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Service Stream	Families and Young People Services	Category	Residential Care and Transitional Services
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1. Scope

Current statistics from the Australian Institute of Family Services outline an 18% growth in the number of children and young people entering Out of Home Care in the four (4) years between 2013 and 2017. Due to this drastic increase, it is critical for service providers to ensure they are caring for children and young people in a holistic and therapeutic approach, with an overarching goal to support them to engage in trauma recovery and be able to safely move towards either family/foster care placement or transition into successful independent living.

Historically, maintaining momentum and direction of children and young people's development while in Out of Home Care has been challenging. This has been observed as some children and young people in Out of Home Care placements reach critical transition ages (between 16 and 18 years old) without the required life skills or emotional resilience to successfully overcome the increased life challenges and responsibilities. It is widely acknowledged that children and young people who have trauma histories will require additional support during childhood and into adulthood. Due to this, it is critical to ensure that they are provided with a type of care that supports them to continue to grow and develop, and to ensure they are actively moving towards recovery and positive mental and physical outcomes.

This Practice Paper is designed to provide an understanding of the Phased Trauma Recovery Model for Out of Home Care; the theory underpinning the model and the process of implementation has been developed by Mercy Community's (MC's) Clinical Lead, Emma Braun. The purpose is to support MC's Families and Young People Services to strengthen therapeutic intervention provided by our residential care programs and increase achievement of positive outcomes that are in line with current trauma recovery research and Queensland Government Frameworks. Along with improving outcomes for children and young people, this model aims to increase the readiness of young people to engage in critical transition periods.

2. Literature Review

Trauma Recovery Models

Finkelhor and Browne (1986) presented a model of analysing the effects of trauma in terms of four trauma-causing factors, referred to as 'traumagenic dynamics': Traumatic sexualisation, stigmatisation, betrayal, and powerlessness. Finkelhor and Browne (1986) state that when present, these traumatic dynamics alter the child's emotional and cognitive orientation to the world and create trauma by distorting a child's self-concept, world view, and effective capacities. Findings such as these point strongly towards the need to ensure out of home care services engage proactively in trauma recovery practices to support children and young people recover positive and resilient emotional and cognitive capacities.

The use of a phased approach has been at the heart of trauma recovery systems since the late 1800's and the work of Dr Pierre Janet (Van Der Hart, Brown, and Van Der Kolk, 1989). Janet proposed a three (3) phased recovery model which began with a phase of (1) stabilisation and period of preparation for the coming phases of the recovery, this then moving into a second phase of (2) identification, exploration, and modification of the traumatic memories, and finally the third phase of (3) relapse prevention, relief of residual symptomology, personality reintegration and rehabilitation. Moving towards a more modern proposed model, Judith Herman (1992; 1997) adapted Janet's original model, presenting the Three Phases of Trauma Recovery as (1) Safety

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and Stabilisation, (2) Recalling trauma memories, loss and mourning and (3) Reconnection and Integration.

Within the Out of Home Care sector, variations of these existing trauma recovery phases have been presented, such as Friedrich (1996) four phases of the trauma recovery. This phased process identifies additional aspects that are relevant within the Out of Home Care sector, as well as working specifically with children and young people who have experienced traumatic events. Friedrich outlines the phases as (1) Establishment (both of the therapeutic relationship and a safe and nurturing environment), (2) Exploration of Trauma (including the various aspects of treatment and reparative experience), (3) Repairing the sense of self (processing aspects of feelings of guilt and shame stemming from the trauma and developing protective skills) and finally (4) Becoming Future Orientated (developing the ability to focus on the present and future, as well as acknowledge the accomplishment that has led to recovery).

Developmental Milestones

The effects of trauma on children and young people's development are well researched and explored. Cook et al (2005) provides a clear summary of the effects that trauma has on the development of children and young people:

- **Attachment:** Trouble with relationships, boundaries, empathy, and social isolation.
- **Physical health:** Impaired sensorimotor development, coordination problems, increased medical problems, and somatic symptoms.
- **Emotional regulation:** Difficulty identifying or labelling feelings and communicating needs.
- **Dissociation:** Altered states of consciousness, amnesia, impaired memory.
- **Cognitive ability:** Problems with focus, learning, processing new information, language development, planning and orientation to time and space.
- **Self-concept:** Lack of consistent sense of self, body image issues, low self-esteem, shame, and guilt.
- **Behavioural control:** Difficulty controlling impulses, oppositional behaviour, aggression, disrupted sleep and eating patterns, trauma re-enactment.

