



Child Aware Approaches Project: Trauma-informed family sensitive practice for adult oriented health services

Henry von Doussa
Julie Beauchamp
Melinda Goodyear
Jennifer Power
Jeff Young

Child Aware Approaches Project: Trauma-informed family sensitive practice for adult oriented health services



January 2013

Henry von Doussa
Julie Beauchamp
Melinda Goodyear
Jennifer Power
Jeff Young

ACKNOWLEDGEMENTS

This project is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs from a grant allocated under the Federal Government's Child Aware Approaches Program 2012.

We would like to acknowledge and thank organisations and individuals in the adult health and community sectors who were open to and supportive of this research. For their generous contribution to the direction of the project and the development of the Practice Guidelines, we thank the many consultation participants from across the human service sectors.

We also thank The Bouverie Centre Trauma Team clinicians who gave generously of their wisdom and time in a series of interviews. Their contribution to the development of the Practice Guidelines was significant. The Trauma Team clinicians modelled the respectful, open and collaborative relational processes that we advocate in trauma-informed family sensitive practices. The enthusiasm they showed for the Child Aware Approaches Project is gratefully acknowledged.

We acknowledge the support and advice given by The Bouverie Centre Program Managers: Robyn Elliott particularly for her content and editorial support, Brendan O'Hanlon, Kerry Proctor, Shane Weir and Team Leader Franca Butera-Prinzi. We also thank Julie Contole for her invaluable advice and editing.

Finally we especially acknowledge and thank the many human service sector consumers whose wisdom and dedication to recovery has taught us much about resilience and the effect of trauma in families.

Copyright © The Bouverie Centre, La Trobe University 2013
The Bouverie Centre
8 Gardiner Street
Brunswick 3056
Australia
Tel (03) 9385 5100
Fax (03) 9381 0336
www.bouverie.org.au

Suggested citation:

Beauchamp, J., Goodyear, M., Power, J., von Doussa, H., and Young, J. (2013). Child aware approaches project: Trauma-informed family sensitive practice for adult oriented health services. The Bouverie Centre, Melbourne Australia.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS	iii
EXECUTIVE SUMMARY	1
Key Findings	1
Consultation with the health and welfare sectors	1
Development of Practice Guidelines	2
Conclusion	2
INTRODUCTION	3
Background to this Project	3
Policy Context	4
Some Questions	6
Why a focus on trauma?	6
Why family sensitive practice?	6
Does a family sensitive approach improved outcomes?	7
THE PROJECT	9
Project Objectives and Strategies	9
Clinical interviews with The Bouverie Centre Trauma Team clinicians (family therapists)	9
Sector Consultations	9
Development of Practice Guidelines	10
What we learned	10
Findings from Interviews with Clinicians	10
Findings from Sector Consultations	14
Practice Guidelines for trauma-informed family sensitive practice in adult health services	19
CONCLUSION AND RECOMMENDATIONS	23
APPENDIX	25
Appendix 1 – Child Aware Approaches Project: Report against Key Performance Indicators	25
Appendix 2 – Trauma Team Development and Clinical Work with Families	28
Appendix 3 – Consultations: Participating Organisations	30
Appendix 4 – Guidelines for Trauma-informed Family Sensitive Practice in Adult Health Services	31
REFERENCES	39

EXECUTIVE SUMMARY

This report outlines the findings from a project conducted by The Bouverie Centre, La Trobe University, titled, *Child Aware Approaches Project: Trauma-informed family sensitive practice for adult oriented health services*. This project was funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) from a grant allocated under the Federal Government's Child Aware Approaches Program 2012.

The project was established to investigate and understand effective delivery of trauma-informed family sensitive practice in adult oriented health services. A key output from this investigation was a set of Practice Guidelines for use by workers across a range of adult oriented health services. This project involved a series of interviews with clinicians who work with families affected by trauma along with a series of group-based consultations with workers employed across a range of health and welfare sectors. The Practice Guidelines were developed through knowledge and information gained from the interviews and consultations, as well as from the current literature.

KEY FINDINGS

CLINICIANS' PERSPECTIVES ON TRAUMA-INFORMED FAMILY WORK

The Bouverie Centre has a specialised Trauma Team, members of which are family therapist clinicians who are specialists in working with families affected by trauma. Each member of this team was interviewed three times over the course of this project about their experiences in working with families affected by trauma and to gain their recommendations for Practice Guidelines to inform other services about this area of work. All clinicians involved in the trauma team have extensive experience in working with families who have experienced multiple and complex presenting issues related to mental illness, sexual abuse, family violence and alcohol and other drug (AOD) use. Clinicians noted that many families they work with have also experienced intergenerational poverty, lack of education and employment or other issues, which exacerbates stress and the effects of trauma.

In interviews, clinicians stressed the value of working with families as a whole, even if only one family member has been directly involved in a traumatic experience. Largely this is because all family members are likely to be affected by one person's trauma, and trauma often has a negative impact on family relationships. Even where trauma has occurred within the family, as might be the case with family violence or sexual abuse, working with families places a focus on the impact of that trauma on family relationships. Most importantly, family is often the core site of recovery and healing from trauma. Family is the main context where individuals lead their lives and strong relational bonds are known to help people recover from trauma.

The clinicians interviewed advocated the importance of involving family members even in service settings where the primary client is an adult who had been affected by trauma. Apart from the potential for this to help the adult client, a family focus across the adult oriented service sector will provide greater scope for vulnerable family members, especially children and adolescents, to be identified and supported.

CONSULTATION WITH THE HEALTH AND WELFARE SECTORS

Workers representing a total of 33 organisations from the mental health, sexual assault, child protection, family violence, AOD, Gambler's Help and acquired brain injury (ABI) sectors participated in a series of Knowledge Sharing Forums. The forums looked at barriers and opportunities for trauma-informed family sensitive practice in adult oriented health services.

Participants reported a need for increased training and resourcing in the area of trauma-informed practice, and reported constraints to family inclusion generated by individualised funding sources in the treatment of adult clients, particularly for clients with dependent children or adolescents. Participants demonstrated an enthusiasm for increased resourcing and training in the use of a trauma-informed and family sensitive 'lens' when working with individual clients. However, they reported that there were challenges as many individuals, organisations and sectors were unfamiliar with or not confident in using these lenses.

DEVELOPMENT OF PRACTICE GUIDELINES

A set of Practice Guidelines for trauma-informed family work were produced based on recommendations from the clinicians involved in Bouverie Centre Clinical Trauma Team along with the sector consultations (knowledge sharing forums).

All project participants stressed the need to include as much practical information as possible to help workers operationalise the ideas about relational trauma within vulnerable families that are increasingly circulating in the healthcare environment.

Participants in management roles reported an anxiety from direct care workers in their organisations that they felt a pressure to include families in their work with adult clients, even if they did not feel they had the skills to do so. Anxieties about how to ask trauma-related questions and then regulate a client's possible emotional responses were also reported. A number of participants identified the guidelines as a potential training resource that would have an application in orientating new workers to an organisation or assisting with skills updates for workers.

Participants gave a number of suggestions related to successfully embedding guidelines into the day to day practice of staff. They suggested that:

- guidelines need to be endorsed and supported at management level.
- guidelines need to be supported by training and web-based resources.
- research 'snapshots' such as posters can support the guidelines and are helpful for busy workers as a quick reference guide.
- guidelines need to be rolled out through social workers or portfolio holders in an organisation. Frontline workers need support to take up new practice guidelines.

CONCLUSION

Trauma-informed perspectives are effective for providing a common understanding of presenting issues within and across a range of sectors in the health and welfare fields. Even where the common presenting issues may differ across sectors, a focus on trauma and trauma-informed care is relevant to most sectors and services across the fields of AOD, mental health, family violence, sexual assault and ABI. Alongside this, a focus on families also has relevance to all of these sectors and services, both because family provides an important site of recovery from trauma but also because a focus on family enables greater potential to identify vulnerable children where parents are accessing adult oriented services.

There is much that can be translated from a systemic family therapy and trauma-informed clinical service setting to settings where these are not routine perspectives or services. Additional research, workforce development strategies and resources should aim to help embed these perspectives into day to day practice.

INTRODUCTION

The objective of *The Child Aware Approaches Project* was to increase understanding of the ways in which both a trauma-informed and a family sensitive approach within the adult oriented health service sector can improve outcomes for vulnerable children and their families.

There are two core focuses of this approach: 1) the importance of a trauma-informed approach to practice and 2) the benefits of a family sensitive approach to practice in the adult oriented health service sector. Many adult clients entering the health services sectors, particularly the alcohol and other drug (AOD), mental health and family violence sectors, have a history of trauma, whether that be a past history of sexual or physical abuse or exposure to a traumatic event such as an accident. Often the issues with which people present to services are a symptom of a response to trauma as much as they are 'problems' in themselves (Elliott, Bjelajac et al. 2005). However, services are often not well equipped to work with clients in trauma recovery, particularly if their funding objectives and the skillset of their workforce are focused on a particular issue such as the management of substance misuse or mental illness. Similarly, services are often not well equipped to work with clients in the context of their family life.

Clients are generally part of a family: most have partners and/or children. Families, particularly children, can be highly vulnerable to experiencing trauma themselves when living with an adult affected by substance misuse or mental illness or who is violent or experiencing violence. Conversely, strong family relationships can be important sites of healing for people with a past history of trauma and people currently experiencing issues such as mental illness or drug or alcohol addiction (Figley 2010). On both these fronts, there is a strong rationale for services across the health service sector to work with clients in the context of their family lives. This may involve speaking to clients about their family relationships or their parenting, working with families as a whole or involving families in treatment, or at minimum, inquiring about care responsibilities and the wellbeing of children and offering appropriate referral. However, as with trauma-informed care, services are often not well equipped to engage in family focused work. There may be a number of reasons for this including limited worker skills or confidence in working with family groups or with children, limited time and resources for workers which make it impossible to address the needs of more than one client within each 'case', or cultural and funding barriers to family work within an organisation.

The foundation of this project was a recognition of the benefits for both vulnerable children and adult clients of adopting a broad, holistic approach to service delivery that focuses on an adult client's presenting issues as well as on their past histories and their current family context. The aims of this project were to better understand barriers and opportunities to the introduction of this broader focus across a range of services. We also sought to produce a set of Practice Guidelines designed to support services and workers to introduce a focus in their work that is both trauma-informed and family sensitive.

BACKGROUND TO THIS PROJECT

The Bouverie Centre, Victoria's Family Institute, is a unique publically funded organisation located within La Trobe University. Our work focuses on the important role of the family and the power of relationships to foster social, emotional and mental wellbeing for 'at risk' individuals and their families and for the community at large. In May 2012 a group of Bouverie Centre clinicians established a specialist Clinical Trauma Team with the following aim:

To provide a context for further developing knowledge in working with trauma and its relational impact on families as well as the family being the arena where healing can occur.

Team members were selected on basis of experience working with trauma including content area and service system knowledge and their expertise in achieving the project goals of the team including model development, publishing, transfer of knowledge, workforce development and research.

The Team's target population were families attending The Bouverie Centre where children or adults had experienced trauma. It was envisaged that over time the Team might develop partnerships with other services and potentially provide clinical services in other service sectors.

In June 2012, shortly after the development of the Clinical Trauma Team, The Bouverie Centre became aware of a research opportunity under the FaHCSIA led Child Aware Approaches Program. The Department had advertised one-off funding for projects of six-months duration that 1) built evidence or research about the connections between the mental health, sexual assault, family violence and AOD sectors and 2) encouraged greater collaboration across these sectors.

The Department outlined two objectives:

- To identify good practice and/or to research various approaches that have been taken in community services to meet the needs of children and young people experiencing, exposed to or at risk of exposure to domestic/family violence, mental illness and sexual abuse, recognising that substance abuse issues may intersect with these risks and to document what has proven effective (including formal evaluation).
- To improve or enhance the service response for children and young people experiencing, exposed to or at risk of exposure to domestic/family violence, mental illness and sexual abuse, recognising that substance abuse issues may intersect with these risks.

The Bouverie Centre saw an opportunity to link the work they were currently developing in the Clinical Trauma Team with the Child Aware Approaches Program. The synthesis of the two projects was particularly evident as many of the families who make up the target population of The Bouverie Centre present with complex multiple issues related to the four sectors identified in the Child Aware Approaches initiative – mental health, sexual assault, family violence and AOD (the Bouverie Centre also has a long history of working with families experiencing trauma related to Acquired Brain Injury). Children in these families may be at risk of abuse or neglect, further providing an intersection with the research aims of the FaHCSIA grant.

The Bouverie Centre submitted a proposal that suggested encouraging a family orientation within these sectors was a key way in which cross-sector collaboration could be built. For example, if workers in the drug and alcohol or adult mental health sectors speak to clients about children and families, it may create another pathway to support or intervention where there is a risk of violence, abuse or neglect.

We also suggested that a trauma focus was important in all these sectors as it creates a way of understanding how the 'presenting' issues in each sector are related. For example, many clients presenting at AOD services have a history of sexual assault, and it makes sense to understand how trauma can influence alcohol and other drug use. Additionally, we proposed that a focus on trauma could potentially provide a common lens to encourage discussion across sectors and in so doing enhance the often 'siloed' service responses to vulnerable families with complex presentations.

Our proposal also highlighted that frequently workers do not have knowledge of the trauma that underlies presenting client symptoms and the relational effects on the children of adults who have experienced such trauma. As a family therapy centre, The Bouverie Centre was well placed to explore the relational impacts of trauma on vulnerable infants, children and adolescents, and further proposed that a systemic family approach was a key intervention for working with vulnerable families. Our grant application centred on developing a set of 'Practice Guidelines' with the assistance of and direct input from:

- key organisations/workers from each of the sectors (via a series of forums)
- the Clinical Trauma Team's work with families over a period of 6 months.

The Practice Guidelines would integrate trauma theory and practice with a systemic family focus to assist workers in adult oriented services to identify the effects of trauma in their clients and identify and assist vulnerable children in their client's family.

