Disability Guidelines for Trauma-Informed Practice

Supporting people with disability who have experienced complex trauma

Blue Knot Foundation

Dr Cathy Kezelman AM
Julie Dombrowski

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Authors: Kezelman, C.A. and Dombrowski, J. K.

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Disclaimer

This document is a general guide to appropriate practice. The guidelines are
designed to provide information to assist decision making and are based on the
best available evidence at the time of development of this publication.

Acknowledgements

Blue Knot Foundation (BKF) respectfully acknowledges the traditional owners of country throughout Australia and their continuing connection to land, waters and community. We pay our respects to First Nations peoples and their cultures, and to their elders, past, present and future. We acknowledge their strength and resilience to thrive as sovereign owners and are honoured to journey with them on the path to healing and reconciliation.

Blue Knot Foundation (BKF) is the Australian National Centre of Excellence for Complex Trauma, empowering recovery, and building resilience for the more than five million adult Australians (1 in 4) with a lived experience of complex trauma, their families and communities. Blue Knot is a thought, policy, training and practice leader in the areas of complex trauma and trauma-informed service delivery. In 2019 it was funded to deliver the National Counselling and Referral Service supporting people engaging with or impacted by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The scope of this service has subsequently expanded to additionally support people with disability with a lived experience of complex trauma – violence, abuse, neglect and exploitation, their caregivers, advocates and service providers.

We gratefully acknowledge the Department of Social Services who funded the development of these guidelines. These guidelines are an important step in further **supporting the disability sector to support** people with disability to overcome the barriers they often face to social justice and participation. They were developed over a 12-month period. It entailed a number of collaborative and consultative iterative processes with **people with disability,** caregivers, advocates, support workers and services, representing **diverse groups of people from within** the disability sector. The rich insights provided have **informed this guide, extending knowledge** from the relevant literature to identify practice tips and resources to enable better responses to people with disability who have experienced trauma.

We would like to acknowledge and thank the many people with disability, trauma survivors, caregivers, support workers, and advocates from across Australia who generously shared their experiences and insights to inform this work. They provided invaluable feedback on the content and format of these guidelines, which we have integrated into this document. We hope the guidelines will help provide the knowledge and skills needed to enable those working on the front line every day to empower people living with disability with experiences of trauma along their path to recovery from their trauma experiences.

Blue Knot Foundation

Formed in 1995, Blue Knot Foundation provides a range of services. These include:

- specialist trauma counselling, information, support and referrals
- educational workshops for survivors and their family members, partners and loved ones
- professional development training for workers, professionals and organisations   from diverse sectors
- group supervision
- consultancy
- resources including fact sheets, videos and website information at www.blueknot.org.au
- advocacy
- research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it. In 2012, Blue Knot Foundation released Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery http://professionals.blueknot.org.au/resources/publications/practice-guidelines/ These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice.

In 2015, Blue Knot Foundation released an Economic Report, The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts, and in 2018 the paper The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance of Trauma was launched and released.

In 2018-19, Blue Knot Foundation released its Talking about Trauma series. In 2019, it released its updated Practice Guidelines for Clinical Treatment of Complex Trauma and accompanying Complementary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma. Earlier in 2019-20, it launched its Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma and Dissociation and Practice Guidelines for Identifying and Treating Complex Trauma-related Dissociation. In 2021, Blue Knot released its updated Organisational Guidelines for Trauma-Informed Service Delivery. For more information, visit professionals.blueknot.org.au/resources/

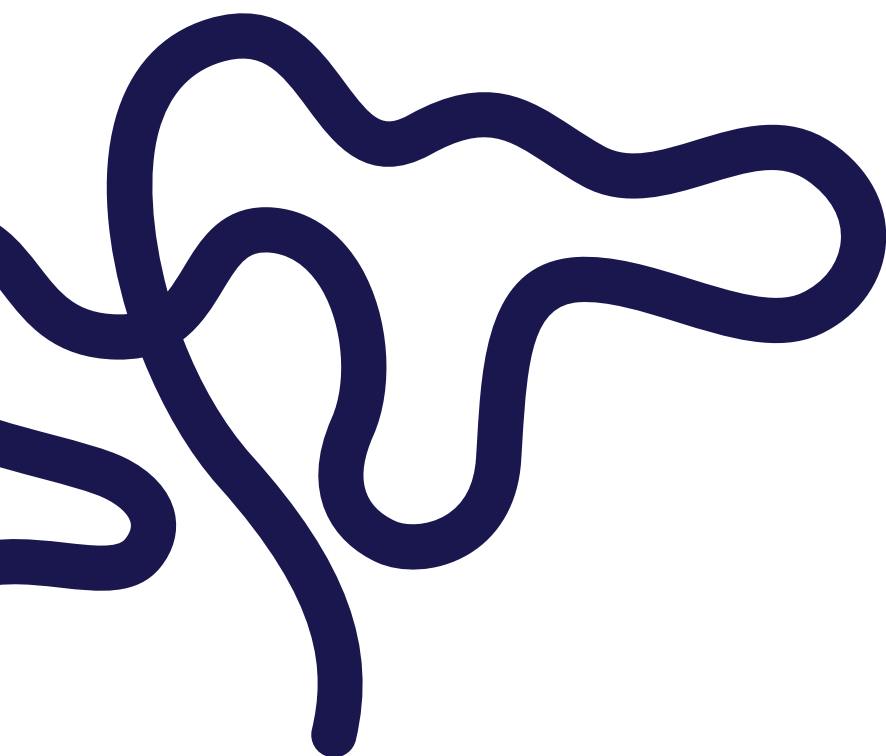If you are living with disability, you can receive support from the Disability Gateway by phoning 1800 643 787 between 8am-8pm Monday to Friday (see https://www.disabilitygateway.gov.au/).

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Introduction

Introduction

"Suffering is universal: you attempt to subvert it so that it does nothave a destructive, negative effect. You turn it around so that it becomes a creative, positive force.'

Terry Waite, trauma survivor (cited in Joseph, 2014)

Experiences of violence, abuse, neglect and exploitation can lead to long-term trauma impacts. Trauma can arise from something that a person does to another person at home or in relationships. This is called interpersonal trauma. It can also happen in services and systems, such as employment, education, medical, and legal systems and institutions. More than 5 million Australian adults are estimated to have experienced interpersonal trauma. Trauma that is repeated, extreme and ongoing is called complex trauma. Complex trauma from childhood events is common. Childhood trauma affects approximately 1 in 4 Australian adults and often causes a lot of harm (Kezelman, Hossack, Stavropoulos & Burley, 2015).

With violence, abuse, neglect, and exploitation, the harm can be intentional. That is, the person means to hurt the other person. At other times, a person does not mean to hurt the other person. This can happen if that person has their own trauma, and they are impacted by it. If a person caring for a child has their own trauma, they might not be able to support the child as well as they want to. This can happen if they have a mental illness or misuse alcohol or drugs. Sometimes the parent or caregiver might not have a safe or stable home or enough money. A child can also experience trauma from grief and loss. This can happen if a loved one dies, or if caregivers separate.

People can experience trauma at any age. Many people experience trauma across different ages. When trauma is experienced during childhood, it can still affect people when they are adults. People can also experience repeated ongoing trauma as an adult. People can experience abuse at home, school, workplaces, hospitals, prisons, churches, and anywhere else

in the community. Examples are domestic and family violence, school or workplace bullying, war and refugee trauma. Many people experience abuse and trauma in institutions and services. Some experience medical trauma. This can happen even when the treatment helps. Certain life situations can also make trauma more likely. For example, not having choices about where or with whom you can live. Sometimes trauma is caused by large systems or societal structures that are not sensitive to the needs of the people who are affected by the system. For example, this can occur in the justice, education and welfare systems.

Trauma can affect whole communities. It can also occur between generations. First Nations people have experienced a lot of trauma. This is for lots of reasons. Like the effects of colonisation and its policies. An example is the forced removal of children. This has broken important bonds between families and kin. It has also damaged connection to the land and place. This has caused a loss of cultural identity and safety, across generations. Prior to colonisation, there were over 65,000 thriving, sophisticated and sustainable cultures. Many different groups of people experience more trauma than other groups. For example, refugees and asylum seekers, and women. Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) people also experience more trauma than other people. This happens because of discrimination like homophobia or transphobia.

It is important to know that not every person who experiences abuse, neglect, exploitation or violence will experience long-term trauma impacts. Of those people who do experience trauma, many people can and do recover. Some First Nations people have demonstrated extraordinary resilience and resistance to ongoing trauma caused by discrimination, including racism and ableism. It is always important to acknowledge and celebrate the strengths of survivors and honour their choices around recovery. Some people experience considerable personal growth through the experience of trauma and develop breath-taking resilience.

People with disability experience and witness repeated trauma more often than people without disability (Jackson et al., 2015). Many children as well as adults with disability have experiences of repeated trauma. Many people with disability experience a lot of obstacles a lot of the time. People with disability who have experienced trauma

are disproportionately affected by systemic or structural inequalities. Experiencing trauma adds even more obstacles to living a happy, healthy and fulfilling life. Australian governments want to understand why people with disability experience more violence, abuse, neglect, and exploitation. Governments want to do something that will change this for the future. This is the reason for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

In April 2019, the Australian Prime Minister, Hon. Scott Morrison MP announced the Disability Royal Commission. It is called the Royal Commission into Violence, Abuse, **Neglect and Exploitation of People with Disability. The aim of this Royal Commission is to** help Australian governments, institutions, and the community to prevent and better protect people with disability from violence, abuse, neglect and exploitation. It is looking at all forms of violence, abuse, neglect and exploitation of people with disability. It is hearing from people with disability of all ages. It is also look at all settings and contexts including the family home.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability is covering what should be done to:

- prevent and better protect people with disability from experiencing violence, abuse, neglect and exploitation
- achieve best practice in reporting, investigating, and responding to violence, abuse, neglect and exploitation
- promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

There is more information on the Royal Commission into Violence, Abuse, Neglect and Exploitation of people with Disability at this website: https://disability.royalcommission.gov.au/

Purpose of these Guidelines

These guidelines have been developed to help support people with disability to recover from trauma. They are for people who provide support to people with disability. They are also for organisations that provide services for people with disability. The intended audience is very broad. The audience has a range of knowledge, needs and skills. It is not possible to fully capture the unique needs and experiences of each person with disability. It is also not possible to respond to the full breadth of need, knowledge and skill in one document.

These guidelines are not training documents for caregivers, support workers or advocates to become trauma-specialist therapists. Or to enable the provision of therapeutic services to people with disability who have experienced trauma. Rather, these guidelines aim to provide enough knowledge and practical skills to help people provide general support for people with disability who have experienced trauma. These guidelines also aim to provide organisations with an understanding of what is needed to genuinely deliver trauma-informed services for people with disability.

These guidelines are comprehensive but are not the sole solution to creating trauma-informed services. Rather they are an important first step to increasing awareness and capacity within the sector. Implementation of these guidelines will require ongoing training, appropriate funding and resourcing, and service and sector-wide support.
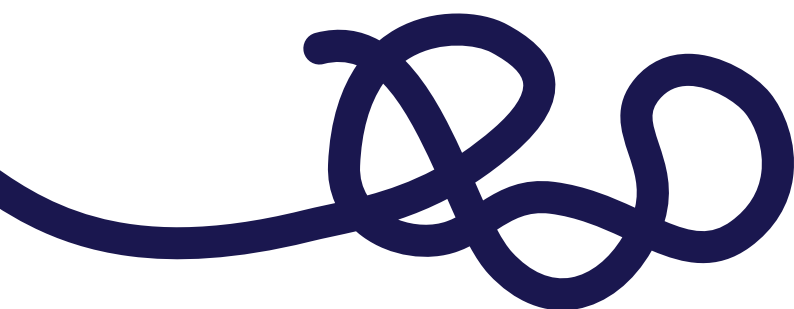
Language, Terminology and Definitions

Every attempt has been made to write these guidelines in simple and easy-to-understand language. This is to allow as many people as possible to read the guidelines. This document complies with Web Content Accessibility Guidelines. Throughout these guidelines, the following terminology is used:

Advocates are people who act, speak or write to support someone with a specific issue. Advocates are usually employed by an independent advocacy organisation to ensure any conflicts of interest are minimised. Advocates may have specific qualifications or training in this role.

Caregivers are often family members or friends who provide a range of care, assistance and support to people with disability. They are often unpaid. Caregivers may assist with a range of different needs, including personal care, transport, communication and social support.

Culturally and Linguistically Diverse (CALD) is the term that acknowledges the range of different cultural and linguistic groups in Australia. Culturally and Linguistically Diverse people may be born in a non-English speaking country or have a cultural heritage that is different to the dominant culture.

Deaf (with a capital D) is used to refer to those who use sign language such as Auslan and identify culturally as members of the signing Deaf community.

deaf (with a lowercase d) is a broader term than Deaf (with a capital D). It is used to describe people who are physically deaf or the physical condition of not hearing but do not identify as members of the signing Deaf community.

