commission for children and young people and child guardian

A better life for Queensland children

Views of Young People in Residential Care Survey

Responding to trauma and attachment needs in residential care: What young people's perceptions tell us about how well we're doing in Queensland

This paper aims to contribute to the task of evaluating Queensland's efforts to cultivate trauma and attachment informed residential care environments. This is achieved, firstly, by identifying broad therapeutic goals and core therapeutic tasks of trauma and attachment informed residential care based on an examination of the theoretical and research literature. The paper then considers evidence from a valuable contemporary source of information about the quality of therapeutic practice in Queensland residential care – the 2011 *Views of Young People in Residential Care Survey*. This survey investigates young people's observations and perceptions of the care environment and aspects of their personal wellbeing relevant to two core therapeutic tasks – *building therapeutic caring relationships* with young people and *creating sanctuary* in the care environment.

The findings suggest some success is being achieved in Queensland with regard to building therapeutic caring relationships, but that many programs are falling short of creating a sanctuary in the care environment, potentially jeopardising positive therapeutic and developmental outcomes for young people. A key implication of the findings is the urgent need for more trauma-sensitive program design in residential care, with particular consideration given to how the environment is managed so that it is not experienced as threatening or stressful by young people and promotes their sense of predictability and rationality.

Introduction

A new approach to residential care in Australia

The last 15 to 20 years have seen a dramatic increase in knowledge about the impacts of trauma and attachment difficulties on children and their development. In many parts of the world, including Australia, this has nurtured interest in the application of trauma, attachment and child development theories to the care and treatment of young people in statutory residential care. This follows from recognition that the vast majority of young people accommodated in residential care at the present time have experienced severe trauma and attachment problems in their early childhood and typically demonstrate the emotional and behavioural sequelae of what is known as *complex trauma* (Bath, 2008). It also follows from recognition that traditional approaches to residential care have widely failed to address the complex interrelated problems these young people experience and have at times made these worse (Downey & Holmes, 2010; Morton *et al.*, 1999).

Interest in developing trauma and attachment informed approaches to residential care reached a critical mass in Australia in 2010 with the inaugural National Therapeutic Residential Care Workshop being held in Victoria with the endorsement of the Community and Disability Services Ministers' Advisory Council. This forum resulted in, amongst other things, a national definition of therapeutic residential care:

> Therapeutic residential care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment and developmental needs. (McLean *et al.*, 2011: 2)

Developments in Queensland

In line with this national policy movement, the Queensland Government's policy has evolved in

recent years to stipulate that statutory residential care is to be "informed by attachment, trauma and child development theories and research to respond to the physical, social and emotional needs of each child or young person placed" (Department of Communities, 2010: 1).

To assist with developing practice in this area, the Department of Communities, Child Safety and Disability Services, in partnership with the lead agency for residential care services in Queensland, PeakCare, developed a broad overarching framework for trauma and attachment informed practice in 2010 – the *Contemporary Model of Residential Care for Children and Young People in Care*. The Model puts forward some principles for trauma and attachment informed residential care and identifies some of the possible implications for implementation at various levels of the service system. The Model emphasises:

- comprehensive, skilled assessments to inform placements, transitions and interventions for each young person
- relationship-based work with young people at the direct-care level supplemented by specialist therapeutic services as required
- the importance of highly skilled and well supported staff
- collaborations across agencies in responding to the multiple interrelated needs of young people
- supporting young people to build/rebuild/ achieve healing in relationships with family, and build connections to culture and community
- empowering young people through nurturing their participation in shaping their care, treatment and futures, and
- adherence to the Department's Positive Behaviour Support Policy which specifies a relationship-based approach to managing children's behaviour issues and the use of behaviour management techniques that aim to avoid re-traumatising children.

Beyond these elements, however, the Model does not specify what trauma and attachment informed residential care constitutes. It does not articulate core therapeutic goals, tasks or methods based on trauma and attachment theories and research, nor does it define what is intended by terms like trauma and attachment-responsive interventions (p. 20) and "relationship-based care" (p. 29). The unfortunate effect of this is to leave the concept of "trauma and attachment informed residential care" without clarity and specificity.

Current minimum service standards for residential care which underpin the licensing and monitoring of service providers (Department of Communities, 2011) do not help to clarify what trauma and attachment informed residential care is or is not. There are no service design specifications relating specifically to trauma and attachment informed care, nor is there a requirement on service providers to evidence the application of these conceptual frameworks in program design. Similarly, service providers are not required to show evidence of staff knowledge, skill, personal attributes and professional supervision in line with those that current research suggests are necessary for providing effective trauma and attachment informed care. Indeed, there are currently *no* minimum qualifications specified for residential care staff in these standards. Neither are services required to specify or demonstrate therapeutic or developmental outcomes for young people in line with the broad objectives of trauma and attachment informed care, such as improvements in young people's emotional, social and cognitive functioning over time.

The central problem with this lack of specificity in the concept of trauma and attachment informed residential care is that it prevents assessment of the implementation of the Government's residential care policy and whether or not it is achieving desired impacts on the lives of the young people being cared for.

The objectives of this paper

This paper aims to contribute to the task of evaluating Queensland's efforts to cultivate trauma and attachment informed residential care environments. The first stage in this process is to address the current lack of specificity in the concept of trauma and attachment informed residential care. This is achieved in two steps:

- Firstly, the *broad therapeutic goals* of such care are identified through an examination of how the needs of young people in residential care are conceptualised within trauma and attachment theories.
- Secondly, five *core therapeutic tasks* of trauma and attachment informed residential care are proposed based on an examination of key themes in the therapeutic literature about how to achieve these various goals.

Once the concept of trauma and attachment informed residential care is given clarity and specificity, the paper turns to examine evidence from a valuable contemporary source of information about the quality of therapeutic practice in Queensland residential care – the 2011 *Views of Young People in Residential Care Survey*. This survey investigates young people's observations and perceptions of the care environment and aspects of their personal wellbeing relevant to two of the core therapeutic tasks identified – *building therapeutic caring relationships* with young people and *creating sanctuary* in the care environment. Various implications of the findings for policy and practice are then discussed.

A new understanding of the needs of young people in residential care

Young people in residential care frequently behave in ways that may seem disturbing or perplexing to others. Such behaviour may include sudden and unexpected outbursts of aggression or rage, self-harming, suicidal ideation, bullying and controlling behaviour towards others, and other inappropriate social or sexual behaviour. It may include being in depressive or dissociative states, or routinely demonstrating irritability, inattentiveness, impulsiveness or risk-taking. These and other common behavioural characteristics have resulted in this population of young people over successive decades being judged as "mad" or "bad", with resulting prescriptions for intervention focused on containment, discipline, moral education, and/or behaviour modification (Abramovitz & Bloom, 2003; Commission of Inquiry into the Abuse of Children in Queensland Institutions, 1999). Not only have many such interventions failed to improve young people's behaviour but they have often compounded their problems (Bath, 1998; Commission of Inquiry into the Abuse of Children in Queensland Institutions, 1999; Morton *et al.*, 1999).

Trauma and attachment theories and associated research provide a compelling alternative framework for making sense of the common behavioural characteristics of young people in residential care. Within this framework, as will be outlined shortly, such behaviour is the predictable outcome of specific neurobiological adaptations that take place when infants and young children are exposed to care environments that are abusive or neglectful to the point that the child's immature psychological defences are overwhelmed. These adaptations are understood to have profound consequences for children's subsequent social, emotional, cognitive and even physiological development.

Trauma and attachment theories are often referred to as a composite noun – trauma-and-attachment theory – because of their complex inter-relationship in the context of child development (Hoehn, 2011). This section briefly highlights some of the insights of each body of theory as relevant for understanding the needs of young people typically referred for residential care.

Attachment theory

Originating with the seminal work of John Bowlby (1969) and later Mary Ainsworth (1978), attachment theory has undergone extensive empirical investigation and theoretical development over the last half century and is today a core component of human development theory (Rolfe, 2004). As Rolfe (2004: 5) notes, "much rethinking" has been part of the evolution process in attachment theory, particularly in response to emerging research findings. While there continues to be debate around some aspects of attachment theory, and new research findings continually emerging, Bowlby's original proposition that responsive nurturing relationships with caregivers are essential for a child's emotional and cognitive development is widely accepted (Sroufe, 1988; Rolfe, 2004). Moreover, it has received influential support in the last two decades from neurobiological research which has found that secure attachments "produce a growth-facilitating environment that builds neuronal connections and integrates brain systems" (Stien & Kendall, 2004: 7).

Role of attachment in development

Attachment theory posits that human beings are born with a biological drive to seek proximity to protective adults. This drive is expressed through a range of *attachment behaviours* such as crying, smiling, reaching out, or vocalising (Schofield & Beek, 2006). Through the attachment relationship that emerges, usually with primary caregivers, the infant achieves the protection and nurturance required for survival. In addition to immediate survival, core tasks of child development are undertaken in the context of these relationships and the quality of the caregiving system has a major role to play in the outcomes for the infant (Schofield & Beek, 2006).

Some of the core tasks of child development that are understood to be facilitated by having a sensitive, responsive, nurturing relationship with a caregiver are described below. These are the building blocks for much of the social, emotional, cognitive and even physiological development that follows infancy, pointing to the seriousness of the developmental challenges faced by children and young people who are severely neglected in infancy and unable to meet their attachment needs.

Emotional self-regulation

Emotional self-regulation refers to our ability to manage emotional experience and to keep our emotional arousal at a level that is comfortable such that we can accomplish our goals (Rolfe, 2004). We are not born with the capacity to regulate the intensity of our emotional arousal and initially rely on caregivers to help us achieve this through the mechanism of what is referred to as *attunement* (Schore, 1996). The emotionally attuned caregiver both experiences the infant's discomfort, and at the same time maintains a "meta" non-aroused emotional state that soothes the infant and helps to reproduce within the child the caregiver's own psychobiological state (Schofield & Beek, 2006). Children who repeatedly experience their emotional states balanced through arousal escalation and de-escalation within an attachment relationship are found to gradually develop the ability to self-regulate

emotions and cope with stressful events (Schore, 1996). After infancy, attuned caregivers continue to develop children's capacity for emotional self-regulation in other ways by helping them, for example, develop a vocabulary to describe and reflect on internal emotional states, which ultimately expands their repertoire of coping mechanisms (Stien & Kendall, 2004: 7).

The effective regulation of emotional and stress arousal in early childhood has been found to have life-long benefits, directly influencing the development of the brain's stress response system (Schore, 1996). Effective regulation of stress arousal is also important because all other developmental processes depend on it (Perry, 2006). This is because the brain develops in a sequential and hierarchal way in infancy and the ability to develop higher order parts of the brain, i.e. the cortex, and to integrate brain systems, including emotional, sensory, motor, and cognitive systems, relies on successfully developing and regulating lower-brain systems and functions, including stress arousal (Perry, 2006). Living with chronically unregulated stress arousal also places huge demands on the developing body and brain and can rob children of the energy and curiosity they need to explore the world and thereby learn and grow (Cairns, 2002).

Impulse control

Attuned caregivers are thought to help young children learn how to inhibit their sometimes life-threatening impulses. On the basis of his neurobiological research, Schore (1996) theorises that this is achieved by caregivers temporarily breaking their attunement with the child in response to such behaviour, causing the child to experience the uncomfortable affect of shame. Provided that experiences of shame are routinely followed by re-establishing attunement, so that the child is not overwhelmed by stress, the child gradually learns to regulate their impulses. Schore theorises that this development occurs because the mild stress caused by these changes in attunement leads to an increased delivery of a certain neurochemical to the pre-frontal cortex (Schore 1994, cited in Stien & Kendall, 2004). This neurochemical is important in building descending neural pathways that eventually allow the pre-frontal cortex to override impulses and desires generated in lower centres of the brain.

Children who do not experience attuned caregiving are observed, therefore, to find impulse control more difficult and to have more difficulty resolving feelings of shame that arise in their explorations of the world (Schore, 1996). Cairns (2002) notes that children who experience a high level of unresolved shame (what she refers to *disintegrative shame*) tend to be controlling towards others as well as chronically angry, which can manifest in destructive, harmful behaviours. She notes they can also come to internalise these experiences of shame, so rather than thinking of themselves as having done something shameful, they come to regard themselves as shameful (Cairns, 2002).

Autonomy and competence

The attachment relationship that forms between a responsive nurturing caregiver and child is understood in attachment theory to provide the child with a *secure emotional base* (Rolfe, 2004). This sense of emotional security is believed to be essential to the child's capacity and interest in exploring their physical and social environments (Schofield & Beek, 2006). According to Sroufe (1995, cited in Rolfe, 2004), supportive caregiving during these explorations – caregiving that responds sensitively to the child's anxieties but also allows the child as much self-direction as possible – facilitates the child's development of a sense of autonomy and feeling effective. Moreover, the safe boundaries that the caregiver places around the child's explorations help them "cope with failure and enjoy success" (Schofield & Beek, 2006: 36). The child's explorations in turn support rapid and rich brain development reflected in the achievement of a range of competencies – cognitive, social, emotional and physical (Stien & Kendall, 2004). Such achievements in turn support the child's emerging sense of identity, self-worth and self-efficacy (Cairns, 2002).

Development of a sense of self and others

According to attachment theory, we develop a concept of self and others as a result of patterned interaction with caregivers. As Stien and Kendall explain:

> By engaging in complex interactions, such as extended conversations with caregivers, the infant/toddler creates an image of herself and others. She learns to anticipate reward, punishment, pleasure and disapproval. Depending on the child's experiences, she may have a picture of the world as safe and caring or as dangerous and hurtful. How she views herself reflects the responses that she has evoked from others. She may see herself as a person to be respected and loved, or as a person to be rejected and humiliated. (Stien & Kendall, 2004: 51)

These *internal working models* of self, others and the world can potentially shift over time in response to new relationship experiences; however, early caregiving relationships are thought to be particularly influential and our earliest internal working models the most resistant to change (Rolfe, 2004).

Part of developing a sense of self involves achieving a sense of coherence across time and experience (Blaustein & Kinniburgh, 2010). This involves being able to integrate different parts of self and lived experience into a cohesive whole – our emotions, sensations, thoughts and actions. Children who have attuned caregivers are

supported in building connections between these aspects of self in a whole variety of ways, which in turn aids the integration of brain systems (i.e. motor, sensory, cognitive, and emotional systems) (Stien & Kendall, 2004). When these connections do not exist, it is hard for children to understand themselves and to process and learn from their experiences. Streeck-Fischer and van de Kolk (2000: 905) note that "without internal maps to guide them, [these children] act instead of plan, show their wishes in behaviours, rather than discussing what they want… [and] take, rather than ask".

