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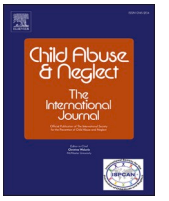

Foster carers' perspective on trauma-informed practice in out-of-home care

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ABSTRACT

Background: When children and young people are unable to live with their family, they are placed into out-of-home care (OoHC). Almost all children and young people in OoHC have experienced trauma, which has well-documented negative impacts on current and future functioning of the individual.
Objective: This study aimed to explore trauma-informed practices in OoHC from the unique perspective of foster carers, and how these practices impacted their day-to-day care of vulnerable children and young people.
Participants & methods: Twelve foster carers in Australia were interviewed using a semi-structured interview schedule and the interviews were analysed using thematic analysis.
Results: Four themes were identified in the data: (1) Exploring the diversity of trauma; (2) Trauma-informed practice in action; (3) Roadblocks to trauma-informed practice; and (4) Enablers of trauma-informed practice.
Conclusion: Results demonstrated that systemic change is required to support foster carers to implement trauma-informed practice in their day-to-day care of vulnerable children. Future research should consider evaluation of initial foster carer training.

1. Introduction

In Australia, out-of-home care (OoHC) is defined as "overnight care for children aged under 18 who are unable to live with their families due to child safety concerns" (Australian Institute of Health and Welfare [AIHW], 2022 p.12). According to the AIHW (2025a), there were approximately 44,999 children living in OoHC as of June 30, 2024, a decrease of 2% since 2022 (AIHW, 2022). Most children in OoHC reside in home-based care placements, which consist of kinship care (55%) and foster care (32%; AIHW, 2025a). Kinship care is when a child or young person cannot live at home but is cared for by a relative, close family friend, or member of the community known to the child (AIHW, 2022). In comparison, foster carers have been trained, assessed, and accredited by a foster care agency, which supports them to care for children with whom they have no previous connection (AIHW, 2022). This study will focus on foster carers and their unique experiences with trauma-informed practice, exploring how this may impact how they care for children and young people in OoHC. The term 'children in care' will be used to refer to children and young people in foster care specifically.

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1.1. Children and young people in out-of-home care in Australia

Out-of-home care is a last resort for children and young people who are unable to live with their birth family (AIHW, 2022). Children are typically placed into OoHC due to a substantiation of abuse, where the relevant child protection authority has determined that "there is reasonable cause to believe that a child has been, is being, or is likely to be abused, neglected or otherwise harmed" (AIHW, 2022, p. 9). In Australia, the number of substantiations in the year 2023–2024 has decreased slightly from 2018 to 2019, with parental/familial emotional abuse and neglect being the most common experiences for children (AIHW, 2025b). These prolonged and repeated abuse or neglect experiences within a child's caregiving system are referred to as complex trauma, which can have long-lasting impacts on many areas of a child's life including their brain development, sense of self, emotional and behavioural regulation, and their ability to attach to a caregiver (Spinazzola et al., 2007; van der Kolk, 2007).

Most children in the general community experience a secure attachment to a primary caregiver or parent in early life. A secure attachment style allows children to recognise a caregiver as a 'secure base', whom they can rely on for safety and comfort and from whom they can model how to regulate their emotions and behaviours (Bowlby, 1969). When a child experiences abuse and/or neglect within that relationship and is unable to feel safe, they may develop avoidant or resisting behaviours to survive and protect themselves from further harm (Conley Wright & Kong, 2023). Even in the safe environment of a foster carers home, children in OoHC can be detached, indiscriminately affectionate, avoidant, and physically violent toward their carers, which can be challenging for foster carers (Lieberman, 2003; Tarren-Sweeney, 2008; Withington et al., 2016). A review by Tarren-Sweeney (2008) found that children in care were three to four times more likely to have clinically significant levels of behaviour problems reported by their carer than children in the general community. Australian and international research has also reported that children in OoHC experience higher rates of mental health concerns including suicidality and self-harm, higher rates of problem sexual behaviour, anti-social behaviour, involvement with the criminal justice system, and lower levels of educational achievement and employment than the general population (Carbone et al., 2007; Gypen et al., 2017; Sawyer et al., 2007; Sullivan & van Zyl, 2008; Walsh et al., 2018; York & Jones, 2017).

