. Western Australia has adopted the Sanctuary model for government-provided residential care services (Mclean, 2016; McLean, 2018).

129. Several organisation-wide therapeutic care models have been developed over the past two decades to respond to the complex issues associated with child maltreatment frequently found in residential care settings. These models incorporate a range of therapeutic techniques and provide an overall approach and common language for organisations. Bailey et al. (2018) carried out a systematic review to examine evidence for organisation-wide, trauma-informed therapeutic care models for children in OOHC. Drawing on a limited research base from between 2002 and 2017, Bailey et al. (2018) identified three models a) Attachment Regulation and Competency framework (ARC); (b) the Children and Residential Experiences programme (CARE); and (c) The Sanctuary Model (Bailey *et al.*, 2019). Several other research papers have identified and discussed the same organisation-wide therapeutic care models (See for example Bailey *et al.*, 2019; McPherson *et al.*, 2019b).

130. Although these models have been relatively influential in shaping TRC practice and policy overseas, there is currently insufficient evidence to support them or to support one therapeutic care model over another. Further research and evaluation is required to get a clearer idea of 'what works for whom' and gather information on contextual factors and longer-term outcomes. There is significant common ground in these models, including the provision of a nurturing environment, building attachment, and helping children to develop critical practical, social and emotional competencies. The models also all subscribe to the importance of non-confrontational approaches to problem resolution and provide training in

concepts and principles (Macdonald and Millen, 2012; Queensland Government, 2015; Mclean, 2016; Bailey *et al.*, 2019).

131. McLean (2018) examines several examples of therapeutic residential care models identified by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) as either promising or supported by evidence. Citing a number of research papers, McLean (2018) writes that while the models are all different, they also share common elements:

    131.1 Emphasis is on the therapeutic culture and positive, safe relationships between young people and staff. Physical and psychological safety is a priority – residential care 'does no further harm'.

    131.2 Emphasis is placed on all staff sharing a common understanding and approach to young people's behaviour. Extensive training is provided to facilitate common, agency-wide understanding of young people's difficulties.

    131.3 There is recognition that most young people in residential care have experienced a wide range of traumatic experiences and disadvantage. Accordingly, emphasis is placed on understanding and responding to the reasons behind the behaviour. Emphasis is on both staff and young people being aware of, and regulating, their responses to stressful situations and reminders of trauma.

    131.4 Emphasis is placed on the development of competencies in young people (e.g. coping skills, emotional regulation, psychoeducation about trauma) that are aligned with young people's current developmental level.

    131.5 Casework that requires staff to include the young person's wider environment is emphasised (e.g. school, family, community); in order to promote strong and vital family and community linkages.

    131.6 Practice draws on evidence-informed models that are effective, articulated in policy and practice, and replicable (McLean, 2018).

132. Drawing on the CEBC, Table 3 below outlines several therapeutic care programmes that are well supported by research evidence (1), supported by research evidence (2), or show promising research evidence (3).[19] Table 3 includes 'Alternatives to Long-Term Residential Care' programmes and 'Higher Levels of Placement' programmes (their respective ratings are given in 'Alt' and 'PM' columns on the right-hand side). The former is defined by the CEBC as "family-home-based or short-term residential programs that meet the clinical or therapeutic needs of children and youth in out-of-home care who were traditionally served in congregate care settings", while the latter is defined as programmes for "group, residential, and community treatment facilities" that offer greater therapeutic provision and tend to be more restrictive. All these therapeutic programmes exist at the level of therapeutic models, however, they are also frequently evidenced for other therapeutic settings or levels (California Evidence-Based Clearinghouse (CEBC), 2020b, 2020a).

133. Key therapeutic system levels models (for trauma treatment) are defined by the CEBC as programmes "designed to create a therapeutic environment that is more conducive for clients who have experienced trauma and their families, reducing the risk of retraumatization

[19] The CEBC Scientific Rating scale is used to evaluate practice based on the available research evidence. The scale includes: '1. Well-Supported by Research Evidence, 2. Supported by Research Evidence, and 3. Promising Research Evidence'. For details of the scale see https://www.cebc4cw.org/ratings/scientific-rating-scale/ (California Evidence-Based Clearinghouse (CEBC), 2019).

by service providers and agencies". This includes programmes designed to help organisations provide trauma-informed care. The Sanctuary Model is the only programme well supported by research. Several system-level models have 'not been rated' by the CEBC. This includes several notable models discussed widely elsewhere in the literature such as Attachment, Regulation, and Competency (ARC) and Trauma Systems Therapy (TST) (McPherson *et al.*, 2019a; California Evidence-Based Clearinghouse (CEBC), 2020d).

Table 3: Group, residential, and community programmes

Model	Overview	Alt	PM
Children and Residential Experiences (CARE)	CARE is a principle-based programme designed to enhance the social dynamics in residential care settings through targeted staff development and ongoing reflective practice. Using an ecological approach, CARE aims to engage all staff at a residential care agency in a systematic effort to orient practices in order to provide developmentally enriched living environments and to create a sense of normality for youth. CARE is organised around six principles related to attachment, trauma recovery, and, ecological theory. The principles state that child care practices must be 1) Relationship-based, 2) Trauma-informed, 3) Developmentally-focused, 4) Competence-centred, 5) Family-involved, and 6) Ecologically-oriented. CARE consultants follow a standardised set of steps to train and support staff over the 3-year implementation period. An essential activity is the formation of a local Implementation Team with multilevel representation that provides support, modelling, and mentoring to staff as they incorporate CARE principles into their work. This approach is designed to cultivate personal investment and ownership among all staff levels at the agency.	3	3
Functional Family Therapy (FFT)	FFT is a family intervention program for dysfunctional youth with disruptive, externalising problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programmes, sessions are spread over a three-month period. FFT has been conducted both in clinical settings as outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases, which organises the intervention in a coherent manner, allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.	2	-

Model	Overview	Alt	PM
Multidimensional Family Therapy (MDFT)	MDFT is a family-based treatment for adolescent substance use, delinquency, and other behavioural and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and community. Therapy sessions are held alone with the youth, alone with the parents, and with youth and parents together. Once a therapeutic alliance is established and youth and parent motivation is enhanced, the MDFT therapist focuses on facilitating behavioural and interactional change. The final stage of MDFT works to solidify behavioural and relational changes and launch the family successfully so that treatment gains are maintained.	1	-
Multisystemic Therapy (MST)	Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues, and their families. The primary goals of MST are to decrease youth criminal behaviour and out-of-home placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behaviour change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behaviour change.	1	-
Positive Peer Culture (PPC)	PPC is a peer-helping model designed to improve social competence and cultivate strengths in youth. “Care and concern” for others (or “social interest”) is the defining element of PPC. Rather than demanding obedience to authority or peers, PPC demands responsibility, empowering youth to discover their greatness. Caring is made fashionable and any hurting behaviour is totally unacceptable. PPC assumes that as group members learn to trust, respect, and take responsibility for the actions of others, norms can be established. These norms not only extinguish antisocial conduct, but more importantly reinforce pro-social attitudes, beliefs, and behaviours. Positive values and behavioural change are achieved through the peer-helping process. Helping others increases self-worth. As one becomes more committed to caring for others, s/he abandons hurtful behaviours.	2	-
Risk Reduction through Family Therapy (RRFT)	RRFT is an integrative, ecologically informed, and exposure-based approach to addressing co-occurring symptoms of PTSD (and other mental health problems), substance use problems, and other risk behaviours often experienced by trauma-exposed adolescents. RRFT is novel in its integration of these components, given that standard care for trauma-exposed youth often entails treatment of substance use problems separate from treatment of other trauma-related psychopathology. RRFT is individualised to the needs, strengths, developmental factors, and cultural background of each adolescent and family. The pacing and ordering of RRFT components are flexible and determined by the needs of each family and symptom severity in each domain. Substance use (as relevant) and post-traumatic stress	3	-

Model	Overview	Alt	PM
	(PTS) symptoms are monitored throughout treatment to help track progress and guide clinical decision-making. The average frequency and duration of RRFT depends on the symptom level of each youth, but typically involves 18-24 weekly, 60-90 minute sessions with periodic check-ins between scheduled appointments.		
The Sanctuary Model	The Sanctuary Model is a blueprint for clinical and organisational change, which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus, not only on the people who seek services, but equally on the people and systems who provide those services. Sanctuary has been used in organisations that provide residential treatment for youth, juvenile justice programmes, homeless and domestic violence shelters as well as a range of community-based, school-based and mental health programmes.	3	3
Stop-Gap	The Stop-Gap model uses a multi-component approach (i.e., environment-based, intensive, and discharge-related) to service delivery for residential treatment settings. The two-fold goal of the Stop-Gap model is to interrupt the youth's downward spiral imposed by increasingly disruptive behaviour and prepare the post-discharge environment for the youth's timely re-integration. Youths enter the model at Tier I, where they receive environment-based and discharge-related services. The focus at Tier I is on the immediate reduction of "barrier" behaviours (i.e., problem behaviours that prevent re-integration) through intensive ecological and skill teaching interventions (e.g., token economy, social and academic skill teaching). Simultaneously, discharge-related interventions are started. To the extent that problem behaviours are not reduced at Tier I, intensive Tier II interventions that include function-based behaviour support planning are implemented. The Stop-Gap model recognises the importance of community-based service delivery while providing intensive and short-term support for youths with the most challenging behaviours.	3	3
Teaching-Family Model (TFM)	TFM is a unique approach to human services characterised by clearly defined goals, integrated support systems, and a set of essential elements. TFM has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. The model uses a married couple or other “teaching parents” to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children’s parents, teachers, and other support networks to help maintain progress.	3	3
Treatment Foster Care Oregon - Adolescents (TFCO-A)	TFCO-A (previously referred to as Multidimensional Treatment Foster Care – Adolescents) is a model of foster care treatment for children 12-18 years old with severe emotional and behavioural disorders and/or severe delinquency. TFCO-A aims to create opportunities for	1	1

Model	Overview	Alt	PM
	youths to successfully live in families rather than in-group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide them with effective parenting. Four key elements of treatment are (1) providing youths with a consistent reinforcing environment where he or she is mentored and encouraged to develop academic and positive living skills, (2) providing daily structure with clear expectations and limits, with well-specified consequences delivered in a teaching-oriented manner, (3) providing close supervision of youths' whereabouts, and (4) helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships. TFCO also has versions for pre-schoolers and children.		
Treatment Foster Care Oregon for Pre-schoolers (TFCO-P)	TFCO-P (previously referred to as Multidimensional Treatment Foster Care for Pre-schoolers) is a foster care treatment model specifically tailored to the needs of 3- to 6-year-old foster children. TFCO-P is effective at promoting secure attachments in foster care and facilitating successful permanent placements. TFCO-P is delivered through a treatment team approach in which foster parents receive training and ongoing consultation and support. Children receive individual skills training and participate in a therapeutic playgroup, and birth parents (or other permanent placement caregivers) receive family therapy. TFCO-P emphasises the use of concrete encouragement for pro-social behaviour; consistent, non-abusive limit-setting to address disruptive behaviour; and close supervision of the child. In addition, the TFCO-P intervention employs a developmental framework in which the challenges of foster pre-schoolers are viewed from the perspective of delayed maturation.	2	2

Source: CEBC summaries for 'Alternatives to Long-Term Residential Care Programs' and 'Higher Levels of Placement' (California Evidence-Based Clearinghouse (CEBC), 2020a, 2020b).