The natural progression of developing skills and abilities is disrupted by the experience of trauma, resulting in the child not being able to progress with their individual development successfully and adaptively. It is in this space that children and young people develop maladaptive and, at times, harmful, approaches to managing their ever-increasing complex environment.

The use of a phased trauma recovery model can support children and young people to engage in opportunities to learn more adaptive and functional skills, and reach developmental milestones shared by their peers.

Skill Acquisition Order

Due to the developmental deficits that trauma experiences can cause in children and young people, there is the need to support development of these necessary skills with a therapeutic and informed progression which enables children and young people to build upon each skill as they learn them. The ARC Framework developed by Blaustein and Kinniburgh (2010) provides a framework which structures the phases to support children and young people to progress through developing positive attachment, to developing regulation (self-regulation) skills and into achieving high levels of competency. The ARC Framework is based on the concept that each skill is built upon to achieve higher and more complex skills.

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Resilience

It is through healthy human development that people develop the capacity to be resilient in times of challenge. Resilience is the ability to rebound from adversity with greater strength to meet future challenges (Walsh, 1998). Research into resilience has found that all have the capacity to develop and strengthen their resilient response, and that the human brain is wired to overcome many challenging experiences (Brendtro and Larson, 2006). Resilience is both an internal personality trait, as well because of external supports or protective factors. Through supporting children and young people to move through a trauma recovery process and see the positive success and recovery, they are being exposed to positive external support and new experiences that provide a new internal script of their capacity to survive and thrive. The process to support children and young people with developing positive normed resilience can be challenging and difficult, in that they often need more support to continue to try and overcome the challenges. This is often represented as needing to support the young person to fill up their cup when they are low on resilience, motivation or experiencing high emotional distress.

3. The Phased Trauma Recovery Model for Out of Home Care

The four areas noted above; trauma recovery, childhood development, resilience and the order of skill acquisition have all been used to develop the Phased Trauma Recovery Model for Out of Home Care. This phased intervention for trauma recovery within an out of home care setting provides support to guide interventions to achieve positive outcomes for the children and young people within MC's residential care programs. The Phased Trauma Recovery Model has been developed specifically for use within out of home care and Specialty Settings and is used across all MC's Residential Care and Transition Services (RCaTS) programs to support a continuum of care that is specifically designed to support young people in different stages of their development and recovery to reach their full potential. It is important to acknowledge that this trauma recovery model aligns with the Queensland Hope and Healing Framework and its presentation of The Phases of Care.

As well as providing a clinically informed overarching structure to support trauma recovery and capacity development, the Phased Trauma Recovery Model provides a platform for deeper assessment and understanding of the type of support a young person requires, development of meaningful long-term planning and opportunity to explore progress and growth.

Understanding that out of home care service provision does not have a solely intervention focus, the Phased Trauma Recovery Model aligns with the operational needs of providing residential care to children and young people. This can be seen in how it supports planning around the long-term progression and need to explore transitions, either within a service or to another service (such as in Phase Four). It supports rostering and staffing models by proving projected capacities of the young people to manage with less intensive support and provides clear goals and outcomes to demonstrate meeting accreditation requirements. The Phased Trauma Recovery Model is designed to sit within the real-world requirements of providing therapeutic residential care.