POLICY CONTEXT

This project fits with a wider policy context that sees adult oriented health services as key places for the identification, support and/or referral into appropriate services of vulnerable children. The following national and state policy documents highlight the need for child aware and family sensitive practice across a range of healthcare environments. The Child Aware Approaches Program, which is part of the Government's Second Action Plan and falls under The National Framework for Protecting Australia's Children 2009-2020 also highlights the need for collaboration between service sectors and the resourcing of adult oriented services to meet the needs of young children in families accessing services.

Closing the Gap: National Framework for Protecting Australia's Children 2009-2020 is clear in its articulation of the need to foster strong connections within Indigenous communities and families in targeted areas where children may be at risk of neglect or abuse (Babington 2011). *The Child Aware Approaches Project* draws from consultation with Indigenous professionals with links to the mental health, family violence, sexual assault/child protection and the AOD sectors.

Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020 (Council of Australian Governments 2009) identifies a number of risk factors that are concurrent with the interests of this project. Domestic violence, parental alcohol and drug abuse and parental mental health problems are identified as key risk factors in the report. Importantly for the focus of this research, past experiences of trauma are identified as a risk factor for child abuse and neglect that needs to be addressed. As with other research, the report notes that many vulnerable families experience more than one risk factor, noting that adult treatment and support services 'need to be more child-focused, and responsive to the needs of families' (Council of Australian Governments 2009:21).

Investing in the Early Years – A National Early Childhood Development Strategy (2009) fits well with the aims of this project. One of the goals of the National Early Childhood Development Strategy is to 'strengthen the capacity of adult focused services such as general practice to respond to the needs of young children in families accessing these services' (2009:27). Using a family sensitive approach in adult oriented health services will help assess, identify and facilitate appropriate onward referrals for children and adolescents at risk.

In addition to the above named national policy directions, there are a number of key Victorian policy documents and reports relevant to the *The Child Aware Approaches Project*.

- *The Child Aware Approaches Project* closely aligns with the recommendations of the Protecting Victoria's Vulnerable Children Inquiry 2012. The enquiry finds any system for identifying Victoria's vulnerable children must have as a core principle early intervention strategies that focus on the family as a whole, in so doing, facilitating the identification of 'at risk' parents and children as early as possible (Cummins, Scott et al. 2012). Holistic assessments of family needs are pivotal in this regard, a key part of which is the awareness of children in adult oriented specialist health services. The focus on families with multiple trauma presentations across a range of healthcare environments is central to the *The Child Aware Approaches Project* and is closely aligned with the Inquiry's call for services to be coordinated at the local level to support an integrated, multidisciplinary response to individual families (Cummins, Scott et al. 2012). Following from this, another key area identified in the Vulnerable Children Inquiry is the often siloed nature of the health service systems in Victoria, which can contribute to failures to adequately address families with complex service use needs across sectors.
- Connecting services: Learning from child death inquiries when the co-existing parental characteristics of family violence, substance misuse and mental health place children at risk (Office of Child Safety Commissioner 2012). This report draws on enquires of 41 child deaths in Victoria in the period 2004-11 in which the three parental risk factors of family violence, substance misuse and mental health issues were present. Of the 41 child deaths analysed, it was found that in 25 of the cases parents had used specialist adult health services, but there was 'little evidence of an integrated multi-service response', which highlights an 'absence of a collaborative and synchronous interaction between child protection, family violence, alcohol and other drug and mental health services' (2012:33). As such, the report concludes that 'specialist adult services all have a role to play in the protection, safety and wellbeing of children. Family violence services, alcohol and other drug services and mental health services can help reduce the risk of child abuse and neglect through improved and effective collaboration across all levels of service delivery' (2012:42).
- Connections: Family Violence and AOD (Victorian Alcohol and Drug Association 2011) recommends the collaboration of services across sectors for better outcomes for families. This paper recommends greater recognition of the relationship between AOD misuse and family violence in policy and practice documents and the inclusion of cross-sector capacity building. Along with this, the recommendation to increase state-wide partnership between AOD services, mental health and family violence services – including women's and children's services and men's behaviour change programs – is closely aligned with *The Child Aware Approaches Project*.
- Families where a parent has a mental illness (FaPMI) Service Development Strategy (Victorian Government Department of Health 2007) is aimed to reduce the impact of parental mental illness on all family members, particularly dependent children, through timely, coordinated, preventative and supportive action by adult oriented mental health services and collaborative partnerships across AOD and family services in order to deliver greater opportunities and more positive outcomes for family members.
- Building partnerships between mental health, family violence and sexual assault services (Victorian Government Department of Human Services 2006) further supports the need for sector collaboration to facilitate improved relationships between the family violence, sexual assault and mental health sectors to increase health outcomes for Victorian women and children. A key recommendation that speaks to the task of this project is the need for 'specialist projects designed to meet the needs of clients that services

have in common' (2006:20).

SOME QUESTIONS

WHY A FOCUS ON TRAUMA?

Three out of four people in Australia have experienced a traumatic event at some point in their lives (Mills, Ewer et al. 2011; National Drug and Alcohol Research Centre 2011). This might be from the direct primary experience of an incident or event that compromises the safety of a person, such as a traffic accident, assault or robbery, or it might be from a secondary witnessing of a traumatic event happening to someone else (Mills, Ewer et al. 2011). For some people, trauma is not a one-off incident, but something that occurs over many months or years, as may be the case with prolonged sexual or physical abuse or living in other unsafe conditions, such as countries affected by war or famine (Figley 2010).

Trauma has a profound effect on people's wellbeing. Even many years after trauma has occurred, people may still physically and emotionally be experiencing its impact. Anxiety, depression, suicidal thoughts, an inability to concentrate or regulate emotions, physical ailments or disabilities are not uncommon for people following trauma (Herman 2001).

Increasingly, the health service sector has come to recognise the extent to which trauma may be linked to other behaviours or conditions such as violence, alcohol or substance misuse or mental illness (Elliott, Bjelajac et al. 2005). However, often these services are not well equipped to deal directly with trauma. For instance, a drug and alcohol service may not be in a position to provide the long term, specialist trauma counselling that may be required to assist a client to appropriately address some of the issues that may have led them to addiction, and which may surface when drug and alcohol use is reduced or stopped. Unfortunately, this puts some services in a bind as clients are likely to be confronted with traumatic memories in the course of a drug or alcohol treatment program that may cause relapse (Mills, Ewer et al. 2011; UnitingCare ReGen 2012). Similarly, mental health clients may benefit from attention on their past traumas along with their current presentation. However, mental health workers may not feel skilled or confident to even raise these issues with clients (Maybery 2012). Additionally, services may not be adequately linked with other sectors or services that may be equipped to work with clients around issues of trauma. This means there often aren't processes in place that enable workers across different sectors to co-manage client cases or to routinely work together in the care of a shared client. Commonly, workers also don't have access to the funding or time resources required to engage in issues that technically fall outside the primary brief of their service.

The effect of trauma is likely to be a factor that is common to clients and their families across the health services sector. A clinical approach that incorporates evidence-based approaches to understanding and treating trauma will be relevant to a range of sectors, including the mental health, sexual assault, family violence and AOD sectors.

WHY FAMILY SENSITIVE PRACTICE?

A family and child sensitive approach to working with clients in adult oriented services enables the service to be a pathway for children to receive appropriate support and protection. Children who live in families where there are high levels of parental mental illness, sexual assault, family violence or AOD misuse can be at continued risk of experiencing abuse or neglect and entering the child protection system (Scott 2009). Increasingly, attention has been paid to preventing child abuse and neglect through child-focused interventions such as universal maternal and child health services (Scott 2009). However, there has been less attention to the need for a child focus within adult oriented health services (Scott 2009; Jeffreys, Rogers et al. 2011). This is a major gap in the service sector as it means adult oriented services do not open a door for children to receive appropriate early intervention. A lack of focus on families also means the complex interconnection between issues confronting clients, such as past trauma or the relationship between parental mental illness, sexual assault, family violence and AOD misuse and/or children's risk behaviours, is not properly understood or addressed.

The potentially destructive impact on children and adolescents of parental mental health problems, sexual assault, family violence and AOD misuse is increasingly well understood (Battams, Roche et al. 2010; Battams, Roche et al. 2010; Jeffreys, Rogers et al. 2011; Cummins, Scott et al. 2012). Additionally, the benefits of systemic interventions involving, where appropriate, the whole family are also increasingly well documented (Carr 2000; Sheinberg and True 2008; Carr 2009; Pernice-Duca and Bernardon 2010). In response to this, some current initiatives have sought to increase family centred practice in particular service settings. For example, the Australian Government initiative Children of Parent with a Mental Illness (COPMI) has demonstrated the success of a program that strengthens the capacity of adult services, in this case adult mental health, to respond to children (Scott 2009). More recently,

the National Centre for Education and Training on Addiction has released a document encouraging family focused practice in the AOD sector (Battams, Roche et al. 2010).

However, there is a need to expand such initiatives more widely and to build an evidence base around the nature of effective family focused interventions, practitioners' skills and confidence delivering family and child sensitive practice, and the extent to which the organisational setting and the wider policy context support child and family sensitive practice (Scott 2009).

DOES A FAMILY SENSITIVE APPROACH IMPROVE OUTCOMES?

The impact of trauma is not felt only by those who experience it directly but also by those in their close circles, most acutely by their immediate family. Trauma potentially has a destructive impact on family relationships. However, strong family bonds are known to play an important role in trauma recovery (Figley 2010; Coulter 2011). This is particularly the case for children, as family contextual factors – including positive family support and stable family functioning – can be protective factors in children's capacity to recover from trauma (Pernice-Duca and Bernardon 2010). For these reasons, a family approach to trauma recovery is advocated by many in the trauma field (Walsh 2006; Coulter 2011).

There is only limited evidence regarding the efficacy of family therapy or family-systems approaches to trauma recovery for adults or families as a whole, in part due to the complexity of measuring change in family relationships and in managing large studies that involve family groups (Lebow and Rekart 2004; Coulter 2011). However a small body of research has shown that family systems therapy and/or couple therapy may be useful in assisting war veterans to recover from trauma or avoid more complicated post-traumatic stress disorder (Rosenheck and Thompson 1986; Ford, Chandler et al. 1988; Johnson, Feldman et al. 1995).

Alongside this, there is evidence from various fields that family based interventions are likely to be effective in improving outcomes for children at risk of experiencing trauma within the family, including abuse or neglect. For example, there is evidence from several studies that interventions which focus on the family system – including patterns of interaction and beliefs within the family – can reduce recurrence of abuse and neglect within families identified as at risk (Carr 2000). Interventions may include family counselling sessions, couple counselling sessions for parents (Brunk, Henggeler et al. 1987) and problem-solving therapy for the family following an assessment of family functioning (Nicol, Smith et al. 1988). There is also strong evidence for the benefits of a family focused approach to the treatment of mental illness, both for parents and children. Family sensitive practices can promote positive family functioning, reduce the incidence of children developing a mental illness and improve care of children within the family (McFarlane, Dixon et al. 2003; Milkowitz, George et al. 2003; Mihalopoulos, Magnus et al. 2004; Beardslee, Wright et al. 2008; Siegenthaler, Munder et al. 2012).

THE PROJECT

PROJECT OBJECTIVES AND STRATEGIES

The Child Aware Approaches Project was established to investigate and understand effective delivery of trauma-informed family sensitive practice in adult oriented health services. This project was approved by the La Trobe University Faculty of Health Sciences Human Research Ethics Committee.

A key output from this investigation was a set of Practice Guidelines for use by workers across a range of adult oriented health services. This was achieved in the following ways:

CLINICAL INTERVIEWS WITH THE BOUVERIE CENTRE TRAUMA TEAM CLINICIANS (FAMILY THERAPISTS)

The Bouverie Centre Trauma Team is a team of family therapist clinicians who specialise in working with families affected by trauma. Each clinician in the Trauma Team was interviewed three times each during the six-months of this project. The project researcher also attended team meetings. Interviews were transcribed verbatim and then analysed for common themes. The main objective of the interviews was to investigate, understand and record how trauma manifested within the families seen by the Team during the life of the project; the relationship between issues of family violence, substance misuse, mental illness, ABI and sexual abuse within the families; and effective strategies that have been employed by the clinicians to work with families who had experienced trauma.

Clinician interviews also focused on how to translate the knowledge and skills of workers in a family therapy setting into settings that don't routinely include children or other family members in their work with adult clients.

The extensive data gathered during the interviews is to be published in future papers and presented at conferences to increase the evidence for family inclusion as an effective intervention for families who have experienced trauma.

On average, seven families were seen by each of the seven clinicians in the six-month project period. For further details of the family numbers, their trauma presentations, and the interventions used with them, see Appendix 1.

SECTOR CONSULTATIONS

A series of consultations were held with workers in five sectors (AOD, adult mental health, family violence, sexual assault and ABI) and with Indigenous workers from The Bouverie Centre Indigenous Team. The consultations had two main objectives: 1) to learn from workers about barriers and opportunities for family and child focused work in their sector, and 2) to learn from workers about the barriers and opportunities to trauma-informed practices within their sectors.

The consultations involved researchers asking about participants' understandings, practice experiences, wisdoms and partnership links related to trauma-informed client work. Researchers were also keen to understand whether family sensitive practice within the trauma-informed framework could be beneficial, whether this occurred in the participant's organisation and/or their sector and if not, how this approach to client work could be applied into their practice area.

A significant part of the consultation process was to understand how best to implement ideas of trauma-informed and family sensitive practice in settings that may have limited resources or practice knowledge about these ways of engaging clients and their families. An additional challenge was to understand the opportunities and barriers for integrating these two paradigms which are often understood separately.

The sector consultations were also a chance for participants to give feedback on a draft of the Practice Guidelines.

The numbers of participating organisations was 33. For further details of participating organisation in relation to each sector, see Appendix 3

DEVELOPMENT OF PRACTICE GUIDELINES

Practice Guidelines for family and child sensitive practice in adult orientated health services were developed based on the findings of both the clinical interviews and the sector consultations as described above.

