Take Two – Implementing a Therapeutic Service for Children who have Experienced Abuse and Neglect: Beyond Evidence-Informed Practice

Helping children recover from the impact of child abuse and neglect is complicated by the limited evidence available on programme effectiveness and efficacy. This paper describes the implementation of a therapeutic service, in Victoria, Australia, known as Take Two, and provides a profile of client characteristics. The paper describes some of the barriers to children in the child protection system accessing therapeutic or mental health services and the approach attempted to overcome these barriers. The Take Two Practice Framework and the subsequent contribution of the Child Trauma Academy’s Neurosequential Model of Therapeutics are discussed. There is exploration of evidence-based practice and how this and related concepts are considered in the evolving theory of change and the Practice Framework. This includes consideration of what else is needed to supplement the evidence. The paper provides a useful model for other agencies that are planning or implementing a therapeutic programme for children traumatised by abuse and neglect. © 2019 John Wiley & Sons, Ltd.

KEY PRACTITIONER MESSAGES:

• Systematic reviews conclude that there is insufficient evidence to allow reliance on any single intervention with this client group.
• This poses a genuine dilemma for services that aim to utilise evidence-informed interventions but find their offerings limited.
• Taking a research-based and evidence-informed approach with a strong theory of change has assisted one such programme to respond to this dilemma.

KEY WORDS: child abuse; mental health; evidence-based practice; practice learning

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Introduction

This paper provides a description of the design, implementation and evolution of a therapeutic service, the Berry Street Take Two programme, which commenced in 2004. This programme assists children in their recovery following abuse and neglect. We provide an analysis of the challenges, dilemmas and overall approach to programme implementation with a client group whose lives are epitomised by complexity, multiple trauma and cumulative harm.

The rate of reported cases of child maltreatment is increasing in Australia, and is acknowledged internationally as a serious public health problem (World Health Organization, 2014). The number of child abuse substantiations in Victoria, Australia, doubled in six years from 7687 in 2010 to 15,488 in 2016–17 (Australian Institute of Health and Welfare (AIHW), 2018).

Child maltreatment encapsulates physical abuse, emotional abuse, sexual abuse and neglect, including exposure to family violence. Child maltreatment can lead to long-term harmful consequences for the child and the broader family, creates a substantial health and economic burden on society (World Health Organization, 2014), and can have repercussions for subsequent generations (Buchanan, 1998).

An important focus of public policy is early intervention and the prevention of child maltreatment (Fox et al., 2015), however there is less emphasis on intervening to assist recovery after harm has occurred (Brandon et al., 2013). Helping children recover from the impact of maltreatment is not only required to reduce the human, economic and societal costs, it is a human right documented in the United Nations Convention on the Rights of the Child. Supporting recovery following childhood trauma is a tertiary intervention, but it should also form part of any early intervention strategy, as many of these children will become parents of the next generation.

Drawing upon our experience of developing Take Two and informed by the literature, we identify and discuss factors influencing programme design. Descriptive data of the Take Two client group, based on information received from the referrer, are also provided. Ethics approval for this research was received from the Department of Human Services (DHS), now known as the Department of Health and Human Services (DHHS), and La Trobe University.

Descriptions of the Take Two Client Group

Take Two is a statewide-accredited health service in Victoria, Australia, for children aged from newborn to 18 years who have experienced trauma and disrupted attachment due to abuse and neglect and who are statutory child protection clients. Take Two is funded to provide a clinical service, with embedded research and training. In its first 13 years of operation (2004–16), Take Two worked with 2724 children in 3510 episodes of care: 26 per cent of children were under the age of six years, 39 per cent were between the ages of six and 11 years and 35 per cent were between the ages of 12 and 18 years. The gender distribution was 51 per cent males and 49 per cent females, with approximately 75 per cent of the children in out-of-home care, such as foster care, residential care and kinship care.
There was an over-representation of Aboriginal children and this increased from 14.6 per cent in 2004 to 22 per cent in 2016. This is a striking over-representation given that less than two per cent (1.6%) of children in Victoria are Aboriginal. Aboriginal children are also over-represented in the child protection system with 13 per cent of substantiations of abuse and neglect being in relation to Aboriginal children (AIHW, 2018).

