

# Framework for trauma-informed practice

Supporting children, young people and their families



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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services.

This publication may contain images of deceased Aboriginal and Torres Strait Islander peoples.

In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

ISBN 978-1-76096-950-9 (pdf/online/MS word)

Available at [Framework for trauma informed practice](https://www.dffh.vic.gov.au/framework-trauma-informed-practice) <<https://www.dffh.vic.gov.au/framework-trauma-informed-practice>>

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## Foreword

Trauma experience is common in our community. It is more common in those who work in health and human services than in other sectors. These two statements help us to understand the importance of services and systems being trauma-informed for all who use them, as well as all who work within them. For children and young people, trauma experience has the potential to shape every aspect of their lives. Working in ways that understand and respond to trauma and its impacts can prevent further trauma. It can have a positive influence on all aspects of a child's development and relationships. The significance of trauma-informed practice is its ability to reduce the likelihood of intergenerational trauma. Working with children and families in this way becomes critical to better outcomes.

The **Framework for trauma-informed practice** supports our understanding of trauma and related concepts. It gives us principles that underpin trauma-informed ways of working and outlines the key domains of trauma-informed practice. The domains are explained through 'I' statements that we can all relate to in how we think about, reflect on and demonstrate trauma-informed practice every day.

A key feature of the framework is the way the 'I' statements can reach into the hearts and minds of our clients. How do I feel when I work with this person or when I am at this place? What do I expect from the way people work with me and support me? The framework also provides those working in organisations with 'I' statements that reflect their responsibilities through a trauma-informed lens. If I am a practitioner, a manager or a service leader, I can see for myself how I can work in ways that reflect trauma-informed practice. I also know what to expect of those around me and how I will be supported in my work.

Practice examples are a tangible way to help us see the domains of trauma-informed practice in action. The framework uses a fictional case study, which describes the thoughts, feelings, needs and experiences of a family with strengths and vulnerabilities. It also describes the experience for those working with families across different service settings. Some of you will work in these settings, or you may choose to create your own 'I' statements relevant to your clients and programs. A key benefit of the framework is the ability to use it flexibly to enhance your own trauma-informed practice.

We are excited to see this framework published. The COVID pandemic brought new challenges to our practice and new trauma impacts have emerged. We appreciate and honour all those who worked tirelessly to adapt their services and continued to support children and families in need, despite such extraordinary circumstances. At its heart, trauma-informed practice transcends events, even global pandemics. It compels us to focus on strengthening and healing our individual and collective human experience.

**Office of Professional Practice**



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## Acknowledgements

The Department of Families, Fairness and Housing acknowledges Victoria's Aboriginal communities and pays respect to Elders past, present and emerging. We acknowledge Aboriginal people as Australia's First Peoples and as the Traditional Owners and custodians of the land and waters on which we live and work.

We recognise and value the ongoing contribution of Aboriginal people and embrace the spirit of self-determination, self-management and reconciliation. We acknowledge the invaluable contributions of Aboriginal Elders, children and families to this framework. We look forward to a continued partnership.

We acknowledge the leadership of Victorian Aboriginal organisations in understanding and promoting healing from trauma across generations. This framework is inspired by this work. It promotes the wellbeing and healing of all people touched by the child and family service system.

We acknowledge the diverse and distinct cultures of Aboriginal and Torres Strait Islander people. In this framework, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

We acknowledge that many people have experienced trauma through a range of adverse circumstances and events. These include immigrants, refugees and other displaced people living in our community. We recognise the strength, resilience and resourcefulness of survivors of trauma. We welcome the expertise that people with lived experience bring in helping shape a better system and a better future.



## Key terms

Developing a shared understanding of trauma and trauma-informed practice helps different service sectors to communicate effectively using a common language. This promotes consistency across sectors and program areas. It also supports a more coherent experience for people using services. The definitions included here describe terms that align with international literature on trauma-informed practice. They have been tested with people who have an interest or a role in delivering and/or using Victorian public health and human services. The key terms are used throughout the framework.

### Aboriginal cultural safety

'An environment that is safe for people: where there is no assault, challenge or denial of identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and true listening' (Australian Human Rights Commission 2011, p.123; Williams 2008, p. 213).

### Aboriginal self-determination

Self-determination needs to be understood as a living, dynamic creation of Aboriginal communities. The definition published in the **Victorian Aboriginal affairs framework 2018–2023** is:

Aboriginal self-determination encompasses a spectrum of rights that are necessary for Aboriginal Victorians to achieve economic, social and cultural equity, based on their own cultural values and way of life. This includes rights to: not be discriminated against; enjoy language, culture and heritage; land and natural resources; have access to the basic necessities of life and be economically self-sufficient; make decisions that impact their lives from a position of wellbeing and empowerment; 'grassroots community' having ownership and responsibility for their own affairs and their own communities, including through designing and delivering policy and services on their own terms, setting their own funding priorities and holding their service providers accountable (State of Victoria 2018, p. 22).

### Intergenerational trauma

Unresolved individual or collective trauma can be transferred to later generations in a growing, prolonged and persistent pattern.

This can occur across parenting relationships, through the 'collective, cultural memory' of a community (Australian and Torres Strait Islander Healing Foundation 2013, p. 3) and through system failures to address ongoing adversity and discrimination of certain groups.

## **Intersectionality**

'Intersectionality describes how systems and structures interact on multiple levels to oppress, create barriers and overlapping forms of discrimination, stigma and power imbalances based on characteristics such as Aboriginality, gender, sex, sexual orientation, gender identity, ethnicity, colour, nationality, refugee or asylum seeker background, migration or visa status, language, religion, ability, age, mental health, socioeconomic status, housing status, geographic location, medical record or criminal record' (Family Safety Victoria 2019a, p. 12).

## **Lived experience**

Lived experience is a term originally used in research, and now in policy and practice. It reflects people's experiences and their response to those experiences (Boylorn 2008). Increasingly, in service design, development and delivery, people with lived experience are seen as experts on their lives and experiences. A more recent term being explored is 'living experience' in recognition of the ongoing impacts of trauma.

## **Positive Behaviour Support**

Positive Behaviour Support (PBS) is a multicomponent framework for developing an understanding of behaviours of concern. PBS is based on the assessment of the broad social, physical and individual context in which the behaviour occurs, to develop evidence-based supports. The goal of PBS is to enhance the person's quality of life, to prevent behaviours of concerns occurring (PBS Academy 2016).

## **Psychoeducation**

Psychoeducational approaches can be used to support people to understand trauma as a concept, and their own trauma in terms of triggers, feelings and coping strategies. Traditionally used in health care, psychoeducation is strengths-based, can be used with individuals and with groups, and empowers people to communicate effectively with others. Psychoeducation incorporates both educational and therapeutic techniques. It is a partnership approach that assumes that the person and their caregivers will be able to realise better outcomes if they are informed and empowered in their decision making (Lukens & McFarlane 2004).

## **Reframing symptoms**

Trauma-informed practice requires us to see 'symptoms' and problems as coping mechanisms that may have initially been protective (Kezelman & Stavropoulos 2012). These coping mechanisms may be resourceful and creative attempts to 'survive adversity and overwhelming circumstances' (SAMHSA 2014, p. 9). At all times, behaviour should be viewed as an adaptive response to challenging life experiences. In this context, all interactions should be respectful, empathic, non-judgmental and convey optimism (Kezelman & Stavropoulos 2012).



### **Re-traumatisation**

Re-traumatisation is when a person who has experienced trauma has a physiological and emotional stress response triggered by a thought, sense activation, event, circumstance or interaction that causes trauma. Re-traumatisation can occur when a person's experience of a service (as a service provider or user) results in further harm.

### **Therapeutic approach**

A non-judgemental way of working that creates a sense of safety, builds a trusting relationship and supports, affirms, educates and empathises with the person using a service, treating them with dignity and respect.

An approach in which a practitioner engages holistically with people to support healing from harm, prevent further harm, build resilience and promote personal agency. This includes a focus on repair, recovery, meaning-making, awareness of potential triggers, restoration of choice, safety and wellbeing.

### **Trauma**

'Trauma can be defined as the experience and effects of overwhelming stress. Trauma overwhelms a person's ability to cope when faced with a threat' (Kezelman & Stavropoulos 2018, p. 7). Trauma arises from activation of the instinctive survival response, sometimes referred to as flight/fight/freeze to overwhelming threat (Kezelman & Stavropoulos 2012). As such, it originates as a response in the nervous system.

'Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being' (SAMHSA 2014, p. 7).

Collective trauma can be experienced by whole communities of people. For example, this is seen in groups of people with shared experiences (such as surviving a natural disaster, forced adoption or institutional abuse). It is also seen in indigenous populations and people from refugee backgrounds who have been exposed to violent dispossession and physical, cultural and spiritual genocide over long periods.

### **Trauma-informed practice**

Trauma-informed practice is an approach that recognises that trauma is common and that people accessing services and people delivering services may be affected by trauma. Trauma-informed practice is an approach that is holistic, empowering, strengths-focused, collaborative and reflective. It promotes physical, emotional, spiritual and cultural safety.

## Trauma and violence-informed practice

While trauma-informed practice involves creating safe environments and understanding the effects of trauma, trauma and violence-informed practice 'expands this concept to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life' (Varcoe et al. 2016, p. 1). This includes taking an intersectional view to highlight current and historical experiences of violence, so problems are not seen as originating within the person. Instead, these aspects of their life experience are seen as adaptations and predictable consequences of trauma and violence.

## Trauma-informed services

Trauma-informed services are designed and delivered in ways that expect that people using services and people working in services may have experienced trauma. Trauma-informed services appreciate that each person's experience and expression of trauma is unique. They recognise trauma can affect people in many ways, including physical, emotional, psychological, behavioural, social and interpersonal impacts.

Trauma-informed services may not directly treat trauma but work to ensure the service experience will not cause further trauma, harm or distress. They do this by including principles and values that support wellbeing and applying them in dynamic and reflective ways across the service environment, workforce, culture, policy and practice. And they seek to provide relationships and environments in which people feel safe to disclose and discuss trauma.

'A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths to recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization' (SAMHSA 2014, p. 9).

## Trauma-specific services

Trauma-specific services and practitioners use therapeutic interventions intended to support healing and recovery for people in relation to their experiences of trauma and their individual needs. While not all trauma-informed services will be trauma-specific in their focus and intent, all trauma-specific services should be trauma-informed if they are to benefit the people using them (Australian Institute of Family Studies 2016).

## Vicarious trauma

Vicarious trauma is 'the cumulative effects of exposure to information about traumatic events and experiences, potentially leading to distress, dissatisfaction, hopelessness and serious mental and physical health problems' (Monash Gender and Family Violence Prevention Centre 2021, p. iii).

Vicarious trauma is not experienced in the same way by all people. However, it includes cognitive changes that affect a person's belief systems. It may include intrusive thoughts, disturbed sleep, difficulties with boundaries, withdrawing from others and loss of pleasure in life.

Vicarious trauma can be understood as 'a normal, cumulative response to repeated exposure and empathic engagement with traumatic material', which is an unavoidable risk of 'emotionally strenuous' work (Knowmore 2013, p. 1).

