TRIPLE-A

MODEL OF THERAPEUTIC CARE

Evidence & Practice Foundation

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External research foundations + direct Triple-A evidence + implementation history

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This document is an evidence-position statement. It does not claim regulatory endorsement, independent validation, or guaranteed clinical outcomes.

1. Purpose and evidence position

The Triple-A Model of Therapeutic Care (Triple-A) is an evidence-informed framework for organising therapeutic caregiving for children and young people affected by adversity, disrupted caregiving, abuse, neglect and relational insecurity. This document provides a transparent account of the Model's theoretical and empirical foundations, its implementation history, the direct evidence concerning Triple-A itself, and the limits of the claims that can responsibly be made.

It is intended for organisations considering Triple-A, commissioners, regulators, service leaders, practitioners, researchers and others seeking an evidence-based understanding of the knowledge on which the Model is built. It distinguishes evidence supporting the foundations of Triple-A from evidence evaluating Triple-A itself.

Current evidence position

> *The Triple-A Model of Therapeutic Care has a peer-reviewed conceptual foundation, more than a decade of real-world implementation across Australian and Irish child-welfare settings, and preliminary direct evaluation demonstrating high acceptability and promising practice-based outcomes. Its principal components are informed by substantial external research concerning attachment, caregiver sensitivity, emotion regulation, co-regulation and therapeutic care. A contextualised CARE framework explicitly incorporating Triple-A was implemented at scale with the support of the South Australian Department for Child Protection between 2018 and 2020, with additional practice-based evaluation. Further independent research is required to establish the effectiveness of Triple-A itself and its child-level outcomes.*

A necessary distinction

Evidence that supports attachment theory, caregiver sensitivity, co-regulation or therapeutic residential care is not the same as evidence that Triple-A itself causes particular outcomes. The external literature establishes the plausibility and relevance of important principles incorporated into Triple-A. Direct Triple-A research is required to determine whether the Model, as a complete implementation system, produces the intended effects.

2. Evidence hierarchy

Evidence relevant to Triple-A is organised in four levels:

Level	Evidence type	Question answered
1	Foundational empirical evidence	Are the developmental and caregiving principles incorporated into Triple-A supported by research?
2	Population and practice evidence	Are those principles relevant to children affected by maltreatment, disrupted care, foster care and residential care?
3	Implementation evidence	What is known about translating therapeutic models into organisation-wide practice?
4	Direct and closely related implementation evidence	What evidence exists about Triple-A itself, and what additional evidence comes from contextualised

	implementations explicitly built from Triple-A?

The evidence is strongest and broadest at Levels 1 and 2. Level 3 supports the Model's emphasis on implementation and organisational embedding. Level 4 has strengthened through the recovery and review of the original 2010 paper, the 2016 Donegal evaluation and expanded report, and later Tusla organisational documentation, but remains preliminary in relation to causal child outcomes.

3. Development of Triple-A

Triple-A developed from clinical practice with children affected by abuse, neglect, disrupted caregiving and relational adversity, together with work with the adults responsible for their care. Its purpose was to integrate psychological theory and research with reflective clinical practice in a form that could influence everyday caregiving.

The 2010 peer-reviewed foundation

Pearce (2010), writing in Educational and Child Psychology, described an integrative Triple-A approach centred on three areas: Attachment, Arousal and Accessibility to needs provision. The paper integrated attachment theory, developmental and neurobiological knowledge, learning theory and reflective clinical practice.

The same paper described therapeutic caregiving in terms of caregiver accessibility, understanding, responsiveness and affective attunement. These qualities are the conceptual antecedents of the contemporary AURA framework. AURA is therefore a later formalisation and extension of caregiving qualities already present in the original published Triple-A formulation.

The 2010 paper was conceptual rather than an intervention trial and explicitly recognised the need for further research into the effectiveness of integrative clinical approaches. This caution remains central to the current evidence position.

4. AAA - a framework for understanding

AAA supports formulation rather than diagnosis. It asks caregivers and teams to consider three overlapping dimensions when trying to understand what may be happening for a child.

Attachment: How might the child's experiences and expectations of relationships, security, dependence, protection and caregiving contribute to what is happening?

Arousal: What might be happening in relation to emotional and physiological arousal, stress and regulation, and how might this influence current functioning?

Accessibility to needs provision: What might the child have learned about whether important needs will be recognised and reliably met, and how might that learning influence current expectations and behaviour?

AAA encourages movement from a purely surface-level question - 'How do we stop this behaviour?' - toward a broader formulation question: 'What might help us understand why this behaviour makes sense for this child, in this state, in this relationship and context?' Understanding does not remove the need for safety, limits or accountability.

