Integrative Practice
FRAMEWORK

for Young People with Extreme and Socially Disconnected Behaviours

Safe Places for Children

professional care, guaranteed outcomes

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The Safe Places Integrative Practice Framework for Young People with Extreme and Socially Disconnected Behaviours

Version 2.0

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Introduction

Safe Places provides children in care with individualised therapeutic residential services in Australia. Our goal is to offer every child in our care a solid foundation upon which to build a bright future.

The Safe Places Integrative Practice Framework* is the product of many years of practical experience and evidence-based research. It draws inspiration from a range of internationally regarded, contemporary, evidence-based, therapeutic models of care. This document provides a detailed overview of the principles and practices of our therapeutic model and explains how the various components are integrated into our work.

Each young person in our care is treated individually.

* *The Safe Places Integrative Practice Framework was developed in collaboration with Complex Care.*

A clear therapeutic framework is critical.

Application of the Framework

Typically children with whom Safe Places works have been through many stages of the care system, and experienced several dozen placements. While existing, well-known models of care have aspects which are applicable to our unique situation, no other model satisfies all our requirements. For this reason, we developed the Safe Places Integrative Practice Framework; a flexible and adaptable model which ensures each young person in our care is treated individually and with regard for his or her particular history and current needs.

Purpose of the Framework

Without a set of guiding principles for understanding and responding to young people with extreme behaviours, there is a risk that care workers will interact with children based on their own interpretation of the role, the organisational culture surrounding them, and their own, personal philosophy of child-rearing. In addition, if care workers are not supported to develop an understanding of the impact of complex relational trauma on children's development, they are at risk of personalising the young person's aggressive and resistant survival behaviours and may respond to children using counter-productive strategies that are coercive and punitive. A clear therapeutic framework is critical. Further, the framework must be based on a theory of how children develop and heal that is consistent with the needs of the children, motivates both children and care workers to adhere to routines, structures and processes, and minimises the potential for interpersonal conflict.

Elements of the Framework

The Framework draws heavily on strategies utilised in Bruce Perry's Neurosequential Model of Therapeutics, Daniel Hughes' Dyadic Developmental Principles for Facilitating Attachment (PACE model), and Ross Green and Stuart Ablon's Collaborative Problem Solving Approach. The Safe Places Integrative Practice Framework consists of:

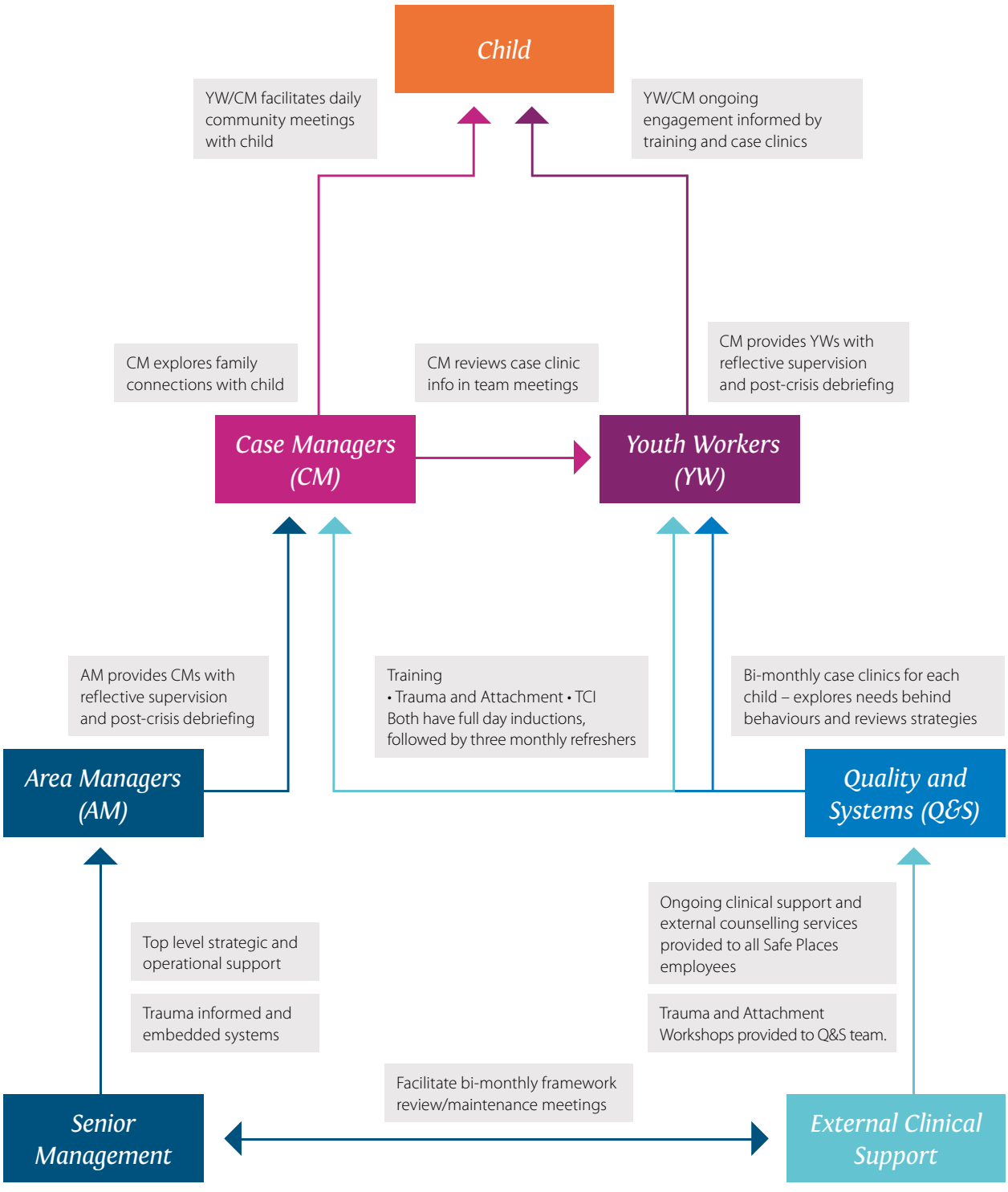
- ***Therapeutic Crisis Intervention*** training
- ***Child Focussed Case Clinics*** for each young person
- ***Reflective Individual Supervision*** for employees
- ***Community Meetings*** involving the young person
- ***Understanding Trauma*** training.

What makes us unique?

Everyone at Safe Places is responsible for providing individualised therapeutic care with these processes maintained and continuously implemented, even at times of crisis.

The main point of difference between the Safe Places Integrative Practice Framework and most internationally known models of care, such as the Attachment, Self-Regulation and Competency (ARC) Model, Children and Residential Experiences (CARE) Model, Sanctuary Model and Therapeutic Crisis Intervention (TCI) System, is its greater focus on children with extreme behaviours.

The Safe Places Integrative Practice Framework System



The Safe Places Integrative Practice Framework incorporates six key practice domains:

1. ***Attachment***
2. ***Trauma***
3. ***Competence***
4. ***Family***
5. ***Home***
6. ***Organisation***

The Safe Places goal is to offer the young people in our care a solid foundation upon which they can build a bright future.

Key Practice Domain 1:
Attachment

In order to regulate emotions, manage behaviour, achieve autonomy and self-reliance, and develop a sense of self, a child must have confidence in, and feel secure with, an adult. Through building attachments with safe adults, children can learn to trust, feel safe, develop relationships, overcome obstacles and solve problems. The Attachment domain of the Safe Places Framework recognises that the youth workers and case manager are shouldering the primary care-giving role. As such, they are fundamental parts of this system, even though the child's biological parents or other caregivers may remain involved.

The Safe Places Integrative Framework targets three key areas of Attachment: Care Worker Affect Management, Attunement, and Consistency.

Care Worker Affect Management

Care workers' ability to recognise and regulate their own emotional experience is fundamental to the workers' capacity to facilitate healthy attachment in the children they support. In line with the ARC, CARE and Sanctuary models, all Safe Places care workers receive training around the impact of trauma and disrupted attachment on a child's functioning both during induction and on an ongoing basis through refresher and ongoing development training.

An important clinical component of the ARC model involves providing ongoing opportunities to depersonalise a child's behaviours and actions. For this reason, the Quality and Systems managers are responsible for facilitating reflective case clinics for each child on a bi-monthly basis. Again, this helps to reframe the child's behaviours in the context of the child's developmental experiences of trauma, grief and loss. The case clinics also aim to explore other potential contributors to current difficulties in functioning or failure to meet expectations, such as developmental delays, or current environmental factors and stressors.

