Foundational Theories and Knowledge Trauma lens Practice Paper

1. Introduction

This practice paper explains the importance of trauma-informed and responsive child protection practice. Consideration is given to the way trauma can affect children and young people, parents, caregivers and foster and kinship carers and residential care workers. The potential for case management staff to experience trauma is also discussed. Implications for case management and self-care are outlined. This practice paper must be read in conjunction with the Trauma Practice Paper.

Please note that in this document, the term Aboriginal refers to all people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. This term is used as the First Nations Peoples of South Australia are predominantly Aboriginal peoples and it is their preferred term. We acknowledge and respect that it is preferable to identify Aboriginal peoples, where possible, by their specific Language group or Nation.

2. Trauma-informed and responsive practice

Trauma-informed and responsive practice (TI-RP) seeks to:

- apply a trauma lens to all aspects of professional and organisational practice
- assist practitioners to understand the significant and wide-ranging impacts that trauma (including intergenerational trauma) may have on children, young people, families, communities, carers, professionals and organisations
- acknowledge the importance of recognising the signs and symptoms of trauma, not only for children and young people, families and communities, but also within systems
- promotes the integration of trauma-awareness into practice, policies and procedures within organisations
- do no further harm to or create any further risk for those who have experienced trauma
- be therapeutic by focussing on strengthening resilience and protective factors, and promoting physical, emotional and cultural safety.

To be effective, TI-RP must be embedded at all levels of service delivery, from the first point of contact with children, young people, their families and carers through to the policies and governance of the agency.

3. Impacts of trauma on Aboriginal families

It is important for practitioners to acknowledge the strength and resilience shown by Aboriginal families and communities in the face of intergenerational and complex trauma. The Stolen Generations, colonisation, disconnection from Country, racism and institutionalisation continue to have a significant impact on Aboriginal people and communities and result in intergenerational trauma. Intergenerational trauma is defined as "…the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as 'cumulative emotional and psychological wounding'".[i] Intergenerational trauma has profound impacts on families

and communities, causing both families and communities to live in a state of distress. It can result in parents and caregivers experiencing difficulties that may be harmful for their children and young people (for example, alcohol and other drug use or poor mental health). Aboriginal infants, children and young people may also experience a range of distressing life events as a result of the impacts of intergenerational trauma including loss of identity, lack of self-determination, early illness or death of family members, exposure to violence, loss of family and cultural connections and financial stress.[ii] It is essential for practitioners to consider how intergenerational trauma impacts engagement between Aboriginal people and services, as it makes it extremely difficult for Aboriginal families and communities to trust both government and non-government services. Supporting Aboriginal families in Family Led Decision Making is an essential approach in implementing the Aboriginal Child Placement Principle. Refer to the Aboriginal Child Placement Principal Practice Paper for information on intergenerational trauma.

4. Impacts of trauma on families who are from culturally and linguistically diverse (CALD) backgrounds

Some children, young people and their families who are from CALD backgrounds may have sought asylum or have been refugees. This may mean that they have experienced living with hardship, war, violence and persecution, and may be living with the impacts of trauma. Other experiences may also include human rights violations, forced dislocation, political repression, loss or separation from family members and traumatic experiences in refugee camps. The impact of these trauma experiences can be significant and contribute to fear of the government and the child protection system. The impact of migration and refugee experiences should be explored sensitively to ensure a positive working relationship is developed and maintained. Refer to the Working with cultural diversity Practice Paper for further information.

5. The impact of trauma on parental functioning

Childhood trauma can significantly interfere with a child or young person's developmental trajectory (refer to the Trauma Practice Paper for further information). Without appropriate therapeutic care from loving and nurturing caregivers and engagement with professionals, the trauma that children and young people experience can have pronounced effects that persist into adulthood. These impacts can be compounded and further intensified if further trauma is experienced. Childhood trauma can create vulnerabilities that increase the likelihood of experiencing further trauma in adulthood. If unaddressed, the long-term impacts of trauma can interfere with a range of functional abilities in adulthood and may seriously compromise parenting capacity.[iii] It is important to be aware of how trauma affects an individual will vary based on many factors including; "….characteristics of the individual, the type and characteristics of the event, developmental processes, the meaning of the trauma and sociocultural factors".[iv] Parents and caregivers, who themselves were not provided with a safe, nurturing and culturally strong care environment during their childhood, can find it difficult to provide adequate care to children.

