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The Spiral to Recovery: An Australian Model for Therapeutic Residential Care

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This article gives a brief overview of the Spiral to Recovery practice framework as it is being used at Catalyst child and family services in far north Queensland. The Spiral is an evidence informed framework for therapeutic residential care (TRC), designed for children and young people with complex and extreme emotional and behavioural difficulties who reside in out-of-home care (OOHC) placements. The Spiral is a stage-based framework where the initial aim is to establish actual and felt safety before young people meet the challenges of healing and growth. The framework rests on a theoretical base of trauma, attachment and socialisation theories. The article also describes how the Spiral framework has been implemented at Catalyst, demonstrating the need for congruence between organisational and practice frameworks.

Keywords: child, adolescent, trauma, therapeutic residential care, mental health, practice framework

Introduction

This article aims to give some brief context to TRC both internationally and within Australia, before moving to discuss the development of an Australian practice framework, the Spiral to Recovery (Downey, 2012). There is a thread of criticism in the TRC literature that bemoans the lack of description of programs and practices, which Harder and Knorth (2014) call the 'black box', or the internal workings of therapeutic care. This article attempts to unpack the Catalyst black box.

Catalyst child and family services is a not-for-profit NGO established in 2013 in far north Queensland. Even though Catalyst is very new, and there is a lot of time ahead of us to make mistakes, we are extremely pleased with our achievements to date. At the time of writing this article, Catalyst has four therapeutic care houses, one with a mixed group of adolescents, and three with sibling groups. Two of our sibling groups are reunification houses, while the others are all under the long-term guardianship of the state. None of our services are as yet grant funded.

In general, the preference at Catalyst is to work with children and young people aged nine to thirteen (on entry to the residential program), who are exhibiting extremes of emotional and behavioural distress. We believe that it is better to put extensive resources into this group at a younger age, so that they can return to family life as soon as possible and avert the need to age out of care from a residential setting. While it is difficult to obtain the relevant data, from personal experience it seems that the most problematic young people in the OOHC system have been in care for many years. It seems logical that if we put intensive resources into helping them earlier, this can produce a cost saving, in terms of the young person's suffering and a reduction in expensive police and juvenile justice involvement. There are also medium term savings, in that we are returning young people to family based or less expensive forms of care, reducing the overall cost of residential services, and long-term cost savings into the future in relation to the use of justice, mental health and welfare resources.

In far north Queensland, around 75% of all children in OOHC are Indigenous, with up to 90% of those in residential care. To date all our children at Catalyst have been Aboriginal, some from remote Cape York and others from local communities. It is important to note that our frameworks and ways of working are not very different to how we work with non-Indigenous children. The way our program works is to automatically adjust to the needs of the specific children in our care. Having a high proportion of Indigenous clients does, however, force us to focus on cultural safety, which for us requires a great deal of work on workforce development, cultural awareness for all staff, and the recruitment and support of Indigenous staff.

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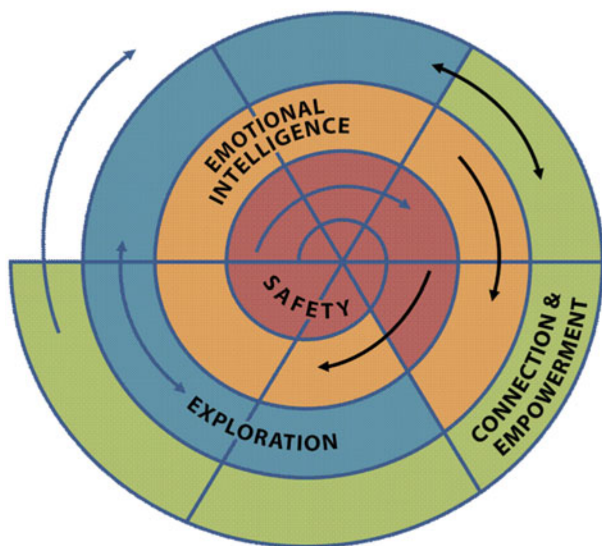

FIGURE 1
The Spiral to Recovery

Catalyst faces the challenge of being a small NGO with fluid and vulnerable funding. However, being small also gives us the opportunity to be responsive, flexible and highly creative in our work with children and families. We can easily respond to our own learnings, and we continuously modify our practice, policy and procedures, to meet the needs of the children. Hopefully, this article will convey some of the excitement Catalyst has generated about our work, and the possibilities and potential for genuine healing and growth that TRC offers.

Residential Care in Australia

Residential care in Australia is still seen generally as a placement of last resort, although the introduction of TRC over the last ten years has shifted this perception somewhat. The 'last resort' issue is thought to be due to the over-extended and crisis driven nature of OOHC, which has been reported on internationally for at least fifteen years and continues to worsen (Ainsworth & Maluccio, 2006; Australian Institute for Health and Welfare, 2014.