## Violence

Acts of threat, control, assault or attack; violations of human rights or physical, sexual, emotional, financial, spiritual or cultural safety, which can be:

- interpersonal (relational)
- structural (inequality, discrimination and social exclusion)
- institutional (a service response that perpetuates harm)
- lateral (within communities).

People's experiences of violence can be either historical or ongoing and can be individual or collective experiences (EQUIP Healthcare 2017). Both direct and indirect experiences of violence are harmful.

Interpersonal violence, such as family violence can have a significant impact on infants whilst in utero, during the formation of early attachment relationships and childhood development, into adolescence. Infants and children are especially vulnerable to the impacts of family violence as they are reliant on adults for their safety. The trauma that children experience from violence, abuse and neglect has a cumulative effect that can continue to affect health, safety, and wellbeing into adulthood.

All experiences of violence are more complex than simply a personal event or story. Violence always exists 'within broad social circumstances' that make it possible, and often invisible, in a range of different ways (Varcoe et al. 2016, p. 4).



# Introduction

This framework promotes and supports a shared understanding of what being trauma-informed means to children, individuals and families, professionals and volunteers. It is presented in three sections. Section 1 gives background to the key aspects of the framework. Section 2 offers ideas about how the framework can support better awareness and understanding of what it means to experience a trauma-informed service as either a service user or service provider. The third section provides a practice example.

The framework explains trauma, trauma-informed practice, and other terms that are used when working with people who have had negative life experiences that have impacted on their health and wellbeing. Learning about trauma gives us a way to understand behaviours, responses, attitudes, and emotions as a collection of survival skills developed in response to life experiences. The experience of Aboriginal and Torres Strait Islander peoples is highlighted in the framework in recognition of the importance of working with Aboriginal and Torres Strait Islander people in ways that are grounded in cultural safety and self-determination to do no further harm, and to promote stability, resilience, healing and recovery.

## Purpose

This framework provides accessible and practical advice to support services to be trauma-informed when working with all people including:

- children
- young people
- individuals
- families.

Trauma-informed practice supports the wellbeing of everyone. This is regardless of whether they are currently, or have previously, experienced trauma. Trauma-informed practices are designed and delivered in ways that intend to cause no further harm or distress. They promote healing and recovery. Trauma-informed practices reflect values that foster safety and wellbeing. They show up in preventative, proactive and timely responses across all aspects of an interaction, practice, program, service and sector. People accessing services, as well as using services and people delivering services do not need to have experienced trauma to benefit from a trauma-informed approach. To support and enable services to be trauma-informed, this framework:

- outlines the principles at the foundation of trauma-informed systems
- describes the different domains of trauma-informed practice
- offers practical examples that describe how trauma-informed practice can be understood by a child, parent, caregiver, individual, family, practitioner, manager, service and at the system level
- defines key terms about trauma-informed practice to help practitioners across sectors to talk to each other using a shared language and understanding of trauma.

The features of this framework aim to:

- increase awareness and understanding of how people experience trauma differently
- reduce the risk of re-traumatising people engaging with the service system
- describe trauma-informed practice in the context of cultural safety and Aboriginal self-determination
- promote safe, connected and person-centred experiences that support the wellbeing, healing and recovery of people using services
- promote the safety and wellbeing of the workforce.

## Who is this framework for?

This framework supports delivery of trauma-informed practice in child and family services. These include family violence services, for children and young people, individuals and families. The framework can also be used to inform practice across all health and human services.

The framework speaks to practitioners (paid and volunteer workers), managers, service leaders and policymakers. It applies to all people involved regardless of their role or level of contact with people using services. This includes client-facing staff such as:

- peer workers
- practitioners
- clinicians
- case managers
- support workers
- students
- foster and kinship carers.

The framework audience also includes admin or office staff, building maintenance staff, team leaders, program managers, boards of management, and governing bodies. It is written in a way that can support service users to better understand what they can expect from services and may wish to experience when working with a service provider.

**Trauma-informed practice is a whole-of-system approach. If people using services (and people working in services) are to have truly helpful and healing experiences of our service system, all elements must work together in a trauma-informed way.**

## How should I use this framework?

The framework has been designed to complement existing practice frameworks and guidance. It is aligned with the Department of Families, Fairness and Housing Community Services Quality Governance Framework (QGF). It references all domains of the QGF: leadership and culture, best practice, client and family partnerships, workforce and risk management. An example of alignment with the QGF is the framework's expectation that trauma-informed practice is actioned at all levels of an organisation. The framework is also aligned to the department's Client Voice Framework for Community Services in recognition of the critical role of client voice and lived experience informing and contributing to everything we do.

Organisational and practice reform involves the implementation of different practice models and frameworks. When focused on working with people, these are often trauma-informed and some are designed to be trauma-specific in their intent. This framework does not replace those models and frameworks, instead it is a complementary way of assuring that trauma-informed practice is implemented across the service system. A key example of a complementary approach is the Family Preservation and Reunification Practice Modules that are being implemented in Family Services. Practice elements within the modules guide practitioners in undertaking intentional practice to support trauma-informed ways of working.

This framework can be used flexibly. The following ideas show how people and organisations can use the framework. In addition to promoting the framework and making it available to all staff, use the framework 'I' statements in Section 2 and Practice example to:

- promote greater understanding of trauma and related concepts
- help staff to see trauma-informed practice from different perspectives
- inform strategic direction and planning
- review and align policies and procedures
- include in position descriptions and codes of conduct
- embed into professional development curricula
- develop local practice examples of trauma-informed practice
- create opportunities for reflection in individual and group supervision
- build supports for staff and volunteers
- promote lived experience expertise and participation
- embed in client feedback surveys and program evaluation
- inform continuous improvement and auditing activities
- build into submission requirements and service agreements.

The list above is not exhaustive. There will be many other ways that the framework can be used to support and enable trauma-informed practice.



## What we did and how we consulted

We reviewed the recent literature on trauma-informed practice including:

- accounts of people's lived experience
- practice expertise
- policy reform work
- evidence-informed research.

We also consulted:

- people involved in using and delivering services
- people involved in administering public health and human services
- people generally interested or invested in the system such as academics, peak bodies and advocates.

We did this in person and using an online survey.



## COVID-19 pandemic

At the time of publication, Victoria was adjusting to a sustained period of living with the COVID-19 global pandemic. In Victoria, we endured one of the world's longest lockdowns to prevent the spread of the virus (Boroujeni et al. 2021). With high vaccination rates across the state and country, Victorians were able to resume pre-COVID activities with minimal restrictions. Activities such as gathering with family and friends, travelling and going to venues such as workplaces, schools, shops and entertainment recommenced.

The COVID-19 pandemic has affected life for everyone in some way. Early studies about the potential long-term social and economic impacts indicate that 'Australia's public health restrictions have substantially affected families experiencing adversity, and their mental health. These impacts are likely to exacerbate inequities arising from adversity' (Bryson et al. 2021, pp. 3–4). From a clinical viewpoint, some studies have found that:

... some of the measures implemented to manage the coronavirus disease 2019 (COVID-19) pandemic, such as physical isolation and lockdowns, have had the potential to exacerbate pre-existing risk factors for social isolation and loneliness, such as living alone (Australian Institute of Health and Welfare 2021, p. 1).

A report from the British Academy (2021, p. 10) states that 'COVID-19 has generated a series of social, economic and cultural effects which will have long-term impacts. In particular, the pandemic has exposed, exacerbated and solidified existing inequalities in society'.

We will need to consider the added financial and social burden for people over the longer term. The pandemic did offer opportunities to reduce barriers to accessing services. For example, we saw increased access to telehealth and online options for service access. Many agencies made positive changes that will continue over the long term.

However, we need to balance increased access to services via technology with other challenges the pandemic has created. Barriers to accessing the service system may be greater for some in the community now. It has affected some people's ability to develop informal supports, relationships and social connectedness, and to earn an income. When designing and developing the workplace and ways of working for service providers, we need to think about the links between work and personal life. When working with service users, we have to consider:

- the impacts some have endured, their resilience and adaptations
- how they prefer to access and work with services
- the best ways to get the social, economic and cultural support they need.

# Section 1: Key aspects of the framework

## Language is meaningful

Language has the potential to promote or undermine wellbeing and to support or deny personal power. There are many different terms used to describe people who access health and human services. Service users have criticised some of these. This critique has shown how people’s experiences of language have sometimes been harmful. Labelling people in ways that point out what is ‘wrong’ with someone can wear away self-worth. People who use services often have different preferences about how they would like to be described. In practice, this means following the cues of individuals and changing language to reflect what they prefer. For example, it is important to observe body language and other non-verbal or cultural cues used by Aboriginal people.

In this framework, we refer to people with lived/living experience or people accessing/using services. We also refer to people delivering services with an acknowledgement that they too may have experienced trauma. Sometimes we use terms such as ‘survivor’ or ‘client’ if this makes sense to the practices and services we are describing.

This framework carefully considers how we can use language to convey the values of trauma-informed practice by privileging the voices and lived experiences of people. The language in this framework is person-centred, respectful and empowering. It models how practitioners, services and systems can use language to enhance (rather than undermine) people’s wellbeing. Table 1 lists terms we might have used in the past to describe ways of understanding and working with people. It then compares with trauma-informed approaches and language. This is language that encourages a more equal power base and invites a strengths-based perspective.

Table 1: Traditional vs trauma-informed

<b>Traditional</b>	<b>Trauma-informed</b>
Doing for people	Doing with people
What’s wrong with you?	What has happened to you? What is going right for you?
Service as expert/practitioner as expert	Person as expert on own life
Symptoms and pathologies	Coping strategies
Treatment and cure	Healing and recovery
Noncompliant/disengaged	Overcoming barriers to engagement: <ul style="list-style-type: none"><li>• What makes you feel safer and how can we better support you?</li></ul>
These are the service options	What might you need to live well?

## Why a framework for trauma-informed practice?

### Trauma is common

Trauma is very common in the community:

- Trauma affects millions of Australians (Kezelman & Stavropoulos 2017).
- Sixty-nine per cent of adults will have a serious traumatic event sometime in their life (UnitingCare ReGen 2012).
- One in six women and one in 9 men experience abuse before the age of 15 (ABS 2019).
- One in six Australian women have experienced physical or sexual violence by a current or previous partner (AIHW 2019).
- One in four Australian adults are living with the impacts of childhood trauma (Kezelman & Stavropoulos 2017).
- In 2021, one in 17 Indigenous children in Australia were in out-of-home care (AIHW 2022).
- About 80 per cent of people using alcohol and other drug treatment services report a trauma history (Dore et al. 2012).


Trauma is even more common among people who experience structural inequality and marginalisation (Fallot & Harris 2011). It is higher among people accessing public health and human services (Kezelman and Stavropoulos 2017). We also know that many people have contact with a range of services for co-occurring issues, such as child protection, housing, mental health and family violence. Research shows trauma history is common among people who use mental health and alcohol and other drug services (SAMHSA 2014). Trauma is common among people working in the health and human service sectors (Warrener et al. 2013).