5.1 Impact on mental health

Parents and caregivers who are living with unresolved trauma often experience symptoms of poor mental health and may lack the emotional regulation skills and social support to manage these symptoms appropriately. As such, they may develop a range of maladaptive coping strategies in an attempt to manage their symptoms, and life's stressors. Examples of maladaptive coping mechanisms include:

- alcohol and/or other drug use
- self-harm
- hoarding
- social withdrawal
- gambling
- controlling behaviours.

Unfortunately, many of these coping strategies detract significantly from a parent or caregiver's ability to provide emotionally attuned and safe care to their child.

5.2 Impact on attachment relationships

Parents and caregivers who were not provided with opportunities to develop healthy attachment relationships as children may struggle to foster healthy attachment relationships with their own children and are more likely to have children who also experience attachment difficulties. As discussed in the Attachment Practice Paper, a child experiencing trauma in the context of their relationship with their attachment figure can lead to disruptions to the child's attachment relationships. If severe, children can develop unhealthy attachment relationships which can lay the foundation for an internal working model that views relationships as unsafe, unresponsive and unfulfilling. These unhealthy relationship templates can persist into adulthood, and may influence the way parents or caregivers later interact in their relationship with their own children and others.

5.3 Impact on parenting capacity

Parents and caregivers who have experienced childhood trauma often have difficulty assessing the safety of their children, as their sense of what is appropriate and safe is shaped by their childhood experiences.

Parents and caregivers who have experienced abuse and neglect have often lived in environments where:

- poor and harmful parenting practices were role modelled
- they did not have the opportunity to learn the fundamental parenting skills necessary to ensure a child's basic care needs are met (for example, how to keep a house clean, dressing a child appropriately for the weather or creating a stimulating environment for their child)
- poor emotional regulation, aggression, verbal abuse and physical discipline were normalised and seen as 'acceptable'
- their parents or caregivers regularly used alcohol and/or other drugs
- there were blurred sexual boundaries, inappropriate views of child sexual development or sexual abuse
- their parents or caregivers had poor mental health, including symptoms of severe depression, anxiety or personality disorder.

Such experiences compromise the parent or caregiver's own development as a child, potentially leading to challenges with alcohol and/or other drug use, mental health difficulties and domestic and family violence into adulthood; and thus a similar harmful care environment is replicated. In addition, given their own childhood experiences, it may be difficult for parents or caregivers to understand why exposure to such risk factors is unsafe for their own children.
Parents and caregivers whose trauma remains unsolved (including intergenerational trauma) can have a narrow window of tolerance (refer to the Trauma Practice Paper for further information about the

window of tolerance). This can cause them to be easily overwhelmed or distressed by life events or experience triggers of their own trauma, which may cause them to move in and out of states of hyper or hypo arousal. In these states, they cannot be as attentive or attuned to the needs of their children, and their children become vulnerable to harm. Another way of thinking about hyper- and hypo-arousal is the 'flight/flight/freeze/fawn' response. When hyper-aroused, parents and caregivers may misperceive their child as a psychological threat and behave in a way that is verbally or physically aggressive towards their child ('fight'). Alternatively, the parent or caregiver might move into 'flight' or 'freeze' mode in response to their children's behaviour, rendering them largely unavailable to meet their children's needs or to act protectively in the face of harm (for example, when there is domestic and family violence occurring in the home). Other parents or caregivers who may have experienced trauma may be triggered into a 'fawn' response by their children's behaviour where they try to appease their child but do not meet their needs for clear parental expectations and boundaries.