Most importantly, the reflective case clinics examine the child's current attachment base, including willingness/resistance to connect with care workers, control/avoidance strategies used to manage perceived vulnerability in becoming more connected, and the child's capacity to directly cue caregivers about her or his needs. Strategies are then tailored to facilitate healthier attachments, increase opportunities for connection to others, and establish relational permanence, i.e. the child's perception of, and likely access to, reliable caregivers in the future, and the identification of potential attachment figures that could continue to support the child after transition from the program.

Case clinics occur on a bi-monthly basis and the strategies developed are reviewed fortnightly in team meetings, facilitated by the case manager. This ensures that a deeper understanding of the child's needs remains at the centre of all decision-making and responses. In a similar process to the reflective case clinics, all employees also participate in individual reflective supervision with their line managers. The goal is to improve the ability of care workers to identify, understand and appropriately manage affect.

To ensure that this culture of reflective practice is paralleled on an organisational level, senior management ensures that operational systems are trauma informed and contracts ongoing clinical support, counselling and debriefing services from external clinical organisations around Australia. This support, available either face-to-face or over the phone, provides opportunity to explore issues/stressors occurring both within and outside the workplace. The aim is to improve employees' reflective capacity, stress management, and use of healthy communication and coping strategies. The support also aims to mitigate burn-out and vicarious trauma, and ultimately increases care workers' capacity to respond therapeutically to children.

Attunement

Attunement is the capacity of caregivers and children to accurately read each other's cues and respond effectively. Both the ARC and CARE frameworks place significant emphasis on incorporating interventions that target a caregiver's capacity to recognise and respond to the emotional needs underlying a child's distressing behaviours or symptoms. In line with these recommendations, and as part of the Complex Care Trauma and Attachment training, all Safe Places staff are provided with training around Daniel Hughes' Dyadic Developmental Principles for Facilitating Attachment in Maltreated Children. This approach draws on contemporary understandings of developmental attachment and the theory of inter-subjectivity. It teaches care workers to maintain engagement, soothe/co-regulate, and support the development of empathy in children through taking a calm, playful, accepting, curious and attuned response. This process of safely reflecting back the child's emotions replicates the same pattern of engagement that occurs in a healthy infant-parent exchange, allowing care workers to help the child rebuild the early templates for trust and connection that they did not previously experience.

Through building attachments with safe adults, children can learn to trust, feel safe, develop relationships, overcome obstacles and solve problems.

Consistency

Due to the aggressive, controlling and avoidant responses characteristic of children who have experienced complex relational trauma, a caregiver's ability to respond consistently and appropriately to the child's behaviour is often compromised, especially at times of crisis. As Safe Places recognises the importance of having a clear system of strategies for consistently responding to young people at different stages of crisis, it ensures that all Q&S managers are accredited to deliver Therapeutic Crisis Intervention (TCI) training to frontline care workers as part of the comprehensive induction program. The TCI system is a crisis-management protocol developed by Cornell University. Its purpose is to provide a crisis prevention and intervention model for residential childcare facilities which will assist them in:

- Preventing crises from occurring
- De-escalating potential crises
- Effectively managing acute crisis phases
- Reducing potential and actual injury to children and staff
- Learning constructive ways to handle stressful situations
- Developing a learning circle within the organisation.

The TCI system is further embedded into the Safe Places model through the provision of regular refresher training, the use of TCI flash cards, prompts in incident reports, formal post-crisis debriefing and reflective individual supervision.

Bi-monthly case clinics and fortnightly team meetings also support the child to experience a consistent response from caregivers. These processes ensure that the strategies provided in the Trauma and Attachment training are regularly reviewed and specifically tailored to the dynamic needs and situation of the child. They ensure a relevant, considered, and consistent response from all care workers.

In this area, the Safe Places model of care has some similarities to the ARC model but is more focused on the specific issues associated with the extreme needs of the young people in our care.