The Take Two referral documentation (Frederico et al., 2010) categorises the experiences of maltreatment based on the Victorian legislation (Children Youth and Families Act 2005 (Victoria)). Ninety-five per cent of children referred to Take Two experienced multiple forms of extreme or serious maltreatment (see Table 1).

Evidence-Informed Practice

Programmes that aim to deliver effective treatment are rightfully expected to utilise interventions demonstrated to be effective. However, there is often confusion between evidence-based treatment (EBT), evidence-based practice (EBP) and evidence-informed practice (EIP) (Brandt et al., 2012). EBT refers to an intervention subjected to empirical study utilising randomised control trials (RCTs) and resulting in an intervention that is considered effective with a particular cohort. The sample selection criteria for inclusion in an RCT are usually limited to reduce the number of variables that complicate interpretation of the results (Brandt et al., 2012). As a consequence, children with complex presentations such as multiple trauma or those with an intellectual disability are often excluded from RCTs (Chorpita, 2003). Leenarts et al. (2013) in a systematic review of psychotherapeutic treatment for maltreated children found that trauma-focused cognitive behavioural therapy (TF-CBT) was the best-supported intervention and identified other interventions as promising. However, the authors excluded children under six years from the review and also noted the small sample sizes and high drop-out rates of the included studies. Although these issues do not negate the value of the findings of RCTs, they do give cause to question their applicability to children excluded from the studies. Cohen and Mannarino (2010) identified five established treatments for post-traumatic stress disorder (PTSD) and found that they were effective for the multiple domains of affective, behavioural, cognitive and relational dysfunction. However, none of these treatments apply to the entire Take Two age range or living situations. Another area of caution is the ability to generalise from one culture to another, for example, there are very few RCTs that have involved Australian Aboriginal children.

Table 1. Multiple maltreatment experienced by Take Two clients at the time of referral

<table>
<thead>
<tr>
<th>Type of maltreatment</th>
<th>Percentage of clients</th>
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<tbody>
<tr>
<td>Emotional abuse</td>
<td>92.5</td>
</tr>
<tr>
<td>Abandonment, lack of supervision and/or parental incapacity</td>
<td>81.0</td>
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<tr>
<td>Physical abuse</td>
<td>80.4</td>
</tr>
<tr>
<td>Exposed to developmental and medical harm</td>
<td>59.5</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>30.8</td>
</tr>
<tr>
<td>Exposed to family violence</td>
<td>68.7</td>
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</tbody>
</table>

Note: The family violence category is drawn from descriptors for emotional abuse and physical abuse.
Source: Frederico et al. (2010).
There is not enough EBT research available that is applicable to the range of children's presentations, developmental histories and wide-ranging contexts that present to programmes such as Take Two. It is also not possible for government-funded programmes to limit their referred clients to those whose presentation is consistent with the EBT criteria. In addition, a programme which only used EBTs with this population would be ignoring promising interventions (Leenarts et al., 2013) and the results of systematic reviews which suggest the evidence is not yet strong enough to rely on any single intervention (Goldman Fraser et al., 2013).

The design of Take Two included a focus on understanding the client group and on developing a model to suit the range of presentations and cultures of the referred children. In doing so, we aimed to draw on EBP or EIP. EBP and EIP are usually interchangeable terms and constitute a broader understanding of how evidence of what works can inform practice. They involve learning from research including RCTs but it should not be assumed that this is the only form of evidence with value (Brandt et al., 2012). Sackett et al. (1996, p. 71) described EBP in a medical context as informing practice in a 'conscientious, explicit, and judicious' way through considering the best that research can offer and the best available clinical wisdom, judgement and experience, and demonstrating consistency with the client's and family's values and preferences.

We considered ‘evidence-informed practice’ to be the more accurate term to describe the approach for the design and delivery of interventions in the Take Two programme. The programme was designed to draw on the best evidence available to inform practice, rather than it being the basis for all practice. Consistent with Holmbeck et al.'s (2003) description of programme design, we emphasised that research should inform which intervention best matches different developmental imperatives and that the following elements should be considered:

- The child's developmental stage
- Critical developmental tasks and milestones relating to the child's presenting problem
- Incorporating the child's social context, especially their family, carers and other significant relationships.