Childhood trauma can cause parents and caregivers to develop unhealthy internal working models which impacts the way in which they engage in and perceive relationships (refer to the Attachment Practice Paper for further information on internal working models). An unhealthy working model can impact the parent or caregiver's ability to identify harm and act protectively towards their child (for example, a parent or caregiver may have developed a working model that relationships are not reliable or satisfying and may therefore struggle to identify when a relationship is unhealthy or violent).

6. Family based carers' experiences of trauma

Caring for children and young people who have experienced trauma can itself be a traumatising experience. Kinship and foster carers carry with them not just the responsibilities associated with parenting but those associated with providing children and young people with therapeutic care. While caring for traumatised children and young people can be rewarding, it can also be demanding and overwhelming at times and can contribute to carers experiencing trauma themselves.

Kinship and foster carers are vulnerable to experiencing direct or vicarious trauma due to:

- witnessing the child or young person's disclosures or re-enactments of harm, which can negatively affect the way the carer views and interacts with the world
- observing the symptoms of trauma in the children and young people they care for
- exposure to situations where the child or young person's behaviour threatens their sense of safety or otherwise overwhelms their capacity to cope
- their psychological resources being stretched and having limited time and energy left to take care of themselves
- experiencing isolation if their friends and family struggle to understand why they choose to care for a traumatised child
- stressors associated with interacting with the child protection system (for example, change of case worker, family contact that leaves the child or young person unsettled or having to seek approval for activities that would ordinarily be a parental decision)
- living with a lack of predictability and certainty about case direction (for example, whether reunification will be pursued or if the child or young person will remain in their care
- triggering of their own trauma experiences.

Carers may also hold the view that children and young people will recover from trauma simply with love and care. While the provision of love and care is important, trauma recovery is far more complex. Kinship and foster carers may experience a sense of shame if, after providing the child or young person with care for some time, the child or young person is not “fixed” or “healed”.

6.1 The unique experience of kinship carers

Kinship carers experience specific challenges when caring for children and young people who have experienced trauma. Kinship carers are often requested to provide care at short notice and have therefore had no or little opportunity to prepare, either psychologically or practically. Kinship carers often agree to care for the child or young person with limited information about why that child or young person is coming into care, how long they will be in care and without the opportunity to carefully consider their options. Once the child or young person is placed with them, kinship carers not only have to manage the child or young person’s trauma but deal with crisis within their own family. The experiences of the family that led to the child or young person coming into care may be similar to their own experiences in childhood, and may be a trigger for their own trauma or bring up feelings about their own contact with DCP in the past. This can be particularly an issue for Aboriginal kinship carers due to the impacts of the Stolen Generations and the intergenerational trauma experienced in families and communities as a result. Having past experiences of contact with the department and then working with the department as part of their caring role can be challenging and triggering.

Kinship carers may also have to manage complex family dynamics, including establishing boundaries to protect the child or young person in their care. This can be stressful for all parties and have a negative impact on other family relationships. There may also be a sense of shame within the family about the traumatic events that have occurred which can provoke defensive emotions and behaviours among kinship carers, which may then undermine their protective capacity. Aboriginal kinship carers may experience disconnection from family and community and there may be tensions between their caring role and cultural and community obligations. In summary, kinship care is a complex task and kinship carers require specialised support to ensure they have the skills and resources necessary to care for children and young people within their family.

6.2 Supporting family based carers

Carers must feel supported, energised and capable to provide safe and nurturing care to children and young people who have experienced trauma. Using relationship based practice to establish a strong, trusting relationship is crucial to supporting carers and recognising and effectively responding if they are experiencing trauma. Building a strong relationship can assist in gaining insight into the carers’ past experiences, which informs how they react to and manage the stressors inherent in caring. For further information, refer to the Relationship based practice Practice Paper.