Disability is the result of the interaction between a person with impairment(s) and attitudinal, environmental or social barriers that compromise full, equal and effective participation in society.

First Nations people is the phrase used throughout the guidelines to reference Aboriginal and Torres Strait Islander people. This is consistent with the language used by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. However, it is recognised that the terms First Peoples of Australia and First Australians are also increasingly commonly used. It is also recognised that in situations in which a person's specific cultural group or mob is known, reference to the specific cultural group is preferred.

Impairment is a condition or personal attribute. For example, a cognitive impairment might relate to a condition or attribute that compromises memory, spatial awareness or planning. It is not the same as a cognitive disability, which occurs when cognitive impairments interact with attitudinal, environment and/or social barriers and prevent full and equal participation in society.

LGBTIQ+ is the internationally recognised acronym used for the Lesbian, Gay, Bisexual, Transgender and gender diverse, Intersex, Queer and questioning people.

Organisations (in the context of these guidelines) are those organisations or services that employ support workers or advocates or use volunteers to provide services for people with disability. Services are varied and may include personal care, housing, transport, social support, education, and legal services.

Person with Disability is the person-first language used throughout the guidelines to refer to people with disability. This is intended to convey respect and acknowledgement to not unnecessarily focus on a person's disability. However, it is recognised that this phrase does not fully capture all the unique differences within living with disability. It is also recognised that some people prefer identity-first language. For example, deaf person or autistic person.

Support Workers are contracted as paid or voluntary workers. They provide a range of assistance and support to people with disability. Support workers may not have any formal qualifications or training. They may be employed by an organisation or service or directly by the person with disability. Support workers may assist with a range of needs, including personal care, transport, communication and social support.

Supporters is the term used throughout the guidelines to refer collectively to anyone who provides support to a person with disability. This may include a caregiver, support worker or advocate.
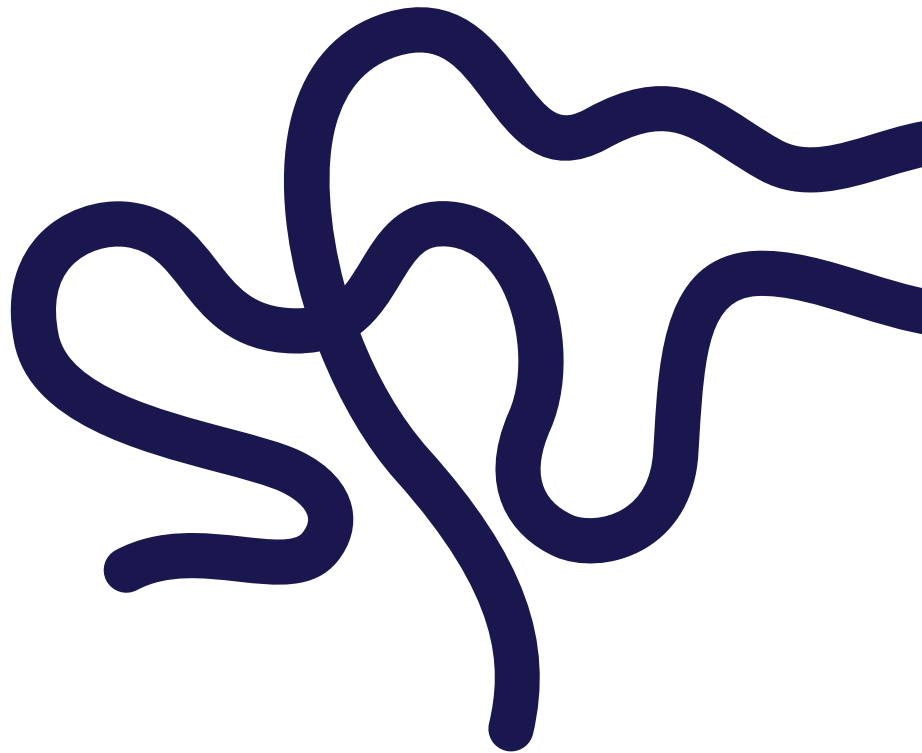
How to use the Guidelines

The guidelines are in three sections:

Knowledge Development

The first section provides information about disability and trauma.
This section provides information for individuals and services that provide assistance, support or advocacy for people with disability. This includes volunteers, caregivers, family and friends of people with disability who have experienced trauma. This also includes executive, managerial, supervisory and frontline workers who work for organisations that provide services to people with disability.

Skill Development

The second section provides information about practical skills that are needed to adequately support people with disability who have experienced trauma. This section provides information for people who provide support to people with disability who have experienced trauma. People who work in executive, managerial and supervisory positions for organisations that provide services can also read this section to gain a better understanding of the skills their workers need to provide trauma-informed support and how best to support frontline workers.

Support for the Supporters

The third section provides information on how best to support caregivers, support workers and advocates to provide trauma-informed support. Organisational responsibilities for providing trauma-informed workplaces and services are also highlighted.

Each section includes a summary of the information provided at the end of the section. Information about further resources and reading is also provided for those wanting to learn more about trauma-informed disability practice. Important information is highlighted in boxes with an icon for easy reference throughout this publication:

Knowledge Base
These boxes hold important information to know about disability and complex trauma.

Practice Tips
These boxes provide useful practical skills for supporting people with disability who have experienced complex trauma.

Service Tips
These boxes hold important information needed for a trauma-informed service for people with disability who have experienced complex trauma.

Additional training in key areas, ideally supported by reflective practice sessions and trauma-informed supervision, is important to embed the knowledge and practice tips presented in these guidelines and further support their application in practice. Blue Knot Foundation (BKF) provides professional development training in complex trauma, building trauma responsive services, leadership, and worker wellbeing including around vicarious trauma. The training offered can be tailored to the particular needs of the group, using case scenarios which can be workshopped to enhance skills. This provides opportunities for peer learning and exploration of specific questions that may arise from reading the guide. Individual training options are also available. **For more information see Blue Knot Foundation website** www.blueknot.org.au **and links to the Professional Community** professionals.blueknot.org.au

Case Studies

A number of case studies are used throughout the guidelines. These are to help illustrate the different needs and experiences of people with disability who have experienced complex trauma. Some of these case studies are drawn from first-hand accounts that people have provided to the Royal Commission into Violence, Abuse, Neglect and **Exploitation of People with Disability. Names have been** changed to protect the person's identity. These case studies are attributed accordingly. Some case studies have been written to demonstrate concepts and practice tips. They are fictional and have been developed in consultation with the reference group.

Content Warning

Please be aware that these guidelines contain information that may be distressing to some readers. This includes real and fictitious accounts of violence, abuse, neglect and exploitation of people with disability. Suicide and self-harming behaviours are also discussed. If any of the information included in these guidelines raises difficult feelings it is important to seek support. You may have your own support system you can access. You can also be provided with information and connected to counseling services through the Disability Gateway by phoning 1800 643 787 between 8am-8pm Monday to Friday.
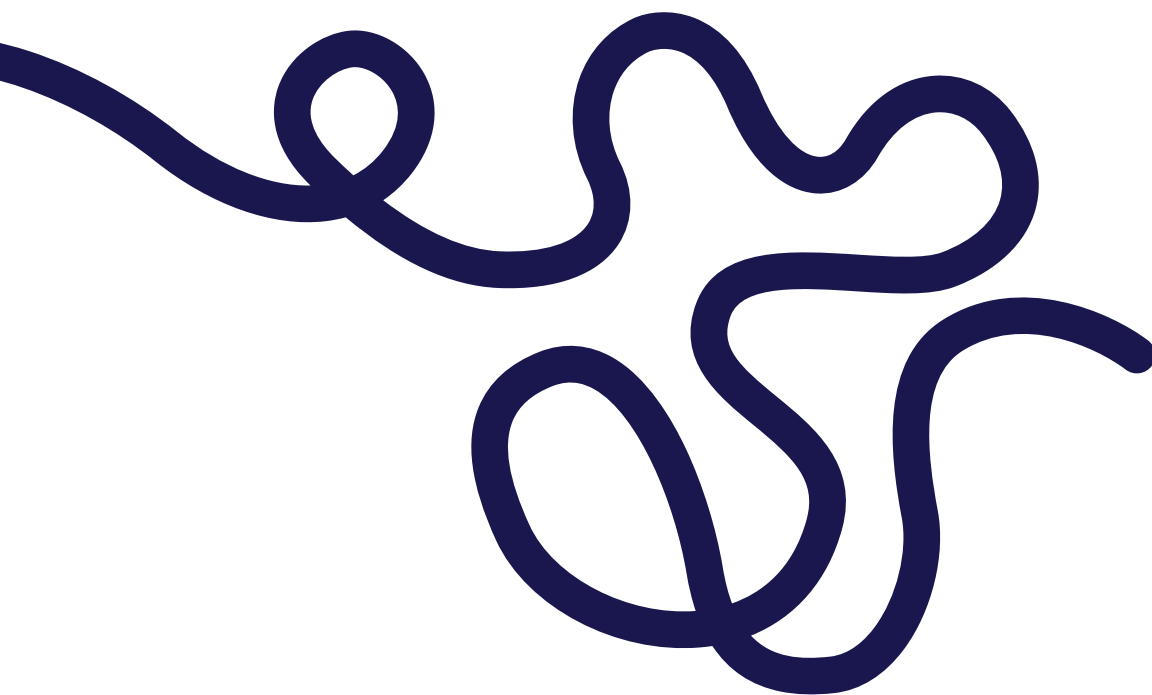
SECTION 1

Knowledge Development

This section provides information about disability and trauma. This is important information for anyone who is supporting a person with disability who has experienced complex trauma. It is written in easy-to-understand language to make it as accessible as possible. This section is for caregivers, families, friends, support workers, and advocates who have a wide range of different backgrounds and life experiences. This section is also for people in executive, managerial and supervisory positions of organisations that provide services to people with disability. Throughout this section, key information is presented in boxes labelled 'Knowledge Base' or 'Service Tips'.

Blue Knot Foundation **www.blueknot.org.au**
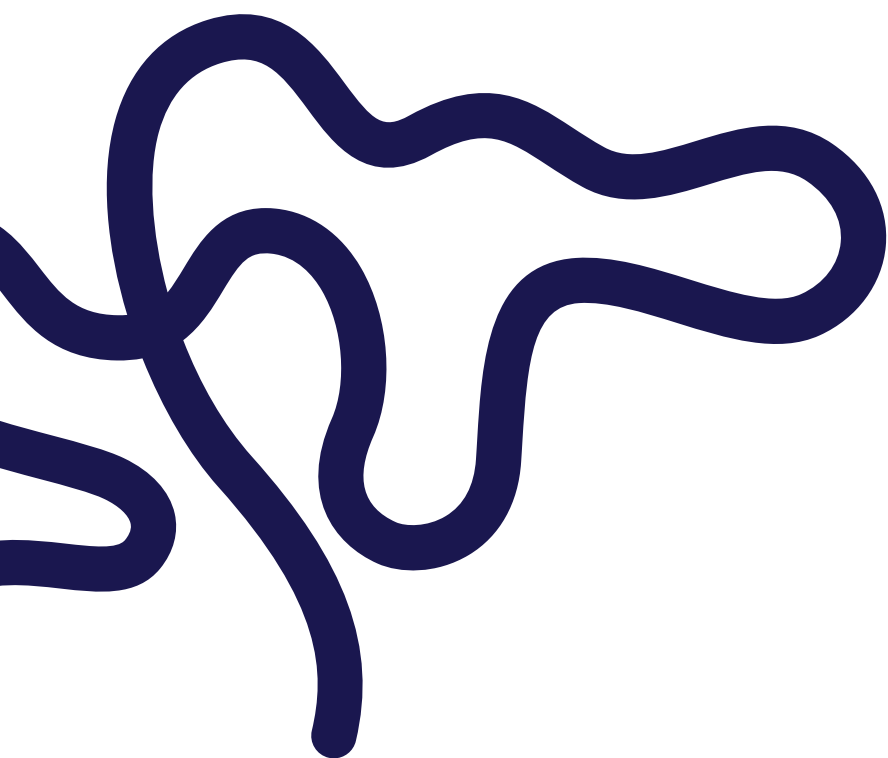
Disability and Human Rights

The United Nations Convention on the Rights of Persons with Disabilities 2008 (UN Convention, 2008) stresses that all people are human beings with their own needs and goals. And all people have their own strengths and face unique obstacles. The Convention recognises people with disability as:

> **... those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. People with disabilities may include, for example, people who use wheelchairs, people who are blind or deaf, people with intellectual impairments or people with mental health conditions, as well as people who experience difficulties in functioning due to a wide range of health conditions such as chronic diseases, infectious diseases, neurological disorders, and as a result of the ageing process.**
>
> https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

All people, including people with disability, deserve to be treated with dignity and respect. People with disability have the right to live a full and rewarding life. No two people are the same, and no two people experience disability in the same way. The Convention recognises the importance of difference and diversity. It is not always easy to notice a person living with a disability and many people do not understand disability. People with disability often experience stigma. This is because of bias and negative attitudes about people with disability. This can contribute to discrimination. People with disability often experience discrimination. But people should not be stigmatised or discriminated against because of difference.