Asif et al. (2024) conducted the Pathways of Care Longitudinal Study (POCLS), the first large-scale longitudinal study of children in out-of-home care in Australia. Placement stability, defined as the maintenance of a child's living situation in terms of adults he or she lives with (Pecora et al., 2006), was identified as a key factor associated with positive developmental outcomes for children in care (Asif et al., 2024). Asif et al. (2024) and Rubin et al. (2007) have found that placement stability increased the probability that a child will experience positive social, emotional, and behavioural outcomes, fine and gross motor skill development, and non-verbal thinking skills. This is consistent with suggestions by Pereira et al. (2025) that positive carer-child relationships can enhance wellbeing and lead to positive outcomes for both children in care and their carers. Asif et al. (2024) also found that foster carer satisfaction is a protective factor for improved developmental outcomes of children in care (). When carers were able to reach their foster care agency workers, were provided with assistance, and had sufficient information about the child in their care, a child's social and emotional development was more likely to be in the expected range for their age (Asif et al., 2024). In comparison, Asif et al. (2024) found that children placed with carers who were experiencing moderate to high levels of stress were more likely to have poor social, emotional, and language development, consistent with the literature (Brown et al., 2019; Tarren-Sweeney, 2008). Contributors to stress of foster carers include lack of agency support and increased strain on their family and social supports (Adams et al., 2018; Cooley et al., 2015; McKeough et al., 2017; Riggs, 2021; Withington et al., 2016).

Research has demonstrated that Australian foster carers experience high levels of stress and poor mental health, as the needs of the foster child often take priority over the needs of the carer, including at times, their own families (Adams et al., 2018; Harding et al., 2018; McKeough et al., 2017; Riggs, 2021; Withington et al., 2016). Over time, many foster carers experience emotional exhaustion as they are repeatedly exposed to the trauma and emotional burden of the child in care, which can lead to feelings of physical exhaustion, frustration, depression, and feelings of inadequacy (Hannah & Woolgar, 2018; Riggs, 2021). These experiences are reflective of global trends of the mental health challenges experienced by carers of children in OoHC (Chibana et al., 2025). Drawing on the POCLS data, Ryder et al. (2022) found 12–20% of Australian carers experience reduced wellbeing, which is further compounded by pressures such as work commitments and additional caregiving responsibilities, while carer satisfaction with caseworker support appeared to result in more favourable wellbeing. These experiences can result in 'blocked care', which is when a carer is no longer able to provide positive emotional and physical responses to a child due to that child's negative behaviour or responses to the caregiver (Esaki et al., 2013; Hughes et al., 2012; O'Hara, 2019). As a result of blocked care, breakdown of a foster care placement can occur, as well as placement instability, when a child experiences frequent moves or disruptions to placement (Adams et al., 2018; Brown & Bednar, 2006; Tarren-Sweeney, 2008).

Placement instability has been identified as a contributor to poor educational, physical and mental health outcomes for children in care (Tarren-Sweeney, 2008; Unrau et al., 2008). Over the last five years, the overall number of available foster carer households in Australia has decreased on average by 13.6% (AIHW, 2022). In 2020–2021, 315 households in Victoria were accredited, while 580 households exited, demonstrating that the number of available placements in Victoria is declining (AIHW, 2022). A meta-analysis drawing on international data showed that the prevalence of foster care placement breakdown is approximately 26.3% (Eltink et al., 2025). An effective working relationship and the identification and provision of early supports for foster carers is vital in increasing placement stability and improving outcomes for children in care (Adams et al., 2018; Asif et al., 2024; Bloom, 2017). Knight (2018) stated that trauma-informed practice models should also ensure children feel empowered and have a sense of control of their lives and be able to experience trust with adult figures through consistent boundaries, transparency, and confidentiality. Trauma-informed practices aim to build the capacity of foster carers so that they can appropriately care for children in OoHC, improving the child's life outcomes, and reducing long-term costs and needs for services (Bloom, 2016; Hanson & Lang, 2016; Lotty et al., 2020).

1.2. Trauma-informed practice

Trauma-informed practice (TIP), also referred to as trauma-informed care or approach, is the notion that services such as mental health, child welfare, and education need to be conscious, understanding, and responsive to the potential impact of trauma on individuals (Hanson & Lang, 2016). In OoHC, mandatory training for Victorian foster carers aligns with the popular 'four Rs' approach of TIP (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; The Association of Children's Welfare Agencies [ACWA], 2017a, ACWA, 2017b). This model includes supporting carers to realise the prevalence and impact of trauma on children in care, recognising and responding appropriately to the signs and symptoms of trauma, and preventing re-traumatisation, which is the recurrence and re-experience of trauma (ACWA, 2017a, 2017b; Kezelman & Stravropoulous, 2012; SAMHSA, 2014). When provided with trauma-informed training, research has shown that foster carers report fewer behavioural problems exhibited by the children in their care, greater carer wellbeing and satisfaction, and improved parenting skills (Akin et al., 2017; Lotty et al., 2020; Randle et al., 2017; Solomon et al., 2017). Current literature identifies a gap in research into the implementation of trauma-informed programs in foster care systems (Solomon et al., 2017).