Key Practice Domain 2:
Trauma

Complex trauma has been defined as 'the experience of multiple, chronic and prolonged, developmentally adverse traumatic events'. For children in care, this has usually occurred within the context of a care-giving relationship. Complex trauma can compromise the development of relationships, thinking, memory, self-worth, health, and a sense of meaning and purpose in life (van der Kolk, 2005).

According to Allan Schore (2003), the most significant consequence of early relational trauma is the loss of the ability to regulate the intensity and duration of emotional states. In the absence of a care-giving system that supports the development of more sophisticated skills, children are unable to regulate internal states, such as fear, anger and sexual impulses, and are forced to either disconnect from their feelings or use unhealthy coping skills. Not only do these children not develop the capacity to regulate emotions, but under conditions of chronic, overwhelming trauma, the child's stress activation system becomes overly sensitive to potential danger, and can trigger fight, flight and dissociative mechanisms in response to even minor stressors.

Affect Identification and Monitoring

Children who have experienced trauma are often unable to identify internal emotional experience, or to understand from where these emotions come. Through Trauma and Attachment training and TCI training, Safe Places equips all care workers with a range of strategies that support children to build a vocabulary for emotional experience, and to form connections between identified emotions and precipitating events, physiological states, behaviours, coping styles, and the impact of past experiences on current situations.

The Cornell University TCI training utilised by Safe Places is a fundamental part of this process, as the training incorporates a number of strategies that support the child to identify his or her emotions in real-time through reflecting back and labelling feeling states during the triggering phase and, later, using the Life Space Interview (LSI) process to support the child to connect identified emotions to triggers, behaviours and experiences. Care workers are trained to ensure that the implementation of these strategies always occurs using the principles of Daniel Hughes' PACE model (Playfulness, Acceptance, Curiosity and Empathy), which ensures that children are constantly receiving feedback about their emotional state, even when at base-line, through the care worker's attuned and curious stance.

Complex trauma can compromise the development of relationships, thinking, memory, self-worth, health, and a sense of meaning and purpose in life.

(van der Kolk, 2005)

Affect Modulation

Children who have experienced trauma often live within bodies that feel overwhelmed or shut down, with few strategies to modulate arousal effectively. In the absence of a reliable, predictable, responsive caregiver, children do not experience the usual healthy ongoing arousal-relaxation cycle, within which the child is continuously soothed and redirected following periods of normal stress associated with care needs. As a result, the child is often delayed in their capacity to modulate arousal, which is then often compounded by the deleterious effects of abuse. The Safe Places Integrative Practice Framework draws on a range of practices that target a child's ability to tune into, tolerate, and sustain connection to internal states, and to identify and use strategies to manage her or his emotions.

As part of the Trauma and Attachment training, all care workers are trained in the core principles of Bruce Perry's Neuro-Sequential Model of Therapeutics. This provides care workers with information critical to understanding why, and how easily, traumatised children can be triggered by their environment (below conscious awareness), and the important cognitive capacities that deteriorate once they move into a hyper-aroused or dissociative state. This training also supports the care workers to more accurately assess the child's state and tailor a response to their level of arousal.

The importance of continuous co-regulation through the use of empathy, soothing and playful redirection is taught within Daniel Hughes' PACE model, and a range of specific strategies for supporting redirection and maintaining safety during periods of escalation are provided to care workers as part of their TCI training. Case clinics are then used to ensure that the child's ongoing behaviour is understood and not personalised by care workers, and to ensure the strategies are tailored, implemented and reviewed on a regular basis.

This ongoing reflective and consultative process is the key to ensuring a consistent therapeutic response, especially when the team is supporting a child who frequently escalates to intimidating or violent behaviour.

Affect Expression

Sharing emotional experience is a critical aspect of human relationships; the inability to effectively communicate emotions prevents children from being able to form and maintain ongoing healthy attachments. Safe Places works with children to identify safe emotional resources, and build skills to effectively communicate inner experience.

The use of LSI and Collaborative Problem Solving ensure that the child has regular, structured opportunities at which a curious and attuned care worker supports the child to articulate needs, feelings and concerns. Each LSI validates experience and helps the child to integrate his or her own needs with the feelings and concerns of others.

Safe Places practice is also aligned with the Sanctuary model in that it incorporates daily community meetings into the routine of each child. This involves facilitating a space within which all children and care workers have an opportunity to communicate their feelings and concerns using the Sanctuary tool, SELF, which provides a shared language, and prompts ongoing dialogue around Safety, Emotions, Loss and Future.