Overall, the Take Two therapeutic intervention is inherently relational, whether it is with the individual child, facilitating the child's relationship with others, or with the child's community and service system. This occurs both through the direct provision of individual therapy as well as in supporting others to create therapeutic encounters throughout the child's day. Trauma-informed approaches (Cloitre et al., 2009), attachment-informed approaches (Gimson and Trehwella, 2014) and developmental (van der Kolk, 2005) and ecological perspectives (Bronfenbrenner, 1992; Green and McDermott, 2010) form the foundation of the Take Two approach, in the context of systems and network interventions and always with a cultural lens, thus engaging children in the context of their social world (see Figure 1).

**Purpose and Expectations of the Therapeutic Service**

Numerous studies have found that, despite demonstrable mental health and developmental concerns, many children in the protection and care system face...
### Elements of the Take Two Practice Framework

<table>
<thead>
<tr>
<th><strong>The Take Two programme</strong></th>
<th>(Therapeutic service for children who have experienced maltreatment)</th>
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</thead>
<tbody>
<tr>
<td>Clarify and confirm expectations of funders and governing consortium and determine <strong>programme parameters</strong> and scope of practice</td>
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<tr>
<td>Apply theory to understand the children, families and phenomenon of maltreatment</td>
<td><em>(Theoretical framework)</em></td>
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<tr>
<td>Examine <strong>research and scientific principles</strong> to understand mechanisms for how children are harmed by adversity and how they build resilience. Adopt a <strong>biological logic</strong> for why certain strategies were more or less likely to affect positive change and under what circumstances</td>
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<tr>
<td>Select a model to guide and support but not replace clinical decision-making</td>
<td><em>(NMT)</em></td>
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<td>Develop <strong>programme logic</strong> to articulate key assumptions including programme parameters, theoretical framework and biological logic as well as core values and expected outcomes per the research and evaluation strategy</td>
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<tr>
<td>Develop and revisit <strong>practice principles</strong> <em>(through consultation and literature review)</em></td>
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<tr>
<td>Articulate <strong>service model</strong> to describe process from referral to closure across different Take Two roles, including process of seeking consent and planning intervention with client and family as informed by assessment and NMT and application of outcome measures</td>
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<td>Summarise programme logic and service model in Take Two <strong>clinical operating manual</strong> incorporating guidelines and procedures. This includes examples of interventions, but it is not a manual of how to use them. The manual emphasises the clinical decision-making process of determining which interventions to use and when to use them, and the importance of engagement and collaboration with client, family and carer</td>
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<tr>
<td>Continuously examine research and <strong>systematic reviews</strong> of what works and why as well as the limitations of evidence</td>
<td><em>(EIP)</em></td>
</tr>
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<td><strong>Utilise therapeutic intervention templates</strong> <em>(tools with questions to interrogate the literature and key informants)</em> to determine which interventions or techniques are endorsed by Take Two or endorsed and supported by Take Two, or neither</td>
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<td>Devise a <strong>clinical capacity strategy</strong> incorporating a training strategy to support the application of particular interventions, along with supervision requirements, accreditation processes and other elements required to use interventions or techniques with fidelity</td>
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**NMT = Neurosequential Model of Therapeutics ; EIP = Evidence Informed Practice**

**Figure 1.** Elements of the Take Two Practice Framework. EIP = Evidence-informed practice; NMT = Neurosequential Model of Therapeutics.
several barriers in accessing the requisite services. Barriers include: parental reluctance to engage with services and accessing of office-based services for clients (Stahmer et al., 2005); difficulties in obtaining child client consent for services (Woolverton, 2002); and scarcity of services (Guglani et al., 2008).

In addition, service utilisation can be reduced by the lack of recognition that these children need therapy to help their recovery, and also by the lack of hope that recovery for these children is possible (Guglani et al., 2008). Take Two was expected to address these barriers directly for children accessing therapeutic services.

The report *When Care is Not Enough* by Morton et al. (1999) of ten high-risk adolescents in the Victorian child protection system led to the establishment of Take Two. Morton et al. (1999) concluded that young people with high-risk behaviours required specialised support to assist their recovery from trauma and yet this had rarely been available. They recommended funding a therapeutic service for children of all ages to address barriers for these children accessing therapeutic services.