Trust, empathy and relating effectively to others

Attachment theory posits that through the model of caring responsive relationships developed with caregivers, children learn how to relate effectively to others in their worlds – how to trust, connect emotionally, communicate their needs, experience empathy and be discerning about in whom they place their trust (Schofield & Beek, 2006). Children who have not experienced emotional attunement in a relationship with a caregiver will not only struggle with developing a coherent sense of themselves but will also struggle to make sense of others. Streeck-Fischer and van de Kolk (2000: 905) explain: "Unable to appreciate clearly who they or others are, they do not know how to enlist other people as allies on their behalf; people are sources of terror or gratification, but rarely fellow-human beings with their own sets of needs and desires".

Adaptation to differing qualities of attachment relationships

While many children will experience less than optimal attachment relationships with primary caregivers (what is referred to as *secure attachment*), attachment theorists propose that most can adapt to an insecure arrangement to some extent (Schofield & Beek, 2006). For example, children whose caregivers find it difficult to accept or respond sensitively to their attachment needs learn to hide some of their feelings to avoid upsetting the carer and provoking rejection (such adaptation is referred to as *insecure avoidant attachment*). This also makes it more likely that the caregiver will stay close and meet the child's attachment needs, at least partially (Schofield & Beek, 2006). Similarly, children whose caregivers respond to their demands but only in a sporadic, unpredictable and at times insensitive way, adapt by making constant demands, being clingy and being resistant (referred to as *insecure resistant attachment*) (Schofield & Beek, 2006). While having unmet attachment needs may impact on their development, sometimes in significant ways, these children still have a degree of emotional security upon which to explore the physical and social worlds and thereby learn and grow. Other children may succeed in meeting unmet attachment needs through caring relationships with other adults in their world, including professional child care workers (Rolfe, 2004).

Attachment theory proposes, however, that some children are unable to develop an organised attachment strategy to ensure their needs are met even partially (referred to as *insecure disorganised attachment*). This occurs most commonly when the child experiences chronic violence and abuse from their primary caregiver. In these cases, the child experiences the caregiver not only as inconsistent and insensitive to their needs but as frightening (Schofield & Beek, 2006). Insecure disorganised attachments can also occur when the child's caregiver is themselves frightened to the point of abdicating their caregiver role, as may occur in a context of domestic violence. Such a caregiver represents themselves to the child "as helpless, out of control and unable to control or properly care for the child" (Schofield & Beek, 2006: 117). In both these contexts, the child faces what Herman has described as "formidable tasks of adaptation":

> [The child] must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defences. (Herman, 1992: 96)

Children with severely disorganised attachments are therefore at great risk of serious injuries to their psychological health as well as to their emotional, cognitive and social development (Herman, 1992; Schofield & Beek, 2006; Schore, 2001). The effects of such chronic childhood trauma are discussed further in the following section on trauma.

Disruptions to attachment

Schofield and Beek (2006) note that regardless of the quality of an attachment relationship in terms of security or insecurity, all attachment relationships develop in the context of a powerful drive for proximity, care and protection and accordingly tend to be strongly enduring. Along with others who work with attachment disturbed children (such as James, 1994), they observe that even children who have disorganised attachments to abusive parents will still maintain strong emotional ties to their parents. As a consequence, the experience of being separated from primary attachment figures, such as occurs when children are removed into out-of-home care, can be extremely distressing to children, even if it removes them from objective harm. According to Hoehn (2011), disrupted attachment relationships can result in:

- biochemical changes in the developing brain
- abnormally high levels of stress hormones
- altered brain structure and function

- impaired growth and development of infant brains and bodies
- emotional and social problems, and
- vulnerability to stress, mental health problems and substance abuse.

It is therefore critically important to help children who are placed in out-of-home care manage this stress and grief effectively to avoid causing them secondary trauma.

Implications

From this brief overview, attachment theory can be seen to be a useful framework for advancing our understanding of certain things. Chief among these is the range and seriousness of the developmental challenges likely to be faced by children and young people whose attachment needs in infancy were not met due to abuse or neglect. Many of the young people referred for residential care in Queensland will fall into this category and may struggle, as a result, with emotional self-regulation, impulse control, learning delays, low self-esteem and shame, poorly developed sense of self and others, and difficulty understanding, trusting and relating to others. They may also be experiencing a range of negative impacts as a consequence of separation from primary attachment figures.

Trauma theory

Trauma theory offers a conceptual framework for understanding the effects of traumatic experiences on psychological wellbeing. Evidence suggests that when humans are exposed to highly stressful and frightening circumstances that overwhelm their ability to cope, certain neurobiological adaptations can take place which compromise normal social, emotional and cognitive functioning.

Key neurobiological adaptations to trauma

Principal among these adaptations is *dysregulation* of the individual's stress arousal system. Perry and colleagues (1995) explain that in traumatised individuals the initial fight/flight/freeze response to danger, which may have helped them survive the traumatic events, does not recede fully after the traumatic events have passed such that they live in a perpetual state of hyperarousal and fear. When under even minor stress, these individuals can rapidly escalate into a terrorised state, feeling or acting as if they were being traumatised all over again (Perry *et al.*, 1995; van de Kolk, 1994).

This terrorised state in some individuals can take the form of *dissociation* – a complete disengaging from stimuli in the external environment and a retreat to an "internal" world (Perry et al, 1995). Perry and colleagues note that dissociative patterns of stress response are often labelled "oppositional-defiant behaviour":

> The child will feel anxious due to an evocative stimulus to which their sensitised neural systems are reacting (e.g., a family visit). They are often not aware of the evocative nature of a given event, but what they do experience – deeply – is anxiety. At this point, they tend to feel somewhat out of control and will cognitively (and often, physically) freeze. When adults around them ask them to comply with some directive, they may act as if they haven't heard or they "refuse". This forces the adult – a teacher, a parent, a counsellor – to give the child another set of directives. Typically, these directives involve more threat. The adult will say, "If you don't do this, I will…" The non-verbal and verbal character of this "threat" makes the child feel more anxious, threatened, and out of control. The more anxious the child feels, the quicker the child will move from anxious to threatened, and from threatened to terrorised… If sufficiently terrorised, the "freezing" may escalate into complete dissociation. (Perry *et al.*, 1995: 280).

In addition to hyperarousal and dissociation, it has been found that the parts of the brain that unconsciously register threat, like the amygdala, become over-reactive in traumatised individuals so that they readily and often dramatically react to all kinds of stimuli in their environments that are associated, at least unconsciously, with past trauma (van de Kolk, 1994).

Dysregulation of the stress arousal system has serious consequences for the individual's ability to function normally. Due to the hierarchal structure of the brain, the more fully the body's stress arousal system is engaged, a role performed by the brain stem and diencephalon, the more difficult it is for the higher-order parts of the brain, such as the cortex, to operate and for the various systems of the brain (i.e. sensory, motor, cognitive, emotional, etc) to function in an integrated way (Perry, 2006; Stien & Kendall, 2004). Amongst other things, this means that the individual's ability to think and reason, solve problems, regulate emotions, control behaviour, and reflect on and learn from experience can be compromised (Perry, 2006; Streeck-Fischer & van de Kolk, 2000).

Another significant neurobiological adaptation to traumatic experience relates to the storage and retrieval of traumatic memories. Stress related chemicals released during traumatic events are thought to impair the functioning of the hippocampus which is responsible for the encoding and storage of memories (Stien & Kendall, 2004). As a result, traumatic memories are not processed and integrated into *conscious narrative memory* like other experiences. Instead, they are left in an unintegrated, unconscious and fragmentary form, often as images, sounds, smells and sensations with few associated thoughts (Stien & Kendall, 2004). This incomplete coding and storage of traumatic memories results in perpetual troubling disturbances in trauma survivors' conscious awareness, including constant intrusion of memory fragments such that the individual feels they are endlessly reliving the trauma (Stien & Kendall, 2004; van de Kolk, 1994).

Post-traumatic stress disorder

These and other neurobiological adaptations are implicated in post-traumatic stress disorder (PTSD). PTSD is a psychiatric diagnosis that has emerged in recent decades with the growth of knowledge about the impacts of trauma on the body and mind. PTSD recognises and groups together the symptoms that severely traumatised individuals exhibit as a result of neurobiological adaptations to trauma including those described above.

Herman (1992) notes that symptoms of PTSD fall broadly into three categories: hyperarousal, intrusion and constriction:

- *Hyperarousal* refers to persistent increased levels of stress arousal leading to heightened irritability, attention difficulties, being easily startled, finding it difficult to tune out repetitive background stimuli, difficulty sleeping and sudden overwhelming reactions to specific stimuli associated with traumatic events.
- *Intrusion* refers to the constant intrusion of traumatic memories (often sensory rather than verbal) into conscious awareness and dreams and their constant often obsessive re-enactment in thoughts, actions, play and relationships.
- *Constriction* refers to altered states of consciousness that help a trauma survivor avoid overwhelming thoughts, emotions and sensations and enables them to function in their environment to some extent. It is often characterised as a state of numbness, detachment, unresponsiveness, amnesia or dissociation from body or from the present time. The desire for detachment and numbness can also lead trauma survivors to abuse and become dependent on substances that assist them to achieve such states. Self-harming can perform a similar function.

Consequences of chronic childhood trauma

While traumatic experience can have serious negative long-term consequences for adults, trauma that occurs in early childhood, particularly that of a sustained or chronic nature, has been found to be even more profoundly damaging. This is because it fundamentally interferes with normal child development (Perry, 2006; Schore, 2001). As noted in the section on attachment, the brain develops in infancy in a sequential and hierarchal way and the ability to develop high-order regions of the brain and integrate brain systems relies on successfully developing and regulating lower-brain systems and functions, including stress arousal (Perry, 2006). Being in a chronic state of unresolved stress and fear, as occurs when children are traumatised, can therefore compromise every aspect of brain development associated with normal child development (Perry, 2006; Perry *et al.* 1995).

Core developmental tasks that have been found to be inhibited by the fear state include identity formation, regulation of emotional states, cognitive processing (for example, the integration of sensory, emotional and cognitive information into a cohesive whole), moral and spiritual development, ability to control behaviour, experience bodily integrity, trust self and others, and form affective relationships characterised by mutuality, empathy and emotional connectedness (Cook *et al.*, 2005; James, 1994; van de Kolk, 2005; Perry, 2006; Perry *et al.* 1995; Schore, 2001; Stien & Kendall, 2004; Streeck-Fischer & van de Kolk, 2000).

While secure attachment relationships with primary caregivers may help to protect children from some of the impacts of traumatic experience and facilitate normal development in spite of it, when trauma takes place within these primary attachment relationships (as is the case in insecure disorganised and/or disrupted attachment), children are at great risk of negative long-term impacts on their psychological health and normal development.

Because chronic childhood trauma can affect every dimension of child development, it is difficult to compile a comprehensive list of the possible effects of such trauma additional to general PTSD symptoms noted above. A brief summary of some of the pervasive effects of chronic childhood trauma provided by Morton *et al.* (1999: 49) includes the following:

- impacts on relationships with others, including an inability to trust, difficulty in maintaining relationships, a tendency to be re-victimised, and a tendency to victimise others
- difficulties in the regulation of emotional arousal, including aggression, self-harm and suicidality, difficulty modulating sexual involvement, impulsiveness and risk-taking, hyper-vigilance and irritability
- impacts on self-perception, including chronic guilt and shame, self-blame, and feelings of helplessness;
- impacts on systems of meaning including alienation, despair and hopelessness, and sometimes involving distorted beliefs about the perpetrator, or idealisation of the perpetrator and his/her values
- alterations in attention and consciousness, including attention and concentration difficulties, amnesia, and dissociation, difficulty in planning, problem solving, and putting feelings into words, and
- somatisation (a tendency to experience physical symptoms in the place of emotion).

These wide-ranging effects help to explain why children who have experienced chronic childhood trauma frequently experience difficulty at school

(Cairns, 2002; Streeck-Fischer & van de Kolk, 2000). Their participation and achievement at school are likely to impacted by attention, concentration and memory problems, low self-esteem and inclination to shame, difficulty planning and problem-solving, difficulties with regulating emotion, impulse and stress, and social-relational problems. In their summary of research findings and clinical observations regarding the impacts of trauma on children, Streeck-Fischer and van de Kolk (2000) note that traumatised children are also prone to difficulties processing novel information and forming mental images of present, past or future, fundamentally undermining their ability to learn from experience. They also note that many have acoustic and visual perceptual problems that can impact on ability to read and write. Poor school performance or social exclusion at school can then further exacerbate these children's low sense of self-worth and sense of disconnection from others (Cairns, 2002).

Overlooking the role of childhood trauma

Because chronic childhood trauma can have such diverse behavioural, social, physiological and cognitive consequences, the common traumatic origins of these issues is often overlooked (Bloom, 2005). It has also been noted that individuals who are suffering the psychological and developmental impacts of chronic childhood trauma often do not meet the diagnostic criteria for PTSD and are instead given and treated for multiple co-morbid psychiatric diagnoses including conduct disorder, oppositional defiant disorder, somatisation disorder, borderline personality disorder, multiple personality disorder, ADHD, depression, anxiety and/or other mood disorders (Cook *et al.*, 2005; Creeden, 2004; Herman, 1992; Hodas, 2006; Perry *et al.*, 1995; Stien & Kendall, 2004; van de Kolk, 2005; Thomas, 1995).

A growing number of influential traumatologists have argued that this is counterproductive because it fails to capture the complexity of the problems these individuals experience. van de Kolk (2005: 401), for example, has stated that "approaching each of these problems piecemeal, rather than as expressions of a vast system of internal disorganisation runs the risk of losing sight of the forest in favour of one tree". Along with his colleagues (Cook *et al.*, 2005) he has argued in favour of the term *complex trauma* to describe this symptomatology and proposed a new diagnosis of *developmental trauma disorder* with a view to more effectively understanding and treating the complex interrelated effects of chronic childhood trauma.