Many authors also comment, that along with the stresses and strains felt by care givers and workers in the OOHC system and the poor attention paid to OOHC politically and academically, the national data indicates that we are continuing to fail to halt the rise of children coming into care, the rise in placement breakdown, poor reunification rates, poor educational outcomes, and the poor social and emotional health and wellbeing of children in care (Barber, 2001; Carter, 2004; Cashmore, Paxman, & Townsend, 2007). The National Standards for OOHC: Consultation Paper (2010) states that it is 'widely reported that children who have been placed in OOHC have poorer life outcomes than other children' (FACSIA, 2010). It is also noted the high prevalence of mental health difficulties in the OOHC care population, stating that mental health is critically important for children and young people to develop emotional connections, stability and confidence.

In research conducted in 2007, foster carers indicated that more than half (54 %) of children and young people living in foster care arrangements required professional help for their mental health issues; however, only 27 % received this assistance. Further, 61 % of children in foster care had exhibited behavioural problems compared with 14 % of those in the general community (FACSIA, 2010).

All these factors contribute to the need for residential care as an option when family based placements are no longer possible, however residential care without a therapeutic focus has not proved to meet the needs of the complex group of young people to whom it provides a service (Verso Consulting, 2011).

Ainsworth and Thoburn (2014) suggest that TRC is most relevant for children and young people where foster or adoptive placements have been tried and failed, and should provide a more intensive service for children and young people with serious behavioural and mental health difficulties. TRC's should be clinically staffed treatment environments, that sensitively respond to 'stability' and 'belonging' needs. (Ainsworth & Thoburn, 2014).

Overview of the International Literature

TRC appears to come into focus as a field of practice and research at the beginning of the 21st century, even though much of the practice of TRC had been in use much earlier (Lee & Barth 2014; Lieberman, 2004; Teather, 2001; Whitaker, 2000). The typical client group for TRC are vulnerable and troubled children and young people, who have experienced multiple and complex abuse and neglect, usually beginning in infancy and early childhood, magnified by removal into care and subsequent disruption of placements and dislocation from family, community and identity. These young people all too frequently graduate to lives of conflict, violence, drug and alcohol misuse, mental health problems and criminal life styles, costing themselves, the next generation and the community multiple points of personal and financial suffering (Gilligan, 2014).

Outcomes in TRC

Recent reviews of existing research on TRC are not, as yet, particularly encouraging (Curry, 1991, Pecora, Whitaker, Maluccio, Barth, & DePanfilis, 2009). Lee, Bright, Svoboda, Fakunmoju, and Barth (2011) in a carefully executed, detailed and thorough analysis of residential care research in the US contrasted group care with non-residential treatment alternatives like Multi-Systemic Therapy or Multidimensional Therapeutic Foster Care, and found little in the research base favouring therapeutic residential services over these, except some family-oriented group care models (Lee and Thompson, 2008). They note the extremely

varied nature of group care treatment theory, which was also highlighted by Whitaker (2013). Whitaker (2013) also commented that TRC studies showed an absence of clear-cut diagnostic indicators for therapeutic residential placement; did not address concerns about attachment, in particular for young children placed in residential care; did not address the potential for further abuse and neglect within residential settings; had questionable outcomes; and could not form a consensus on critical intervention components. Whitaker also suggested that there was an atrophying of TRC theory and model development, and that the rising costs of residential care could not compete with the growing preference for family based alternatives.

While this is dismal news for TRC, particularly in the context of US based residential treatment facilities, where much of the research has been conducted, the Victorian evaluation of TRC (Verso Consulting, 2011) found a more positive picture. The Verso evaluation began with the hypothesis that a particular set of therapeutic resources, applied consistently, will provide better outcomes for children and young people than what is currently found in residential settings where those resources are not available, which was proven by the outcome data they collected.

They found that children and young people in the TRC pilots showed significant improvement over a range of outcome measures, and that the comparison group in their study, who were in general residential care, did not show this evidence of positive change. While TRC is more expensive than non-therapeutic care, they concluded that it does provide immediate, medium-term and long-term benefits for children and young people, for the community and service system, and for government, and net benefits are gained in reduced demand for crisis services and intensive intervention services such as secure welfare, youth justice, police and the courts (Verso Consulting, 2011).

Research into other programs that have a focus on therapeutic approaches to behaviour and are inclusive of family work have shown also good short term outcomes (Knorth, Harder, Zandberg, & Kendrick, 2008), while yet others found that better outcomes came with more time for the program to be effective, particularly when the service combined a residential program with extensive aftercare treatment, which allowed for a continuity of significant relationships (Curry, 1991).