The Practice Guidelines were designed to sit among a series of family inclusive guidelines that are currently being developed at The Bouverie Centre. Other guidelines in the series are 1) Guidelines for healthcare providers working with same-sex parented families and 2) Guidelines for including families and carers: A model for mental health and alcohol and other drug services.

In excess of 5,000 copies of the Guidelines will be printed and distributed Australia wide.

A copy of the Guidelines of Trauma-informed Family Sensitive Practice in Adult Health Services can be found in Appendix 4.

WHAT WE LEARNED

This section of the report outlines what we learned during each of the three project phases outlined above. In line with the FaHCSIA reporting requirements of the project, the major outcomes have been reported against a series of Key Performance Indicators (KPIs). These additional findings are reported in a table that can be found in Appendix 1.

FINDINGS FROM INTERVIEWS WITH CLINICIANS

It's always puzzled me how you can work with an individual with trauma and not include significant others when often trauma's biggest impact is on relationships (Trauma Team clinician).

Clinicians interviewed for this project are strong advocates for family-based therapy to be included as part of trauma support and recovery. When one person in a family or other relationship is experiencing trauma, those around him or her will be affected too. Because a key part of relational responses to trauma can be isolation, divisiveness and reactivity, the reverberations in a family can be left unattended to when interventions focus solely on the individual client. Working with families as a whole ensures the impact of trauma on all family members is addressed and also that the restoration of positive family relationships is recognised as an important part of trauma recovery.

Furthermore, working with families facilitates the development of a safer and more stable environment for all family members. This is particularly important for children as the adverse developmental effects on infants, children and adolescents of living in a traumatised and traumatising relational environment can be life-long.

Clinicians reported that involving family members in the work with a primary adult client has a number of benefits:

- Family is the main context where individuals lead their lives. Where one family member is affected by trauma, all other family members can become affected by that trauma.
- Family can also become part of the solution or healing from trauma. Family members often understand better than anyone else the context of a client's traumatic response and involving a whole family in change supports the change of each family member.
- Trauma may result from experiences in relationships but the potential for recovery can also occur within relationships.
- Vulnerable family members, especially children and adolescents, can be identified and supported.

TRANSLATING PRACTICE KNOWLEDGE TO OTHER SETTINGS

A major aim of this project was to identify ways in which knowledge about trauma-informed family work developed in the family-therapy setting of The Bouverie Centre could be translated into other settings. Clinicians from the Trauma Team provided the following recommendations regarding how their expertise could apply to other settings.

The use of a systemic family model was reported to have benefits for working with adults and children who had experienced trauma, which, in its simplest form, may be nothing more than enquiring about the childcare responsibilities of adult clients. Clinicians also reported the deeply beneficial role that family inclusion can play in the recovery from trauma.

Ultimately I believe that their family are the people that are going to be around. I'm one hour out of their [day] however often they come to see me, so the family being around them is going to be the most important. They're going to be the most important for that person who's traumatised, or they're going to have the best understanding of their own child and what they're going to need — what ideas are going to be useful, what ideas aren't going to be useful, and they can provide that nurturing (Trauma Team clinician).

Along with the healing potential of family relationships, clinicians also reported the healing capacity of the therapeutic relationship, which aims in all instances to avoid any replication of the dynamics of trauma. A key principle of trauma-informed care is to be alert to and curious about the effects of violence and trauma (including neglect) so as to avoid inadvertently triggering trauma symptoms while engaging with individuals or families (Harris and Fallot 2001). Many of the skills used to nurture the therapeutic relationship (creating safety, openness, curiosity, collaboration) were described by clinicians as 'just good practice' and therefore easily translated into the everyday work practice of most people working in the health services sector.

Whatever you do, it's got to be fighting against the dynamic of the abuse (Trauma Team clinician).

Clinicians also reported the effectiveness of giving parents information and strategies that allow them to make sense of the complex relational responses that go hand in hand with traumatic experiences, both for them and for their children. The provision of information to families through the use of trauma psychoeducation (what one clinician termed 'collaborative psychoeducation') was shown to be an effective normalisation strategy that decreased feelings of self-blame and shame about the way a family responds to trauma.

I think once parents get a bit of an idea they know what to do. They really want to try and do something with it... I think you can see the relief in parents too, that they've got this framework to help them understand what's going on. I think you've got so many different ways that you can work with trauma that kind of frees parents up a bit (Trauma Team clinician).

While this report does not provide the space for an extensive discussion of the Trauma Team findings, the following principles bring together practice elements from the work of the Trauma Team clinicians. Key interventions to enhance engagement with traumatised families that can be translated to other settings include:

Creating safety

- Aim to create an environment that is safe and empowering. Being respectful, open and transparent with clients is important.
- Aim to create a family sensitive environment: make the waiting room child and family friendly. Make appointments available at times that suit parents.
- Aim to create an environment that is inclusive of a diverse range of families. Posters that show Aboriginal families, refugee families, or same-sex parented families demonstrate a desire for culture inclusivity and will help families feel that this is a place they could belong.

Using existing 'good practice' knowledge and skills

- Many of the skills needed to be trauma-informed are the skills that practitioners use every day: acknowledging and validating people's experiences, building safety and monitoring peoples' distress levels.

Building the therapeutic relationship

- Creating a healing therapeutic relationship is one of the most critical elements of a trauma-informed family sensitive model. Relational trauma will only be healed in a context of relationships that are the opposite of traumatising (Elliott, Bjelajac et al. 2005).
- Minimise re-traumatisation – survivors of trauma are vulnerable to having past negative experiences triggered in health service settings. Invasive or insensitive procedures may trigger trauma-related symptoms. Workers' actions can inadvertently parallel interpersonal power dynamics that 'trigger' traumatic experiences.

Using a relational model

- Where appropriate include family members: families are often the best support and resource for each other and understand better than anyone the family context of their traumatic experiences. Remember that individuals exist in families and ask about family members and relationships in the family.
- Hold the family in mind: being family sensitive means you can work with the family even if they are not physically present in the room.
- Family involvement in the work with the primary client may be beneficial. This should always be in consultation with the client.

Collaborative client-led processes

- Maximise collaboration and client choice.
- Because loss of personal control is a key feature of experiencing trauma, control over what is discussed, key decisions and the timing and implementation of interventions should belong to the client/family as much as possible. In complex cases with multiple trauma presentations, collaboration may also be between sectors and agencies.

Strengths-based approach

- Employ a strengths-based model that emphasises a client's and family's capabilities and highlights adaptation instead of symptoms, and resilience instead of pathology. In a trauma-informed model of care, instead of asking, 'How do I understand this problem or this symptom?', workers might ask, 'How do I understand this person or family and their unique strengths and resources to address difficult circumstances?' Asking an individual or family and being curious about 'what has happened' rather than focusing on 'what is wrong?' reflects this change in perspective. Work with a family's strengths as well as their challenges and help families recognise the effects of trauma on themselves and each other (Harris and Fallot 2001).
- Families are understood as being motivated by survival rather than malevolence. When family members behave in destructive ways (including family violence, substance misuse, abuse and neglect), an appreciation of the family situation can help workers address this destructiveness more effectively.

Psychoeducation

- When clear and easily understood information about how the body and brain react to trauma is provided, individuals, families and communities have a framework to understand their responses and reactions.
- Information is in itself therapeutic. Information about how other families have dealt with similar situations can be normalising and provide relief from feelings of guilt, confusion, powerlessness and hopelessness. Provide clear and detailed information to families regarding the nature of the service, service options and limitations, consent needed and any likely consequences to giving consent.

Distress reduction and affect regulation

- It is not always necessary to talk about the details of traumatic experiences. It can be dangerous to delve too deeply into the details of events if workers don't have the skills to manage client reactions. Workers should endeavour to talk about the effects of traumatic experiences without asking about the details.
- Simple techniques can be used in the room with the client to reduce their distress levels.
 - simple breathing technique: breathing in slowly to the count of five, breathing out slowly to the count of 10.
 - simple grounding technique: the client noticing their feet on the ground, noticing the chair they are sitting in, noticing the colour of the room, client noticing the 'here and now'.
- Teaching clients and all family members how to manage or reduce their symptoms is empowering. These techniques can then be used outside of the clinical setting, in the family home for example.

Sub-systems work and co-therapy

- Working with sub-groups within a family can help create safety, especially if there has been sexual abuse or family violence.
- If the resources are available, working with more than one therapist/worker can help contain a family where there might be many members and multiple issues. Having two workers in a room increases the amount of resource to support parents and children.
- Co-therapy also supports workers.

Including young people

- Asking appropriate questions of parents and other family members in front of children provides them with both acknowledgement of family struggles and reassurance.
- Providing paper and pencils or other simple activities for children helps them feel included.
- Children can be engaged in simple breathing and relaxation techniques and can see these as a game to calm down.

Supervision and self-care

- Trauma experiences can be triggered by hearing other's traumatic stories. Staff working with traumatised individuals and families should have frequent supervision from a person who understands the effects of vicarious trauma.
- Even if workers have not had experiences similar to those of a client, vicarious trauma responses can still be triggered from hearing the traumatic events of others.
- Supervisors need to create a safe space for supervisees to disclose their challenges of working with traumatised families.

PHASES OF CLIENT ENGAGEMENT

Clinicians described a trauma-informed approach to working with vulnerable families as being on a 'continuum of levels of influence'. On such a continuum, trauma-informed perspectives function as an overarching lens whose influence on engagement with an individual or family is dependent on the client's unique set of histories and circumstances. Clinicians identified three areas of focus on the trauma-informed continuum that can be translated into everyday practice. They suggest that by working in a graduated way, non-trauma specialist workers can engage clients in a trauma-informed family sensitive way.

1. What is the worker thinking about when they first see the individual or family? What are they noticing? How is the person or family right now? Are there any signs of trauma, e.g. the client seems highly reactive/emotionally 'dysregulated' or do they appear to be numbed? What the worker notices might not affect the conversation with the adult client or family but the worker assesses client presentations through a trauma lens. The worker is concerned with what needs to happen in the room so the client or family feels safe and in control.
2. The worker makes what they are noticing more overt. The worker is curious about what they are seeing, e.g. 'I am wondering if you are feeling comfortable/ok in this room and with this conversation? Worker asks client how they view their current difficulties e.g. 'I'm really curious to understand what's happening in your life and how you make sense of it in terms of the problems you are having now.' The worker is curious about other relationships, including care relationships and responsibilities for infants, children or adolescents.
3. The worker establishes a mandate in collaboration with the client and family to work on the effects of trauma. If the individual or family agrees, the worker can talk about their history. Why is it relevant? What impact has trauma had on the way the family functions? Unless the worker feels they have the skills to manage emotional responses, it is safer to talk about the effects of trauma rather than the traumatic events themselves.

THE IMPORTANCE OF BEING CURIOUS

Multiple presentations of trauma were a key feature of the families seen during the life of this project. Clinicians identified the importance of being curious about the presence of multiple co-morbid presentations in the lives of adult clients who are experiencing high levels of complex trauma.

I think that in probably most families we would see — where there has been sexual abuse or family violence, or both, because they do tend to go hand in hand that—those avoidance strategies we were talking about: using illicit drugs and alcohol, would be part of that avoidance strategy. And, if they're a family that hasn't received the help they need and you get that huge snowball effect and it gets really bad, then you're going to get several members, I would imagine, that might either demonstrate mental illness, particularly the victim, or be at high risk of sexual abuse or of family violence or of mental illness and/or substance abuse. So they all interlink and overlap (Trauma Team clinician).

The adults seen by the clinicians in this study often experienced problematic alcohol and drug use alongside other presenting issues, which research in this area has shown is common (Mills, Ewer et al. 2011; Schafer 2011; Victorian Department of Health 2011). The presence of intergenerational poverty, lack of education and employment or other issues demonstrates the interconnectedness of stressors in vulnerable families. Evidence from the literature confirms that 'when there is more than one parent-based risk factor present, the likelihood of risk and the consequences of harm for the child can increase exponentially' (Office of Child Safety Commissioner 2012:11) and that substance misuse, family violence, mental illness and sexual abuse are closely related in a high proportion of child protection cases (Scott 2009).

Clinicians spoke not only of the importance of being curious about the presence of multiple issues in the primary client's life, but also highlighted the need to assess for trauma responses across a family. Avoidant, addictive or other attempted soothing behaviours may be present in the family members around the person who has experienced trauma as they too seek strategies to cope with trauma effects. Clinicians reported the importance of maintaining a focus on other family members, looking for 'what might be in their history that could pre-dispose them, either to be more vulnerable or more resilient to dealing with the reverberations of a family members trauma'. This is particularly so for infants, children and adolescents. Clinicians spoke about the increased likelihood of children who are abused or neglected at home being vulnerable to abuse in other contexts. For instance, one clinician said, [There is] co-presentation around bullying, too; so kids who have perhaps been abused in their family then experience another form of abuse in the context of school.

FLOW ON EFFECTS

In addition to the above elements of a trauma-informed family sensitive perspective that were effective in working with vulnerable families, the increased discourse around trauma generated by the project had positive organisational implications for The Bouverie Centre. Trauma Team members reported an increase in 'trauma conversations' that happened in the workplace as a result of an increased trauma focus. These conversations had a positive flow-on effect through intake and assessment and in the way clinicians were able to frame the presenting issues of vulnerable families during referral contacts with other services. Trauma Team members also reported the benefits of the reflective space that the fortnightly team meetings provided. It is intended that the distribution of the Practice Guidelines from this project will facilitate similar conversations within numerous organisations.

Clinicians identified the following benefits of meeting regularly in a reflective space:

- Having a space to work with other clinicians provided a forum in which to learn from different theoretical and practice perspectives and to appreciate their own experiences and knowledge. Increased learning and practice ideas for engaging with traumatised families and young people were reported.
- Regular trauma-focused meetings moved workers from where they were comfortable with the theories and practices they used regularly, encouraging them to expand their approaches to trauma treatment.
- Regular meetings and attention being placed on trauma-informed perspectives increased the subtlety with which they looked for trauma. One clinician reported, 'I'm thinking more about complex trauma where it may not present as your typical PTSD (post traumatic stress disorder).'
- In the context of ABI work, putting a focus on emotional and psychological trauma and asking about history is often marginalised because acute trauma is the priority. Involving ABI in the trauma research provided a forum to explore this division.
- One clinician said that in the face of the individual client-focused funding constraints of many other organisations, working in a family therapy organisation and/or team such as the Trauma Team gives permission to incorporate the whole family in a focus on relational healing which is important when trauma has been experienced.