Trauma can be experienced through a single incident (single-incident trauma) or through repeated exposure to harmful incidents (complex trauma). Complex trauma is chronic, cumulative and has its origins in people's relationships. This includes trauma that occurs early in life and impacts development and attachment relationships. Both single incident and complex trauma can severely disrupt a person's identity, relationships, health and wellbeing (Kezelman & Stavropoulos 2017).

### Trauma is harmful

Our understanding of the impacts of trauma is increasing. We know that experiencing trauma can have lifelong impacts on development, relationships, health and wellbeing. There is compelling evidence that links exposure to traumatic events in childhood with:

- increased uptake of health risk behaviours such as smoking, alcohol misuse, illicit drug use and risky sexual activity
- greater risk of a range of serious physical and mental health problems including potential for early death (Felitti et al. 1998).
- In this context, trauma is a major public health issue that harms individuals, families and communities. It is also costly for the public health and human service system (Kezelman & Stavropoulos 2012).



**Our understanding of the impacts of trauma is increasing. We know that experiencing trauma can have lifelong impacts on development, relationships, health and wellbeing.**

### **Re-traumatisation: Are we helping or harming people?**

Unfortunately, services intended to support people can harm them. When we consider the service experience from a trauma-informed viewpoint, features of a service can cause trauma and interfere with the intended experience and outcomes. These include a service's:

- physical environment
- culture
- practices
- use of language
- processes
- procedures.

This is true both for people using services (and their families and support people) and people delivering services.

Sometimes with the long-term goal of safety, re-traumatisation will occur because engagement with a service may be involuntary and/or unavoidably traumatic. One example is involvement with child protection when there has been a history of child removal.

Where re-traumatisation does occur for whatever reason, it comes at a high cost to:

- a person's wellbeing, both at the time and into the future
- a program (in interfering with engagement and outcomes)
- the system (in continuing a need for a specialist service response).

Therefore, trauma-informed practices become critical to safe, effective, connected, and person-centred service delivery. Setting up a trauma-informed service response must be supported at all levels of an organisation. This is the only way for all people involved in delivering and receiving a service to feel safe. Some services already apply a trauma-informed lens in a range of different ways. However, instilling system-wide trauma-informed practice requires changes that extend across the workforce, culture, policy and practice. It requires an ongoing process of reflection, learning and continuous improvement.

## Principles supporting the framework

The following principles are the basis of a trauma-informed system. These principles underpin every interaction, practice, program, service and sector that supports people across the health and human service system. Sometimes, staff view the working environment, resourcing, reporting requirements and many other things as getting in the way of applying these principles. Working in this way may be challenging. However, not fully applying these principles undermines the benefits of the services we provide and the help we offer. This can cause unintended harm. Reflecting on how we can apply these principles in our day-to-day work will support trauma-informed practice.

### Human rights

Human rights belong to every one of us, 'regardless of our background, where we live, what we look like, what we think or what we believe' (Victorian Equal Opportunity and Human Rights Commission 2012, p. 2).

Human rights, in practice, acknowledges human diversity, equality and non-discrimination and gives individuals a framework for advocacy, community development work and direct service delivery ... Human rights are above politics and ideology, so they are a useful tool in arguing for change. Human rights mean that individuals, whether they are accessing or providing services, respect the dignity and worth of every person and respect the human rights expressed in the United Nations Universal Declaration of Human Rights and in *Victoria's Charter of Human Rights and Responsibilities Act 2006* (Family Safety Victoria 2019a, p. 26).

### Cultural safety

Delivering culturally safe services is everyone's responsibility. To be culturally safe, services need to pay attention to the political and social conditions that shape health and wellbeing. This means considering people's living conditions and how these link with risk factors to produce people's experiences of health and wellbeing. It includes an awareness of how experiences of personal and structural violence shape people's experience of the world. We must recognise the unintentional harm that services, policies, procedures and practices can cause when cultural safety is not thoughtfully considered (Varcoe et al. 2016).

The bio-psycho-socio-cultural-spiritual model (Box 1) is a helpful way of framing the interplay of factors that shape health and wellbeing. Culture is an important part of the model.



### Box 1: Bio-psycho-socio-cultural-spiritual model

The bio-psycho-socio-cultural-spiritual model comes from the bio-psychological model of health and illness. This was first derived by George Engle in the early 1960s. The model proposed that biological factors alone do not determine the cause, manifestation and outcome of wellness and disease. Instead, it is the interaction between biological, psychological and social factors. The model developed over time in the health and mental health fields to include spiritual factors and, more recently, cultural factors. This holistic approach encourages us to consider the social relationships and wellbeing of the person within a broader fabric of their family and community. The cultural domain includes thinking about a person's sense of culture, their response and belief about mental illness/stress and the impact of the majority culture on their cultural values and beliefs. The spiritual domain is about the client's practices and beliefs that support a sense of spiritual connection with their country, ancestors, community, prayer, dance, meditation and music. The model focuses on the whole of the person and the interaction between mind and body. In a social work context, the models offer a framework for gathering, sorting and documenting information about the various systems that affect a client's life. Considering all the domains offers an understanding of the client's unique lived experience. It not only identifies the presenting problem but also a client's strengths and resources for their recovery (Schultz et al. 2014).

### Aboriginal cultural safety

The right to cultural safety in daily relationships and community life, service and education settings and workplaces is critical. Safe systems and structures, built on access, equity and inclusion need to be in place, with Aboriginal and mainstream services accountable for providing Aboriginal Victorians with culturally safe, appropriate and sensitive responses (Dhelk Dja Partnership Forum 2018, p. 31).

Australia's history of colonisation and discriminatory policies continue to impact the health, safety and wellbeing of Aboriginal and Torres Strait Islander peoples. This includes overrepresentation of Aboriginal children in care. A lack of cultural safety, and fear of child removal are seen as critical barriers to Aboriginal people accessing services. Therefore, our systems, services and the people delivering services, need to be experienced by all Aboriginal and Torres Strait Islander peoples as culturally responsive and culturally safe. Culturally safe organisations ensure their staff and volunteers regularly take time to reflect on how their own beliefs, values and behaviours impact on the safety of others. It is vital that those working in organisations are educated to understand the history, different experiences, languages and customs, strengths, resilience and self-determination of Aboriginal and Torres Strait Islander peoples. Culturally safe practices and programs are those that are understood by Aboriginal and Torres Strait Islander peoples to do no further harm, are effective, facilitate healing and recovery, and promote stability in people lives.

A culturally safe and racism-free health and human services system is one in which people feel safe, where there is no challenge or need for the denial of their identity, and where their needs are met. A culturally responsive health and human services system is one in which non-Aboriginal people take responsibility to understand the importance of culture, country and community to Aboriginal health, wellbeing, and safety, by working with Aboriginal communities to design and deliver culturally responsive services (Department of Health and Human Services 2017, p. 45).

### Aboriginal self-determination

Aboriginal self-determination means 'exercising true freedom, full and total control of our own safety, healing, connections to land and culture, communities, futures, and lives' (Dhelk Dja Partnership Forum 2018, p. 20). Aboriginal self-determination can be understood as 'a systemic shift' in the way services have traditionally been offered 'that requires the transfer of power, control, decision making and resources to Aboriginal communities and their organisations' (p. 13).

Self Determination is an ongoing process that ensures the continuance of choice, participation, decision-making and control over one's destiny: it involves the freedom to live well, humanly, and respectfully according to values and beliefs. It includes the notion of collective identity for Aboriginal peoples. It requires recognition and support with appropriate representation at all levels of society (Department of Health and Human Services 2018, p. 13).


### Children's rights, safety and wellbeing

Children have the same rights as adults and some other rights due to their vulnerability as set out in the United Nations Convention on the Rights of the Child (United Nations General Assembly 1989). As a party to this treaty since December 1990, Australia has a duty to ensure all our children enjoy the rights set out in the treaty.

They are further protected in Victoria under the Best interest principles, sections 10 and 12 of the *Children, Youth and Families Act 2005* (State Government of Victoria).

Some children are unable to live with their parents and may reside in alternative care.

**Every child, every chance**, Victoria's charter for children in out-of-home care (State of Victoria 2007), identifies rights to be respected. These rights are reflected in 'I' statements used throughout this framework.



**Seeking, listening to and acting on the voices of children and young people recognises and respects their unique and valuable insights, knowledge and expertise in the services we provide. It is the best way to ensure we are delivering high quality services that achieve positive and meaningful outcomes for children, families and the wider community (Department of Families, Fairness and Housing 2022).**

To promote children's rights, safety and wellbeing, this framework follows these principles that support children to safely and successfully take part in matters that affect them:

- 'Children and young people have human rights, including the right to make decisions and to have a say in the decisions that affect their lives.
- Hearing and acting on the voices of children and young people is essential to their safety and for the quality and safety of services.
- Children and young people have experience and expertise to share.
- Seeking, listening to and acting on the voices of children and young people is part of everyone's role.
- The voices of children and young people are diverse. All children and young people are valued and respected, and their differences appreciated.
- The voices of children and young people lead to positive action.
- Children and young people know how they can participate and are engaged in ways that make sense to them.
- Participation promotes a strong voice for Aboriginal and Torres Strait Islander children and young people.
- Children and young people are informed and understand what it means to participate and how their participation will link to outcomes.
- Child and youth participation is ethical, accessible, inclusive, safe, and culturally, linguistically and religiously appropriate.
- Participation is sought from children and young people with lived experience' (Department of Families, Fairness and Housing 2022).



### Value of lived experience

Every person is the ultimate expert on their own life and there is no greater source of information about the quality and the physical, emotional, and cultural safety of health and human services than the experiences and views of people who have used these services. This framework recognises and honours the expertise of each person in relation to their own life experience, safety, and wellbeing.

### Intersectional view

Intersectionality is a concept for understanding how power and privilege is used to either support or disempower marginalised people. It is not an identity (or intersecting types of identities), nor is it a set of characteristics that creates siloed approaches to policy development and service provision. Intersectionality is useful to centre the voices of people who have been systemically marginalised. It is a way for us to assess and reflect on power and privilege in relationships, social institutions and structures.

Taking this view means challenging and advocating for change to structures and systems of inequality. It is a way of understanding our own circumstances, experiences and position of power and privilege within society. It should not be used to focus on an individual being vulnerable or at risk, nor to assume that barriers to help-seeking are set. Intersectionality is not a way to list and determine who is most discriminated against, nor is it a generation of categories and rank of oppressions. Taking an intersectional view means seeing circumstances as contextual and dynamic. It requires engaging in ongoing self-reflection and analysis of power dynamics.

(Adapted from: Family Safety Victoria, unpublished, p. 26)

## **Do no further harm**

This principle applies to all exchanges and decisions. It recognises that what we do and say could cause harm. Sometimes the systems designed to help and support people can cause unintended harm. Service involvement can be distressing, triggering memories of past trauma and wrongdoing. Re-telling one's story over and over is also re-traumatising. Teamwork and good communication promote meaningful service delivery. Being respectful of rights, culture, gender, other identities and family relationships does too. We show the concept of 'doing no further harm' by being curious and respectful, keeping appropriate boundaries and maintaining client privacy.