Other research indicates the need for assessment, particularly risk assessment, and for therapeutic behavioural methods, empathy training, family work, adapted education, vocational assistance, relationship building, managing interpersonal conflicts, celebrating good things, relaxing, playing, processing thoughts and emotions through words and symbols, and encouraging a sense of purpose (Hillan, 2008). These elements are seen to be crucial in providing stability and improving medium to long-term outcomes for children and young people.

Several authors have commented that studies of residential care do not adequately specify program characteristics, measure disparate outcomes, lack control or comparison groups, do not randomly assign participants or correct for selection biases, and rarely assess long-term outcomes (James, 2011; Lee, Fakunmoju, Barth, & Walters, 2010; Whittaker, 2006), which makes using the literature to formulate new directions for TRC difficult. In reviews that have considered the effectiveness of residential care in improving various developmental outcomes, the findings are mixed (Lee et al., 2010).

Lee and Barth (2014) astutely caution against making sweeping conclusions about the effectiveness of residential care based on research studies that put together disparate programs. Not only do these fail to identify specific types of residential care that are shown to improve outcomes, but they rarely separate out other programs that may be ineffective or even have iatrogenic effects. This indicates the need for much more focused research into what actually works for which groups of young people in residential settings.

Whitaker, Valle and Holmes (2014) have provided a working definition of TRC, in stating the following.

> 'Therapeutic Residential Care involves the planful use of purposefully constructed, multi-dimensional living environments designed to enhance or provide treatment, education, socialisation, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum, of community-based formal and informal helping resources' (Whitaker et al., 2014, p. 24).

It is hoped that the Spiral to Recovery model, and the Catalyst organisational framework, fit the criteria outlined in the above definition; however, we have also aimed to take the work much further by providing a strong, easily understood yet complex framework that provides structure to our services, so that everyone knows where they are right now, where they have been and where they are going. The Spiral to Recovery is not a treatment protocol, as such, but it is far more than an 'approach' like milieu therapy, psychodynamic, attachment, trauma-informed or cognitive behavioural approaches used in residential programs, although it draws on aspects of all of these. The Spiral was initially developed through gathering up useful, practical, ethically and theoretically sound practices. We then put them together in an orderly way, so that residential staff would know how to best respond to the needs of abused and neglected children as they heal and grow. The model, in its essence, is a sequential 'map' of recovery, and is based on the idea that children cannot begin to heal until they feel safe, and cannot achieve growth until they have healed.

In utilising the Spiral to Recovery model, our experience indicates that TRC is much more than a residential program with a therapeutic or clinical component provided by an internal or external clinician or therapist. The therapeutic nature of a TRC program is deeply embedded into the residential structure, into every routine, scheduled activity and interaction between staff and children, and it cannot be

separated out or brought in as an 'add on'. It is the backbone of the service, holding everything else in place. Therapeutic care is also not the provision of therapy to a young person who is living in a residential placement. This article is an attempt to explain why the 'therapeutic' is embedded in the whole service, and how it can work in practice.

Our Focus

At Catalyst we focus on four main areas, the strength and health of our organisation, building the capacity of our residential managers to lead their teams to strong outcomes through modelling and supporting excellent therapeutic practice, training and supporting our staff to provide ongoing good quality care to our children and young people, and the clinical lens we bring to the assessment, planning and implementation of interventions on the ground.

The Organisation

Catalyst was set up in the belief that we could make a difference, and the original intention was to remain small and place based, although we recognise that we will have to grow to survive. This gives us incredible strength in terms of congruence (Anglin, 2002), in that everyone who works at Catalyst speaks the same language about the work; our policies and procedures follow and support the work, rather than leading and shaping the work; and our organisational structures and frameworks allow us to operate from a strong value base.

Leadership and Management

Catalyst frameworks rest on the belief that effective leadership is *the* essential element in successful TRC. Successful leaders are open with their staff, visible and active in the home, and communicate a clear and compelling vision. We have a Residential Manager (full or part time) in every house, who we support to hold the Spiral model and communicate it to their staff.

Having a leader who is present creates a sense of attention being paid to everyone in the residential environment, which in turn creates security and reduces anxiety. The Residential Managers think about the needs of both staff and children, and stand firm regarding limits and boundaries, while encouraging the formation of healing relationships. At Catalyst, we put a lot of effort into supporting and assisting our managers to cope with the ups and downs and the uncertainties of the work, so that the staff and young people can too (Downey, 2013).