Knowledge Base
– UN Convention on the Rights of Persons with Disabilities

The UN Convention states:
- the human rights of people with disability
- that every person with disability deserves respect
- that every person with disability needs to be treated with dignity
- that people need to be treated with respect and dignity regardless of their gender, sexual preference, faith, culture and values
- that people need to be treated with respect and dignity if they have experienced trauma

For more information about the United Nations Convention on the Rights of Persons with Disabilities 2008 (UN Convention, 2008) access

https://www.un.org/development/desa/disabilities/convention-on-the-rights-of- persons-with-disabilities.html

It is important to live and work from a sound ethical framework. Using an ethical framework helps us uphold a person's rights. This is especially important for people with disability. It is additionally important for people who have experienced trauma. It is every person's responsibility to treat others ethically. Caregivers, support workers and advocates have a duty to provide the best quality support possible. This means meeting the needs of the people receiving support. It also means doing whatever is necessary to not cause injury or harm to others. This includes physical, emotional, sexual or financial harm. In the event of mistreatment, every person has the right to raise concerns and make complaints. Being ethical also includes supporting people to raise concerns, make complaints or access independent advocacy when this is needed.

Social Model of Disability

"The social model sees 'disability' is the result of the interaction between people living with impairments and an environment filled with physical, attitudinal, communication and social barriers. It therefore carries the implication that the physical, attitudinal, communication and social environment must change to enable people living with impairments to participate in society on an equal basis with others."

https://pwd.org.au/resources/disability-info/social-model-of- disability/

Disability is sometimes seen as a problem or something that needs to be fixed. People with disability are sometimes seen as people who are different to "normal". This is because we used to think about disability from a medical viewpoint. We used to focus on what a person cannot do, rather than what they can do. This results in excluding people with disability. The needs of people with disability become ignored or minimised. This creates a situation where people with disability are more likely to be abused or experience violence, neglect and trauma. It also means that systems like schools, hospitals, courts or police may not have adequate ways to address disclosures of abuse from people with disability. As a consequence, people with disability may have less access to complaint processes, justice or redress.

The social model of disability looks at what a person can do. It sees disability as being socially constructed. It sees a problem with how we view disability and people with disability. Not a problem with the person or the disability. That means that we could change society to better accommodate people with disability. Disability is about diversity or differences that should be celebrated. However, some of these differences can mean that people face barriers. The social model of disability helps

us identify the barriers that people with disability face. These barriers can prevent people from participating fully in life and the community. Supporters can support people to address the barriers in their environment.

No two people are the same, and no two people experience disability in the same way. It is important to listen to people with disability to identify what each person needs. Everyone has unique needs. It is important that supporters try to understand and support people with disability to meet those needs.

Knowledge Base
– No 'one size fits all'

· A 'one size fits all' response is not appropriate.
· It is important to respond to each person and their unique needs.
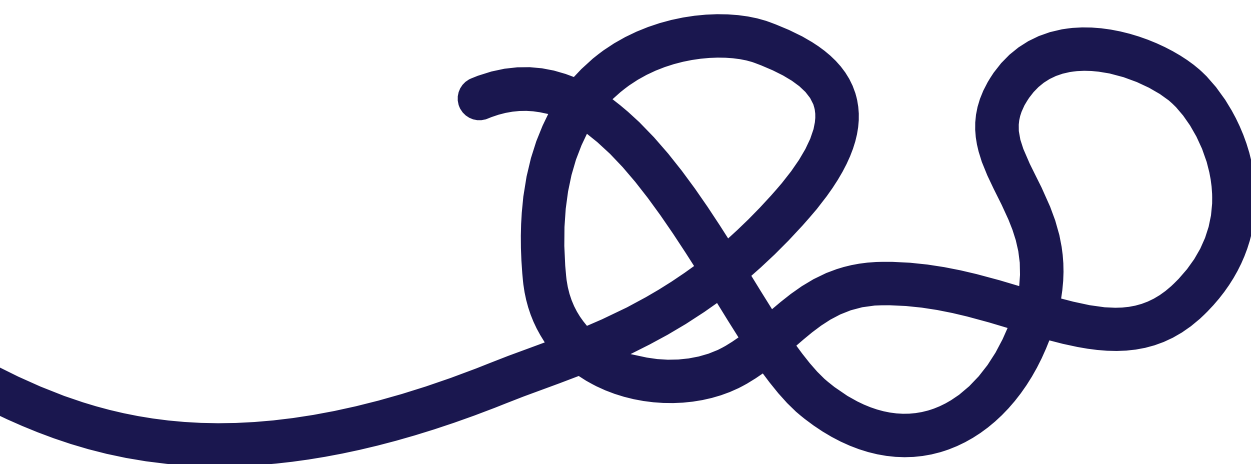
Disability in Australia

There are lots of different types of disability. Some people have intellectual disability. People with intellectual disability regularly face barriers to communicating, learning and remembering. These barriers can make decision making, planning and problem solving difficult. Some people have physical disability. People with physical disability often face barriers to mobility and communication. Some people have sensory disability. This might affect one or more senses such as sight, hearing, smell, touch, or taste. Sensory disability can make spatial awareness (being aware of spaces and distance) or receiving sensory input harder. Some people have psychosocial disability because of mental health issues. This can affect thinking, feeling and behaviour. Some people are born with disability. Other people develop disability from illness or injury. People may be affected by disability temporarily or permanently.

In 2018, over 4.4 million Australians were estimated to live with permanent, temporary, and age-related disability (ABS, 2019). Official statistics do not include every person with disability. Also, not everyone who has disability identifies as a person with disability. These can make it difficult to accurately determine true prevalence rates of disability. Of those people who identify as having disability and who were included in the government data:

· Most people (estimated 75-80%) have physical disability (ABS, 2019);

· Approximately 11-19% have psychosocial disability (ABS, 2019);

· Over 400,000 Australians have intellectual or developmental disability (NSW Ministry of Health, 2016);

· Around 38% of First Nations people have disability (ABS, 2020). However this is likely to be underreported and twice as many First Nations people have disability than non-Indigenous people (ABS: National Aboriginal and Torres Strait Islander Health Survey, 2018-2019; ABS: Survey of Disability, Aging and Caring, 2018)

·

In 2018, 8.2% of Australian children under the age of 18 had some level of disability (ABS, 2019). Most often, these included intellectual and sensory or speech disability. The rate of disability generally increases with age (AIHW 2015). Some people with disability experience poorer health and chronic conditions as they age. Many people with disability are not able to access the support needed to stay strong and healthy. Other people age faster and sooner as their health deteriorates. The most common disabilities for people over 65 are physical disabilities. Supporters need to be sensitive to the effects of ageing on people with disability. This helps to provide the right support at the right time.
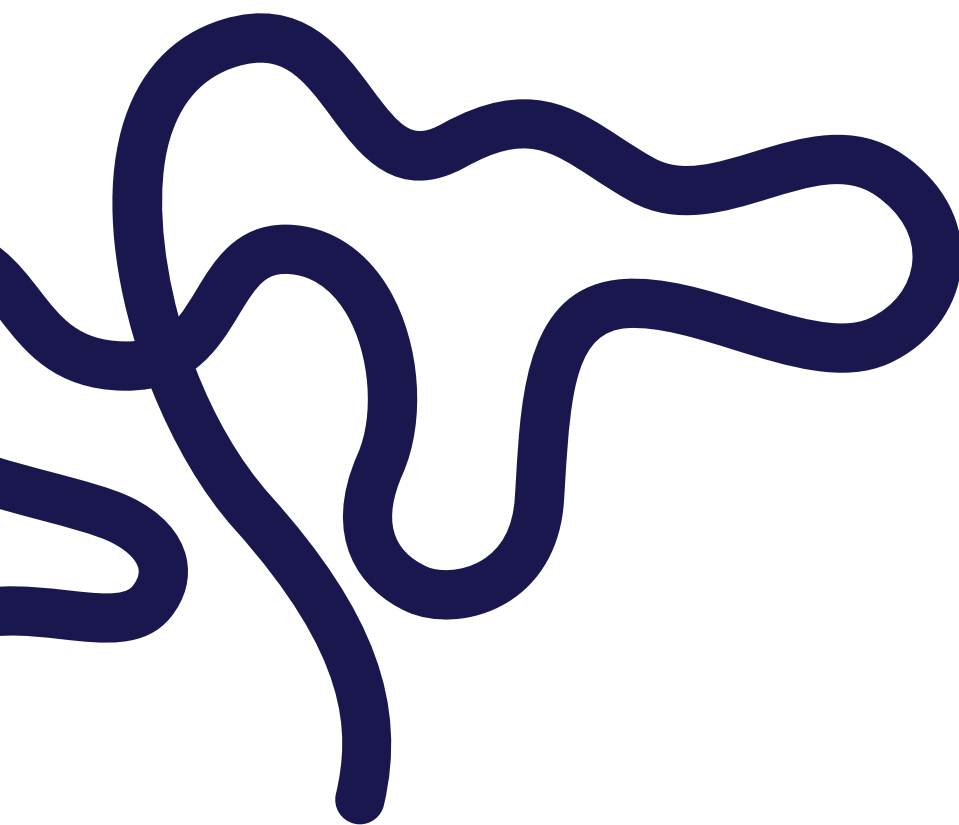
Disability Services in Australia

Many people with disability live independently and do not receive support from formal systems or services. Most people with disability receive support from friends and family. Carers Australia estimate that there are over 2.65 million caregivers across Australia (see https://www.carersaustralia.com.au/about-carers/who-is-a-carer/). This is often referred to as 'informal support'. The people who provide informal support are often referred to as 'carers' or 'caregivers'. Some caregivers receive a small government allowance, such as the Carers Allowance. However, people are not usually paid for informal support, despite this representing the vast majority of support provided to people with disability.

Approximately 1.5 million Australians with disability are supported by formal providers or disability services. Disability services vary enormously. They range from small support groups to large organisations that offer a range of different services. Services may be government funded, private enterprises, volunteer, not for profit organisations or a combination. Some services are specific to a particular disability or impairment with which people live. For example, services specifically for people with intellectual disability, on the autism spectrum or with psychosocial disability. Some services relate to the type of support people are offered. For example, accommodation, employment, assistance in the home, support coordination, assistive technology and equipment, community access or social participation, therapeutic or respite services. Together, these disability organisations employ a large number of support workers throughout Australia.

Approximately, 170,000 people receive daily support from formal service providers (ABS, 2018). It is estimated that 13,500 people with disability aged 15 to 64 years live in supported accommodation. This number is likely to be higher because it can be hard to accurately identify

the number of people with disability. Some people have to stay in institutions such as hospitals, prisons, residential care, group homes or aged care facilities. Some people with disability go in and out of different institutions, services and systems. Some do this frequently and some do this over long periods of time. Many people have experienced repeated institutionalisation throughout life. Many people with disability who have experienced trauma receive support from multiple services at the same time and across the lifespan. This also includes services that are not disability specific. For example, generalist medical or therapeutic, transport, and financial services.

Advocacy is important for ensuring the rights of people with disability are upheld. It is also important for fostering autonomy, dignity and self- determination for people with disability. Systemic advocacy may also be conducted to change policies and systems. We need systems that understand and adapt to the needs of people with disability. Some systems of support have improved, and some institutions and services have been closed because they were harmful. Many people with disability are supported to develop and achieve greater independence. Yet there is still a long way to go. We need to do more to remove the barriers that prevent people with disability from fully participating in their communities and lives. We need to eliminate harmful and traumatising practices from Australian services.
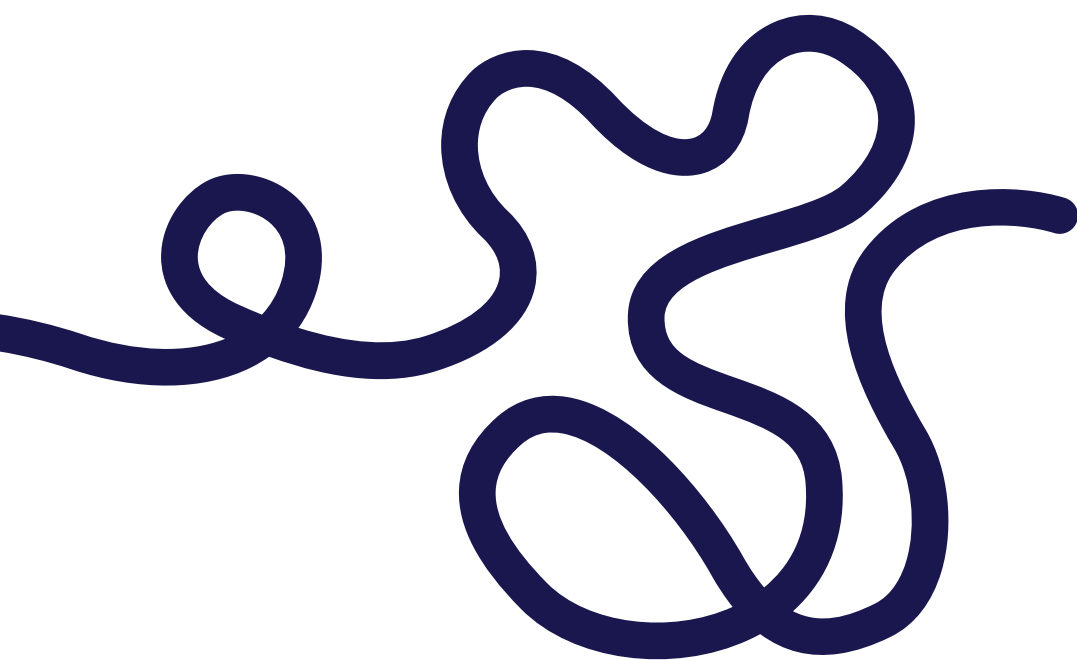
Social Justice and Barriers to Inclusion

> **"Inclusive society is defined as a society for all, in which every individual has an active role to play. Such a society is based on fundamental values of equity, equality, social justice and human rights and freedoms, as well as on the principles of tolerance and embracing diversity"** (UNESCO, 2012).

