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Lighthouse Foundation Therapeutic Family Model of Care: Stages of Recovery and their Application to Young People in Out-of-home Care

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The Lighthouse Foundation provides long-term accommodation to young people aged 15–25 at risk of homelessness, through a therapeutic model of care. This paper will explore its application to young people with histories in the out-of-home care system and those who are leaving care, by focusing on a four-stage process of recovery and the unique experiences it raises for this population based on their history. Drawing on themes identified through our practice with vulnerable young people, it is proposed that key elements of the programme and process hold particular relevance to the long-term recovery of this population, including the provision of stable and consistent therapeutic residential workers, an integrated care team, and the capacity to work with the young person beyond his or her eighteenth birthday. (Please note, no specific examples of young people are provided, rather the article will present observed themes at the various stages of the Therapeutic Family Model of Care.)

■ **Keywords:** out-of-home care, therapeutic residential care, leaving care, homelessness

Introduction

In Australia, the term 'out-of-home care' commonly encompasses five categories: residential care; family group homes; home-based care, of which there are three types: relative or kinship care, foster care and other home-based out-of-home care; independent living (including private board and lead tenant models); and other (including boarding schools, hotels/motels and the defence force) (Australian Institute of Health and Welfare (AIHW), 2013).

Children and young people entering the care system have often already experienced a multitude of difficulties, such as abuse and neglect, family histories of mental illness and/or drug and alcohol abuse, exposure to substance abuse and family violence, family dysfunction and criminality (Schneiderman et al., 1998).

In 2012 there were an estimated 39,621 Australian children and young people in out-of-home care, of whom 6207 were in Victoria. In 2012, 3034 young people transitioned from out-of-home care nationwide, including 857 in Victoria (AIHW, 2013).

Leaving care is defined as the cessation of legal responsibility by the state for young people living in out-of-home care. This significant life event involves transitioning from dependence on the state for accommodation and support, to reliance on self (Mendes, Johnson, & Moslehuddin, 2011). However, there is ample evidence regarding the difficulties experienced by care leavers, with many entering entrenched cycles of homelessness, unemployment and poverty.

The *Just Beginnings* report published by Whyte (2011) identified minimal transition and post-care accommodation options for care leavers. The Lighthouse Foundation works with young people aged between 15 and 25 years, and is uniquely placed to provide residential and clinical support to care leavers not yet ready to live independently. In 2012 and 2013, Lighthouse received 53% of referrals from refuges. A majority of these referrals were young people with histories in the out-of-home care system and who had recently transitioned from state care and entered homelessness.

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When providing care for this vulnerable population, and in order to genuinely facilitate recovery from trauma, an overarching therapeutic model of care is required. As stated by Barton, Gonzalez and Tomlinson (2012), 'When we are faced with the challenging and complex task of facilitating recovery for traumatized children, it is essential to have a theoretical base to draw upon' (p. 30).

The Lighthouse Live-In programme provides an integrated model of therapeutic care for homeless young people who come predominately from backgrounds of long-term neglect and abuse. Key elements of the programme include: the provision of consistent and stable therapeutic residential workers; a home environment with a focus on routines and rituals; an integrated supporting care team, including psychologists and social workers; creation of a sense of community (both between the homes and wider community) and the capacity to work with young people up to 25 years of age.

Young people entering the programme are encouraged to participate in education, employment and personal development, and to engage in one-to-one therapy with a psychologist. There is evidence that when traumatised children and young people are offered a safe and consistent physical living environment with positive parental role models and therapeutic support services, they can (re)build their sense of self, learn new ways of trusting and relating to others, and develop pro-social skills (Becker-Weidman & Shell, 2005; Bowlby, 1969; Dockar-Drysdale, 1990; Perry & Szalavitz, 2006, 2010; Tomlinson, 2004).