Workforce Development

Many models of residential care focus exclusively on the children and young people admitted to the program. At Catalyst, we pay particular attention to acknowledging the impact the work has on our Care Practitioners (direct care staff), and the need to focus on the personal development of staff, as well as professional development. The interventions, responses and reactions of staff need continual refinement, as they need strategies to manage their own thoughts, emotions and reactions when working with the disturbed thoughts, emotions and behaviours of traumatised children and young people. We use reflective practice supervision and team meetings to ensure our staff are able to maintain calm, considered interventions and responses. The presence of the residential manager in the house contributes to this sense of containment, safety and the maintenance of high standards.

Workforce development is a crucial issue for therapeutic care in Australia, as our workforce tends to be under or unqualified, and there are currently no appropriate tertiary or industry qualifications in therapeutic care. At Catalyst we promote a learning culture, and try to maintain a high level of training for all our staff. While there are certificate courses for residential care, and we support our staff to attend these, none take a therapeutic approach, and so it is essential that the workforce grows and develops the knowledge, skills and expertise to bring to life the practice of therapeutic care. Currently Catalyst provides a 12 day internal training course, that follows the Spiral framework, and is delivered sequentially, so that knowledge and skill build over time.

The Interaction of Residential and Clinical Work

Developing a way of working in therapeutic care has been a long process and there have been major changes of thinking during this time. When first working in TRC, it seemed that through training all the workers in a theoretical understanding of the impact of trauma and attachment disruption, they would be able to work out how to respond to the needs of distressed, angry and frightened young people. Our work at Catalyst has demonstrated that this is not the best approach, as the theory (trauma, attachment, child development) is too complex for all but the most educated of our staff, and needs to be translated into 'doable' activities to make any real difference for young people.

In fact, what we have found to be effective is to give our staff practical tools for intervention, and a strong management team who can direct them on the ground, so that they operate as cogs in the wheel, rather than as independent practitioners who need the full complement of theory and practice to know what to do in any given situation. This approach is strengthened by our approach to team work, which we see as being a key ingredient in successful residential care. When a team works well together, they provide a collective response to the young people, reducing power battles and splitting, which in turn reduces complex behaviours.

In each of the Catalyst houses, alongside the Residential Manager, we have a Clinical Care Coordinator (CCC), who conducts assessments and develops Clinical Care Plans that

identify specific interventions the Care Practitioners are expected to use, to address the complex difficulties our young people present. The CCC may also conduct individual therapy or family work, as required.

Inside the Spiral to Recovery framework we also use the Child in Context Assessment framework (ChiCA) (Downey, 2012). These frameworks have been refined so that they now look simple on the surface, are easily explained (to staff and to stakeholders), and have become the language of the organisation. The frameworks remain quite complex, as they need to, but the complexity is not always obvious, as knowledge of that complexity is held in varying depths by different groups within the organisation. As staff mature into the work, and attend our carefully designed twelve month, sequential training program, they are exposed to more complex theory and refinement of practice, but they can still be effective in the work *before* they have a complete understanding of what is going on. The Clinical Care Plans direct them in their work, and they come to an understanding of what they are doing and how it is impacting on the young people over time. We have found that our Care Practitioners do not need to fully understand the complexities of trauma or attachment theory to undertake effective action.

Some of our practice at Catalyst may also seem somewhat controversial. We are perhaps not as inclusive of the young person's voice as is currently usual in OOHC, at least in the early stages of the recovery process. We take the perspective that we are 'parent like', and that young people need the safety and security of having adults in their lives who make good decisions, even when those decisions are not what they thought they wanted. We take the position that 'this is what we as adults think is best for you', and do not progress towards empowerment and independence until we are sure there has been some developmental healing. We set very firm limits with young people, particularly in the early stages of the program, and have found over and over that many young people coming from other care settings have been allowed to please themselves far too much, and that when we say no, there is often an aggressive response, because that has worked for them in other settings where they have been able to use aggression to get what they wanted and to escape from adult supervision and relationships.

We firmly believe that setting boundaries and challenging antisocial behaviour will not re-traumatise young people, but in fact give them a much needed sense of safety. We do challenge our young people and are not afraid of the consequences.

We have a strong pro-touch position, which is supported by policy, training and supervision. We touch the young people, hug them, rub their heads and rough house where appropriate, while also being very aware of personal boundaries and the potential to trigger sexual trauma responses. We are very careful with our male staff, of whom we have many, and support them to remain safe while also demonstrating that men can be gentle, nurturing and can show affection to young people in safe ways.