5. External evidence: attachment and developmental outcomes

Attachment as a developmental context

Attachment theory proposes that repeated interactions with important caregivers contribute to children's expectations concerning protection, availability, responsiveness and the use of relationships in times of need. Triple-A treats attachment as a developmental context rather than a deterministic explanation of behaviour (Bowlby, 1969/1982, 1973, 1980; Ainsworth et al., 1978).

Maltreatment and attachment

Cyr et al. (2010) meta-analysed 55 studies involving 4,792 children. Children exposed to high-risk circumstances showed lower rates of secure attachment and higher rates of attachment disorganisation than children in low-risk families. Particularly large differences were found in maltreatment samples. This is directly relevant to care populations in which histories of abuse, neglect, frightening caregiving, separation and placement disruption are common.

Attachment and behavioural/emotional outcomes

Meta-analytic findings indicate probabilistic, not deterministic, associations between attachment and later functioning. Fearon et al. (2010), drawing on 69 samples (N=5,947), found a significant association between insecure attachment and externalising problems, with disorganised attachment associated with elevated risk. Groh et al. (2012), using 42 independent samples (N=4,614), found a smaller but significant association between insecurity and internalising symptoms.

Attachment and social competence

Groh et al. (2014) examined 80 independent samples involving 4,441 children and found a significant association between attachment security and social competence with peers. The finding supports the developmental relevance of relational security while not implying that attachment alone determines social outcomes.

6. External evidence: caregiver sensitivity and responsiveness

Caregiver sensitivity is one of the strongest empirical foundations relevant to AURA. Sensitive caregiving broadly involves noticing a child's signals, interpreting them appropriately and responding in a timely and fitting way.

Madigan et al. (2024) synthesised 174 samples, 230 effect sizes and 22,914 caregiver-child dyads. Caregiver sensitivity was positively associated with attachment security (pooled r=.25), with associations evident for both maternal and paternal sensitivity. The scale and recency of this meta-analysis make it an important contemporary foundation for Triple-A's emphasis on accessibility, understanding, responsiveness and attunement.

Earlier intervention evidence is also important. Bakermans-Kranenburg, van IJzendoorn and Juffer (2003) meta-analysed 70 intervention studies. Randomised interventions were effective in changing insensitive parenting and, to a smaller degree, attachment insecurity; interventions that improved sensitivity more strongly were also more effective in promoting attachment security.

These findings support the proposition that caregiving qualities are not merely correlated with child development but can be targets for intervention. They do not independently validate AURA as a four-component framework.

7. External evidence: emotion regulation and co-regulation

Triple-A's Arousal dimension reflects the principle that behaviour occurs within emotional and physiological states. Stress and heightened arousal can affect attention, emotional regulation, learning and the capacity for thoughtful action. Triple-A therefore asks caregivers to consider the child's state as well as the form of the behaviour.

Attachment and emotion regulation

Cooke et al. (2019) meta-analysed 72 studies of parent-child attachment and children's emotional experience and regulation. More securely attached children showed more positive affect, less negative affect, better emotion-regulation ability and greater use of cognitive and social-support coping strategies. These findings support treating Attachment and Arousal as related dimensions rather than isolated processes.

Additional meta-analytic work has linked attachment security with effortful self-regulation. Pallini et al. (2018), reviewing 101 independent samples and more than 20,000 participants, found a significant association favouring securely attached children.

Co-regulation

Paley and Hajal (2022) describe co-regulation as processes through which caregivers provide external support or scaffolding while children navigate emotional experiences. This provides an important empirical and conceptual basis for Triple-A's emphasis on the adult's contribution to regulation.

Triple-A's practice translation is that when a child is dysregulated, the relevant question is not only how to stop behaviour but what relational, environmental or practical support might help the child regulate sufficiently to cope. This is a Triple-A application of the broader co-regulation literature, not a proposition directly tested by Paley and Hajal.

8. External evidence: relational intervention in foster care

Research with children in foster care demonstrates that relational interventions targeting caregiving can influence measurable outcomes. Dozier et al. (2008) reported a randomised clinical trial of Attachment and Biobehavioral Catch-up (ABC) with infants and toddlers in foster care. Children receiving the attachment-based intervention showed cortisol patterns more similar to children who had not experienced foster care than children receiving the control intervention.

This is not evidence for Triple-A. It is population-specific evidence that changing relational caregiving in foster care can influence a regulatory outcome, strengthening the rationale for a Model that deliberately targets everyday caregiving relationships.

9. Accessibility to needs provision

Accessibility to needs provision is a distinctive Triple-A construct. It concerns what children may learn through repeated experience about whether important needs will be noticed, recognised, taken seriously, responded to and met predictably through conventional caregiving.