## **Perpetrator accountability**

People who use violence in intimate partner relationships often report a previous trauma history. A trauma-informed approach is helpful when working with perpetrators of family violence. It may lead to better engagement (State of Victoria, Expert Advisory Committee on Perpetrator Interventions 2018). Focusing on the trauma histories of people who use violence without upholding accountability can risk justifying, minimising or reinforcing violent behaviour. Using violence is a choice. Practitioners must remember that the person using violence remains responsible and accountable for using violence. Understanding the powerful emotions linked to violence does not justify violence of any kind. Shame can be a powerful emotion for both people using violence and victim survivors. It can manifest in a range of ways. Offering trauma-informed responses to people using violence does not change the need to ensure trauma-informed responses are available to all victim survivors.

## **A note about language**

The term perpetrator is used at a legal and policy level in Victoria, it is not used in direct practice. Aboriginal people and communities may prefer to use the term 'people who use violence' rather than perpetrator. When discussing violence across a range of identities and communities, the term 'person using family violence' can be used.

The term perpetrator is not used to describe young people who use violence. Family violence used by young people is a distinct form of family violence and requires a different response to adults. This is because of their age, developmental stage and the possibility that they are also victim survivors of family violence (Family Safety Victoria 2019b). Young people who use violence towards family members and intimate partners benefit from a developmental approach and models of care that include their family and caregivers.

## Section 2: Applying the framework to practice

This section outlines trauma-informed practice when working with each other and with service users. It brings together the information from Section 1 to inform how we approach our day-to-day work. It does this by drawing on consultations with consumers and health and welfare professionals as well as a literature review. It lists common questions and considerations that practitioners, parents, children and families will find helpful when working together.

### Domains

Several themes feature across the literature on trauma-informed practice. Our consultation with people involved with services supported these. The framework arranges the themes into domains of practice:

- knowledge and understanding
- safety
- relationship-based and collaborative
- client voice
- holistic approach
- focus on wellbeing
- reflection.

The domains of trauma-informed practice explain:

- how service users experience the service system
- how services need to respond to create helpful and healing experiences for people
- how practitioners will work in trauma-informed ways
- how service leaders will work in trauma-informed ways to support workforce and clients
- how the system supports positive experiences for all people involved (including people using services and people working within services).

The domains should be reflected in system reform, organisational culture and service leader responsibilities. The domains help identify strengths and gaps in practice.

We should use them:

- when creating safe spaces
- when developing policies and procedures
- as a tool for reflective practice and supervision of practitioners.

### Domain – Knowledge and understanding

Trauma-informed practice begins with two things. The first is the needs of people who have experienced, or are experiencing, trauma. The second is service providers having the knowledge, skills and confidence to respond to those needs in a way that promotes:

- safety
- healing
- recovery.



This includes knowledge of:

- how common the experience of trauma is in our community and in our service system
- ways of coping and how a person's challenges (or resistance to accepting support) might be their way of adapting to overwhelming life experiences
- how a service or practice might be triggering or harmful, increasing the risk of re-traumatisation, and how to best prevent this from happening
- how sometimes practices such as child removal may be unavoidable and, at these times, knowledge and understanding is used to do everything possible to promote safety and minimise re-traumatisation
- how trauma experience includes secondary impacts of traumatic events such as grief and bereavement following death or feelings of loss or abandonment when relationships change
- common ways people adapt to trauma and the long-term impacts of trauma that are reflected in their behaviour.

For both practitioners and service leaders, this knowledge and understanding should be used for:

- awareness raising within and beyond the service environment
- information gathering to understand the unique risks and needs of a person or family presenting to a service to reduce the risk of re-traumatisation and promote recovery
- making culturally appropriate information available in multiple languages about the effects of trauma and supports available to promote healing and recovery.



## What does knowledge and understanding look like?

All people working in services for and with children, young people and families, regardless of their position, need to have a basic understanding of trauma and its impacts. This means assuming services users have experienced trauma. It means understanding that people may be affected by these experiences in many ways. This includes knowing that responses to trauma can often include differences in the way people:

- perceive things – for example, a loss of trust in other people, a feeling that the world is not safe
- behave – for example, difficulty staying calm, sensory triggers such as sight, sound and smell, appearing agitated, aggressive, alert to perceived threats (hyper-arousal), or appearing disengaged, unmotivated or unresponsive (hypo-arousal)
- process information – for example, trouble using language to describe trauma, difficulties with attention, concentration, memory and learning (MHCC 2018).

## Reframing problems

People who experience trauma develop and adopt ways to manage and survive overwhelming life experiences and adversity. Surviving a trauma experience is a strength, and the trauma survivor's experience should be respected and validated. Sometimes ways of coping may become a problem in themselves. For example, a person may use substances to cope with distressing life circumstances. The person may then need support to manage their substance use. However, the substance use is only the presenting problem and does not reveal the trauma experience. In the same way, when children, young people or adults show behaviours of concern, this may be an understandable response to traumatic life experiences. Attempts to stop this behaviour without considering the origins and purpose of the behaviour is likely to be unsuccessful. It may cause more harm.

## Avoiding re-traumatising

Nursey and colleagues (2015) found that many common policies, practices and service environments unintentionally can cause distress for people, triggering a trauma response. Aspects of services that might trigger trauma responses include:

- physical aspects, such as the layout or lighting, or lack of privacy of consultation rooms and access to bathrooms
- routine procedures, such as assessment with a style of questioning that may feel like an interrogation
- not listening, understanding, believing, validating and empowering people to make choices
- power dynamics – for example, the client–practitioner relationship may mirror a victim–perpetrator relationship because the practitioner may hold more decision-making power.

## All people working in services for and with children, young people and families, regardless of their position, need to have a basic understanding of trauma and its impacts.

Other factors that may be re-traumatising include:

- circumstances, such as abrupt or frequent changes in staffing (and loss of valued connections with service providers), limited choice, arbitrary rules and dependence on a service (MHCC 2018)<sup>1</sup>
- restrictive practices, such as restraining someone who has experienced interpersonal violence or seclusion of someone who has been neglected as a child (SAMHSA 2014, p. 10).

These experiences can be profoundly disturbing and distressing for service users. They can worsen trauma for those who have lived experience of previous or current trauma. Setting up respectful, trusting, empowering and safe interpersonal relationships can have a positive impact for the person seeking support. Practitioners can also use psychoeducational approaches to support people to understand their own trauma (or that of a family member/partner/child they are caring for) and to identify their triggers, feelings and coping strategies (Lukens & McFarlane 2004). Psychoeducation includes both educational and therapeutic techniques. The educational part offers information and care strategies in response to a life challenge (for example, a trauma symptom, a trigger, a behaviour or a diagnosis). This way, people have a frame of reference for their experience. The psychotherapeutic part offers safety, structure, feedback and time for people to absorb information that may be unfamiliar and challenging and may trigger complex emotions.

The balance between the two techniques helps people to increase their own understanding of, and responsibility for:

- tracking symptoms and triggers
- placing personal adaptive behaviours and response patterns in context
- processing complex emotions
- building coping and wellness skills that promote hope and that can be applied in everyday circumstances.

Psychoeducation can be offered individually, in groups, with families, or with multiple family groups. It is also used to train professional, para-professional and peer providers.

Offering information about trauma and its impact on health and wellbeing, as well as the range of options and supports available to support healing and recovery, can help people to understand how their experiences of trauma might be affecting them or their family members, and what support they can receive.

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<sup>1</sup> Trauma can have an adverse impact on early attachment relationships. The changes that affect service provider–user relationships may leave the person feeling abandoned, neglected and distressed.

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## How does it feel for people with lived experience?



- I am not defined by my trauma experience
- I don't feel like a problem to others.
- I know I will be listened to and believed.
- I know that information about me will only be shared to help me.
- I can tell someone if I am unhappy.
- I can talk about bad things that have happened to me in the past or are happening now.
- I understand that the feelings I have may be felt by others, but my own experience is unique.
- I and my family, community and culture are seen as solutions.
- I know that connection to my Aboriginal cultural heritage is central to my identity and a necessary part of my support and healing.
- I am given the information and supports that make it easier for me to communicate and engage with my workers and others around me.

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## What does this mean for a practitioner?



- I assume that everyone may have experienced trauma at some point in their lives.
- I prioritise meeting basic needs to begin to heal and recover from trauma.
- I expect to come across people with lived experience of trauma that is affecting their health and wellbeing.
- I expect that behaviours that I experience as difficult or resistant might be expressions of survival, distress or lack of trust.
- I validate my client's trauma experience through simple messaging such as: 'I believe you', 'I'm glad you told me', 'I'm sorry it happened', 'It's not your fault' and 'I will help you' (Fanslow & Kelly 2016).
- I am curious about: 'What has happened to you?' 'How did it affect you?' 'What sense did you make of it?' 'What did you have to do to survive?' (Johnstone et al. 2018, p. 9).
- I share feedback about client experiences with my organisation for continuous improvement.
- I write case notes, reports and letters in a way that, on reading them now and in the future, a client would experience them as helpful, respectful and meaningful.
- When working with children and young people, I remember that children often blame themselves for things going wrong. I let children know that they are not going to get into trouble for telling me about their experiences.
- I consider there may be patterns of trauma experienced by a family over time and over generations.



## What does this mean for a service leader?

- I implement best practice processes for screening, assessment, case planning, case coordination, secondary consultation, warm referral and client feedback.
- I implement confidential processes for regularly receiving staff and client feedback for continuous improvement.
- I build client education (psychoeducation) into the service model. This includes ensuring:
  - there is information available in multiple languages
  - the service is committed to clients' informed consent
  - service offerings are clear to all clients
  - our service is connected to the broader system of support.
- I ensure the programs we deliver are evidence-informed, drawing on lived experience, practice expertise and research evidence. I make sure they are tailored to the needs and preferences of the client.
- I make sure staff have options for support, flexibility and accessibility in the workplace.
- I ensure trauma-informed practice is written into policies and protocols and as part of the service mission.
- I ensure all staff can engage in learning and development around trauma and trauma-informed practice including non-client facing staff.
- I make sure staff ask questions about the impact of the COVID pandemic or other significant events on peoples' preferences for service access and any barriers to this they may have.
- I understand the positive and protective factors of Aboriginal connection to family, community, culture and land. I engage in my own cultural learning to support a culturally safe workplace and service.
- I ensure my organisation includes the department's Aboriginal and Torres Strait Islander cultural safety framework into ongoing professional development where required (Department of Health and Human Services 2019b).





## What does this mean for the system?

- Funding is available to support trauma-informed practice in the form of:
  - lived experience co-design and expertise
  - staff training
  - peer support
  - staff supervision and support
  - client screening and assessment of risks and needs
  - referral pathways and partnerships
  - therapeutic interventions
  - continuous improvement and evaluation.
- Across the service system, there is consistency in practice and shared language and understandings about trauma.
- Across the service system, practitioners are trained in and deliver evidence-informed programs that are culturally safe and trauma-informed.
- Trauma-informed principles and capabilities feature in:
  - recruitment
  - onboarding
  - supervision
  - staff support
  - performance review.