Outcomes

It would be presumptuous to describe Catalyst's outcomes due to the newness of the organisation. However, we have a robust outcomes framework and are collecting data as we go. Laurel Downey is engaged in PhD research that will use the data to demonstrate our results. We are, however, very pleased with the achievements of our young people so far. Our aim with all our young people is to return them to family life of some sort, if they wish, whether it is with their own parents or extended family, a kinship arrangement or general foster care. Our belief is that if we can connect young people with a caring family who can assist them in their continued journey toward positive wellbeing, and who can sustain them after they age out of care, they are much more likely to maintain and build on the gains they make while in the residential program, and much more likely to succeed in life and make a positive contribution to society. Over the life of Catalyst, some eighteen months at the writing of this article, we have returned one sibling group to their mother's care, another sibling group is on the way to reunification, a number of our complex to extreme young people have moved to foster care or less intensive residential options, while others are close to moving to kinship placements. It is also worth noting that we have very few interactions with police, with few callouts and we never use the police to help with the management of difficult behaviours.

Future Directions

While we have not yet had the opportunity to use the Spiral to Recovery in therapeutic foster care settings, we are confident that it will be effective, and it will be a matter of getting the right programmatic elements in place that may be the challenge, as the recruitment, training and support of foster carers can be a difficult business. We hope eventually to have a small suite of services that provide continuity of care, so that our young people can maintain relationships with staff and the organisation as they move from home-based care to residential or vice-versa, or return home to their families.

Overview of the Spiral to Recovery

Theoretical Base

The Spiral framework helps us think about and work with the impact of adverse early experiences on a child's sense of who they are, their ability to relate to others, to understand the normal expectations of behaviour and moral reasoning, their ability to manage stress, their capacity for relationships with family and peers, their physical and mental health and wellbeing, and their overall development and learning. The Spiral takes a resilience and strengths based approach to developing or re-developing the skills children and young people need to heal from past traumas and regain healthy developmental pathways.

The Spiral framework is a framework for recovery from abuse, neglect and other trauma, and as such has been

developed through theory and constant reviewing of practice. There are several points of theory that are very important to understand in relation to the recovery aspect of the program. In particular, the theoretical framework has moved away from a focus on only trauma and attachment theories, as we have been found that while trauma theory is vital to understand the fear response in traumatised children, and attachment theory is vital to understanding the child's internal working model, if we only use one or two theoretical lenses to develop practice, we can become one dimensional, which reduces our capacity to see and respond to the whole child.

We have noticed when discussing therapeutic care with other professionals and mental health clinicians, that there is a tendency to think that behavioural problems are caused solely by affect dysregulation, and are therefore all 'pain-based behaviours' (Anglin, 2002). The conclusion to this thinking is that if we understand this and work with the child or young person on regulating their emotions and actions, their behaviour will change, and they will no longer have behavioural problems. Anglin (2014) makes this point in stating that virtually all young people in residential care experience deep and profound psycho-emotional pain as a result of various traumatic experiences, and that this is often not consistently or effectively addressed, particularly in programs that focus on socialisation. He states that '... *while social capital and competencies need to be fostered, we must not ignore the fact that many of the challenging actions of the residents can be understood as "pain-based behaviour"*' (Anglin, 2014, p. 98).

Working with the Spiral to Recovery has led us to challenge this thinking, in that while affect regulation is a key factor in explosive behaviours, and we need to target regulation as an aspect of achieving safety and healing, it is not the only issue underlying problem behaviours such as lying, stealing, drug and alcohol use, criminal activity, instrumental aggression or relationship conflicts. It has been our experience that these issues rest more closely with the beliefs, attitudes, values and moral choices of young people, in the arena of socialisation, and are impacted on by the young person's sense of self, and identity. The 'trauma and attachment' approach suggests that training workers to think clinically, i.e., to understand the child and their experiences both positive and negative, will lead to good practice. The 'trauma and attachment' approach has therefore become polarised against a 'behaviour management' approach that is sometimes seen as punitive and not 'trauma-informed'. However, our experience has been that it is necessary to combine these approaches and find ways to work with children and young people that addresses antisocial behaviours while also understanding the impact of trauma.

These considerations have led to the use of an integration of theory within the Spiral to Recovery that gives a broader scope for practice interventions, and brings a focus to our work on the child's socialisation, integrating trauma and attachment theories with behaviour management. Socialisation in this context means the child's ability to respond to adult authority without too much shame, and to have an internalised sense of right and wrong that offers a moral compass to decision making and planning. The theory behind this thinking comes in part from social learning theory, and is heavily influenced by Schore's work on attachment, regulation and the development of the self (Schore, 1996; Schore & Schore, 2008). This focus is a real difference in the way the Spiral works, compared to other programs, and we are finding that it fits well with the Catalyst values-led organisational approach, as it allows our staff to think about their own beliefs and values and act in pro-social ways themselves.