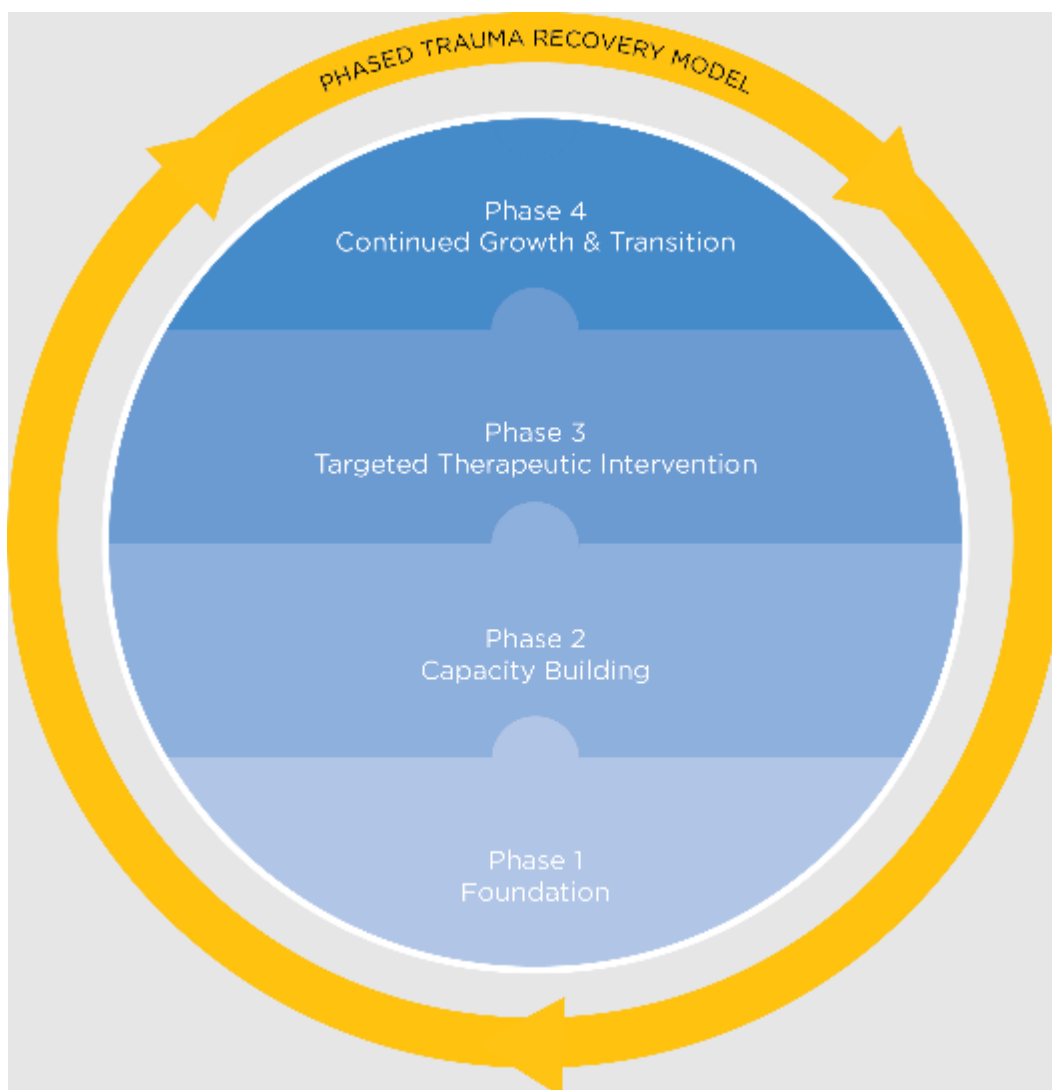
Divided into four (4) phases, the Phased Trauma Recovery Model follows the progression of a young person from stabilisation of crisis, towards skill and capacity building, through trauma integration and into continued growth and future transition planning. Each phase of the model is underpinned by the need to engage in the four main areas to support the continued development and recovery. These are Attachment, Regulation, Competence and Community. These four main

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areas have been designed to encompass tools that reflect trauma recovery research and practice, and the goals outlined in the Queensland Out of Home Care Outcomes Framework.

The Phased Trauma Recovery Model can be visualised as supporting a young person to ‘fill their cup’ as they move through the model. This is represented in the images associated with each phase, progressively showing the sphere filling. This is not a linear model and allows space for a young person to experience challenge and build resilience as they progress through the model. This may be experienced as encountering a challenge that they do not yet have the skills or capacity to overcome, and therefore need to return to the pervious phase to either continue to practice and refine their skills or learn new skills and capacities to overcome the presenting challenge. It is important to provide language around children and young people’s progression towards trauma recovery as each child has their own unique journey with its own unique twists and turns. The Phased Trauma Recovery Model does not hold a child to a perfect progression, but rather supports them to experience both aspects of a healthy and desired resilient response, both the challenge and the success. Through supporting those who work within the child protection sector to view the child’s journey through this lens of ‘filling their cup’ supports a child-focused approach and can re-frame an often crisis driven/focused mindset.