The 2010 and 2016 Triple-A formulations explicitly use learning theory to consider how inconsistent or absent needs provision may contribute to persistent, intensified, indirect, coercive or markedly self-reliant strategies for attempting to secure important outcomes. Triple-A therefore integrates attachment-related caregiving experience, learning theory and reflective clinical observation.

Accessibility to needs provision has not yet been independently validated as a discrete psychological construct. Its use should therefore remain conceptual and hypothesis-generating rather than diagnostic. Direct research into construct validity, measurement and incremental explanatory value is a priority.

10. Understanding behaviour as adaptation and communication

Triple-A encourages adults to consider what behaviour may communicate or accomplish for a child. Behaviour that is problematic in the present may sometimes reflect strategies that were understandable or adaptive in an earlier environment. Possible strategies include intensifying signals, suppressing vulnerability, rejecting assistance, seeking control, remaining vigilant, avoiding dependence or obtaining needs indirectly.

These are hypotheses, not assumptions. Triple-A does not propose that all challenging behaviour reflects trauma, that every behaviour represents unmet need, or that understanding behaviour removes the need for limits, safeguarding and accountability.

Residential care and pain-based behaviour

James Anglin's research on staffed group homes identified responding to children's pain and pain-based behaviour as a central challenge of residential child and youth care (Anglin, 2002). This perspective is compatible with Triple-A's effort to retain curiosity about the experience from which behaviour emerges while maintaining safety and appropriate boundaries.

11. AURA - a framework for therapeutic responding

Dimension	Reflective question
Accessible	Am I emotionally and physically available when needed?
Understanding	Have I tried to understand what might be underneath the behaviour?
Responsive	Did my response meet the child's need in that moment?
Attuned	Was I connected, warm and emotionally in sync?

AURA is not a behavioural prescription and does not suggest that every situation has a single therapeutically correct response. It organises caregiving qualities substantially consistent with the sensitivity, responsiveness and co-regulation literature into a practical Triple-A framework for reflection and action.

The appropriate evidence claim is that AURA integrates caregiving qualities supported by developmental and attachment research. It should not presently be claimed that AURA itself has been independently validated or shown to outperform other caregiving frameworks.

12. External evidence: therapeutic residential care

International therapeutic residential care literature provides the broader practice context for Triple-A in residential settings. Whittaker and colleagues' international consensus work conceptualises therapeutic residential care as the purposeful use of a deliberately constructed, multidimensional living environment to provide treatment, education, socialisation, support and protection (Whittaker et al., 2016).

This is highly compatible with Triple-A's proposition that therapeutic care is not confined to formal therapy sessions. Ordinary residential moments - waking, meals, travel, school preparation, recreation, disappointment, conflict, limits, success, bedtime and repair - create repeated opportunities for relational experiences of availability, predictability, responsiveness, regulation and belonging.

Triple-A does not replace specialist mental health, medical, disability, educational, cultural or family interventions. It seeks to strengthen the therapeutic quality of the everyday caregiving environment in which those interventions occur.

13. External evidence: organisation-wide implementation

Training alone does not ensure that a Model of Care becomes visible in everyday practice. Triple-A therefore distinguishes staff learning from practice integration, organisational embedding and fidelity.

Bailey et al. (2019) systematically reviewed organisation-wide trauma-informed care models in out-of-home care. Seven articles covering three organisational models met inclusion criteria. The review found potentially positive outcomes but also substantial methodological limitations, with high risk of bias in six of seven studies. The authors called for stronger evaluation of organisational care models.

This literature supports two aspects of Triple-A's position. First, therapeutic models in out-of-home care need organisation-wide implementation rather than isolated training. Second, caution is warranted when models are described as evidence-based without adequate direct evaluation.

Practice Integration and Organisational Embedding

Practice Integration: Is Triple-A recognisable in what staff actually do - in everyday interactions, use of AAA and AURA, reflection, repair and responses to distress?

Organisational Embedding: Has the organisation created structures that support staff to do this consistently - through leadership, induction, supervision, team reflection, care planning, workforce development and relevant systems?

The distinction is a Triple-A implementation formulation that is conceptually consistent with broader organisation-wide implementation literature. It requires direct evaluation within Triple-A implementations.

14. Direct evidence concerning Triple-A

Pearce (2010)

The 2010 peer-reviewed paper is the foundational published description of the Triple-A conceptual approach. It establishes the intellectual lineage of AAA and the caregiving qualities later formalised as AURA. It does not constitute outcome evidence.