It is important that practitioners are able to recognise the signs of trauma among carers. Carers who are struggling and experiencing trauma or vicarious trauma may present as:

- irritable
- quick to anger
- demanding
- highly emotional
- withdrawn
- keeping the DCP case or carer support worker at a distance
- reluctant to disclose difficulties they are having with the child or young person in their care

- engaging in alcohol and/or other drug use or other maladaptive coping strategies to manage stress and trauma
- increasing their use of childcare or respite (compared to what has been typical of them in the past).[1]

Awareness that the above behaviours can occur as a reaction to past and/or present stress and trauma is essential to ensuring that misattributions of behaviour do not occur. If a trauma lens is not applied, carers may be considered "difficult" or "disengaged" when in fact their behaviour is a reaction to their circumstances. Having a strong relationship with a carer also assists practitioners to recognise when a carer's behaviour changes, which is an important sign that additional supports should be implemented.

Whilst engaging additional supports is important when a carer is experiencing stress, crisis or trauma, it is crucial that supports are provided proactively and in a timely way to prevent crisis. There are many ways that practitioners can proactively support carers' resilience including:

- developing a relationship with the carer through regular contact
- communicating clearly and being transparent in decision making
- ensuring carers are involved in care team meetings and decision making processes
- encouraging and normalising requesting additional supports when they need it
- creating as much predictability as possible for the carer and for the child or young person
- being responsive when help is requested
- ensuring carers feel valued and heard
- providing practical and emotional support.

When carers are experiencing crisis or trauma, increasing both practical and emotional support is essential (for example, taking children to appointments on behalf of the carer or working with the carer on strategies to respond to trauma based behaviours). Talking the carer about what will best assist them is imperative to ensure that well intentioned attempts to provide support do not add to the carers stress levels. Having a strong, positive relationship with the carer will make it more likely that support will be effective and help to prevent a placement breakdown.

7. Residential carers' experiences of trauma

Residential carers experience unique challenges in the care that they provide. Children and young people placed in residential care often present with more complex trauma histories, attachment disturbance, a history of placement instability and emotional and behavioural difficulties. In addition, placing children and young people with complex behavioural and emotional needs together can create a complex dynamic for staff to manage. Residential carers are at risk of experiencing direct trauma as a result of the behaviours of the traumatised children and young people they care for, as well as vicarious trauma through hearing about the experiences of children and young people. Residential care environments are often changing and unpredictable both in terms of the needs and behaviours of

[1] It is important to note that accessing supports such as childcare or respite are not considered to be a sign of not coping, however, an increase in the request for or use of these supports, in conjunction with other factors, might signal that the carer is experiencing challenges in caring and requires additional support.

children and young people and the complexity of caring for children and young people in a team. Residential carers are also vulnerable to experiencing distress due to systems issues that can impact efforts to achieve stability, predictability and consistency within residential care settings.

As with kinship and foster carers, residential carers require support from the care team and within their own teams to help them build and maintain resilience to the effects of trauma. Supporting residential carers to be involved in the care team is valuable as they provide a unique insight into the needs and views of the child or young person. In addition to the strategies outlined above, it is imperative that residential carers access training to develop their capacity to provide trauma-informed and responsive care to the children and young people in residential care settings.

8. Trauma-Informed case management

Case management staff must reflect on how trauma has affected a child, young person and their family when undertaking assessments and making critical decisions. The DCP Assessment framework is a useful tool which can help practitioners explore the trauma that has occurred, what risk and protective factors might exist, and how the trauma has affected children, young people and their families.

For Aboriginal infants, children and young people, practitioners must consider the family's experiences of intergenerational trauma as a result of the Stolen Generations, colonisation, displacement from country and institutionalisation. Practice and cultural consultation are essential processes to assist practitioners in their understanding of trauma and how it may apply to case management.

A trauma lens should be applied in all phases of work, from intake through to long term care.