Below, the model is displayed pictorially.



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Phased Trauma Recovery Model for Out of Home Care



Phase 1 – Foundation

Entry to 3 months: Crisis containment, assessment, and stabilisation.

The priority when a child enters a MC residential placement is to contain the crisis. Attachment issues are addressed by providing a safe and structured environment with predictable expectations and routines. Initial plans are put in place to address immediate health needs, family contact arrangements and education requirements. The young person's new home environment is personalised to suit them, through supporting them to set up their bedroom to reflect their own personality. During the initial assessment period, the practitioner will engage with the Department of Child Safety, Seniors, and Disability Services (the Department) to understand the future plans and goals for the young person, with the aim of tailoring support to best suit the young person. This conversation will be regularly revisited as the young person grows and develops to re-assess and review progress. The young person entering the program will be introduced to their MC Reference Person, which will be the CTL. The role of the Reference Person is to be a central point of contact and decision making within the program, as well as supporting the young person to engage in therapeutic conversations.

In a co-tenanted program, the introduction of a new young person can be a destabilising and challenging time. This process will be supported by a program re-set. During this time the existing young people in the program will be supported to understand the reasons behind a house re-set (such as ensuring everyone is safe), while the new young person will be supported to learn the expectations of safety and appropriate boundaries in the program. The care team will engage the young person with attuned carer skills, helping them to identify their internal emotional experiences and model ways to safely express emotions. Alongside this teaching, the care team will introduce psychoeducation and regulation tools to support the young person to communicate their emotional states and feel connected and a part of their new placement. At the start of this phase, a Positive Behaviour Support Plan (PBSP) and goals are developed for the young person. These are regularly reviewed at scheduled intervals and as behaviour changes or new behaviours present. The care team use Therapeutic Crisis Intervention (TCI) skills to prevent, de-escalate and capture learning opportunities provided by crises that emerge.

During the Foundation phase, the young person's needs are comprehensively assessed in collaboration with agency partners and other key stakeholders. These assessments support detailed plans to be established for the next phase. The Foundation phase is aimed to support the young person to be orientated into the MC residential care program and begin to develop the primary skills to progress through onto a deeper and more beneficial development.

Attachment	Regulation	Competence	Community
<ul style="list-style-type: none"> Weekly house meeting – provide feedback and concerns. Risk assessment and safety planning. Consistency in MC care team and introduction to Reference Person. 	<ul style="list-style-type: none"> Go-2-Plan Introduction to house expectations and responsibilities. Introduction of Reference Person. Goal-based incentives. Development of PBSP and goals. 	<ul style="list-style-type: none"> Therapeutic Assessment Report (TAR): <ul style="list-style-type: none"> Functional/Living Skills Assessment. Social Skills Assessment. Initial Education/Vocation 	<ul style="list-style-type: none"> Maintain and support any positive existing community engagement. Focus on supporting positive house dynamics and local community engagement.

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Attachment	Regulation	Competence	Community
<ul style="list-style-type: none"> • ARC Framework Base Blocks. • Placement orientation – personal needs, support, rights. • Support with current family contact plan. • Possessions register. 	<ul style="list-style-type: none"> • TCI – co-regulation skills. 	<ul style="list-style-type: none"> • Engagement Assessment. <ul style="list-style-type: none"> ◦ Developmental Milestone Assessment. • Strengths and Needs Assessment. • House re-set agreement (if co-tenant present) 	<ul style="list-style-type: none"> • Develop safety and support network (via stakeholder group). • Introduction to Community Meetings, house meetings, and daily planning meetings. • Setting of stakeholder meetings. • Commencement of Cultural Support Plan.



Phase 2 – Capacity Building

3 to 6 months: Capacity building to strengthen coping and protective factors.

The groundwork that has been done during the Foundation phase becomes the basis of the Capacity Building Phase. The focus now shifts to systematically strengthening the coping and protective factors in the young person's life.