## Domain – Safety

Our sense of safety is vital to our recovery from trauma and experience of wellbeing. This includes all types of safety:

- physical
- emotional
- psychological
- spiritual
- cultural

For a service to truly help someone, attending to their safety is the first priority. There may be aspects of the service that make a person feel unsafe.

**At the individual and systems levels, services working with children, young people and families should be alert to how the service experience could be made safer for people.**



## What does safety look like?

The service promotes people as the experts on their own lives. People feel heard and understood, without judgement. The service tailors to individual:

- needs
- preferences
- wishes
- aspirations
- circumstances.

People are supported to have their basic needs met. This includes adequate food, housing, childcare, mental health, financial assistance, accessibility assistance, technology and transport.

The service conveys respect for difference and diversity. It is inclusive, respectful and curious about what matters to the person. This is conveyed through:

- signs
- inclusion policies
- attention to service design
- arrangement of spaces
- the attitudes, language and engagement of practitioners with the people who use services.

The physical spaces make people feel at ease, with:

- comfortable places to wait
- clear directions and pathways to bathrooms
- culturally safe and inclusive play spaces for children
- warm lighting
- safe, private, quiet spaces in otherwise busy and noisy service settings.

Different people might be triggered by different sensory activations (such as noise, lighting, colours, smells and the appearance of other people). It won't be possible to predict every person's individual triggers. However, all attempts should be made to create warm, friendly, welcoming environments where people are acknowledged and spoken to with respect. We help people to feel that 'I am in the right place' and 'People here will help me'.

Choices are available wherever possible, for example:

- how someone chooses to identify
- the gender of the worker
- where they sit
- what they disclose
- which type of service they access
- how they want to share their story – verbally, written or visually (Short 2016), or for children, through play.

Where choice is not possible, we clearly explain what is happening, how decision making is occurring, and processes for complaining or objecting. Safety is prioritised.

Staff feel safe and supported to do their work in line with accepted policies and procedures. They receive:

- professional development
- practice resources
- opportunities for reflection through supervision and other formal and informal supports.

Each staff member's own sense of safety in the workplace is a priority. Mutually agreed strategies are put in place to achieve this.

**Organisational leaders take responsibility for a safe and productive work and service delivery environment. They schedule regular review, including feedback from service users, make necessary changes and take opportunities to enhance safety for staff and clients.**

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## How does it feel for people with lived experience?



- I feel that the people working with me show me respect and treat me well.
- I feel safe and trust that my workers/carers have learnt what safety means for me.
- I know where I am going to sleep tonight.
- I trust that when I have a problem, someone will help, and something will be done.
- I trust that staff will do what they say they are going to do. If they cannot or don't know something they will tell me.
- I know what to expect because this is a consistent, predictable environment.
- As a child, my right to play, to have fun, to be loved and to explore are respected, valued and prioritised as critical to my development and wellbeing.
- Adults caring for me set appropriate boundaries that consider my needs, support my safety and show good role modelling so I can learn to set boundaries for myself.
- Plans are made with and for me that alert others early to what makes me feel distressed or triggered. Plans are enacted in a way that best suits me and my wellbeing.
- I know that my mob and community are looking out for me. That helps me feel safe.



## What does this mean for a practitioner?

- I give people as much choice as possible about all aspects of service involvement.
- I remember that developmental stage is never a reason not to speak to a child about what is happening. Even small children can be spoken to and engaged in reassuring ways that help convey that there are people helping to keep them safe.
- I consider how some people might feel unsafe to engage and reflect on what I can do to make them feel at ease. I use language that is inclusive and aligns with what I am hearing.
- I observe and ask people about the things they know that help and the things they know make them uncomfortable or distressed.
- I use a calm, clear voice and open body language. I explain the purpose of any conversation or appointment and how long it is likely to take.
- I explain why notes are being taken and offer clients the opportunity to review the notes I've taken. It is important that they are accurate and relevant.
- I explain how services have helped people before and I offer peer support where available.
- I look for cues about how safe a child feels (if non-verbal or pre-verbal). I speak with their parent or caregiver about what I observe.
- I talk openly with a child or young person about their culture to help understand who they are and where they are from. I know that safety is increased when a person's connection to family, community and culture is strengthened.

### **When working with people from different cultures to my own:**

- I view the individual or family as the expert in their culture. I listen deeply, stay curious and open to learn more about their culture.
- I understand there are many reasons why some people may not know a lot about their community or their culture.
- I reflect on how I can hold an attitude of cultural humility. I do this in seeking to understand a family's cultural identity, ethnicity and language preferences.
- I reflect on my own world view and cultural values. I question my own assumptions and check these with the client and other practitioners.
- I try to understand cultural norms and cultural practices of the clients I am working with.
- I am attentive to the ways my facial expressions, body language and word choices could be interpreted as racist or judgemental (Family Safety Victoria and the Australian Centre for Social Innovation 2018).
- I use an interpreter through an approved provider every time a client needs or requests one. I am guided by client preference for a phone or face-to-face interpreter service.
- I explore parenting practices and different care arrangements in people's country of origin to identify strengths, supports and protective factors.

### **For myself**

- I feel safe to speak up in my workplace and I feel comfortable to ask for help.
- I can make mistakes and, with support, learn from these experiences.
- My workplace understands the importance of safety and actively promotes this for staff and service users.



## What does this mean for a service leader?

- Our service has developed and signed a document about diversity and inclusion. We display this where people using the service and people working in the service can clearly see it.
- We give exit surveys to every person leaving the service. We review the information as a group (such as a quality governance group) to determine changes to improve the service.
- I encourage my staff to check in regularly with clients, including at each decision making point.
- I prioritise a consistent worker for each child.
- I ensure the physical environment promotes a sense of safety and warmth for staff and service users.
- I strive to be honest and transparent in all my communication.
- My leadership team regularly reviews every aspect of the service as to whether it is helpful or harmful – for example, by asking:
  - ‘Is this policy or rule necessary?’
  - What purpose does it serve?
  - Who does it help? Who does it hurt?
  - Does the policy facilitate/hinder consumer inclusion and control?
  - Were consumers included in its development?
  - Could this policy or rule re-traumatise the consumer?’ (Guarino et al. 2009, p. 35).
- I understand the effects the COVID pandemic and other significant events may have had on a person’s ability to make decisions about their safety. I encourage staff to discuss this and plan with their clients.





## What does this mean for the system?

- Movements through care options are potentially harmful for children. Ensuring safety, stability and permanency is an urgent priority for all children and young people.
- Attention is given to the unique strengths, risks and needs of people in rural and remote areas.
- Different mechanisms are in place to understand whether the system is 'safe' for those within it and can change to suit the individual or family's circumstances.
- Children's safety is prioritised across all services.

## Domain – Relationship-based and collaborative

Relationships are the basis of an effective service response. For people to receive a safe and helpful service, they must experience practitioners as:

- authentic
- attuned
- empathic
- trustworthy
- non-judgemental.

**A collaborative and partnering approach, which brings together lived experience and expertise with practitioner skills and knowledge, shares power while balancing risk.**

Trauma-informed interventions are relational interventions. They convey the importance of connection and relationship for safety and healing. Positive relational experiences are critical in assisting trauma recovery (Kezelman & Stavropoulos 2018).

Service users are key members of their care team. They experience the care team as willing and ready to work with them as equals. Service users' own views and preferences about their circumstances are sought in decision-making processes. Practitioners work with the person or family in ways that suit them.

### What does relationship-based and collaborative look like?

- Relationship building begins at the first point of service engagement.
- Start by asking 'What can I do to help you?'
- Information is shared between professionals to support collaboration.
- The views and wishes of the client are actively sought.

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## How does it feel for people with lived experience?



- I feel I matter. I have strengths and potential.
- I feel that people see me and hear me and listen to my story if or when I want to share it.
- I have the chance to repair things if I lose my cool.
- I feel connected to my family, my community and my culture.
- I am cared for and nurtured.
- If I am a child needing care, I am placed with my siblings, unless it is unsafe to do so.
- I get to build trusting relationships with workers/carers so I don't have to keep telling my story to new people.
- I am supported to stay in contact with my family, friends and people and places that matter to me. This includes supporting me in my grief when I lose someone close to me.
- I know who is looking after me and who I can trust.
- I trust that those around me will do a good job for me and work with me.
- People don't assume to know anything about me just based on my Aboriginality.

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## What does this mean for a practitioner?



- I find ways to reduce the power imbalances in the worker–client relationship.
- I work with people on building their support networks.
- I ask permission if I need to touch a person (child, young person or adult).
- I explain to clients how they can contact me.
- I understand the importance of safe, nurturing and responsive early caring relationships to lifelong health and wellbeing.
- I acknowledge the important role parents and caregivers play in children and young people's lives.
- When working with young children, I sit on the floor, talk and play with them at their level.
- I understand the risk of collusion when working with perpetrators of violence. I actively resist colluding and violence-affirming narratives.
- I look for relationships in a child or young person's life that are healthy and positive. I aim to strengthen them.
- I convey positive messages to children about them being loved and lovable.



## What does this mean for a service leader?

- I recognise the profound impact of early trauma, which can be lifelong.
- We review the service for risk of re-traumatising people through practices, language, decisions, and experiences of services that may worsen trauma and cause distress.
- We see relationships as the platform for wellbeing and healing. We structure service offerings around this understanding.
- I support and model a work culture that is collaborative and that values relationships.
- I see the potential in staff and aim to build their confidence and competence through opportunities for mentoring and working with others.
- I look for evidence of meaningful listening and a focus on strengths and resilience in service documentation. I conduct audits to explore the extent of this focus.



## What does this mean for the system?

- There is cross-sector collaboration, coordination and shared understandings of how to support people engaging with different parts of the system.
- The system recognises the complexity and harm caused by interpersonal violence and abuse, along with the potential for healing and recovery through safe relational experiences.
- The system enables relationship and connection through all services and modes of service delivery.
- Consistent, predictable interactions build trusting relationships across the system.

## Domain – Client voice

Client involvement is an essential ingredient of a quality service system and aligns with human rights to participation. It is the main source of information about the safety, quality and effectiveness of services. It is a vital part of program and system design and evaluation. The department's Client voice framework for community services (Department of Health and Human Services 2019a) advocates five key principles:

1. The client voice is essential for quality and safety.
2. Clients have expertise.
3. The client voice is part of everyone's role.
4. There are many client voices.
5. The client voice leads to action.



The experiences people have when they use community services are the richest and most important source of information about the quality and safety of those services. Actively empowering clients to have their voices heard, to make informed decisions and to have real influence leads to services that are better tailored to individual needs, preferences and values. It helps prevent avoidable harm and results in better outcomes. When we seek, listen to and act on the client voice, we can make real and lasting improvements in ways that matter most to clients (Department of Health and Human Services 2019a).

When accessing client voice through consultation and involving people with lived experience in policy and program design and development, it is essential that this is done in trauma-informed ways. This means that attention is paid to meaningful engagement, consideration of time and contribution, awareness of and strategies to address power imbalance, and avoid re-traumatisation.

