THE UNIVERSITY OF SYDNEY

Research Centre for Children and Families

# Developing a trauma-informed approach to birth family contact

Huddle 24 October 2019

## Background

Direct contact is the norm in Australia even when children will not be reunified with family. Despite this, evidence on the benefits of direct contact is mixed (Boyle, 2017). When it goes well, it supports identity formation, resolution of grief and loss, and positive attachment and offers children information to understand their family history and why they entered care. Knowing that their families are safe and still care about them can help children come to terms with their loss and promote placement stability (Neil, Cossar, Jones, Lorgelly & Young, 2011). Regular contact can also maintain positive relationships with siblings and grandparents (Cashmore & Taylor, 2017; Sen & Broadhurst, 2011). When contact does not go ahead as planned, children can feel rejected and disappointed and when it goes badly, it can undermine a child's sense of security and placement stability. Interactions at visits can be distressing if birth parents undermine carers, or provide promises and gifts that encourage idealisation. In extreme cases, covert abuse may occur at visits (Boyle, 2017).

The Children's Court makes decisions about contact that agencies then implement into concrete action plans which are reviewed at least annually. The Children's Court of NSW's contact guidelines suggest contact is better dealt with care plans rather than specific orders to promote flexibility (Marien, 2011). The challenge for agencies is to create plans that are dynamic and collaborative not procedural and combative. To embed relationship-building or repair into the fabric of contact and move children and families away from the adversarial processes that preceded it.

There is limited evidence about what helps professionals make children's experience of family time positive and enriching, what gets in the way and how to help adults overcome obstacles and find common purpose (Collings, Neil & Wright, 2018). This is a critical gap because children in care have invariably experienced trauma –either directly attributable to the abuse and neglect that led to them enter care or through separation from primary attachment figure, or both. Intergenerational trauma has an indirect effect on children by increasing a risk of social disadvantage within families and communities and compounding issues such as substance misuse, mental illness, family violence and homelessness, all of which increase the risk of child protection involvement. These factors continue to be reflected in the disproportionate removal of Aboriginal and Torres Strait Islander children from families (Australian Institute of Health and Welfare, 2018).

## What is the issue?

Whether children are placed with kin or in foster care, trauma history can impact on the ability of caregivers and parents to form or repair relationships that support children's sense of belonging, identity and safety.

Intergenerational trauma has a disproportionate impact on Aboriginal and Torres Strait Islander children, families and communities. Intergenerational healing can be hampered when contact practices are not trauma-informed.

## Practice development

Australian practitioners urgently need guidance to ensure that they are not implementing plans that undermine the emotional and physical wellbeing of children and lead to re-traumatisation. The challenge for agencies is to create plans that are dynamic and collaborative not procedural and combative.

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## Definition of Trauma

The most widely cited definition says individual trauma is a result of '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' (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 7). Footnote (+6pt before)

*"The professionals who assist child welfare in its work need to become proficient in childhood trauma and its impact, so they have the knowledge and skills to undertake their work in a way that promotes healing for children and families"* (Szilagyi, 2018, p. 10).

# Childhood trauma

The DSM-5 does not currently include a specific sub-category of developmental trauma disorder and lack of agreed diagnosis hampers treatment and support. It is widely agreed that exposure to trauma in childhood is particularly damaging as it interferes with critical developmental processes leading to lasting and profound impacts over the lifecourse. Physiological effects include impaired cognition, memory, arousal and attention which have flow on effects on social skills, identity formation and relationships (Tucci & Mitchell, 2015).