Theoretical Base for a 'Stages' Model

The Spiral to Recovery is a stage based model, beginning with Safety to provide containment and settle the young person before moving to healing and then to growth.

Other authors have described the need for a staged or phased approach to recovery from trauma, most of whom have been influenced by Herman's seminal work (Herman, 1992). Herman described three stages of recovery from trauma, being Safety, Remembrance and Mourning, and Reconnection. Cook and colleagues, in re-developing these stages of recovery from trauma for children, discuss the stages as needing to include:

- safety in one's environment, including home, school, and community
- skills development in emotion regulation and interpersonal functioning
- meaning-making about past traumatic events they have experienced so that youth can consider more positive, adaptive views about themselves in the present, and experience hope about their future, and
- enhancing resiliency and integration into social networks (Cook, Blaustein, Spinazolla, & van der Kolk, 2003).

They also discuss the need for a phase based or sequential approach, citing research that shows treatment for adults that has all aspects of the work occurring simultaneously tends to create overload, and full recovery does not occur. They go on to say:

> 'This is likely to be especially true for children whose ability to attend to and process information is less well developed than adults. The sequential order of the treatment is such that the lessons learned in one phase serve as a building block for those that come next. The process is not linear, however, so that it is often necessary to revisit earlier phases of treatment in order to remain on the overall trajectory.' (Cook et al., 2003, p. 23)

The Spiral to Recovery outlines the stages of recovery a child or young person travels through as they heal and grow. There are four stages of recovery in the model, which have been developed through a process of deliberating on the research, designing the stages and modifying them through

feedback and review during the work with several other residential programs, and now with Catalyst. The stages are Safety, Emotional Intelligence, Exploration and Connection & Empowerment.

In using the Spiral framework at Catalyst, we begin the placement in Safety Stage with a brief assessment, so that we have some idea of the child's history, and current strengths and difficulties. We have come, over time, to believe that this first assessment can only be a snapshot of the child, and will reflect only their current functioning and not their potential. This assessment is very useful, however, as it gives us preliminary understanding of the difficulties they are likely to experience in Safety Stage, and the strengths they may have that we can promote and draw on to develop relationships that are necessary for healing and growth.

Safety, in our program, is developed through the establishment of structure, the provision of high levels of nurture, the setting of boundaries and limits, and we use the 'rupture and repair' strategy of allowing escalations to occur because we do set firm limits, allowing the relationships with care givers to rupture as the child becomes so angry at being asked to do something, or when we are saying no to something they want. In Safety Stage we say that the repair is the responsibility of the caregiver, that after the escalation is over, it is up to the adult to offer reassurance that the relationship is not damaged. This is a carefully designed strategy to assist young people develop internal regulation and to reduce toxic shame.

The young people in our programs are expected to respond to the adult care givers, and the Care Practitioners work hard to develop appropriate personal authority, so that they remain in charge. Consequences are used sparingly, and are not seen as punishments. Consequences are logical, and usually take the form of increased supervision and reduced freedom ('I will have to stay with you if you cannot . . . . . .', 'you can't go to late night shopping tonight because last week you ran away', or 'I'm sorry but we won't be able to go for a swim until you have cleaned that up'). As the young people progress through the Spiral, restorative consequences are introduced, so that the consequences have a relational perspective, and include apologies and tasks to help those who have been hurt, to make restoration.

In Safety Stage the activity schedule is very structured and fairly rigid, while the activities themselves are designed to be fun and catch the attention of the young people to give them many opportunities to spend time with the Care Practitioners so that relationships can be built while the young person is enjoying him/herself. The activities take up the whole day, so that the young person is kept busy and occupied, and not left to their own devices. For young people who are able to attend school, as much support is offered as necessary, and the structured program takes up the rest of the day. As young people move through the stages of the program, assessments are completed, and the program of activities is tailored to meet their specific needs. This system of scheduling is part of our 'black box'. The schedules are developed by the Residential Managers in collaboration with the CCCs, which combines the clinical lens with the practical and resource aware perspective of the Residential Manager. The schedules follow the young person's Clinical Care Plan goals, and relate to where they are in the Spiral.

Cultural safety is a key aspect of the whole program, which brings a focus on how a young person is most able to feel comfortable and safe at Catalyst. Being in far north Queensland, with a large over-representation of Indigenous children in care, we have spent considerable time reflecting on how to deliver the most culturally appropriate service. We encourage Indigenous staff in our recruitment and retention strategies, and have a big picture overview of cultural awareness and a little picture focus on the specific needs of children. This is an area for continued work in the future, and requires more collaboration and work with families and communities.