The Therapeutic Family Model of Care (TMFC^{TM})

The following section will explore the three major theories that underpin the TFMC^{TM}. These include Attachment, Object Relations and Psychological Wellness theories. Attachment theory describes the biological and psychological need to bond with and relate to primary caregivers as fundamental to the survival of human beings (Bowlby, 1969, 1979). The ability to trust and relate to others is established in infancy to childhood through the quality of the infant/primary caregiver relationship, which shapes development, behaviour and relationship patterns in later life. There are strong links between maladaptive attachments in infancy and childhood, and the development of psychopathology later in life (Sroufe, Carlson, Levy, & Egeland, 1999). The TFMC^{TM} provides young people who have experienced severe disruptions in their attachment relationships with the opportunity to develop an attachment with a carer. The attachment to a carer assists the young person to develop confidence in relationships, and provides a reparative attachment experience (Becker-Weidman & Shell, 2005; Bowlby, 1969, 1979; Bretherton, 1997; Hardy, 2007; Sonkin, 2005). There is support in the literature for reparative attachment experiences as a protective factor against the development of psychopathology (Paley, Cox, Burchinal, & Payne, 1999; Pearson, Cohn, Cowan, & Pape Cowan, 1994; Phelps, Belsky, & Crnic, 1998; Sroufe et al., 1999), along with other kinds of current and often long-standing developmental supports (Roisman, Padrón, Sroufe, & Egeland, 2002).

Object Relations theory (Winnicott, 1953) suggests that a prime motivational drive in every individual is to form relationships. The style of relationship that develops in early childhood becomes part of an internal blueprint or a learned way of relating, which is replicated when we establish and maintain future relationships. Young people who have experienced trauma in infancy and early childhood may have difficulty in forming and maintaining constructive and healthy relationships (Barton et al., 2012; Dockar-Drysdale, 1990, 1993; Winnicott, 1953, 1990). The implications of this are significant across all domains of life, including education, employment, peer relationships, romantic relationships and stable living arrangements.

Psychological Wellness is a psycho-ecological concept that highlights the importance of promoting favourable conditions that nurture the personal (individual), relational (group) and collective (community) wellbeing of individuals (Prilleltensky & Nelson, 2000). It is important to support young people to develop wellness in all these areas, as the young person's overall wellness depends not only on their individual wellbeing (emotional, psychological and physical) and their internal resources, but also the quality of relationships they form with their networks of family, peers and the wider community.

Process of Recovery

Stage 1: Intake and Induction

The TFMC^{TM} intake process involves a number of stages that have been implemented to ensure that the young person is at the centre of the decision-making process. The process is aimed at ensuring that the programme is in the best interest of the young person. The different stages of intake include the following:

A. Initial contact
B. Referral
C. Contact to gather information
D. Intake interview
E. Potential resident in waiting
F. Vacancies
G. Psycho-social screen
H. Gathering of relevant documentation
I. Entry

Throughout all stages of the intake process the focus is on positive and affirming engagement with young people. The building of trusting relationships between care team members and young people begins at the initial contact phase. The intake interview involves an initial holistic assessment

of the young person's presenting issues, to assist in determining suitability of the programme for the young person. This interview also provides detailed information regarding what support can be offered and what it is like to live in one of the homes and be part of the Lighthouse therapeutic community. This is to ensure that the young person is making an informed decision to enter the programme. The young people are made aware that the Lighthouse Live-In Program is not just accommodation, but that it is a programme that requires a level of resilience and commitment from them for self-improvement. The process from initial intake to final entry varies between 4 weeks and 12 months, depending on various factors, including access to relevant material, assessments, actual suitable places available, initiative and specific needs of young people, choices of young people, transition requirements, cooperation of other services and the dynamics in the home (Gonzalez & Tomlinson, 2011).

Based on 2012–2013 programme data, the average age at intake of a young person entering Lighthouse is 17 years and 9 months. This is a point of differentiation with other therapeutic residential programmes. At the time of intake, 37 per cent are engaged in education, training or employment, while 74 per cent present with a mental illness diagnosis or presentation. Excluding public transport related offences, a further 27 per cent present with charges or convictions. Homeless refuges are our most significant referral source (53%), followed by the Department of Human Services (16%), Youth Support Services (16%), Mental Health Support Services (12%) and families (3%).