Social justice is about fairness in society. It is about truly embracing diversity. It relates to how wealth and opportunities are shared within society. Social inclusion is about everyone having the same opportunity to participate. People with disability and their families are often excluded from social and economic life. 'Social inclusion means that all people should be respected and valued and encouraged, supported and able to take part fully in the life of society' (Honey et al, 2010). Some of the groups of people who often don't have the same opportunities in life include First Nations people, asylum seekers and refugees, women, the homeless, people from LGBTIQ+ communities and many other groups. This causes the person to become disconnected from other people and from society. This can affect a person's mental health. It also puts additional pressure on the person's family and friends.

All services that support people with disability have a responsibility to promote social justice and inclusion. This is required to uphold the United Nations Convention on the Rights of Persons with Disabilities 2008 (UN Convention, 2008). Promoting social justice and removing barriers to inclusion can increase people's sense of belonging and connection. This can also increase people's opportunities to participate. This in turn, helps to improve the health and wellbeing of individuals and their communities.

Some people with disability who have experienced trauma, and the groups that advocate for them, are excluded through stigmatization and discrimination. Stigma and discrimination can arise from ignorance, judgement, and fear. Disability services, as well as services generally, have an ethical and leadership responsibility to challenge discrimination. They have a responsibility to challenge the exclusion of people with disabilities. This includes people whose disabilities are visible, as well as those whose disabilities cannot be easily seen. People with disability can experience barriers to inclusion on a daily basis. These barriers can prevent access to different opportunities. This includes access to education, a job or housing. These barriers can seriously affect a person's ability to get their needs met. Examples include access to medical, dental, educational, transport or support needs. Barriers to access can prevent achieving basic human rights. These barriers can occur anywhere. Barriers can occur at home, school, work, services, communities and institutions. We need to be more aware of these barriers to be able to remove them. We need to consider how the barriers affect people.

People with disability often face the following barriers:

Attitudinal Barriers

Attitudinal barriers are the beliefs and attitudes that other people hold about people with disability. Beliefs about what people with disability can and cannot do. Stereotyping people with disability is an example. Attitudinal barriers can occur because of discrimination. Discrimination is often based on fear and ignorance. Judgement, intolerance and misinformation cause barriers for lots of different groups of people. Awareness and education are very important. Supporting a person with disability means being open to understanding and learning more about living with disability.

Disability services can routinely screen for worker attitudes, beliefs and understanding of the support needs of people with disability. This could especially happen during the recruitment process. Workers who discriminate against people with disability and/or trauma experiences cannot provide trauma-informed support to people with disability. Training and support to address any biases and unhelpful attitudes are an important part of providing services to people with disability. Training

and support can help to challenge discrimination in the workplace. Suitable training may be accessed through National Disability Services (NDS) (see [Disability Aware: An awareness and inclusion program (https://nds-marketplace.etrainu.com/product/disability-aware-an-awareness-and-inclusion-program/)](https://nds-marketplace.etrainu.com/product/disability-aware-an-awareness-and-inclusion-program/)). This can reduce possible harm to people who engage with the service. Addressing these issues makes the service more psychologically or emotionally accessible for people.

Physical or Environmental Barriers

Barriers to inclusion can also exist in the environment. There might be physical barriers that prevent people from participating. Such as steps or curbs that a person with mobility issues cannot use. Or environments that do not have wheelchair ramps or enable companion animals to attend. Transport access might also be a barrier. Alternative transport options and suitable parking is very important. Environments that have too much sensory stimuli might also be a barrier for some people with sensory disability.

Language and Communication Barriers

Language has a lot of power. It tells people what we think and feel. It can welcome or dismiss people. Language can show respect and inclusivity. It can also divide and exclude. Different cultures use words differently. We cannot always be sure that a person **understands** what we are saying. Some words can bring up uncomfortable memories or feelings for people.

It is important to be sensitive to language preferences. Some people prefer person-first language (e.g. 'person with disability'). This is because person-first language speaks to the person first. No person is just their disability. However, it is also important to know that some people prefer identity-first language (e.g. 'disabled person'). It is important to ask the person what language they prefer to use. For more information about person-first language go to https://www.and.org.au/pages/inclusive-language.html

Disability services need to communicate using a range of formats and modes. It is important to cater for the language and communication needs of the people accessing the service. Written content should be

accessible. For more information about accessible content see https://www.and.org.au/pages/a-beginners-guide-to-accessible-content.html. Digital content should also be accessible. The Web Content Accessibility Guidelines (WCAG) 2.0 standard aims to improve accessibility for people with cognitive, vision or hearing impairment to webpages, electronic documents and multimedia. For more information about improving accessibility see https://pwd.org.au/wp-content/uploads/2019/09/Creating-Access-GeneralReccomendations_WEB.pdf.

Communication is a two-way interaction. It is not just about language. It is about non-verbal communication too. Some people might need access to translation and interpreter services. Deaf people may need someone to support communication with people who do not sign. People from Culturally and Linguistically Diverse (CALD) backgrounds may need an interpreter. People with disability can experience not feeling listened to. Removing communication barriers is about everyone's voice being heard and listened to. This includes listening to people who are speaking, signing, drawing or gesturing. It includes listening to the voices of children and young people with disability and the voices of people who are marginalised – First Nations people, people from CALD backgrounds, people of other faiths, spiritual beliefs and cultures.

Social Barriers

People with disability regularly face social barriers to inclusion. Some social barriers prevent access to employment, education, or finances. These barriers can disrupt the development of friendships and intimate relationships and make people feel alone. Different groups of people experience additional social barriers to access. First Nations people with disability regularly face 'double discrimination'. This is because of barriers arising from their disability as well as their culture (see Intersectionality later in this section). Some people from Culturally and Linguistically Diverse (CALD) backgrounds might have certain cultural rules to follow. This might include not being able to go to certain places at particular times. It might also include who you can and cannot be with. Another group that experiences additional barriers to access are people from LGBTIQ+ communities. People often experience stigma around sexuality or gender identity. People from different faiths, women, children and young people can also experience exclusion and ostracism.

People from particular cultural groups will be able to more easily access services if they are socially and culturally safe. Supporters should work with people from particular culture groups to build the necessary skills and knowledge to provide culturally safe support and supports that are free from racism.

Systemic Barriers

Systemic barriers include services or systems that place unrealistic demands on people with disability. An example may be not providing enough time to complete a task or access a service. Or making a person with disability stay in environments that do not support the person's needs. Like making young people with disability live in an aged care facility because it is the only place that they can receive the supports they need. Or providing services in places and at times that people cannot get to them. Or not making changes that can help people in the workplace. These are all examples of systemic barriers to inclusion. Disability services should take action to minimise and address the systemic barriers to access that are within their control. Disability services can also support and strengthen collective efforts to improve the systems that affect the lives of people with disability that they support.

Service Tip
– Service Accessibility

Services can increase accessibility by addressing the following:

Attitudinal Barriers to Access
- Screen for attitudes that may limit the delivery of quality services during recruitment
- Provide supervision and support to reflect on and address unhelpful attitudes
- Ensure training on culturally safe practices is provided to help address attitudinal barriers
- Model appropriate attitudes that promote support for people with disability and trauma recovery

Physical or Environmental Barriers to Access
- Conduct an audit of the physical environment and address any physical barriers to access
- Reduce sensory stimuli and remove any likely trauma triggers from the environment (see Environmental Safety later in this section)
- Consider the possible impact of the service environment for people who access the service and develop alternative ways to provide choice around access (e.g. home visits, by telephone etc.)

Language and Communication Barriers to Access
- Communicate using diverse formats and modes to suit different people and their needs
- Have ready access to interpreters, multilingual workers and/or technology that aids communication

Social Barriers to Access
- Ensure cultural accessibility and provide supports that are free from racism
- Support people with disability to form and maintain social supports
- Be aware of shame or embarrassment as a barrier to access (e.g. minimal street signage, use of unmarked vehicles, attending to people's sense of shame regarding the need for support, awareness of culturally-bound elements of shame etc.)

Systemic Barriers to Access
- Engage in systemic advocacy when needed to overcome systemic barriers to access
- Be creative with problem-solving or working around systemic barriers

Discrimination

"Differences are not intended to separate, to alienate. We are different precisely in order to realise our need of one another."
Desmond Tutu

People with disability can regularly experience discrimination because of their disability, sometimes even from other people in the disability community. This is called ableism. Some people with disability also experience discrimination because of their gender. This is called sexism. Some people with disability also experience racial discrimination. This is called racism. Discrimination because of sexual orientation is called homophobia and can also be experienced by people with disability. People can be discriminated against because of poverty, or religious beliefs or many other things. Sometimes people are discriminated against because of their age. This is called ageism. Either because they are viewed by others as too old or too young.

People with disability are sometimes bullied because of their disability. This may happen at school, in workplaces or in the community. Sometimes people with disability can experience neglect. This happens when people with disability are not provided adequate support for their needs. Sometimes people wrongly think that people with disability are not sexual beings. This means that people with disability, including those from the LGBTIQ+ community, can face additional barriers to the development of healthy sexual relationships. Nobody wants to be discriminated against. But many people can experience discrimination because of their disability, culture, religion, gender, sexual orientation, age, and experience of trauma. This is a breach of human rights.

Intersectionality

"Aboriginal and Torres Strait Islander people with disability experience unique forms of 'intersectional discrimination' and social inequality that is an interaction of discrimination that is both Aboriginal and Torres Strait Islander and disability related"
(Avery, 2018).

Intersectionality refers to how different aspects of a person's identity such as gender, class, race, and sexual identity can overlap and combine.

This then causes overlapping discrimination and marginalisation. Experiencing multiple forms of discrimination also increases the likelihood of experiencing complex trauma. It can make it harder to recover from trauma. For example, people might incorrectly assume that women with disability are less capable than men with disability. This is an example of sexism and ableism occurring together. Some people including people with intersex variations and women with disabilities have been forced to undergo medical treatment or surgery to prevent pregnancy. This is called forced sterilization and continues today (Disability People's Organisations Australia, 2018). Sometimes women with disability are subjected to medical interventions to prevent menstruation. This may not be for the woman's benefit but for the benefit of others, such as their supporters. Some people with disability have had their babies removed or were subjected to forced adoption (Disabled People's Organisations Australia, 2018). This has also happened to people who experienced trauma or psychosocial disability that resulted from violence perpetrated against them.

In addition to racial and cultural discrimination, people with disability from CALD communities may also experience discrimination because of their disability. Sometimes other people in their own CALD community do not understand or accept the person's disability. First Nations people also often experience overlapping forms of discrimination **and marginalisation. In addition to racial and** cultural discrimination, First Nations people with disability may also experience discrimination because of their disability. Compared to non-Indigenous Australians, there are more First Nations people with disability among homeless people, in the criminal and juvenile justice systems, and in the care and protection system both as parents and children (Aboriginal Disability Network of NSW, 2007, p. 1). This is because of the intersectionality of multiple forms of discrimination and marginalisation. Some First Nations people with disability have died while incarcerated. This happened because they were mistreated by authorities who failed to recognise their disability or take their needs seriously.

The case study below provides an example of how people can experience multiple forms of discrimination at the same time. In this case, Linda is experiencing ableism and sexism.

Content Warning

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Case Study – Linda*

Linda is a 24-year-old woman with psychosocial and intellectual disability. She resides in a government funded group home with five other women with disability. Most of the other women are older – ranging in age between 40-60 years. The organisation managing the group home also operates several other group homes in the area. Linda is told by staff that she is being taken to visit 'Jack' – a young man with intellectual disability who resides in one of the other group homes run by the organisation. Jack is considered to have significant 'behavioural issues' and is 'difficult for staff to manage'. Jack is considered easier to 'manage' if he is not 'sexually frustrated'.