The 2015-2016 Donegal implementation

A formal implementation of the Triple-A Model of Therapeutic Care was conducted in County Donegal, Ireland, between December 2015 and March 2016 with the support and funding of Tusla. It followed an earlier introduction to the Model for Donegal Tusla staff and included designated implementation liaisons, a full-day workshop for professional staff supporting foster carers, and five weekly half-day workshops for two groups of Tusla-registered foster carers. Approximately 29 foster caregivers participated.

Training addressed the theoretical basis of Triple-A, the therapeutic-care environment, therapeutic caregiving and relating, caregiver self-care, and monitoring and evaluation. This establishes that implementation, workforce support and evaluation were explicit features of Triple-A by 2016.

Acceptability and training experience

Across both Donegal locations and all five weeks, 100% of respondents reported that the programme had been communicated effectively and 100% said they would recommend it to others. All but one respondent on one session considered the programme appropriate to their level of experience. Usefulness ratings were also high.

Qualitative feedback emphasised practicality and usefulness. Critical feedback included programme intensity, homework requirements and the burden of online monitoring. The data therefore support high acceptability and perceived usefulness among participating foster carers, not proof of improved child outcomes.

Preliminary child-level monitoring

The expanded Donegal evaluation included pre-, post- and daily monitoring. One detailed illustrative case involving a nursery-school-aged child showed caregiver-reported reductions in the frequency and duration of emotional outbursts, aggression, refusal of directions, requests and other attention-seeking behaviour, alongside increased independent play.

The reported pre/post changes in this illustrative case included a 50% reduction in emotional-outburst frequency, a 67% reduction in duration, an 80% reduction in aggression towards people, elimination of reported aggression towards objects, an 80% reduction in ignoring/refusing directions, an 85% reduction in requests of the caregiver, a 60% reduction in other attention-seeking behaviour and a 200% increase in independent play.

These findings are promising single-case practice data. They cannot establish that Triple-A caused the changes. Alternative explanations, natural variation, expectancy effects, concurrent influences and measurement effects cannot be excluded.

Methodological limitations

- No comparison or control condition in the Donegal Triple-A evaluation.
- No randomisation.
- Substantial reliance on caregiver-reported outcomes.

- A relatively short implementation period.
- Only six complete monitoring protocols containing pre/post data and at least some intervening monitoring data were available at the time of reporting.
- No independent or blinded outcome assessment reported.
- No long-term follow-up reported in the evaluation publication.
- Involvement of the Model's developer and implementation personnel in the evaluation.

The authors themselves recommended revision of the monitoring methodology and/or a longer implementation timetable. The appropriate conclusion is feasibility, high acceptability and promising preliminary signals of change rather than established efficacy.

15. Organisational embedding within Tusla Donegal

A Tusla Donegal Fostering Service Training Needs Analysis dated December 2017/January 2018 provides organisational documentation that Triple-A continued beyond the original pilot. The analysis was undertaken in the context of feedback from a 2016 HIQA inspection and a subsequent HIQA Action Plan concerning foster-carer training systems.

Tusla's document identifies Triple-A among training deemed mandatory and then delivered to foster carers on a rolling basis, describing it as commissioned training. Its conclusion again identifies Triple AAA among mandatory training being provided, and the Care Placement Support Service is identified as providing AAA Training alongside other foster-care learning and development activity.

This is contemporaneous evidence of organisational embedding: Triple-A had moved from pilot implementation into ongoing service training arrangements.

Regulatory interpretation

> *The Tusla document does not establish that HIQA approved, endorsed, required or validated Triple-A. The defensible claim is narrower: following a HIQA inspection and related Action Plan concerning foster-carer training, Tusla Donegal documented Triple-A/AAA as commissioned mandatory training within its rolling foster-carer training provision.*

One Tusla page expands Triple A using terminology inconsistent with the established Model. Where the Tusla document is quoted, its wording should be reproduced accurately; elsewhere the Model's correct terminology remains Attachment, Arousal and Accessibility to needs provision.

16. South Australian implementation history

The South Australian record materially extends the implementation history beyond the Donegal evaluation. It includes an early direct Triple-A implementation in foster care, followed by a large-scale government-supported implementation of Kinship CARE - a contextualised CARE framework that explicitly incorporated Triple-A - and later continuation through an Aboriginal kinship-care program. These phases strengthen the evidence for feasibility, scale, transferability and organisation-wide implementation. They should not be treated as equivalent to controlled evidence of Triple-A effectiveness.

Centacare Family Preservation Foster Care Service - 2014

Triple-A was implemented in 2014 within the Centacare Family Preservation Foster Care Service in South Australia. Outcome data were collected in association with this implementation; however, permission has not been obtained to disclose those data. Accordingly, this public Evidence & Practice Foundation records the implementation as part of Triple-A's history but does not reproduce, summarise or rely upon the unpublished outcomes when making evidence claims.