Implications for meeting young people's needs in residential care

From the preceding discussion, trauma and attachment theories can be seen to offer a compelling new way of understanding the needs and presenting behaviours of young people in residential care. Trauma and attachment theories suggest that experiences of abuse and neglect and disrupted attachment have left these young people with "developmental injuries" (Abramovitz & Bloom, 2003: 131) that impact on their social, emotional and cognitive functioning. The complex and profound nature of these injuries means they cannot be addressed simply by providing the young person with care and protection, or good discipline and moral guidance, as may have previously been believed. Rather, they need:

> consistent and high quality care, which offers continuity of positive relationships. However, they also need *systematic therapeutic interventions* to assist them to rebuild their lives and address post-traumatic states and developmental disturbance associated with the severe abuse and neglect they have suffered. (Morton *et al*., 1999: 1)

Therapeutic goals

Based on a trauma-attachment conceptualisation of the needs of children who have suffered severe abuse and neglect, the therapeutic goals of trauma and attachment informed care could be defined broadly as follows (adapted from Jenkins, 2004: 24 and Stien & Kendall, 2004: 135):

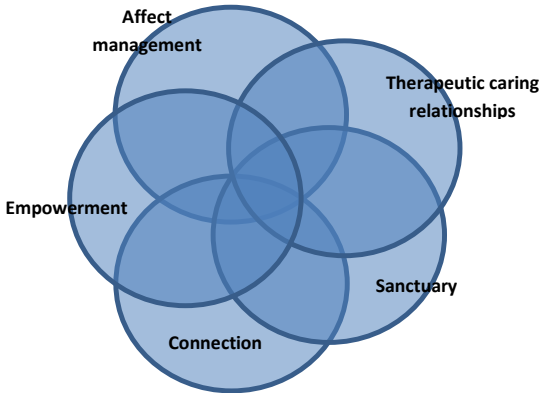
- to enable the child to regulate their emotions and cope with painful emotional issues
- to enable the child to change behaviours that have negative consequences
- to promote a unified identity by helping the child achieve a sense of congruence with regard to thoughts, emotions and behaviours
- to enable the child to function comfortably and adaptively within the external environment
- to bring about positive changes in the child's internal working models of self, relationships and the world (such that they are more able, for example, to regard themselves as loveable, others as potentially supportive and trustworthy, and the world as a place of interest, worthy of exploration)
- to enable the child to achieve key developmental milestones they have been prevented from achieving, and
- to enhance the child's resilience and social and emotional wellbeing so that they can ultimately live full and rich lives and be less vulnerable to future adversity.

Core therapeutic tasks of trauma and attachment informed residential care

A large body of therapeutic and research literature provides a combination of practice wisdom and research evidence regarding effective strategies for achieving these therapeutic goals. This literature can be drawn on to help define core therapeutic tasks of trauma and attachment informed residential care in the absence of a universally agreed-upon handbook of practice.

What follows is the specification of five core therapeutic tasks of trauma and attachment informed residential care based on an examination of key themes in this literature. As will become apparent, these tasks – *sanctuary, therapeutic caring relationships, affect management, empowerment* and *connection* – are interrelated and interdependent (Figure 1).

Figure 1. Interrelated nature of therapeutic tasks



Empowerment, for example, can only be achieved in the context of sanctuary and therapeutic caring relationships, while affect management is a critical form of empowerment necessary for trauma recovery. Similarly, affect management cannot be achieved outside the context of therapeutic caring relationships and a safe, soothing environment.

These tasks should not be regarded as an exhaustive account of the therapeutic work of trauma and attachment informed residential care. Rather their articulation here is an attempt to give basic form and substance to a concept that has been unhelpfully amorphous in policy formulations in Queensland to date. Defining the concept is also the first stage in the process of evaluating therapeutic practice – the primary objective of this paper.

Task 1 – Sanctuary

Create and vigilantly maintain a safe and healing environment in the residence to enable young people to achieve the baseline calm and stability they need to undertake higher order therapeutic and developmental tasks. Such an environment is characterised by the absence of threats to safety, a positive social and emotional climate, predictability and rationality.

As discussed, chronic childhood trauma, unmet attachment needs and disrupted attachment all impact negatively on an individual's ability to regulate their stress arousal. Dysregulation of stress arousal in turn has serious negative consequences for an individual's ability to function normally and undertake normal development.

Accordingly, there is a strong consensus in the trauma/attachment therapeutic literature that the initial focus of therapeutic work needs to be addressing the individual's constantly elevated and high-reactive stress-arousal system (Cairns, 2002; Foderaro & Ryan, 2000; Hodas, 2006; James, 1994; Perry, 2006; Streeck-Fischer & van de Kolk, 2000). Until this occurs, no higher-order therapeutic or developmental work can take place. As Perry notes:

> All the best cognitive-behavioural, insight-oriented, or even affect-based interventions will fail if the brainstem is poorly regulated. Extreme anxiety, hypervigilance, and a persistently activated threat response will undermine academic, therapeutic and socioemotional learning opportunities... The child must feel safe to start to heal. (Perry, 2006: 39)

A sense of safety is typically achieved by protecting the individual from ongoing abuse, including self-harm, and cultivating around them a warm, soothing, non-threatening environment without trauma-triggers which allows them gradually to reduce their inclination to hypervigilance and dissociation (Barton *et al.*, 2000; Cairns, 2002; Foderaro & Ryan, 2000; Hawkins-Rodgers, 2007; Streeck-Fischer & van de Kolk, 2002). Such environments are characterised by a high level of consistency and predictability often achieved with daily routines, structures, rituals, clear expectations, consistently applied limits, and well-defined roles (Anglin, 2002; Barton *et al.*, 2012, Cairns, 2002, Schofield & Beek, 2006; Stien & Kendall, 2004).

A sense of rationality is also considered important for cultivating a non-threatening environment. Often survivors of chronic childhood trauma have experienced extremely arbitrary disciplinary regimes and creating "a framework for understanding", as Anglin (2002: 67) terms it, enhances their sense of predictability as well as their sense of meaning, justice and fairness. Amongst other things, this involves carers explaining reasons for rules and decisions, modelling expected behaviour and using "natural consequences" where possible (Anglin, 2002; Barton, *et al.*, 2012; Forbes & Post, 2007; Morton *et al.*, 1999). The use of "no-harm" contracts (where the individual agrees to not harm themselves or others while in the program) and/or involving the individual in developing a safety plan or a behaviour de-escalation plan are other common techniques for increasing a trauma survivor's sense of their environment as rational, predictable and safe and of themselves as being in control (Foderaro & Ryan, 2000; Hodas, 2006; Stien & Kendall, 2004).

As well as predictability and rationality, another common feature of soothing, non-threatening therapeutic environments is that they provide opportunities for individuals to experience pleasure and mastery – subjective experiences that tend to lower baseline stress arousal levels (Barton, *et al.*,

2012; Hughes, 2006; Streeck-Fischer & van de Kolk, 2000).

Finally, in the residential care context, creating a safe and soothing environment involves careful consideration of the placement of young people with peers who may generate anxiety or engage in abusive behaviours (Bath, 2008). Even with such consideration, vigilant management of the social environment is considered necessary to ensure young people do not experience this as threatening or participate in traumatic re-enactments with other young people or carers (Bath, 2008; Streeck-Fischer & van de Kolk, 2000). This work includes the active promotion of a positive social-emotional climate in the residence by way of such things as peer helping programs (such as Gibbs *et al.*, 1995; Vorrath & Brendtro, 1985) and skilling staff in therapeutic crisis intervention strategies (such as Holden, 2001; Long *et al.*, 1998).

The task of creating and vigilantly maintaining this kind of environment is considered a central therapeutic task in trauma-informed residential care programs. It has been described variously as "creating sanctuary" (Abramovitz & Bloom, 2003: 119), "developing a sense of normality" (Anglin, 2002: 123) and constructing a "holding environment" to contain trauma survivors' overwhelming fear (Barton *et al.*, 2012: 45).

Task 2 – Therapeutic caring relationships

Build respectful, consistent, reliable, nurturing, empathic relationships with young people that are responsive to their inner worlds and "pain-based behaviour" and support their pursuit of therapeutic and developmental goals.

It is widely agreed in the therapeutic literature that recovery from trauma must take place in the context of healing relationships (Anglin, 2002; Blaustein & Kinniburgh, 2010; Cairns, 2002; Hawkins-Rodgers, 2007; Herman, 1992; Hoehn, 2011; Holden *et al.*, 2010; James, 1994; Jenkins, 2004; Perry, 2001; Stien & Kendall, 2004; Streeck-Fischer & van de Kolk, 2000). Herman explains:

> Recovery can only take place within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity and intimacy. Just as these capabilities are originally formed in relationships with other people, they must be reformed in such relationships. (Herman, 1992: 133)

Therapeutic relationships are also thought to provide the necessary structure for containing "the chaotic processes of integrating the trauma" (Cairns, 2002:123; Barton *et al.*, 2012; Streeck-Fischer & van de Kolk, 2000). In other words, it is in the emotional safety of these relationships that the trauma survivor is ultimately able to face their painful and overwhelming emotions and begin the process of "integrating" these experiences and mourning their losses.

In the case of children and young people recovering from chronic childhood trauma, responsive, nurturing relationships are also seen to be important from a developmental perspective. Attachment theory highlights the critical role that nurturing, responsive care giving relationships play in facilitating fundamental stages in child development. As noted earlier, children and young people who have experienced severe abuse or neglect in early childhood are likely to have been prevented from undertaking aspects of such development with negative consequences for their later social, emotional and cognitive functioning. Addressing these unmet developmental needs in the context of healing relationships with carers and therapists is therefore a primary focus of trauma and attachment therapeutic work with such children and young people (Anglin, 2002; Blaustein & Kinniburgh, 2010; Cairns, 2002; Hawkins-Rodgers, 2007; Hoehn, 2011; Holden *et al.*, 2010; James, 1994; Jenkins, 2004; Perry, 2001; Stien & Kendall, 2004; Streeck-Fischer & van de Kolk, 2000).

While potentially of great value in the therapeutic process, a caring relationship with a therapist is not generally considered a substitute for a relationship with a therapeutic carer. Like infants and young children, these children and young people need to experience in a day-to-day, moment-to-moment way a positive and sustained relationship with a caregiver (Blaustein & Kinniburgh, 2010; James, 1994; Perry, 2006; Stien & Kendall, 2004). Through this relationship and the secure emotional base it provides, they can begin to:

- learn to regulate their stress-arousal, emotional states and related behaviour
- develop a coherent and positive sense of themselves;
- learn to relate effectively to others
- experience themselves as competent and autonomous, and
- gradually develop new internal working models of self and others – a view of themselves as loved, cared for and safe, and of other people as potentially supportive and trustworthy (Blaustein & Kinniburgh, 2010; James, 1994; Perry, 2006; Stien & Kendall, 2004).

The trauma and attachment therapeutic literature is rich with descriptions of the qualities and skills regarded as important for therapeutic caring. Some of the general personal qualities that have been identified as important include being friendly, empathic, trustworthy, attentive, respectful,

steadfast, consistent, thoughtful and non-judgemental (Anglin, 2002; Blaustein & Kinniburgh, 2010; Cairns, 2002; James, 1994; Hawkins-Rodgers, 2007; Schofield & Beek, 2006; Streeck-Fischer & van de Kolk, 2000). Other personal capacities, skills and knowledge that are referred to as important for therapeutic caring include:

- Ability to "acknowledge and respond sensitivity to the inner world of the child", particularly their "psycho-emotional pain" and "pain-based behaviour", helping them to accept and understand their emotions and to feel accepted and understood (Anglin, 2002: 108-9).
- Understanding the child's need to process and integrate painful past experiences and willingness to face these hurts with them (James, 1994)
- Curiosity about who the child is, what they think and feel and where they come from, helping them to understand themselves and feel accepted and respected (Hughes, 2006; Cairns, 2002; Rose, 2012)
- Commitment to care for the child regardless of their behaviour, helping them learn to trust (Cairns, 2002; Streeck-Fischer & van de Kolk, 2000).
- Ability to de-escalate the child's heightening emotional states, helping them to avoid disintegrative shame and other re-traumatising states (Barton *et al.*, 2012; Cairn, 2002; Hughes, 2006; James, 1994; Jenkins, 2004).
- Ability to be physically and emotionally available, helping the child to feel loved and cared for (Cairns, 2002; Hughes, 2006; Schofield & Beek, 2006).
- Ability to offer effective emotional and developmental support to children, helping them on one hand to process and cope with their thoughts and feelings, and on the other to develop skills and a sense of competence and autonomy (Anglin, 2002; Barton *et al.*, 2012; Schofield & Beek, 2006; Ward, 2004).
- A solid understanding of child development, the biological, cognitive, emotional and social impacts of trauma on children, and trauma recovery stages and processes (Barton *et al.*, 2012; Hodas, 2006; Jenkins, 2004).
- Capacity for self-awareness and reflective practice (Barton *et al.*, 2012; Cairns, 2002; James, 1994).
- Willingness to withhold negative personal judgements of children on account of their anti-social and destructive actions, appreciating that these are effectively survival strategies for them (Hughes, 2006; Hodas, 2006; Cairns, 2002).
- Understanding of the ways that traumatised children will tend to re-enact trauma dynamics and events in their subsequent relationships, including those with carers, and a sophisticated skill-set for avoiding traumatic re-enactment in relationships with children (Barton *et al.*, 2012; Jenkins, 2004; Streeck-Fischer & van de Kolk, 2000).
- Willingness to work as part of a treatment team and to take on board clinical guidance (Cairns, 2002; James, 1994).

It is widely recognised in the therapeutic literature that caring for traumatised children can be very challenging and deeply distressing at times. For carers to sustain their therapeutic work and undertake it effectively, it is generally agreed that they need a high level of personal and professional support, including clinical supervision (Barton *et al.*, 2012; Cairns, 2002; Hodas, 2006; Schofield & Beek, 2006). Based on the experiences of the Lighthouse Foundation residential care program, Barton *et al.* (2012: 78) argue that support provided to a therapeutic carer is "the critical factor in any progress the child makes".

Task 3 – Affect management

Systematically nurture young people's ability to regulate their emotional states and achieve mastery over their behaviour through helping them identify, reflect on and accept their emotions, develop skills and techniques for coping with emotions, and find safe and appropriate ways for expressing themselves. This task involves actively avoiding power struggles and coercive, punitive and/or shaming responses to problematic behaviours.