Therapeutic care interventions

134. As discussed in the earlier section on trauma-informed care, children who are placed in OOHC as a result of maltreatment have to deal with trauma-related challenges and have a range of complex needs. Individual therapies and programmes (interventions), including in residential care settings, demonstrate effectiveness if they are responsive to these complex needs. These interventions include behaviour modification, family/whānau focused interventions, and specific skills training tailored to children's developmental level (e.g. social skills, assertiveness training, self-control/self-instruction management). It is especially important to consider children's developmental levels (and reflective ability) as this will determine how likely they are to respond to the interventions. Consideration should also be given to the extent and type of difficulties faced and their longevity given their impact upon children's outcomes (Mclean, 2016).

135. Therapeutic interventions are what many people would first think of when asked what therapeutic care comprises. In child welfare services these therapeutic interventions, commonly respond to the clinical mental health needs of individual children who have been traumatised by maltreatment i.e. psychotherapy. However, a wider range of therapeutic

interventions is often required to respond to the diverse needs of children who have experienced maltreatment, i.e. diagnostic, medical, and surgical.[20]

136. The main psychotherapy approaches are commonly referred to by the 'theories' upon which they are based. These include cognitive and behavioural, psychodynamic, humanistic/experiential and integrative (common factors) approaches. Older and established approaches often inform new and ostensibly different ones. For example, CBT, now widely accepted and used, originated from traditional behaviour therapy. Given the sheer number of psychotherapies emerging, EBP is an avenue to test and understand their efficacy and effectiveness. Nonetheless, there is ongoing debate – captured in the earlier discussion about common factors – about whether the different approaches produce significantly different results from one another (Someah, Edwards and Beutler, 2017).

137. It is opportune to note that there is no agreed upon classification of psychological therapies and that the distinctions made often vary among researchers (and therefore the basis on which evidence is gathered is also variable) (Shinohara *et al.*, 2013). Collard (2019) writes about the understandable confusion when discussing psychological approaches that result in misunderstandings in psychological research, practice and education.[21] Collard (2019) distinguishes between three levels: frameworks of human functioning (theories), specific therapy packages (modalities), and individual therapy interventions (techniques).

    137.1 The theoretical framework provides an understanding of how various aspects of psychological functioning interact (e.g. thoughts, feelings and behaviours) and explains how various functions are adaptive or maladaptive, how change occurs and how disorder arises.

    137.2 Therapy modalities are typically created by an individual or a group of individuals and may have mini-theories and an idiosyncratic vocabulary. The various therapy modalities can often be drawn together within a "school of therapies" that adheres to the same underlying theoretical principles.

    137.3 The therapy intervention level describes the specific strategies, techniques and tools used within therapy to create change for individuals (Collard, 2019).

138. This evidence brief does not include a systematic review of the differing approaches available, of modalities or interventions, nor does it advocate for any specific modality or intervention.[22] Rather it presents a summary of predominant modalities and interventions:

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[20] The International Classification of Health Interventions (ICHI) defines health interventions as an "act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions". This can cover therapeutic interventions of different types across the health spectrum, including diagnostic, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine, and public health (WHO, 2020b).

[21] Collard (2019) says the confusion "is completely understandable when taking into account that there are over 400 psychological therapies to date, with a variety of methods used for defining and classifying them" (Collard, 2019). Moreover, there are additional ways of defining and classifying these psychotherapy approaches, which can add to the confusion, including theoretical model (i.e., behavioural, systemic, cognitive, psychodynamic, etc.), format (i.e., individual, family, group), temporal length and frequency of the sessions, as well as any possible combination of these elements (Zarbo *et al.*, 2016).

[22] The National Institute for Health and Care Excellence (NICE) in the UK carried out a significant review of the evidence for psychological, psychosocial, and other non-pharmacological interventions for the treatment of PTSD in children (and young people), completed in 2018. This is perhaps the best and most up-to-date resource found by the Evidence Centre on the efficacy and effectiveness of interventions for the treatment of PTSD in children (NICE, 2018a). The review

cognitive and behavioural, in particular CBT and TF-CBT, psychodynamic therapy, and humanistic/experiential therapy, with reference to integrative (common factors) where relevant. Briefly, these approaches are described as follows:

138.1 *Cognitive-behavioural* approaches seek to identify and change patterns of thinking that lead to emotional and behavioural difficulties, while at the same time reinforcing positive behavioural change.

138.2 *Psychodynamic* approaches tend to focus on unconscious experience and areas of relational and developmental difficulty.

138.3 *Humanistic/experiential* approaches tend to emphasise emotional expression and the development of a greater understanding and acceptance of affective, sensory and visceral experience.

138.4 *Integrative* approaches seek to draw concepts and techniques from the above traditions in a coherent manner in order to tailor the therapy to the individual patient (Hill *et al.*, 2008).

139. There is significant debate and disagreement over the evidence and significance of differing psychotherapy approaches, with some arguing that CBT in particular, represents the best evidenced form of psychotherapy, others arguing for a pluralistic openness, with strong evidence available demonstrating common factors in psychotherapy (Leichsenring *et al.*, 2018).

140. CBT combines behaviour therapy and cognitive therapy – both established forms of psychotherapy that have been shown to be effective in treating anxiety and stress-related disorders. CBT sources its understanding of trauma from learning theories (e.g. classical and instrumental learning) and cognitive theories (e.g. dysfunctional thoughts, beliefs and assumptions about the traumatic event and oneself). It aims to change behaviours, thoughts, and emotions of individuals who are traumatised through specific theory-informed treatment components (Landolt and Kenardy, 2015).

141. As Landolt and Kenardy (2015) note, there are many variations of CBT, although most share a number of common components, and for children who are traumatised, combine individual sessions with children and parents, and combined child-parent sessions. Common components include:

141.1 psychoeducation about trauma-related symptoms and the CBT approach

141.2 affective modulation skills for managing physiological and emotional distress (used in preparation for the exposure-based part of the therapy)

141.3 training of coping skills

141.4 cognitive processing and restructuring of dysfunctional cognitions

141.5 creation of a trauma narrative

141.6 in vivo exposure to traumatic reminders (graduated exposure to trauma-related stimuli) (Landolt and Kenardy, 2015).

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informed the subsequent NICE guideline on 'Post-traumatic stress disorder' (ng116), which largely recommended TF-CBT as the optimal treatment for children with PTSD (NICE, 2018b).

142. These common components are not part of all CBT modalities and other distinct components can be included. CBT modalities can also comprise common structural components such as behaviour modelling and coached practice of new skills (Landolt and Kenardy, 2015).

143. TF-CBT is the best supported and most widely used CBT intervention for treating children who have been traumatised. Over the past two decades TF-CBT has been used with children who have been through a wide variety of traumatic experiences and with a diversity of trauma symptoms (Landolt and Kenardy, 2015). These symptom domains include, for example, Post-traumatic Stress Disorder (PTSD), depression, anxiety, externalising behaviour problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT particularly focuses on developing skills for regulating affect, behaviour, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills and family communication. TF-CBT has also been adapted for differencing situations, including for children from different cultural backgrounds (NCTSN, 2012).

144. A recent review on the availability, modality and effectiveness of psychosocial support services for child and adult victims and survivors of child sexual abuse for the Australian Royal Commission into Institutional Responses to Child Sexual Abuse found that for child and adolescent victims of child sexual abuse TF-CBT had the "best evidence of treatment effectiveness, with large and substantial reductions in trauma-related symptoms and internalising symptoms (such as depression and anxiety)". The report noted the best way to deliver TF-CBT was through individual treatment or a family-based approach and that involving a non-offending parent is likely to provide some additional benefit. The report also indicated that treatment gains tend to be maintained over the short to medium-term, however, seem to diminish somewhat over time (Shlonsky *et al.*, 2017).

145. Numerous other studies, including findings from randomised control trials, support the effectiveness of TF-CBT. There is also strong generalised support for the effectiveness of CBT (See for example Cohen, Mannarino and Iyengar, 2011; Dorsey, Briggs and Woods, 2011; Leenarts *et al.*, 2013; Landolt and Kenardy, 2015; Miller-Graff and Campion, 2016; Sigurvinsdóttir *et al.*, 2020). The National Institute for Health and Care Excellence (NICE) in the UK recommends TF-CBT for children who have experienced sexual abuse and similarly for the treatment of children with PTSD (NICE, 2017, 2018b).[23]

146. However, a note of caution is sounded regarding CBT and its variations from an evidence and comparative standpoint. There is a sizable amount of research on CBT and over the past several decades CBT has become more widespread. Macdonald et al. (2012) said in a Cochrane Database of Systematic Reviews on 'Cognitive-behavioural interventions for children who have been sexually abused' that the reporting of studies was poor and there were often significant study quality issues. Macdonald et al. (2012) noted that the CBT evidence indicated a reduction in depression, post-traumatic stress and anxiety for children who had experienced sexual abuse, however the results were generally modest (Macdonald *et al.*, 2012).

147. Concerns surrounding the quality of CBT studies and overestimated effect sizes are accompanied by research that suggests CBT is largely comparable in its effect to bona fide

[23] Several other therapeutic interventions are also recommended by NICE for children who have experienced physical abuse, emotional abuse and neglect. These include attachment, parenting, and group therapies, multi-systemic therapy, and some psychoanalytic programmes (see NICE, 2018c).

non-CBT treatments (Baardseth *et al.*, 2013; Laska, Gurman and Wampold, 2014; Cuijpers *et al.*, 2016). Underlying this suggestion is that psychotherapy interventions share common factors, principal among them, therapeutic alliance, empathy, goal consensus and collaboration, positive regard and affirmation, mastery, congruence/genuineness, mentalisation and emotional experience. Research on common factors demonstrates particularly that relationships in the therapeutic setting predict psychotherapy outcomes. Nahum, Alfonso, and Sönmez (2019) write that the "effectiveness of psychotherapies may rely more on commonalities rather than on differences of theory and technique" (Nahum, Alfonso and Sönmez, 2019).

148. There has been significant investment in large-scale psychotherapy programmes overseas. These programmes have seen successes and attracted criticism. They provide an opportunity for a natural experiment assessing the efficacy of psychotherapy treatments. For example, in 2008 the UK implemented the Improving Access to Psychological Therapies (IAPT) programme. It aimed to improve access to evidence-based psychological therapies for people with conditions such as anxiety and depression. The programme has seen some success, increasing access to mental health services, and recently meeting its target of 50% recovery for all individuals completing treatment. However, it has attracted criticism for focusing largely on CBT – at least until recently – and for the sizable attrition levels. While the headline recovery rate for 2018/19 is 52.1% that represents less than one in five of the total number referred who are achieving recovery. Nearly one in three referrals do not enter therapy and less than four in ten referrals reach the end of therapy (NHS Digital, 2019).[24]

149. There have also been concerns raised that the recovery rate itself may be too high. Specifically, Scott (2018) suggests that only the 'tip of the iceberg' fully recovers from their disorders (9.2%), and that the recovery levels show only the immediate recovery rate and not the longer-term recovery rate. Some studies have shown CBT recovery rates diminish over time (for discussion see Marks, 2018; Scott, 2018). Moreover, it has been noted that CBT has in some studies only demonstrated small to modest short-term effects and that where counselling was used instead of CBT as part of the IAPT stepped care approach, outcomes for the treatment of depression were comparable (Pybis *et al.*, 2017; Bastiampillai *et al.*, 2019). In 2011, the Children and Young People's IAPT (CYP-IAPT) was initiated. It aimed to improve children's access to evidence-based psychological therapies in the community-based child and adolescent mental health services (CAMHS) setting (for discussion see Fonagy and Clark, 2015; Timimi, 2015).