Young people in Safety stage are often angry, aggressive and violent. Running away is also very common. Our Care Practitioners attempt to follow or go with young people who are running away, and go out into the community to actively find them and bring them home. This allows the Care Practitioners to get to know the young person's family or other people the young person is spending time with, and gives the young person the idea that they are cared about and their safety is important. These practices have proved to reduce absconding, and increase the likelihood that the young people will let workers know where they are. When a young person is regularly running away to family members, we actively work with those people to help them understand that we want the young person to be safe, and that means them helping us to get the young person to return home. This can be delicate work, as young people will often say that we are not treating them well, and the family member will want to side with the young person. When it works, however, it closes off the child's access to inappropriate places to stay and allows them to see our staff working closely with their family members to keep them safe. It is also an effective strategy to work on a transition back to family based care.

Our young people have often become accustomed to getting what they want through escalation and intimidation, or by just taking off. In Safety Stage there is usually a mixture of fear based reaction, lack of trust in the adult world and a history of exposure to adults acting dangerously, dismissively and hurtfully, as well as the child having been allowed to get what they want through escalation in previous living environments. This requires a great effort from the team, who need extensive support through this period. When things work well, the team understands what they need to do and are able to hang together, Safety Stage usually lasts between three and six months.

We have come to see that often when Safety Stage goes on for longer, or becomes so intense that there is regular violence, it is our work that needs to be adjusted, with extra input from our senior staff to guide and direct that work on the ground. Our staff use a range of strategies to

assist in establishing safety, such as co-regulation, closeness and time-in, close supervision, redirection and constant attention, but are encouraged and support to stand firm in response to inappropriate behaviour. We train our staff in Therapeutic Crisis Intervention, which gives them the necessary strategies to de-escalate situations and manage their own reactions during a violent crisis. We do not use restraint, unless it is necessary to preserve life or prevent serious injury, but at times we will escort a young person outside to calm down, to reduce the potential for harm to themselves, to staff or to property.

Safety Stage mirrors work done in attachment focused programs based on the work of Hughes (1997), which has been very influential in the development of the Spiral framework (Becker-Weidman & Shell, 2005), along with elements of other models, theories and approaches. The model has a detailed Outcomes Framework that maps small changes in observed behaviour for each stage of the Spiral, so that we know how each young person is travelling through the program. This gives feedback to the residential team that allows them to see small progress, giving them hope that things are changing, as when they are in the thick of it they can easily lose that perspective. Over time we have noticed that the maps of Safety Stage start out looking quite positive, which we think is due to the 'honeymoon' effect, and that as the young person bounces up against our rules and boundaries, and realises that we are genuinely trying to connect with them, all their defences and problem behaviours will come out, and the maps look worse and worse for a while, before we start to see some progress. This requires intensive work with our stakeholders, who may not understand that this worsening of behaviour is to be expected and is part of the healing process.

When Safety has been developed, as evidenced by behavioural changes such as reduced running away, self-harm and aggression, as well as greater participation in programs, relaxation and enjoyment, the work shifts to the next stage, Emotional Intelligence.

The Emotional Intelligence Stage requires further clinical assessment to determine the child's capacity to regulate emotions and reactions, be aware of their own feelings and those of others, develop empathy and a conscience and operate within normal social rules and structures. A full assessment is possible after Safety Stage, as we see more of who the child really is. It is much easier to assess attachment security and style of attachment, once the escalated behaviour reduces. Many young people coming into a new placement look like they have characteristics of disorganised attachment or even Reactive Attachment Disorder (and they may have attracted this diagnosis), however once they are feeling safer with care givers, their attachment behaviours change, often dramatically, and we see more evidence of insecure avoidant and insecure ambivalent patterns. We have developed a range of interesting strategies and interventions to address different types of attachment behaviour, which our CCC's 'prescribe' and assist the Care Practitioners to implement. This is worth an article on its own, as it is very interesting to observe and measure.

The emphasis in Emotional Intelligence Stage is on the further development of secure relationships, the regulation of emotions, and developing appropriate behavioural responses to all situations. In this stage we also use rupture and repair strategies, but we may allow the young person to take some responsibility for repair. At this time we also introduce restorative consequences, where the young person has to make some effort to explain, apologise and make up for antisocial behaviour. We do not do this in Safety stage because the young people have not yet developed relationships and do not care enough about the care givers for it to be useful.

Again we use the detailed Outcomes Framework that is an integral part of the whole model, to map each stage, which gives constant feedback to the residential team and the Care Team, allowing ongoing refinement of strategies and interventions.