The earlier theoretical discussion highlighted the multiple serious challenges with managing emotions and behaviour likely to be faced by children who have experienced severe abuse and neglect in early childhood. Without the ability to meet their attachment needs, many will not have been able to develop the capacity for emotional self-regulation and impulse control. Their difficulties with managing emotional experience and behaviour will then be intensified by overwhelming emotional experiences associated abuse, neglect and/or separation from primary attachment figures – that is, feelings of terror, fear, abandonment, helplessness, guilt, shame, grief, loss and anger. Neurobiological adaptations that take place in response to such trauma will then further compound the child's difficulties with managing emotions and behaviour – by increasing their emotional reactivity and sense of threat, as well as reducing what ability they may have developed to think and reflect on their emotions and behaviour.

As discussed earlier, common behavioural manifestations of these neurobiological adaptations include physical and verbal violence or aggression, bullying, "oppositional-defiant" behaviour, dissociation, self-harming, a tendency to be withdrawn and/or overly-compliant, suicidal ideation, and other maladaptive social and/or

sexual behaviours. Some of these behaviours themselves contribute to young people's difficulties leading, for example, to the breakdown of out-home care placements, expulsion from school, or incarceration in youth detention facilities.

Helping children learn to regulate their emotions, cope with painful emotional issues and change behaviours that have negative consequences are therefore central concerns of trauma and attachment therapeutic work. From his influential study of effective residential care practice in Canada, Anglin (2002: 107) has argued, in fact, that responding sensitively and therapeutically to residents' "pain-based behaviour" represents "the major challenge for staff".

Depending on the child's needs and level of emotional dysregulation, *affect management* work, as it is commonly referred to, may include such elements as:

- routine rhythmic sensory activities, like drumming, yoga, dance, and massage, which are believed to help regulate the brainstem (Perry, 2006)
- psychodynamic therapies, like Life Story Therapy (Rose, 2012), that help children explore and integrate painful emotions and experiences, and
- psycho-educational and skills development programs that help children understand the impacts of trauma on stress arousal; work through emotions behind problematic behaviours; and gain skills in de-escalation, affect tolerance and modulation, and positive emotional expression (Blaustein & Kinniburgh, 2010; Foderaro & Ryan, 2000; Jenkins, 2004; Cook *et al.*, 2005).

One of the most critical aspects of affect management work, however, is responding effectively and therapeutically to maladaptive behaviour when it arises. There is general agreement in the therapeutic literature that coercive, shaming or punitive approaches to correcting the behaviour of traumatised children, and/or those that involve interpersonal power struggles, are counterproductive and very likely to cause further trauma to children (Anglin, 2002; Barton, *et al.*, 2012; Bath, 2008; Cairns, 2002; Cimmarusti & Gamero, 2009; Forbes & Post, 2007; Hodas, 2006; Hughes, 2006James, 1994). It has been noted that disciplinary practices in traditional residential care have often fallen into this broad category (Anglin, 2002; Bath, 2008; Cimmarusti & Gamero, 2009). Such approaches are observed to intensify traumatised children's problematic physiological and neurological states, undermine trust in the therapeutically important relationship with carers, and fail to address the child's developmental difficulties with tolerating, processing and integrating overwhelming emotions that underlie problematic behaviour (Cimmarusti & Gamero, 2009).

Similarly, widely used behaviourist approaches that focus on changing maladaptive behaviour through a system of rewards and consequences can also be ineffective and/or cause harm to children unless this avoids shaming the child and integrates an adequate understanding of why they behave the way they do (Cimmarusti & Gamero, 2009; Creeden, 2004; Forbes & Post, 2007). Behaviourist techniques may achieve a degree of change in children's behaviours but without engaging with the underlying emotional content of the behaviour, these changes will not ultimately correspond to transformations in the child's internal working models or assist them to achieve psychological healing (Forbes & Post, 2007). Forbes and Post maintain that these techniques inadvertently convey to children that the feelings behind their behaviour are not valid or intelligible (Forbes & Post, 2007).

Various models of behaviour intervention are described in the trauma and attachment therapeutic literature such as "compassionate accountability" (Cimmarusti & Gamero, 2009) and "reintegrative shaming" (Cairns, 2002, drawing on John Braithwaite's concept). These approaches prioritise the child's relationship with the carer and use this as a resource for supporting the child to de-escalate and self-soothe, explore their underlying emotions and patterns of response, make connections between these responses and past traumatic experiences, devise and practice new ways of coping with emotional states, and ultimately assume responsibility for behavioural incidents that have impacted negatively on others.

This allows the child over time to achieve understanding of and mastery over trauma-related symptoms, build their relationship with the carer, and acquire a sense of themselves as empowered (i.e. responsible and capable of taking responsibility for themselves). It also helps them to make critical connections between what they do, what they feel, and what has happened to them; it enables them to "get in touch" with their feelings, and to develop a language to describe internal states, all of which are important developmental tasks as well as necessary for healing the brain after trauma (Cairns, 2002; Jenkins, 2004; Streeck-Fischer & van de Kolk, 2000).

Task 4 – Empowerment

Cultivate a "living-learning environment" in the program where program activities, daily living routines, relational experiences and treatment planning are all oriented towards building young people's skills, knowledge and sense of mastery (competence) and their sense of agency, control and responsibility (autonomy).

Herman (1992) has noted trauma is definitively an experience of powerlessness, of being overwhelmed by terror and unable to escape and exert control. She notes that the lasting effects of traumatic events can themselves be overwhelming and the trauma survivor feel as if they have little control over what is happening to them, including their feelings and behaviours. Locked into recurring and oscillating states of hyperarousal and constriction, these individuals find it very difficult to think about a timeframe beyond the present or the past. As a result, they struggle to plan and typically approach new experiences with fear (Herman, 1992).

A sense of powerlessness can also arise from having unmet attachment needs. As discussed earlier, attachment problems impact on children's developing sense of autonomy and competence (Schofield & Beek, 2006). Insecurely attached children, and especially children with disorganised attachments, are burdened by unresolved stress and anxiety in their explorations of the world. They often do not find these explorations enjoyable and struggle to achieve a sense of themselves as autonomous and competent. This can leave them feeling powerless and without hope (Cairns, 2002).

The trauma and attachment therapeutic literature therefore places great emphasis on nurturing traumatised children's sense of personal empowerment, or their *self-efficacy* (Abramovitz & Bloom, 2003; Anglin, 2002; Bertolino & Thompson, 1999; Blaustein & Kinniburgh, 2010; Holden *et al.*, 2010; Jenkins, 2004; McNeal, *et al*., 2006; Morton *et al.*, 1999; Schofield & Beek, 2006; Ward, 2004). Such a focus is equally emphasised in resilience theory and its application to work with vulnerable children (Dearden, 2004; Gilligan, 1997, 2000; McNeal *et al*., 2006; Prilleltensky *et al*., 2001), highlighting the central role that self-efficacy plays in psychological wellness and the capacity to overcome adversity.

Nurturing children's self-efficacy generally focuses on two dimensions: on one hand it concerns building children's *competence* and sense of mastery through the development of skills and knowledge and the achievement of developmental milestones; on the other hand, it concerns building their *autonomy* or sense of agency and control through the development of their ability to make decisions, pursue goals and take responsibility for action.

A wide range of techniques, activities and interventions for building self-efficacy is described in the therapeutic literature. In milieu settings, such as residential treatment, this focus is often described and conceptualised as integral to the culture and organisation of the care environment. Abramovitz and Bloom (2003) in the Sanctuary residential care program, for example, talk about it as "a living-learning environment", and Holden *et al.* (2010) describe the CARE residential care program as "competency-centred" care. While interventions in such programs include formal psycho-educational activities, much of the developmental work is less formalised and woven into moment-to-moment social interactions and routine activities within the residential and through the modelling of behaviour. Ward (2004: 217) refers to this as *special everyday living* and *opportunity-led work*. Common empowerment strategies in these environments include giving young people choices, engaging their views and opinions, involving them in goal-setting, and giving them responsibility for tasks or projects and the opportunity to contribute to household decisions and rules (Anglin, 2002; McNeal, *et al*., 2006).

Another common aspect of empowerment work is collaborating with schools and teachers to re-engage children in formal education, and/or to help them to function better in this environment so that they can achieve learning milestones (Long & Hogan, 2012; Shah, 2012).

Task 5 – Connection

Build young people's sense of identity, belonging and connectedness to others by supporting them to form, maintain and/or achieve healing in their relationships with caregivers, friends, family members, and people in the wider community and culture.

Herman (1992) has influentially argued that trauma erodes the individual's sense of connectedness to others:

> Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. (Herman, 1992: 51)

Recovery from trauma, therefore, involves reconnection to others – the formation of new relationships, the healing of damaged relationships, and with these the creation of a new sense of identity and belonging. Others share Herman's view and see the building of new connections and networks as critical for transforming a child's internal working models of the world. As Barton *et al.* (2012) explain:

> The therapeutic task must address the need for a positive experience of community – one that is accepting and supportive and where the child can also make a meaningful contribution. This is vital in shifting the child's internal working model of the world and is essential in the recovery process. (Barton, *et al.*, 2012: 193)

It has also been argued that trauma recovery must concern itself with relationships to family, community and society because wellness is an *ecological* concept (Barton, et al, 2012; Cairns, 2002; Harvey, 1996; Bloom *et al.,* 2003). That is, "a child's wellbeing is determined by the level of

parental, familial, communal and social wellness" (Prilleltensky & Nelson, 2000). So if we are concerned about the child's healing, this cannot happen without attending to the health of the social and cultural environment within which the child is situated. Cairns (2002) elaborates on the ecological view of trauma recovery:

> The impact of the trauma affects the entire child/community/society which is in reality the location of the traumatic events. It is not enough to remove the child from a place of danger to a place of safety. Rather we need to examine the strengths and weaknesses of the whole ecological system that includes the child in order to enable the community to construct an environment safe enough for the child to recover from harm. (Cairns, 2002: 123).

Young people's capacity to connect with others, to form or rebuild positive enduring relationships, and to achieve a positive sense of community are accordingly important aspects of trauma and attachment therapeutic work (Cairns, 2002; Barton, *et al.*, 2012; James, 1994; Stien & Kendall, 2004). They are also important aspects of resilience-based approaches to working with children in out-of-home care more generally (Gilligan,1997, 2000; Schofield, 2002).

The therapeutic task of *connection* can involve a wide range of interventions and activities. Some of these may be performed at the direct care level and others will typically be performed by third parties and/or occur outside the direct care environment. Regardless of where these activities take place and who has primary responsibility for them, care providers play a critical role in facilitating these activities and supporting children to process related experiences and emotions. A few aspects of connection work are now described.

A common aspect of connection work concerns working therapeutically with children's families of origin. This work aims to develop secure attachment relationships, facilitate healing where violence and abuse have caused deep rifts in relationships, and establish new non-abusive ways of relating (Stien & Kendall, 2004; Hughes, 2007). Where healing and development is not possible or likely in significant family relationships, the focus of family therapy becomes helping children mourn the loss of these important attachments (James, 1994). James (1994) notes that such mourning can often be necessary before children will accept new primary attachments or take up new family membership. Family therapy can also focus on helping a child to transition into a new family – building the attachment relationships as well as the sense of family membership and belonging that are necessary for this to become a long-term secure base for the child (James, 1994; Hughes, 2007).

Another common element of connection work is building *alternative* families and communities around young people. This is particularly critical for young people who have few if any family relationships that they can heal or rebuild, as Gilligan explains:

> For a young person without a viable secure base in their immediate or extended family of origin, a network or "base camp" of social support based on work, social, educational, recreational and professional helping relationships is probably the best practical alternative facing a young person leaving care. A major task of care takers and care providers in adolescence is to help a young person to develop *the scaffolding of relationships* necessary to sustain these "base camps" for exploring and coping with the vicissitudes of life. (Gilligan, 2000: 40, emphasis added).

Gilligan (2000, 1997) argues that supporting young people's participation in school and school-based activities, as well as in sport, volunteering, part-time work and other community and recreational activities are important ways of assisting young people to build these networks and relationships.

Another kind of alternative family or community is the *therapeutic* family or community. A number of residential care programs that have a long-term commitment to working with attachment-disturbed children and young people, such as the Lighthouse Foundation Therapeutic Family Model of residential care (Barton *et al.*, 2012), the Jasper Creek residential care program (Ziegler, 1994), and those that adopt the Teaching Family Model of residential care), intentionally construct around the child or young person a therapeutic family and community. This scaffolding of relationships and networks is intended to provide ongoing sources of attachment, belonging and identity to the child or young person beyond the placement.

A sense of connection to culture can also be important for building a child's sense of identity, belonging and emotional security. Based on their work with Aboriginal young people in therapeutic residential care in Victoria, Morgan and colleagues (2012) argue that cultural connection is supported by:

- culturally competent care environments that ensure the residents' *cultural safety* and *cultural rights* (like rights to maintain and use language)
- meaningful contact for the child with members of their extended family and cultural community, and
- facilitating the child's participation in cultural experiences and events as they feel comfortable.

From an ecological perspective, culture is also an important site for trauma recovery (Atkinson, 2002). Atkinson (2002) notes, that for Aboriginal children, individual trauma often sits within a broader context of intergenerational community and family trauma relating to a history of colonial dispossession and its profound social, economic

and cultural consequences (Atkinson, 2002). Morgan *et al*. (2012) argue that providing opportunities for children to make these connections and participate in culturally relevant trauma recovery processes can be very powerful in their healing and development.

Finally, for children who have experienced severe abuse and neglect, many will not have developed the interpersonal skills necessary to form healthy relationships. Addressing these skill-deficits is therefore a critical aspect of connection work (Anglin, 2002; McNeal *et al.*, 2006; Cook *et al.*, 2005). This work takes place at various levels – for example, through relationship modelling and attunement processes in the therapeutic caring relationship, through the use of positive peer relationship programs, and through structured skills-development activities.

Other important considerations in meeting the needs of young people

The research and therapeutic literature points to a number of other issues that should be considered in the development of interventions aimed at meeting the needs of traumatised and attachment-disturbed children and young people.

Consideration 1 – Change takes time

There are no quick fixes – a sustained approach to the treatment of trauma and attachment problems is necessary.