Phase	**Examples of using a trauma lens**
Intake	Gathering information on the current and past traumatic events and environments a child, young person and their family has experienced to inform assessment.
Investigation and assessment	Exploring domains of the safety, harm, cumulative harm and risk of harm assessment as outlined in the DCP Assessment framework. For example, consider: • what does the child protection history indicate about the child or young person's past experiences? • is the parent's own experience of trauma impacting on their parenting? • is intergenerational trauma impacting on the child or young person and immediate and extended family?
Protective intervention	Exploring the domains of reunification viability assessment as outlined in the DCP Assessment framework, including giving consideration to the impacts of trauma on the child and parent. For example, consider whether: • intergenerational or recent trauma is affecting the parent's progress towards addressing the child protection concerns

	• whether the child or young person has additional care and developmental needs as a result of the trauma they have experienced.
Long-term care	Exploring domains of assessment for children in long term care as outlined in the DCP Assessment framework. For example, consider: • what supports does the carer need to develop and implement trauma-informed care practices? • how have the child or young person's experiences of trauma impacted their development across all life domains? • is trauma impacting family contact?

8.1 Considerations for engagement

Practitioners working from a trauma-lens appreciate that trauma can interfere with children, young people and their families' willingness and ability to engage with the department. Individuals and families who have experienced trauma will likely struggle to manage the complex and emotionally challenging task of engaging with child protection services. These families are more likely to have smaller windows of tolerance, have heightened stress-arousal response systems and be more easily activated into fear and states of fight, flight or freeze. Practitioners need to understand this and draw on their compassion and empathy in their efforts to form genuine working relationships.

Aboriginal families who have experienced intergenerational trauma related to the Stolen Generations and other experiences of institutional racism may be deeply distrustful of the department. It is each practitioner's responsibility to develop their cultural competence and to work with Aboriginal families in ways that help to build trust. Working in partnership, as well as promoting self-determination and Family Led Decision Making for Aboriginal families, are important contributors to building trust.

Families from CALD backgrounds may have had traumatic experiences in relation to authority and government in their country of origin which can produce fear and impact engagement. Relationship based practice should be used to maximise opportunities for respectful, effective and culturally safe engagement (refer to the Relationship based practice – Practice Paper for further information).

8.2 Considerations for reunification

Whilst applying a trauma lens is important in all phases of child protection intervention, it is particularly important for practitioners working in reunification. The enduring effects of trauma on a child or young person's functioning and their relationship with their parent or caregiver must be considered when exploring reunification. Parents may make significant positive gains towards addressing the child protection concerns and improving their capacity to provide safe care to their child, but if a child is still experiencing significant effects of trauma, reunification may not be viable or successful. Some parents may improve to the point that they can provide safe and adequate care to a child but may not be able to provide trauma-informed and therapeutic care to meet the needs of their highly traumatised child or repair their trauma-affected relationships. Trauma must also be considered from an attachment perspective. If a child or young person has developed a healthy attachment to their foster or kinship carer, separation from that carer could constitute a traumatic event for the child or young person.

8.3 Considerations in family contact

The impacts of trauma must also be considered when making decisions about family contact arrangements. Children who have experienced complex trauma in the care of their parents are likely to experience some form of re-traumatisation during contact with their parents. It might be that the parent triggers memories of traumatic events or that seeing the parent activates unhealthy dynamics that existed within the relationship which may overwhelm the child or place them at risk. Practitioners should closely observe the behaviours of children and young people before, during and after family contact, as these behaviours will give information about the impact of the family contact on the child or young person. Practitioners should also speak with carers about their observations of a child or young person's behaviour before and after family contact.

The aim of family contact is to promote the best possible relationship between a child or young person and their family. However, continuing to send a child or young person to family contact when they are experiencing distress or are being re-traumatised by the contact is not in the child or young person's best interests, and will undermine efforts to develop healthier family relationships. Consultation with practice leaders or DCP Psychological Services should be considered when reviewing family contact arrangements if there are concerns that a child or young person is struggling with or could be re-traumatised by contact. Refer to the Family contact for children and young people Practice Paper for further information.