In Australia, several trauma-informed models have been adopted by government departments for state and territory wide implementation in OoHC, however these models have exclusively been used and evaluated in residential care settings (Esaki et al., 2013; Galvin et al., 2021). A review of trauma-informed models in residential care has demonstrated some evidence of positive outcomes for children (Bailey et al., 2019). Evidence based research is still lacking however, with the models adopted by Australian government departments for residential care commonly referred to as evidence-informed (Esaki et al., 2013; Galvin et al., 2021). These preliminary results may be applicable to children in foster care, however further research is needed. Treatment and Care of Kids (TrACK) (Gatwiri et al., 2019) and Treatment Foster Care Oregon (Department of Families, Fairness, and Housing, [DFFH], 2022) are examples of therapeutic models used within foster care programs in Australia, however implementation and evaluation of these programs is even more limited than programs used in residential care (Cooper et al., 2023; DFFH, 2022; Frederico et al., 2017; Gatwiri et al., 2019). Galvin et al. (2021) examined the implementation of one of these models, the Sanctuary Model, across residential care programs in Australia. The results found that a lack of practice-based and ongoing training, limited resources, and poor model fidelity created barriers to the implementation of TIPs. These results may be applicable to children in foster care; however, the research is not available.

1.3. Study aim and research questions

Recent research in Australia and internationally has highlighted the benefits of trauma-informed care for children in foster care, while also emphasising the need for broader systemic support. Cooper et al. (2023) examined TIP among foster and kinship carers in Victoria and found that although carers viewed these approaches as beneficial, substantial system-level change is required to better support their implementation. Similarly, Lotty et al. (2020) reported that Irish foster carers were broadly supportive of trauma-informed care but identified the need for accessible, flexible educational programs, and recommended that caseworkers receive dedicated training to effectively support TIP. Across both studies, the need for system-wide trauma-informed approaches emerged as a consistent and critical theme. This study aims to examine Australian foster carers' understanding and experience of TIPs in their day-to-day caring of children and young people in OoHC. The potential implications of this study would be to further understanding of the experiences of foster carers when implementing trauma-informed care. Results of this study have the potential to improve day-to-day implementation of TIPs for foster carers, through provision of support which may lead to improved outcomes for children in care. The research questions for this study include:

- How do foster carers understand trauma and its impact on children and young people in OoHC?
- What are foster carers' experiences of implementation of TIP, if any, including training and supports from their agency?
- What barriers or supports impact the implementation of TIP in foster care, if any?

2. Method

2.1. Researchers and positionality

The first author is a provisional psychologist registered with the Psychology Board of Australia, has extensive experience in the OoHC system, and has been trained in the method and analysis used in the current study. The first author has significant knowledge of the Australian OoHC sector, including familiarity with policies, services, and the lived experiences of children and foster carers. This in-depth knowledge and experience may have shaped how the first author understood and interpreted data arising from this project. The study was overseen by the second author who is a registered psychologist with the Psychology Board of Australia and has published several works using qualitative research to explore staff experiences of TIP. The second author does not have direct experience working in the OoHC sector, however does have extensive experience researching trauma-informed approaches for children exposed to trauma. Although both authors collaboratively designed the study and analysed the data, helping to reduce potential bias, it remains important to consider their positional perspectives when interpreting the findings. For example, the first author's professional experience may have heightened their sensitivity to the challenges foster carers face and the systemic barriers to implementing trauma-informed care, while the second author may have approached the data with a more optimistic orientation toward the potential benefits of trauma-informed care in the foster care sector.