150. Significant research over the past decade has focused on CBT, and more especially TF-CBT for traumatised children. Research has also been completed that supports other types of psychotherapy, in particular psychodynamic therapy. Psychodynamic therapy is one of the most frequently used treatments for mental health difficulties (alongside CBT and pharmacotherapy) (Steinert *et al.*, 2017).

151. Psychodynamic therapy focuses on emotional conflicts caused by traumatic experiences, especially as it relates to people's early life experiences. Importantly, psychodynamic therapy focuses on symptoms and on the meaning and effect of the traumatic experiences on the life and development of the individual. As trauma effects are considered to be different for each individual, providing the best treatment relies on understanding the individual. Contemporary psychodynamic therapy includes a range of different modalities and

[24] For discussion see: http://therapymeetsnumbers.com/iapt-2019-still-failing-to-thrive/.

interventions, based on the unique circumstances of each case, and can include for example, talk therapy, trauma-focused play therapy, parental counselling and interventions in schools. For younger children the focus is on the mother (parent)-child relationship (based on attachment theories). Psychodynamic therapy also considers transference and countertransference. Psychodynamic treatment of traumatised children varies significantly depending on the individual so it is difficult to describe typical psychodynamic procedure (Landolt and Kenardy, 2015)

152. Several studies suggest psychodynamic therapy is comparable in its effects to CBT (see for example Steinert *et al.*, 2017), however, further research is required. While there is support for the equivalence of psychodynamic therapy, there is still much to be learnt about what works for whom and in connection with specific subjects such as child maltreatment. Much of the work to date is in areas such as the efficacy of psychodynamic therapies for depression (Driessen *et al.*, 2013; Parker and Turner, 2013). One study into short-term psychodynamic psychotherapies for common mental health disorders found modest treatment benefits that were generally maintained over the medium and long term (Abbass *et al.*, 2014). Another study into long-term psychoanalytic therapies found them to be effective treatments for a large range of pathologies, with moderate to large effects (De Maat *et al.*, 2009). The research literature into psychodynamic therapy also notes study design and quality issues (Parker and Turner, 2013; Abbass *et al.*, 2014).

153. Much of the evidence therefore points to a cautious approach. TF-CBT is strongly supported in the research literature, and psychodynamic therapy is also well supported. Arguably, research also points to ensuring a pluralistic approach to the inclusion of different modalities and interventions to support improvements and innovation in accordance with evidence-based practice.

154. The CEBC also looks at client-level interventions (child & adolescent) for trauma treatment, which it defines as interventions designed to help an individual process a trauma or multiple traumas they have experienced and learn how to cope with the feelings associated with the experience (e.g., fear, post-traumatic stress, anxiety, depression, etc.). Several key therapies are noted below in Table 4 (California Evidence-Based Clearinghouse (CEBC), 2020c).

Table 4: Client-level interventions for trauma treatment

Model	Overview	Rating
Trauma Focused-CBT	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioural difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioural, family, and humanistic principles.	1
Eye Movement Desensitization and Reprocessing (EMDR)	EMDR therapy is an eight-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, guided by standardised procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist-directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used.	1

Model	Overview	Rating
Prolonged Exposure Therapy for Adolescents (PE-A)	PE-A is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they can tolerate this distress.	1
Child-Parent Psychotherapy (CPP)	CPP is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the pair is treated together. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture, and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviours that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviours and affect.	2

Source: CEBC summaries for 'Trauma Treatment – Client-Level Interventions (Child & Adolescent)' (California Evidence-Based Clearinghouse (CEBC), 2020c).

155. The humanistic approach involves a collaborative relationship between their therapist and client intended to promote transformative change. It focuses on holistic and more person-oriented objectives. Humanistic therapists focus on life stories or narratives, often in combination with analytical data, as a means to best understand people and their trajectories. Humanistic therapists also focus on the socio-ecological circumstances that support personal identity and social intimacy within a community as important components of healthy personality development (Bland and DeRobertis, 2019).

156. Humanistic therapy is often described as the third force in psychology after behaviourism and psychoanalysis (Maslow, 1962). Humanistic therapy incorporates several therapeutic principles. As described by Bland and DeRobertis (2019):

> Humanistic therapy assumes that clients are holistic/irreducible (i.e., not determined by their past or conditioning, capable of agentic change) and that they are experts on their own experiences, their potentials within themselves, and the social, community, and cultural contexts within which they forge their identities and senses of control, responsibility, and teleological purpose. Thus, clients are granted an autonomous role in the therapy process, with therapists respecting their freedom and potential to make choices about whether and how to change (Bland and DeRobertis, 2019).

157. While contemporary humanistic therapies differ from one another in their clinical approach, they all focus on the importance of an authentic therapeutic relationship where the therapist's 'core conditions' of empathy, genuineness and unconditional positive regard are considered therapeutic cornerstones for facilitating client insight and change (Rogers, 1951). Humanistic therapies can be categorised into seven subcategories: person-centred therapy (Rogerian), gestalt therapy, experiential therapies, transactional analysis, existential therapy, non-directive/supportive therapies and other humanistic therapies (Shinohara *et al.*, 2013).

158. The humanistic therapy evidence base for the treatment of mental disorders, including depression, is less extensive than for CBT approaches. Systematic reviews carried out were limited to person-centred / experiential therapy approaches or otherwise narrow in their scope (Churchill *et al.*, 2010). One of the reasons for this limited evidence base is that humanistic theory is primarily phenomenological, i.e. about subjective experiences of the mind, rather than a simple explanatory medical model. This has led to an inability or reluctance to engage in developing the 'evidence base' (Bland and DeRobertis, 2019).

159. The book 'Person-Centered and Experiential Therapies Work' looked at the research and evidence base for person-centred and experiential therapies. In chapter one, Elliott and Freire (2010) highlight the international pressure for person-centred and experiential therapists to evidence their practice on an empirical basis. They also point to the range of studies that support the effectiveness of person-centred and experiential (PCE) therapies. This includes findings that support PCE therapies having comparable effectiveness to other therapeutic modalities (Elliott and Freire, 2010). Elliot (2016) writes that over the past 50 years PCE therapies have been the subject of more than 200 quantitative outcomes studies. Based on meta-analyses of these studies, Elliott (2016) and research colleagues concluded the following:

    159.1 PCE psychotherapies are associated with large pre-post client change.

    159.2 Clients' large post-therapy gains are maintained over early and late follow-ups.

    159.3 Clients in PCE therapies show large gains relative to clients who receive no therapy.

    159.4 PCE therapies in general are clinically and statistically equivalent to other therapies.

    159.5 So-called non-directive-supportive therapies have worse outcomes than CBT.

    159.6 Person-centred therapy is as effective as CBT.

    159.7 PCE therapies are most effective for interpersonal/relational problems/trauma.

    159.8 PCE therapies meet criteria as evidence-based treatments for depression.

    159.9 For psychotic conditions, PCE therapies appear to meet criteria as evidence-based treatments.

    159.10 PCE therapies have promise for helping people cope with chronic medical conditions and for reducing habitual self-damaging activities.

    159.11 For anxiety difficulties, the PCE therapies studied so far appear to be less effective than CBT (Elliott, 2016).

160. There is an ongoing discussion in the UK about the role of counselling, and more specifically, person-centred counselling for depression, which is one of the therapies offered as part of the IAPT programme (one of the more commonly practiced humanistic therapies) (Barkham,

Moller and Pybis, 2017; Haake, 2017; Thornton, 2018; Wise, 2019).[25] Research based on data collected from 33,243 patients involved in the IAPT programme in the UK found that outcomes for counselling and CBT in the treatment of depression were comparable. The IAPT programme offers CBT first and then counselling for people who do not respond to CBT. Arguably, the benefits of counselling are harder to demonstrate. Counselling is collaborative and non-directive so benefits can appear long after treatment has finished (Pybis *et al.*, 2017). Experiential therapies emerged from and refer to a broad grouping of humanistic and phenomenological therapies. Experiential therapies aim to "promote client agency, emotional expression and exploration of life-project choices through being actively responsive and attending to and articulating the client's experience" (Westwell, 2015). It is similarly described as "knowing by experience" in the promotion of change. While experiential therapy is often widely used within psychotherapy generally, the varying experiential therapies, go beyond traditional 'talk therapy', and can include alternative experiential therapies such as adventure therapy, animal-assisted therapies (e.g., equine-assisted therapy), art therapy, music therapy, recreational therapy, psychodrama, and wilderness therapy, among others.[26]

161. The Institute for Research and Innovation in Social Services (IRISS) carried out a review of (alternative) experiential therapies for children who have experienced trauma. They describe experiential therapy as a "therapeutic technique that uses expressive tools and activities, such as role-playing or acting, props, arts and crafts, music, animal care, guided imagery, or various forms of recreation to re-enact and re-experience emotional situations". The review found, however, that there was limited high-quality evidence on the impact of experiential therapies on children who had experienced trauma. They noted that, with few exceptions, experiential therapies tended to compare unfavourably with TF-CBT and that more robust and rigorous research was needed to evidence experiential therapies (Smith, 2018; see also Mavranezouli *et al.*, 2020).

162. There are demonstrated and emerging areas of understanding that require further enquiry and research. For example, there is renewed and growing interest in landscapes and nature as therapeutic treatment options, although arguably, landscapes and nature have always been one of humankind's surest therapeutic refuges. Treatment possibilities such as horticulture therapy, green care, and wilderness therapy, among others, are increasingly being described and evidenced (see for example van den Bosch, Bird and Frumkin, 2018).

163. The needs of specific groups also require attention. For example, promising approaches for working with disabled children and their families/whānau focus on family centred, collaborative, and wrap-around services, in addition to more traditional therapeutic models and interventions (Kelly, Dowling and Winter, 2016). This can include ensuring family-centred approaches that recognise family as the experts in their children's lives and ensuring wraparound service provision. Further factors typically need to be considered when treating disabled children to provide the most effective models and interventions (Houdek and

[25] Counselling for depression (CfD) comes from the humanistic tradition and is the name given by the IAPT programme to person-centred experiential therapy. It is one of the four non-CBT therapy modalities approved for use in the IAPT programme. The others are dynamic interpersonal therapy (DIT), interpersonal therapy (IPT) and couples therapy for depression (CTfD) (Haake, 2017).

[26] Some interventions of this kind may also be described as 'psychosocial therapies', where the emphasis is primarily on psychological or social factors rather than simply biological factors (see for example Forsman, Nordmyr and Wahlbeck, 2011).

Gibson, 2017). More research is required into which therapeutic models and interventions are the most effective for disabled children.

164. For children and young people involved in the youth justice system, systematic therapeutic approaches that include the child or young person, their family, and wider community are recommended. Young people get the most value from multi-level, therapeutic interventions, given they typically have entrenched and recognised antisocial behaviour patterns. Suggested interventions that are efficacious for youth justice populations include MST, FFT, and TFCO. There are several overarching characteristics of evidence-based, effective, youth-offending therapeutic interventions:

    164.1 Therapeutic intervention philosophy, targeting high-risk offenders and programme integrity (quality).

    164.2 Comprehensive, systemic, and social-ecological approach (involving the young person, their family/whānau, and/or other social system, e.g., church, school etc.).