IMPLICATIONS FOR THE SERVICE SECTOR

The potential for vulnerable parents and their children to experience fractured care when engaged with multiple agencies is an additional risk factor.

One of the things that can happen is that people are sent off to an AOD counsellor, sexual assault counsellor, they see the psychiatrist – these people end up seeing this cast of many which is not terribly containing and actually can just replicate... (Trauma Team clinician).

The potential for parallel trauma processes to trigger traumatic responses in vulnerable families can lead to strained, chaotic or fractured relationships with health services. The 'fractured narratives' that clinicians reported as a major effect of trauma within the lives of individuals and families can be replicated by service engagements that are piecemeal or presentation-specific in relation to the broader realities of a family's life. One clinician said, 'When multiple presentations are being treated by many agencies and only part of a treating system know part of a client's story, important issues can fall through the gaps.' Close collaboration between organisations and sector partners has the potential to bring together the fractured narratives that trauma leaves in its path. As has been noted in the Building Partnership Report (2006:18), 'Effective shared care requires that services have a clear understanding of their respective roles and responsibilities, and clarity about who maintains overall case management responsibilities in each case. It also requires good communication mechanisms and processes for sharing client information.'

FINDINGS FROM SECTOR CONSULTATIONS

Five Knowledge Sharing Forums (consultations) were held in Melbourne with workers representing 33 organisations across the sexual assault/child protection, mental health, family violence, AOD and Gambler's Help, and ABI sectors. In total, 39 people attended the consultations and a further three representatives from The Bouverie Centre Indigenous Team were interviewed and asked to review the Guidelines. Consumer consultation occurred with the assistance of the Victorian Mental Illness Awareness Council (VMIAC), the peak Victorian non-government organisation for people with a mental illness or emotional distress. Consumer consultation occurred this way because the short timeframe for the project did not allow widespread consumer consultation with potentially vulnerable clients. For a more thorough explanation of the consultation process see Appendix 3.

Forum participants were asked to reflect on the barriers and opportunities to trauma-informed family sensitive practices in their sector. The core themes that emerged from these discussions are described below. With each of the identified barriers we have also suggested practice recommendations based on the discussions about 'opportunities' that occurred in the consultations. These recommendations are suggested to guide individuals and services in what can be done to help create the conditions where trauma-informed family sensitive practices can be adopted.

LANGUAGE AND DEFINITIONS

Defining the parameters of trauma in the context of trauma-informed practices is a major part of increasing the confidence with which workers can assess clients for trauma responses. Also, clear definitions of different types of trauma allows for a common language across sectors and within care teams. Definitions of what is meant by 'family' may also need to be clarified. Divergent language and ideologies create the potential for fragmentation between services.

...trauma is a lens that can create a common language for many of our families across the different ways of looking at a problem (Forum participant).

...if there was across the board a common language and a common understanding about trauma, then you can have conversations with these [different] sectors (Forum participant).

What can be done?

- Disseminate trauma information within the workplace or undertake professional development activities to increase trauma-informed and family sensitive practice knowledge.
- Consider trauma-informed training across the workplace so a common understanding and language is established.

TRAUMA IS HIDDEN

A key finding across consultations is the hidden nature of trauma for both individuals and families. Forum participants explained that often when clients present to services many months or years after traumatic events have occurred they may have developed strong protective strategies in response to trauma. This means that a client experiencing trauma or post-traumatic stress may not necessarily be easy to identify, particularly by workers who are not trained in trauma work. Workers may have no idea about a client's past history and the client may not present any obvious reasons for a worker to ask.

When individuals and families enter the mental health system, what the adult mental health workers are seeing are those strategies, rather than the trauma anymore, so that trauma is hidden again (Forum participant).

In addition to the trauma being hidden by developmental protective strategies, participants also spoke of clients being actively discouraged from speaking about trauma when services did not feel equipped to help those who were ready to speak about their traumatic backgrounds. One participant said,

I've certainly heard instances where people have said, 'This has happened to me and I need to talk about it', and being told, 'Actually, no this is specialist work. You're not ready for this and this is specialist work and we'll refer you out.' And that person learns, you can't talk about it. No one wants to talk to me about it (Forum participant).

A reluctance to speak about trauma in the clinical setting was particularly evident when participants spoke about the move from individual to family work. The need to protect children from hearing traumatic stories and speaking about traumatising events was often used as a reason not to speak about trauma in a family setting. This was articulated as a significant barrier for staff and clients, both of whom, it was suggested, are often uneasy and unclear about what can be spoken about in the presence of children.

What can be done?

- Research shows that if people feel safe and they can control what is discussed and the pace of disclosure, they generally want to talk about their traumatic experiences.
- Often it is okay to talk about the effects of trauma without discussing the details of what happened.
- Most children are aware of the struggles in their family even if they are not openly spoken about at home. It can be a great relief to children to hear that things they have witnessed, know about and are worried about, can be discussed by their parent and someone who can help. However, these conversations need to be appropriate to the child's age and it is important that parents 'give permission' to raise these topics with children.

UNCERTAINTY IDENTIFYING TRAUMA

Closely related to both the hidden nature of trauma and the lack of clarity around what constitutes trauma is the uncertainty many workers experience in recognising trauma responses in children and adults. Consultation participants reported that staff across many sector are not trained to clearly understand trauma or how trauma responses might manifest. For example, uncertainty in recognising trauma responses in children at different developmental stages is a clear barrier to assessment and referral. Transgenerational trauma is another circumstance in which trauma is hidden as many workers may not know to ask about experiences of trauma in their client's family of origin. Trauma responses in Aboriginal and Torres Strait Islander communities in particular need to be understood in the context of marginalisation, racism and our history of colonisation.

And there's also a lack of knowledge I think. People have talked to me about well I don't know what's appropriate for certain ages, so it's really difficult to assess, because I haven't got a full gamut of what a child should be doing and what's normal, what's not normal? (Forum participant).

What can be done?

- There are a number of good resources that help workers identify responses to trauma in different groups. Seek additional training or do some reading in the area of trauma responses within your sector.
- When working with populations or scenarios with which you are unfamiliar seek secondary or cultural consultations. This can move both clients and workers towards favourable outcomes.

FRAGMENTED SERVICE SYSTEMS

Consultation participants spoke about the ways in which they felt the service sector often reflected client's experiences of trauma. Trauma can lead people to experience their life and their relationships as disorganised, conflicted and ruptured. Often they encounter a similar experience in the service sector, particularly given that the often co-morbid or multiple presentations of trauma survivors means individuals and families will be involved with a number of services at the same time. When this is not well coordinated or coherent it can become confusing and chaotic for clients. Not all workers will have a full idea of a client's or their family's story or history or people may be required to repeat their stories multiple times to different workers. As such, client's narratives can become fragmented and clients can feel lost or unheard within the service sector.

I've just been thinking about how many parallels there are between what the broader system does to families and what families do (Forum participant).

I think also, trauma does disrupt narrative. So often the family members don't have a narrative of their trauma, and often different professionals who are working in silos, don't have a narrative of the family's trauma, as a whole (Forum participant).

...when we work in silos and we're not working as care teams, we can replicate those traumatic narratives, and we don't help bring things together for the family member (Forum participant).

What can be done?

- Where possible establish cross-agency and cross-sector working groups or care teams which have the potential to support increased cross-sector collaboration.
- Remember cross-sector responses need to be well coordinated so that the trauma a family is experiencing is not increased by conflicting or disorganised service responses.
- Effective care teams have the potential to increase the positive outcomes for clients and for workers.

FUNDING

Across all consultations the lack of funding for trauma-informed and family sensitive work was highlighted. Participants saw the following as major barriers to reliable ongoing trauma work within families:

- funding being attached to a specific presentation such as mental illness or drug use which does not easily provide resources for trauma care.
- funding being attached to working with vulnerable adults and therefore not providing a space to consider their children as clients.
- funding being inadequate to support a whole family.
- inconsistent funding pockets that supports short term programs and prioritises crisis intervention and immediate care rather than the longer term work that may be needed for trauma recovery for individuals and families.

I think that one of the constraints philosophically and therapeutically is focussing on the client, and funding kind of reinforces that idea, and I wonder if it's to the detriment of family members, including children, so they're kind of secondary victims if you like, and absolutely deserving of attention (Forum participant).

What can be done?

- Consultation participants reported that trauma-informed interventions within families can have financial advantages as they are often briefer and have longer lasting effects than individual work.
- Locating appropriate research and evidence regarding the benefits of both trauma-informed care and family sensitive practice might help to incorporate this focus into future funding agreements.
- Where it is not possible to provide trauma care or family work, it might be appropriate to refer clients to services which can do this work with them.
- Family sensitive practice may not always involve working directly with clients' families. It may be highly beneficial to a client to talk to them about their family relationships or their parenting.

WHO IS THE CLIENT?

As noted above, in many instances funding arrangements perpetuate the need to focus on the individual client in a way that limits the inclusion of family members or other key relationships in a client's life. There were examples from workers in the child protection sector of workers outside their sector feeling they must advocate for the parent at the expense of the child, or workers from the AOD sector felt there were not the funds to work with children or other family members. Both these examples illustrate sources of frustration to workers who can see the benefits of using a systemic family model.

I had some interesting conversations with workers around who is the client, and some of them will still feel that child protection is the enemy and that they should be advocating for their client, the parent, over the child (Forum participant).

I guess what I find with a lot of workers that come to trainings is that they work with the parent, usually the mother, and yeah often don't consider that the children are actually clients (Forum participant).

What can be done?

- The family sensitive practices advocated in this project acknowledge the primary client as the central focus of the work. At the same time we encourage workers to ask about and use family or other significant relationships to advance the work of the primary client and to assess for vulnerable people around the client.
- Be curious about the client's significant relationships. Using a relational lens means enquiring about and holding in mind the significant relationships of a client and the relationship dynamics that might help or hinder their recovery.

NOT WANTING TO OVER-BURDEN ALREADY BUSY STAFF

Senior staff spoke of their reluctance to introduce new 'paradigm shifts' to staff who often feel over-burdened by high workloads, increasing community demands, expectations and limited resources. Managers spoke of a perceived increased workload that might accompany the dual paradigm shifts towards both trauma-informed and family-sensitive perspectives. As one participant said,

It feels overwhelming, to be honest because thinking about just getting people comfortable with doing the family stuff and then popping the trauma lens on top of that, actually feels overwhelming to get people comfortable with that (Forum participant).

What can be done?

- Encourage workforce development rather than 'one off' training days. Development of trauma-informed and family sensitive awareness across an organisation, supported by senior management is more effective than having a few workers attending specific training.
- After implementing trauma-informed models in the workplaces, some consultation participants reported very positive outcomes for clients and workers.

TRAUMA AND FAMILY WORK AS OPTIONAL ADD-ONS

The issue of service sector specific work being designated as 'core business' sees a trauma perspective regarded as an 'add-on' or optional extra. Some health sector participants highlighted family work being seen

as an optional extra rather than core business – being done informally by staff who felt confident to implement family work in their organisational setting. The lack of sector and management level endorsement of trauma-informed or family sensitive work left programs vulnerable when motivated or skilled staff moved from an organisation taking their skills with them. As one participant said of family work within the mental health sector, 'It's not core. It's an optional extra and it can be chopped at any time and it doesn't have the resources put into it.' Similar experiences occurred across sectors in relation to family work.

Management support for trauma-informed family work was seen as a vital factor in its successful implementation. It is important to have senior management convinced of the worth of work so that they can argue for its implantation as 'core business' at more senior levels. A key tenet of trauma-informed organisational change is that change occurs at all levels of an organisation.

What can be done?

- Trauma-informed and family sensitive organisational change supported by senior management.
- Ongoing training and support in trauma-informed and family sensitive practices and care across all sectors

PERCEPTIONS OF TRAUMA AND FAMILY WORK AS 'SPECIALIST ONLY' WORK

A lack of clarity in the distinction between trauma-informed and trauma specialist practices can act as a barrier to the uptake of trauma-informed perspectives. As the clinician interviews identified, many of the skills used in trauma-informed work are the 'good practice' skills that most service providers already use in their work with clients. Increased knowledge and in-house support to use trauma-informed responses, along with increased knowledge about trauma specialist referral pathways, have the potential to increase worker confidence to respond to trauma.

I think the delineation is actually really important, because it is so confusing for people and there's so much around, so to say what trauma-informed care is and what it's not is crucial (Forum participant).

I think one of the traps of it, too, is that trauma work is a bit mystified. That's a perception, I think, of clinicians... there's sort of a fear that we can't do any of the work and that we need to always be referring to someone else (Forum participant).

What can be done?

- Just being curious and listening can help individuals, families and communities to heal – see table on Page 5 in the Guidelines (Appendix 4).
- Provide resources to help familiarise staff with trauma-specialist referral pathways.

FEARS OF WORKING WITH TRAUMATISED FAMILIES

A number of common fears hold workers back from engaging with trauma-informed practices. A key fear identified in the forums was anxiety about causing distress to individuals or families by inquiring about trauma. Feeling under-skilled and lacking confidence in helping clients regulate emotions is a common fear. This fear often manifests as increased uncertainty about asking questions, which has implications for assessment and referral.

Another perceived fear was working with children. Participants told us that workers in adult oriented services are often unsure of what to do with children in a family session and what to say to parents when children are present. It was also suggested that the increased momentum around family inclusive practices could leave workers feeling a pressure to include family members in their work with a primary client even though they may not feel they have the skills.

There is this sense that if you ask about it, it will make it worse (Forum participant).

My understanding is that they're scared that they're going to re-traumatise the person and that they're going to open up this flood of something that they will just drown in (Forum participant).

What can be done?