Certain subgroups within the child protection client group are likely to experience additional difficulties in accessing services. For example, barriers were particularly noted for: children living with their parents (Stahmer et al., 2005); children in kinship care (Royal Australasian College of Physicians (RACP), 2006); Aboriginal and Torres Strait Islander (Aboriginal) children (RACP, 2006); infants and young children (Stahmer et al., 2005); and children with internalising symptoms (Guglani et al., 2008).

Placement instability has been a well-recognised obstacle to children receiving mental health or therapeutic services (Frederico et al., 2010). The trauma literature is unequivocal that the traumatic situation should be over, and that children should be safe, before receiving therapy about these experiences. This issue of safety includes having a consistent attachment figure to support them during the process (Lieberman and Van Horn, 2004). Most trauma-focused and attachment-focused interventions assume that a committed and consistent caregiver is available (Goldman Fraser et al., 2013). Little is therefore written about how to provide therapy when a child's safety or stability of placement cannot be assured. As such, the evidence base for this population is limited. Given that Take Two is expected to work with children who may not yet be safe or have a consistent attachment figure or a stable placement (DHS, 2002), the challenge has been how to undertake such work effectively, contribute to improvement in the safety of the child and not cause further harm.

Another barrier is when a child's presentation, whilst complex, does not meet the criteria for a diagnosis. Perry (1999) concluded that children exposed to trauma may experience multiple trauma symptoms but not necessarily in sufficient number or combination to fit the PTSD diagnosis. This can be a barrier when diagnosis is the means to screen children's intake into mental health services. It is also a problem when therapeutic interventions (particularly EBTs) are based on matching the intervention to a specific diagnosis. Tarren-Sweeney and Hazell (2006) note that treatment studies may not generalise to children in the protection and care system as the mechanisms of trauma such as abuse and neglect may lead to a set of symptoms which may be different to those who were the subject of an EBT study.
The different processes that continue to make up the Take Two Practice Framework are portrayed in Figure 1. This illustrates that the Practice Framework is a dynamic and iterative process rather than a static document.

Development of Services for Aboriginal Children

From the outset, it was determined that one of the staff positions in the Take Two programme would be an Aboriginal clinician role. This was critical given the persistent over-representation of Aboriginal children in the protection and care system and the recognition of intergenerational trauma, resulting from past policies of forcibly removing Aboriginal children from their families and communities, known as the Stolen Generations (Human Rights and Equal Opportunities Commission, 1997). When it became clear that employing a sole Aboriginal position was not sustainable, a second designated role for an Aboriginal clinician was created in 2005. In 2008, Berry Street funded an expansion of the Take Two Aboriginal team to provide Aboriginal-specific consultation for Take Two clients and to train Aboriginal clinicians in therapeutic practice.

‘Although the whole development of Take Two has been a learning journey, this is nowhere more obvious than when working with Aboriginal children who have been traumatised. This has required some ‘unlearning’ as well as new learning, which has only been made possible through the Aboriginal staff and relationships with Aboriginal services.’ (Frederico et al., 2010, p. 59)

The Take Two Practice Framework

From the outset, we have had the challenge of determining and refining the selection of therapeutic interventions included within Take Two to achieve positive outcomes for this heterogeneously complex client group.

When strong evidence is not available, it is particularly important to develop a clear programme theory, which articulates a model of how the programme and its interventions intend to achieve the desired change. As such, we have undertaken an incremental approach to developing the overarching therapeutic model, referred to as the Practice Framework. A programme theory has two components: a theory of change – the mechanisms by which change is believed to occur; and a theory of action – how the programme is constructed to activate the theory of change (Funnell and Rogers, 2011).

We began by determining which theories shed light on the children’s situations in the context of maltreatment and in the context of the child protection and care system (Lieberman and Van Horn, 2004; Perry, 1999; Stahmer et al., 2005; Woolverton, 2002). Take Two’s theoretical base emphasises a developmental, cultural, bioecological and systems perspective when applying attachment and trauma theories (Frederico et al., 2010). As discussed in more detail below, Take Two’s focus of intervention extends beyond therapy with individual children/young people. Research demonstrates that up to 40 per cent of the improvement experienced by clients of psychotherapy can be attributed to client variables and ‘extra-therapeutic’
influences (Lambert, 2013). The child/young person's environment and the interaction with - and between - people and systems outside the therapy room are crucial for effective intervention. The consideration of multiple systems and the connections between them offers the clinician the choice of multiple points of intervention. For instance, an assessment may suggest that intervening with the carer and the care team might offer the greatest opportunity for change, rather than - or in addition to - direct therapy with the child/young person.