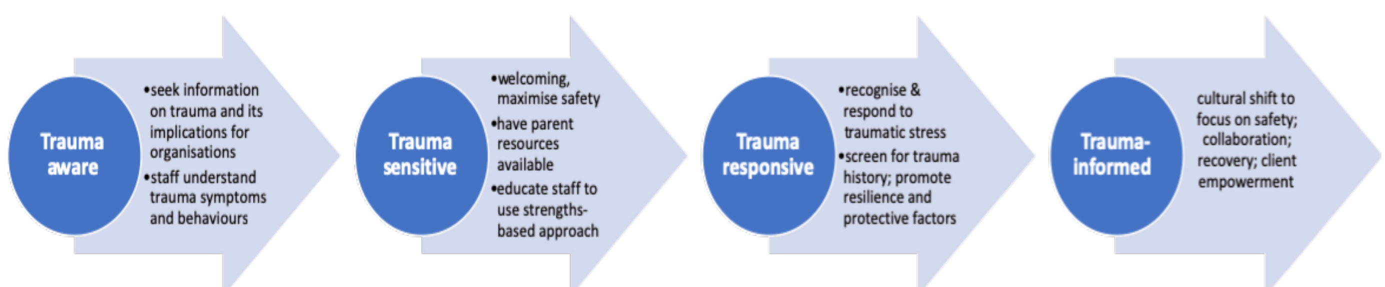
In their ground-breaking study, Felitti and colleagues (1998) identified an association between childhood experiences of abuse, neglect or household dysfunction and poorer health outcomes in adulthood, including higher rate of disease, high risk behaviours and premature mortality. In the decades since the Adverse Childhood Experiences Study commenced, the results have been replicated in a large body of international research, and resulted in early intervention treatments and practice frameworks for children and adult trauma survivors (Anda et al., 2006; Szilagyi, 2018). Responses to secondary or intergenerational trauma necessitate an ecological framework that sees children in the context of family and community, as well as distal environmental factors, rather than to simply focus on individual behaviours (Atkinson, 2013).

# Trauma informed practice

The United States led international efforts to incorporate trauma theory into mental health service delivery following growing evidence of the prevalence of trauma and mental illness comorbidity. Therapeutic treatment models tended to focus on addressing symptoms of acute traumatic stress and those suffering from chronic trauma needed help to rebuild a sense of safety and control (Carbonell & Parteleno-Barehmi, 1999). In fact, even trauma-specific services could inadvertently trigger traumatic responses in clients by exposing them to spaces and practices that undermined physical and emotional safety. This recognition led to efforts to create organisational responses that were attuned to signs and symptoms of trauma in clients, families and staff and oriented toward potential paths for recovery. Known as trauma-informed practice, this involves fully integrating knowledge of trauma into the decisions, policies, procedures and practices of organisations. Due to the pervasiveness of chronic trauma among its clients, child welfare services were quick to recognise a need to adopt trauma-informed practice (Donisch, Bray, & Gewirtz, 2016).

A model of trauma-informed practice developed by Misler and Myers (2013, cited in Wall, Higgins & Hunter, 2016) expresses this as a continuum in which services first become *trauma aware*, and start to plan and implement an understanding of trauma, its effects, and the importance of specialist services into their business operations. When services become *trauma-sensitive* they implement strategic training and workers adapt their practice to avoid re-traumatising clients, and when they become *trauma-responsive*, work takes place at a broader level to reorient services to address trauma. By the time an organisation is *trauma-informed*, trauma is no longer seen as something to be addressed as a separate issue and is instead integrated across the whole organisation (See Figure 1).

**Figure 1: Trauma-informed practice continuum (Adapted from Miesler & Myers, 2013 in Wall, Higgins & Hunter, 2016 p. 4-5*)***



## Building an evidence base

Trauma-informed practice is an emerging research field and lacks an established empirical base or an agreed practice model (Jankowski et al. 2019; Kerns et al., 2016). There is no clear definition of trauma-informed practice or set of agreed measures to test them, evident in the interchangeable use of terms like 'trauma-responsive', 'trauma-informed' or 'trauma-aware' in the literature. Internationally, there is also little evidence to support application of any specific model or empirical evidence of whether and how trauma-informed care influences child outcomes (Hanson & Lang, 2016). Australia lacks a coordinated approach to trauma-informed care, and there is no clear policy mandate or framework to guide evidence-based practice (Wall, Higgins & Hunter, 2016).

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### Well documented principles and processes include:

1. Plan for change at all levels of the organisation.
2. Provide ongoing staff and carer training to understand trauma-based behaviours.
3. Create physically, emotionally and culturally safe spaces for survivors.
4. Collaborate with survivors, families and other services on the healing and recovery process.
5. Recognise and respond to long-term impacts of violence on individuals, families and communities.
6. Reach agreement on definitions and standard measures to test practices.
7. Participate in research and evaluation to understand effective approaches and interventions.

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### Next steps

Trauma is central to the experiences of children in out-of-home care, including their experiences of face-to-face contact. The Huddle offers a chance bring together academic, legal and practice experts in trauma and out-of-home-care to brainstorm how to close the research to practice gap. The aim is to co-develop applied research on a practice approach to contact that is trauma-informed.

The Huddle will invite discussion on direct contact, including a comparison between Australian and Northern Ireland; the neuroscience and treatment of complex childhood trauma and what helps families and communities to heal; and what is needed to change practice and close the research to practice gap.

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**For more information**
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