Key Practice Domain 3:

Competence

All children require the same basic experiences and opportunities to develop into positive adulthood, however most children in care have missed out on fundamental developmental experiences and/or been subjected to traumatic experiences that do not support – and in many cases actually impede – their normal development. Children experiencing trauma within the context of their early care-giving system must invest their energy into survival, rather than into the development of age appropriate competencies. As a result, they lag behind their peers in a variety of developmental domains, or fail to develop a sense of confidence and efficacy in task performance. Children in care usually require additional support and nurturing-replacement experiences to develop, function and meet normal social expectations. From this perspective, unusual behaviour can often be viewed in terms of where it fits into the child's developmental progression, instead of being labelled deviant or defiant behaviour.

Safe Places recognises that, if an expectation or rule is important for teaching skills, maintaining functioning of the home, enhancing relationships or keeping people safe, then a focus should be kept on the actual expectation or competency, not the violation. The Integrative Practice Framework facilitates the development of age appropriate competencies and social skills, through a visual, positive, individualised, child focussed rewards chart. Expectations are what we hope for the young person to achieve. Expectations remain, regardless of whether the child has met them. When the expectation is not met, it does not become an issue of non-compliance, but a challenge for the care worker to help the child meet the expectation in the future. If the response is to assign consequences whenever an expectation is not met, the focus then immediately shifts to how to get the child to comply with the consequence, instead of how to develop the skills to consistently meet the expectation.

Strategies for change are more effective when they meet the child's present level of functioning, and when the skills and resources required to meet a new challenge do not overwhelm the child. This is known as the child's 'zone of proximal development'. Typically, these strategies involve setting tasks and expectations that, while difficult for the child to achieve on their own, can be accomplished with the help of a care worker. Care teams define a small, specific set of achievable competencies linked to functional skills and social capabilities required for effective functioning to build relationships and operate in the community.

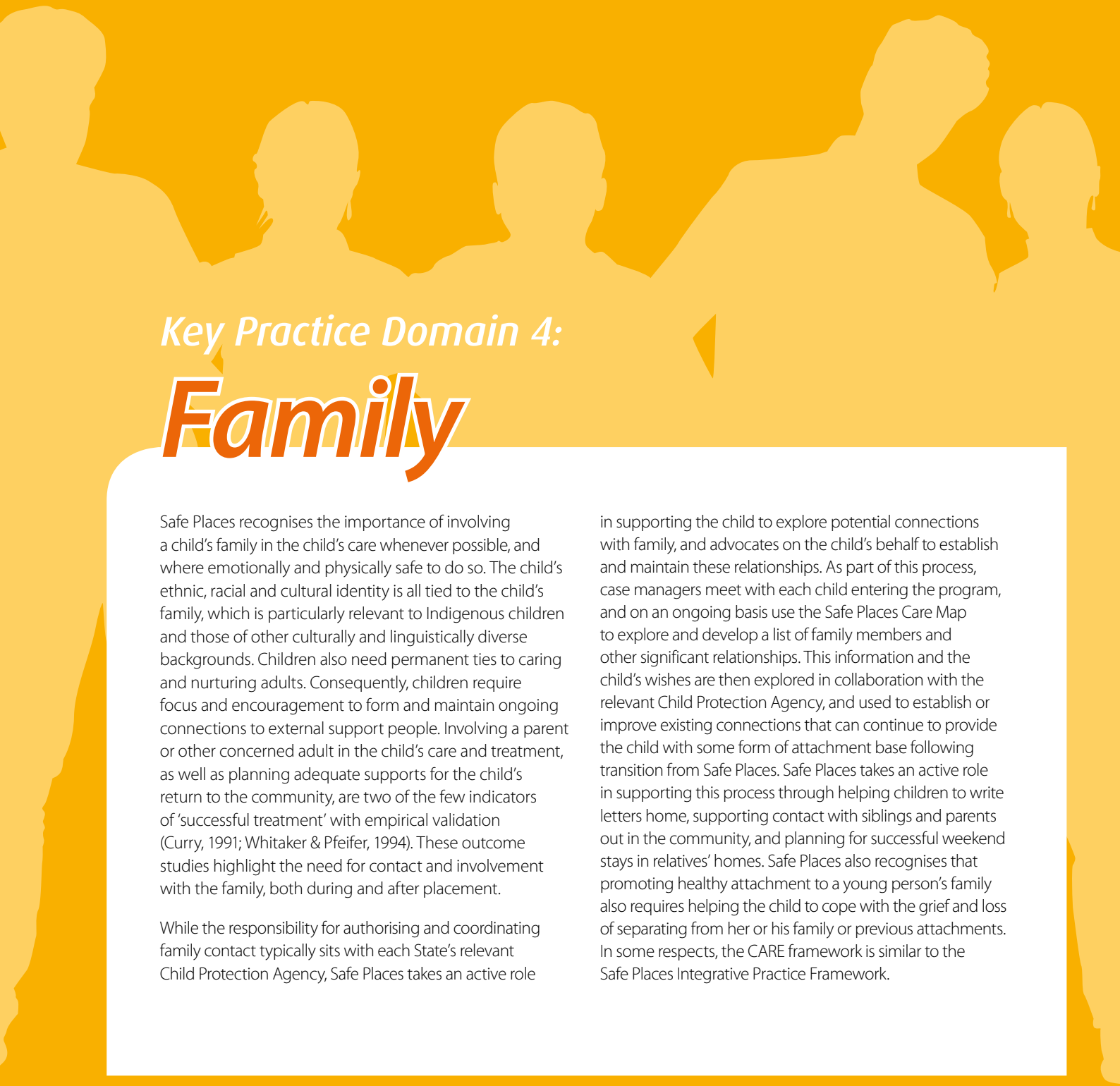
Children in care usually require additional support and nurturing-replacement experiences to develop, function and meet normal social expectations.