- You can ask about the effects of trauma without discussing the details of what happened and remind people they are in charge of how much they say.
- Seek professional development in basic techniques that can be used help regulate the emotions of adult clients, e.g. breathing and simple 'grounding' techniques.
- Seek professional development in basic techniques that can be used to help regulate the emotions of

children e.g. calming activities like blowing bubbles, drawing, slow tapping of bongo drums.

- Provide regular supervision so staff have a safe place to consider their responses to working with traumatised families.
- Provide opportunities for staff to reflect together and share experiences and practice knowledge about working with children.

KEEPING UP WITH CURRENT AND CHANGING INFORMATION

Participants spoke about the 'growing momentum' around trauma-informed perspectives across the sectors in which they work, a momentum which was regarded positively but which potentially left some workers overwhelmed by large amounts of new and complex information. This was particularly so in the area of neurobiological information about the effects of trauma. One of the barriers identified by participants was anxiety about how to operationalise this information to make it useable in their everyday work practice.

Maybe the whole neurological big revolution is happening and people are saying... what do we do with it on the ground? (Forum participant).

What can be done?

- Provide regular opportunities for staff to attend workforce development and education sessions on relevant topics.
- Collect written resources about trauma that are clear and easy to understand.

CARE OF WORKERS

Many consultation participants spoke about the importance of ensuring workers are cared for within their organisations. Working with traumatised clients can be upsetting and exhausting for workers, particularly if the worker themselves has a history of trauma. It is important that organisations have systems in place and a workplace culture that supports workers to receive appropriate debriefing, supervision and care.

And I think there is so often a parallel process about how we expect to look after the clients and how we need to be looked after within the organisation – that it should be safe, that it should be non-blaming (Forum participant).

What can be done?

- Provision of reflective supervision that is 'safe' so that workers can discuss the effects on them of the work with clients who have experienced trauma.
- Development of an understanding of the effects of vicarious trauma.
- Acknowledgement by senior management and supervisors that a percentage of their staff will have experienced trauma in their own lives and that while their own experience can really add to their effectiveness with clients, they may also be vulnerable to this past trauma being 'triggered' at times.
- Development of trauma-informed practices at all levels of an organisation can benefit clients and workers alike.

PRACTICE GUIDELINES FOR TRAUMA-INFORMED FAMILY SENSITIVE PRACTICE IN ADULT HEALTH SERVICES

The findings from both the Trauma Team clinician interviews and the sector consultations informed the development of a set of practice guidelines for trauma-informed care and family sensitive practice in the adult oriented health and welfare service sectors. The intention of these guidelines is to encourage trauma-informed family sensitive practice in a range of sectors by providing some easily-digestible, brief information for workers about what it means to work in these ways. The Guidelines are pitched toward workers who may not know much about what trauma-informed care involves or who may not understand clearly how they can incorporate family sensitive practice into their work, but who are interested in some ideas about how to adopt this practice.

Draft versions of these Guidelines have been reviewed by all members of The Bouverie Centre's Clinical Trauma Team, all consultation participants, members of The Bouverie Centre's Indigenous Team, a representative for the Victorian Mental Illness Awareness Council (VMIAC), the peak Victorian non-government organisation for people with a mental illness or emotional distress and all project workers and researchers involved in the project.

Feedback from these consultations and reviews suggested the need to include as much practical information as possible to help workers operationalise the ideas about trauma (particularly complex relational trauma) that are increasingly circulating in the health services environment.

People want to know, 'What's expected of me, what do I have to do?' I think people on the whole like practical information (Forum participant).

While we have identified in this report that there is an increasing interest in trauma and family inclusive perspectives, participants overwhelmingly felt that this type of practiced-based resource would be a useful tool for workers less knowledgeable about or confident in shifting towards these paradigms than those who participated in these consultations. A number of staff identified the Guideline's potential as a training resource that would have an application in orientating new workers to an organisation or doing skills updates with workers. Some more specific suggestions for this resource included:

Core elements

- Where possible include practice tips.
- Endeavour to make guidelines simple and usable.
- Distinguish between trauma-informed and trauma specialist ways of working.
- Use statistics to argue for a specific trauma and family focus.
- Include key principles of trauma-informed care to facilitate organisational change.
- Highlight signs of trauma for assessment – use a model like: 'Understand it. Look for it. Respond to it.
- Use clear definitions to facilitate the acquisition of a common trauma language.
- Explain vicarious trauma, and the need for supervision and self-care when working with traumatised clients.
- Use case examples that incorporate multiple sectors..

Tone

- Directly address the reader so the guidelines are interactive, really emphasising the difference that each worker can make.
- Emphasise the relational therapeutic opportunities of this model. i.e. you might be one of the most valuable things that has happened in a person's life because the relationship you provide as a trauma-informed worker might be starkly different to the relationships they have already had.
- Find ways to acknowledge and empower the reader because workers often feel disempowered, feeling that when it comes to trauma presentations they have to refer their clients on.
- A lot of workers will think trauma work is difficult work, so emphasise that this resource is going to be really helpful to enhance their work and make a difference to vulnerable children and their families.
- People who are traumatised respond to affirmation and feeling respected and workers are no different.

It has been said that there can be a 'professional ambivalence towards guidelines, stemming mainly from uncertainty about their effectiveness and how best to introduce them into clinical practice' (Grimshaw and Russell 1993:243). We are mindful that this resource, to have a major impact on service delivery, will need to sit as part of a range of initiative including training and organisational change programs. However, the following suggestions regarding the implementation and dissemination of the Guidelines were made:

- guidelines need to be endorsed and supported at management level.
- guidelines need to be supported by training and web-based resources.
- research 'snapshots' such as posters can support the guidelines and are helpful for busy workers as a quick reference guide.
- guidelines need to be rolled out through social workers or portfolio holders in an organisation. Frontline workers need support to take up new practice guidelines.

STRATEGIES FOR DISSEMINATION OF PRACTICE GUIDELINES

The Practice Guidelines will be distributed Australia wide. The Bouverie Centre is in the process of producing a series of Practice Guidelines, of which the Guidelines for Trauma-informed Family Sensitive Practice in Adult Health Services will be part. Other guidelines in the series are: 1) Guidelines for Mainstream Service providers Working with Same-sex Parented Families and 2) Including Families and Carers: A Model for Mental Health and Alcohol and Other Drug Services. These Guidelines will be promoted as a series as well as independently to enable a wide reach across a range of sectors. The close connections The Bouverie Centre has with peak bodies and organisations (from frontline workers to senior executive staff) representing the sectors targeted in this project, including Aboriginal and Torres Strait Islander organisations, provide many opportunities to promote The Bouverie Centre's guidelines series through email networks, attendance at events and conference and direct mailout of the Guidelines. An electronic version of the Guidelines will be available on The Bouverie Centre website.

Key distribution strategies for Guidelines for Trauma-informed Family Sensitive Practice in Adult Health Services include:

- A launch of the Guidelines to be held as soon as possible after the completion of the project.
- Present a half day workshop on trauma-informed family sensitive practice, following the launch, to interested workers from the targeted sectors.
- Mail out to all the relevant Bouverie Centre contacts in adult and family health services Australia wide. The Bouverie Centre has approximately 2500 organisations on its database for which the guidelines would be relevant.
- Mail out to all individuals and organisations involved with the consultations for this project.
- Present key findings at the Child Aware Approaches Conference in April 2013. The Bouverie Centre's staff will deliver two presentations and a poster related to this project.
- Publish papers and conference proceedings written from the data collected in this project.
- Development of Professional Development training in Trauma-informed Family Sensitive Practice in Adult Health Services.
- Consult with Managers of The Bouverie Centre's Beacon Projects about dissemination of the Guidelines via existing workforce development projects and to consider new workforce development opportunities.
- Make Guidelines available to all students attending Academic programs at The Bouverie Centre and highlight the Guidelines in relevant courses/lectures.

CONCLUSION AND RECOMMENDATIONS

Analysis of clinical interview and consultation data shows that adult oriented health services can potentially play an important role in the safety and wellbeing of infants, children and adolescents if workers in these services are attentive to the family context in which their adult clients live. Adult mental health services, family violence services, sexual assault and child protection services, AOD services and other adult health services such as ABI and Gambler's Help services can help reduce the incidence of childhood abuse and neglect and can become a pathway for 'at risk' children to receive appropriate referral and support.

The findings from this project indicated that there are likely to be numerous barriers to the adoption of both trauma-informed and family sensitive practice within adult oriented health services. In particular, it was noted that funding restraints often mean that services do not have the resources to work with clients' families or to engage in longer-term trauma care with clients. This often means that workers are reluctant to speak to clients about their family lives or about their trauma history for fear of moving into territories that they do not have the skills or resources to manage.

Workers and clinicians consulted as part of this project saw the need for a two-pronged response to these barriers. Firstly, it was felt that workers would benefit from information and resources (such as the Guidelines produced as part of this project) that provided workers with information about how they could incorporate a trauma-informed and family sensitive 'lens' into their existing practice, without major time or resource implications. For example, being open to asking clients about what has happened to them in their lives, while realising this may not have to involve intensive trauma counselling, being able to make appropriate referrals where necessary and learning some basic skills (such as breathing techniques) to help clients manage emotional responses to some discussions can all be part of trauma-informed care with individual adult clients. Similarly, being curious about adult client's family lives and inquiring about whether they feel they need parenting support or assistance with family relationships could be incorporated into a session with an adult client. Beyond this, it was felt that there needed to be a more fundamental shift in the thinking and culture of the adult oriented health service sector for trauma-informed and family sensitive practice to be adopted as a routine. These changes would also need to be reflected in funding agreements. For example, the incorporation of trauma recovery programs into AOD or mental health services would require a shift in the orientation of those services, so that trauma recovery was seen as part of the core business of treating alcohol or drug problem or of managing mental illness. This change would need to be taken up at all levels of the service – from management through to frontline workers – and allowed for in funding arrangements. It also might require significant staff training and development. There is also a need to build the evidence base around the benefits of both trauma-informed and family sensitive practice to create a more solid foundation from which to advocate for changes to practice across these service sectors.

Trauma-informed perspectives are effective for providing a common understanding of presenting issues within and across sectors. While sectors may have a different focus in the core presenting issues with which they work, all sectors are likely to have a high number of clients who have experienced trauma and many clients may be presenting at a range of services because of their response to trauma. As such, trauma-informed care is relevant across the human service sector and a service development or training initiative in this area would have relevance to a wide range of services. Similarly, family sensitive practice is relevant across the adult health service sector, particularly to the extent that a focus on adult clients' families and children may reveal situations where children may be at risk or in need of support – or where potentially risky situations could be improved by providing clients with opportunities to access parenting support. Further, positive family relationships are likely to support clients accessing services in all sectors. So again, a focus on family sensitive practice is relevant to a wide range of services.

There is much that can be translated from a systemic family therapy and trauma-informed clinical service setting to settings where these are not routine perspectives or services provided. Additional research, workforce development strategies and resources should aim to help imbed these perspectives into day to day practice. This would increase the confidence with which workers can understand, assess and respond to their clients and client's families experiencing the complex and destructive effects of trauma.

RECOMMENDATIONS FOR FURTHER RESEARCH

On the basis of the findings from this project, we recommend the following strategies as a means to support trauma-informed family sensitive practice in adult oriented health service sectors:

1. Further research to be conducted into the benefits of trauma-informed approaches for better outcomes in adult clients and also in their vulnerable children within the adult oriented health services sector. There is a need to build a stronger evidence base regarding the ways in which trauma recovery can assist in the development and strengthening of resilience of individuals and families and the ways this can assist in the prevention of harm to children.
2. Conduct further research to build an evidence base regarding the efficacy and benefits of a systemic family sensitive approach for trauma recovery work with adult clients and their vulnerable children.
3. Conduct research into the barriers and workforce development opportunities to the integration of trauma-informed practices into current models of care within the adult health services sector.
4. Explore the development of a national service development strategy for a trauma-informed family sensitive approach for the adult oriented health services sector within each state and territory. This service development strategy is recommended to be modelled on the Victorian Families where a Parent has a Mental Illness (FaPMI) Service Development Strategy (Victorian Government Department of Health, 2007). The success of such a strategy in workforce development in the area of family sensitive practice and the identification and protection of vulnerable children across the health services sector, lies primarily with the recruitment of local coordinators assisting in cross-sector collaboration to better meet the needs of vulnerable families and their children. Training and development resources for workers and service managers are also produced as part of this model.