    164.3 Well-structured (e.g., one or more weekly sessions), well planned, well implemented, and evaluated.

    164.4 All aspects of a young person's functioning are addressed (physical, mental, school, and peer relationships, etc.).

    164.5 Interventions also strive to enact change among key members of a young person's environment, rather than just change in the young person (Gluckman, 2018).

165. It is important to note that most of the therapeutic interventions used in Aotearoa New Zealand originate in part or entirely from overseas. They do not adequately address Aotearoa New Zealand's unique cultural context, specifically for Māori, and also for other ethnic groups. They frequently have a monocultural viewpoint and are often based on evidence from a predominantly Western perspective. Research is needed in Aotearoa New Zealand to address this shortcoming (Pihama *et al.*, 2017). There are particular implications for how research is undertaken and understood, which needs to be reconciled in Aotearoa New Zealand, if culturally sensitive evidenced-based treatments are to be successfully developed (La Roche and Christopher, 2009). For example, emerging evidence suggests that for Māori, successful engagement interventions are based on Māori cultural world views and processes (Te Pou o Te Whakaaro Nui, 2010).

166. Colonial influences redefined understandings of Māori healing and wellbeing. Whakapapa kōrero in their simplest form are knowledge frameworks that offer pathways for rediscovering traditional wellbeing strategies for responding to trauma (Smith, Tinirau and Smith, 2019). Wirihana and Smith (2014) write that "Māori have been promoting the use of traditional knowledge and practice to enhance wellbeing for many decades". Māori healing methods that support wellbeing are used regularly within Māori communities. They include for example waiata, mōteatea, haka, whakanoa and whakawhanaungatanga. Māori-centred approaches to therapy such as Paiheretia have also developed in response to the need and desire for te ao Māori perspectives that seek to enhance identity, reconnect cultural heritage, and balance relationships within families/whānau and wider tribal networks (Wirihana and Smith, 2014).

167. Elder (2017) affirms that western medical interventions are important but not sufficient to meet the culturally defined needs of Māori. Te Waka Oranga describes a process where whānau and health workers are brought together to identify recovery goals and improve the recovery experience. This process is guided by their collective knowledge, skills, and feelings.

Te Waka Oranga is likely applicable beyond its original purpose as a response to traumatic brain injury to other health areas such as mental health, addictions, and neurodegenerative disorders. It is a practical tool for bringing Māori knowledge into partnership with clinical knowledge to ensure a comprehensive response and improved outcomes. Key points made my Elder (2017) include:

167.1 Thinking about and applying Māori concepts of health in practice.

167.2 Recognising the importance of assessing whānau cultural needs.

167.3 Understanding the concept of wairua.

167.4 The importance of making time for cultural practices of engagement.

167.5 Increased awareness of mātauranga Māori and use of the whānau mātauranga resources (Elder, 2017).

168. 'He rongoā kei te kōrero: Talking therapies for Māori' reviewed the effectiveness of talking therapies for Māori. It noted the lack of evidence, with some exceptions, outlined general limitations and investigated the effectiveness of CBT for Māori (Te Pou o Te Whakaaro Nui, 2010). Bennett (2009) adapted CBT to incorporate significant Māori concepts with positive results. The treatment reduced symptoms of depression and improved wellbeing in four culturally relevant domains. Limitations to the adaption of CBT largely arose from the differences in cultural worldview between CBT and te ao Māori (Bennett, Flett and Babbage, 2008; Bennett, 2009). 'He rongoā kei te kōrero' points to key factors that need to be incorporated into therapy to support effectiveness for Māori. They include:

168.1 the importance of bicultural therapy (the combination of both westernised and kaupapa Māori health models)

168.2 inclusion of culturally appropriate values, such as whanaungatanga (relationships), whakamanawa (encouragement) and mauri (spirit)

168.3 use of traditional Māori mythology

168.4 maintaining awareness of the diversity of cultural identity among Māori, and avoiding use of cultural checklists or of generalising cultural needs and wants (Te Pou o Te Whakaaro Nui, 2010)

169. The importance of encouraging strong cultural identity for tamariki Māori and adults is a prominent theme in the literature. The importance of cultural identity is also found in the literature overseas on therapeutic approaches involving Indigenous populations, along with considerations of spirituality, understanding family dynamics, and crucial links to the surrounding environment (Te Pou o Te Whakaaro Nui, 2010). Pihama (2017) writes about the Australian Aboriginal context, where trauma-informed practices informed by Indigenous culture demonstrate promising results. Examples that support healing and recovery include art therapy and yarning therapy – where people tell their stories as part of the therapeutic healing process that validates their experiences (Pihama *et al.*, 2017). Moss and Lee (2019) describe 'TeaH (Turn 'em around Healing): a therapeutic model for working with traumatised children on Aboriginal communities'. Critical factors identified essential to Aboriginal models and in the TeaH therapeutic model include a recognition of past trauma, services based on local culture and values underpinned by community empowerment, capacity building and social justice, with the involvement of Elders and spirituality being central to the model. The TeaH therapeutic model showed promising early signs of success, although several factors

imposed limitations, including the remoteness of the communities involved and funding constraints (Moss and Lee, 2019).

170. 'He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction' noted that in hui with Māori, kaupapa Māori providers and iwi were achieving good outcomes for tāngata whaiora. However, historical trauma, institutionalised racism, unconscious biases and Western wellbeing models continued to undermine Māori health and wellbeing (Government Inquiry into Mental Health and Addiction, 2018). Much of the growth in understanding and development of Māori therapeutic interventions has been in the absence of available research. As outlined in 'He rongoā kei te kōrero' promising avenues of research include looking at overseas therapies that have shown encouraging results for Indigenous populations and developing Māori approaches further (rather than adapting overseas models or therapies) (Te Pou o Te Whakaaro Nui, 2010).

CONCLUSION

171. This evidence brief concludes by looking at the evidence gathered and offers suggestions for a practical and strategic way forward for realising therapeutic care. It does so by looking at the notion of a therapeutic care framework, something that has been adopted in several overseas jurisdictions, and then reviewing some of integration and implementation considerations. Specific recommendations follow.

172. As mentioned earlier, a central question of James Anglin's (2002) seminal research into residential services was 'what makes a well-functioning residential service?' Anglin's (2002) work described the importance of having a trauma-informed organisational culture – a place where trauma could be acknowledged in a safe environment. Along with other similar works, his research has contributed to idea that a 'whole of organisation approach' is required in the provision of therapeutic care (McPherson *et al.*, 2019b).

173. This evidence brief resolved to ask a similar question: 'what is good practice therapeutic care?' As the evidence presented across a broad spectrum in this paper shows, this is a far from simple question. Identifying the therapeutic care environment is an important first step and one achieved in collaboration with a wide range of stakeholders. The details of the therapeutic environment need to be disentangled in parallel, and reconstructed to incorporate critical factors including EBP, a focus on relationships, common factors, and crucially for Aotearoa New Zealand, te ao Māori perspectives. The goal should be an effective therapeutic environment that consistently reflects and reinforces all of these factors.

A therapeutic care framework

174. Oranga Tamariki exists within a wider therapeutic milieu of social sector agencies such as primary health care providers and child welfare NGOs. Oranga Tamariki itself determines its own therapeutic environment, and to a sizable degree, the therapeutic environments of child welfare organisations in Aotearoa New Zealand.

175. An important additional concept is that of a therapeutic care framework, which this evidence brief simply defines as *a set of therapeutic care principles and structures for describing, understanding, and guiding practice.*[27] These therapeutic care principles and their accompanying structures should be consistent with organisational and community aspirations and values. They should also be informed by EBP. Such a therapeutic care framework maps out what should be done and why, providing a rationale for good

[27] Lambie et al. (2016) provides an authoritative guide on international and national evidence-based literature about best practice and optimal service delivery in relation to secure residences and the wider continuum of care for the care and protection population in Aotearoa New Zealand. In it they state a framework is useful as an "overarching perspective or philosophy in understanding the development of behavioural and psychological difficulties, as well as guiding principles in the assessment and treatment process". Models of therapeutic care sit underneath the overarching framework and can support a "common understanding between all staff and professionals as to the aims, goals and philosophies of the services provided" (Lambie *et al.*, 2016).

therapeutic care practice, while promoting a range of therapeutic care models and interventions (Baron *et al.*, 2019).[28]

176. Common to therapeutic care frameworks overseas are congruent, whole of organisation commitments to therapeutic care and the use of trauma therapy, and include trained staff. A whole of organisation approach to therapeutic care is required to address the needs of children and families/whānau as well as to ensure that social workers and staff at all levels experience safety and support in their practice (McPherson *et al.*, 2019a).

177. A therapeutic care framework offers a promising evidence-based option for creating collective therapeutic intent and responsibility for everyone working in the child welfare system and for best supporting children and families/whānau within and across therapeutic environments. Many questions remain about what such a framework might look like – its appropriate design, implementation, and sustainability. Such a framework could support children and families/whānau from the earliest intervention stages to those children who enter OOHC.

178. It is difficult to identify critical or particular models or therapies among the tapestry of offerings, both in Aotearoa New Zealand and internationally, which contain the essential ingredients for our tamariki and families/whānau. It is perhaps more appropriate to identify what among the many therapies available offers the greatest effectiveness and success, and therefore the greatest chance for improved therapeutic care in Aotearoa New Zealand. These criteria, whether expressed as therapeutic principles or standards of care, are common threads that should be articulated in any therapeutic care framework adopted. They are not therapeutic outcomes as such; rather, resources and inputs that are critical to the therapeutic outcomes Oranga Tamariki is seeking.

Realising therapeutic care

179. Oranga Tamariki could develop suitable therapeutic care models across socio-ecological levels, for conceptualising and organising services in different care settings, including residential care. In due course these models could be applied more broadly to the wider therapeutic care environment, i.e. the entire organisation. These models would preferably be multifaceted and multidisciplinary, reflecting relevant evidence and the preferences and needs of children, families/whānau, iwi, community groups and organisations, among others. Any models should be underpinned by a sound therapeutic care framework (Davidson *et al.*, 2006; Nilsen, 2015).

180. Several domains should be considered when developing therapeutic care models at any of these levels. They include:

    180.1 How therapeutic is the care?

    180.2 What is the framework and how are principles operationalised?

    180.3 What is the service user pathway?

    180.4 What is the process for monitoring and reviewing day-to-day and clinical outcomes?

[28] Frameworks have also been described as an 'overarching approach to practice applicable across different models of care, cohorts of children, and care services', and a 'guide for staff recruitment, policies, procedures and understanding of children's behaviour and needs' (Queensland Government, 2015; Mclean, 2019)

180.5 What is the mechanism for ensuring the needs of all groups are met?

180.6 How does the model ensure appropriate adaptation to local need while staying consistent with the need for regional and national consistency?

180.7 How does care provision coordinate between primary, secondary and social sectors?

180.8 Is the model supported by appropriate administrative and IT platforms?

180.9 What resources are dedicated to workforce capacity and capability?

180.10 How are social sector organisations supporting the model?

180.11 What are the funding mechanisms and do these support model of care aspirations?

180.12 What processes are in place to monitor and improve service performance and quality (adapted from Collings *et al.*, 2010)?