The young person's program is refined to address the specific needs that have been identified in the assessment PBSP and goals. Structured activities and coaching are provided to build self-regulation capacities, as well as specific competencies identified across the outcome domains.

During this phase, the care team supporting the young person begins to gather information relating to the young person's life history. This includes working with other stakeholders, family, and the young person to gather information, views, and current understanding of their life history.

The young person will begin to develop more capacities to manage increasing expectations and increase goal setting, with the aim of working towards preparing the young person to engage in targeted therapy during the next phase.

Attachment	Regulation	Competence	Community
<ul style="list-style-type: none"> • Weekly house meeting – provide feedback and concerns. • Risk assessment and safety planning. • Consistency in MC care team and Reference Person. • ARC Framework Base Blocks – continue. • Life history information gathering. • Possessions register (review and update as the gather more personal items). 	<ul style="list-style-type: none"> • Reference Person to guide and structure readiness for therapy. • Goal-based incentives. • ARC Framework Regulation Blocks. • Ongoing PBSP, goal plans, and TAR reviews. 	<ul style="list-style-type: none"> • Targeted living skill development. • Social skills – body language and appropriate reactions. • Education Support Plan and review. • Physical activity focus/group sport. • Ongoing clinical assessment update. • Critical decision – making point (targeted therapy). • Family focused psychoeducation 	<ul style="list-style-type: none"> • Participation in community events and activities. • Connection to cultural background. • Increased community access risk assessment and safety planning. • Ongoing Cultural Support Plan reviews. • Peer Contact Plan. • Formulation meeting (every 6 months).

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Attachment	Regulation	Competence (based on future transition plan).	Community



Phase 3 – Targeted Therapeutic Intervention

6 to 12 months: Trauma recovery and integration.

During the first 6 to 12 months of the program, the young person's situation has been stabilised and they are developing key coping skills. The pre-counselling relationship with the Reference Person has prepared the young person so that they are now able to fully engage in the therapy program that matches their needs. The young person's aptitude or interest in a particular activity or skill is fostered during this phase.

Engagement in community is also extended, so that the child builds feelings of self-efficacy and positive identity by actively contributing to a pro-social community event or program.

During this phase, the young person is supported to actively engage in the appropriate level of life history work. This will be supported by their Reference Person, external therapy support, the department and, if possible, family members. The aim of this project is to support the young person to understand their life history and to develop a resilient view of their experiences and capacity to handle possible future challenges.

Attachment	Regulation	Competence	Community
<ul style="list-style-type: none"> Weekly house meeting – provide feedback and concerns. Risk assessment and safety planning. Consistency in MC care team and Reference Person. ARC Framework Base Block - continue. Life History project. Family contact in line with Child Safety assessment. Possessions register (review and update as the gather more personal items). 	<ul style="list-style-type: none"> External therapy engagement. ARC Framework Regulation Blocks – continue. Goal-based incentives. Ongoing PBSP, goals, and TAR reviews. 	<ul style="list-style-type: none"> Targeted activities aim to build on existing talents/interests. ARC Framework Competency Blocks. Critical decision-making point (transition). Assessment of co-tenant options (if single tenanted). Family focused psychoeducation (based on future transition plan). 	<ul style="list-style-type: none"> Specific community program – making a positive contribution. Risk assessment and safety planning for community engagement. Ongoing Cultural Support Plan reviews. Peer Contact Plan. Formulation meeting (every 6 months).

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Phase 4 – Continued Growth and Transition

12 months to transition: Ongoing development and transition preparation.

The activities of the earlier phases continue to enhance the young person's resilience in Phase 4. The interplay of therapy, competence building, family and social connections are consolidated. This includes systems being set up to ensure the young person's safety, development of trusting relationship, management of difficult emotions, competence building, therapeutic crisis interventions as well as cultural and community connections. During the Continued Growth and Transition Phase, the therapeutic program is focused on maintaining the improvements and preparing the young person for permanent transition into their next placement. Practical emotional, familial, cultural, and professional supports are established, and contingency plans are prepared.