Everyone benefits when services are co-designed by those with lived experience. Including the client voice in design, development, delivery and evaluation is becoming more commonplace in health and human services. Dedicated funding is often part of a program budget.

### **What does client voice look like?**

- Lived experience roles, panels, recruitment panels and consultation with remuneration.
- Peer workers employed by organisations and provided with appropriate support such as:
  - appropriate remuneration
  - access to safe and appropriate training and professional development
  - career development opportunities
  - access to external supervision.
- Recognising there is not only one journey to recovery, but there may be things that can be learned from other people who have had similar circumstances.
- Seeking feedback to understand whether it is genuinely safe for people with lived experience to speak up and be heard within the service.

**When we seek, listen to and act on the client voice,  
we can make real and lasting improvements  
in ways that matter most to clients  
(Department of Health and Human Services 2019a).**



## How does it feel for people with lived experience?

- I am visible, people listen to me and I feel understood.
- I am recognised as the authority about my life and my experience is acknowledged as valuable.
- I am an expert voice in shaping programs and services and I am supported when sharing my views.
- I am celebrated for my resilience and supported to keep well.

The service gives me options to safely express when it is not working for me such as:

- feedback mechanisms
- options to change practitioners
- flexible access.
- I am asked about my thoughts, feelings and experiences.
- I can choose which services best meet my needs and make me feel culturally safe.
- I feel proud of being Aboriginal and strong in my own culture.
- I have opportunities to use my voice to advocate for change.



## What does this mean for a practitioner?

- I invite clients to let me know of their preferred ways of communicating. These may be non-verbal and require communication aids.
- I start thoughtful, reflective conversations with clients and peer workers about my practice.
- I invite feedback on people's experiences of me as a practitioner.
- I ask people leaving the service if there was anything they would change about the service they received.
- I know that cultural ignorance can be unsafe and harmful for Aboriginal people. I do my best to be informed and to ask Aboriginal clients and colleagues about culture and identity and what I can do to work in culturally safe ways.
- It is a priority in my work that I accurately reflect an Aboriginal person's cultural identity in the documents I prepare.
- I keep the child at the centre when working with parents and caregivers.
- I work with children and young people in developmentally appropriate ways and using their preferred means of communication such as play.
- I support children and young people to take part in discussions and decisions about their life.
- I explore with children their feelings, worries and wishes.



## What does this mean for a service leader?

- I support staff to take the time to explore children's preferences and wishes and worries. I use verbal and non-verbal means, such as visual or technological aids.
- We review all policies and procedures to ensure they don't interfere with the rights of the child or with children's wellbeing.
- We consider the risks and costs of not involving clients in service design and evaluation.
- I support co-design with lived experience consultants to develop, implement and review service environments, activities and processes (formal and informal). This is to ensure they reflect trauma-informed principles and practice approaches.
- I ensure staff have opportunities to identify any lingering impacts of the COVID pandemic or other significant events and access support for themselves.





## What does this mean for the system?

- Governance and leadership levels champion client voice and offer support and investment.
- Client voice and choice at all levels including:
  - program co-design
  - service delivery
  - quality assurance
  - cultural safety
  - peer support
  - workforce development
  - evaluation.
- Evaluation measures for trauma-informed practice are developed with people with lived experience.

## Domain – Holistic approach

People are usually engaging with a service based on one aspect of their situation, wellbeing or life. Sometimes people are engaging with several services, each for a different purpose or issue. However, every person is a complex mix of different qualities, aspirations and identities. As the bio-psycho-socio-cultural-spiritual model shows, taking a holistic view means understanding and flexibly responding to a person's culture, identity and context (Schultz et al. 2014). This includes understanding a person's unique lived experience and identifying a person's strengths and resources for their recovery, along with the presenting problem (Schultz et al. 2014).

### What does holistic approach look like?

- Not looking at the person only in the context of an episode but considering them more broadly, considering their story, history and experiences.
- Trying to understand how each person identifies.
- Using language and talking in ways that makes sense to the person.
- Considering the community and support network of each client.
- Actively supporting people to engage with other services, rather than simply referring them to other services.
- Collaborating with colleagues to draw on their knowledge, skills and expertise.
- Considering people's overall health and wellbeing.
- Considering the strengths and challenges of living in rural and remote areas.

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## How does it feel for people with lived experience?



- I feel like people see the whole of me, my whole story.
- I feel confident that I won't be discriminated against.
- People value the things that are important to me, the experiences I've had and the things I'm good at.
- I am not a risk.
- What matters to me is what matters to those working with me.
- As a child, I see a doctor, dentist or other health professionals to help me stay healthy and well.
- I am supported to receive the best possible education and training.
- As a young person, healthy choices are offered and modelled to me. Respectful guidance and support is given where there are concerns about me.
- I am supported to take part in family traditions and learn about and be involved with cultural and religious groups that are important to me.
- I am supported to develop life skills and grow up to become the best person I can.

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## What does this mean for a practitioner?



- I ask about accessibility: 'How would you prefer your services to work with you?', 'Do you need technology, aids, transport or support to go to appointments?'
- I consider the possibly long and disjointed journey that it has taken a family to get to this point.
- I consider, in assessments and ongoing work, the person and family within their context, including their:
  - culture
  - trauma history
  - experience of racism, inequality, and marginalisation
  - family history
  - family arrangements.
- I connect what I know about individual people and families with professional experience and knowledge, including that of people with lived experience.
- I know that Aboriginal people were more adversely affected by the COVID pandemic. This may have affected their health and disrupted connections with family, community and culture.
- I ask about what is important to each child, young person and family.
- I organise access to support for parents to ensure they can address issues that affect their child's safety and wellbeing.
- I use Positive Behaviour Support (PBS) to understand the child's behaviour and support better quality of life
- I work with people on their strengths, resilience, skills and potential.
- I consider ways to support families in their healing and recovery from trauma. I help them interrupt the possibility of intergenerational trauma.



## What does this mean for a service leader?

- Assessments in our service reflect a person's identity, views, needs, preferences and developmental age and stage.
- We consider the mix of young people in out-of-home care (encouraging safe and supportive relationships between peers).
- We promote safe, healing relationships with family, kin and community, particularly when working with Aboriginal children and young people.
- We connect people with services they need.



## What does this mean for the system?

- An integrated response across programs, service providers or sectors.
- A system response for people living in rural and remote areas considers community strengths and risks. The system adapts to ensure consistency wherever services are needed.
- If specific trauma responses are not available at a service, there is a referral pathway in place to enable client access.
- There are no wrong doors. People can receive an integrated service response wherever they present.

## Domain – Focus on wellbeing

Wellbeing is not just the absence of disease or illness. It is a complex mix of a person's physical, mental, emotional and social health factors. Wellbeing is strongly linked to happiness and life satisfaction. In short, wellbeing is how you feel about yourself and your life.

**A focus on wellbeing means services value and work towards the wellbeing of the people working within them as well as focusing on the wellbeing, healing and recovery of people using services.**

Many people will have contact with a service at a time of personal crisis or following many years of hardship. This should be acknowledged and validated. There is always hope that things can get better for a person or family.

This also means practitioners and service leaders look out for signs in themselves and others of vicarious trauma. There are many risk factors and protective factors. Services should consider these factors and create practices, systems and workplaces that are likely to prevent vicarious trauma.

## Common risk factors for vicarious trauma

- a stressful work environment
- high workloads
- lack of support in the workplace and inadequate supervision
- responsibilities outside of skillset and experience
- constant exposure to traumatic content
- poor workplace culture
- the worker's own lived experience of trauma
- pressure to work in ways that don't align with the practitioners' values
- difficulty defining boundaries
- lack of self-care.

## Common protective factors that can prevent and minimise the impacts of vicarious trauma

- self-care strategies
- staff support in the form of access to regular supervision, debriefing and individualised support
- a focus on strategies that improve staff wellbeing and build resilience
- leave planning
- understanding and recognition of the indicators of stress, burnout and vicarious trauma
- mechanisms to support staff to speak up about concerns and issues in the workplace
- clear communication about unacceptable behaviours and processes to respond to disclosures or complaints about workplace behaviour
- grounding exercises
- critical reflection.

## What does focus on wellbeing look like?

A focus on wellbeing means reflecting on the following questions:

- What is going well now for this person?
- When were things going well? What was happening then?
- What is right with this person?
- What is right with the system?
- What is next for this person?
- What does this person/family need to live well?





## How does it feel for people with lived experience?

- My worker understands what is going well for me.
- I can talk to my workers, carers and my mentor about things that are worrying me, and they listen.
- The people helping me are okay themselves. They keep themselves well so they can be emotionally generous with me and my family.
- This is a healthy place. People here treat each other well.
- I feel good when I come here or spend time with these people.
- I know how to improve and maintain my wellbeing because I have some self-care strategies and ways to relax when I am stressed.
- As a young person in care, careful thought has been given to where I will live so it feels like a home.
- I have fun. I do things that make me feel happy.
- I can relax and be myself without judgement.
- As a young person in care, I am supported in preparing myself to leave care and will be supported after I leave care.



## What does this mean for a practitioner?

- I regularly check in with myself. I ask myself if I am stressed. Am I holding tension in my body? How is what is happening in my work affecting me right now?
- I try to reduce sources of chronic stress and inequality in families' lives.
- I am open to developing knowledge and skills in how to support people through stress responses. These include de-escalation, grounding, mindfulness and relaxation techniques.
- I make hope for healing and recovery visible and evident when I record information.
- If I am not feeling hopeful, I reflect on the assumptions and beliefs I hold that are making me feel concerned for this person/family.
- I talk with a trusted peer or supervisor about my doubts and fears for this person/family.
- I have genuine, authentic conversations with clients to ask how they see the challenges, risks and problems as well their hopes and vision for their future.
- I remember that it is quality of time (not quantity) that makes a difference.
- I follow up with people to check in about how they are doing.
- I know that my organisation and my manager support me to prioritise my health, safety and wellbeing in the workplace. I am aware of the formal and informal supports available.

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## What does this mean for a service leader?



- I consider whether the families using the service might be experiencing racism, discrimination, inequality, or social exclusion. Is this affecting their wellbeing and their capacity to thrive in their relationships?
- I encourage and model self-care and the importance of focusing on health, safety and wellbeing in the workplace.
- I support and champion practices that create a positive and psychologically safe work culture.
- I am alert to signs of vicarious trauma or burnout among staff.
- I set up ways to routinely ask the workforce how I can help them to do their job better.
- I give role clarity and regularly check in about how clear people feel about their responsibilities.
- We develop common tools and resources to support staff to work in consistent ways.
- I ensure adequate staffing to reduce strain and stress, including backfilling vacancies.
- If staff ask for help, I respond in a non-judgemental way.
- I actively build a work culture that recognises and appreciates staff efforts. It is one that provides opportunities for peer support, supervision, debriefing, disclosure of family violence and support to manage the stress of workloads and work with trauma.

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## What does this mean for the system?



- Self-care is common, visible and celebrated at a systems level.
- Support is available, confidential and accessible.
- System level support and strategies assists services prevent burnout and vicarious trauma.