APPENDIX 1 – CHILD AWARE APPROACHES PROJECT: REPORT AGAINST KEY PERFORMANCE INDICATORS

ACTIVITY	DID WE MAKE A DIFFERENCE?	HOW WELL DID WE DO IT?	HOW MUCH DID WE DO?
<p>ACTIVITY 1: Undertake and evaluate trauma-informed family therapy</p>	<p>Multiple presentations of trauma were a key feature of the families seen by members of the trauma team during the life of this project. Clinicians reported that trauma-informed family work helps them better meet the needs of both adults and children within vulnerable families. While measuring family outcomes was beyond the scope of this project, clinicians reported positive outcomes among their clients including:</p> <ul style="list-style-type: none"> → greater capacity to acknowledge the impact of trauma on family relationships → greater recognition of the impact of past traumas among adults on the children → provision of safe space for both adults and children to speak about their family relationships and/or trauma. 	<p>The families seen by the clinicians in this study experienced multiple and complex presenting issues often exacerbated by the presence of intergenerational poverty, lack of education and employment or other issues. Clinicians reported that the integration of trauma-informed and Systemic family practices is an effective strategy for working with vulnerable families. Clinicians were also able to integrate evidence-based individual therapies for trauma-care into their family work. This included:</p> <ul style="list-style-type: none"> → Eye Movement Desensitisation Re processing (EMDR) and Radical Exposure Tapping → Collaborative trauma psycho-education → Mindfulness, grounding and affect regulation. <p>Clinicians reported the effective use of trauma-specific and non-trauma specific Systemic interventions that addressed the interconnections between mental illness, family violence, substance misuse, ABI and sexual abuse within families e.g. circular questioning, sub-systems work, working with a co-therapist. These interventions had a positive impact on children and young people demonstrated by a reduction in their 'problematic' behaviours and via verbal reporting of improvement of circumstances at home. Key interventions utilized by Trauma Team clinicians to enhance engagement with traumatised</p>	<p>There were seven family therapists involved in the trauma team each of which were each seeing seven families (on average) throughout the course of this project. This more than met the target of 12 to 20 families for the whole team in the six month project period July - December 2012.</p> <p>The number of family members who attended was:</p> <ul style="list-style-type: none"> → Mothers – 42 → Fathers – 19 → Same sex parent – 1 → Step parents – 3 → Grandparents – 5 → Out of home carers – 1 → Adult children – 30 → Adolescents – 34 → Children (under 12yrs) – 22 → Infants – 1 <p>Number of families affected by:</p> <ul style="list-style-type: none"> → Mental illness – 19 → AOD misuse – 10 → Domestic violence- 16 → Sexual abuse – 13 → Children directly and adversely affected by parental issues – 14 <p>All families had at least two and more often than not three or more issues related to trauma, e.g. sexual abuse, domestic violence and mental illness; Parental mental illness, AOD misuse and child abuse (in care); ABI, domestic violence</p>

<p>ACTIVITY 2: Conduct consultation about barriers and opportunities to trauma-informed family work in adult oriented services</p>		<p>families that can be translated to other (non-trauma specialist) settings include:</p> <ul style="list-style-type: none"> → Creating safety → Using existing 'good practice' knowledge and skills → Building the therapeutic relationship → Using a relational model → Collaborative client-led processes → Strengths-based approach → Psycho-education → Distress reduction and affect regulation → Including children and young people → Supervision and self-care 	<p>and AOD misuse. In some instances one person presented with multiple issues and in others family members each presented with a different issue related to traumatic experiences.</p> <p>Future directions for the Trauma Team will include further development of models of trauma-informed family work that can be translated into settings that don't routinely ask individuals about their family context or how presenting issues might be trauma related.</p>
<p>ACTIVITY 2: Conduct consultation about barriers and opportunities to trauma-informed family work in adult oriented services</p>	<p>Five consultations were conducted across five sectors</p> <ul style="list-style-type: none"> → Mental health → Alcohol and other drug and Gambler's help → Sexual assault → Family violence → Acquired brain injury <p>Consultation with staff from The Bouverie Centre Indigenous Team and with representative of consumers.</p> <p>The consultations were effective in identifying a range of barriers and opportunities for the incorporation of trauma-informed family sensitive practice across these sectors.</p> <p>Barriers identified during consultation:</p> <ul style="list-style-type: none"> → Trauma is hidden → Language and definitions → Uncertainty identifying trauma → Siloed work practices → Funding → Who is the client? → Staff burnout 	<p>The consultation was reconfigured to capture the knowledge of the participants rather than to engage them in training. As such we will not report on training outcomes.</p> <p>Forum participants however did report that the networking opportunities provided by the sector-specific meetings were useful. Participants spoke favourably of the opportunity to engage in a 'conversation' around trauma-informed family sensitive practices and regarded the forum as a useful contribution towards its growing momentum.</p> <p>Participants identified strategies for translating information into Practice Guidelines.</p> <p>Participants identified strategies for the distribution of Practice Guidelines in their sector.</p> <p>In addition to favourable outcomes reported by participants, the consultation process was a valuable way of The Bouverie Centre networking with key sector</p>	<p>Participant Numbers:</p> <ul style="list-style-type: none"> → 39 people participated in forums → 37 women, 2 men → 3 interviews with representatives from Indigenous team → 5 project manager interviews (The Bouverie Centre Staff) → Consumer consultation <p>Number of participating organisation from each sector:</p> <ul style="list-style-type: none"> → Mental health – 8 → Alcohol and other drug and Gambler's Help – 9 → Sexual assault – 7 → Family violence – 5 → Acquired brain injury – 3 <p>For the names of participating organisations go to Appendix 3.</p>

<p>ACTIVITY 3: Developing clinical guidelines on Trauma-informed family work</p>	<ul style="list-style-type: none"> → Trauma and family work as optional add-ons → Perceptions of trauma and family work as 'specialist only' work → Fear of working with traumatised families → Keeping up with current and changing information → Parallel processes 	<p>representatives to promote Systemic Family Therapy principles and Trauma Informed Practice across sectors.</p>	
	<p>Knowledge from the clinical practice of the Trauma Team and from sector consultation has been successfully translated into Practice Guidelines. Feedback for the draft guidelines during consultations was positive. Participants reported a need for a practice-based resource on trauma-informed family work.</p>	<p>Feedback from the consultations suggested the need to include as much practical information as possible to help workers operationalise the ideas about relational trauma that are increasingly circulating in the healthcare environment.</p> <p>A number of staff identified the guidelines potential as a training resource that would have an application in orientating new workers to an organisation or doing skills updates with workers.</p> <p>Participants feedback on the draft guidelines was grouped under the following headings:</p> <ul style="list-style-type: none"> → Core elements → Tone → Implementation 	<p>In excess of 5,000 copies of the guidelines have been printed for wide distribution.</p>

APPENDIX 2 – TRAUMA TEAM DEVELOPMENT AND CLINICAL WORK WITH FAMILIES

The Bouverie Centre Clinical Trauma Team was established in May 2012. The team comprises a clinician from each of our programs/teams - one each from Mental Health, Community Services, Academic, Clinical, Indigenous and Acquired Brain Injury Teams. Members were selected on basis of their experience working with trauma (including content area and service system knowledge) and their expertise in achieving the project goals (model development, publishing, transfer of knowledge, workforce development, and research).

The structure of the Trauma Team, i.e. representatives from each team or program, was intended to provide a forum where specialist knowledge may be exchanged or shared between the Trauma Team and all other programs/teams at The Bouverie Centre. It was envisaged that this two-way sharing process would promote the integration of Systemic trauma work at the Centre.

In addition the Trauma Team structure is designed to facilitate the development of knowledge, learning and clinical practice which would be transferable to our partners and relevant organisations in mental health, alcohol and other drugs and, child protection, for example, via our Clinical Consulting, Academic and Workforce Development Programs.

The Team's target population was families attending The Bouverie Centre where children or adults had experienced trauma. It was originally envisaged that over time the team may develop partnerships with other services and provide clinical service to them within such partnerships.

The clinical focus of the team was to provide family therapy to families where there was a significant behavioural, emotional or psychiatric difficulty which was not improving.

Our Intake team members spoke to a family member over the telephone to establish whether their situation met our criteria which includes:

- Major/serious mental health issues (i.e. diagnosis, treating psychiatrist, medication) including families where a parent has a mental illness
- Complexity of presentation, multiple issues and previous contact with services for example; child sexual assault/abuse, child abuse and neglect with involvement of child protection services

For the purposes of the Child Aware Approaches Project, the Intake team was asked to allocate to a Trauma Team member, families affected by one or more of the following: (serious) mental health issues; sexual abuse; child abuse/neglect; alcohol and other drug abuse issues; or domestic violence

Members of our Indigenous Team are developing processes to encourage the referral of Aboriginal families.

The initial goals for the Team were:

1. To provide Systemic family based clinical approaches to families where trauma has had an impact on family relationships. This may include;
 - sexual abuse (with capacity to work with sibling offenders)
 - physical, emotional, psychological abuse and neglect (referred by DHS/child protection)
 - domestic violence
 - ABI
 - traumatic experiences in the context of serious mental illness, and within disenfranchised Indigenous communities.
2. To develop practice knowledge which consolidates and further develops family focussed trauma interventions /therapy. This would include family and individually focussed sessions and consideration of transgenerational trauma.
3. To explore the integration of individual trauma specific approaches into family therapy/family focused trauma work. In essence this was to 'make relational' specific individual trauma interventions such – as EMDR, Radical Exposure Therapy (i.e. tapping) and to explore the role of Borderline Personality Disorder workshops, body focussed activities (e.g. Taekwondo and drumming), creative therapeutic activities (e.g. sand play, reading/writing stories, art) in systemic approaches to trauma.
4. To identify research questions and via an action research method begin a research project.
5. To identify and develop opportunities for external consultation and the transfer of practice knowledge and learning to other services working with these clients/families.

6. To add value to the mental health and welfare service system as well as 'trauma inform' the work of all of The Bouverie Centre's programs and teams.

During the six-month project period the team met every 2 - 4 weeks to:

- Develop a team plan that aligned the original project goals and the Child Aware Approaches project goals.
- Develop basic protocols for team operation e.g. allocation of families, clinical operation, meeting processes, how to record learning.
- Provide mutual clinical support and guidance and consider ways to learn from each other including team members and others presenting interventions used e.g. 'Lets Talk' and resilience presented by member of Research Team.
- Review the trauma literature in relation to family based interventions and those which can be integrated into family work.
- Reflect on and document learning.
- Contribute to the Child Aware Approaches Project by participating in individual clinician interviews with the Researcher, working on the Child Aware Approaches Project Guidelines document. A member of the Trauma Team also participated in each of the Knowledge Sharing Forums.

APPENDIX 3 – CONSULTATIONS: PARTICIPATING ORGANISATIONS

The consultation process for this project involved a series of Knowledge Sharing Forums with the sexual assault/child protection, mental health, family violence, AOD and Gambler's Help, and ABI sectors. The forums were held at The Bouverie Centre and ran for three hours. Lunch was provided.

A purposive sampling approach was used to select a diverse range of participants from each sector. A semi-structured interview instrument developed in consultation with the research and project co-ordination teams was used to guide forum discussions. A list of key questions and a copy of the draft guidelines were sent to all participants a week before the forums.

The forums involved researchers asking about participant's understandings, practice experiences, wisdoms and partnership links related to trauma-informed client work. Researchers were also keen to understand whether family sensitive practice within the trauma-informed framework could be beneficial, whether this occurred in a participant's organisation and/or their sector and if not, how this approach to client work could be applied into their practice area.

The initial project brief described the Knowledge Sharing Forum as a chance for a two-way exchange of information, where The Bouverie Centre staff would take the lead by providing a training component. The training component was originally conceptualised to provide information to participants who may not be familiar with the principles of trauma-informed care or the practice of using a trauma lens in their current work. In addition to this, the training was marked as an opportunity to give information about the latest family sensitive work being undertaken at The Bouverie Centre.

After consultation with The Bouverie Centre Project Manager related to each sector and the compilation of an invitation list for forum participants, it was decided that those attending the forum would be skilled in the field of trauma theory and the use of trauma-informed care and therefore may not benefit from training in this area. The primary aim of the forums was to learn as much as we could from experts in the field. The training component of the forum was therefore reduced so we could use the time to capture the expert knowledge of forum participants. The Bouverie Centre Trauma Team members briefly shared their experiences of being part of the project.

The forum was also a chance for researchers to get feedback on a set of draft Practice Guidelines about the use of trauma-informed family sensitive practices in a wide range of services. The evaluation of consultation engagement with the draft Practice Guidelines is reported in Practice Guidelines for Trauma-informed Family Sensitive Practice in Adult Health Services on Page 19.

PARTICIPATING ORGANISATIONS

Sexual Assault/child protection Sector

Victorian Aboriginal Child Care Agency
MacKillop Family Services
West CASA
Children's Protection Society
Australian Childhood Foundation
Take Two at Berry Street
Gatehouse – The Royal Children's Hospital

Mental Health Sector

Northern Region Mental Health Service
North West Area Mental Health Service
The Alfred Hospital
Inner West Rehabilitation Services
North Western Mental Health
Forensicare Victoria
Private Practice
Bendigo Health
Victorian Mental Illness Awareness Council

Family Violence Sector

Royal Children's Hospital
Western Region Health Centre
Relationships Australia Victoria
Domestic Violence Recourse Centre Victoria
Peninsula Health

Alcohol and Other Drug and Gambler's Help Sectors

Salvation Army
Berry Street
EACH Social and Community health - Eastern Drug and Alcohol Service
Peninsula Health
Reconnexion Youth Projects YNOT team
UnitingCare ReGen formerly Moreland Hall
Family Eclipse Program at Odyssey House
Relationships Australia Bendigo
Gamblers Help Southern

Acquired Brain Injury Sector

The Royal Children's Hospital
Arbias Ltd
ISIS Primary Care

APPENDIX 4

GUIDELINES FOR TRAUMA-INFORMED FAMILY SENSITIVE PRACTICE IN ADULT HEALTH SERVICES



A large number of people entering the human services sector have experienced trauma that is often not recognised by service providers. These guidelines aim to assist workers to consider the impacts of trauma on individuals, families and communities. By adopting a trauma-informed and family sensitive approach, adult health services can play a key part in identifying and meeting the needs of children and families who are vulnerable. Trauma is prevalent enough in our society that you can assume many people who use your service have experienced significant trauma.

DID YOU KNOW?

- 69% of adults will experience a serious traumatic event at some stage in their lifetime.^[1]
- 1 in 3 women and 1 in 6 men are abused before the age of 18.^[2]
- 1 in 5 women and 1 in 20 men have experienced sexual violence since the age of 15 years.^[3]
- Around 80% of people in alcohol and other drug treatment report a history of trauma, including a life threatening event or accident, sexual or physical assault.^[4]
- 34% of Australian women have experienced violence from a current partner.^[5]
- Between 10 and 13 per cent of Australian children are affected by parental substance misuse.^[6]
- Indigenous people are hospitalised for mental and behavioural disorders at almost twice the rate of non-Indigenous people and die from intentional self-harm at 2.5 times the rate of non-Indigenous people.^[7]
- The Indigenous imprisonment rate rose by 52% between 2000 and 2010.^[8]

Being curious and asking an individual or family 'what has happened to you?' rather than 'what is wrong with you?' is a key to changing everyone's perspective so that it is trauma-informed. ^[9]

WHAT IS TRAUMA?

Trauma can be caused by natural events like floods or bushfires or by human actions, as in child abuse and neglect; sexual assault; and violence, including domestic assault. Trauma involves single or multiple experiences that have the effect of overwhelming a person's ability to cope and can leave a person unable to make sense of the experience and their own or other people's responses to it.