Care workers ensure focus is on learning agreed and understood competencies rather than reactively enforcing each care worker's individual preferences of desired behaviour.

The ARC model, which goes beyond the targeting of pathology to support the mastering of key developmental tasks, has been considered when developing the Safe Places Integrative Practice Framework. Children who have experienced chronic trauma may have difficulty with problem-solving and other tasks that require concentration, and they often lack a sense of personal agency. The Integrative Practice Framework emphasises the importance of care workers considering the array of developmental tasks crucial to healthy development, including but not limited to social skills, school/community connection and achievement, independent responsibility and autonomy.

Safe Places works actively with children to build an understanding of the link between actions and outcomes, and to increase their capacity to consider, implement and evaluate effective choices through the use of LSI (following critical incidents) and a collaborative problem-solving approach. The Collaborative Problem Solving Approach (Ross Greene and Stuart Ablon) is a conversational tool that is often used by care workers whenever the child is faced with a problem or disagreement, has trouble meeting an expectation, or opposes a boundary. This competence-based tool supports a child to articulate concerns and validate responses, and assists the child to develop solutions that integrate the needs and concerns of others. In doing so, this response not only prevents power struggles and reduces the likelihood of a child escalating extreme behaviour, but teaches important skills across domains such as working memory, social skills (perspective taking), cognitive flexibility, frustration tolerance, language processing, and emotional expression and regulation. This process also helps to build healthy attachment, through teaching children that they can directly cue adults and have their needs met, without using threatening behaviour or other attempts to gain control over their environment.

Only when the care team has established that the child has all the required skills and emotional capacity to meet an expectation in that moment, but still chooses not to, would the team consider using a consequence. In that situation, natural consequences should be highlighted or logical consequences provided (providing they have previously been established and agreed upon) by a calm, empathetic and non-judgemental care worker.



Key Practice Domain 4:

Family

Safe Places recognises the importance of involving a child's family in the child's care whenever possible, and where emotionally and physically safe to do so. The child's ethnic, racial and cultural identity is all tied to the child's family, which is particularly relevant to Indigenous children and those of other culturally and linguistically diverse backgrounds. Children also need permanent ties to caring and nurturing adults. Consequently, children require focus and encouragement to form and maintain ongoing connections to external support people. Involving a parent or other concerned adult in the child's care and treatment, as well as planning adequate supports for the child's return to the community, are two of the few indicators of 'successful treatment' with empirical validation (Curry, 1991; Whitaker & Pfeifer, 1994). These outcome studies highlight the need for contact and involvement with the family, both during and after placement.