The ecological model was originally developed from the perspective of the developing child (Bronfenbrenner, 1992) and although it has been applied more broadly, the focus of the child as the centre is relevant to Take Two practice. A key aspect of the ecological perspective is that it is based on general systems theory and therefore explains the world in terms of transactions. More recent discussion of ecological theory has recognised the importance of knowledge gained from advances in several fields, including neurobiology (Green and McDermott, 2010) and epigenetics (Perry, 2006). This also promotes an understanding of the chronosystem – that the interaction between and within different systems may influence and be caused by effects beyond that particular point in time. For instance, early parenting will greatly influence brain architecture and the child's understanding of, and response to, the adult world.

In terms of its application beyond the basic consideration of the dynamics within and between systems, ecological theory guides clinicians' practice approach. Firstly, an ecological perspective to understanding abuse and neglect is not only concerned with negative consequences but also with resources, adaptations and strengths. It is more than a biopsychosocial approach as the focus is as much on the positive and difficult interactions between the systems as on the systems themselves. This perspective avoids locating the problem entirely within the individual or the environment.

Secondly, ecological theory directs the clinician to consider the child/young person's culture and the associated strengths and barriers. For instance, de Vries (1996) notes that research provides evidence of the positive role of culture in building resilience and ameliorating the effects of trauma.

Take Two clients have experienced a series of traumatic events. They may have grown up in threatening environments where their family may not always be able to provide care, comfort and protection and is the source of harm or is unable to protect them from harm. This can result in problems with self-regulation such as ‘…difficulties with anxious arousal, anger management, dissociative symptoms, and aggressive or socially avoidant behaviours’ (Cloitre et al., 2009, p. 400).

Affect regulation is developed through early attachment relationships. Ideally, an infant learns to regulate his or her affect through co-regulation with safe and secure adults. This provides the template for future emotional development (Frederico et al., 2010).

Children, young people and adults will have more capacity to self-regulate if they are surrounded by people who are trusted, familiar, in tune with them and safe. This is not just the case within families but also within communities.

There are sensitive periods in brain development where the brain is more susceptible to being shaped by experience. This is highly adaptive as it is this ability of the brain to change in response to experiences that enables children to
develop, grow and learn; however, when those experiences are traumatic and dysregulating, this sensitivity places future development in jeopardy (van der Kolk, 2005). It is important for a programme focused on children’s exposure to traumatising events to not only be aware of the impact of this trauma on their functioning but also on the inter-relationship with their development.

Key founding principles underlying Take Two’s Practice Framework are that the approach is both person-centred and culturally respectful. Enacting these principles into practice means ensuring that the voice of the child guides practice and that interventions are individualised and informed by the child's culture (Frederico et al., 2010).

The Take Two Practice Framework continues to be constructed over time using a recursive, action research-based process, as research and practice wisdom inform theory building within a cycle of open, transparent and rigorous reflective practice. The framework develops as clinicians and the leadership group develop skills as scientist practitioners in the evaluation and research of the efficacy of practice interventions (Downey, 2004, p. 2).

We have undertaken an ongoing review of the literature to explore and explain the mechanisms responsible for the wide-ranging harm experienced by children and the associated mechanisms responsible for achieving positive change (Cohen and Mannarino, 2010; Gimson and Trewhella, 2014). The programme is continually developing, and an action research approach is taken to ensure that learning informs the ongoing development of the programme. For example, at the time of establishment, new knowledge of neuroscience via contact with Dr Bruce Perry (personal communication, 14th September 2005) highlighted potential targets for change, such as how to increase physical and emotional regulation and how to build on the resilience of children and families. Overall, Take Two employs a biopsychosocial approach to consider the range of potential mechanisms responsible for harm and the mechanisms for buffering adversity and positive change.