South Australian Department for Child Protection Kinship CARE Project - 2018-2020

Between 2018 and 2020, Secure Start and the South Australian Department for Child Protection undertook a two-year Kinship CARE Project. Project documentation describes the CARE Therapeutic Framework as drawn from the Triple-A Model of Therapeutic Care and using Triple-A to understand behaviour. The broader CARE Curriculum also explicitly describes Triple-A as the framework for understanding how CARE influences individual outcomes. CARE at that time emphasised Consistency, Accessibility, Responsiveness and Emotional Connectedness, while Triple-A addressed Attachment, Arousal and Accessibility to needs provision.

The implementation was deliberately systemic rather than limited to carer training. Project documentation describes preparation of kinship carers, Department for Child Protection Kinship Care staff and psychologists; continuing implementation support; and a layered approach intended to support common language, practice, embeddedness and fidelity across the Kinship Care Program.

By completion, Secure Start's CARE Curriculum record reports that the two-year initiative had reached 250 kinship carers across 24 South Australian locations - 17 metropolitan and 7 regional - with 12% of participants identifying as being of Australian Aboriginal descent. This represents the largest documented implementation associated with the Triple-A/CARE framework family reviewed for this Evidence & Practice Foundation.

Kinship CARE evaluation findings

Among participant kinship carers who completed the training and a three-month follow-up survey, the final project figures reported by Secure Start were:

- 84% reported improved relationships with the children in their care;
- 89% reported greater confidence in the kinship-care role;
- 98% reported learning strategies that had helped them in the kinship role; and
- 100% reported receiving helpful information.

Session-by-session evaluations reported that more than 98% of participating kinship carers considered the training informative, practical and useful, were satisfied with it, and would recommend it to other kinship carers. Pre/post questionnaires for the first twelve implementation groups also found that carers were more than twice as likely after four training sessions to refer to behaviour as an expression of needs rather than naughtiness.

These findings are valuable practice-based implementation evidence. In particular, the shift in how carers conceptualised behaviour is relevant to a central Triple-A mechanism: moving from surface-level judgement of behaviour toward formulation of what may be happening for the child. The relationship and confidence findings are also promising. However, the project was not a randomised or controlled evaluation of Triple-A itself, outcomes were substantially self-reported, and CARE was a contextualised implementation framework rather than the contemporary Triple-A package. Causal claims are therefore not warranted.

Martinthi Aboriginal Kinship CARE Program - 2021-2024

Kinship CARE continued to be implemented through the Martinthi Aboriginal Kinship CARE Program between 2021 and 2024. Secure Start identifies Martinthi as a collaboration involving InComPro, Bookyana, UCWB and Secure Start. The available public material establishes continued application of the CARE/Triple-A framework in an Aboriginal kinship-care context, but does not provide sufficient outcome data for an effectiveness claim. Martinthi is therefore included here as evidence of continuity, contextual adaptation and implementation across a culturally specific service context, not as outcome evidence.

Interpretation of the South Australian evidence

Taken together, the South Australian history adds three distinct forms of evidence: historical depth through the 2014 Centacare implementation; scale and evaluated implementation through the 2018-2020 Department for Child Protection Kinship CARE Project; and continuity and contextual adaptation through Martinthi from 2021 to 2024. This substantially strengthens the implementation history of the Model and its related CARE/AURA framework without changing the need for independent controlled evaluation of Triple-A itself.

Unpublished and non-disclosable data

Triple-A has been implemented in settings in which outcome data were collected but are not available for public reporting. Such data are not relied upon in this Evidence & Practice Foundation unless permission for disclosure has been obtained. Their existence may be noted as part of implementation history, but no outcome claims are made from them.

17. Implementation lineage

- 2010 - Peer-reviewed publication of the foundational Triple-A conceptual approach.
- 2014 - Implementation of Triple-A within the Centacare Family Preservation Foster Care Service in South Australia. Outcome data were collected but are not publicly reported because permission for disclosure has not been obtained.
- 2015-2016 - Tusla-supported and funded implementation and evaluation of Triple-A in Donegal, Ireland.
- 2016 - Publication of the preliminary Donegal evaluation in Foster, together with an expanded evaluation report.
- 2017-2018 - Tusla Donegal documentation of Triple-A/AAA as commissioned mandatory training within rolling foster-carer training provision in the context of the HIQA-related Training Needs Analysis process.
- 2018-2020 - Two-year South Australian Department for Child Protection and Secure Start Kinship CARE Project, implementing a CARE framework explicitly incorporating Triple-A across metropolitan and regional South Australia, with systematic practice-based evaluation.
- 2021-2024 - Continued Kinship CARE implementation through the Martinthi Aboriginal Kinship CARE Program.
- Contemporary phase - Consolidation of Triple-A around AAA and AURA, accompanied by formal licensing, implementation support and fidelity structures.