While the responsibility for authorising and coordinating family contact typically sits with each State's relevant Child Protection Agency, Safe Places takes an active role in supporting the child to explore potential connections with family, and advocates on the child's behalf to establish and maintain these relationships. As part of this process, case managers meet with each child entering the program, and on an ongoing basis use the Safe Places Care Map to explore and develop a list of family members and other significant relationships. This information and the child's wishes are then explored in collaboration with the relevant Child Protection Agency, and used to establish or improve existing connections that can continue to provide the child with some form of attachment base following transition from Safe Places. Safe Places takes an active role in supporting this process through helping children to write letters home, supporting contact with siblings and parents out in the community, and planning for successful weekend stays in relatives' homes. Safe Places also recognises that promoting healthy attachment to a young person's family also requires helping the child to cope with the grief and loss of separating from her or his family or previous attachments. In some respects, the CARE framework is similar to the Safe Places Integrative Practice Framework.

Key Practice Domain 5:

Home

Children in care have often experienced both external and internal chaos. A consistent, reliable, care-giving response occurring within a comfortable, homely and predictable environment/routine forms the basis for establishing safety and improving self-regulation. Safe Places ensures that all children are provided with a consistent, predictable structure to their day, within which expectations, rules and limits are discussed with the children in advance. Safe Places uses the reflective case-clinic process, along with fortnightly team meetings, to review routines, adapt the program to support the child through difficult times such as transitions and, wherever possible, remove/avoid activities or events that are likely to trigger the child's stress response.

The two most critical aspects of a home are the social and physical features that enable and encourage the child to participate in a variety of activities with children, adults and on their own. The more the environment is enhanced to motivate the child's participation in more complex activities and relationships, the more growth and development will occur. In line with the CARE and Sanctuary models, Safe Places actively seeks to incorporate activities that promote nurturing interactions and future orientation, such as caring for animals, plants and people. The case clinics are also used to identify social, physical and educational activities that can be incorporated into the child's routine and provide opportunities to support the child to practise skill deficits in residential and community settings, without overwhelming the child's capacity to cope. The use of the Sanctuary model's daily community meetings is a fundamental part of the routine, and teaches critical social and cognitive skills, while improving safety and a sense of democracy within the home.

Being strongly influenced by the research of Jim Anglin (2003), the CARE framework views the physical setting as a fundamental component of a well-functioning, extrafamilial living environment. Significant time and financial resources are invested into ensuring that every home is attractive, well-maintained, and communicates to the child that he or she is cared about. The use of homely furnishings and uplifting pictures aims to promote a sense of warmth and normality within each home, while the efforts invested by care workers to help each child personalise her or his room adds a sense of ownership and belonging, as well as an opportunity for the child to express individuality.

Safe Places ensures that all children are provided with a consistent, predictable structure to their day.

Atmospheres of recurrent or constant crisis can severely constrain the ability of an organisation to involve all levels of staff in decision-making processes.

Key Practice Domain 6:

Organisation

A core theme of the Integrative Practice Framework (and of other models, such as CARE and Sanctuary) is the importance placed on the organisation's culture and the need for all levels of management to reflect the same values as those practised by frontline care workers in their engagement with children. Safe Places incorporates a number of key processes to ensure organisational congruence around decision-making and to mitigate the risk of stress or secondary trauma being paralleled across different levels of management.

Safe Places understands that parallel processes can occur on an organisational level as a result of the complex interaction between traumatised children, stressed care workers, the external pressures placed on services by other agencies, and an often unsupportive social and economic environment. Atmospheres of recurrent or constant crisis can severely constrain the ability of an organisation to involve all levels of care workers in decision-making processes. In turn, this impacts an organisation's ability to constructively confront problems and engage in complex problem solving. Importantly, Safe Places recognises that internal communication is integral to safety, i.e. the better the communication, the safer the residential environment. This knowledge has strongly influenced Safe Places' practice and led to the development of a number of processes that serve to promote increased democracy, open communication, reflection and emotional management. These include community meetings, case clinics, reflective supervision, post-crisis response and the use of the SELF language/process in team meetings.