## Domain – Reflection

Reflective practice is the foundation of professional development – it makes meaning from experience and transforms insights into practical strategies for learning, growth and organisational impact. By deconstructing or ‘pulling apart’ experiences and critically examining each aspect, staff can gain further understanding to guide their decision making about what practice should be repeated or extended and what might be changed (Macnamara & Mitchell 2019, p. 6).

### **Reflective practice involves:**

- making sense of complex needs, situations and behaviours
- practitioners challenging their own beliefs and assumptions
- recognising the differences in power in relationships, particularly between people using services and people providing services
- developing insights into our own triggers, sensitivities and stress (Macnamara & Mitchell 2019).

### **What does reflection look like?**

- 'integrating activities into daily life on a routine basis which raise awareness, prompt critical analysis and aid self-management and decision making' (Macnamara & Mitchell 2019, p. 6)
- learning to pay attention to our thoughts, our assumptions, our reactions, our emotions and physiological changes in our bodies
- noticing patterns in how we are responding to types of conversations and situations
- reflecting on what we are thinking, we are saying and what we are doing.
- asking ourselves 'How is the practice consistent with our beliefs, values and services?' (Macnamara & Mitchell 2019, p. 3)
- finding meaning in the words and actions of others
- noticing what triggers create stress for self and others
- stepping back from day-to-day demands to think deeply about what is happening and why
- doing this work individually and with peers, supervisors and teams
- noticing gaps in practice that might require personal or professional development
- building emotional intelligence.

### **Why it is important?**

Macnamara and Mitchell (2019) highlight that reflective practice:

- prevents mistakes by taking time to reflect on what happened and why
- recognises that practice evolves over time as the evidence base changes
- prevents stagnation and complacency
- creates a curious and questioning approach that promotes reflection
- builds emotional intelligence (including self-awareness, self-regulation, self-motivation, social awareness and social skills)
- supports critical thinking
- slows down assumption making
- helps construct professional knowledge (Macnamara & Mitchell 2019, pp. 8–10).

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## How does it feel for people with lived experience?



- I feel supported.
- I can ask questions about things that are worrying me.
- I am supported to learn how to reflect on my own life experiences.
- I feel confident that the people working with me are trying to do their best to ensure their practice is safe for me.
- I work with practitioners who are curious, non-judgemental, interested and committed to their own personal and professional improvement.
- I feel that I can go at my own pace. I am not rushed to talk.
- My practitioner knows me well and takes time to understand more about me.
- There is a care team that works with me. Decisions are not rushed.
- The least intrusive and least restrictive options are made available to me.
- I am asked for feedback about the service I have received to improve it for others and to help me make sense of it for myself.

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## What does this mean for a practitioner?



- I understand that reflective practice is not a luxury. It is vital for a safe service and prevents mistakes that could harm people.
- I understand that my own views and beliefs are shaped by historical and cultural context.
- I prioritise opportunities to talk to my peers and supervisor to discuss the safety and wellbeing risk and needs of the people we work with.
- I accept that sometimes I might get things wrong. I use my mistakes to learn and grow.
- I continually reflect on language so it is non-judgemental, ethical and respectful.
- I seek expert advice to draw on specialist knowledge and experience.
- I am committed to promoting Aboriginal self-determination. I continuously reflect on my learning about Aboriginal history and culture.
- I consider how intergenerational trauma and lateral violence (community violence) may affect current family relationships.
- I use critical analysis and professional judgement.
- I look for support around the things that most worry me about my practice and about the service I provide.



## What does this mean for a service leader?

- I have an attitude of curiosity, interest and exploration.
- I role-model ethical and respectful behaviour.
- I regularly take time to reflect deeply about my own assumptions, beliefs and judgments in relation to my staff and the people, families and communities we work with.
- I give feedback, advice and support generously and respectfully to colleagues.
- I am generous in sharing my professional knowledge.
- I reflect on how the service is capturing a child's voice and supporting their participation.
- I am honest when I make a mistake and look for ways to improve.
- I repair things where there has been a conflict, whether with a colleague or a client.
- I reflect on how my organisation can support the principle of self-determination.
- I make reflective practice a standard expectation.



## What does this mean for the system?

- Reflective practice and supervision are provided.
- Opportunities to reflect and seek support are made available after incidents.
- There is continuous improvement monitoring in relation to trauma-informed practices to:
  - assess the level of embedding and effectiveness
  - identify gaps
  - find opportunities for ongoing improvement.



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## Conclusion

Becoming trauma-informed is essential for designing, leading and delivering services. The intention is to help and not harm, the people using the services and the people working within them. Becoming trauma-informed is an ongoing change process. There are deliberate and necessary actions at every level of the service system, from the individual practitioner (and other staff and volunteers who may or may not come into direct contact with clients), to service managers and leaders and system governance bodies. How the service or system makes people feel is critical to understanding whether there has been a shift to, and active maintenance of, trauma-informed practices.

Community services working with children, young people, individuals and families are uniquely positioned to:

- be informed by lived experience expertise
- continue to learn about and understand the impacts of trauma
- provide a safe workplace
- provide supports that are safe, enable choice and attend to client needs and preferences.

This framework is an invitation to all people working across the system to build a trauma-informed system and services. It invites us all to work in trauma-informed ways. It gives permission to make a real difference to how people feel by prioritising the safety, wellbeing, healing and recovery of many people in our community. A commitment to being trauma-informed can create better client experiences and outcomes. It can promote healthier and happier children and young people, individuals and families.



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## Appendix: Practice example

We have included a fictional case study based on how each member of a family and different people in the service system understand and experience trauma-informed practice. It begins with a young person who is a service user in the care system. It focuses on how he feels and what his expectations are of how people work with him and his family in line with the practice domains of this framework. Statements that reflect his parents' feelings and expectations of a trauma-informed approach and those of the staff in various services who are working with the family follow.

Key features of this practice example include working with families who have experienced the impacts of colonisation and discrimination, intergenerational trauma and recent family violence. It shows how members of a family may engage across numerous services and settings as individuals with unique risks and needs while being recognised and supported as part of a family and community with cultural identity and connection.

The case study shows how each domain can be applied when expressed as a feeling or an action that illustrates trauma-informed practice. If your service setting or area of practice does not appear in the examples below, a blank template has been provided at the end of this document for you or your service to complete.





## How does it feel for people with lived experience?

### Child's perspective

I am a 14-year-old Aboriginal boy who lives in residential care. I have not lived at home for two years now, and I have moved to lots of different houses. Sometimes I get in to trouble for doing stupid stuff. My dad is in prison and my brothers and sisters are in other houses. My mum loves us, but she can't look after us right now. I have a new sister that I haven't seen yet. I hope she is okay.

#### Knowledge and understanding

- I don't feel like a problem to others.
- I feel I matter.

#### Safety

- I can talk to my carers and my mentor about things that are worrying me, and they listen.
- I know my mob and community are looking out for me, and that helps me feel safe.

#### Relationship-based and collaborative

- I feel I am accepted by my workers, carers and community, even when I push them away.
- Me, my family and community are all part of my care team.

#### Client voice

- I am asked about my experience and views.
- I can choose the activities I want to do and be supported to take part in them.

#### Holistic approach

- My carers value the things that are important to me, the experiences I've had, and the things I'm good at.
- I am supported to be closer to my family, community and culture and do the things that protect my body, mind, spirituality and family relationships.

#### Focus on wellbeing

- My carers want to know what is going well for me.
- I have a cultural mentor who I can talk to.

#### Reflection

- I feel confident that the people working with me are trying to do their best for me.
- My family are proud to be Aboriginal and I am too.



## How does it feel for people with lived experience?

### Adult victim survivor – mother of a 14-year-old

I am the mother of four children. Most of them have been taken away from me. My husband has been violent towards me and the children for a long time. He is now in prison. I took drugs and drank so that the pain would go away. I am sad that I cannot look after all my children. I feel like a failure.

#### Knowledge and understanding

- I feel that those working with me are treating me with respect. They are interested in what matters to me.
- I and my family, community and culture are seen as solutions.

#### Safety

- I have a safety plan that is based on what I know keeps me and the children safe.
- I can choose which services best meet my needs and make me feel culturally safe.

#### Relationship-based and collaborative

- I want my children back in my care and I believe those working with me are helping me to work towards this goal.
- I am encouraged and supported to have regular contact with my children.

#### Client voice

- I am recognised as the authority on my own life.
- I can take part in meetings and decisions about my care and the care of my children.

#### Holistic approach

- I feel that the needs and risks of my whole family is the focus of those who work with me.
- My care team is helping to strengthen my and my children's connection to our family, community and culture.

#### Focus on wellbeing

- This is a healthy place. People here treat each other well.
- I am being supported in a range of ways. There is more than just a focus on my immediate presenting problems.

#### Reflection

- My worker takes her time with me. I don't feel rushed and I feel understood.
- I am supported by my care team who understand my hopes and dreams and help me to feel positive about the future.



## How does it feel for people with lived experience?

### Adult using family violence – father of a 14-year-old

I am the father of four children. I am in jail because I was abusive towards my partner. I was not working, and I drank a lot. I wanted to look after my family, and I was angry that I could not. My children are in strangers' care and I know my partner was drinking and taking drugs to escape me. She is a good mother. I am ashamed.

#### Knowledge and understanding

- I feel that those working with me are interested in what matters to me.
- I am encouraged and supported to maintain a relationship with my children even if I cannot see them.

#### Safety

- Staff do what they say they are going to do. If they can't, they tell me why.
- I know my children and partner have not been safe around me. I have a plan that I can keep to that ensures they will be safe.

#### Relationship-based and collaborative

- I feel I can talk openly about my use of violence and I won't be judged for it. My worker will help me see that I can be different and do things differently.
- I understand that to prevent me needing to repeat my story, those working with me will share information from others about my situation.

#### Client voice

- I am recognised as the authority on my own life.
- I can take part in meetings and decisions about the care of my children.

#### Holistic approach

- I feel that the needs and risks of my whole family is the focus of those who work with me.
- People working with me understand what I need to be well and supported.

#### Focus on wellbeing

- This is a healthy place. People here treat each other well.
- I feel better than I did when I first met these people.

#### Reflection

- I know that my violence makes it hard for some people to respect me. My worker challenges me about my behaviour and not about me as a person. I can see they want to help me.
- I am supported to reflect on my behaviours and make a choice not to use violence.





## What does this mean for a practitioner?

# Residential care worker's perspective

### Knowledge and understanding

- I expect that behaviours I interpret as difficult or resistant might be expressions of distress.
- I know that being connected to family, community and culture is a positive and protective factor for Aboriginal children.

### Safety

- I explain what is happening to the child and family in clear ways that consider what is developmentally appropriate and their preferred means of communication.
- I make the care setting homely and welcoming. I check in with each child about how they are feeling.

### Relationship-based and collaborative

- I look for ways to strengthen each child's connection to their family, community and culture.
- I work with the local Aboriginal organisation. This helps me provide the best care to the Aboriginal children in my care.