The next stage is Exploration, and as you may have gathered, we are trying to mimic children's normal development through the stages of the Spiral. We could see Safety Stage as a stage like infancy, where the child is held close, the adults are required to provide all the nurture and structure, in an attempt to make up for the developmental insults they have suffered. Emotional Intelligence stage is like toddlerhood, where we are focusing on regulation and moral development, on socialisation in fact, while in Exploration, we want them to go out into the world and explore relationships with peers, school experiences, and any other learning and development experiences we can give them. Many of our young people also need a lot of attention to issues of identity in this stage. Some of our young people are from remote Aboriginal communities where language and cultural practices are strong, and we need to assist them to remain strong in their culture. Others are from local, urbanised Indigenous communities where people may have lost touch with language and culture, and there is a need for them to understand and connect with their land and sense of identity as Aboriginal people. We try to ensure that we have Indigenous staff in all our houses, as this increases the opportunity for discussion and exploration of identity, history and place. Many of our children, wherever they are from, have family histories of stolen generations, and of dispossession and exploitation. These painful histories can be explored once children feel safe and have the emotional maturity to cope with strong feelings.

This is the stage where the child's trauma story may be explored, either through Life Story work or through formal therapy, with our clinicians or externally. In fact the majority of our children haven't done any formal therapy, and their progress through the Spiral suggests that this may not be needed, as the therapeutic work is getting done in the residential setting. Again, this is an area for future research. In every stage we support young people's connection with their biological families, and where possible, we include

family work in our program, although many of our children visit their families, there is not often the opportunity to do much work with them, for a range of reasons. And, as Dowden and Andrews (2000) comment, not all family interventions work for all troubled youth.

In Exploration Stage, however, we hope to assist the young people to make sense of their families, and resolve for themselves what their families mean to them, what has happened in the past and what their feelings are toward family members. Many young people, particularly Indigenous young people, will have lost contact with extended family during their time in care, and we make efforts to find family and build relationships with family members, where this is safe to do.

Around 60–80% of young people attempt to return home after leaving care (Hillan, 2008), with some successfully making this transition and others suffering further rejection or abuse. Engaging and working with families is very important in assisting young people in care to make successful transitions to adult life, a complex undertaking for the client population of residential care.

If the young person has no or few available family members, or family members not able or suitable for reunification, we then work to find potential foster families for them. In our experience of working with the Spiral to Recovery in a variety of settings, many young people can return to family based placements, or to their natural families, often surprising us with their ability to do this successfully. If, however, a transition to independent living is the most useful pathway for a young person, the Connection and Empowerment Stage is built to assist in that process.

The final stage, Connection and Empowerment, continues the work of exploration, allowing young people greater freedom and free time, and encouraging them to take greater responsibility. In this stage, conflict resolution, problem solving and other relationships skills are emphasised so that young people can live with others safely and manage life tasks. During this stage some young people will be working on empowerment for independence, as they are not likely to return to a family based placement or home, and others will be working on empowerment with family, depending on their age and circumstances. We take quite different tacks with each of these forms of Connection and Empowerment, as it is a very different life for a sixteen year old returning to a family setting, where adults will be making a lot of the decisions and they will need to abide by house and family rules, compared to a young person who is going to be living independently, who will need to take care of themselves, pay their own bills, get themselves to where they need to be and probably live in some kind of shared accommodation, where they will need to get on with others and solve conflicts and disagreements.

These final stages are mapped as extensively as the first two, and while the work is not as crisis driven, it still requires a great deal of attention and focus from the residential team.

The stages are not conceptualised as proceeding in a linear way, hence the spiral motif, although Safety always comes first. The model is conceptualised as a spiral because there is often a return to earlier stages with a need for more security and safety, as the young people grow and move, tackle difficulties and deal with traumatic past events. Progress does move forward, but often as two steps forward and one step back, and this needs to be tracked (using the outcomes framework) to ensure that the program is sensitive to the young person's actual needs at any given time.

Nurture is a vital aspect of the Spiral approach. The program relies heavily on structure, rules and boundaries, which can feel institutional if it is not balanced with nurture. Nurture is given unconditionally through affection, touch, kindness, words, gestures and support. There is a tendency in OOHC to use 'easy nurture', such as fast food and other rewards (the pizza and X-Box syndrome). At Catalyst we try not to give easy nurture, either as a reward or as a form of soothing. (Fast food can be a treat, but is not used as nurture). Nutritious food is nurturing, although care must be taken not to over-use food as a tool for engagement and soothing, as many young people put on excessive amounts of weight in residential care. Physical presence, help with grooming, affectionate touch, words and gestures are the primary vehicles we use to demonstrate nurturing care.

Conclusion

We have tried in this article, to give a peek into the 'black box' of the Spiral to Recovery framework for TRC, as it is used at Catalyst child and family services. The critical elements of the framework are the integrated theoretical lens, the stage or phase-based nature of the work, and the combination of clinical thinking and good residential management and leadership.

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