Another important and unique component of the Safe Places system is the development and function of the Quality and Systems team. As the Quality and Systems team provides all training and facilitates the case clinics, it plays a fundamental role in ensuring that the Integrative Practice Framework is successfully implemented and embedded into Safe Places' systems. Allocating this responsibility to a team that is not directly responsible for case management or line supervision drastically reduces the risk of the team being pulled into crisis at times of increased stress, and ensures the continuation of all processes required for the Integrative Practice Framework's successful implementation.

The final overarching process required to successfully implement and maintain the Integrative Practice Framework is senior management support, including CEO and board support, to align with organisational strategy. Without top management support, conflicting environmental demands can result in pressures or conflicts that undermine the effectiveness of practice. When required, senior management will engage an external clinical consultant from time to time to review the Integrative Practice Framework's implementation. This process will identify gaps between theory and practice, explore opportunities to further develop the Integrative Practice Framework, overcome challenges and better support the care workers to engage in therapeutic practice.

Conclusion

The Safe Places Integrative Practice Framework has similarities with the core practice elements of the CARE, ARC and Sanctuary models presented under the practice domains of Attachment, Trauma, Competence, Family, Home, and Organisation. It incorporates a range of processes across each level of the organisation to ensure that these evidence-based theoretical concepts are successfully integrated into care workers' practice and the program's physical and social environment.

Implementing the Integrative Practice Framework is the responsibility of everyone at Safe Places, supported by senior management and the Quality and Systems team to ensure it is consistently applied and continuously improved, even at times of crisis. The ongoing evaluation and development of this system is also maintained and supported through reviews involving consultation with care workers and managers from every level of the organisation as well as external clinical consultancy. This ensures that new, emerging, evidenced-based strategies and models of care continue to be integrated into practice. This also allows the Integrative Practice Framework to continue evolving, and ultimately ensures that all children placed with Safe Places receive the high level of care, nurturing, structure and individualised therapeutic support they require for optimum healing and development.

Glossary

ARC Model	Attachment, Self-Regulation and Competency model
CARE Model	Children and Residential Experience model
LSI	Life Space Interview
PACE Model	Playfulness, Acceptance, Curiosity and Empathy model (Daniel Hughes' Dyadic Developmental Principles)
Safe Places	Safe Places Community Services Limited ACN 131 345 910 trading as Safe Places for Children
Sanctuary Model	The Sanctuary Model of Organizational Change for Children's Residential Treatment
SELF	Safety, Emotions, Loss and Future, a Sanctuary Model tool.
TCI	Therapeutic Crisis Intervention

References

Anglin, J. (2002). Pain, normality, and the struggle for congruence. New York: The Haworth Press.

Blaustein, M. E. & Kinniburgh, K. M. (2010). Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience Through Attachment, Self-Regulation, and Competency. New York: Guilford Press.

Bloom, S. L. (1997). Creating Sanctuary: Toward the Evolution of Sane Societies. New York: Routledge.

Bloom, S. L. (2005). The Sanctuary Model of Organizational Change for Children's Residential Treatment. Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations 26(1), 65-81.

Bowlby, J. (1988). A Secure Base. New York: Basic Books.

Curry, J. (1991). Outcome research on residential treatment: Implications and suggested directions. American Journal of Orthopsychiatry, 61, 348-358.

Greene, R. W. & Ablon, S. (2006). Treating Explosive Kids: The Collaborative Problem Solving Approach. New York: Guilford Press.

Hughes, D. A. (2004). Facilitating Developmental Attachment. Maryland: Rowman & Littlefield.

Holden, M. J. (2009). Children and Residential Experiences: Creating Conditions for Change. Arlington: The Child Welfare League of America.

Perry, B. D. (1995). Maltreated Children: Experience, Brain Development and the Next Generation. New York: W. W. Norton.

Perry, B. D. (2008). Introduction to the Neurosequential Model of Therapeutics. Journal of Strength Based Interventions.

Schore, A. N. (2003b). Affect Regulation and the repair of the self. New York: W. W. Norton.

Siegel, D. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York: Guilford.

van der Kolk, B. A. (2005). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. Psychiatric Annals, 35(5), 401-408.

Whitaker, J. & Pfeifer, S. (1994). Research priorities for residential group child care. Child Welfare, 73, 583-601.

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