Linda is told by the staff that Jack is her 'boyfriend'. Linda is taken to the group home where Jack resides and sent into his bedroom. Linda is raped by Jack. Linda thinks that she has to let Jack have sex with her even though she doesn't want to because she has been told that Jack is her 'boyfriend'. This 'arrangement' continues for many months until Linda eventually discloses to a family friend that Jack 'hurts her' when he makes her have sex. Linda shows her family friend the cuts and bruises on her genitalia and inner thighs. Linda is eventually taken to a sexual assault support service, accompanied by an independent advocate. After one session, the sexual assault support service says they can no longer assist, because Linda won't 'open up' to them, and they don't have the resources or the capacity to work with her.

*This is a real story provided with consent from the individual and family concerned. Names have been changed and specific situations de-identified to protect privacy. Case Study provided by Women with Disability Australia (WWDA) (See Microsoft Word - Attachment_Case_StudiesFinal.docx (wwda.org.au))

Recognising Grief and Loss

All people have an emotional life. Grief is an emotional reaction to loss. Human beings will often grieve their losses differently. Some people may have an acquired disability because of illness or injury. Being in an accident that results in permanent injury can feel devastating and be very traumatic. Developing disability because of a serious illness can also feel devastating and traumatising. It can take time to learn new ways of coping and doing things after experiencing a permanent injury.
It can also take the person time to accept that they cannot do certain things in the same way that they could before. Sometimes people lose friends because of acquired disability. Sometimes people lose jobs or access to money. Sometimes people cannot continue to live at home or cannot go to the same school anymore. This can be very frustrating and upsetting. Trauma can also cause a lot of loss and grief when it is not expressed or heard.

Living with disability can expose people to a lot of loss. Sometimes these losses can be experienced throughout life. This includes a loss of privacy, independence or freedom. This is often compounded by a loss of agency, social connection and financial security. Just feeling different or being made to feel different from others can cause a lot of grief. This can be made worse by the way other people respond to people with disability. The losses people with disability experience are often not recognised. These experiences can make people feel alone and without support.

Disability and Trauma

Many people with disability have experienced trauma. It is hard to know exactly how many people with disability have experienced trauma. Trauma is more common in people with disability than people without disability. In Australia, people with disability are twice as likely to experience violence as people without disability. This means that two-thirds of people with disability have experienced violence. Women with disability (age 18 to 64) are twice as likely to experience sexual violence as women without disability (Sutherland, Kavanagh, Llewellyn, Byars, Krniacki & Hargrave, 2020). Children with intellectual disability or who face communication barriers are at greater risk of trauma (Hoch & Youssef, 2019). While many people experience trauma at home, many people with disability have also experienced abuse and neglect in the context of receiving services and support.

People with disability are more likely to experience abuse and violence in an institutional setting where there is a power imbalance between the system, workers, and people who access services. This could occur in any organised environment such as a detention centre, prison, group home or residential facility. Power imbalances are more likely to happen when an institution is closed and secretive, and when decision-makers, managers or workers do not behave in an ethical way. In such institutions, it is less likely people abusing others are held to account.

Trauma can change what a person does. Many people do not understand trauma or how it affects people. This lack of understanding can cause more barriers and discrimination for people with disability who have experienced trauma. It is important to be aware of the barriers to inclusion for people with disability who have experienced trauma. Many people with disability do not get to choose a preferred service. Many do not choose caregivers or supporter workers either. Often the support is chosen for the person with disability. Sometimes this is for financial reasons. Sometimes there is only one service available. That service might not understand trauma or disability. It might not be safe. A person with disability might have to accept something even when

it does not feel safe for them. And if the person does not comply with service demands or directions, this might not be safe either. This can make services damaging and abusive.

It is very important to be sensitive to the communication needs of people with disability who have experienced trauma. Many people who have experienced trauma find it hard to speak about the abuse. Many people disclosing abuse are not believed. Children, people who face communication or language barriers, or people with intellectual disability can face additional barriers to speaking about abuse. Sometimes, people with disability are also not understood or believed when they disclose abuse. This is because some people wrongly think that people with disability are not reliable witnesses. The Royal Commission into Institutional Responses to Child Sexual Abuse spoke about the additional barriers faced by survivors with disability in disclosing child sexual abuse: 'Almost one-third did not disclose due to shame and embarrassment, and a similar proportion also feared retribution from the institution' (A Brief Guide to the Final Report: Disability, p.5).

Knowledge Base
– Disability and Trauma

- Sometimes trauma can lead to disability
- Many people with disability experience trauma
- Many people find it hard to talk about trauma
- Some people with disability can find it harder to talk about trauma because of social, communication or language barriers
- This means that some people with disability can be less likely to tell someone about the trauma experienced
- This is why it is important for caregivers, supporters and advocates to understand more about trauma
- It is important to understand about communication, language and accessibility barriers for people with disability who have experienced trauma
- It is also important to recognise and understand signs of distress, trauma impacts, coping strategies and complex behaviour support needs to support people with disability to recover from trauma
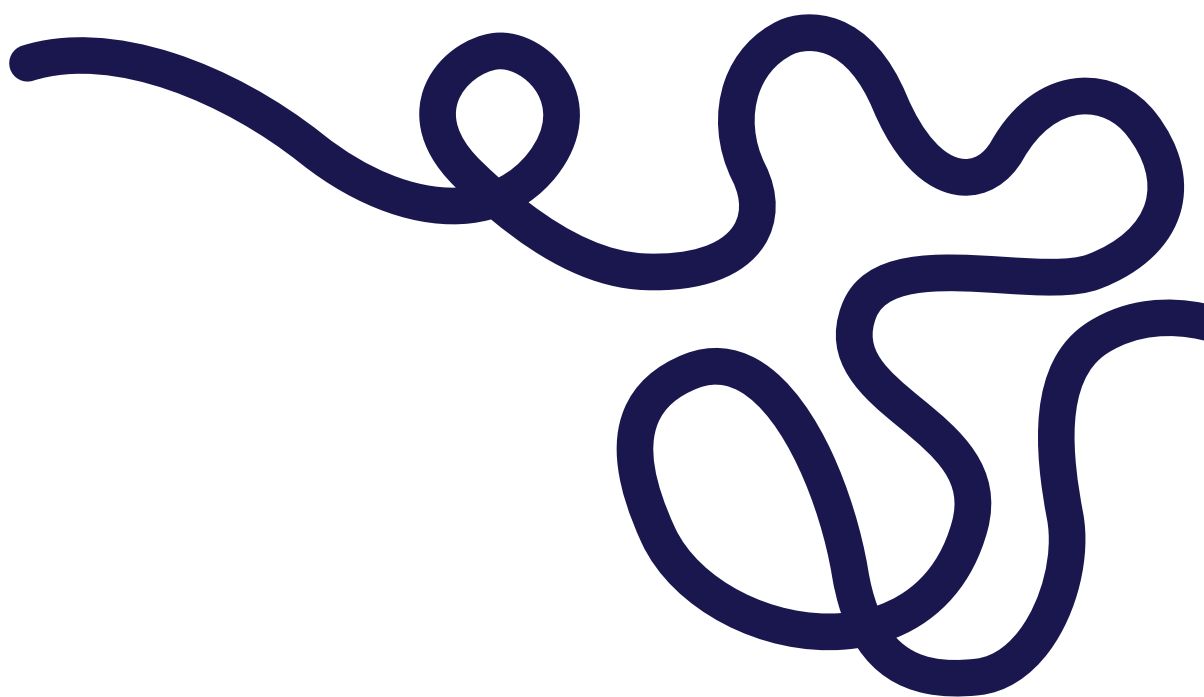
Understanding Trauma

Trauma is a "state of high arousal in which normal coping mechanisms are overwhelmed in response to the perception of threat" (Cozolino, 2002:270).

We all have different experiences. Some experiences change us. Sometimes for the better, sometimes not. Trauma is one of those experiences. Trauma can happen once, or it can be repeated. Trauma is the word used to describe the experience. Trauma experiences are common. We all know someone who has experienced trauma, although that person may not have told us about it. It could be us, a friend, a family member or a work colleague.

The word trauma is also used to describe the effects of extreme stress. The extreme stress of trauma overwhelms a person's ability to cope. This can cause further harm. Events that threaten our survival are traumatic. But not all traumatic events are life-threatening. People can experience trauma even when their survival is not threatened (Cozolino, 2002). This happens when our nervous system perceives threat. For some people this happens over and over again.

Trauma is not always related to the size of the event/s. While some experiences would overwhelm almost anyone, other experiences are different. In fact, things that seem minor to some people can be traumatic for others. People who have experienced trauma have many different reactions to the trauma. Each person is unique. Each person's experience is individual. With trauma, it is not only what happened that is important but the context of the threat. That is, how, where and why it happened.

Trauma can affect us at the time of the traumatic event. It can also affect us over time. If we do not get the right support, trauma can affect us right through our life. It interrupts the connections or 'integration' between different parts of our functioning. It stops our body systems from working

together. When it does this, it can affect our health in lots of ways. It can affect our physical health. It can affect our emotional health. It can affect our wellbeing in general. It can be hard to get good support for trauma. Barriers to inclusion can make it harder to access help or to protect ourselves from further harm. They can make it harder to understand or make sense of the experience of trauma.

Knowledge Base
- Trauma

· Trauma is the result of a violent or otherwise very stressful event or series of events
· The effects of trauma do not always relate to the size of the event. The effects depend on a lot of different factors
· Trauma is experienced as physical or emotional harm
· Trauma results from a threat to life, or the perception of threat
· Trauma can affect how our brain and body work
· Trauma can affect our cognitive, physical, social, behavioural,
· emotional, spiritual wellbeing (SAHMSA, 2012)

Different Types of Trauma

Caregiving during Childhood that is Not Consistent or Reliable

Every child needs a reliable caregiver or parent. A reliable caregiver helps a child to feel understood. A child who feels understood is more likely to develop much needed life skills. A caregiver who is consistent creates a healthy bond with the child. This helps the child to attach to the caregiver in a secure way. A secure attachment in childhood makes the child more likely to have secure attachments or bonds in later life. Secure attachments help the person build safe and healthy relationships. Healthy relationships in early life are very important. This is because children are very dependent on caregivers. It is also a time when the brain is growing and changing rapidly. When a child does not experience consistent or reliable caregiving, the child can find it harder to cope with stress and trauma later on.

The caregivers of some children with disabilities do not consistently meet the child's needs. Children with disability also often need more than one caregiver. Sometimes caregivers change frequently. Each new caregiver means a new relationship. Each new relationship means building trust. Many children with disability live in institutions or group homes. Being in institutions often means lots of different caregivers. This creates inconsistency in caregiving.

The following case study is an example of what inconsistent or unreliable caregiving during childhood might look like.

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Case Study – Annie*

Annie grew up in regional Queensland. When she was aged two, she had an illness that caused her to lose her hearing. She became profoundly deaf. Her mother died shortly after. Her father struggled with his grief and started drinking a lot of alcohol. He was not able to support Annie in the ways she needed. He sent Annie to his sister, Aunt Flora, in Brisbane. He hoped that Flora would be better able to support Annie because she could access specialist disability services in the capital city. Flora did not understand Annie's needs. Flora and Annie could not sign. They could not communicate properly. When Annie cried because she missed her Mum and Dad, Flora did not comfort her. Flora gave up and convinced Annie's father to give up Annie's care. Annie was made a ward of the state at age six.

After that time, Annie was placed in a series of foster placements and children's homes. Some were better than others. In some of those places she received support to overcome communication barriers and to form friendships. In other places, Annie was physically abused and had to do lots of chores. By the time Annie reached her sixteenth birthday, she had lived in eight different places with eight different caregivers. Annie grew very suspicious of people because of all these changes. She did not trust people or feel safe. Soon she did not even try to make friends because she always expected that she would soon have to move.

* This is not a real person's story.

Chronic Mis-attunement

When a child is hungry, caregivers usually feed the child. When a child is upset, caregivers usually comfort the child. When a child is frightened, caregivers usually help the child feel safe. A child whose development is delayed, may experience additional **barriers to communicating** their needs. Barriers to communication can stop needs being understood and met. Caregivers may have their own difficulties too. These difficulties might stop the caregiver providing support that the child needs and wants. Some caregivers might misuse drugs and alcohol, experience violence and abuse or have mental health issues. These difficulties can mean the caregiver cannot always notice and understand what the child needs. Constantly missing or misunderstanding the needs of the child can affect the way the caregiver and child attach or bond.

When early relationships are not nurturing, the child may not develop the capacity to tolerate everyday stress. Everyday stress is different to trauma. The child might learn different ways to regulate emotions. Or to self-soothe when they experience distress. When this happens, the child can stay very sensitive to other life stresses. This can affect the child's health and wellbeing throughout life.

The following case study provides an example of what chronic mis-attunement might look like.