**Practice Principles**

A set of practice principles was developed through engagement with stakeholders and informed by the literature (Downey, 2004). The development process included workshops with clinicians, community service organisations and child protection leaders. The process was also informed through consultation with experts in trauma and development and through continuous evaluation. The practice principles include:

- ‘Therapeutic intervention begins with establishing safety and reducing harm. If a child's safety is not assured, this is the first target of intervention.
- Engagement of clients is the responsibility of the service, not the client.
- A proactive, creative and persistent approach is required to form meaningful therapeutic relationships with children, families and carers.
- Interventions should be informed by a holistic and comprehensive assessment of the child, child's history and current circumstances.
- Interventions should consider a child's developmental readiness and the capacity of parents or carers to provide consistent, nurturing care.
- Therapy should be provided in the location most likely to facilitate engagement’ (Downey, 2004, pp. 33-34).
The following text offers a description of an intervention provided to a client of the Take Two Aboriginal team. This illustrates the complexities, variety and creativity of the work undertaken. It describes a holistic way of working with extended family and the community, adhering to protocols to ensure cultural safety, and the importance of being mindful of experiences of intergenerational trauma.

Sarah is a nine-year-old girl living with her Aboriginal carer, Mandy, but not with her five siblings.

On acceptance of Sarah's referral, a meeting was held with the involved professionals including child protection, the local Aboriginal organisation and carer. Utilisation of a culturally specific assessment tool assisted with the collation of information regarding Sarah's circumstances. Sarah's mother (Noreen) did not want to engage with mainstream services, due to her past experiences, however Sarah's uncle agreed to facilitate a meeting with her. He followed community protocols by approaching the chief executive officer of the Aboriginal mission where Noreen lived to request permission for a visit and by acting as an intermediary he was ‘vouching’ for the clinician.

Both Noreen and Mandy had been significantly traumatised as part of the Stolen Generations and ongoing experiences of trauma within their community. This resulted in mistrust towards mainstream, white professionals. The Aboriginal clinician, who had previous contact with Noreen through the Aboriginal community, was over time able to build a trusting relationship with her as demonstrated by Noreen's acceptance of the clinician into her home and to be alone with her children.

The clinician worked individually with Sarah and also undertook work with Sarah and Mandy as a dyad. Meetings occurred with Mandy before and after Sarah's individual sessions to ensure that Mandy was fully informed and engaged in the therapeutic process. The dyadic work focused on assisting each of them to share affection and to gain a better understanding of each other as their relationship was characterised by the traumatic relationship experiences that they had each experienced.

The clinician also worked systemically in providing psychoeducation to the staff at Sarah's school to assist them in engaging therapeutically with Sarah and also facilitated meetings with Sarah's siblings, keeping them connected despite geographical distance. Members of the local Aboriginal organisation worked together to develop an understanding of Sarah's familial connections through determining which community members had specific knowledge. (Names and some details have been changed to ensure anonymity.)

The ChildTrauma Academy's Neurosequential Model of Therapeutics (NMT) An approach to guide assessment and inform intervention planning was required that was sufficiently flexible to account for the heterogeneity of the client group and their frequently changing circumstances. Although assessment and formulation are part of the Take Two model, a diagnostic framework alone was not considered sufficient as many of the children do not fit particular diagnostic criteria (Frederico et al., 2010). The literature, along with extensive consultations, led us to conclude that Take Two needed a model that was (a) responsive to children of different ages and developmental stages, (b) informed by their history of trauma, positive experiences, vulnerabilities and strengths, and (c) able to adapt with the children if their placement or access to relationships changed. The model also needed to inform working with system issues (family, school and/or community) if these caused
difficulties for children's safety and growth, and to incorporate a diagnostic framework where appropriate and cultural lens when required.

Through a review of the literature, we found that the best match for this complex set of factors was the ChildTrauma Academy's NMT. This model developed by Dr Bruce Perry

‘helps match the nature and timing of specific therapeutic techniques to the developmental stage and brain region and neural networks mediating the neuropsychiatric problems’ (Perry and Hambrick, 2008, p. 38).

The NMT is not an intervention but provides a means of considering the best intervention ‘fit’ for the child's state and functioning (Perry and Hambrick, 2008), and is a promising approach to working with children of different ages who have experienced trauma (Brandt et al., 2012).