Some young people entering Lighthouse from the out-of-home care system can often experience culture shock, by virtue of the de-institutionalisation of the home environment. The presence of consistent primary residential youth workers, and trauma-informed language (e.g., use of home instead of unit) can often be very different to past experiences in residential care units. This cultural shock can at times result in an escalation of acting-out behaviour. Counselling and reflective processes often result in young people revealing various versions of "I'm not used to this lovey, huggy shit". A common experience is that the young person refuses to unpack his or her bags, maintaining a readiness for flight. One of the early treatment goals can be the gradual transfer of belongings into the wardrobe, which can be met by very strong resistance.

Often young people present at the induction stage as quite guarded and at times intimidating, warning off potential threats, with the most threatening being connection. This presentation can be interpreted as a learnt coping strategy developed through a lifetime in unsafe and unpredictable circumstances, particularly abuse, neglect and homelessness. As time in the programme passes and the *real-self* emerges, it is often very different to the *projected-self* from the early days of their programme involvement.

Stage 2: The Home Environment

When working with traumatised young people, providing the right type of environment can be the beginning of the recovery process (Barton et al., 2012). A healthy home environment is generally safe, clean and reflects the interests and relationships of those living in it. According to the TFMC^{TM}, the aesthetics of the home are important and help to create a personalised, comfortable, positive and respectful space for carers and young people. The home should encourage play and curiosity through offering an enriching environment of books, toys, games, sports equipment, computers and music. Although some of our young people may be in their early twenties, it is important to provide opportunities to meet early developmental needs for play that were not met during childhood. This is part of having a focus on young people's developmental, rather than chronological age. Privacy and security are also essential to creating the sense of safety necessary for the recovery process to begin.

The holding environment of the home is another essential component of the TFMC^{TM}. Perry and Szalavitz (2006) state, 'I also cannot emphasize enough how important routine and repetition are to recovery. The brain changes in response to patterned, repetitive experiences: the more you repeat something, the more engrained it becomes'. Daily routines, limits and anchor points are essential in creating a sense of safety when working with traumatised young people. All aspects of the daily programme need to be considered, and routines developed that engender predictability, consistency and stability. This encompasses all activities from the use of television and computers, free time and the provision of food/meals, to bedtime and waking routines, play and celebrations (Barton et al., 2012).

The Lighthouse Foundation Care Team is made up of residential youth workers, psychologists and social workers, who provide the key assessment, planning and intervention function for the young person during the home environment stage. The key theme of this stage is the primary experience mediated through the attachment with the primary residential youth worker. Parallel to this experience is the home environment and daily routine (i.e., meal times, bed times, etc.). These experiences promote a sense of relational and physical safety, trust, stability and security. They can also create confusion for the young person, leading to the intensification of reactive and disorganised attachment styles. Young people can be hostile and aggressive toward their residential youth worker, while at other times be loving and affectionate. This dynamic of unpredictability and continually feeling as though they are failing the young person can result in the residential youth worker becoming hypervigilant, doubting their competence and making them want to withdraw.

In the context of such powerful dynamics, it is imperative that Lighthouse ensure that all staff have a common interpretive framework, based on sound theoretical principles, to make sense of such behaviour and any personal

reactions. This common interpretive framework is essential for the capacity of the care team to develop and maintain an intervention plan.

The very powerful transference–countertransference (Winnicott, 1953, 1990) dynamic that can often occur within the home environment also requires that Lighthouse maintain robust staff support systems in the form of regular and protected operational and clinical supervision, professional development and reflective processes. However, due to the nature of parallel processes (i.e., dynamic between young people and frontline staff may be recreated between frontline staff and supervisors), it is also essential such support systems be made available to supervisors and managers.

Once the young person transitions out of the chaos of homelessness and completes the TFMC^{TM} intake and induction process, the availability of an attachment figure and the stability of the home environment can result in the re-emergence of traumatic memory. This stage of the programme can be particularly challenging for young people managing substance misuse. In the case of such young people, painful emotions may have been managed historically by using substances. TFMC^{TM} guidelines do not permit young people using substances in the home, or returning to the home substance-affected. Accordingly, our ability to hold the young person through this process is dependent on the availability and responsiveness of the allocated Lighthouse psychologist, in addition to Lighthouse's relationship with drug and alcohol services, which may expedite entry into detox programmes.