2.2. Participants

Participants included nine females and three males who were registered as foster carers. Participants had a foster child in their care at the time of the interview or within the previous six months. This inclusion criterion was used to increase the likelihood that participants would be able to provide recent experiences of their use (or not) of TIP in the OoHC system. To preserve anonymity of participants and foster care agencies, participants were randomly assigned a number and were not asked to identify their foster care agency during the interview. Table 1 outlines the demographic information of the participants, including information on how long the participants have been registered as foster carers and the types of foster care placements they provide. In the current study, participants reported providing a range of care to children. This included respite care, which is defined as short-term and/or intermittent care, typically for a weekend a month, or as required (Department of Health and Human Services [DHHS], 2017), as well as emergency care, which is classified as typically one night, where immediate care is required due to safety concerns for the child (DHHS, 2017). Provision of short-term care is typically overnight to six months, and long-term care is classified as a placement of over six months in duration (DHHS, 2017). Therapeutic care is with carers who can provide any of the care arrangements previously listed, but are provided with additional training, support, and financial assistance (DHHS, 2017).

2.3. Materials and procedure

Ethics approval was granted by the [removed for blind review] Human Research Ethics Committee (Project ID: 37460). Three managers and one team leader across four different foster care agencies were contacted via their direct email, obtained through professional contacts of the first author. One support group for foster carers was also contacted via the email address available on their website. Five emails with a summary of the research were initially sent, as well as a request to post an advertisement online. Snowballing was also used, which involved asking agencies and participants to share information about the study with their contacts who met the recruitment criteria. Twelve participants who expressed interest to participate were contacted by the researchers. The participants were offered the opportunity to ask questions and their eligibility was confirmed. Following this, an interview time was scheduled, and all twelve participants participated in a semi-structured online interview via Zoom. Verbal consent before the interview was provided by the participants.

Interviews were guided using a semi-structured interview schedule developed through consultation between the two authors and based on the second author's significant research in the field of TIP. Open-ended questions, such as “What does your foster care agency do to support you in implementing TIP in your home, if anything?” were used. Prompting questions were also used, however these are not specifically included in the interview schedule as these questions varied for each interview. The interview schedule has been included as a supplementary document to this article.

Interviews lasted between 24 and 89 min, with a mean interview time of 43 min. Audio was recorded by Zoom, transcribed via Otter.Ai and then checked by the first author for accuracy. Audio-recordings and transcriptions of the interviews were stored on a password-protected computer of the first author. Interview transcripts were then emailed to the participants, who were provided at least two weeks to review and confirm the content of the transcript (a process known as member checking). Specifically, the participants were prompted to review and provide any additional comments, to clarify comments already made, or to request that comments be removed from their transcript. Four confirmed no changes were required, one responded with five changes, including one clarification and four corrections of single words, such as “tricked” instead of “trigger”. These changes were accepted and did not have any significant bearings on the meaning of interview data. Seven participants did not respond to the email inviting them to check their data. All data were retained for analysis.

Table 1
Participant demographic information.

Participant	Gender	Age	Ethnicity	Years registered as a foster carer	Type of foster care placement typically provided	
Grace	Female	31–40	European-Australian	5–7	Long Term Short Term	Emergency Therapeutic
Naomi	Female	60–64	European-Australian	20+	Long Term	Short Term
Sam	Male	41–45	European-Australian	5–7	Long Term Respite	Emergency
Rachel	Female	41–45	Aboriginal-Australian	5–7	Long Term	Therapeutic
Jason	Male	21–25	Australian	0–4	Long Term Therapeutic	Short Term
Lyla	Female	31–40	Australian	5–7	Long Term Emergency Therapeutic	Short Term Respite
Kate	Female	31–40	Australian	0–4	Emergency	Respite
Madisyn	Female	60–64	European-American	0–4	Long Term Respite	Emergency
Georgie	Female	41–45	Australian	5–7	Short Term	Respite
Helen	Female	50–55	Australian	0–4	Short Term	Respite
Scott	Male	31–40	Australian	5–7	Long Term	
Anna	Female	31–40	Australian	0–4	Long Term	Short Term

3. Design and analysis

A qualitative research design was used, and data were analysed using inductive thematic analysis, which involved the collection and analysis of data without predetermined categories. Analysis was conducted in several stages based on the stages of Braun and Clarke (2006). The first author undertook an initial immersion in the data through repeated reading of the transcripts before generating preliminary codes, which were organised in an Excel spreadsheet. Coding was conducted iteratively and in regular consultation with the second author to promote reflexivity and analytic depth. To enhance transparency and reflexivity, the first author also maintained a reflexive journal documenting their assumptions, interpretive decisions, and rationale, which were discussed with the second author throughout the analytic process.