A growing body of evidence suggests that neurological adaptations to chronic childhood trauma are typically profound and not easily reversible (Cook *et al.*, 2005; Perry *et al.*, 1995; Perry, 2006; Schore, 2001; Streeck-Fischer & van de Kolk, 2000; van de Kolk, 2005). While some improvements in social, emotional and cognitive functioning may be achievable, the brain changes relatively slowly after infancy and only in response to constant repetition of behaviour or sustained exposure to new experiences (Perry, 2006). So if a child has never had a positive attachment relationship with someone, they need to have a sustained experience of a trustworthy, responsive, sensitive carer to have a chance of developing the capacity to trust and form secure attachments (Cairns, 2002; Streeck-Fischer & van de Kolk, 2000; Ziegler, 1994). It has been noted, accordingly, that "rectification of attachment disturbances and the development of a secure sense of self is a slow process that requires long term interventions" (Morton *et al.*, 1999: 48).

The recovery process can also be slow because of the complexity of developmental issues that need to be addressed. As child trauma expert Beverley James states: "Treatment of attachment- and trauma-related problems is exacting, laborious, and often lengthy, reflecting the severity and complexity of these disturbances" (1994: 63). Based on extensive clinical experience, she argues that rushing through the stages of recovery does not just risk ineffectiveness but is likely to result in counter-therapeutic outcomes – re-traumatising the child, damaging the clinical relationship and reinforcing beliefs the child holds that adults cannot be trusted to protect them.

Consideration 2 – Everyone is different

An individualised approach to treatment and care based on thorough assessment of individual circumstances, needs and capacity is key to efficacy.

Because of the multiple interrelated impacts of complex trauma and their highly individual manifestations, it has been argued that helping individuals recover from trauma "is a complex process that cannot simply be described like a cookbook recipe" (van de Kolk, 2007, in Barton *et al.*, 2012: 19). It is generally agreed in the literature that therapeutic interventions need to be developed for each individual based on a thorough understanding of their trauma and attachment history and the specific psychological and developmental consequences of that history for them (Cook *et al.*, 2005).

Therapeutic interventions also need to be developed and reviewed based on a comprehensive assessment of the various "developmental ages" (e.g. chronological, emotional, social, cognitive, physical, moral, spiritual) of the child or young person for them to be effective (Barton *et al.*, 2012; Creeden, 2004; Perry, 2006). Perry (2006) notes that because the brain develops in a sequential and hierarchical way in infancy, if particular stages of development have not yet occurred, interventions that assume such development will be useless. For example, group therapy is unlikely to be of therapeutic value for a young person if they have the relational skills of a pre-schooler (Perry, 2006). Similarly, using reasoning and logic to get children to modify their behaviour or reactions through reward and consequence mechanisms requires the child to have considerable cortical functioning. If a child's development has been arrested prior to such development, these approaches will not be effective. Barton *et al*. (2012) suggest that more effective strategies might focus on dealing with the underlying emotion the child is experiencing through physical and sensory experiences which stimulate the lower regions of the brain.

Determining a child's multiple developmental ages is also considered important for assessing the types of developmental experiences they have been deprived of and which they need to be exposed to in order to develop particular capacities. Likewise, it is regarded as important for highlighting areas where the child may have

developed more rapidly and have strengths that can be built on (Barton *et al.*, 2012; Perry, 2006).

Consideration 3 – A team approach is critical

> *To increase the likelihood of therapeutic interventions being effective, there needs to be a shared understanding of the child's developmental and therapeutic needs and the appropriate responses to those needs across all those involved in the care, treatment and education of the child.*

The vital importance of collaborations between carers, teachers, parents and therapists in responding to the complex interrelated needs of children who have been traumatised is a powerful theme in the research and practice literature (see for example Abramovitz & Bloom, 2003; Barton *et al.*, 2012; Berlin, 2001; Bloom, 2005; James, 1994; Long & Hogan, 2012; Shah, 2012; Stien & Kendall, 2004).

While such collaborations make sense at an intuitive level, they also make sense from a neurological perspective. As noted earlier, the brain changes relatively slowly after infancy and then only in response to constant repetition of behaviour and sustained exposure to new experiences that generate new ways of thinking, feeling and behaving (Perry, 2006; Stien & Kendall, 2004). Therefore, the more opportunities for practising new ways of being and relating, the more likely it is that these experiences will result in the development of new neural pathways (Perry, 2006; Stien & Kendall, 2004). This consistent observation over 20 years of clinical practice and research has led Perry to argue that effective therapeutic interventions with abused and neglected children cannot be limited to work undertaken in formal therapy sessions. In detailing his influential *neurosequential model of therapeutics*, he argues, that:

> Enrichment or therapeutic services for maltreated children need to be consistent, predictable, patterned and *frequent*… If interventions with these children are going to work, the number of repetitions required cannot be provided in weekly therapy. Effective therapeutic and enrichment interventions must recruit other adults in a child's life – caregivers, teachers, parents – to be involved in learning and delivering elements of these interventions, in addition to the specific therapy hours dedicated to them during the week. (Perry, 2006: 38).

The challenge of turning theory into practice

Designing a program and organisation that can successfully implement the core therapeutic tasks of trauma and attachment informed residential care, and give consideration to these additional issues, is undoubtedly a complex and challenging undertaking. The research and practice literature suggests that it takes considerable planning, commitment and leadership for organisations and programs to become genuinely trauma/attachment informed (Hodas, 2006; Holden, *et al.*, 2010; Hummer, *et al.*, 2010; Rivard *et al.*, 2005). With specific regard to trauma-informed practice, Hodas (2006) has argued that there is a continuum of competency apparent in organisations with at least six definable stages. At one end of the continuum is *trauma destructiveness*, programs that involve extremely negative attitudes, policies and practices destructive to children who have been affected by trauma. At the other end is *trauma proficiency*, where trauma sensitivity and competence are consistently evident and integrated throughout the organisation along with continuous improvement mechanisms and trauma specialist knowledge.

A recent book that details the trauma and attachment statutory residential care program of the Lighthouse Foundation in Victoria (Barton *et al.*, 2012) shows how one organisation has successfully faced the challenge of turning theory into practice. The book powerfully demonstrates the complexity of thinking and designing that sits behind a trauma proficient program and organisation. In the Lighthouse Foundation program, knowledge about the impacts of trauma and attachment problems and effective therapeutic interventions is intricately woven into all program design elements, including the young person's assessment and intake; specification of the tasks of carers and their recruitment; the design of the home environment; day-to-day work with individual young people and group work; and the creation of a "holding environment" around young people with daily routines, structures and rituals that help them achieve a sense of safety, predictability and stability.

The rigorous assessment and selection of young people to help ensure that their needs can genuinely be met within the program and the particular household is strongly emphasised in the interests of not doing further harm to traumatised young people. Once in the program, a long-term commitment to therapeutic relationships between carers and young people is emphasised with reference to attachment theory. Enormous importance is, therefore, given to supporting staff at both clinical and operational levels so that they can sustain this difficult work over time and be effective in their therapeutic roles.

Of overarching importance in the Lighthouse Foundation model is the creation of an organisational culture that at every level reflects understanding of, and commitment to, the therapeutic project, and protects staff and residents against re-traumatisation and vicarious traumatisation. The child, the carers, the household and the organisation are conceptualised as a therapeutic community that can be nurtured to provide long-term protection and healing to young people, as well as a sense of identity and belonging.

And finally, in line with Hodas' (2006) specification of trauma-proficient practice, the model places

importance on establishing clear therapeutic goals and outcomes and continuously evaluating practice with reference to progress towards these.

Evaluating therapeutic practice

The relevance of young people's views

Defining the goals and tasks of trauma and attachment informed residential care is the first step in evaluating therapeutic practice. The next step is to consider sources of information about the quality of therapeutic practice in residential care related to these goals and tasks. One valuable source of such information is the views, experiences and perceptions of the young people being cared for. While service users will not be able to provide a complete picture of the care environment or objectively assess its therapeutic quality, they can provide unique and valuable insights into each of the core therapeutic tasks previously described.

Each of these tasks is intended to bring about specific changes in young people's internal working models of self, relationships and the world which reflect restored psychological health and improved resilience. The relationship between these tasks and desired shifts in young people's perceptions is shown in Figure 2.

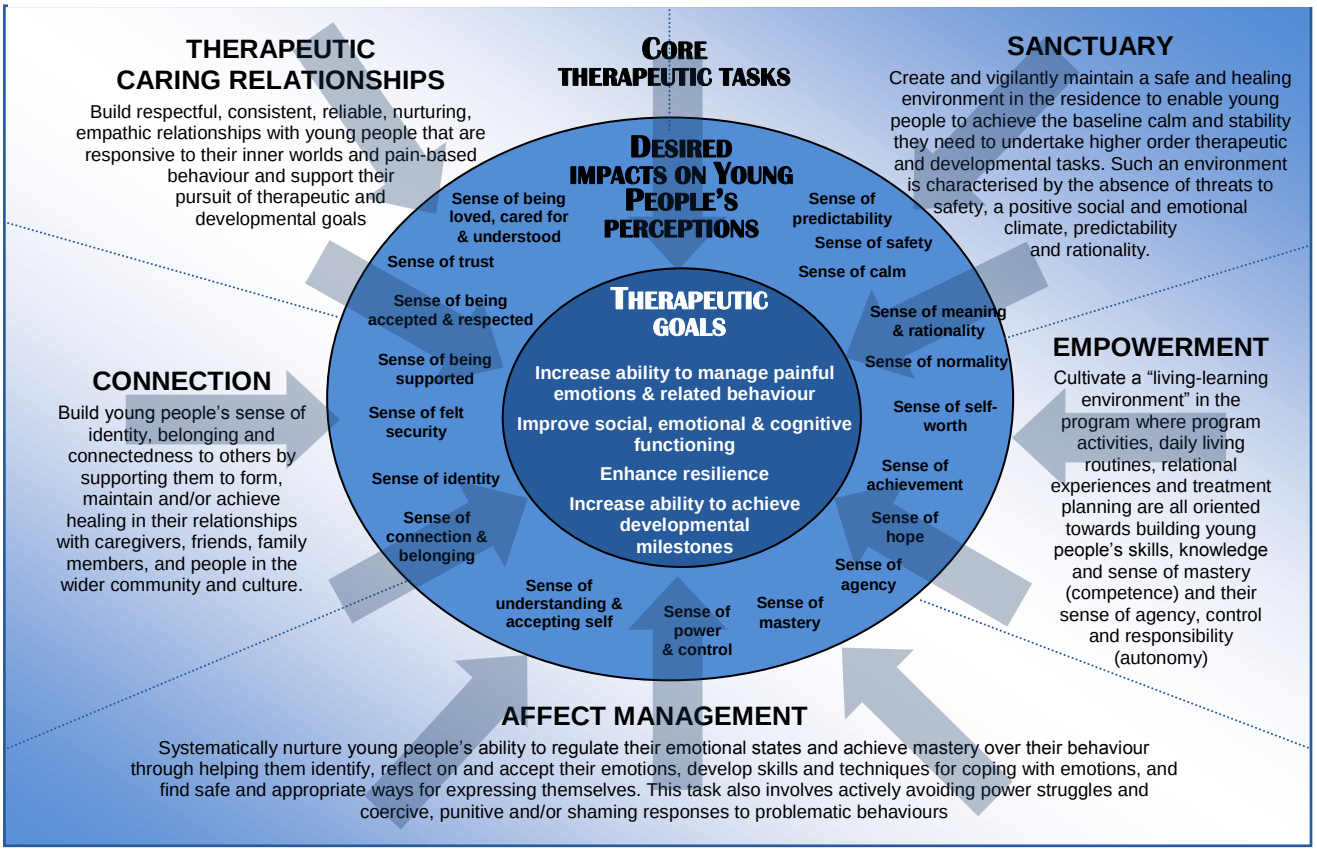
- Creating *sanctuary* around young people, for example, aims to bring about a sense of safety, calm, rationality and predictability.
- *Therapeutic caring relationships* contribute to young people's sense of trust and being supported, of being loved, cared for and understood, and of being accepted and respected.
- *Affect management* contributes to young people's growing sense of control over their emotions and behaviour, and their sense of being understood and accepted, and of understanding and accepting themselves.
- *Empowerment* contributes to their sense of mastery, achievement, agency and hope.
- *Connection* is intended to build young people's sense of belonging, identity and "felt security".

Young people's shifting perceptions are therefore relevant indicators of therapeutic work being undertaken and valuable to explore in the process of continuous improvement in therapeutic practice.

Some of the specific things young people can tell us that would be useful in evaluating the therapeutic quality of residential care environments include:

- their perceptions of the social and emotional climate of the household
- their perceptions of the qualities and behaviours of care staff
- their perceptions of how staff relate to them, support them and respond to their behaviour
- their perceptions of how the place is managed

Figure 2. Core therapeutic tasks and goals of trauma and attachment informed residential care and their intended impacts on young people's perceptions



and whether it "makes sense" to them and supports their sense of predictability and calm
- their perceptions of their personal support needs and how well these needs are currently being met
- the way they feel in the environment (e.g. whether or not they feel safe, accepted, respected, cared for, understood) and how they perceive the environment is impacting on them (e.g. whether or not it is helping them to feel better about themselves, understand and cope better with their emotions, learn new skills, feel more hopeful about the future)
- whether or not they perceive themselves to have enduring relationships and support networks, and whether or not they are being supported to build/maintain/repair these relationships while in the program, and
- whether or not they perceive themselves to have people in their lives who can support them with various things, and/or who give them a sense of belonging and identity.

The *Views of Young People in Residential Care Survey*

Given the relevance of young people's perceptions and observations in evaluating therapeutic practice in residential care, the Commission's *Views of Young People in Residential Care Survey* is a valuable source of information that can be drawn on in evaluation work.

The *Views of Young People in Residential Care Survey* is a biennial survey of young people across Queensland living in statutory residential care. It is part of the Commission's *Views of Children and Young People* survey series (the *Views Surveys*) – an ongoing body of research that gathers the views and experiences of children and young people in foster care, residential care and youth detention. These surveys were established in response to the 2004 Crime and Misconduct Commission inquiry into the abuse of children in foster care to allow children and young people to make their own assessment of the quality of their care, to share their lived experience of care in their own words, and to have direct input into important areas of child protection policy and practice. They represent the largest repeat cross-sectional longitudinal study of its kind involving the direct participation of children and young people in care.