181. Developing a therapeutic care framework, and over time suitable therapeutic care models, is an iterative process. It would involve the development of processes, resources, skills, and systems to reduce the gap between research evidence and evident needs and day-to-day and clinical practice. Collaborative approaches are one good way of pursuing change and developing a therapeutic care framework, and in due course suitable models. A collaborative approach entails a cyclical process of setting aims, establishing measures, developing informed changes to practice, and evaluating the impact of these changes (Davidson *et al.*, 2006). This is similar to the Ministry's existing 'learn and grow' approach.

182. Evidence and experience highlight the importance of taking a collaborative approach that draws on "multiple types of expertise and experience, demands precision in identifying and measuring outcomes and target domains, and focuses on what works (and what doesn't) for whom and why". Utilising this approach would open new opportunities for changing therapeutic care within the ministry and across the sector. Space must also be given to promising and innovative responses (Center on the Developing Child, 2016).

183. Developing an effective therapeutic care environment can be challenging. It requires organisational change and is inevitably a multifaceted and long-term process. It is argued that any framing of the care environment should recognise core principles, including those currently recognised and collaboratively designed, and, in particular for therapeutic care, should deliver parity of esteem. This is characterised by:

> equal access to the most effective and safest care and treatment; equal efforts to improve the quality of care; the allocation of time, effort and resources on a basis commensurate with need; equal status within health care education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes (Naylor, Taggart and Charles, 2017).

Recommendations

184. This evidence brief suggests the best way forward it is to adopt a therapeutic framework and set of common good practice principles that reflect the aspirations and intentions of Oranga Tamariki, the Government, and New Zealanders. This therapeutic care framework would provide a benchmark and should include particular ethics of care and te ao Māori perspectives.

185. There is no one best way of characterising a therapeutic care environment. However, there are ways to improve upon 'therapeutic care' good practice and establish the fundamental parameters of therapeutic care. These should be developed in an Aotearoa New Zealand

context, using te ao Māori paradigms; learning from overseas good practice where appropriate and necessary; and ensuring there is room for adaption, innovation, and formation of good practice therapeutic care.

186. Based on this review of evidence it is recommended that three substantive areas be given consideration.

186.1 Current state: the review of current state needs to incorporate a better understanding of the Aotearoa New Zealand therapeutic care environment. It is recommended that a survey of agencies and providers to assess existing therapeutic frameworks, therapeutic models, and therapeutic interventions be undertaken. The survey should consider organisational and staff 'ways of working' as a clear understanding of this is critical to knowing what is available and ensuring effective therapeutic care over time. Several overseas studies have included these kinds of surveys.

186.2 Therapeutic care framework: it is recommended that Oranga Tamariki develop a therapeutic care framework. Based on the evidence, there is much to support the development of a therapeutic care framework, as several overseas jurisdictions have done. The intent is to set clear parameters for therapeutic care, including day-to-day and specialist care that is responsive to children's needs and backgrounds. There are several factors that need to be taken into account in the development of such a therapeutic care framework:

186.2.1.1. *Common factors*: research is increasingly demonstrating that there are common core therapeutic care components to effective models and interventions, which should be considered when developing a therapeutic care framework, i.e. what are the common elements of a successful therapeutic care environment.

186.2.1.2. *Relationships*: are a pivotal common factor and have proven essential across the work of Oranga Tamariki and wider social sector. Relationships must be considered as central to the development of any therapeutic care framework. This includes day-to-day 'therapeutic' interactions with caregivers, care staff, and social workers. Therapeutic care should be broadly understood and not only a 'specialist' occupation. This has resource implications long-term, for example, ensuring the appropriate 'therapeutic relational' training of all caregivers, care staff, and social workers.

186.2.1.3. *Te ao Māori* : any therapeutic care framework should be led by and support the development of te ao Māori perspectives. The incorporation of te ao Māori is broader than collective aspiration or responsibility. Evidence shows that therapeutic care is more effective when people's backgrounds are considered, and correspondingly, that therapeutic care approaches are more effective when developed according to local circumstances and cultures.[29]

186.3 Evidence-based practice: it is clear from the evidence that several therapeutic care approaches (i.e., models and interventions) demonstrate effectiveness or show

[29] This would also support the Oranga Tamariki commitment and responsibility to address historical disparities for Māori and set measurable outcomes. It would also support the development of partnerships with Māori. For further information see https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Report-and-releases/Cabinet-papers/Enhancing-the-wellbeing-of-tamariki-Maori/Cabinet-paper-Enhancing-the-Wellbeing-of-Tamariki-and-Rangatahi-Maori.pdf.

promise, in particular, TF-CBT as a response to trauma in children. However, much remains unclear, including in some instances the basis of modalities and interventions effectiveness (and the best way to 'evidence' effectiveness). A coherent approach to assessing and adopting EBP is required for Aotearoa New Zealand that accounts for existing evidence and practice, where overseas modalities and interventions have been adopted or adapted for the Aotearoa New Zealand context. It must also encourage and remain open to developing the evidence base for practice that shows promise (or has to date lacked research support). It should also encourage innovation in Aotearoa New Zealand and be grounded in and support te ao Māori approaches. It is **recommended that a structured evidence review process be developed** to support the systematic assessment and evidencing of therapeutic care approaches in Aotearoa New Zealand. This includes the assessment and evidencing of different modalities and interventions for effectiveness and outcomes. Priority areas will need to be identified.

187. There remains much to be understood and coalesced from the evidence to better support therapeutic care. Much though is known about common factors, relationships, and the importance of people's backgrounds to the success of therapeutic care. We also know the demands and ethical imperative of providing a holistic therapeutic care environment in response to children's needs and trauma. And although the subject of much debate, there is a growing body of evidence that supports particular therapeutic approaches along with ensuring a pluralistic therapeutic paradigm continues.

APPENDICES

Research design

This evidence brief supports the Ministry's work developing an improved therapeutic care response that better meets the needs of our children and families/whānau. It aims to advance the Ministry's understanding of therapeutic care and identify the approaches that best support children and families/whānau.

The evidence brief incorporated a comprehensive narrative review of the literature to identify key therapeutic care concepts, settings, models, and interventions. This type of approach gathers information about a subject from many sources and is considered appropriate for summarising and synthesising literature to draw conclusions on 'what is known' about a subject. The narrative review helps collate diverse and plural understandings.

The research design itself followed a standardised methodology. It was circumscribed given the limited time available for the evidence brief. The key steps in the research process included:

1. Evidence brief scope document
2. Evidence brief document outline and formatting
3. Evidence brief literature search, including noting of key search words and terms
4. Inclusion of identified documents into Nvivo for thematic analysis and coding
5. Evidence brief analysis and writing
6. Development of recommendations based on findings

The evidence brief insights support work detailing therapeutic care in Aotearoa New Zealand and overseas as well as those therapeutic care services specifically provided by Oranga Tamariki and our partners. This will enable need and services mapping and improved understanding of the respective challenges and opportunities involved in improving the delivery of therapeutic care.

This evidence brief offers a clearer idea of what good practice therapeutic care could look like for Oranga Tamariki and what the Ministry might do in the future to improve delivery of good practice services.

There are several primary and secondary research questions:

1. Definition: What is the definition of therapeutic care?
2. Need: What are the needs of our children and families/whānau?
3. Therapeutic care: What does the therapeutic care and therapeutic care continuum look like?
4. Te ao Māori: What is the te ao Māori perspective?
5. Recommendations: What are the next steps in identifying and understanding therapeutic care and developing how Oranga Tamariki best utilises therapeutic care approaches?

The research design followed from the commissioning of the evidence brief by Care Services and was informed by subsequent discussions. A draft structure was developed and within that scope a set of search terms (strings) was used in select databases, repositories, and search engines. Terms

included ‘therapy’, ‘therapeutic’, ‘care’, ‘intervention’, and ‘children’. Other search terms were used when particular insights were sought, or themes developed.

This evidence brief draws on a range of Aotearoa New Zealand and overseas literature and endeavours to provide a clear understanding of the varying facets of therapeutic care and good practice. This is an important step in supporting the improved provision of therapeutic care for tamariki and families/whānau by Oranga Tamariki.

The search was kept reasonably broad so as to not unnecessarily exclude relevant materials. Several hundred titles were scanned for relevance. Given the significant volume of results, where required, searches were delimited by date (2005-) and type (evidence, guidance, and policy-related).

Given the higher-level focus on therapeutic frameworks and settings of care the research design also sought out more generalised literature and reports that provided innovative and insightful thinking on the subject area.

Limitations

This evidence brief does not attempt to gather all the available evidence on therapeutic interventions in order to assess their effectiveness. Rather, it starts with a fundamental question: What is good practice therapeutic care? The term therapeutic care is chosen over therapeutic intervention, given the connotations and parameters of both. Care implies an ethic of due attention or consideration and is more general. Intervention implies an action or process of undue involvement and is more specific. Care also broadly speaks to a wider therapeutic environment, and is more inclusive, whereas intervention speaks to (specialist) treatment only.

This evidence brief has not been circulated widely for consultation on the meaning or form of the term ‘therapeutic care’. Although the research gathered draws together literature with significant expertise from a wide range of sources, the evidence brief should be considered in the context of other necessary design and development activities, given the significance of therapeutic care to our tamariki and families/whānau and the future of Oranga Tamariki.

It is also worth noting a contradiction and a challenge for ‘evidence’ and this brief, i.e., how to adequately reflect the depth of knowledge and significance of te ao Māori ‘therapeutic care’. This is due to the scarcity of available te ao Māori reporting and research. It is relied upon To some extent this brief has relied on the evidence that good practices seen in available research on te ao Māori therapeutic care are similar to those observed elsewhere.

The evidence brief is a comprehensive rather than an exhaustive search of the literature. The evidence brief sought out a wide range of literature from a variety of sources. This includes materials from researchers, NGOs, and government sources. The materials have not been rated for quality in the sense that the underlying methodologies were assessed for rigour and findings for validity. The sources were instead chosen based on metrics associated with publication status (peer-reviewed), coverage (meta-analyses or synthesis), and/or relevance (therapeutic care and/or government related).

A note on ‘evidence’

The research in this evidence brief supports the broader concept of evidence-based practice (EBP). EBP is understood as comprising the “integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (Goodheart *et al.*, 2006). EBP utilises “treatments for which there is sufficiently persuasive evidence to support their effectiveness in attaining the desired outcomes” (Roberts and Yeager, 2006). EBP should not be confused with the

narrower concept of empirically supported treatments (ESTs) in the field of psychology. ESTs are specific psychological treatments that have been shown to be effective in clinical trials, whereas EBP incorporates the broader range of clinical activities (e.g., psychological assessment, case formulation, therapy relationships) (Goodheart *et al.*, 2006).

Therapeutic care overseas

It is useful to draw on several overseas examples to demonstrate the course taken towards the adoption of therapeutic care frameworks. There is a growing body of research and insights from Australia, outlining the evidence supporting therapeutic care and the steps many states have taken towards therapeutic care frameworks, particularly in residential care, and more generally within OOHC. Their paths and progress provide informative practical examples.