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Case Study – Becker*

Becker grew up in Hobart. He lived with his parents and younger sister. When he was age seven, his school teacher noticed that he was falling behind at school. His mother took Becker to see a paediatrician. The paediatrician diagnosed a mild intellectual disability. Becker's father was often away from home for work. When he was at home though, he **was often violent towards** Becker and his mother. Becker's mother had her own struggles. She had regular periods of depression that stopped her even getting out of bed. Sometimes she took medication and illicit drugs to try and manage her depression. The drugs sometimes made her behaviour erratic and scary. She struggled to notice, understand and meet Becker's needs. He often had to make dinner for himself and his sister. One time, he came home from school upset because other children teased him for being "dumb". His mother told him she would wash his clothes to make him look smarter. Becker did not seek his mother's support much after that. Instead, he started hitting his own head as punishment for being "dumb".

* This is not a real person's story.

Developmental Trauma

Trauma in childhood can affect the way a child develops. This includes the development of the brain, body and mind. It also includes the development of thoughts and feelings. If a child experiences a traumatic event during a critical developmental period, it can take longer for the child to develop age-appropriate skills. Like learning to talk or walk or play with others. This can affect the child's relationship with themself and others.

A child's developmental age may be different to the child's chronological age. This is often referred to as developmental delay. Trauma can cause developmental delay or disability. It is sometimes hard to know if trauma helped to cause a child's developmental delay or disability. Or whether trauma affected the disability the child already had. This means that supporters need to always think about a person's age, stage of development and disability.

The following case study provides an example of what a developmental trauma might look like.

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Case Study – Mai*

Mai was in a serious car accident when she was three years old. Thankfully, she did not appear to be seriously injured, but her arm and leg were broken. Mai had always been a very quiet child, but she hardly spoke at all after the car accident. Mai's mother took her to lots of doctors. The doctors could not work out whether her brain, the muscles in her mouth and tongue, or her experience of trauma had caused the delay in her speech.

* This is not a real person's story.

Single Incident Trauma

Single incident trauma is a one-off event. This can be a natural disaster. Examples are a bushfire, flood or drought. It can also be an accident. With these traumas, the harm is not caused by a person, or if it is, it is not meant to harm another person. Single incident trauma also includes a one-off sexual or physical assault as an adult without any other history of trauma.

The following case study provides an example of what a single incident trauma might look like.

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Case Study – Dean*

Dean was out with friends celebrating his 21st birthday. Dean has muscular dystrophy, which can make him unsteady on his feet. Sometimes he uses a crutch or walking stick to help him walk. Sometimes Dean does not want to use his walking stick because he feels like it makes his disability more obvious. For his 21st birthday, he went to a nightclub with his friends. He had not been there long and had only drunk two beers when a **security guard approached him. He** told Dean he needed to leave the nightclub because he was too drunk. He tried to tell the security guard about his disability, but the security guard would not listen. The guard escorted him out of the nightclub and pushed him onto the street. This caused Dean to fall and hit his head against the pavement. A group **of people waiting to get into the nightclub** jeered and taunted him. Dean had nightmares about this event for months afterwards. He stopped going out and started to get depressed.

* This is not a real person's story.

Intergenerational or Transgenerational Trauma

"Aboriginal and Torres Strait Islander peoples have been exposed to generations of trauma through colonisation, dispossession, assimilation, child removal policies, and marginalisation. Owing to past and present government policies, trauma has taken place at the community, family and individual levels. Trauma can be transferred from one generation that have experienced or witnessed traumatic events, to the next generation, potentially leading to a cycle of worsening social, economic and cultural consequences". (Lowitja Consulting, 2018)

Intergenerational trauma is: "the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes" (Atkinson, Nelson & Atkinson 2010). Transgenerational trauma is passed across lots of generations (Atkinson, 2003). Many families have transgenerational trauma where the parents' experience of trauma affects their children. For example, an experience of war and displacement might make a person parent a child differently. Many First Nations people have experienced intergenerational or transgenerational trauma. For example, First Nations families today continue to feel the impact of trauma experienced by previous generations as well as during their own generation. Such traumas include violence, child removal, displacement, discrimination, genocide, and colonisation.

The following case study provides an example of what trauma across two generations might look like and how the impacts of these traumas might interact with each other.

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Case Study – Eliana and Esther*

Eliana's mother, Esther is a holocaust survivor. Esther has severe anxiety and a history of trauma. She was interned in a concentration camp in Poland for three years during **World War II, where she nearly starved** to death. Esther worked hard to recover from these traumatic experiences. She came to Australia on her own after the war after all her immediate family had died. She met and later married a man, another Polish migrant she met on the boat on her way to Australia. Esther was 35 years old when Eliana was born. She took good care of Eliana but became very anxious when she was separated from her. By the age of two, Eliana was very overweight. Esther told doctors that she worried that Eliana might starve.

Eliana struggled with her weight throughout her school years. She was bullied regularly for being overweight. Esther did not allow Eliana to go to birthday parties or other social events outside of school because of her anxiety. Eliana grew up feeling isolated and without friends. She wanted to become a human rights lawyer but left school after Year 9 to avoid the bullying. She developed severe depression and an eating disorder and required periods of hospitalisation during her adulthood.

* This is not a real person's story.

Complex Trauma

Complex trauma is repeated and ongoing trauma. It is cumulative or builds up and happens when one person or several people seriously harm and cause trauma to another person. When trauma starts early in childhood it can be especially damaging. The impacts can be lifelong and affect people in many areas of life. Complex trauma can result in changes in thoughts, including memory and self-belief changes. It can **cause changes** in feelings. This includes strong overwhelming emotions or feeling numb. It can cause changes in behaviours, like self-harm or aggression. It can also result in changes to social, physical, financial and spiritual wellbeing. These changes can affect a person's self-identity, relationships with family and friends, education and employment. People use strategies to cope with complex trauma. Some of these strategies can cause harm. These

include misusing alcohol and drugs, self-harming, taking risks, or socially withdrawing. This can make the trauma more complex and harder to recover from. These trauma impacts and coping strategies are discussed in greater detail in later sections of these guidelines.

The following case study is an example of a how multiple traumas can have impacts that compound throughout life.

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Case Study – Ralph*

Ralph is a First Nations man in his thirties. He is Deaf and has depression and anxiety. He has been abused, bullied, harassed and discriminated against all his life because of his disability:

"In life I had no support and all this experience impacted my depression and anxiety. I was a survivor of suicide, twice ... all this trauma of life ... and the missed opportunities of good education ... good jobs and good future".

Ralph was abused by his foster parents during the 1990s:

"They both hurt me. When I was [nine] and [10] my foster father tried to choke me and my foster mother tried to break my finger. They both hit me ... It was so traumatic. I had to live it until I was out of care when I turned 18. At the time I did not know any services or education on where to get help. I still live in pain from this".

The abuse continued at school. In primary school the teachers restrained him almost every day. In high school, the teachers told him that he would not be able to go to university to get a social work degree, because of his disabilities. He was not allowed to choose the subjects he wanted to study – those decisions were made by his teachers:

"I wasn't able to make subject decisions like other mainstream students … I went to TAFE and did a community service and business management course and completed it."

When Ralph was employed, his employers and co-workers harassed and bullied him because of his disabilities. His employers did not want to make reasonable adjustments to his work environment:

"I tried to advocate myself but the battle was difficult to win over. I worked at a coffee shop in [a] support[ed] employment program … they decided not to pay me full wages (70 per cent), which I didn't agree. The employer said it was because of my learning disability … The boss clapped in my face and yelled at me … and had no attention in learning about my disability. I had anxiety meltdown at this job. I brought in my psychologist to try and manage things but when my psychologist left my work the supervisor had a go at me, saying 'how dare you bring your psychologist in my workplace'. I had no choice but to resign".

Ralph felt excluded from his culture because of his disability and trauma:

"There is not enough education or awareness out into the community. It feels like we are hopeless and people don't understand the life we live. We need to work on equality and [be more] inclusive in Australia … We need more disability advocates like myself … We also need politicians to listen to us.

*Name changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Knowledge Base
– Complex Trauma

· Trauma can be a one-off event or single incident trauma
· Trauma can be repeated, ongoing and extreme – it is called complex trauma
· Complex trauma is more common than single incident trauma and can be more damaging
· Some people experience trauma right through life, as a child and also as an adult
· Some groups of people are more likely to experience complex trauma
· The ability to form relationships, manage stress and manage strong emotions develops in early caregiving relationships
· Trauma during childhood disrupts the development of these skills
· These skills can be learned later in life and can help a person recover from complex trauma

When Trauma Happens in Childhood

The Adverse Childhood Experiences Study is a US (United States) study. This study had more than 17,000 participants. It explored the impact of adverse or negative childhood experiences on people. It has 10 different categories of adverse childhood experiences (ACEs). Figure 1 shows the 10 ACE categories. It also shows how they relate to single incident and complex trauma. Trauma that is experienced for the first time in adulthood or the trauma of a one-off event can certainly cause a lot of harm and distress. People experiencing trauma for the first time as an adult have had prior experiences of feeling safe and were able to develop and grow without trauma disrupting their development. However, trauma from childhood is often more damaging. People who experience trauma in childhood often have long-lasting impacts in multiple areas of functioning.

Fig 1: ACE Categories

ACE (ADVERSE CHILDHOOD EXPERIENCE)

Incarceration
Parental
Substance Misuse
Separation
Witnessing
parental violence

Childhood
Emotional
Abuse
Physical Abuse
Sexual Abuse

Chronic Life
Threatening Illness
Domestic Abuse
Sexual Abuse in
Adulthood
Torture
Trafficking
War as a Civilan

Military
Trauma

Acute Health Crisis
Rape
RTA
Assault

TRAUMA

COMPLEX TRAUMA

SINGLE INCIDENT TRAUMA

The ACE study showed that negative experiences in childhood can affect our mental and physical health as an adult. It also shows that they can affect our ability to function and our behaviours as an adult (Felitti, Anda et. al., 1998). The study showed that some health problems, including heart, stomach and lung diseases, arise from the different strategies people used to cope. These coping strategies were ways the person tried to protect themselves from trauma and adverse childhood experiences. The study also showed that people who had more adverse childhood events, were more likely to experience disruptions in their emotional or behavioural functioning. This includes things like substance abuse, depression, anxiety, aggression. For example, adults who had lots of negative childhood experiences were much more likely to make a suicide attempt than those people who did not (Dube, Felitti, Dong, Chapmna, Giles & Anda, 2001). The ACE study showed that these social and health conditions were not a sign of weakness. Rather, these conditions had grown from the person's attempts to cope with trauma (Cozolino,2012). For more information about the Adverse Childhood Experiences Study, go to https://acestoohigh.com/got-your-ace-score/ or https://www.cdc.gov/violenceprevention/aces/about.html

Children with trauma experiences can develop into adaptive, resourceful and resilient adults. However, if not appropriately supported, they can miss opportunities to learn and develop. For example, when schools do

not understand a child's trauma, the child's coping strategies can be misunderstood and viewed as a problem behaviour. The child can be punished for using coping strategies. That can cause a child to leave school early. This can affect a person's job or career opportunities.

For many people, this can affect a person's long-term financial security. It can also disrupt a person's relationships with friends, family and possible partners. Some young people adopt coping strategies that involve them with the juvenile justice system. For example, drug taking, street racing, hypersexuality, stealing. Children and adults with disability who have experienced trauma as a child, experience lots of barriers to education, employment, relationships and economic independence.

Understanding Human Development

All people grow and change throughout life. There are certain developmental tasks that we need to achive and needs that must be met to be able to develop. According to Berk (2014), there are distinct developmental stages:

1. **Infant Stage – Newborn to 12 months old**
   In this stage, babies typically start to develop the beginnings of language. Babies use sounds and behaviours, such as crying to communicate their needs. They also start to develop movement, such as rolling and sitting. Babies start to become familiar with their environment. They start to develop attachments with their primary caregivers. Babies need to be in safe and stimulating surrounds to be able to develop.

   When a trauma occurs during this stage, the baby faces significant communication barriers because understanding and language have not yet developed. Experiencing a trauma when non-verbal can create a long-term barrier to being able to talk about the trauma. Experiencing trauma during this stage can also lead to delays in further developing language and movement. Supporters might need to pay special attention to changes in patterns of behaviour or responsiveness as well as possible injuries to notice when a baby's needs are not being met.

2. Toddler Stage – 1 to 3 years old

In this stage, the toddler continues to develop language and can use words and phrases. Typically, the toddler is much more mobile and starts to walk. This means they can explore their environment more and engage in play.

When trauma occurs during this stage, the toddler will certainly not understand what constitutes abuse or a traumatic event. However, toddlers will be able to use words and behaviour to demonstrate distress or hurt. Experiencing trauma during this stage can create barriers to exploration and play. It can lead a toddler to view the world as an unsafe place. Supporters might need to notice when a toddler appears reluctant to explore or be separated from a primary caregiver. Changes in patterns of behaviour or injuries are also important to notice.