Given the Queensland Government's policy commitment to trauma and attachment informed residential care and the importance of this agenda for meeting the needs of a highly vulnerable group of young people in the child protection system, the Commission has committed three administrations of the *Views of Young People in Residential Care Survey* to exploring the core therapeutic tasks described above.

- The *2011 survey* (current survey) investigates the tasks of creating sanctuary and building therapeutic caring relationships
- The *2012 survey* will investigate the task of connection.
- The *2014 survey* will investigate the task of empowerment and the developmental aspects of trauma and attachment informed residential care more generally.

Research design

The methodology of the 2011 *Views of Young People in Residential Care Survey* has been described in detail previously (see Commission for Children and Young People and Child Guardian, 2012). This section explains specific design elements relevant to investigating the therapeutic tasks of *creating sanctuary* and *building therapeutic caring relationships*.

Respondents

The survey was open to all children and young people in statutory residential care in Queensland between 1 August and 30 November, 2011. A total of 211 young people responded, corresponding to a response rate of 32%.[1]

Instruments

Young people completed a 10-page anonymous self-report instrument comprising predominantly fixed-response items. The instrument collects basic information about respondents' personal characteristics and circumstances as well as information about the responsiveness of the Department to their needs. These items are collected each administration of the survey for cross-sectional longitudinal analysis.

The main focus of the 2011 instrument, however, was to gather respondents' observations and perceptions of the care environment relevant to the therapeutic tasks of *creating sanctuary* and *building therapeutic caring relationships*. In line with the theoretical and therapeutic literature presented earlier, various sub-concepts related to these tasks were investigated:

- Qualities of sanctuary
  - Predictable/consistent
  - Rational
  - Calm/warm/non-threatening
  - Positive social climate
- Qualities of therapeutic carers
  - Empathic
  - Reliable/consistent/trustworthy
  - Supportive/empowering
  - Fair/respectful
  - Available

The instrument also gathered young people's perceptions of aspects of their personal wellbeing

in the care environment, and their sense of how the environment is impacting on them, as relevant to the therapeutic tasks under investigation. The therapeutic literature reviewed earlier indicates that the tasks of sanctuary and therapeutic caring relationships are intended, amongst other things, to nurture young people's sense of:

- safety
- being accepted and respected
- increasing competence
- gaining self-worth, and
- increasing hopefulness about the future.

Young people's perceptions of these aspects of personal wellbeing are therefore investigated.

Procedure

The Commission's Community Visitors (CVs) administered the survey during their scheduled monthly visits. Young people were told that their participation was voluntary and that they could withdraw from the survey at any time. They could elect to complete the survey alone or with the assistance of the CV in a private space without carers and other young people present.

Data analysis and reporting

In this report, survey data are mostly presented as proportions (percentage of respondents) and in some cases as medians or means (average of respondents) or frequencies (number of respondents). Data presented in tables and graphs have been rounded and may tally to more than 100%.The margin of error for proportions is generally around +/-8% when calculated from the whole sample of young people. Unless otherwise specified, the amount of missing data on any given variable is less than 15%.

Findings

Characteristics and circumstances

The characteristics and circumstances of survey respondents and the relationship between sample and population characteristics have been described in detail previously (see Commission for Children and Young People and Child Guardian, 2012). A brief summary of respondent characteristics and circumstances follows.

Demographic characteristics

Young people ranged in age from 6 to 17 years, but most were in their mid-adolescence (median = 14 years). Roughly two thirds (62%) were male; one third (36%) were Aboriginal or Torres Strait Islander; and quarter (24%) reported having a disability. All geographical regions in Queensland were represented in the sample.

Care history

Young people were 9 years of age on average (median) when they entered out-of-home care and reported being in care for 3.8 years on average (median). Roughly 3 out of 4 (72%) reported being in foster care previously. The total number of out-of-home care placements respondents reported having ranged between 1 and 47 with a median total of 4 and a mean of 7 (sd = 8.3). Approximately two-thirds (68%) indicated they had not been reunified with their families since coming into care.

Current placement

Young people reported being in their current placement for 6 months on average (median). Seventeen per cent reported living on their own without other young people. Those living with other young people reported living with between 1 and 7 others. The average (median) number of other residents is 3. Young people reported having between 1 and 28 different carers each week, the average (median) number of different workers each week is 6. Seventy-one per cent reported having at least one carer from the same cultural background as themselves.

Observations and perceptions of care environment

Young people were presented with numerous survey items exploring their observations and perceptions of the care environment. Each item was designed to explore the presence/absence of specific environmental qualities one would expect to see if the core therapeutic tasks of *building therapeutic caring relationships* and *creating sanctuary* are being performed adequately in the residential care program. These qualities are as follows:

- *Calm/non-threatening* – there is an absence of conflict, threat or disturbance in environment
- *Warm* – there is a positive emotional/social climate in the household
- *Predictable* – the environment is consistent and predictable and care staff are reliable and trustworthy
- *Rational/fair/respectful* – the environment is managed in a way that makes sense and feels fair
- *Caring* – care staff are attentive, caring, empathic and available
- *Empowering* – care staff help young people to deal with their problems, and increase their competence and/or autonomy.

Table 1 presents findings in relation to these six environmental qualities. The data presented in each column of the table is now described:

Column A indicates the particular environmental quality under investigation.

Column B presents the individual survey items used to explore the presence or absence of the

Table 1. Qualities of therapeutic care environments explored in survey (2011)

A Quality of environment	B Survey items that explore presence of environmental quality	C Response/s to survey item that suggest *presence of quality*	D % who gave response in Column C	E Response/s to survey item that suggest *insufficient presence or absence of quality*	F % who gave response in Column E	G α*
Calm/non-threatening *Absence of conflict, threats or disturbances in the environment*	Workers here often fight with each other	not at all true	81%	a bit true/very true	19%	.742
	I'm scared of breaking the rules because of what happens	not at all true	67%	a bit true/very true	33%	
	When young people behave in the wrong way, the workers often yell at them	not at all true	50%	a bit true/very true	50%	
	Some of the other young people make me feel nervous	not at all true	46%	a bit true/very true	54%	
	Some young people here are bullies	not at all true	46%	a bit true/very true	54%	
	I'm careful about what I say to workers because of how they may react	not at all true	43%	a bit true/very true	57%	
	There's often fighting between young people in this place	not at all true	21%	a bit true/very true	79%	
Warm *Positive social /emotional climate in the household*	Do you get along with the workers?	all/most	89%	not many/none	11%	.836
	Do you have enough privacy?	yes	84%	no	16%	
	Do you get along with the other young people?	all/most	83%	not many/none	17%	
	The place feels warm and friendly	yes	83%	no	17%	
	Young people are made to feel welcome when they come into this program	very true	82%	a bit/not at all true	18%	
	When kids fight, the workers help calm them down and show them how to sort things out	very true	73%	a bit/not at all true	27%	
	The workers encourage young people here to look after each other	very true	70%	a bit/not at all true	30%	
	The workers are easy to talk to	very true	65%	a bit/not at all true	35%	
	Most kids here get along well together	very true	38%	a bit/not at all true	62%	
	Young people here try to help each other with problems they are having	very true	38%	a bit/not at all true	62%	
Predictable *Environment is consistent and predictable and care staff are reliable and trustworthy*	I understand what is expected of me here (like house rules, behaviour, routines, chores)	very true	85%	a bit/not at all true	15%	.747
	Even when young people do something wrong, the workers here still care about them	very true	75%	a bit/not at all true	25%	
	The workers are always in control of this place	very true	65%	a bit/not at all true	35%	
	There are always lots of planned activities in this program	very true	60%	a bit/not at all true	40%	
	You can count on the workers here – they do what they say they will	very true	57%	a bit/not at all true	43%	
	Each day we have a schedule so we know what we are doing	very true	56%	a bit/not at all true	44%	
	Different workers have different rules	not at all true	26%	a bit true/very true	74%	
Rational/ fair/ respectful *Environment managed in a way that makes sense and feels fair*	Young people get some choice in everyday things	very true	68%	a bit/not at all true	32%	.817
	Young people get rewarded for good behaviour	very true	67%	a bit/not at all true	33%	
	Since you arrived here, has a worker explained the program to you?	yes, really well	64%	yes, but just the basics/no	36%	
	Young people are treated equally by the workers	very true	63%	a bit/not at all true	37%	
	The consequences for breaking the rules are fair	very true	62%	a bit/not at all true	38%	
	The workers usually explain the reasons for their decisions	very true	57%	a bit/not at all true	43%	
	There are too many rules and they are too strict	not at all true	48%	a bit true/very true	52%	
	Young people get some say in what the rules or consequences are	very true	36%	a bit/not at all true	64%	
Caring *Staff are experienced as attentive/ caring/ empathic and available*	The workers here are very caring	very true	73%	a bit/not at all true	27%	.880
	The workers make an effort to understand what I'm thinking and feeling	very true	68%	a bit/not at all true	32%	
	The workers encourage me to talk about my feelings	very true	60%	a bit/not at all true	40%	
	The workers listen to me and take my views into account	very true	59%	a bit/not at all true	41%	
	I get enough time on my own with workers to talk about things	very true	59%	a bit/not at all true	41%	
	The workers are always asking about my views and opinions	very true	47%	a bit/not at all true	53%	
Empowering *Staff help young people to deal with problems, and increase competence and/or autonomy*	The workers expect me to do my best at things	very true	75%	a bit/not at all true	25%	.879
	The workers help me with problems I am having	very true	72%	a bit/not at all true	28%	
	The workers encourage me and believe in me	very true	71%	a bit/not at all true	29%	
	The workers try to help young people with their behaviour	very true	69%	a bit/not at all true	31%	
	The workers help me understand and cope better with my feelings	very true	64%	a bit/not at all true	36%	
	The workers are always getting me to set goals for myself	very true	63%	a bit/not at all true	37%	

* Cronbach's **α**

environmental quality. This is the way the item was worded in the young people's questionnaire.

In most cases, these items take the form of a statement which respondents rank on a 3-point scale – *not at all true*/*a bit true*/*very true*. While binary response scales (e.g. yes/no) are used in equivalent therapeutic climate assessment instruments (e.g. Moos, 2011), a 3-point scale was chosen for most items in the current survey to reduce respondents' likelihood of non-response. Forcing respondents to categorise their experiences and views primarily through binary response options is also contrary to the philosophical vision of the *View's Surveys* which is to give children and young people in care a voice.

However, for the purposes of the current investigation and analysis, it is necessary and appropriate to recode the 3-point scale into binary response options, with one end of the scale constituting "presence of environmental quality" and the middle and other end of the scale constituting "absence/insufficient presence of environmental quality". The particular end of the scale that indicates the presence of the environmental quality varies depending on whether the item is worded positively or negatively.

- For positively worded items, like "The workers here are very caring", *very true* represents the presence of the relevant environmental quality and *a bit true/not at all true* represents the insufficient presence/absence of the environmental quality.
- For negatively worded items, like "I'm scared of breaking the rules because of what happens", *not at all true* constitutes the presence of the environmental quality and *a bit true/very true* represents the insufficient presence/absence of the environmental quality.

The central item on the scale – *a bit true* – is always coded to "absence/ insufficient presence of environmental quality" because it indicates a level of ambivalence on the part of the respondent in relation to the presence of the environmental quality.

The small number of remaining survey items with different response scales were either already binary response items or they were recoded into binary response items. The same principle for recoding was applied – i.e. response options were divided into those that indicated non-ambivalent affirmation of the presence of the environmental quality on one hand, and those that indicated ambivalence towards or denial of the presence of the environmental quality on the other.

Column C in Table 1 indicates the particular response to the survey item in Column B that corresponds to "presence of environmental quality".

Column D indicates the proportion of respondents who gave the answer in Column C. The higher the proportion, the more commonly the environmental quality under investigation is experienced or perceived by respondents, judging by that particular item.

Column E indicates the response/s to the survey item in Column B that correspond/s to "absence or inadequate presence of environmental quality".

Column F indicates the proportion of respondents who gave the answer in Column E. The higher the proportion, the less commonly the environmental quality under investigation is experienced or perceived by respondents, judging by that particular item. Columns D and F sum to 100%.

Column G indicates Cronbach's alpha (α) for the set of survey items associated with a particular environmental quality to gauge how reliably the items measure the same underlying construct.

Cronbach's alpha was greater than .7 for all six constructs indicating an acceptable level of internal consistency. It should be noted, however, that a number of these constructs overlap conceptually such that individual survey items may be relevant for exploring more than one environmental quality. For example, "Even when young people do something wrong, the workers here still care about them" is arguably relevant for exploring both the predictability of the environment and its caring quality. For simplicity in the present analysis, however, each survey item is linked uniquely to one of six environment qualities.

Findings related to each environmental quality are now described. In the main, these refer to data in columns C and D. However, when describing data pertaining to negatively worded survey items, it is generally easier grammatically and conceptually to refer to the data in columns E and F.

Calm/non-threatening environment

The most basic quality of sanctuary is being free from danger, threats and stress-provoking experiences. Seven survey items were developed to explore the calm/non-threatening quality of young people's care environments. From the data presented in columns E and F of Table 1, is apparent that young people frequently experience stress-provoking disturbances and threats in their care environment. While certain disturbances are not commonly experienced – like workers fighting with each other – others are very commonly experienced, at least to some extent – like workers yelling at young people when they behave in the wrong way or young people fighting or not getting along with each other. For example:

- 19% responded *a bit true/very true* to the statement "Workers here often fight with each other"
- 50% responded *a bit true/very true* to the

statement “When young people behave in the wrong way, the workers often yell at them”, and

- 79% responded *a bit true/very true* to the statement “There’s often fighting between young people in this place”.

The data presented in columns E and F also indicate that more than half of young people experience a level of anxiety or threat in relation to other residents:

- 54% responded *a bit true/very true* to the statements “Some of the other young people here make me feel nervous” and “Some young people here are bullies”.

Many also indicated a level of anxiety about the reactions of workers to things young people say or do:

- 57% responded *a bit true/very true* to the statement “I’m careful about what I say to workers because of how they may react”, and
- 33% responded *a bit true/very true* to the statement “I’m scared of breaking the rules because of what happens”.