The Australian Senate Standing Committee on Community Affairs reported on its inquiry into out of home care in 2015. The Committee acknowledge the progress being made in the area and increasing evidence in support of therapeutic care. It noted also the challenges of scaling therapeutic models of care and high short-term costs. However, given the long-term benefits it recommended the development of national therapeutic care standards and evaluation of best practice models of therapeutic care across all care types, increased resources to fund evidence-based therapeutic models of care, implementation of a nationally consistent, best practice model of professional foster care, and mandatory training for all residential care workers (The Secretariat of the Senate Community Affairs Committee, 2015, p. 279).

Victoria has continued to reform its child welfare system over the past several decades.[30] Victoria initiated the Circle Program in 2007, a therapeutic foster care programme designed to provide a care environment that could contributing to healing the traumatic impacts of child maltreatment as part of ongoing reform efforts to improve outcomes for children who had experienced maltreatment and were placed in OOHC. A therapeutic specialist supports caregivers as part of the Circle Program. The guidelines for the Circle Program published in May 2009 said:

> We are aiming, in the medium to long term, to build a system of home-based care in Victoria where all children receive the therapeutic response they require when they require it, not a system where only those whose behaviours are so extreme, and who have suffered additional harm due to placement disruption or other adverse consequences of being in care, become eligible for a therapeutic response. In short, we seek to develop a therapeutic system not just a therapeutic model (Department of Human Services, 2009, p. 6).

A 2012 evaluation of the Circle Program found it was working effectively, supported carers, and led to positive outcomes for children. The evaluation also found it offered the potential to be an excellent early intervention programme. The evaluation team noted five key programme components: enhanced training; intensive and well-integrated foster care support; therapeutic service to family members; specialist therapeutic support; and a support network for the child and young person. The evaluation supported the concept of the care team surrounding the child and argued the positive outcomes were related to the overall therapeutic approach facilitated by training caregivers as well as professional staff to ensure they had the theoretical knowledge necessary to care for children who had experienced maltreatment and were in OOHC (Frederico *et al.*, 2012).

Victoria also initiated TRC across 12 pilot sites in 2007 and following a positive evaluation of their outcomes and cost-effectiveness in 2011; TRC was integrated into Victoria's OOHC landscape. Victoria articulates what is expects from residential care in the state in the document 'Program requirements for the delivery of therapeutic residential care in Victoria'. It summarises guiding principles and legislation, and links these to domains of support for young people in care. The document also outlines the organisational features, the elements of programme design, therapeutic

[30] For discussion see: http://childprotectioninquiry.vic.gov.au/report-pvvc-inquiry.html.

plans, staffing configurations and physical characteristics of the home required by therapeutic residential care services (Department of Health and Human Services, 2016; McLean, 2018; McPherson *et al.*, 2019a).

Victoria describes TRC as a "contemporary model of residential care that aims to improve outcomes and life trajectories for children and young people with complex needs who have experienced abuse or neglect related trauma". TRC interactions between children and residential staff are recognised as an opportunity to affect and heal past instances of trauma and disrupted attachment. The TRC setting for children in Victoria must:

- be based on a guiding framework that incorporates theories of attachment, trauma and the neurobiological development of children and young people that can lead to complex, challenging and trauma-related presentations
- address the therapeutic needs of each child or young person based on specialised, comprehensive and ongoing assessment and the development of an individualised therapeutic treatment plan which responds to their characteristics and needs so they can heal, develop and grow
- seek to bring about directed and clinically significant change in the child or young person's presenting issues through goal directed, planned and integrated therapeutic interventions using all interactions as opportunities for therapeutic gain and positive engagement
- ensure the environment provides a sense of safety, structure, acceptance and security at all times for children and young people and for staff
- offer a specially created multi-disciplinary and collaborative TRC team encompassing residential carers and supervisors, a therapeutic specialist, a program manager, case managers and the input and support of the whole organisation
- ensure the appointment of highly skilled professional staff who have substantial opportunities for training, reflective practice and professional development in order to provide unconditional, high quality, therapeutically focused care and never give up
- hear the voice of children, young people and their families and ensure they are supported to participate in decision-making about their therapeutic program and life
- be sensitive, respectful and actively seek to understand each child or young person's unique circumstances, experiences, and culture, particularly Aboriginal children and others from culturally and linguistically diverse backgrounds[31]
- have well-developed service networks to facilitate the provision of a broad range of specialist and ongoing supports to children and young people (Department of Health and Human Services, 2016).

Victoria is continuing to build on its more recent 'Roadmap for Reform: strong families, safe children' (2016) policy, which set out a systematic approach to improving the Victorian child and family welfare system. Noteworthy developments include the recently released 'Strong carers, stronger children' strategic framework to guide and inform the direction of home-based care. The framework includes goals that support improvements in the experience of carers and to help support them to provide nurturing and therapeutic care (Department of Health and Human Services, 2019). Victoria also recently put in place a 'Framework to reduce criminalisation of young people in residential care'. The framework's goal is to reduce inappropriate and unnecessary contact of young people in

[31] Victoria also has in place 'Balit Murrup: Aboriginal social and emotional wellbeing framework', a companion document to 'Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027'. For further information see: https://www.dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework.

residential care with the criminal justice system. It includes guiding principles for trauma-informed responses, connection to culture, and positive behaviour approaches (Department of Health and Human Services, 2020).[32]

Since 2017, NSW has initiated several changes to their child welfare system. Following a strategic review of its residential care services, NSW implemented the Therapeutic Care Framework (TCF) and Intensive Therapeutic Care (ITC). TCF provides a set of 16 core principles for providing care to children. TCF includes a trauma-informed approach. ITC aims to reduce the time children need to spend in intensive OOHC services and provide them with the necessary support to recover from child maltreatment and trauma. It is intended that ITC will progressively replace residential care in NSW (Department of Communities and Justice, 2018, 2019).

The NSW TCF is described as a "framework that guides service provision and works towards improving outcomes for children and young people in statutory Out of Home Care". It defines therapeutic care for children in OOHC as a "holistic, individualised, team-based approach to the complex impacts of trauma, abuse, neglect, separation from families and significant others, and other forms of severe adversity". According to the TCF document this is achieved by providing a care environment that is "evidence-informed, culturally responsive and provides positive, safe and healing relationships and experiences to address the complexities of trauma, adversity, attachment and developmental needs" (NSW Government and Association of Child Welfare Agencies, 2017). The core set of 16 TCF principles is as follows:

Children and young people focussed

- Children and young people will be active participants in the development of their care and case plans, including cultural plans, where appropriate. These plans should be based on in-depth assessments that are trauma-informed and respond to their individual needs.
- Therapeutic Care programs need to be planned and based on appropriate assessments of the child or young person, taking into account their development stage, own views, needs and preferences.
- The mix of young people in care should be taken into account in order to consider a young person's individual needs (i.e. including encouraging safe and supportive relationships between peers); and to maximise the opportunity to address shared client needs.
- Promotion of safe, healing relationships between children and young people and their family, kin and community are important for family, social, community and cultural connections. This is a particular priority for Aboriginal and Torres Strait Islander children.
- Therapeutic Care addresses aspects of the child or young person's life including health and disability needs, community, culture, education, and recreation.

Organisations

- Agencies should have a clearly articulated statement that: outlines the values and culture behind their evidence-informed Therapeutic Care program; is advised by relevant trauma and

[32] As part of its commitment to implementing recommendations from the Royal Commission into Family Violence and on implementing it's 'Roadmap for Reform: strong families, safe children', Victoria has established a network of support and safety hubs, now known as The Orange Door, across the State. The Orange Door provides a way for women and children to access coordinated support if they are at risk of experiencing or have experienced family violence or families in need of support with the care or wellbeing of children. For discussion see: https://www.vic.gov.au/orange-door-annual-service-delivery-report-2018-2019.

attachment theories; and clearly defines their program logic / theory of change. This statement should be understood and agreed to throughout the organisation.
- All care team members should have relevant experience and qualifications or be working towards relevant qualifications. They should also receive Therapeutic Care training that addresses the rationale and theoretical underpinnings of practice.
- Therapeutic Specialists will support staff and carers in providing a safe and healing care environment for children and young people.
- Carers should be trained, supported and adequately assessed to ensure their capacity for providing a consistent, healing response to children and young people.
- For Intensive Therapeutic Care settings / homes, appropriate staff-to-child ratios coupled with consistent rostering of staff should be used to create a safe and stable environment for children and young people.

Environment

- The physical environment provided to children and young people in OOHC must be safe, nurturing, and predictable to enable effective reparative care.
- Care teams should aim to create a 'home-like' care environment to build opportunity for positive, healing experiences and relationships.

System

- A shared understanding of Therapeutic Care helps organisations and their external stakeholders to act congruently and with a shared purpose.
- Congruent action must also be taken across agencies and government bodies, particularly education, health, disability and child protection – to provide children and young people with integrated responses to their needs.
- A good system requires robust central-level and district-level governance. The roles and responsibilities of all stakeholders, including government, should be clearly articulated and understood to enable agencies to fulfil program requirements.
- Outcomes (i.e. safety, permanency and wellbeing) for children and young people need to be measured and evaluated (NSW Government and Association of Child Welfare Agencies, 2017).

Queensland has been through a similar process to Victoria and NSW. Broad consultation within the Queensland residential care sector and with key stakeholders across the State, led to the publication of 'A Contemporary Model of Residential Care for Children and Young People in Care' in 2010. The publication set out core elements of therapeutic residential care comparable to those from Victoria. This included reference to a "clear child-focused system with a focus on creating nurturing and healing care for traumatised young people, responsive to assessed needs of children" and "access to required therapeutic supports for all children and young people" (PeakCare Queensland and Department of Communities, 2010).

Queensland published 'The Hope and Healing Framework for Residential Care' in 2016. It outlines the "foundation for caring and working with young people in residential care in a way that understands and responds to trauma and is therapeutic in approach". The framework presents four key domains for therapeutic focus:

- The residential care environment including day-to-day care, interactions between children and young people and with staff, care planning, purposeful programming and the physical environment

- The connections to the child or young person's world including family, community, culture and country
- The service provider/organisation providing the residential care home including governance, management, policies and procedures, human resource management, quality assurance and evaluation
- The service system including the child or young person's connections to other services such as health and education, matching for best fit of care, range and mix of services, funding, workforce development and partnerships (PeakCare Queensland and Queensland Department of Child Safety, 2019).

The 'The Hope and Healing Framework for Residential Care' also sets out common practice principles that underpin a trauma-informed approach:

- Care is individualised, taking account of age, stages of development and cognitive functioning and abilities
- Care is relationship-based
- Care promotes engagement in decision making and life choices
- Care occurs within the context of family
- Care supports links with community
- Care is culturally safe and culturally proficient, supporting Aboriginal and Torres Strait Islander cultural identity and culturally and linguistically diverse identities
- Care understands and responds to behaviour as communication
- Care provides unconditional commitment (persistent allegiance)
- Care is collaborative and integrated across all services involved with each child and young person (PeakCare Queensland and Queensland Department of Child Safety, 2019).