This lineage shows progression from published conceptual formulation to direct implementation, evaluation, organisational adoption, large-scale contextualised implementation and contemporary formalisation. It is evidence of sustained real-world development and transferability; it should not be conflated with proof of effectiveness.

18. Emerging Triple-A theory of change

1. Children bring developmental, relational and learning histories into current care.
2. Those histories may influence attachment expectations, arousal/regulation and what children have learned about the accessibility of important needs.
3. These processes may influence emotions, relationships and behaviour.
4. Staff use AAA to develop a broader, less reactive understanding of what may be happening.
5. Staff use AURA to orient caregiving toward accessibility, understanding, responsiveness and attunement.
6. Children experience repeated interactions characterised by greater relational availability, predictability, appropriate responsiveness and emotional connection.
7. Organisational systems support staff to provide these experiences with reasonable consistency and fidelity.
8. Over time, children have opportunities to develop new expectations concerning relationships, regulation and access to important needs.
9. Potential change may become visible through greater relational security, regulation, connection, direct help-seeking, recovery after distress and more conventional ways of meeting needs.

Each link in this chain is informed to varying degrees by external research, theory and practice evidence. The complete causal sequence remains a Triple-A hypothesis requiring direct empirical evaluation.

19. Considering successful therapeutic endeavour

Triple-A asks a third question after understanding and responding: How will we recognise whether our therapeutic endeavours are helping? Potential indicators may include:

- Increased use of adults for support and greater comfort with appropriate dependence.
- More direct communication of needs and greater expectation that adults will respond.

- Increased relational security and capacity for repair.
- Greater capacity to recover following distress.
- Reduced reliance on extreme strategies for communicating or securing needs.
- Improved regulation, engagement and participation.
- More conventional and socially workable ways of obtaining important needs.

These are hypothesised indicators of therapeutic progress, not guaranteed Triple-A outcomes. Children differ in history, developmental capacity, culture, disability, strengths and needs; outcome selection should be individualised and, in research, measured with validated tools.

20. What the evidence currently supports

Statement	Evidence position
Triple-A has a peer-reviewed conceptual foundation.	Supported. The foundational approach was published in Educational and Child Psychology in 2010.
Core Triple-A principles are consistent with substantial external research.	Supported, particularly for attachment, caregiver sensitivity, emotion regulation, co-regulation and relational caregiving.
Triple-A has been implemented in real-world care settings.	Supported, including the documented Tusla Donegal implementation.
The Donegal pilot was highly acceptable to participating foster carers.	Supported by session-by-session feedback.
Triple-A has promising preliminary child-level data.	Supported with strong qualification: illustrative caregiver-reported single-case data and limited completed monitoring.
Triple-A has demonstrated efficacy or effectiveness.	Not established. Direct controlled, independent outcome evidence is insufficient.
Tusla Donegal embedded Triple-A in ongoing foster-carer training.	Supported by Tusla's 2017/18 Training Needs Analysis.
HIQA approved or endorsed Triple-A.	Not established by the documents reviewed; this claim should not be made.
AAA and AURA are validated assessment instruments.	No. They are conceptual and reflective practice frameworks.
Triple-A/CARE has been implemented at substantial scale in South Australia.	Supported with qualification. The 2018-2020 DCP Kinship CARE Project reached 250 kinship carers across 24 locations and explicitly incorporated Triple-A, but CARE was a contextualised framework and the evaluation was not a controlled test of Triple-A itself.
The 2014 Centacare implementation produced outcome data.	Outcome data were collected, but are not publicly disclosed or relied upon here because permission to share them has not been obtained.

21. Responsible external description

Recommended core wording:

> *Triple-A is an evidence-informed Model of Therapeutic Care with a peer-reviewed conceptual foundation, more than a decade of real-world implementation across Australian and Irish child-welfare settings, and preliminary direct evaluation demonstrating high acceptability and promising practice-based outcomes. It integrates attachment, arousal/regulation and learning about accessibility to needs provision through the AAA framework, and translates this understanding into therapeutic caregiving through AURA. A contextualised CARE framework explicitly incorporating Triple-A was subsequently implemented at scale with the support of the South Australian Department for Child Protection, providing additional practice-based evidence concerning caregiver learning, acceptability, relational outcomes and organisation-wide implementation. Direct evidence of Triple-A effectiveness remains at an early stage and further independent evaluation is required.*