Complex trauma that is ongoing has a profound impact on relationships and on the way individuals, families and communities function. Living with ongoing trauma affects the neurological, psychological, social and emotional development of children and when unresolved can have lifelong consequences.

Whole communities or populations can be affected by trauma. There are increased difficulties for people to recover from trauma when the community on which they depend for nurturance and support is

disrupted, fractured or dislocated. Examples of this exist in Aboriginal communities affected by a history of child removal and the dislocation of communities from their traditional lands and culture. Refugee groups experiencing war trauma and communities experiencing bushfire are also examples. The effects of intergenerational poverty, family violence, mental illness, oppression from racism, the Holocaust and other genocides are examples of trauma that can occur across generations.

COMMON REACTIONS TO TRAUMA

Each person responds to trauma differently. Responses may be immediate or take months or even years to emerge. Responses to trauma may occur within a range of conditions such as mental illness, substance misuse, self-harm, sexual acting out or problem gambling. Specific responses can be understood as attempts to manage the painful and

intrusive effects of trauma. Listening to and normalising these responses as attempts to cope can be healing in itself.

There are three broad usual reactions to trauma that occur when events are so frightening or stressful that they cause a heightened alarm response: (1) fight, (2) flight or (3) freeze. Hormones like adrenalin and cortisol regulate these three basic protective responses of fighting back, taking flight or freezing in situations where people respond to threat. When trauma is ongoing or unresolved a

high state of alert and emotion, or its opposite, a sense of numbness and avoidance, is persistently just under the surface and can be triggered in seemingly 'normal' situations. Trauma responses can take priority over everything: for example, addictive or avoidance behaviours can take priority over the care of self and family.

For more information about the neurobiological effects of trauma on the brain, see the Further Reading section on Pg 8.

'A traumatic experience impacts the entire person; the way they think, the way they learn, the way they remember things, the way they feel about themselves, the way they feel about other people, and the way they make sense of the world are all profoundly altered by traumatic experiences.' [10]

WHY A TRAUMA-INFORMED FAMILY SENSITIVE PERSPECTIVE IS USEFUL FOR WORKERS

There is evidence that a family oriented approach to service delivery improves outcomes for children and parents.[11] Families and communities can be important places of healing

from trauma – places where damaging and damaged relationships may be changed and restored. Family sensitive practices within adult health services also help the service to be a pathway for vulnerable children to receive help and support. While most adult health services will be at different points in terms of how they include families in the assessment and ongoing treatment of adult clients, services can build on what they already know. Inclusion of families and attention to the needs of children can significantly improve outcomes for individual adults, families and children.

Devastating events don't always have a destructive ongoing impact on people's lives. In fact research shows that

most people recover from negative experiences.[12] This is particularly so if they are supported by close relationships and are able to openly discuss the experience and then come to understand its place in their life. As James and MacKinnon state, 'with good social support, human beings are resilient.' [13]

Including Families and Carers: A Model for Mental Health and Alcohol & Other Drugs Services is a related resource for understanding how services can become more family sensitive and more responsive and inclusive in their work with families.[14]

'Family sensitive policy and practice becomes a process whereby the unit of investigation becomes the family – a mother, a father, a child, an aunty – however family needs to be defined, and thus shift the focus of the investigation from individual case management to working out how the family can function better.' [6]

TRAUMA IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

‘The greatest gift you can give someone is to listen, deeply listen. It becomes a form of witnessing which in and of itself can be healing.’ (15)

Why is it any different?

Colonisation has had a profound impact on grandparents, parents, uncles, aunties, cousins, Elders and children. Loss of family, language, land, spirituality and culture have impacts on Indigenous people that non-Indigenous people may not realise. It is the responsibility of service providers to make sure we acknowledge this impact on Indigenous communities today, which is why we need to create an environment where Aboriginal and Torres Strait Islander people can make the most of services. When seeing Aboriginal or Torres Strait Islander people in an adult health service remember:

- to be curious, authentic and open, and listen deeply.
- to understand that everyone in the family and community has experienced trauma.
- to be culturally aware and provide culturally appropriate resources.

- that it is necessary for your environment to be culturally safe and informed, i.e. by ensuring there is something in your waiting room that a family can connect with like a flag or poster.
- to collaborate with individuals and families about all the decisions made about them.
- that ‘family’ has a broad definition for Indigenous people. When an individual is presenting to your service, an extended family and community is connected to them.
- to ask about their child care responsibilities.
- to be curious about similar issues/trauma in families across generations. Ask how families have managed trauma in the past.
- that a high percentage of Aboriginal and Torres Strait Islander people will present with multiple stressors in their life. For example, high levels of anxiety and stress can frequently co-exist with prolonged grief and depression.
- that trauma will continue down the generations until a healing action breaks the cycle. (16) You can be part of this healing.
- to look for stereotypes that might inadvertently influence your thinking.
- that the journey an Aboriginal or Torres Strait Islander person or family has taken to get to your organisation has probably been a long one, with other services involved. Consider what your organisation might do differently to make this appointment really worthwhile.

Guidelines for understanding and responding to trauma, grief and loss in Indigenous communities can be downloaded from <http://www.mhfa.com.au/cms/mental-health-first-aid-guidelines-project/#mhfaatsi> or contact your local Aboriginal or Torres Strait Islander organisation.

‘Traumatic experiences can be dehumanising, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma and disasters that include powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one’s spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. Healing is possible.’ (17)

10 common fears for workers	What we know
If I ask about trauma, I might make things worse.	Research shows that if people feel safe, can control what is discussed and the pace of disclosure, they generally want to talk about their traumatic experiences. Talking about trauma gives people a space for healing.
If I ask about trauma I will open the floodgates of emotion. I'm not a counsellor, that's not my role.	You can ask about the effects of trauma without discussing the details of what happened. Take care to remind people they are in charge of how much they say.
My organisation is not funded to do trauma or family work. There is no workplace support for me to do this kind of work.	Talk to your manager about supervision and organisational support, but keep in mind that trauma work might not be that different to what you already do. You may wish to seek additional training or do some reading in the area of trauma responses within your sector.
I am not a trauma expert. What can I do to help?	There is much that you can do. Just being curious and listening deeply can help individuals, families and communities to heal. You might be one of the first people in their life that they have told, who listens and who believes them. This is trauma work.
Involving children might compromise my relationship with the adult client – what if I have to report to Child Protection?	Child safety comes first. Openness and transparency with parents helps them know how information will be used and what your obligations to notify are if children are at risk or are experiencing harm. Except in extreme cases where children need to be removed, child protection services will generally work to support parents to ensure the safety of their children, e.g. refer to child and family support services. Respectfully putting issues 'on the table' is usually more preserving of relationships in the long run.
I don't have the skills to work with children. I don't know how to work with them in a clinical setting.	Most of the time children are aware of the struggles in their family, even if they are not talked about. It can put children at ease to have a space to talk about fears and worries and to know someone can help. As with adults, curiosity, gentle engagement and going at their pace are key ways of working.
What can I say to parents with the child in the room?	Check out sensitive topics with parents before raising them. Ask parents what's OK and not OK to talk about in front of children.
I don't know what is appropriate for each developmental stage with children. It makes identifying trauma difficult.	Having an idea of developmental milestones and signs of trauma will help. Department of Human Services – Child Development and Trauma Guide is a helpful resource.
Working with traumatised individuals or families seems like slow and difficult work.	A lot can happen in a short period. Listening and understanding, giving information and, where necessary, making referrals to a trauma specialist can all be helpful.
Sometimes if I ask about trauma it brings up emotions for me. I have some similar past experience to my clients, which is why I decided to work and make a difference in this sector.	This is a normal and expected reaction. Your own responses may get triggered, and vicarious trauma may also happen from hearing traumatic stories even if you have not had similar past experiences. It is important to have supervision when you are working with traumatised people. After a challenging session you could speak with a co-worker or go for a walk. Remember your work is very valuable and potentially life-changing for those you work with.

BEING MINDFUL OF THE IMPACTS OF TRAUMA

At each stage of an adult client's journey through an organisation there are opportunities to contribute to healing by asking about the effects of trauma in their life, by being inclusive of their family, and by being aware of the potential vulnerability of their children.

	Individual adult client	Family/community	Infant, child and adolescent
Signs of trauma – what to look out for	<ul style="list-style-type: none"> → Feeling on edge, agitated → Sweating, racing heart → Difficulty sleeping, nightmares → Loss of appetite → Extreme feelings of vulnerability → Easily startled → Emotional reaction seems disproportionate to current event. → Defensiveness, anger, aggression, hate for the world → Guilt or shame, numbness, sadness or depression → Disconnecting or tuning out → Intrusive thoughts, flashbacks → Withdrawing from others, avoidance of people or places → Chronic physical conditions – eating disorders, migraines, fatigue → Difficulties with memory, poor concentration, disorganised → Attempted self-soothing – addictive or self-harming behavior → Negative sense of self 	<ul style="list-style-type: none"> → Family fragmentation → Sudden changes in relationships → Tense and difficult relationships. → Breakdown in communication. → High conflict → Highly reactive to each other → Over protectiveness → Disorganisation – lack of routine → Confused/unclear roles and responsibilities → Social isolation → Blaming each other → Difficulty adapting to change → Unstable housing → Mistrust of services 	<ul style="list-style-type: none"> → Fear and insecurity → Sleep problems, including nightmares → Separation anxiety, clingy/demanding behavior → Stomach aches and eating problems → Frequent highly emotional reactions to small problems → Aggression and frequent uncooperativeness → Unexpected regressed behavior → Changes in relationship with parents → Not meeting developmental milestones → Having problems at school → Difficulties with concentration, learning and making friends → Ongoing problem behaviours that can't be effectively managed → Behaviour that is too good or overly compliant
Helpful tips for workers	<ul style="list-style-type: none"> → Aim to create an environment that is safe and empowering – be respectful, open and transparent with clients. → Aim to create an environment where parents feel comfortable to discuss their children's needs and any difficulties they may be having in their parenting role. → Use your existing knowledge, skills and strategies, such as acknowledging and validating people's experiences, building safety and monitoring people's distress levels. → Attend to cultural safety and demonstrate cultural awareness/sensitivity. → Collaborate with client about all the decisions made about them. → Hold the family in mind – consider family involvement when appropriate and in consultation with client. → Provide information about the possible effects of trauma on the individual, their family (including children), their relationships and their community. → It may be harmful to delve deeply into details of traumatic experiences unless you have the skills to manage client reactions. Consider whether secondary consultation and cultural consultation may be needed. → Aim to safely talk about the impacts of trauma without asking about the details of traumatic events. → If the client wants to talk about the details of trauma, this should be supported but check regularly to assess levels of distress and go at their pace. → Using a simple breathing technique may be helpful to manage distress – e.g. breathing in slowly to the count of 5, breathing out slowly to the count of 10. → Facilitate referral to specialist services if required. 		<p>Asking appropriate strategic questions of parents and other family members in front of children provides them with both acknowledgement of family struggles and reassurance. You could say to children:</p> <ul style="list-style-type: none"> → We know things are tough at home; I'm going to keep working with mum/dad/ other family members to help make things better. <p>With the children present you could ask mum/dad/other family members:</p> <ul style="list-style-type: none"> → Do you have any ideas about what might help? → What would help the kids? <p>You could engage children in a simple breathing technique by getting them to blow bubbles. Keep paper and pencils or other simple activities for children handy.</p> <p>If a child discloses abuse, appropriate authorities must be contacted and this is best done in consultation with parents.</p>
Useful questions	<p>About the Individual</p> <ul style="list-style-type: none"> → What has happened in your life that has contributed to your current difficulties? → What do I need to know (about that) for me to help you? → What's been the impact on you? → How do you cope and what have you found helpful? 	<p>About the Family</p> <ul style="list-style-type: none"> → Who else in your family knows about your current difficulties? <p>Whether family members know or not you could ask:</p> <ul style="list-style-type: none"> → What is the impact on them? → How do they react? → How does their reaction affect you? → How are family or community relationships affected? 	<p>About the Infant, Child or Adolescent</p> <ul style="list-style-type: none"> → What do you think your children know? → What are your children most worried about? How do you know? → What are your worries about your children? → What do you do that helps your children cope? → What or who else could help them?

CASE EXAMPLES

Intake, assessment and treatment are all opportunities to be more trauma-informed and family sensitive in adult services. The following scenarios illustrate practices to keep in mind.

Scenario 1

A worker is making a visit to a family where the father is suffering anxiety and depression following an acquired brain injury from a car accident. He has been drinking excessively to help him cope. The family has three children. The worker has been supporting the family for some time and she has started to have more in-depth conversations with the mother. The mother has told the worker that the older boy's grades at school have suffered, and he has become argumentative. The younger child has regressed, is clingy and has started to wet the bed. The mother is also concerned about some people the father has recently invited into the home.

The worker can make effective interventions by:

- as far as possible taking a respectful collaborative approach with the mother.
- remembering that changed behaviour in one family member affects all others.
- asking about children's age, wellbeing and developmental milestones. These are a doorway to identifying trauma reactions.
- asking about educational outcomes of children. These may be flags for trauma, particularly where there is significant change.
- providing information about the effects of trauma. Information in itself can be therapeutic.
- acknowledging that she may not have all the skills to deal with the complex trauma in this family and seeking out support and/or referral options.
- asking about care arrangements and supervision of children to ensure their safety.

Scenario 2

An Aboriginal man arrives at a residential withdrawal service for a seven day stay. The alcohol and drug worker knows some history about the client from the referral, which talks about symptoms of depression. The worker is cautious about asking questions regarding his background or family.

Helpful tips the worker could keep in mind:

- Trauma is likely to be an issue and the potential for re-traumatisation is a real concern. It is safe to assume Aboriginal people have experienced community and relational trauma, but knowing their individual story is important. The worker might say to this man, 'Where do you come from?' 'How did you get to be here in the place you are today?' 'I'm interested in hearing what your journey has been like.'
- Because people who have experienced trauma may not see the world as a safe place, safety and trust need to be built with each individual. We might assume our organisation is always safe, but this may not be the way your client experiences it. The worker could ask, 'What could I do to make your stay here as easy as possible?'
- It's important to ask about significant family relationships in this man's life, including any care responsibilities for children. 'Family' may have a broad definition reflecting his collectivist culture. Some questions to ask might be, 'Is there anyone that you would have liked to be here? If they were here, what might they do to help you recover?'
- Consider ways to be more culturally informed. Consider cultural consultation.