9. Case management staff's experiences of trauma

Professionals working in child protection are also vulnerable to the impacts of trauma. Call Centre staff receiving initial notifications of harm are exposed to traumatic content for the majority of their working day. DCP office staff are also often exposed to traumatic information both via written information and direct contact with children, young people and their families and carers. Leaders in offices can experience trauma through exposure to traumatic information and stress from supporting staff in the complex work of child protection. Demanding workloads can limit the ability to engage in self-care practices.

The context surrounding child protection work also contributes to practitioners' vulnerabilities to the effects of trauma. Media portrayal of child protection work can be unsupportive. Friends and family members often do not understand the work and for confidentiality reasons, practitioners cannot discuss and debrief with those who would otherwise provide the greatest support.

For these reasons, professionals working in child protection are vulnerable to compassion fatigue, vicarious trauma and direct trauma. It is imperative that attention is given to enhancing practitioner's resilience and offering timely and appropriate support when there are critical incidents or effects of trauma are identified.

Some strategies for reducing the impact of trauma include creating environments that encourage practitioners to:

- make use of peer support and debriefing
- actively engage in supervision and reflective practice

- be aware of and utilise counselling and therapeutic supports as needed (including the employee assistance program)
- build external support networks
- create balance between working and non-working hours
- engage in self-care both at work and during non-working hours
- take regular periods of annual leave
- attend trauma-informed training.

It is important to note that Aboriginal staff have a unique experience of trauma. As a result of colonisation and intergenerational trauma, Aboriginal peoples experience poorer social determinants of health and are overrepresented in the child protection, out of home care and justice systems. Due to the systemic nature of past policies and practices, the intergenerational trauma experienced by Aboriginal peoples is collective rather than individual and crosses generations. It is essential to understand the context of this collective experience, as well as acknowledging each individual Aboriginal person's unique experiences of intergenerational trauma, intergenerational resilience, healing and the strength and protective factors of culture. Cumulative trauma may arise for Aboriginal staff due to the combination of both lived experiences and exposure to stress and trauma when working with Aboriginal families and communities in a child protection context. Aboriginal employees experience additional complexities when working in a child protection context including the need to balance significant family, cultural, community and caring obligations. This means Aboriginal workers are often engaged well beyond office hours responding to both obligations and expectations of community. Aboriginal staff can also experience cultural fatigue as a result of intergenerational and vicarious trauma, racism, reduced sense of belonging, systemic barriers and feeling culturally unsafe in the workplace.

10. Reflective practice

Practitioners are better able to develop skills when they engage in reflective practice. Practitioners are encouraged to seek feedback about their understanding of trauma and the application of a trauma lens to all areas of their work, including their own coping.

In supervision, reflect on and consider your practice in relation to:

- considering a child or young person's and family's experiences of trauma, including intergenerational trauma
- your understanding of the potential impacts of trauma on a child or young person's emotional and behavioural functioning
- considering a child's experiences of trauma and their associated needs when making decisions about their future
- the impact of trauma on carers
- how could case management and residential care workers work more closely to support children or young people to begin to address their experiences of trauma.

Government of South Australia
Department for Child Protection

Document control

Reference No./ File No.			
Document Owner		**Lead Writer (position)**	
Directorate/Unit: Quality and Practice Accountable Director: Director, Quality and Practice		Principal Policy and Project Officer, Quality and Practice	
Commencement date	8 November 2023	**Review date**	3 November 2026
Risk rating [Risk Assessment Matrix]	**Consequence Rating**	**Likelihood**	**Risk Rating**
	Minor	Unlikely	Low

REVISION RECORD		
Approval Date	**Version**	**Revision description**
3 July 2020	1.0	Final
3 November 2023	2.0	Review in alignment with the policy review cycle.

[i] Atkinson, J. (2013) Trauma-informed services and trauma-specific care for Indigenous Australian children. Australian Institute of Health and Welfare, Australian Institute of family studies. https://earlytraumagrief.anu.edu.au/files/ctg-rs21.pdf

[ii] Ibid

[iii] Zvara, B. et al (2015) Childhood sexual trauma and subsequent parenting beliefs and behaviours. Child Abuse and Neglect 44, p. 87-97.

[iv] Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014.