Warm environment

A positive social/emotional climate in the residence may help to lower young people’s baseline anxiety or counteract perceived threats in the environment. Ten survey items were developed to explore this quality of the care environment. Young people’s responses to these items, as shown in columns C and D of Table 1, suggest that most experience their care environment as warm. For example:

- 83% responded *very true* to the statement “The place feels warm and friendly”
- 82% responded *very true* to the statement “Young people are made to feel welcome when they come into this program”, and
- 70% responded *very true* to the statement “The workers encourage young people here to look after each other.”

The two items that specifically investigate residents’ contribution to the warmth of the environment were responded to much less positively, however. Only 38% responded *very true* to each of the statements “Young people here try to help each other with problems they are having” and “Most kids here get along well together”.

Predictable environment

Also believed to be important to reducing trauma survivors’ inclination to hypervigilance is providing them with an environment that is consistent, predictable and reliable. Seven survey items were developed to explore this quality of the care environment. Young people’s responses to these items, as shown in columns C and D of Table 1, are mixed. On one hand most young people reported knowing what is expected of them; on the other hand, relatively few denied that workers differ in their expectations:

- 85% responded *very true* to the statement “I understand what is expected of me here”, while
- 26% responded *not at all true* to the statement “Different workers have different rules”. In other words, three-quarters feel that staff differ in their expectations, at least to some extent.

As shown in columns C and D, respondents are more commonly positive about the reliability of workers in terms of the consistency of their care for young people than in terms of the workers doing what they say they will:

- 75% responded *very true* to the statement “Even when young people do something wrong, the workers here still care about them”, while
- 57% responded *very true* to the statement “You can count on the workers here – they do what they say they will”.

Respondents also give mixed feedback about the structuring of time and activities in their care environment. Three out of five or fewer respondents indicated having regularly planned activities or a daily schedule (columns C and D), while 2 out of 5 or more indicated that this is not generally the case (columns E and F):

- 60% responded *very true* to the statement “There are always lots of planned activities in this program”, and
- 56% responded *very true* to the statement “Each day we have a schedule so we know what we are doing”.

Rational/fair/respectful environment

As noted earlier, survivors of chronic childhood trauma have often experienced extremely arbitrary disciplinary regimes. Creating an environment in which things happen for a logical and justifiable reason helps to reduce the unpredictable and arbitrary nature of the world. This in turn is believed to lower individuals’ anxiety levels as well as instil in them a sense of meaning, fairness and of being respected.

For the purposes of the current study, characteristics of a rational/fair/respectful environment are assumed to include the following:

- the rules and consequences make sense and feel fair – they exist for clear and justifiable purposes which have been satisfactorily explained to young people, and are administered in a consistent and unbiased way
- workers give reasons for their decisions
- workers model expected behaviour, and
- young people have some say or choice in everyday decisions and are involved at least to some extent in making decisions about rules and consequences.

Eight survey items were developed to explore this

quality of the care environment. Young people's responses are quite mixed. As shown in columns C and D of Table 1, on five of the eight items, roughly two out of three respondents gave responses indicating the presence of this environmental quality. For example:

- 62% responded *very true* to the statement "The consequences for breaking the rules are fair", and
- 68% responded *very true* to the statement "Young people get some choice in everyday things".

For the remaining three items, the proportion of respondents indicating the presence of a rational, fair and respectful environmental quality was considerably lower:

- 57% responded *very true* to the statement "The workers explain the reasons for their decisions"
- 48% responded *not at all true* to the statement "There are too many rules and they are too strict", and
- 36% responded *very true* to the statement "Young people get some say in what the rules or consequences are".

The second last item here suggests that half of young people perceive rules surrounding their living environment to be unjustifiable or unfair to some extent. This perception is also evident in young people's responses to an open-ended question asked later in the survey about what they would "most like changed" about where they are living. The most common theme in response to this question was dissatisfaction with household/program rules and management (42 open-ended comments out of a total of 152 corresponded to this theme). Much of the dissatisfaction appears to be about rules impinging unfairly on young people's freedom and independence and/or on young people's ability to have friends over or spend time with friends, or not having enough say in things. For example:

- *Less rules.*
- *Some rules, like what time to be back, need more freedom!*
- *See more friends, being rewarded for good behaviour, rules not so strict. Want to have fun and stuff too.*
- *The rules in this house to be less strict.*
- *Not so many rules and the workers should do what we want.*
- *The RULES! We should be allowed out more, not as f***ing strict rules and MORE FUNDING for everyday living and activities! And friends should be allowed over. I'd move if I could and if I thought the rules were fair.*
- *Most of the rules are extremely stupid!*
- *More free time, instead of 3 hours on a Sunday.*
- *I want independent time.*
- *I want my friends to stay sometimes.*
- *Later curfew and bed time.*
- *More social time.*
- *More time with friend.*
- *Rules!*

Bivariate correlations between the survey items investigating the presence of a rational, fair and respectful environment were examined. This was with the goal of discerning observations and experiences of respondents that may be related to a sense of the environment as "fair". One set of these correlations is presented in Table 2. These data show moderate and significant relationships between young people's perception that "The consequences for breaking the rules are fair" and such observations as "Young people get rewarded for good behaviour", "The workers usually explain the reasons for their decisions", and "Young people here get some say in what the rules or consequences are".

Caring environment

As established earlier in the paper, therapeutic

Table 2.: Correlation between "The consequences for breaking the rules are fair" and survey items investigating presence of a rational, fair and respectful environment (2011)

Survey items investigating presence of a rational, fair and respectful environment	Correlation of survey item with "The consequences for breaking the rules are fair" (*r*-value^)
"The consequences for breaking the rules are fair"	1
"Young people get rewarded for good behaviour"	.490**
"Young people here are treated equally by the workers"	.465**
"The workers usually explain the reasons for their decisions"	.426**
"Young people get some choice in everyday things	.410**
"Young people here get some say in what the rules or consequences are"	.379**
"Since arriving here a worker has explained the program (like house rules, behaviour, routines, chores)"	.354**
"There are too many rules and they are too strict"	-.269**

^ *r* = (0,1). The larger the number, the stronger the relationship between young people's responses to the two items.
** relationship is statistically significant at the 0.01 level.

caring relationships need to be sensitive and responsive to young people's inner worlds and their "pain-based behaviour". This sensitivity and responsiveness helps the young person over time understand and accept themselves and gain greater control over their emotional states. To build such relationships, carers need to demonstrate a high level of attentiveness, caring and empathy towards young people.

Six survey items were developed to explore this caring quality of the environment. As shown in columns C and D of Table 1, around 7 in 10 young people responded *very true* to statements about care staff being "very caring" and making an effort to understand what they are thinking and feeling. They less commonly reported having enough time on their own with workers, however:

- 59% responded *very true* to the statement "I get enough time on my own with workers to talk about things".

They were also less likely to indicate that workers ask them about their views, opinions and feelings:

- 60% responded *very true* to the statement "The workers encourage me to talk about my feelings"
- 59% responded *very true* to the statement "The workers listen to me and take my views into account", and
- 47% responded *very true* to the statement "The workers are always asking about my views and opinions."

Empowering environment

An important dimension of an empowering environment is having carers who actively support young people's recovery and development – providing help to deal with problems, offering encouragement, having high expectations of young people, and nurturing their development of competence and autonomy.

Six survey items were developed to explore the supportive/ empowering quality of carers' relationships with young people. As shown in columns C and D of Table 1, on four of these items, roughly 7 out of 10 young people indicated the presence of the relationship/environmental quality. For example:

- 75% responded *very true* to the statement "The workers expect me to do my best at things", and
- 71% responded *very true* to the statement "The workers encourage me and believe in me."

The proportion of respondents indicating the presence of this environmental quality was slightly lower for the remaining two survey items:

- 64% responded *very true* to the statement "The workers help me understand and cope better with my feelings", and
- 63% responded *very true* to the statement "The workers are always getting me to set goals for myself".

Perceptions of personal wellbeing

Based on the discussion earlier in the paper, the therapeutic tasks of *creating sanctuary* and *building therapeutic caring relationships* are intended to have positive impacts on young people's sense of:

- safety
- being accepted and respected
- competence
- self-worth, and
- hopefulness about the future.

Young people were therefore asked various questions to explore their perceptions of these aspects of personal wellbeing in the placement.

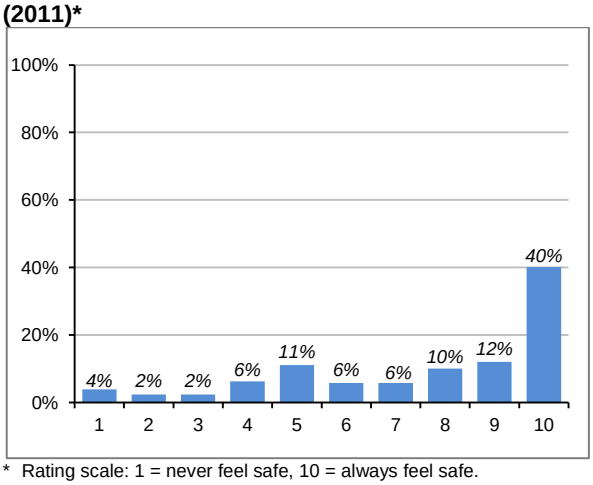
Given how critical a sense of safety is to undertaking therapeutic and developmental work, a set of four fixed- and open-response items were used to explore young people's sense of safety in their living environment. The other four aspects of personal wellbeing were each explored using a single measure in the form of a statement which respondents were required to rate on a 3-point truthfulness scale – *not at all true*/*a bit true*/*very true*. The 3-point scale items are not recoded to binary response items in this part of the analysis. This is because the purpose of the current analysis is to describe the spectrum and frequency of young people's perceptions of personal wellbeing rather than determine categorically the presence or absence of environmental qualities based on their perceptions and observations.

Safety

Do you feel safe here?

Eight-seven per cent of young people reported feeling safe where they are living while 13% said they do not feel safe there.

Figure 3. Frequency of feeling safe in placement (2011)*



* Rating scale: 1 = never feel safe, 10 = always feel safe.

How often do you feel safe here?

Young people were asked to rate how often they

feel safe where they are living by placing a mark on a 10-point visual analogue scale ranging from 1 (never feel safe) to 10 (always feel safe). Fifty-two per cent of young people gave a rating of 9 or 10 (Figure 3). The median rating is 9.

What helps you feel safe here?
One hundred and eighty-one young people (86%) responded to this open-ended question. Responses were analysed thematically with multiple coding of responses permitted. The major themes identified are presented in order of their observed frequency with examples of young people's comments relating to each theme:

Care staff (83 responses):

- *Having real good workers here.*
- *Knowing nothing can hurt me because the workers are very nice ladies.*
- *Staff are always around.*
- *The staff. I can talk to them. They're friendly, used to the bush.*
- *The workers protect us.*

Personal space and privacy (28 responses):

- *Having a lot of privacy and my own room.*
- *Having lock on bedroom door.*
- *Staying in my room.*
- *When I am around a carer or in my room.*
- *Freedom.*

Being treated well (19 responses):

- *Lots of food, people being nice to me…*
- *Don't get yelled at, get treated good, don't get hurt.*
- *Not getting bashed up every day.*
- *When they're being nice to me.*
- *When youth workers tell me they care.*

Good security (11 responses):

- *Having a lock on all doors and safety screens on all windows. Also having two youth workers.*
- *The alarms on the doors and the strictness of the carers.*
- *That we have staff rooms on either side of the house to ensure no one breaks in and if they do action will be taken.*

Co-residents (9 responses):

- *Having the girls around.*
- *Nice kids and more responsibility.*
- *The carers, the alarms and some of the kids stick up for me.*

Exercising, playing games or listening to music (8 responses):

- *Go for walks*
- *Smokes, Xbox, Wii (makes me feel calm and relaxed).*
- *Staying in my room and listening to my friend's iPod.*
- *Go to room, go for a bike ride.*

Support of family members (including having siblings living at the residential) (8 responses):

- *Family.*
- *Carers, brothers, sister, and games and food.*
- *Feel safe when I swim, can sleep with lamp on, being with siblings.*

What makes you feel unsafe here?
One hundred and seventy-one young people (81%) responded to this open-ended question. Responses were analysed thematically with multiple coding of responses permitted. The major themes identified are presented in order of their observed frequency with examples of young people's comments relating to each theme:

Nothing makes me feel unsafe (73 responses):

- *Don't feel unsafe.*
- *Nothing at all. Always feeling safe.*
- *Nothing makes me feel unsafe.*

Co-residents (33 responses):

- *A young person hurting me.*
- *Abused by other kids, verbal and touching.*
- *Another girl frightens me – want to protect my baby (foetus).*
- *Boys picking on me.*
- *Crazy kids.*
- *People threatening me to get smoke.*

Threatening disturbances in the residential environment (including fights, arguments, acts of violence, and outbursts of anger) (15 responses):

- *[Co-resident] when she threatens to kill the youth workers.*
- *Other young people fighting.*
- *Violence.*
- *When we all argue.*
- *When kids are going feral and youth workers don't care.*

Care staff (14 responses):

- *Most youth workers (including team leader), other residents. Sometimes I don't know the worker and I'm anxious and worried.*
- *The workers pissing me off 'cause I'll feel unsafe 'cause I'm scared that I'll hit one of them.*
- *Workers not doing anything about fights happening in the house.*
- *When I find out that one of the workers is talking crap.*

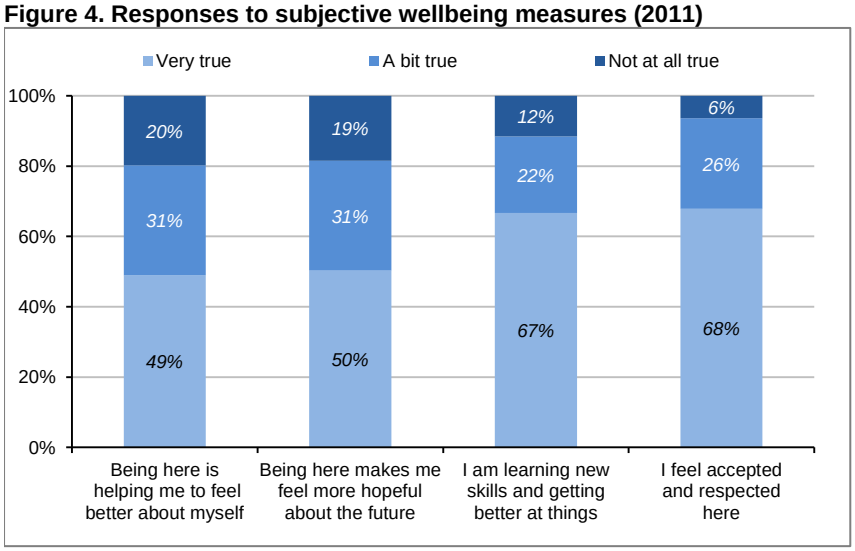
People in the residence (could be reference to care staff or co-residents – relationship to respondent is unspecified) (14 responses):

- *Other people here.*
- *The people.*
- *When [male name] tries to hurt me.*
- *I get punched in the nose by [female name].*

Other things young people mention in their comments as making them feel unsafe where they are living include: themselves or their behaviour, a lack of security or privacy, being alone, visitors to the premises, and ghosts. For example:

- *When I get angry because I might do something stupid.*
- *Being abused by house mates and door currently broken.*
- *No one to talk to. Hate being alone.*
- *Random peeps coming in and out of the house.*
- *Sometimes I think there are ghosts and bad spirits following me everywhere I go.*

Figure 4. Responses to subjective wellbeing measures (2011)



Being accepted and respected

To explore this aspect of subjective wellbeing, young people were asked to rate the truthfulness of the statement "I feel accepted and respected here" (Figure 4). Sixty-eight per cent responded *very true*, 26% responded *a bit true*, and 6% responded *not at all true*.