3. Preschooler Stage – 3 to 5 years old

In this stage, preschoolers become more physically, emotionally, socially and intellectually developed. Typically, preschoolers become more aware of themselves and start to enjoy playing with others.

When a trauma occurs during this stage, the preschooler may become more socially withdrawn or more aggressive in certain circumstances. Some research has shown that children around this age who have experienced trauma might re-enact that trauma during play or experience frightening dreams (Makley & Falcone, 2010). Supporters might need to notice changes in patterns of behaviour, emotional responses, social withdrawal, and injuries. Preschoolers can talk about aspects of their experiences or concerns if provided the opportunity to do so.

4. Middle Childhood Stage – 6 to 11 years old

Physical, emotional, social and intellectual development continues during this stage. Children typically start to seek a little independence and develop a sense of responsibility.

Trauma during this stage can create barriers to developing

independence and social connections. Some research has shown that chronic stress and trauma have the greatest impact on some aspects of brain development (i.e. amygdala development) during this stage. This can leave the child more likely to experience fear and anxiety later in life (Pechtel, Lyons-Ruth, Anderson & Teicher, 2014). Supporters might need to notice changes in emotions and behaviour, particularly social behaviour, and provide opportunities to talk about concerns with the child.

5. Adolescent Stage – 12 to 18 years old

Physical and social development are primary developmental tasks during this stage. Adolescents typically further develop their sense of self and self-identity. Peer relationships become critical, more so than familial relationships. Risk taking becomes an important behaviour to further develop independence.

Trauma during adolescence can greatly confuse the development of healthy relationships and self-identity. Increased risk taking can also potentially contribute to the experience of more trauma. Coping strategies such as substance use and self-harming may commence as well. Supporters need to carefully balance the adolescent's need for independence and risk taking whilst also encouraging sound decision making and responsibility. Peer supporters often have greater influence than parental supporters during this stage.

6. Adult Stage – 18 years old to death

The adult stage may be divided into four sub-stages. Young adult (age 18 to 25), mature adult (age 25 to 55), older adult (age 55 to 75) and elderly adult (age 75 until death). A young adult further develops their independence. The need for self-determination, access to choices and autonomy become critical. A mature adult may typically focus on the development of romantic relationships, a vocation, and creating a family of their own. Older adults tend to experience reduced energy and become more reflective. Some older adults may feel confronted by their sense of frailty and vulnerability. Trauma experienced during the adult stage can greatly disrupt an adult's confidence, self-esteem, vocational aspirations and relationships.

It is very important to understand that not all changes in behaviour or strong emotions are a prior indicator of abuse, neglect or trauma. All babies cry, all children have tantrums or moments of social withdrawal, all adults have moments of feeling overwhelmed or lacking confidence. These are normal human experiences and should not be viewed as indicators of abuse on their own.

Understanding Attachment

Repeated and ongoing trauma during childhood, or complex trauma, can disrupt the development of attachments with other people. The opportunities a child has to attach or bond to a caregiver are important. Caregivers teach children how to bond or attach to other people. The bond that forms becomes a model for all later relationships. It also helps the child learn how to manage feelings. Healthy attachments help calm the child when they experience distress. Healthy attachment helps a child feel safe. It also helps a child to understand healthy boundaries. There are four main patterns of attachment:

Secure Attachment

A caregiver's attuned response to a child's needs builds a good foundation for other relationships. It allows the child to explore and learn. It also helps the child to be resilient and manage everyday stress. Children with secure attachments also develop the skills to manage their feelings. Some studies have found that some children with intellectual disability, who are on the autism spectrum or have other psychosocial disabilities might find it harder to experience secure attachments (Rutgers et. al, 2004; Rutgers et. al, 2007). This happens particularly if the child has adverse childhood experiences.

Avoidant Attachment

A child develops an avoidant attachment style when caregivers do not reliably meet the child's needs. This can mean that the child avoids the caregiver and tries to meet their own needs. This can cause a child, and the adult they become, to avoid strong emotional connections with other people. This can make the person seem self-centered and distant.

Ambivalent Attachment

This happens when a child does not know what to expect from the caregiver. The caregiver may not be available at times. At other times they may be overinvolved. This can confuse the child. The child may become available to other people one moment and reject them the next. This can become a pattern into adulthood and throughout life.

Disorganized Attachment

This happens when a child does not feel 'seen' or feels ignored by the caregiver. It also happens when the child is unable to predict the caregiver. This can make the child feel scared of relationships. It can mean that the child does not know how to interact with people, even when the child wants to be close to other people. This can become a pattern as an adult as well.

Providing opportunities for a child to develop a secure attachment is a caregiver's responsibility. It is not the child's responsibility. However, not every caregiver can consistently provide opportunities for secure attachment to children. It is important to note that the caregiver does not have to be the child's biological mother. It can be any person who is in a role to meet the primary needs of a child. For example, a father, grandparent, family friend, or nanny. This is a common misunderstanding of attachment theory from the past. It led to many mothers, including mothers with disability, being unfairly blamed for their child's insecure attachment. However, when no caregiver is able to provide these opportunities, it can have lifelong impacts for the child. Understanding attachment can help us understand the barriers to developing healthy relationships and boundaries. When the attachment style is not secure, people can experience other attachment losses (real or imagined). When past attachment experiences have made the person believe that relationships are not safe or consistent, it can affect all new relationships. This includes relationships with supporters.

Trauma Impacts

Not everyone who experiences trauma experiences long-term negative effects, but many people do. Trauma can have a lot of different impacts. The impacts are different for different people but largely fall across these six categories:

Physical Impacts

Trauma causes ongoing stress to the brain and body. It can affect the development of the brain, including the structure and function of the brain. It can also affect the development of strong and healthy bodies. Trauma has the most impact in childhood. That is because the brain and body develop the most in childhood. Stress and trauma can affect the brain and body at any age. This is because stress releases chemicals. These chemicals cause inflammation over time and compromise immunity. Inflammation and compromised immunity can lead to chronic disease.

Cognitive Impacts

Cognition relates to thinking, understanding, learning and remembering. Research has shown that children who have experienced or witnessed violence, trauma, abuse or neglect experience cognitive difficulties in one or more areas, when compared to children who haven't experienced these adversities (McCrory et al., 2011; McLaughlin et al., 2014). This is because trauma and chronic stress can disrupt brain development. The left and right parts of the brain usually work together. But trauma can stop the two sides from working together as they usually do. This is called neurodiversity. But some people find it can make it hard to talk about feelings when your brain works like this. It can also disrupt how memories are formed and recalled. Trauma can also make it hard to think clearly and logically. In this way trauma can create barriers to thinking, concentration and memory. Trauma can also change the way people view themselves and the world. Some people develop a low self-worth or poor self-esteem because of the trauma experienced. Some people form views about other people and the world in general as being dangerous and unsafe. This is also an example of the cognitive impacts of trauma.

Some people with intellectual disability or cognitive impairment might

already experience barriers to concentrating, learning and remembering things too. This can mean that people with intellectual disability or existing cognitive impairment who experience trauma as well may face further barriers to recovering from the additional cognitive impacts of trauma (Razza et al., 2011).

Behavioural Impacts

People who have experienced trauma develop behavioural strategies to help cope with the trauma impacts. Behavioural strategies might include self-harm, overeating, being restless, getting aggressive, compulsions and lots of other behaviours. Other people can view some of these behavioural coping strategies as a problem. The coping strategies are sometimes labelled as 'behaviours of concern'. Children with different coping strategies can be given diagnoses. These diagnoses can include Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder and Oppositional Defiant Disorder (ODD). Some people who use these coping strategies may be labelled as having 'behaviours of concern' throughout life. This can happen even when the behaviour is the result of trauma. Or when the behaviour is a legitimate protest to a problematic environment or situation.

Some environments do not encourage social and emotional expression. This can make it hard for people with disability to express strong feelings or needs. It can make it even harder to let someone know about ongoing abuse or a past trauma. Some people who have experienced trauma express their needs and strong feelings like anger, frustration and upset in other ways. This includes through behaviours such as screaming, lashing out or head banging. Some people withdraw and do not respond outwardly at all. It is important for all supporters to try to understand what different behaviours are trying to say. All behaviour has a meaning. We need to listen to it.

Emotional Impacts

Trauma can make it hard for a person to manage, express or feel strong emotions. Trauma from childhood can create barriers to learning how to manage strong emotions.

Adults and children who have learnt to manage strong feelings can calm themselves and self-soothe. Many people who have experienced trauma

become anxious or depressed (Fergusson & Mullen 2007). Some people try to manage strong feelings by numbing the feelings. Sometimes it might be helpful to not express or feel emotions at that time or in that context. Some people might use alcohol, drugs, food, work, exercise, gambling or sex to help manage the strong feelings. This can make people seem dramatic or erratic. Some people find it hard to feel anything and engage in these behaviours to manage the numbness.

Social/Relational

Some people who have experienced complex trauma are able to read other people. Being able to pick up on cues of threat or deception may have been useful to survive. However, sometimes this ability can get in the way of building healthy relationships later in life. For example, trusting others or keeping safe boundaries. Some attitudes towards people with disability, and communication and social barriers can make it even harder. This can happen for some people with intellectual disability, who are on the autism spectrum, or who have other psychosocial disabilities. These barriers also make it hard for people to know how to trust (too much or too little). It can be even harder to form and maintain intimate relationships after trauma. Sometimes people experience "othering" after a traumatic event. This is when you feel different from other people or are made to feel different because of the trauma.

Trauma can make it hard to relate to yourself too. It can affect your self-esteem and identity. It can make you feel like you do not have control over your own life. It can also stop you engaging in everyday social activities. This is because ongoing trauma keeps people in survival mode. This stops people from exploring and learning. Additional attitudinal, physical, communication and social barriers can also affect people with disability. These can make it even harder for people with disability who have experienced trauma to develop relationships and social connections.

Spiritual/Cultural

Trauma can lead to feeling disconnected from culture. This is especially true for First Nations people who have experienced personal trauma in the context of colonisation, marginalisation, forced removal of children, racism and intergenerational trauma. This is also true for people who experienced

trauma escaping war or seeking asylum. Some people question their spiritual beliefs after a traumatic event. Some might question the meaning of life or their purpose in life. This is called existential questioning. Some people try to cope by disconnecting from life. This can leave people just surviving and missing out on the richness of life. But all people need to dream and hope, and not just survive. We need to feel hope to connect with others and ourselves spiritually and culturally.

Trauma Risk and Protective Factors

Lots of factors can change the way in which trauma affects a person. Some factors can make it harder to recover from trauma. Some factors help recovery or protect from harm. These are called risk and protective factors (Carswell et al., 2017). Generally, it is harder to recover from trauma experienced at a young age or on multiple occasions. It is also generally harder to recover from trauma that was caused by a caregiver (i.e. not a stranger), and was experienced as terrifying and life threatening. Access to positive supports, the prior experience of safe relationships, and the ability to make meaning from the event often support recovery from trauma.

Knowledge Base
– Trauma Risk and Protective Factors

- the person's age/s at the time/s of the trauma
- the way the person experienced the event/s
- the meaning the person made of the trauma – this can be affected by cognitive ability
- whether the person had support during the trauma
- whether the person had support after the trauma
- any additional barriers the person faces because of disability
- how long the trauma went on
- how often the trauma was repeated
- number of different types of trauma
- number of perpetrators
- type of attachment
- presence of safe relationships
- some culturally bound beliefs or practices
- the person's relationship to the perpetrator/s

Social Determinants of Health

Some groups of people are more likely to experience complex trauma. This includes First Nations people, asylum seekers and refugees, homeless people, people from LGBTIQ+ communities, women, children, and people with disability. This is because these groups of people often face structural barriers to equality and wellbeing. There are many personal, social, economic, and environmental factors that influence wellbeing. These are called the social determinants of health. People who do not belong to the dominant culture are often less able to access the optimal or the best personal, social, economic, and environmental factors that enhance wellbeing. For example, some people may not have access to adequate food, money, education, medicine, employment, clean and safe housing. These elements can all contribute to poorer outcomes for a person after experiences of trauma. They also increase the likelihood of a person experiencing complex trauma.

It is important to recognise that First Nations people in Australia have experienced lots of trauma. This has happened for many generations. Trauma includes the impact of colonisation of Indigenous land. It also includes deliberate efforts to eradicate First Nations people and forcing them to be more like non-Indigenous Australians. An example is taking children from their families and communities against their will. First Nations people were also prevented from engaging in cultural practices including ceremony and language. The rich culture of First Nations people was generally ignored and devalued. First Nations people still experience discrimination and trauma from systems that are unfair.

First Nations people continue to experience higher rates of incarceration and poorer health outcomes because of this. A Royal Commission into Aboriginal Deaths in Custody (1991) found that First Nations people were also more likely to die while in custody than Anglo-Australians. This is still the case today. Many First Nations people also do not have access to culturally safe health services. Or services that support culturally relevant healing and wellbeing practices. First Nations people who have experienced trauma are often faced with additional barriers to recovery. This is because of limited access to the many personal, social, economic, and environmental factors that influence wellbeing (i.e. social determinants of health).