To further strengthen the credibility of the analysis, a third researcher independently reviewed two transcripts and generated a set of themes. Their interpretations were compared with the primary analysis, and no additional themes were identified. The first author developed overarching themes and subthemes, which were subsequently reviewed and verified by the second author. The analytic process was reviewed against the trustworthiness criteria described by Nowell et al. (2017). In line with these recommendations, multiple strategies were used to enhance the rigour and credibility of the study, including independent and collaborative data analysis by multiple researchers, ongoing review of data collection and analytic decisions by several researchers, explicit reporting of the sample demographics and limitations regarding generalisability, and detailed documentation of researcher reflexivity.

4. Results

Four overarching themes and nine sub themes were identified through thematic analysis. These are summarised in Table 2. Each theme will be described under the related research question. Quotes are also provided in the results to demonstrate participant experiences.

RQ1: How do foster carers understand trauma and its impact on children and young people in OoHC?

4.1. Exploring the diversity of trauma

4.1.1. Recognising trauma

When defining trauma, participants commonly referred to historical experiences which have negatively impacted a young person. Anna defined trauma as "… when there's a stressful, um or traumatic event that happens, um that isn't processed well, and creates trauma, I suppose, or broken stress in someone's life".

All participants interviewed acknowledged that children in care have experienced significant trauma and previous experiences of abuse including, but not limited to physical, emotional, and sexual abuse, neglect, exposure to family violence, substance abuse, and parental mental health concerns.

Participants consistently described the impact trauma has across multiple areas of a young person's life. It was also acknowledged among participants that trauma manifests differently for each young person, which can make it difficult to know how best to respond. Lyla noted "Trauma is...has no set criteria. It can look like anything". Grace also commented "Everyone's trauma's different, and it presents differently".

4.1.2. The impact of trauma

Participants discussed the varied and complex needs of children in OoHC when compared to the general population, including their own children, due to their early life experiences. Jason explained "Pretty well all your normal practices are changed… usual practices for non-trauma kids can um trigger kids who have trauma and causes issues".

Participants reported that typical use of consequences and discipline were not appropriate for children in care and commented on the hypervigilance, persistence, and ongoing management of risk required as a foster carer. Sam stated that a child in his care was always "hypervigilant" when exposed to situations that reminded him of his trauma.

Participants also reported that children in care demonstrate a lack of trust in others and have limited understanding of positive

Table 2
Overarching themes and subthemes.

Overarching theme	Subtheme
1. Exploring the diversity of trauma	Recognising trauma
	The impact of trauma
	The impact on relationships
	The impact on emotional wellbeing
2. Trauma-informed practice in action	From the foster carers' perspective
	Within services and systems
3. Roadblocks to trauma-informed practice	The hours and dollars of caring
	Communication breakdown
	The complexities and challenges of services
4. Enablers of trauma-informed practice	System and service supports
	Support from the community

relationships, which can impact a carer's ability to connect with a young person in their care.

Participants described difficulties or lack of ability for children to regulate their emotions. Helen reported "it's very hard for them, the big- either to express them (emotions) or expressing them overly so. Just having a big blowout or meltdown can happen often".

Physical aggression and physical violence were also commonly reported, and some carers reported that these behaviours resulted in children having reduced hours at school.

RQ2: What are foster carers experiences of implementation of trauma-informed practice, if any, including training and supports from their agency?

4.2. Trauma-informed practice in action

4.2.1. From the foster carers' perspective

Participants commonly defined TIP as acknowledging and making considerations regarding the trauma that children in their care have experienced. Scott stated "Yeah, I mean, it's a term that's thrown around a lot. But I think it's probably thrown around a little too much, um and it probably has lost a lot of meaning".

Four of the 12 participants specifically referred to trauma's impact on behaviour, and two participants didn't know how to define TIP. Participants recognised the importance of providing routine and consistency for children who have experienced trauma. Examples of this included Helen, who spoke about having a visual schedule on the fridge of the meals for the week, "They want to know, when, what time is breakfast every day, what time is dinner, what is for dinner, like having a menu on the fridge and having the same time every day for dinner".

Georgie referred to letting children know ahead of time what the plan for the next day is, "The easiest way to deal with those behaviours is to plan or to make sure you detail out what we're thinking of doing for the next day, rather than surprising them."

