

Strengthening Trauma-informed Therapeutic Practice Approaches in Out-of-home Care

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This paper provides a snapshot of early work undertaken to develop a trauma-informed complex case management and therapeutic practice model for kinship and foster care within a family and community services agency. The approach taken has initially involved supporting case workers and carers and working towards organisational cultural change. The shift in focus described arose from a concern that stability and healing goals were not well supported within the existing programmatic framework and practice approaches. Purposeful integration of theory with practice has been central to the change process. There is a clear rationale that working from a strong evidence base can create better outcomes for children and young people in out-of-home care. The paper reflects on work in progress. Action taken to date has educated the workforce around trauma-informed responses, developed clear protocols and a set of practice tools. This has embedded a strong foundation for further development as resources become available.

■ **Keywords:** therapeutic, trauma, out-of-home care, kinship care, foster care, family welfare

Organisational and Local Context

In 2013, the leadership group within Baptcare Family and Community Services recognised that the time was ripe for developing best practice by instituting changes toward greater practice depth and capacity to respond to complexity. The division had already developed a strong practice platform and some localised capacity for therapeutic practice in two service areas, but wanted to extend and further develop these aspects. This was both a strategic decision as well as a commitment to better outcomes for the children, young people and families that form the client base of the service. The decision was taken to fund a project worker to assist the organisation to catalyse the significant potential that already existed for change. The initial commitment was to enrich and update the existing practice model in a way that would be sustainable beyond the life of the project, but also position the service to attract future targeted funding for therapeutic practice.

Baptcare (<http://www.baptcare.org.au>) is a not-for-profit organisation that operates across Victoria and Tasmania, employing more than 1600 people. The Family and Community Services (FACS) division incorporates a number of discrete programme areas across the two states. Programmes operate within diverse fields such as family support, disability services, mental health, youth services,

housing and support services for asylum seekers and out-of-home care (foster-care and kinship-care programmes).

In Victoria, at the time the project was commissioned in 2013, the field was awaiting the release of the Victorian government's 5-year plan for out-of-home care (Victorian Government, 2014). Specialist therapeutic programmes were already in existence in foster care (Frederico et al., 2012), but not in kinship care, despite recognition of the growth of kinship placements within out-of-home care and projected exponential growth in the future. Within Baptcare and elsewhere, there was an increasing recognition of the need to respond to the complexity of kinship placement issues (Baptcare Research Unit, OzChild, & Anchor, in press) and to look toward the future development of services in this area. Within the Victorian context, there was widespread recognition of the increasing complexity of client needs and the requirements from Department of Human Services for services to be trauma-informed and delivering earlier interventions that have strong therapeutic practice embedded (Victorian Government, 2014).

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In Tasmania, there has been a long-term plan to tender out the provision of out-of-home care services in the state (Department of Health and Human Services Tasmania, 2008) and Bapcare is interested in developing approaches to ensure best practice in the out-of-home care field in the future. Bapcare is one of the lead providers of family and community services in Tasmania and for several years has been applying principles of therapeutic practice in its work with youth. Recognition of the need to better resource existing programmes in the absence of ready access to specialist therapy and trauma services in much of Tasmania was another impetus to the project.

Project Objectives

The initial aims of the work within Bapcare included: to develop a complex case management and therapeutic practice model based on evidence and best practice; and to significantly enhance current capacity so that therapeutic practice is embedded and able to be offered to high-needs clients in both Victoria and Tasmania.

A key intent of the project was to provide a framework that supports the up-skilling of staff and carers to better manage the complexity of client care. The ultimate benefit would be that clients receive services that more fully address their needs and lead to improved positive therapeutic outcomes. Initially, the intention was to develop a fully sustainable model that could continue after the life of the project. The plan was to achieve this without additional resources but, rather, by building the capacity of staff, making changes in practice tools and redevelopment of existing staff roles.

These goals were to be accomplished by appointing a Project Coordinator for up to 12 months, to review, document and develop a customised therapeutic practice model, to embed this in one service area (out-of-home care), to work with staff and carers in training and refining practices, and to assist in the enhancement of the existing practice framework.