Where the Donegal history is relevant:

> *Triple-A was formally implemented and evaluated with Tusla foster carers and staff in Donegal in 2015-2016. A later Tusla Donegal Training Needs Analysis, undertaken in the context of a HIQA inspection Action Plan concerning foster-carer training, documented Triple-A/AAA as commissioned mandatory training within the service's rolling training programme.*

Claims to avoid

- 'Triple-A is evidence-based' where this is intended to mean independently proven effective through controlled outcome trials.
- 'HIQA approved/endorsed Triple-A' unless a specific HIQA source is obtained that explicitly supports that wording.
- 'Tusla validated Triple-A' - implementation and organisational adoption are not scientific validation.
- 'Triple-A causes improved attachment, regulation or behaviour' - the present direct evidence does not establish causation.
- 'AAA/AURA are diagnostic or validated assessment tools.'

22. Training, implementation and fidelity

Triple-A treats training as the beginning of implementation, not its completion. Contemporary implementation involves workforce preparation, practice integration, organisational embedding, consolidation and fidelity review.

Fidelity is developmental rather than a simple compliance score. It considers whether the Model remains recognisable in staff understanding, use of AAA and AURA, workforce learning, everyday practice, organisational systems and protection of Model integrity.

A Triple-A Fidelity & Implementation Review is not a safeguarding inspection, statutory audit, clinical audit or certification that a service or child is safe. Responsibility for safeguarding, regulatory compliance, staffing, clinical governance and individual case decisions remains with the service provider and relevant professionals.

23. Research priorities

The next developmental phase should move from promising practice-based evidence toward independent, prospective evaluation. Priorities include:

- Formal specification of the Model, target populations, intended mechanisms and proximal and longer-term outcomes.
- Operational definitions and measurement of AAA and AURA-related practice without turning reflective frameworks into inappropriate diagnostic instruments.
- Construct development and validation work concerning Accessibility to needs provision.
- Feasible, reliable fidelity measures aligned with the Triple-A implementation framework.
- Prospective measurement of workforce knowledge, reflective capacity, therapeutic orientation and observed caregiving practice.
- Validated child and service outcome measures selected before implementation.
- Pre/post designs with adequate follow-up and, where feasible, comparison conditions.
- Independent data collection and/or analysis to reduce developer allegiance bias.
- Multi-site evaluation as licensing expands, allowing examination of implementation variation and fidelity.
- Transparent reporting of implementation difficulties, adverse events, null findings and positive findings.
- Peer-reviewed publication of contemporary evaluations.

A licensing network creates a practical opportunity to build a cumulative evidence base. Common implementation expectations, fidelity domains and proportionate outcome monitoring could allow participating organisations to contribute to a multi-site practice-based evidence programme without imposing excessive research burden on children or staff.

24. Conclusion

Triple-A has a credible and increasingly well-documented evidence and practice foundation. Its core principles are consistent with substantial research concerning attachment, maltreatment and attachment organisation, caregiver sensitivity, emotional regulation, co-regulation, relational intervention and therapeutic care. Its implementation approach is also consistent with the broader recognition that therapeutic Models of Care require organisation-wide support rather than training alone.

Triple-A itself has a peer-reviewed conceptual foundation dating to 2010, an early documented South Australian implementation in 2014, a Tusla-supported implementation and preliminary evaluation in Donegal in 2015-2016, and later Tusla documentation showing movement from pilot activity into ongoing foster-carer training arrangements. From 2018 to 2020, a contextualised CARE framework explicitly incorporating Triple-A was implemented at substantial scale with the support of the South Australian Department for Child Protection, followed by continued Kinship CARE implementation through Martinthi between 2021 and 2024.

The direct outcome evidence remains early, but the implementation history is now substantial. The appropriate position is therefore neither to understate Triple-A as merely a collection of ideas nor to overstate it as a proven intervention. It is best described as an evidence-informed, theoretically grounded and practice-tested Model of Therapeutic Care with more than a decade of implementation across foster-care and kinship-care contexts, an emerging direct evidence base, and additional practice-based evidence from contextualised CARE implementations.