Participants also spoke about accommodations they made to meet the child at their developmental age rather than chronological age, as their development had been negatively impacted by traumatic experiences. Sam and Jason both referred to examples where they had fed a child with a spoon, who would typically be considered old enough to independently feed themselves with utensils. Sam stated, "I went back to spoon feeding him, even though he was four and then turning five, spoon feeding him, you know he's not a baby anymore".

Participants also mentioned that allowing additional time and taking breaks between daily tasks and activities helped them to provide support with emotional and behavioural regulation. Jason said:

> I always try and allow that time because if there is an issue that arises, I think, if we're late for school, that's okay, if we're late for all different things, that's fine. I just have to focus on this child in this moment.

Participants spoke about a negative stigma and judgement that can be experienced in the community when a child is exhibiting challenging behaviours, as they manage the behaviour differently for a child who has experienced trauma. Rachel stated:

> There's a lot of behaviour that I overlook that I can see people kind of going, like "Why is she like, letting them do that or why isn't she just stopping them or disciplining them?" I mean, it's not, it's not that simple.

Participants also spoke about the importance of clear and honest communication in TIP. Lyla said, "I build really honest open relationships with my kids, regardless, like of their age."

Empowerment of the child or young person to make their own choices was also commonly discussed, such as participants allowing the young person to have complete control over their bedroom or contributing to the development of house rules. Sam commented, "when they're home, at least they're meant to be getting in trouble and doing-, making silly choices."

Participation in both self-sourced and agency-provided training was discussed, including TakeTwo, Triple P, Nikara's Journey, and Mental Health First Aid for teens.

Many participants reported feeling quite equipped to support children who have experienced trauma; however, it was commonly mentioned that this ability was developed over time as their care experience grew rather than as a result of direct training or supports offered by their agencies. Scott stated, "When I first entered my, I guess, caring role as a foster carer, it was a bit of a baptism by fire".

4.2.2. Within systems and services

Agency policies and procedures were referenced as examples of TIP, such as yearly checks of the home environment conducted by the foster care agency to ensure physical safety of children in OoHC and requirements for police checks for adults in the home. Naomi stated, "You know, often they'll have things around safe home environments and police checks for visitors to the home".

Other examples of TIP within foster care agencies included the provision of care team meetings, which are meetings between other people or parties responsible for the outcomes of a child including school, family, child protection and foster carers (DHHS, 2017). Grace reported, "we do monthly meetings…every month there's a new topic, whether that's based around a behaviour or a challenge that we experience at home".

Collaboration with and referral to services as well as supervision were also examples provided. Unfortunately, participants, including Kate who provides primarily respite care, identified that this support offered by case managers was inconsistent.

Frequent turn-over of staff and new case managers with limited experiences were noted to be challenging for participants. She reported "Some are really proactive and check in with you straight away and offer strategies and support and some are more just kind of going through the motions."

Three of the 12 participants also referred to their initial Shared Lives training as an example of TIP, however these participants

noted that little follow up or refresher training in relation to trauma had been provided by their agency.

RQ3: What barriers or supports impact the implementation of trauma-informed practice in foster care, if any?

4.3. Roadblocks to trauma-informed practice

4.3.1. The hours and dollars of care

Participants reported a lack of time as a barrier to TIP, impacting their ability to access ongoing training and implement strategies and routines in the home. Participants discussed reducing or ceasing paid employment to provide them with the time to implement trauma-informed care. Scott stated "I quit my job" to support a young person to attend school and Grace reported "Me taking time off work has not only helped the child immensely, it's helped the child's school, it's helped the foster agency, it's helped myself, it's helped my family". While some participants were able to adjust or decrease their work, Rachel identified the loss in annual leave, superannuation, and career progression she had experienced due to her caring role, stating "It's kind of extremely big impact on me financially, for the long term".

Participants commonly identified financial support as a barrier. Foster carers receive a fortnightly care allowance from DHHS which is intended to contribute to a range of day-to-day expenses associated with providing care for a child in OoHC (DHHS, 2017). Participants often described this support as insufficient, reporting they were unable to afford things such as after school activities or training. Lyla stated:

> "I have to work financially because my carer payment doesn't cover the cost of living at the moment for kids... But I think if I could reduce my hours more where, you know, during the day, I could cook dinner, clean and then be really present with the kids... I think that would be helpful".