Literature and Practice Influences

As new research, theoretical understanding and practice models have evolved over the past decade, there has been an increasing expectation from government funding bodies that services working with complex needs and a traumatised population will incorporate these new approaches as best practice, providing evidence-based approaches to the work and the best possible outcomes for clients (Victorian Government, 2014). Work and thinking previously viewed as being the domain of specialist therapeutic services has become more widespread, and adopted in generalist practice settings. A more systemic way of thinking about trauma and complexity (Beauchamp, Goodyear, Power, von Doussa, & Young, 2013) is now reflected in efforts to encourage take-up of 'trauma-informed' approaches by non-specialist services

(www.multiplyingconnections.org). Literature considered during the project has included the work of Bruce Perry, regarding the adverse and long-term impact of chronic early neglect and abuse experiences on children, and the clinical implications of this neuroscience that 'a child exposed to consistent, predictable, nurturing and enriched experiences will develop neurobiological capabilities that will increase the child's chance for health, happiness, productivity and creativity' (Anda et al., 2006).

James Anglin has also been influential in his work and writing about therapeutic approaches to residential care, although many of his ideas have relevance when thinking more broadly about therapeutic approaches. Dr Anglin has highlighted the importance of congruence in practice and recognition of the issues of complexity for organisations, professionals and carers working with traumatised children and young people (Anglin, 2003). Bath has described the three pillars of trauma-informed care as the development of safety, the promotion of healing relationships and the teaching of self-management and coping skills (Bath, 2008). His model has had considerable influence in the evolving approach within the Bapcare project.

Bloom and colleagues have brought the Sanctuary Model (Bloom, 1999) to Australia. It is a trauma-informed systems approach, with a clearly articulated rationale and the provision of specific operational guidelines for organisations (McNamara, 2014). The model continues to influence practice, most notably in its organisation-wide adaptation by MacKillop Family Services (<http://www.mackillop.org.au/Whoware>). Specific elements of the model have been more widely adopted in Australia, particularly the community meeting and self-care or safety plans. The Sanctuary model's principles of whole organisation change have been influential in the development of the approach within Bapcare.

Although the Bapcare project aims to address client complexity across a range of target groups, a focus on trauma was adopted as the overarching project concept early on. As noted previously, there has been recent emphasis on professionals and organisations working in family and community services becoming 'trauma-informed' rather than becoming 'trauma specialists' (www.multiplyingconnections.org). Changes in practice approaches, tools and thinking naturally follow from adoption of this perspective.

The influence of trauma-informed therapeutic practice is arguably most evident in Australia in the field of out-of-home care. This is, in part, in recognition of the significant history of complex developmental trauma which is typically associated with children and young people being placed in out-of-home care, and the resulting social, emotional and behavioural issues arising from trauma and attachment disruption. It has been recognised that children and young people's capacity to attain normal developmental goals and their opportunities in life have been impacted by their trauma histories, and that there is a risk of secondary

trauma in the out-of-home care system (Verso Consulting, 2011).

In Victoria, additional government funding has been provided for the development and provision of therapeutic residential care and therapeutic foster care (Frederico et al., 2012; Verso Consulting, 2011) in recent years, following the influential report *When care is not enough* (Morton, Clark, & Pead, 1999). Although, in many subsequent reviews and evaluations of these services, recommendations have been made that all out-of-home care services should adopt a therapeutic approach and be provided with the additional funding required for this service model (Victorian Government, 2014), to date funding has been limited to a small proportion of out-of-home care providers (Frederico et al., 2012; McNamara, 2014).

Numerous models and frameworks have been developed to bridge the gap between theory and practice about trauma and complexity (Barton, Gonzalez, & Tomlinson, 2011; Fallo & Harris, 2001; <http://www.sanctuaryweb.com>; <http://www.chadwickcenter.org>; <http://www.multiplyingconnections.org>; <http://familyhomelessness.org/media/90.pdf>). Some common elements in these models and associated tools include: systemic and whole-organisation approaches to becoming trauma informed; recognition that adopting these approaches constitutes best practice (due to research demonstrating better outcomes for clients); a focus on earlier intervention and prevention of lifelong or multigenerational issues; recognition of vicarious trauma for professionals and carers and a consequent emphasis on self-care, strengthening of responsive, not reactive, practice that is less crisis driven and more reflective; increased focus on training, education and capacity building; and the development of theoretical underpinnings.