Take Two's Therapeutic Model
Take Two's overarching therapeutic model works in three overlapping but distinct ways to support recovery and positive change through relationships. A key assumption in the theory of change is that the child's development requires positive relationships (Perry and Hambrick, 2008) and that the process for change will be through relationships. The clinician's role enables others, such as family, carers and teachers, to be therapeutic in their interactions and responses when the child is distressed, angry, dysregulated or disconnected (Frederico et al., 2010). Additionally, Take Two works at the system level. This includes attempts to ensure that those around the child interact with them in a therapeutic manner, but also to advocate and challenge when concerns are held regarding aspects of the system which may traumatises the child further. Elements of the Practice Framework have been portrayed in a diagrammatic fashion (Frederico et al., 2010) and are informed through the programme theory lens. This illustration of Take Two's programme theory depicts the theory of change.

Funnell and Rogers (2011) note that the form of presentation and level of detail for a programme theory depend on its purpose. This portrayal of Take Two's programme theory aimed to clarify and communicate the targets of change with particular attention to the mechanisms for achieving these outcomes. This in turn reflects the mode of therapeutic interventions used to achieve this change.

As reflected in contract requirements and the programme theory, Take Two's therapeutic approach focuses on individual work with the child, as well as dyadic work with the child and parent or carer, family work and/or system work. Informed by assessment, the clinical decision-making process of the NMT and the client's wishes, a therapeutic plan is developed that enacts the mechanisms of change. The therapeutic plan incorporates therapeutic interventions including the sequence, timing and frequency of these interventions. Examples of interventions are: somatosensory activities (Dunn, 2007); family therapy interventions (Carr, 2000); play therapy (Gaskill and Perry, 2014); TF-CBT (Cohen and Mannarino, 2010); and eye movement and desensitisation reprocessing (EMDR) (Shapiro, 2001).

As most of these therapeutic interventions have not yet been subject to systematic reviews, or the reviews have been inconclusive, Take Two has"
continued to test its approach against the research findings and clinical experience, and to critically review its practice. There were three major evaluations of the work of Take Two covering the first ten years of the programme (Frederico et al., 2010), and there is a continuous analysis of clients' clinical outcome measures with an evaluation of interventions underway, namely, somatosensory interventions and EMDR. In addition, Take Two is an accredited health service and is regularly audited to ensure compliance with the Australian Council of Healthcare Standards.

An Evidence-Based Practice Framework for Complex Child Protection Clients

The experience of developing the Take Two Practice Framework demonstrates the value of acknowledging that, in working with children traumatised by abuse, multiple interventions need to be able to be accommodated in a practice framework whilst ensuring that the approach is evidence-informed and building evidence of effectiveness. The role of complexity theory in providing a lens for understanding this process is described by Stevens and Cox (2008) and highlights the importance of understanding the processes involved in working with multiple factors.

A single intervention, even if evidence based or evidence informed, is unlikely to provide an effective intervention for all clients. Further, experience has demonstrated that a linear approach to designing a practice framework is inappropriate given the multiple variables impacting upon the children and their situation (Stevens and Cox, 2008).

In articulating the theory of change and programme theory, the Take Two Practice Framework demonstrates an effective process for creating practice which is evidence informed and at the same time can accommodate multiple interventions, and provides a guide for managing multiple variables. As Stevens and Cox (2008) highlight, complexity theory assists in understanding the uniqueness of each child in the child protection system and the multiple variables which are impacting upon them. This means that, with the current state of knowledge, we cannot prescribe a single model or intervention. Even if it is possible to know all the variables, the fusion of the variables for each child will produce a new and unique situation. The process of the development of the Take Two Practice Framework provides an approach for the development of other programmes for vulnerable populations where the programmes are struggling to apply and/or develop EBP.

Conclusion

The Take Two programme and its Practice Framework aim to help clinicians make sense of what happens when childhood is characterised by violence and deprivation. In doing so, clinicians are supported to develop targeted interventions to facilitate healing from abuse and neglect. EIP is an important lens to consider, however the state and strength of the evidence are insufficient at this time, and so other elements of the Practice Framework have been given weight, such as the experiences of clinicians and clients. Take Two is informed by and contributes to the emerging evidence with children, their families and
their carers through the implementation of this Practice Framework, and provides a guide for others establishing programmes with similar aims. As the Practice Framework is further refined and defined, the comparative contributions of its intervention components should be identified for specific evaluation.

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References