Additional funding is also available in exceptional circumstances, for items or services that exceed the carer allowance and/or create a financial burden for the foster carer (DHHS, 2017), however participants noted this was often difficult and often required negotiation with Child Protection and their agency. Helen said "Whatever you get from the department, you tend to really have to push for". Participants also discussed unreasonable expectations placed on them to pay for services for a child, such as ongoing therapy. When additional funding was approved, participants also noted there were often administrative delays, resulting in participants waiting months to be reimbursed by Child Protection or their foster care agency for costs. Jason stated, "Reimbursements … we've had countless issues with those, had a placement which was unpaid for two months, with two kids, which was hard on us, it put us in a financial hole".

4.3.2. The complexities and challenges of services

While participants were encouraged to access publicly funded services due to limited funding, many participants reported it was very difficult or the children in their care were unable to access services such as the National Disability Insurance Scheme, Centrelink, and the Pharmaceutical Benefit Scheme (PBS) due to documentation. Birth certificates or Medicare cards were either unavailable to the foster carers or had incorrect names. Grace said, "We've had no birth certificate for a five-year-old. That took over 12 months to get. We've had PBS not funded for children."

Another barrier was lack of support, with Naomi saying, "You may see them once a fortnight, or a month for a CTM (care team meeting), but you don't have the 'hands on' with your workers like you used to".

Participants also spoke to the variability of case managers within their agency. While support from a case manager was also identified as a facilitator, inexperienced and/or frequently changing case managers were identified as a barrier. Helen reported:

> The caseworker really makes a difference. I find some caseworkers are a whole lot better than others. I think they've had their own challenges, that they're pressured for time, and their caseloads can be huge, so not necessarily their fault.

4.3.3. Communication breakdown

Despite providing 24/7 care for children, participants commonly reported getting appropriate information about the children in their care was difficult, with Rachel referring to it as "like putting a puzzle piece together along the way". As a respite carer, Kate reported:

> They describe it as a "needs to know basic, ah basis", but a lot of the time they're, they come to us when they're already desperate for help. And they don't really have the build-up of information before the respite happens.

Participants noted they were often only told important information about a child's history after something had upset the child. Anna said, "Ideally, to be able to also look at history and anticipate things that may or may not be a challenge in the future." Participants also described feeling as though their opinion or thoughts weren't valued in the care planning of a child.

Participants commonly discussed the frustration and additional effort required to advocate for the needs of the child in their care, where they felt that Child Protection or their agency weren't listening. Sam spoke about his experience being excluded from meetings because he was not considered a "professional". When collaboration and communication with agencies was present, it was identified as a facilitator by participants. Lyla said "as a carer, I'm- they take on what I say in terms of, I know, myself knowing the child better, the best out of all of them".

4.4. Enablers of trauma-informed practice

4.4.1. System and service supports

In addition to collaboration and communication participants noted access to therapeutic services, such as a psychologist or play therapist, as facilitators to TIP. Four of the 12 participants identified as carers within a therapeutic program, which comes with increased therapeutic support. Jason reported "There's extra training and accreditation and you work with two case workers in that program which is really helpful".

When reflecting on the additional training provided as a foster carer in a therapeutic carer, Lyla said "I think that's helped me to be really present with children when they're having meltdowns".

Provision of timely supports, including debriefing with a case manager or practical supports when a child isn't attending school, was also noted as helpful to TIP. Participants reported that a supportive case manager allowed them to discuss alternative strategies. Anna said, "We talk about them with our case manager and she sometimes has some feedback or suggestions that are trauma informed, which have occasionally been helpful."

4.4.2. Supports from the community

Support from friends, family, and other carers were identified as facilitators to TIP. Participants reported that talking to other foster carers helped them to come up with new ways to support a child and provided the opportunity to debrief. Scott noted that having family who were willing to provide respite was beneficial, as staying with familiar people was much more common than staying with strangers, "Extra support around carers, particularly if they have any family, kind of that natural network support".

Where participants were in formal employment, flexible and understanding workplaces were helpful. Jason discussed how he was sometimes late to work, due to driving the children in his care to their childcare providers which were a significant distance from him and this resulted in him changing employment:

> My previous employment, had some issues, which is how come I left that job. I was late quite often, just with childcare drop-off, I've had lots of issues with that child in our care so I had to have that time with him.