Scenario 3

A recently arrived refugee is seeing a counsellor for anxiety; she talks openly about her experience of family violence. She tells the counsellor that she is thinking of leaving her husband and taking her two children. She seems very overwhelmed, scared and in need of immediate help. She is sleep deprived, sweating and shaking a lot and is unsure where to go or how to keep her children safe. The counsellor knows that past sexual abuse is an issue but is unsure if talking about this trauma now will be useful.

Things the worker can do are:

- Firstly, assess for current danger to her and her children.
- Ask specifically about her children's safety and well being.
- Because the mother is in a state of crisis and is most likely managing all she can at the moment, asking about past trauma might be too much. A useful question to ask is, 'How can I help you now? What needs to happen so you can feel safer and more in control now?' The worker could also ask, 'What else do I need to know about you and your life so that I can be of use to you today?' This gives her control over what information about her past she chooses to disclose.
- The mother has taken a risk sharing this information. Although the worker has not directly asked about her trauma history, the client has told the worker about current traumatising experiences. The worker should ask how she is feeling after telling her this. Possible feelings are relief, guilt, embarrassment, shame or fear that she has created more risk for herself or her children. Does she feel she can manage her emotions when she leaves the service?

Relational trauma will only be healed in a context of relationships that are the opposite to traumatising. (18)

Sometimes the language we use and the assumptions we can make about traumatised clients act as a barrier to them feeling heard and acknowledged. Here are some commonly held attitudes that might cause unhelpful responses, as well as some responses that can help healing and recovery.

UNHELPFUL

What is wrong with this person?!



This person is acting out and is just 'attention seeking'.



Don't ask about it, they'll feel worse. Anyway, it happened so long ago. If they aren't over it now, they never will be.



It didn't happen to them. It happened to a family member.

or

The family and community are permanently damaged.



HELPFUL

What happened to this person?

This person could be showing symptoms of trauma.

People can recover from even long-ago trauma. Talking about trauma at the person's own pace is a way to heal.

The trauma of one family member can have deep and lasting effects on others in the family, but families can change and mend relationships. Relationships can harm and relationships can heal.

(This list has been adapted from Klinik Community Health Centre. www.trauma-informed.ca)

FURTHER READING

- Krieg, A. (2009). The experience of collective trauma in Australian Indigenous communities. *Australasian Psychiatry* 17(s1): S28-S32.
- Herman, J. L. (2001). *Trauma and recovery*. London, Pandora.
- Perry, B. D. (2006). *Applying principles of Neurodevelopment to clinical work with maltreated and traumatized children. Working with traumatized youth in child welfare*, New York, Guilford Press.
- Scott, D. (2009). *Think Child, Think Family: How Adult Specialist Services Can Support Children at Risk of Abuse and Neglect.* *Family Matters*(81): 37-42.
- van der Kolk, B. (2005). Developmental trauma disorder: A new, rational diagnosis for children with trauma histories. *Psychiatric Annals*, 35(5):401-408

OTHER RESOURCES

- Adults Surviving Child Abuse (ASCA) www.asca.org.au Practice guidelines for the treatment of complex trauma and trauma-informed care
- Australian Child & Adolescent Trauma, Loss & Grief Network www.earlytraumagrief.anu.edu.au/
- Australian Childhood Foundation www.childhood.org.au
- Australian Indigenous Health Info Net www.healthinfonet.ecu.edu.au/
- Calmer classrooms: A guide to working with traumatised children. Child Safety Commissioner www.kids.vic.gov.au/downloads/calmer_classrooms.pdf
- Department of Human Services' Child Development and Trauma Guide assists practitioners to understand and recognize indicators of trauma at different ages www.dhs.vic.gov.au
- Domestic Violence Resource centre Victoria www.dvrcv.org.au
- Mental Health Co-ordinating Council (NSW) www.mhcc.org.au Resources

- on trauma-informed care.
- Once Upon a Crime <http://youtu.be/0WouUsQGtI> Concise animated video about the effects of and recovery from single-incident trauma. Organisations can purchase the resource from Western Region Health Centre.
- Putting together the pieces: responding to trauma and substance use. www.regen.org.au/traumaresource Comprehensive guide to trauma for workers in alcohol and other drug area.
- The Bouverie Centre www.bouverie.org.au

REFERENCES

1. UnitingCare ReGen (2012). *Putting together the pieces: Responding to trauma and substance use*. Melbourne Australia.
2. Australian Bureau of Statistics (2005). *Crime & Safety Australia*, Catalogue No. 4509.0, Canberra: Commonwealth of Australia.
3. Fergusson, D & Mullen, P (1999). *Childhood Sexual Abuse: An Evidence Based Perspective*, Thousand Oaks: Sage Publications.
4. Dore et al (2012). Post-traumatic stress disorder, depression and suicidality in inpatients with substance use disorders, *Drug and Alc Rev*, v 31(3):294 - 302
5. Grealy, C et al. (2008). *Practice guidelines: women and children's family violence counselling and support program*. Victoria, Department of Human Services
6. Battams, S et al. (2010). *For Kids' Sake: A workforce development resource for family sensitive policy and practice in the alcohol and other drug sector*. Adelaide National Centre for Education and Training on Addiction.
7. Australian Indigenous HealthInfoNet (2012). *Health facts*. from <http://www.healthinfonet.ecu.edu.au/>
8. AIHW(2011). *The health and welfare of Australia's Aboriginal and Torres Strait islander people: An overview* Cat. no. IHW 42. Canberra Australia
9. Fallot, R. D. & Harris, M. (2001). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Washington DC: Community Connection. <http://www.annafoundation.org/CCTICSELFASSPP.pdf>
10. Bloom, S. L. (1999). *Trauma theory abbreviated*. <http://iheartenglish.pbworks.com/f/Trauma+Theory+Explained+14+pages.pdf>
11. Carr, A. (2000). *Evidence-based practice in family therapy and systemic consultation: Child-focused problems*. *J Fam Ther* 22(1): 29-60
12. Figley, C. R. (2010). *Trauma Resilience: Toward a New Paradigm of Stress Injury Prevention and Treatment*. New Orleans LA, Figley Institute.
13. James, K. & MacKinnon, L. (2012). *Integrating a trauma lens into a family therapy framework: Ten principles for family therapists*. *Aus and NZ J of Fam Ther, Special Issue on Family Therapy and Trauma*, 33(03)
14. The Bouverie Centre 2013 www.bouverie.org.au
15. Latham, R. (2012). *Personal Interview*. Indigenous researcher, The Bouverie Centre, La Trobe University. Melbourne Australia
16. Atkinson, J. (2002). *Trauma Trails: Recreating Song Lines: The Transgenerational Effects of Trauma in Indigenous Australia*. Melbourne Australia, Spinifex Press.
17. National Centre for Trauma-Informed Care (USA) <http://www.samhsa.gov/nctic/>
18. Elliott, D, et al. (2005). *Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women*. *J Com Psych*, 33(4): 461-477

ACKNOWLEDGEMENTS: These guidelines are funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs from a grant allocated under the Federal Government's Child Aware Approaches Program 2012. The guidelines have been developed at the Bouverie Centre, La Trobe University. For their generous support in the development of this resource we thank the many consultation participants from across the health and welfare sectors. We also thank the Bouverie Centre clinicians who gave generously of their wisdom and time and we acknowledge the many health and welfare sector consumers whose wisdom and dedication to recovery has taught us much about resilience and the effect of trauma in families.

REFERENCES

- Babington, B. (2011). National Framework for Protecting Australia's Children Perspectives on progress and challenges. *Family Matters* No. 89: 10-20
- Battams, S., A. Roche, et al. (2010). *For Kids' Sake: A workforce development resource for family sensitive policy and practice in the alcohol and other drug sector*. Adelaide, Australia, National Centre for Education and Training on Addiction.
- Battams, S., A. Roche, et al. (2010). *For Kids' Sake: A workforce development resource for family sensitive policy and practice in the alcohol and other drug sector*. Adelaide, Australia, National Centre for Education and Training on Addiction.
- Beardslee, W. R., E. J. Wright, et al. (2008). Long-term effects from a randomized trial of two public health preventive interventions for parental depression. *Journal of Family Psychology* 21: 703-713.
- Brunk, M., S. Henggeler, et al. (1987). Comparison of multisystemic therapy and parent training in the brief treatment of child abuse and neglect. *Journal of Consulting and Clinical Practice* 55: 171-178.
- Carr, A. (2000). Evidence-based practice in family therapy and systemic consultation Child-focused problems. *Journal of Family Therapy* 22(1): 29-60.
- Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy* 31(1): 3-45.
- Commonwealth of Australia (2009). *Investing in the Early Years—A National Early Childhood Development Strategy*. Canberra, Commonwealth of Australia
- Coulter, S. (2011). Systemic Family Therapy for Families who have Experienced Trauma: A Randomised Controlled Trial. *British Journal of Social Work* 41(3): 502-519.
- Council of Australian Governments (2009). *Protecting children is everyone's business*. Canberra, Commonwealth of Australia.
- Cummins, P., D. Scott, et al. (2012). *Protecting Victoria's Vulnerable Children Inquiry*. Melbourne, Victoria, Victorian Department of Premier and Cabinet.
- Elliott, D. E., P. Bjelajac, et al. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology* 33(4): 461-477.
- Figley, C. R. (2010). *Systemic Trauma: Theory, Research and Treatment Implications*, New Orleans, Figley Institute
- Figley, C. R. (2010). *Trauma Resilience: Toward a New Paradigm of Stress Injury Prevention and Treatment*, New Orleans, Figley Institute
- Ford, J., P. Chandler, et al. (1988). Family systems therapy after Operation Desert Storm with European-theater veterans. *Journal of Marriage and Family Therapy* 24(2): 243-50.
- Grimshaw, J. and I. Russell (1993). Achieving health gain through clinical guidelines. Developing scientifically valid guidelines. *Quality in Health Care* 2: 243-248.
- Harris, M. and R. D. Falloot (2001). Envisioning a trauma-informed service system: a vital paradigm shift. *New Directions for Mental Health Services* 89: 3-21
- Herman, J. L. (2001). *Trauma and recovery*. London, Pandora.
- Jeffreys, H., N. Rogers, et al. (2011). *Keeping the child in mind: child protection practice and parental mental health*. Adelaide, Department for Families and Communities.
- Johnson, D., S. Feldman, et al. (1995). Critical interaction therapy: couples therapy in combat-related posttraumatic stress disorder. *Family Process* 34(4): 401-12.

- Lebow, J. and K. Rekart (2004). *Research Assessing Couple and Family Therapies for Post Traumatic Stress Disorder*. New York, Brunner-Routledge.
- Maybery, D., Goodyear, M., & Reupert, A (2012). The family focused mental health practice questionnaire. *Archives of Psychiatric Nursing* 26(2): 135-144.
- McFarlane, W. R., L. Dixon, et al. (2003). Family Psychoeducation and schizophrenia: A Review of the Literature. *Journal of Marital and Family Therapy*, 29(2): 223-245.
- Mihalopoulos, C., A. Magnus, et al. (2004). Assessing cost-effectiveness in mental health: Family interventions for schizophrenia and related conditions. *Australian and New Zealand Journal of Psychiatry* 38: 511-519.
- Milkowitz, D., E. George, et al. (2003). A randomized study of family focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry* 60(9): 904-912.
- Mills, K., P. Ewer, et al. (2011). *Trauma and Substance Use*. Sydney, National Drug and Alcohol Research Centre.
- National Drug and Alcohol Research Centre (2011). *Trauma and substance use*. Sydney, National Drug and Alcohol Research Centre.
- Nicol, A., J. Smith, et al. (1988). A focused casework approach to the treatment of child abuse: a controlled comparison. *Journal of Child Psychology and Psychiatry* 29: 703-711.
- Office of Child Safety Commissioner (2012). *Connecting Services: learning from child death inquiries when co-existing parental characteristics of family violence, substance misuse and mental illness place children at risk*. Melbourne, Victoria, Office of Child Safety Commissioner.
- Pernice-Duca, F. and S. Bernardon (2010). A Family Systems Perspective to Recovery From Posttraumatic Stress in Children. *The Family Journal* 18(4): 349-357.
- Rosenheck, R. and J. Thompson (1986). Detoxification of Vietnam War Trauma: A Combined Family-Individual Approach. *Family Process* 25(4): 559-570.
- Schafer, G. (2011). Family functioning in families with alcohol and other drug addiction. *Social Policy Journal of New Zealand*: 1-17.
- Scott, D. (2009). 'Think Child, Think Family': How Adult Specialist Services Can Support Children at Risk of Abuse and Neglect. *Family Matters*(81): 37-42.
- Sheinberg, M. and F. True (2008). Treating Family Relational Trauma: A Recursive Process Using a Decision Dialogue. *Family Process* 47(2): 173-195.
- Siegenthaler, E., T. Munder, et al. (2012). Effects of preventive interventions in mentally ill parents on the mental health of the mental health of offspring: systematic review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry* 51(1): 8-17.
- UnitingCare ReGen (2012). *Putting together the pieces: Responding to trauma and substance use*. Melbourne, UnitingCare Regen.
- Victorian Alcohol and Drug Association (2011). *Connections: family violence and AOD*. Melbourne, Victorian Alcohol and Drug Association
- Victorian Department of Health (2011). *AOD Workforce Development Strategy 2012-2015 - Consultation Paper*. Melbourne, Victorian Department of Health
- Victorian Government Department of Human Services (2006). *Building partnerships between mental health, family violence and sexual assault services*. Melbourne, Victoria, Victorian Government Department of Human Services, Mental Health Branch.
- Walsh, F. (2006). *Strengthening Family Resilience*. New York, The Guilford Press.



COPYRIGHT © THE BOUVERIE, LA TROBE UNIVERSITY 2013