Together, these examples from Australia demonstrate the shift towards TRC specifically, and therapeutic care generally. Arguably, this shift is becoming more pronounced in the overseas literature. This includes reform of the therapeutic care environment, across different settings, and utilising different models and interventions. Although most share common aspirations and workings, it is apparent from the research that informed these examples that the available evidence does not point to any particular model of care or sets of interventions. Rather, each has largely developed according to local conditions and insights as well as a plurality of understanding about evidence and practice.[33]

It is also clear that for these environments and services to be successful more than just the models and interventions need to be evidence-based. The way these environments are formed, and how services are delivered is just as important as what is delivered. The quality of the relationships that caregivers and staff form with children and families/whānau is central to success. This means effective relationships should be a focus of service system design, organisational structures, job descriptions, and professional development (Moore *et al.*, 2016).

[33] There are some exceptions. Western Australia for example has adopted the Sanctuary Model for its residential care services and a number of providers in different Australian States have adopted in part or whole aspects of approaches such as the Sanctuary or CARE models.

Therapeutic care overseas (table)

The Evidence Centre undertook an environmental scan of selected overseas jurisdictions focusing on overarching therapeutic service approaches for children in care. The scan findings are presented in the following table. The search may not have uncovered some approaches, as this type of information is not always publicly available. Our search indicated that there are distinct therapeutic care approaches for children in residential and foster care particularly; however, they are often not combined under an overall therapeutic care approach or model.

Table 5: Therapeutic care overseas (case examples)

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
Australia	**New South Wales** The NSW Therapeutic Care Framework (TCF) provides guidance on supporting children and young people. At the centre of the framework is trauma-informed care. The framework will guide NSW service providers, caseworkers, carers and other stakeholders to provide the best possible individualised Therapeutic Care for children and young people. The TCF is consistent with major changes to the child protection system under the Permanency Support Program , which focuses 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. 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. See: https://www.facs.nsw.gov.au/about/reforms/NSWPF/nsw-therapeutic-care/chapters/qanda	The TCF outlines a set of 16 Core principles for providing Therapeutic Care (i.e. casework and care) to children and young people, to ensure their individual and often complex needs are met, given the trauma they have experienced. The TCF focuses on: • developing consistent service delivery of evidence-informed Therapeutic Care (across the OOHC sector) to improve outcomes for children and young people in care • providing quality care environments that support positive, safe and healing relationships and experiences, to address individual and complex needs and work towards addressing the trauma experienced • children and young people with receiving the appropriate level of care, 'in the right way, at the right time' (i.e. throughout their continuum of care) • Therapeutic Care (trauma-informed casework and care) being provided to children and young people, that is individualised, holistic and culturally respectful and responsive • building capability across the OOHC sector to enable assessment, and measurement of outcomes, and to determine whether children and young people in care are receiving quality Therapeutic Care, treatment and support. Children and young people in OOHC have often experienced trauma, abuse, neglect and/or are faced with severe adversity before being placed in care. They may have also suffered after separation from their families or others close to them. This may lead to poor outcomes later in life: developmental, behavioural or mental health issues. Children and young people's care needs are different, and every OOHC journey varies throughout their time in care. A child or young person's needs should therefore be continually assessed, to allow the flexibility to increase or decrease the level of support and services required as their care needs change. This can make a big difference to the lifelong impacts of trauma, and greatly influence a person's lifelong outcomes once they exit care.	In taking a holistic approach to Therapeutic Care, consideration of the cultural context of children and young people is extremely important. A culturally informed perspective affects how we understand underlying issues such as attachment and recognises that 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.	The TCF promotes a holistic, individualised, team-based care approach for children and young people in the Out of Home Care (OOHC) system. The TCF focuses on evidence-informed, culturally respectful and responsive Therapeutic Care practice. This is necessary to address the complexities of trauma, adversity, attachment and developmental needs; and improve outcomes for children and young people in care. 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 will guide 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. Supporting activities such as training and education across the OOHC sector (i.e. carers, caseworkers, practitioners, service providers and stakeholders) will be considered as reform work continues. The TCF will drive best practice and supports the reforms underway as part of the Permanency Support Program.
	Northern Territory	Early intervention and improved access to therapeutic support for children in care will reduce placement disruptions and breakdowns and enhance family relationships, increase emotional wellbeing, encourage greater participation	Development of a comprehensive, culturally safe, Aboriginal family care service model by Tangentyere Council	Caregivers will have greater involvement in the care planning and service delivery of therapeutic care. They will be provided with

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
	In the Northern Territory, trauma-informed care and specialised support will be available for every child and young person in out-of-home care that needs it. The new model prioritises home-based care above all other forms of out-of-home care. Children and young people will have their needs met through home-based placements, preferably with family and in their community. Specialised and intensive therapeutic home-based care will be provided for children with complex needs with services to be available in regional locations. https://territoryfamilies.nt.gov.au/__data/assets/pdf_file/0011/693398/Transforming-Out-of-home-care-in-the-NT.pdf	in education and training and support children and young people to achieve better life outcomes. It also aims to reduce the demand for crisis services by delivering therapeutic and trauma-informed support to children and young people within their family environment by building the capacity for carers to meet the needs of children in the home. The new model also includes therapeutic residential care which will provide time-limited services, delivered in home-like facilities that accommodate small groups of children and young people. Purchased home-based care does not feature in the new model. The transition will be carefully managed to ensure stability for children and young people. The new out-of-home care model will provide services that are able to meet the unique and varied needs of children and young people in care. This includes family care, therapeutic and intensive care services. Localised care and support services will enable children and young people in care to maintain connection to identity, family, community and culture. Under the new model, reunification of children and young people is prioritised because it is known that children and young people do best when raised in a stable family setting. Early intervention services, targeted for families, children and young people at risk and experiencing vulnerability will be provided earlier. Community organisations will work with families to provide intensive family support and coordinate services and engagement.	Aboriginal Corporation. The model will enable more Aboriginal children in care to be placed with family and Aboriginal foster carers so they can stay with family at home in culturally inclusive and appropriate settings. This model will provide a blueprint for implementation across the Northern Territory. it is essential that out-of-home care services are available in communities to meet their individual needs. This includes providing access to therapeutic support to children, young people, families and carers. To do this, the Northern Territory is partnering with Aboriginal organisations to co-design and deliver services and develop local solutions to ensure effective outcomes and positive change to the lives of children in care in remote communities. The Territory is also engaging community organisations to facilitate and improve communication and contact with the families of children and young people in care and to develop and implement cultural care plans.	therapeutic care training, so they are empowered and supported to provide high quality care that meets the needs of the child or young person they care for. Training and support will be delivered in regional and remote centres.
	Queensland Between 2019-2021 Queensland will expand the Hope and Healing Framework, currently in use in residential settings across all care models to support children and young people with their mental and therapeutic health needs. The Hope and Healing Framework for Working with Children and Young People Living in Residential Care sets out the foundation for caring and working with young people living in residential care in a way that understands and responds to trauma and is therapeutic in approach. http://peakcare.com.au/wp-content/uploads/2019/05/Hope-and-Healing-Framework-1-May-2019.pdf	A trauma-informed therapeutic framework is underpinned by these common practice principles, which apply across all types of residential care and all cohorts of children and young people. The practical application of these principles shapes the way in which care is defined and understood: • Care is individualised, taking account of age, stages of development and cognitive functioning and abilities • Care is relationship-based • Care promotes engagement in decision making and life choices • Care occurs within the context of family • Care supports links with community • Care is culturally safe and culturally proficient, supporting Aboriginal and Torres Strait Islander cultural identity and culturally and linguistically diverse identities • Care understands and responds to behaviour as communication • Care provides unconditional commitment (persistent allegiance)	Every child or young person is part of a family and entered care from within the context of family and community. For Aboriginal and Torres Strait Islander children and young people the context of family includes that of community, culture and country. The care service system cannot interface with the child or young person in isolation from family and community. The inclusion of connections as one of the domains recognises this. It recognises the necessity of care staff working in partnership with family and the child or young person's independent entity where one has been nominated, . Family participation as part of the safety and support network is also very important.	A trauma-informed therapeutic approach is always underpinned by the components of needs-informed care, but the practical application and emphasis of each component varies at different phases of a child or young person's journey It is important that governance and management actions reflect an understanding of care and the 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.

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
		• Care is collaborative and integrated across all services involved with each child and young person. Based on a needs-informed approach the framework incorporates: • Fundamentals of care – applied as part of everyday care throughout a child or young person's journey of living in care • Focus areas – core elements of a therapeutic approach • Future orientation – a goal-focused approach incorporating children and young people's hopes and dreams that lead to increased wellbeing for each child or young person. The components of the framework relate to the needs of children and young people and directly inform practice. Within the different phases of a young person's journey in care some needs may take precedence at certain times A therapeutic approach incorporates attention to the four focus areas of: • Relationship • Connections • Emotional Know-how • Positive Identity With the fundamentals in place, these are the focus areas for practice that enable children and young people who have experienced trauma to move towards increased wellbeing. In a therapeutic approach, everyday care is purposeful and individualised in assisting the development of children and young people in these areas.		
	Victoria Since 2016, Victoria has been pursuing its 'Roadmap for Reform: strong families, safe children' policy, which supports the reform of their children, youth, and family service system. The Roadmap aims to deliver a system focused on: • Strengthening communities to better prevent neglect and abuse • Delivering early support to children and families at risk • Keeping more families together through crisis	There are several documents that refer to different aspects of therapeutic care in Victoria. For example, Victoria specifies that each TRC programme must have a clearly articulated therapeutic framework that guides the structure and service delivery of the programme. Each framework must include: • a strong, referenced and well-developed articulation of the trauma-informed philosophy and theory base on which the programme is designed and how it is implemented • reference to how the therapeutic approach is informed by and includes a significant service responsiveness to prior trauma and disrupted attachment • programme arrangements which are informed by resilience theory, and support/promote resilience through the development of positive relationships and nurturing • evidence that the therapeutic approach is informed by other specific theoretical models which respond to the mental health and	VACCA supports culturally strong, safe and thriving Aboriginal communities in Victoria. They effect several principles in their work: • Best interest of the child • Aboriginal Cultural Observance • Respect • Self-determination • Healing and empowerment • Excellence For children in OOHC VACCA has healing teams and offers TRC services, which incorporate:	In its Roadmap, Victoria describes a set of clear principles that underpin immediate actions and guide longer term reforms: 1. A focus on **prevention** and ensuring families are supported and enabled to provide children with a safe and permanent home and a good start to life. 2. **Intervening early** and providing the right assistance to reduce the risks of harm and costly interventions. 3. Improving the way services work together, provide **continuity of care** and integration around the individual needs of children, young people and families.