### Client voice

- I take time with each child to hear their views, worries, wishes and feelings. I validate their experiences, including their confusion, sadness, anger, fears and worries.
- I gently correct any racist, discriminatory or negative language about Aboriginal people even when expressed by an Aboriginal child.

### Holistic approach

- I examine all the information available to me about a person or family and reflect on how I can offer a trauma-informed response to their experiences.
- I know the name of the Traditional Owners whose land I am working on.

### Focus on wellbeing

- I plan activities that are age-appropriate, fun and support self-soothing and regulation.
- I actively use my self-care strategies and have learnt some grounding exercises (such as deep breathing). I use them often.

### Reflection

- I continually reflect on my language and that of others. I model non-judgemental, ethical and respectful language.
- I use reflective practice and supervision to talk about my practice and ways I can improve.



## What does this mean for a practitioner?

# Agency practitioner's perspective – working with the child

### Knowledge and understanding

- I think about the bias and negative stereotypes that I may unconsciously hold and challenge myself to think differently.
- I work with children and young people on their goals and their strengths.

### Safety

- I understand the importance of safe adults in children's lives.
- I aim to develop respectful and open relationships and when I make a mistake, I acknowledge this and seek feedback from the children and families I work with.

### Relationship-based and collaborative

- I use accessible and culturally appropriate services and ways to engage and involve children and families in discussions and decisions that affect them.
- I work with children and their parents/caregivers to ensure a focus on their relationship.

### Client voice

- I start thoughtful, reflective conversations with clients and colleagues. I stay curious at all times.
- I see the child and their family/caregivers as experts in their own lives. I learn from them about what works and what they want from the service.

### Holistic approach

- I consider, in assessments and ongoing work, the child and family within their context. This includes their culture, trauma history, experience of racism, inequality and exclusion, family history and caring arrangements.
- I seek out information about the physical, emotional, cultural and spiritual needs of each child and their family/caregivers.

### Focus on wellbeing

- I talk with a trusted peer or supervisor about my concerns and fears for the child and their family.
- I talk to a trusted peer or supervisor about how I maintain my own self-care and supports.

### Reflection

- I am aware of the power I hold in my position. I look for ways to reduce the power imbalance through respectful engagement, safe spaces and age-appropriate choices.
- I do not know all the answers, so I seek out opportunities to learn and aspire to continually improve the quality of my practice from a strengths and solution-focused perspective.



## What does this mean for a service leader?

# Child protection management and leadership perspective

### Knowledge and understanding

- I support staff to use evidence-informed practice that draws on lived experience, practice expertise and research evidence. This is tailored to the individual needs and preferences of the client.
- I regularly reflect on my own bias. I see connection to family, community, culture and land as strengths for the children and families we work with.

### Safety

- I prioritise the consistency of a practitioner for a child.
- I regularly review practice to look for opportunities to strengthen child safety and wellbeing in our work with families.

### Relationship-based and collaborative

- I work with senior staff to regularly review the team and office culture to understand any negative impacts on practice, language, decisions and the experiences of staff and service users.
- I am aware that silence and active listening are powerful forms of communication. I model this in my work.

### Client voice

- I recognise the benefits of integrating the voice of lived experience in our work to achieve safer outcomes.
- I listen to what clients tell us about the ways in which they would like to be supported in their healing and recovery from trauma. This includes relational ways of working with children and their caregivers.

### Holistic approach

I look for evidence in assessments that a person's identity, views, needs, preferences and developmental age and stage has been sought and considered.

I seek out programs and ways of working that support people from diverse backgrounds including those designed with:

- Aboriginal people
- people from culturally diverse backgrounds
- the LGBTIQ community
- people with disabilities
- other groups in the community that will benefit from co-designed, tailored responses.



### **Focus on wellbeing**

- I provide clarity about roles and responsibilities. I use staff feedback to support this understanding.
- I maintain an open-door policy. I give staff other options for support if they would like to seek support elsewhere. This includes peer support networks, wellbeing services and formal EAP processes.

### **Reflection**

- I provide regular opportunities for reflective practice, supervision, learning and development.
- I commit to my own learning about cultural safety and the cultural load that my Aboriginal colleagues may carry.



## What does this mean for a service leader?

# Agency management and leadership perspective

### Knowledge and understanding

- I know that the staff and volunteers in my agency are trying to do their best for service users.
- I reflect with our staff group that people who are afraid can act in ways that might appear aggressive, resistant or disengaged.

### Safety

- I support my staff to view placement matching in home-based care and residential care as critical to children and young people's safety and stability.
- As a leader in a mainstream service provider, I take responsibility for delivering culturally safe services to Aboriginal children and families. I encourage choice to engage with Aboriginal services.

### Relationship-based and collaborative

- I view respectful relationships as the platform for safe engagement, wellbeing and healing. I structure staffing and service offerings around this understanding.
- I acknowledge that as a non-Aboriginal person that I cannot understand or feel the impacts of colonialisation and inter-generational trauma. I am committed to listen and learn from community, staff and service users.

### Client voice

- I ensure client voice and choice is reflected in all we do by embedding lived experience expertise in:
  - program co-design
  - service delivery
  - quality assurance
  - cultural safety
  - peer support
  - feedback
  - workforce development
  - evaluation.

### Holistic approach

- I consider the mix and diversity of young people in out-of-home care settings to encourage safe and supportive relationships between peers.
- I arrange training and resources to be available to support staff to practise through an intersectional lens.

### **Focus on wellbeing**

- There are mechanisms in place for routinely asking the workforce how I can help them to do their jobs better.
- There is an active support network in place for Aboriginal staff.

### **Reflection – agency management perspective**

- I ensure reflective practice and supervision are provided regularly for all staff.
- I actively support Aboriginal staff to seek cultural supervision.





## What does this mean for a practitioner?

# Men's behaviour change program facilitator – working with Dad

### Knowledge and understanding

- I dispel myths about family violence and Aboriginal culture by explaining that non-Aboriginal people use family violence towards their Aboriginal partners and children.
- I challenge assumptions about who uses violence and who is a victim survivor to reflect the diversity of people our services support.

### Safety

- I consider the needs of the person before engaging with a program. This ensures they are ready and can fully take part in a program that is right for them.
- I understand that people who use violence may have experienced violence, abuse and trauma themselves. I consider their need for safety, including cultural safety.

### Relationship-based and collaborative

- I am clear about my role and the way I work to hold perpetrators to account while supporting them in their commitment to change their behaviour.
- I work with Aboriginal Elders and community to support Aboriginal people who use violence in ways that are culturally appropriate and safe.

### Client voice

- I start thoughtful, reflective conversations with clients and peer workers about my practice and ways I can improve.
- I see my clients as part of a wider network. I find ways to hear diverse voices of lived experience.

### Holistic approach

- I make assessments based on information from a variety of sources to guide what I know about a person or family. I reflect on the things I don't know and how I might find this information.
- I focus on people's connection to their family, community, culture and land because I know these are protective factors.

### Focus on wellbeing

- I have honest conversations with clients to ask how they see the challenges, risks and problems, as well their hopes and vision for their future.
- I promote self-care and responsibility for safety in all aspects of one's life to support personal, family and community safety and wellbeing.

### Reflection

- I reflect on how confident I am in my practice and look for opportunities to build more confidence and capability.
- I aspire to continually improve the quality of my practice.





## What does this mean for a practitioner?

# Specialist family violence worker – working with Mum

### Knowledge and understanding

- I support my client to understand her own trauma experience. We talk about how this affects her self-esteem, parenting, health and mental health.
- I talk in ways that hold perpetrators to account for their violence and abuse. I remove blame and stigma from victim survivors.

### Safety

- I ask: What helps you to feel safer? How can I support you to plan for your safety? Who do you trust? Who supports you?
- I support my client to recognise her strengths and resilience, increase her support network and make choices that feel safer for her and her children.

### Relationship-based and collaborative

- I work collaboratively and closely with other practitioners and with clients, their family and community.
- I understand the importance of working with other services for risk management and safety.

### Client voice

- When they are leaving the service, I ask clients to give confidential feedback on the service so we can learn and improve.
- I seek lived experience expertise to co-design, develop and deliver work projects.

### Holistic approach

- I connect what I understand about each person and family with their own understandings, and my professional knowledge and experience to inform an assessment of risk.
- I regularly review risk assessments because things can change quickly. I need to be aware of what is required to support my client's safety and to address her needs.

### Focus on wellbeing

- I remember that it is quality of time (not quantity) that makes a difference.
- I understand that Aboriginal wellbeing is different from mainstream wellbeing. I look for Aboriginal-led ways to promote wellbeing.

### Reflection

- I take pride in providing a service based on a contemporary understanding of trauma, child development and the importance of permanency for children and young people.
- I regularly reflect on issues of trauma and violence and how these affect individuals, families and whole families. I commit to reducing the incidence and impacts where I can.



## What does this mean for the system?

### Systems perspective

#### Knowledge and understanding

- Individuals, programs and services across the service system are doing their best for service users.

#### Safety

- Training, resources and supports in trauma-informed practice are available to all service providers.
- Different mechanisms are in place to understand whether the system is 'safe' for those within it and can change to suit individual, family or community circumstances.
- Children's safety is prioritised across all services.
- Safety, stability and permanency is an urgent priority for all children and young people.

#### Relationship-based and collaborative

- There is cross-sector collaboration, coordination and shared understandings of how to support people engaging with different parts of the system.
- The system recognises the complexity and harm caused by interpersonal violence and abuse, along with the potential for healing and recovery through safe interpersonal experiences.
- The system enables relationships and connections across all services and modes of service delivery.
- Consistent and predictable interactions are building trusting relationships across the system.

#### Client voice

- Client voice is championed by governance and leadership levels across the system via support and investment.
- Client voice and choice is promoted at all levels.
- Evaluation measures for trauma-informed practice have been developed with people with lived experience.

#### Holistic approach

- There are no wrong doors. People can receive an integrated service response wherever they present.
- If specific trauma responses are not available at a service, there is a referral pathway in place to enable client access.
- Whole-of-family approaches ensure each member of the family receives a service response.



### **Focus on wellbeing**

- Promotion of wellbeing across the system prevents harm and promotes healing and recovery.
- Self-care is common, visible and celebrated at the systems level.
- Confidential and accessible support is available across the service system.
- An integrated system enables services to put strategies in place to prevent burnout and vicarious trauma.

### **Reflection**

- Reflective practice and supervision are provided to staff across the service system.
- Opportunities to reflect and seek support are made available after incidents.
- Continuous improvement monitoring in relation to embedding trauma-informed practices is occurring across the service system.
- Service users are encouraged to reflect on their experiences with the service system.

## Blank practice example template

[If your service setting or area of practice does not appear in the practice example above, take the time to develop one that reflects trauma-informed practice for service users and service providers that is relevant for you or your service setting. The 'I' statements that you include can be drawn from client and staff feedback in your service. They should align with the principles and practice domains of the framework. Delete all text in brackets]

<insert whose perspective is reflected (for example, practitioner)> perspective

### Knowledge and understanding

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### Safety

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### Relationship-based and collaborative

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**Client voice**

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**Holistic approach**

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**Focus on wellbeing**

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**Reflection**

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