Attachment	Regulation	Competence	Community
<ul style="list-style-type: none"> Weekly house meeting – provide feedback and concerns. Risk assessment and safety planning. Consistency in MC Care Team and Reference Person. ARC Framework Base Block – continue. Life History project – review at 3–6-month period. Family contact in line with Child Safety assessment. Possessions register (including possible prep for new placement). 	<ul style="list-style-type: none"> External therapy engagement. ARC Framework Regulation Blocks – continue. Goal-based incentives. Ongoing PBISP, goals, and TAR reviews. 	<ul style="list-style-type: none"> Targeted activities aim to build on existing talents/interests. ARC Framework Competency Blocks – continue. Ongoing Clinical Assessments. Age developmental milestone capacity building. Transition Support Plan and active support to meet transition goals. Family focused psychoeducation (based on future transition plan). 	<ul style="list-style-type: none"> Specific community program – making a positive contribution. Risk assessment and safety planning. Ongoing Cultural Support Plan reviews. Peer Contact Plan. Formulation meeting (every 6 months).

4. Implementation in Out-of-Home Care

The Phased Trauma Recovery Model is an integrated aspect of the residential care structure within MC. This model feeds into both the operational and therapeutic aspects of the planning and support provided to the children and young people supported by MC.

Clinical Planning and Interventions

The Phased Trauma Recovery Model provides and supports several critical clinical underpinnings of the therapeutic work conducted within MC. These are as follows:

- Provides a clinically sound over-arching structure to support trauma recovery within an out of home care setting;
- Provides detailed therapeutic goals appropriate for each stage of trauma recovery;
- Supports individualised and proactive planning while ensuring that all therapeutic aspects of the young person's recovery and future development are considered;

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- Aligns with The Queensland Outcomes Framework and provides a structure to evidence appropriate outcomes based on the specific needs of the young person;
- Supports clinical planning to transition young people out of residential care and into either family based or independent living placements; and
- Provides support to engage in needs-based matching of young people within a program setting and projected co-tenant matching timeframes.

Operational Planning

Although the Phased Trauma Recovery Model is primarily a therapeutic model with a clinical foundation, the structure it provides to residential care program design and the expected transition within the program offers supports to operational planning. Operational plans can be supported by aligning to the projected needs of the young people through the Phased Trauma Recovery Model. . These may include:

- Changes to/or allocation of resources that match to the young person's needs, such as staffing models;
- Assessing appropriate times in the therapeutic recovery of the young people in the program to make significant changes, such as moving to a new house or planned renovations;
- Demonstration of planned outcomes to measure accountability and funding;
- Professional development and training focus for the team; and
- Support rationale for appropriate matching and pairing of co-tenant timeframes.

The Phased Trauma Recovery Model is an overarching structure that supports all strategies and interventions engaged to support the children and young people within the residential setting.

Key interactions:

- Initial meeting with Child Safety and Stakeholders to introduce Phased Trauma Recovery Model and discuss individualised goals and outcomes for the young person;
- Formulation Meetings – Group stakeholder meeting to engage in a clinical formulation of the current challenges and priority interventions. This occurs 6 monthly if possible or as the needs arises. During a Formulation meeting decision-making occurs in the context of the current Phase that the child or young person is in;
- Regular Stakeholder Meetings – to support providing feedback and updates on outcomes and actions/interventions to reach set goals. The Phased Trauma Recovery Model can also be used to support future planning and roles and responsibilities of stakeholder group members. This is a forum for conversations about how to best support the child or young person through the Phases with their specific goals and desired outcomes in mind;
- Positive Behaviour Support Plan – supports the structure of planned interventions and proactive strategies in place as the young person moves through the model;
- Therapeutic Assessment Report – as a tool to demonstrate progressions and trauma recovery stage. This will also support Formulation Meetings when these occur;
- Planning for future transitions;
- Fortnightly meetings with the care team to support whole team vision for sustaining trauma recovery and capacity building, as well as intentionality and reason behind planned intervention.

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The Phased Trauma Recovery Model for Out of Home Care Practice Paper has been developed by Clinical Lead Emma Braun (2019).

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Related Documents
<p>CTARS Documents:</p> <p>CTARS Therapeutic Assessment Report</p> <p>CTARS Cultural Support Plan</p> <p>MercyNet Documents:</p> <p>FS FORM RCaTS Positive Behaviour Support Plan</p>