> *Triple-A's credibility is strengthened by maintaining a transparent relationship between theory, external evidence, direct evidence, practice, implementation, fidelity and ongoing evaluation.*

References

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the Strange Situation. Lawrence Erlbaum Associates.
- Anglin, J. P. (2002). Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth. Haworth Press.
- Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. Health & Social Care in the Community, 27(3), e10-e22. https://doi.org/10.1111/hsc.12621
- Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. Psychological Bulletin, 129(2), 195-215. https://doi.org/10.1037/0033-2909.129.2.195
- Bowlby, J. (1969/1982). Attachment and loss: Vol. 1. Attachment (2nd ed.). Basic Books.
- Bowlby, J. (1973). Attachment and loss: Vol. 2. Separation: Anxiety and anger. Basic Books.
- Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. Basic Books.
- Cooke, J. E., Kochendorfer, L. B., Stuart-Parrigon, K. L., Koehn, A. J., & Kerns, K. A. (2019). Parent-child attachment and children's experience and regulation of emotion: A meta-analytic review. Emotion, 19(6), 1103-1126. https://doi.org/10.1037/emo0000504
- Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. Development and Psychopathology, 22(1), 87-108. https://doi.org/10.1017/S0954579409990289
- Dozier, M., Peloso, E., Lewis, E., Laurenceau, J.-P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. Development and Psychopathology, 20(3), 845-859. https://doi.org/10.1017/S0954579408000400
- Fearon, R. P., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Lapsley, A.-M., & Roisman, G. I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: A meta-analytic study. Child Development, 81(2), 435-456. https://doi.org/10.1111/j.1467-8624.2009.01405.x
- Groh, A. M., Roisman, G. I., van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., & Fearon, R. P. (2012). The significance of insecure and disorganized attachment for children's internalizing symptoms: A meta-analytic study. Child Development, 83(2), 591-610. https://doi.org/10.1111/j.1467-8624.2011.01711.x
- Groh, A. M., Fearon, R. P., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Steele, R. D., & Roisman, G. I. (2014). The significance of attachment security for children's social competence with peers: A meta-analytic study. Attachment & Human Development, 16(2), 103-136. https://doi.org/10.1080/14616734.2014.883636
- Madigan, S., Deneault, A.-A., Duschinsky, R., Bakermans-Kranenburg, M. J., Schuengel, C., van IJzendoorn, M. H., Ly, A., Fearon, R. M. P., Eirich, R., & Verhage, M. L. (2024). Maternal and paternal sensitivity: Key determinants of child attachment security examined through meta-analysis. Psychological Bulletin, 150(7), 839-872. https://doi.org/10.1037/bul0000433
- Paley, B., & Hajal, N. J. (2022). Conceptualizing emotion regulation and coregulation as family-level phenomena. Clinical Child and Family Psychology Review, 25(1), 19-43. https://doi.org/10.1007/s10567-022-00378-4
- Pallini, S., Chirumbolo, A., Morelli, M., Baiocco, R., Laghi, F., & Eisenberg, N. (2018). The relation of attachment security status to effortful self-regulation: A meta-analysis. Psychological Bulletin, 144(5), 501-531. https://doi.org/10.1037/bul0000134
- Pearce, C. M. (2010). An integration of theory, science and reflective clinical practice in the care and management of attachment-disordered children: A Triple-A approach. Educational and Child Psychology, 27(3), 73-86. https://doi.org/10.53841/bpsecp.2010.27.3.73
- Pearce, C. M. (2016). A short introduction to attachment and attachment disorder (2nd ed.). Jessica Kingsley Publishers.

- Pearce, C., & Gibson, J. (2016). A preliminary evaluation of the Triple-A Model of Therapeutic Care in Donegal. Foster, Issue 2, 95-104.
- Pearce, C. (2016). Donegal Evaluation: Triple-A Model of Therapeutic Care. Expanded implementation and evaluation report, 1 April 2016.
- Tusla Donegal Fostering Service. (2017/2018). Donegal Fostering Service Training Needs Analysis. December 2017/January 2018.
- Whittaker, J. K., Holmes, L., del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., et al. (2016). Therapeutic residential care for children and youth: A consensus statement of the International Work Group on Therapeutic Residential Care. Residential Treatment for Children & Youth, 33(2), 89-106. https://doi.org/10.1080/0886571X.2016.1215755

South Australian documentary sources

- Secure Start / South Australian Department for Child Protection. Kinship CARE Project implementation and evaluation materials, 2018-2020.
- Secure Start. The CARE Curriculum. Public programme description and final Kinship CARE Project statistics; accessed August 2026.
- Secure Start. Martinthi - Aboriginal Kinship CARE Program. Public programme description.
- Centacare Family Preservation Foster Care Service / Secure Start. Triple-A implementation, South Australia, 2014. Outcome data not publicly reproduced because permission for disclosure has not been obtained.

Document status

Version 3.3 is intended as the authoritative public Evidence & Practice Foundation as at August 2026. It should be revised as new independent research, implementation data, fidelity evidence or regulatory documentation becomes available.

Public edition note: references to Tusla and HIQA are presented conservatively. Their inclusion in the implementation history does not imply endorsement, approval or scientific validation of Triple-A unless explicitly supported by a cited source.