Stage 3: Transition

The way a young person's transition from care is planned is one of the major determinants of the outcomes achieved (Hannon, Wood, & Bazelgate, 2010). There are four factors that can significantly improve a young person's experience of leaving care and give young people a chance of better adult outcomes: the age at which young people leave care; the speed of their transition; their access to preparation before leaving care and support after leaving care; and maintaining stability and secure attachments after leaving care (Hannon et al., 2010).

When young people *without* complex trauma histories move out of home, some young people will take longer than others to separate from their family of origin. Working with young people with complex trauma histories can be more anxiety provoking for the young person, and much more complex. Not only do they lack internal resources, but also external ones, as they may have limited relational and community supports. Therefore it is vital that the young person has a secure base to return to from time to time. The internalisation of this secure base is really the recipe for success. Hence the work that is done in the home provides the young person with a secure internal working model of the world. This provides him or her with the confidence to develop into an autonomous person, which is so vital for a successful transition to interdependent living.

In its essence, the TFMC^{TM} is preparing young people to develop the emotional, relational and material requirements to transition to autonomy. This work is articulated in the Individual Development Plan (IDP) – a holistic case management plan that is reviewed quarterly and covers the following developmental domains: learning; physical development; emotional development; attachment; identity; social development; autonomy/life skills and relational/community connectedness.

The average length of time a young person remains in the live-in programme is approximately 18 months. Lighthouse is fortunate to have the capacity to continue to work with young people up to the age of 25 years, should they require such support. The average age when young people leave the programme is 20 years and 6 months, and 69 per cent are engaged in education, training or employment (a significant improvement from the intake stage). Based on 2012–2013 data, 13 young people transitioned from the programme. Of that total, seven transitioned to independent living, three were reunited with family, one transitioned to supported accommodation, one relocated overseas and one was exited from the service to crisis accommodation due to programme non-compliance.

The transition process can trigger powerful emotions within the home and the care team. It may re-trigger grief and loss experiences, and not just on behalf of the young person. The young person may experience anxiety and become resistant to the transition. This may result in regression in both living skills and emotional regulation. The therapeutic residential worker, in addition to other members of the care team, may also experience anxiety regarding the transition, hoping the young person will cope when living independently in the community.

Inspired by the concept of the *Safe-base*, the bed of the young person is held for them for 4 weeks after their transition, in the event they seek to return. This option has rarely been used by a young person, but the care team believes that the knowledge that this option exists increases the confidence to transition.

Stage 4: Outreach (Aftercare)

In a family setting, when children 'move out' there is often a coming and going over the years as they develop a sense of autonomy. They have the opportunity to return to the secure base of their parents and family as they explore and experiment with the outside world. When their child 'moves out', the response of a loving family is to provide the child with the confidence that he or she can always come back. This is not available to young people in care, yet they are vulnerable and less equipped to face the challenges of moving out.

The TFMC^{TM} provides life membership to all the young people, to replicate the experience of a healthy family. The

support provided to young people who transition from the home is varied and based on their individual needs. The nature of it will depend on their individual resilience, mental health, general health, developmental needs, support networks, relationship with family of origin, and other factors that impact on their ability to manage interdependent living. When young people have just moved out, the support may be more intensive, such as case management and regular counselling, or being able to return home for respite stays as they continue to build their capacity to manage in the community. Those who have been in the community for a long time may come home for a lunch or dinner, or to celebrate birthdays and personal achievements, or for Christmas (Barton et al., 2012). Based on 2012–2013 data, the most common requests for assistance to the Outreach team are due to financial issues, housing and mental health support.

Conclusion

The Lighthouse Foundation provides long-term accommodation to young people at risk of homelessness, through a trauma-informed therapeutic model of care. The potential of the programme to achieve successful outcomes with young people leaving the out-of-home care system lies in the commitment to a stable, consistent, long-term care model. This is mediated through the primary residential youth worker. Supporting this is the availability of clinical and case-management supports that are integrated into the care experience of the young person. This integrated-care team approach ensures the maintenance of an outcomes focus and clarity around the primary task of all team members.

Additional key elements of the TFMC™, such as the capacity to continue to provide care to young people past their eighteenth birthday, and life membership, make the programme particularly suitable to young people in the out-of-home care system, some of whom may find themselves significantly underprepared at 18 years to meet the challenges of autonomous living.

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