Project Elements

The integration of the various streams of evidence and thinking into project strategy resulted in a commitment to explore the following project elements:

1. Developing our workforce (professionals, volunteers and carers) to be knowledgeable about therapeutic practice, including trauma and its impacts (developing knowledge) (<http://multiplyingconnections.org>).
2. Equipping our workforce to employ skills and strategies to prevent, reduce and ameliorate the effects of trauma on the children, young people, families, adults and communities we work with, and to respond confidently to complex presentations (applying the knowledge) (<http://multiplyingconnections.org>).
3. Recognising the impact of complex work with traumatised people on the individuals and organisations that work with them (recognising impacts).
4. Integrating our model of service delivery so that it does not replicate the fragmentation that is part of the experience of trauma, and also attempts to respond to the

multiple and complex needs of clients. Critical to this is whole-organisational awareness and responses to trauma (integration).

A review of the literature and practice models (Barton et al., 2013; Fallo & Harris, 2001; <http://www.sanctuaryweb.com>; <http://www.chadwickcenter.org>; <http://www.multiplyingconnections.org>; <http://www.familyhomelessness.org/media/90.pdf>) further suggested some ways in which these four goals could be advanced in the Bapcare out-of-home care programme areas and more broadly:

1. Developing knowledge (about therapeutic practice, including responding to complex presentations, trauma and its impacts):
 - training and psycho-education across the division – foundational, ongoing and advanced levels;
 - assessment and review of existing knowledge and awareness levels amongst the workforce, including identification of gaps;
 - resourcing via information sharing, attendance at conferences, provision of reading lists/resource folder;
 - ongoing focus on knowledge development in this area, with an identified person, specialist or working group to champion this, underpinned by management support.
2. Applying the knowledge (about therapeutic practice, including responding to complex presentations, trauma and its impacts):
 - review of current trauma screening tools used and skills already used to screen for trauma;
 - development of new trauma screening tools and skills;
 - development or adaptation of practice tools or approaches;
 - mentoring, coaching and modelling;
 - development of tools to evaluate a client's progress towards recovery;
 - development of appropriate specialist referral options and increasing recognition of when this is useful;
 - secondary consultation – case specific;
 - reflective practice via individual and group supervision, with models developed for practice.
3. Recognising impacts (of working with complexity and trauma):
 - review of current individual and group supervision models and debriefing practice;
 - training in the importance of self-care and recognition of vicarious trauma, cumulative stress and burnout and known impact on staff wellbeing and retention rates;
 - adoption of division-wide approaches to further developing a culture where these issues are acknowledged and addressed.

4. Integration:
- introduction of integrated models across programme areas as appropriate;
 - review of existing practices already reflecting this approach, and extension as appropriate;
 - consideration given to developing integrated intake models.

Methodology

The project utilised a participatory research approach. Evaluation of outcomes occurred via participant feedback (Wadsworth, 1998). A more rigorous outcomes evaluation is planned for a second year, which will incorporate a focus on client outcomes. It is hoped that the project will play a part in enhancing outcomes for children and young people in out-of-home care within Bapcare. Desired indicators of positive change applied in other evaluations of therapeutic approaches include the following measures: significant improvements in placement stability; significant improvements in the quality of relationships and contact with family; sustained and significant improvements in the quality of relationships with carers; increased community connection; significant improvements in sense of self; increased healthy lifestyles and reduced risk-taking; enhanced mental and emotional health; improved optimal physical health and improvements in relationships with school (Verso Consulting, 2011).

The project commenced with a literature and practice review, evaluating the best-practice evidence regarding complex case management and therapeutic intervention models. Options were then developed for a short pilot project within out-of-home care. Elements piloted included secondary consultation models, reflective practice models, trauma-screening tools, training regarding working with trauma, education of staff and carers regarding self-care, vicarious trauma and burnout, consideration of integrated approaches, co-working, coaching and mentoring work with staff and carers.