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
	• Securing a better future for children who cannot live at home. The Roadmap builds on several decades of ongoing review and reform of child welfare in Victoria. https://www.dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children Victoria piloted TRC from 2008-2012 and implemented specific programme requirements for them in 2016. https://providers.dhhs.vic.gov.au/program-requirements-out-home-care-services The Victorian Aboriginal Child Care Agency (VACCA) also provides advocacy and a range of therapeutic supports for Aboriginal children who are unable to live at home. https://www.vacca.org/page/services/children-and-families/children-in-care	developmental needs of the children and young people in the context of their families and networks • articulation of a culturally appropriate healing framework which provides for the assessment and management of Aboriginal children and young people and identifies how this is incorporated into the therapeutic model • a well-developed statement articulating the link between theory and practice and its application to the specific characteristics of the target client group for the individual TRC program • articulation of how the Best Interests Case Practice Model is applied in the therapeutic service model.[34] • strategies to ensure all TRC staff members understand the agreed-upon philosophy, theories, policies and procedures and this is integrated into practice • programme arrangements which place value on strong, positive relationships between TRC staff and children and young people, and emphasise these relationships as integral to healing. https://providers.dhhs.vic.gov.au/program-requirements-out-home-care-services	• A home environment with 24/7 live-in support with our 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 • Education support • Cultural identity support • Support for children, including sibling groups. https://www.vacca.org/page/services/children-and-families/children-in-care Victoria also has in place 'Balit Murrup: Aboriginal social and emotional wellbeing framework', a companion document to 'Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027'. https://www.dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework	4. Supporting the **connection** of all children, young people and families **to their family, cultures and communities**. 5. Ensuring **Aboriginal self-determination** around decision-making and care for Aboriginal children and families. 6. Building **personal capacity to make choices** where appropriate and input to their care, guided by professional support. 7. Increasing the **effectiveness of services**, that are **evidence-based** and linked to the delivery of defined outcomes. 8. Providing **flexibility within and across service provision** to scale up / down and adapt interventions to meet the dynamic needs of all families over time. 9. Building on **localised services** for people in their communities or place to deliver enduring outcomes. 10. Encouraging **interaction** with the people who use and deliver the system, leveraging strong **local partnerships** and joint strengths-based leadership across all communities and sectors. https://www.dhhs.vic.gov.au/publications/roadmap-reform-strong-families-safe-children
	Western Australia Western Australia has a 'care team approach' where care team members work together to promote and meet the overall needs of a child or young person with ongoing joint planning and regular communication. The approach is informed by substantial research that highlights having important people (including a child, their parents, extended family, carers, caseworkers and others) working together and focussing on a child's needs delivers better outcomes for the child. Further, this aligns with care team models being used by many community sector	Children and young people's needs are met through individualised assessment and child-focused practices, encompassing all aspects of their lives and wellbeing. The overall needs of a child or young person are met under the following dimensions of wellbeing: • health • education • emotional and behavioural • family and social relationships • identity and culture	Aboriginal children have rights of identity that can only be enjoyed in connection with their family, communities and cultures. In accordance with the Aboriginal and Torres Strait Islander Child Placement Principle, their rights to stay connected with family and community must be upheld, and the child, their families and communities enabled to participate in decision-making regarding their care. The care team supports participation by family members and connections for Aboriginal children in care to their family,	Care team members have a shared responsibility for meeting the needs of the child in their care journey. This includes celebrating strengths and successes, supporting them to heal from past trauma, sustaining the care arrangement, maintaining existing positive attachments and relationships, and building new, safe relationships. Importantly, strengthening the connection to family, culture and country is important for Aboriginal children's identity. Case managers and key workers actively build a relationship with children and young people and see or communicate with

[34] Best Interests Case Practice Model documents are available at http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications.

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
	organisation (CSO) OOHC providers and child protection agencies in Australia to enable children to receive high-quality therapeutic care and have improved life outcomes. https://www.communities.wa.gov.au/media/1752/ohc-better-care-better-services-2017-november.pdf https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/Care%20Team%20Approach%20Practice%20Framework.pdf	• recreational and leisure • legal and financial This care team approach promotes proactive rather than reactive responses to the child, which in turn helps to provide predictability and stability for the child The care team will be guided by the question, "what do I need to do to support the child's development, learning, stability and growth, as well as healing?" This way of working places the child's best interests and needs as the central focus.	community and culture, which aligns with the Aboriginal and Torres Strait Islander Child Placement Principle and its five inter-related elements (prevention, partnership, placement, participation and connection). The development of a strong and secure cultural identity is integral to an Aboriginal child's wellbeing, and the care team must promote and support this. An Aboriginal Practice Leader must be consulted when identifying care team members for an Aboriginal child, and where possible the majority of people in the child's care team should be Aboriginal.	children and young people at least once a month or at a frequency determined by the child or young person's circumstances.
Scotland	Scotland has the Getting it right for every child (GIRFEC) National Practice Model which includes wellbeing indicators. When the child or young person's needs are clear they can be summarised using the Wellbeing Indicators to develop a plan for action. Wellbeing indicators can be used to identify priorities, describe what needs to change to improve the child or young person's wellbeing and identify the expected outcomes. In the Getting it right for every child approach, any child or young person who requires additional help should have a plan to address their needs and improve their wellbeing. This will be a single child's plan, but may involve more than one agency. https://www.gov.scot/publications/girfec-national-practice-model/	Part 3 of the Children and young people (Scotland) Act seeks to improve outcomes for all children and young people in Scotland by ensuring that local planning and delivery of services is integrated, focused on securing quality and value through preventative approaches, and dedicated to safeguarding, supporting and promoting child wellbeing. It aims to ensure that any action to meet need is taken at the earliest appropriate time and that, where appropriate, this is taken to prevent need arising. An ecological model is utilised to develop a Children's Services Plan which illustrates: • Family and community provide everyday support and care • Universal provision supports development and builds resilience • Additional support works to overcome disadvantage and supports learning • Specialist help addresses more complex needs that impact health and wellbeing • Compulsory intervention ensures action to overcome adversity and risk A Children's Services Plan should also reflect the ecological approach commonly used in planning support for individual children using the values and principles of Getting it right for every child. That is to say that a Children's Services Plan should place individual children at its centre, and consider services and support for those children individually, support for their wider families (this may include links to services for adults), community assets and then finally more specialist services. The plan should describe how these preventative supports build up as required, according to local priorities, through early intervention and onto specialist services. The Children's Services Plan should at all times reflect the joined up nature of this ecological approach and how the right support will be delivered by the right people at the right time.		The Scottish Government has committed to developing an adversity and trauma-informed workforce across Scotland with the ambition to make a positive change in how people who have had adverse childhood experiences (ACES) and traumatic experiences in adulthood, are supported. To support this, a National Trauma Training Programme, led by NHS Education for Scotland (NES) has been established and is consistent with the 2017 publication: 'Transforming Psychological Trauma: A Knowledge and Skills Framework for The Scottish Workforce'. This framework lays out the essential and core knowledge and skills needed by all tiers of the Scottish workforce to ensure that the needs of children and adults who are affected by trauma are recognised, understood and responded to in a way which recognises individual strengths, acknowledges rights and ensures timely access to effective care, support and interventions for those who need it.

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		A Children's Services Plan should explain how CPPs will plan and deliver local services for children and young people at all levels of the ecological model.		
Canada	**British Columbia – Aboriginal policy and practice framework in British Columbia** • An overarching framework to improve outcomes for Aboriginal children, youth and families and communities through restorative policies and practices. • It applies to policy and practices involving Aboriginal children, youth and families • Restorative policies and practices are culturally safe and trauma-informed, supporting and honouring Aboriginal peoples' cultural systems of caring and resiliency • It is Child, Youth, Family and Community-Centred; Culture-Centred; Inclusive, Collaborative and Accountable; and focused on Resilience, Wellness and Healing. More information at: https://www2.gov.bc.ca/assets/gov/family-and-social-supports/child-care/aboriginal/abframework.pdf	The framework identifies the Circle process as a strength-based and holistic way to support policies and practices to be restorative. The Circle process ensures the right people are brought together to collectively plan, make decisions and commit to actions that ensure the well-being of Aboriginal children, youth, families and communities. In this framework, the Circle process is represented by a series of interconnected circles: • Gathering the Circle • Listening, Assessing and Finding Solutions • Creating Security, Belonging and Wellbeing • Keeping the Circle Strong. The Aboriginal Policy and Practice Framework also recognises the restorative process of the Circle and the ability to bring key partners, service providers and practitioners together to effectively support Aboriginal children, youth and families. It applies to policy and practice involving Aboriginal children, youth and families on- and off-reserve regardless if they are being served by a Delegated Aboriginal Agency or the Ministry of Children and Family Development. The framework applies to all of MCFD's six service lines: • Early Years; • Children and Youth with Special Needs; • Child and Youth Mental Health; • Child Safety, Family Support and Children in Care; • Adoption; and • Youth Justice	The framework supports and honours Aboriginal peoples' cultural systems of caring and resiliency. It includes important components of OUR SHARED CONTEXT: The context that we must understand, including the impact of colonial history and its ongoing influence on the present, to support responsive action to current and past realities. OUR VALUES: The values we uphold to support working together and to build an inclusive community which supports positive outcomes for all children, youth and families. OUR FOUNDATIONS: Significant conceptual foundations, or the key educational objectives, that we must intimately understand to effectively champion the Circle process, and ensure policy and practice is restorative. OUR COLLECTIVE RESPONSIBILITY: The collective responsibility and accountability for improved outcomes for Aboriginal children, youth and families through restorative policy and practice. A pathway towards restorative policy and practice undeniably requires a multigenerational journey towards reconciliation. It calls for continuous and conscious efforts by all peoples, organisations and governments to strengthen, revitalise and ensure equity and inclusion in all relationships and partnerships.	CHILD, YOUTH, FAMILY and COMMUNITY-CENTRED: supporting the involvement of children, families, the extended families, traditional family structures, Elders, traditional knowledge keepers and communities in decision making, inclusive of traditional processes, protocols, ceremonies, values and sacred teachings for caring and nurturing children, youth and families. CULTURE-CENTRED: ensuring that all practice and policy supports cultural safety, those working with children, youth and families are culturally competent, and the role of culture is considered central to the wellbeing of children, youth and families. INCLUSIVE, COLLABORATIVE and ACCOUNTABLE: emphasising the inclusiveness of practice and policy processes, the role of the community, the importance of hearing and listening to all perspectives, recognising that solutions are found through the efforts and input of many and transparency, openness and honesty must be present in all communications. Restorative practice requires meaningful collaboration with family, community and across service providers. RESILIENCY, HEALING and WELLNESS FOCUSED: ensuring that practice and policy supports building on the strengths of individuals, with culture as one of many protective factors during adverse or difficult times. As well, ensuring practice works proactively to promote harm reduction and a context of health and wellness is increased.
	Saskatchewan – Children's Therapy Services Service Delivery Model A planning tool to better address issues relating to the delivery of Physical therapy, Occupational	Children's therapy services should be: • Child and family centred • Accessible	Just a notion that the services should be culturally adaptable.	It is recognised that health regions currently provide a variety of child's therapy services through a variety of programs. The Children's Therapy Services Service Delivery Model offers a planning tool to which regional children's therapy services and

Country	Model description (with link)	Principles/components/What needs is it addressing?	Cultural responsiveness	Implications for practice
	Therapy and Speech Language Pathology services to children This model addresses issues of geography, small population and scarce specialised resources, that might be required to build capacity locally, provide quality of care close to the homes of clients, reduce wait time and improve continuity of care Vision: Saskatchewan children and their families have timely access to appropriate therapy services, support and information More information at: https://pubsaskdev.blob.core.windows.net/pubsask-prod/97429/97429-Children's_Therapy_Services_-_Service_Delivery_Model.pdf	• Respectful • Holistic • Culturally adaptable • Collaborative • Knowledge driven • Sustainable Children's Therapy Services provide consultation, education, assessment, treatment, and training to support and assist children with special needs and their families. Therapy services may be helpful when a child needs assistance with communication, mobility, fine and gross motor skills, coordination, personal care, balance, problem solving, behaviour, socialising, or other areas of growth and healthy child development.		specialised services may be integrated and linked within and among health regions. The model focuses on family centred care and intervention within local service areas with support from specialised therapy services, as needed, to diagnose, assess and plan intervention.

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