Competence

Young people were asked to rate the truthfulness of the statement "I am learning new skills and getting better at things" (Figure 4). Sixty-seven per cent responded *very true*, 22% responded *a bit true*, and 12% responded *not at all true*.

Self-worth

Young people were asked to rate the truthfulness of the statement "Being here is making me feel better about myself" (Figure 4). Forty-nine per cent responded *very true*, 31% said *a bit true*, and 20% responded *not at all true*.

Hopefulness about the future

Young people were asked to rate the truthfulness of the statement "Being here makes me feel more hopeful about the future" (Figure 4). Fifty per cent responded *very true*, 31% said *a bit true*, and 19% said *not at all true*.

Discussion & conclusion

This paper has defined trauma and attachment informed residential care in terms of broad goals and core therapeutic tasks with reference to the theoretical, research and therapeutic literature. It has then begun the process of evaluating efforts in Queensland to cultivate trauma and attachment informed residential care environments focusing on two core therapeutic tasks – *building therapeutic caring relationships* and *creating sanctuary*. Some of the research findings are now discussed along with implications for practice and policy.

Therapeutic caring relationships

Strengths

Young people's responses to the survey suggest that residential care programs across Queensland are achieving a level of success in building therapeutic caring relationships.

- About seven in 10 young people strongly indicated having "very caring" carers who make an effort to understand what they are feeling and thinking
- At least seven in 10 strongly indicated that their carers help them with problems they are having, encourage them, believe in them and expect the best of them.
- Nine in 10 indicated at least to some extent feeling accepted and respected where they are living and that they are learning new skills and getting better at things since being in the placement.
- Eight in 10 indicated at least to some extent that being in their current placement makes them feel better about themselves and more hopeful about the future.

These are notable achievements, particularly given that young people in this population have typically experienced attachment trauma, have challenging emotional and behavioural issues, and have significant developmental needs.

Challenges

The findings suggest a few areas of potential concern in relation to building therapeutic caring

relationships. Firstly, it would appear that some aspects of therapeutic caring are less commonly experienced by young people than others. While carers' empathy and caring are most commonly identified by young people, they less commonly report that their carers explore their feelings, thoughts, views and opinions. As noted in the theoretical discussion earlier, this exploratory work is believed to be therapeutically important for assisting young people to understand and accept themselves, develop a unified sense of self, develop a language to describe internal states, and increase their ability to regulate emotions (Cairns, 2002; Streeck-Fischer & van de Kolk, 2000; Stien & Kendall, 2004).

Given that the emotional and physical availability of carers is centrally important in attachment-therapeutic work (Cairns, 2002; Schofield & Beek, 2006), a second area of potential concern is the finding that only three in five young people strongly indicated having sufficient time on their own with workers to talk about things.

Finally, the literature discussed earlier emphasises that attachment-therapeutic work with children who have experienced chronic childhood trauma is typically complex and lengthy and cannot be rushed without jeopardising therapeutic outcomes for the child (James, 1994). In light of this, it is potentially concerning that the average reported current placement length of young people in the sample is 6 months – for the population during the period of the survey, this was only 4 months.[2] Such a brief placement timeframe would seem to be at odds with the attachment-therapeutic approach that has been specified in policy. It raises questions about what is genuinely achievable in these timeframes from an attachment-therapeutic perspective and whether there may be negative consequences resulting from attempting to forge therapeutic attachment relationships that are then terminated after such a short period. If this short average placement length results from a high proportion of placement breakdowns in residential care, then this is also of concern. At a systemic level, it raises questions about the appropriate placement of young people in residential care programs and the quality and effectiveness of therapeutic care and treatment being provided to them.

Sanctuary

Warmth, safety and calm

The findings that relate to the task of cultivating a healing sanctuary in residential care are somewhat mixed. On one hand, young people's observations and perceptions of their care environment indicate that the vast majority experience this environment as warm and friendly and have carers who actively cultivate a positive social and emotional climate in the residence. On the other hand, young people's feedback about their sense of safety raises concern about how effectively residential care programs in Queensland are cultivating non-threatening and calming care environments.

One in eight young people (13%) reported not feeling safe where they are living and more than half (60%) indicated that they do not always feel safe where they are living. The most common source of feeling unsafe described by young people is intimidation, threats or violence from other young people they live with, followed by threatening disturbances that occur in the care environment, such as people fighting, arguing, perpetrating violence against each other, and/or outbursts of anger. A number of young people also cited a lack of effective intervention by care staff in relation to such disturbances. Young people's responses to other survey items suggest that interpersonal conflict, particularly conflict between residents, and threatening disturbances in the care environment, are very commonly experienced or witnessed. Half reported, to some extent, that workers often yell at young people when they do the wrong thing and one in three indicated a level of fear about breaking the rules because of what happens.

The findings about young people's sense of safety are of considerable concern given the consensus in the research and practice literature on the fundamental importance of trauma survivors achieving and maintaining a sense of safety and calm in order to pursue all higher-order therapeutic and developmental goals. The findings suggest the urgent need for more trauma-sensitive program design in residential care, with particular consideration given to how the group environment is managed to ensure it is not experienced as threatening or stressful to young people.

There are numerous well-regarded resources that residential care providers can reference in developing therapeutic group programming and therapeutic crisis management, including Vorrath and Brendtro's (1985) Positive Peer Culture model, Holden's (2001) therapeutic crisis intervention techniques, the peer helping model EQUIP (Gibbs *et al.*,1995) and the LifeSpace Crisis Intervention model (Long *et al.*, 1998). In addition, there are a number of therapeutic and skills development programs for group work with adolescents with complex trauma recommended by leading traumatologists that could be incorporated in program design (see Cook *et al.*, 2005).

Predictability and rationality

Building a healing sanctuary for trauma recovery also involves cultivating a sense of predictability and rationality. Young people's responses to survey items that explore these qualities suggest they are variable across residential care settings in Queensland. With regard to predictability, three in

five or fewer respondents strongly indicated having a daily schedule or regularly planned activities in their program while two in five or more indicated otherwise. Perhaps of most concern, however, is the frequency with which young people indicate that workers at their residence differ in their expectations of young people. Three in four (76%) indicated this to be the case to some extent. On the positive side, however, three in four (75%) strongly indicated that workers' care towards young people is dependable, even when young people do the wrong thing. This further reinforces the positive findings of the survey in relation to building therapeutic caring relationships.

With regard to a rational, fair and respectful environment, more than one in three young people (38%) denied that "the consequences for breaking the rules are fair" to some extent and roughly half (52%) expressed a level of support for the view that "there are too many rules and they are too strict". Moreover, the most common theme in young people's responses to the question about what they would most liked changed about where they are living is dissatisfaction with household/program rules and management. It may be tempting to dismiss young people's common dissatisfaction with the disciplinary regime in their residence as the predictable resentments of any group of adolescents wanting more independence and control over their lives in the face of legitimate parental limit-setting. This may indeed be the case, at least to some extent. However, it is also conceivable that these views reflect problems with cultivating a sufficient sense of rationality and fairness in the care environment. For example, these views may reflect a failure on the part of programs to adequately explain to young people the reasons behind rules and consequences or to design rules and consequences that intuitively make sense to them.

Evidence from the survey that may support this hypothesis was presented earlier in Table 2. The correlations shown in this table suggest that young people are less likely to feel that a disciplinary regime is illegitimate or unreasonable if they:

- feel that the rules of the environment have been fully explained to them
- observe that workers usually explain the reasons for their decisions
- observe that young people get some say in what the rules or consequences are
- feel young people are treated equally by the workers, and
- observe that young people are rewarded for good behaviour.

In light of these findings, it is noteworthy that only about one in two young people (57%) strongly indicated that their workers usually explain reasons for decisions, and only one in three (36%) strongly indicated that young people in the program are given some say what the rules and consequences are.

Given that residential care has until quite recently focused – at least implicitly – on the control and discipline of children and young people judged to be "mad" or "bad", it is possibly not surprising if staff in some programs are not in the habit of explaining decisions to young people or involving them in decisions around rules and consequences. The trauma and attachment paradigm, however, supports such practice. It does not discount the need for setting clear and consistent limits for young people, but it has broader therapeutic and developmental goals than traditional residential care. These include nurturing young people's trust in relationships with carers, self-regulation of emotion and the development of skills, knowledge and autonomy. It is also concerned to reshape young people's internal working models of the world to promote psychological health.

As outlined earlier, these goals are achieved in part by creating a physical and relational environment around the young person in which things happen for logical and justifiable reasons; where people are listened to, treated fairly and with respect and empathy; where people have responsibility to others and to themselves but also have some say in how things work. To create such an environment for traumatised young people is no simple task. Anglin (2002) has argued that it requires a whole-of-organisation commitment to achieve the necessary "congruence" in values and behaviour. This includes workers consistently modelling the behaviour expected of young people. Based on his research, Anglin argues that while this congruence is challenging to achieve, it is nevertheless worth striving towards because it lies at the heart of effective therapeutic practice.

System issues

Licensing and monitoring of programs

The lack of trauma-sensitive programming in some residential care programs in Queensland suggested by young people's observations of their care environments is likely to be related to a lack of specification of such programming in the various documents that surround the licensing and monitoring of residential care (as discussed in the Introduction). The Victorian Department of Human Services has in recent years articulated a set of "essential service design elements" for trauma and attachment informed statutory residential care (see Department of Human Services, 2010). These underpinned the state's therapeutic residential care pilot programs, which in 2011, following a two-year independent evaluation, were found to achieve significantly better outcomes for young people compared with a standard residential care control group (see Sullivan *et al.* 2011). The

adoption of such a framework in Queensland may help to bring trauma-attachment therapeutic thinking and planning into service design and delivery.

Pre-placement assessments

It is possible that some of the difficulties identified in Queensland with creating and maintaining a sanctuary in residential care relate to inadequate pre-placement assessment of young people. Even the most thoughtfully-designed residential care program may be unable to achieve its objectives if there is a fundamental mismatch between the needs and capacities of the individual placed in the program and the program's objectives and methods. As child trauma specialists have noted, appropriately matching a child's developmental needs and capacities to a therapeutic intervention is essential for effectiveness. Perry explains:

> A 17-year-old boy… may only have the relational skills of a 3-year-old. To expect this boy to function well in a group is unrealistic; such an expectation will only lead to problems in the group, and there will be no true therapeutic impact of the group "therapy". No 3-year-old could manage a complex, insight-oriented group – and neither can the 17-year-old with the relational skills of a toddler. (Perry, 2006: 48)

Similarly, if there is a fundamental mismatch between the needs and presenting issues of individuals placed together in a residence, residential care programs will struggle to achieve their objectives.

The Commission is aware that both these issues – matching young people to suitable therapeutic programs and matching young people appropriately to existing residents – are long-standing concerns in Queensland stemming from a lack of appropriate placement options to meet the diverse needs of young people with significant psychological problems. These issues were identified in both the 1999 Forde and 2004 Crime and Misconduct Commission inquiries into the abuse of children in care in Queensland and have been raised by service providers repeatedly in the intervening years. While work continues to be undertaken to address these issues, the inappropriate placement of young people in residential care has the potential to undermine the therapeutic and developmental goals of this mode of care and treatment.

Implications for policy and practice

Various implications for policy and practice arise out of this discussion of the research findings. Key amongst these are:

- Consideration needs to be given at a policy level to the integrity of an attachment-therapeutic approach in residential care given that the average placement length is less than 6 months at present.
- There is an urgent need for more trauma-sensitive program design in residential care, with particular consideration given to how the care environment is managed so that it:
  - is not experienced as threatening or stressful by young people, and
  - supports their sense of predictability and rationality.
- The licensing and monitoring of residential care services needs to give explicit attention to program design elements necessary to support core therapeutic tasks of trauma and attachment informed residential care, as occurs in other states.
- Greater attention needs to be given in Queensland to pre-placement assessment and matching of young people with complex or extreme needs to increase the likelihood of them achieving positive therapeutic and developmental outcomes.

The Commission acknowledges that the residential care sector is right at the start of what is a significant historical shift in practice and that this transition will take time to complete. Attending to the issues identified here will hopefully advance this agenda and reduce the current shortfall between the Queensland Government's worthy policy objectives and what is actually achieved for young people with regard to recovery from the complex impacts of severe abuse and neglect.

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Notes

1 *N* = 669. Population data obtained from Jigsaw – Commission's client data management system.

2 Population data obtained from Jigsaw.

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- The *Youth Works* art program assists young people in the Brisbane and Townsville (Cleveland) youth detention centres to "create a brighter future through art".
- Youth Works is one of a range of programs offered to help these young people develop job and life skills and divert them from the youth justice system once they return to the community.
- Youth Works program is a collaborative effort between the Department of Communities, Child Safety and Disability Services and the Department of Education, Training and Employment.
- All proceeds from the sale of the artworks are paid into the trust account for each young person.

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