A focus was on delivering training and practice support to practitioners to build capacity for therapeutic practice. A wider organisational focus was on supporting the broader FACS division to scope the implementation of therapeutic practice, and updating the FACS practice framework accordingly. All aspects of the approach were directed toward developing therapeutic practice and improving service delivery and client outcomes.

Outcomes and Future Directions

Current plans are for the project work to be ongoing and to incorporate a more formal evaluation of outcomes in the second year of the project (2014–2015). At the present time, a status report regarding promising outcomes and challenges encountered in the first 8 months of the project can be provided.

Early indications point to the key role of a 'senior practitioner' in influencing practice enhancements via secondary consultations, provision of supervision and reflective practice, coaching, co-working and training. Collocation and relational focus builds trust and opportunities for exposure to case discussion; in turn, creating the basis for case-specific interventions. This finding was consistent with the evaluation of residential-care therapeutic practice (Verso Consulting, 2011). This highlights the desirability of an ongoing senior practitioner role, and raises challenges regarding the transfer of this role to another team member if a senior practitioner is not part of funding models.

The focus of change in the first year of the project has been on casework staff and up-line management (organisational cultural changes), with involvement of carers still in the early stages. Initial engagement and education are occurring; however, much more intensive education and support needs to be extended to the carer workforce. As with the senior practitioner role, there are challenges about how to achieve this in the context of current funding. Whereas interest is encouraging, additional resources are essential to enable workforce development at this deeper level, particularly with kinship carers where capacity for building therapeutic practice may be significant.

Initial assumptions made regarding the timeframe for sustained change have been disproved: within a relatively short period, project outputs include significant training and knowledge development, new processes and tools to shape practice. However, embedding and further refining these require an ongoing commitment of resources.

Despite the short duration of the project, a number of practice tools have been developed and applied within the out-of-home care service, including: the devising and implementing a secondary consultation process; creation of a trauma-screening tool, for use with all new referrals to foster care and kinship care, to facilitate early intervention for referrals with high levels of trauma; the trial of reflective practice and group supervision models.

Early in the project, a review was conducted of training needs regarding therapeutic practice and trauma-informed practice. Subsequently, an introductory training session was devised and offered to staff and carers, with a plan to develop additional training as well as ensuring that the foundational trauma training is ongoing and covers all new staff as part of induction.

A further focus of the project has been on self-care, in consideration of the impact on staff and carers of work with traumatised clients. Initial input has been provided via education about vicarious trauma and burnout. Resources have been developed for staff, with a recommended reading list provided.

A number of creative projects and partnerships have begun to be identified during the months of the project. Opportunities for collaboration and partnering have emerged, possibly as a result of Bapcare becoming known as an

organisation with a developing capacity to offer therapeutic practice.

A further focus has been on whole of organisation and divisional change to increase literacy in relation to trauma and therapeutic approaches, via the development of the existing practice framework governing all practice. Trauma-informed and therapeutic approaches have now been identified as a key aspect of practice.

Future directions at the time of writing include the following: a plan to extend the project for a further year, with positions in both states (Victoria and Tasmania). There is recognition that it is difficult to develop some of the processes further without additional funding, particularly in relation to engaging carers. Creative projects, including potential partnerships with specialist therapeutic providers, have generated considerable enthusiasm within the staff group. Further work in adapting practice tools and approaches is likely to address assessment, care teams and provision of therapeutic groups.

Conclusions

The value of the work undertaken to date is clear within and beyond the organisation. One potential contribution to the field is in relation to the incorporation of therapeutic approaches into a diverse generalist but mid-sized agency, which includes an out-of-home care focus, but is without current access to specialist resourcing. The extent and direction of development is somewhat dependent on funding opportunities.

Despite time and resourcing limitations, it is very clear that the project has been well-received and has already yielded positive outcomes, including the generation of considerable enthusiasm amongst staff and an increased awareness of trauma impacts and the de-mystifying of therapeutic practice. While this needs to be further developed, there is already great interest in the possibilities of further cultural change within the organisation, with the ultimate goal of improving outcomes for Bapcare clients.

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