5. Discussion

The aim of TIP is to build the capacity of foster carers to care for children in OoHC. This consequently improves the child's life outcomes, reducing long-term costs and needs for services (Bloom, 2016; Hanson & Lang, 2016; Lotty et al., 2020). This study aimed to examine foster carer's understanding and experience of TIP in their day-to-day caring of children and young people in OoHC. Interviews with the participants revealed that there was a general understanding of trauma and how this has impacted the young people in their care, which is vital in being trauma-informed (SAMHSA, 2014). Participants could identify examples of TIP within both their agency protocol and their own care of individual children. Participants noted that their competence in caring for children with trauma typically came from experience, rather than any specific training provided by their agency. Efforts by participants to be trauma-informed were reportedly often impeded by the foster care system, suggesting a need for systemic change, consistent with previous research (Cooper et al., 2023).

This study identified that when commencing their fostering journey, participants felt unprepared to care for a child who had experienced trauma. They reported that their TIP was developed due to their fostering experience and seeking their own training. This finding is supported by the existing literature which found basic training for foster carers was inadequate in preparing them for the challenges they were likely to face (McKeough et al., 2017). The participants in this study highlighted that additional training for foster carers is helpful in providing appropriate, trauma-informed care to children in OoHC, including training on the impact of trauma, understanding mental health, and improving parenting skills. Trauma-informed psychoeducational programs for foster carers have demonstrated benefits including increased self-efficacy, parenting skills, wellbeing, and satisfaction in their caregiving role (Lotty, Dunn-Galvin and Bantry-White, 2020; Randle et al., 2017; Solomon et al., 2017). However, it is clear from the results of this study that such training programs are not universally or are inadequately implemented across foster care systems.

In addition to the benefits experienced by foster carers, children in care also benefit from improved placement stability and positive mental health associated with high quality foster care (Akin et al., 2017; Solomon et al., 2017). However, when additional TIP training was offered by foster care agencies, participants reported it was difficult to access. Problems accessing services and support for children in care was a common theme reported across the results, such as challenges accessing mental health support, disability support, and general funding and carer training to improve support of children in care. In light of these systemic challenges and pressures on foster carers, it is unclear how current TIP training programs account for carer wellbeing in the implementation of TIP. New and existing education programs should include information and resources designed to increase carer wellbeing, as well as their competence and knowledge to deliver TIP.

In the current study, participants reported inconsistent levels of support from their agency, often needing to negotiate or advocate for appropriate supports for themselves or the child in their care. Lack of financial support was the most reported barrier to accessing appropriate services to support the child in their care. This is supported by the existing literature in foster care and residential care (Cooper et al., 2023; Galvin et al., 2021). Participants also described feeling left out of decision-making for the child in their care, consistent with previous research (Cooper et al., 2023). The findings of this research corroborate previous studies that have demonstrated inadequate supports from foster care agencies lead to carers feeling unheard and can negatively contribute to foster carer stress. These systemic factors are vital in supporting the retention of carers (McKeough et al., 2017). In the context of the increasing

number of children entering care - and the decreasing number of available foster care placements - these results highlight the need for further exploration into foster care agency policies and supports, as it is unclear how current approaches account for carer wellbeing and retention.

5.1. Limitations

A limitation of this study is that the participants may not be representative of the foster carer population as snowballing and convenience sampling was used. While there was variation in age, gender, ethnicity, and caring experience, bias may also be present in the sample as individuals who had an interest in TIP were more likely to volunteer. Future research should consider looking at a representative sample to ensure the results can be considered representative of foster carers.

Another variable which may have impacted the participants experience of TIP is their foster care agency. Foster care agencies offer different supports based on the size of their program and resources available to them. This was demonstrated in the experience of participants who were foster carers within a therapeutic program. Future considerations may look at exploring TIP within a single foster care agency to explore the specific supports offered. However, it is also noted that this may lead to further difficulties with confidentiality and researchers would need to be mindful of this.

6. Conclusion

This research aimed to explore the understanding and experience of foster carers in the implementation of TIP. Participants expressed their knowledge of trauma and its impact on children in care. They also reported that financial constraints, the need for advocacy, and system challenges were their greatest barriers to implementing trauma-informed care. New and existing programs and foster care agency policies should include information and resources designed to increase the competence and knowledge of foster carers in TIP. It is currently unclear how current supports account for foster carer wellbeing. Existing examples in the literature, such as Mockingbird Family Model (McLaren et al., 2024), may provide an appropriate avenue for foster carers to further explore these challenges and build their capacity to support child wellbeing and their own mental health in the context of their foster carer role.

CRediT authorship contribution statement

Dana Santon: Writing – original draft, Methodology, Investigation, Formal analysis, Data curation. **Emily Berger:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Data curation, Conceptualization.

Data availability

The authors do not have permission to share data.

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