Many people from Culturally and Linguistically Diverse (CALD) communities have also experienced trauma. Sometimes before travelling to Australia. Sometimes after arriving in Australia, and sometimes both. Sometimes people are made to feel unwelcome by others in Australia. Different religious or cultural practices may not be understood. There may be an added barrier of language and a lack of support from others too. People from CALD communities also face additional barriers to recovery from trauma because of the social determinants of health. In fact, many different groups of people that experience more trauma than other groups also have poorer access to the optimal personal, social, economic, and environment factors that enhance wellbeing. For example, women, people from the LGBTIQ+ community and people with disability. This creates further barriers to recovery from trauma for these groups.
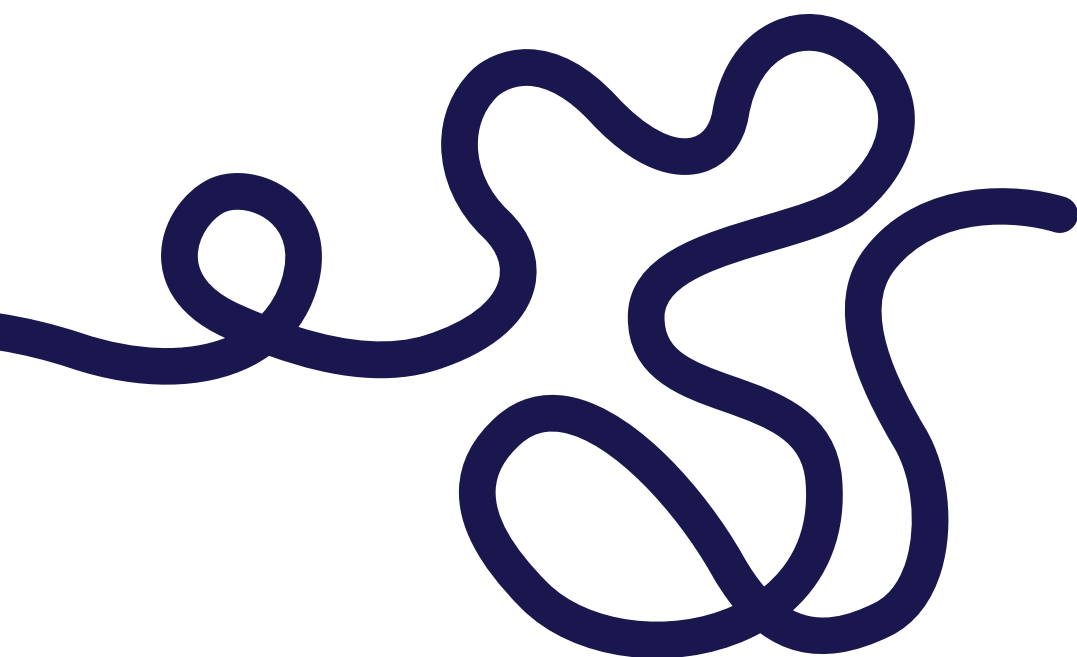
Trauma and the Stress Response

Neuroscience helps us understand how stress affects our body and brain. When we are threatened or feel threatened, a part of the brain called the amygdala detects the threat. It signals to our body and brain that we are in danger. When this happens, we often feel fear, panic and distress. Our stress response takes over and we go into survival mode. In survival mode we react automatically and do whatever we need to protect ourselves. We go into fight, flight and freeze mode – our survival response. When we are in survival mode, we use all our energy to protect ourselves. Our brain controls this for us. This can make it very hard to think clearly and make decisions. We just react automatically without being aware of our thoughts.

Our stress response is part of our biology. It helps us survive danger. A perception of threat sets off the stress response. There are lots of possible threats. Some threats stimulate our senses – smells, sounds, sights, touch, tastes. Others come from cues in our environment. Different people feel threatened by different things. Some people may feel threatened by lots of things lots of the time. It can be hard to always identify or predict what threatens a person. It can be hard for the person feeling threatened. It can also be hard for the people supporting or assisting the person feeling threatened. The person's reaction can be hard to understand when the threat cannot be identified. The reaction seems to happen for no reason. This can mean the reaction is misinterpreted. This can make people judge and punish the person for the reaction - instead of understanding that this is a survival response and it simply cannot be helped.

We respond to stress in one of three main ways. We fight, we run away (flight) or we freeze (shut down). When we fight or flee, we become agitated and are on high alert. We call this hyperarousal. When we freeze, we shut down, go numb or dissociate. Dissociation is when we disconnect from our current experience – this is not conscious. We call this hypoarousal. Freeze is when we 'play dead' or faint. Sometimes

people might also 'fawn' or 'appease' when hypoaroused. This is when the person complies or attempts to please the person who is hurting them. This response is designed to minimise the harm caused and to protect the person. These responses happen when we cannot defend ourselves anymore because we are not fast enough or strong enough to protect ourselves or find protection. When the danger passes, we can start to think more clearly. Our body becomes calm. We return to a resting state. In the resting state we can repair and recover.

We can return to the resting state with everyday stress, but trauma is different. With trauma we feel threatened often. With repeated trauma, our stress response can stay switched on. It can be harder for us to return to a resting state. This can mean that we react more to everyday stress as well. This happens especially with complex trauma. The person may know that danger no longer exists but can still feel in danger. The person might even still hear, feel, taste, and smell things from when the trauma happened.

> **"People who have experienced childhood trauma often find that seemingly unrelated events, sensations or sensory cues such as a scent or sound, happening in day-to-day life can trigger unwanted thoughts, feeling and memories of their traumatic experience to come flooding back. Strong associations with past experiences can persist and the survivor can relive details of the abuse, the environment in which the abuse occurred, or be reminded of the perpetrator of the abuse. For the survivor this can feel like the trauma is occurring in the present and can be frightening, confusing and overwhelming. It is not possible to predict and avoid every trigger in advance – this is often not possible even for the survivor themselves. Triggers are words, symbols, situations, items, sounds, smells, colours – just about anything that the mind correlates to a negative past experience and causes a reaction based on it."**

Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report, Volume 9, p.126

· Trauma is different to everyday stress - it overwhelms a person's capacity to cope
· With trauma the stress response stays turned on
· Our body and brain are flooded with stress hormones, like adrenaline and cortisol
· With trauma, we stay in survival mode
· With trauma, it is hard for us to return to a calm state
· Trauma causes fear
· Trauma can make us feel helpless and powerless
· Trauma means we are less able to explore and learn
· Trauma can make us rigid and less flexible - this makes us less able to respond to new experiences
· Trauma makes it harder for us to engage socially as well
· People with complex trauma swing between hypo and hyper arousal all the time
· With changes in arousal come strong emotions
· These strong emotions can bring different coping strategies and behaviours

Arousal and the 'Window of Tolerance'

When we experience complex trauma, we are locked in survival mode and move between fight, flight and freeze responses. We do this to try and manage strong emotions and changing levels of arousal. Arousal is the state of physiological alertness and readiness for action (Reber, 1985). Some people who have experienced trauma live in constant fear and anticipate danger a lot of the time. The world and people feel unsafe. The person may find it hard to trust and to ever feel calm. This is because trauma has caused the person to feel and often be unsafe throughout life.

The Window of Tolerance Model describes the range of arousal in which a person functions best Prof. Dr Dan Siegel, a leader in the trauma field, developed the Window of Tolerance Model. The model describes some of our normal brain and body reactions when we are outside our optimal or best range of arousal. The Window of Tolerance recognises the ups and

downs in emotions we all experience. We can all experience hurt, anxiety, pain and anger. When we experience strong emotions, we can move close to the edges of the Window of Tolerance. When we are overwhelmed, we move outside of the window.

Most of us use strategies to stay within this window. It is also useful to have strategies that support us to return within our window when we are outside it. When we experience complex trauma, we can easily move out of the Window of Tolerance. Sometimes other people support us to return to our window. We may also need help to learn these strategies. It is not possible to 'reason' traumatised people out of feeling overwhelmed. This is because trauma activates a stress response which switches off the part of our brain that helps us to reason.

Most people feel safer and more able to stay within the Window of Tolerance in a predictable and stable routine and environment. Lots of unexpected changes to routine or environment can be unsettling and even scary. For example, having to move to a new home, school, or hospital can feel threatening. Some people with disabilities need a lot of different people to support them. When lots of different people provide support, changes in routine and supporters are common. Even a good change can feel not safe to a person whose nervous system is on high alert. Trauma can affect the ability to respond flexibly to change. This is why people with disability who have experienced trauma often react to change in ways that seem extreme or are hard to predict.

Understanding the stress response helps us recognise when a person is having a trauma response. This can present in different ways. The person can become hyperaroused or hypoaroused. People who have experienced complex trauma can go between being 'on high alert' (hyperaroused) and 'being shut down' (hypoaroused) at different times.

Hyperarousal

Some people who go out of the Window of Tolerance and have a trauma response appear agitated. This is called hyperarousal. This is when the world does not feel safe.

Some people may not feel safe at home or in the community. Some people may not feel safe with other people. Some people with disability and complex trauma have never felt safe. Some people live in fear and check for danger a lot. It is easy to recognise when a person is hyperaroused. The person may shake, sweat or have wide pupils. When people are in fight or flight mode, they are hyperaroused.

Hypoarousal

Some people shut down during a trauma response. This is called hypoarousal. When some people shut down, the person finds it hard to respond to others. It might seem that the person is not trying. The person might be labelled as 'resistant' or 'difficult'. The person may be forced to do things. This may make the person react more. If the person is having an active freeze response, challenging the person can cause more trauma. It can be harder to tell when a person is hypoaroused. When a person is hypoaroused they are 'shut down', 'zoned out' or 'on autopilot'.

Knowledge Base
– Arousal

· Understanding the stress response helps us to notice when a person is having a trauma response
· Some people might appear agitated and fearful often – this is called hyperarousal
· Some people might appear shut down or frozen - this is called hypoarousal
· Some people move between these states
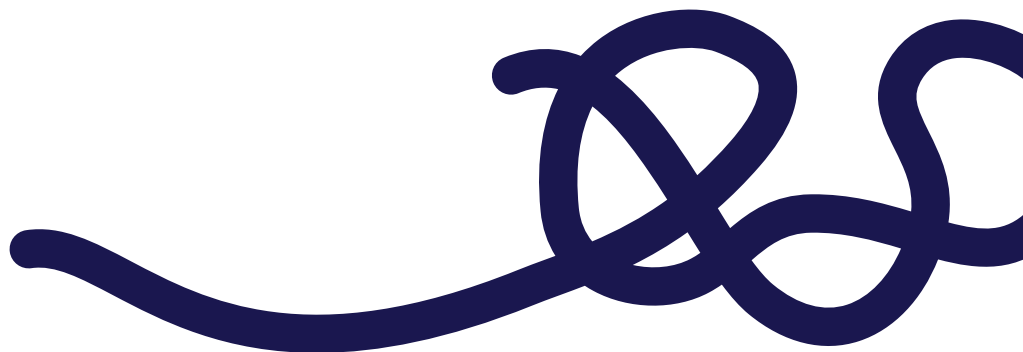
Dissociation and Flashbacks

> **"A key characteristic of trauma (regardless of its source and who experiences it) is that it activates divisions or 'splits' in the person's conscious experience"**
> (Howell & Itzkowitz, 2016: 35)

When a person is in freeze mode, they are usually hypoaroused although not always. **Dissociation is a type of freeze** response. It is a helpful but complicated response to threat and trauma. Sometimes dissociation is obvious. More often it is hard to detect.

We all dissociate sometimes. Examples of everyday dissociation include daydreaming or being very absorbed in a task. This is normal and does not cause a problem for the person. Dissociation can vary from mild to severe. It happens on a spectrum. It is important to understand the basic characteristics and function of dissociation.

Dissociation, which occurs with trauma, causes 'disconnects' between different brain and body functions that usually work together. These include thoughts, feelings, body sensations and behaviours. When we dissociate because of trauma we cannot function in a smooth integrated or coordinated way. These splits or divisions in our key functions happen outside of our conscious awareness.

> **'If the overwhelming traumatic event could not be taken in….it is dissociated. There is a split in experience. Experience that is too overwhelming to be assimilated will cause a division of experiencing and knowledge. Part of self-experience will be separated or split off from one another, and one part of ourselves will not know of other parts of ourselves… the result of trauma is dissociation'**
> (Howell & Itzowitz, 2016: 35)

The 'split' of experience in dissociation is a core characteristic of trauma. This applies to all traumas. It is important to understand that dissociation is adaptive and a survival response to trauma. Some people with trauma-related dissociation are diagnosed with different conditions. These are called Dissociative Disorders. Dissociative Disorders are viewed as a form of psychosocial disability. A severe form of dissociation is called Dissociative Identity Disorder (DID).

Sometimes people experience flashbacks and re-enactments. Flashbacks or re- enactments are the sudden and unexpected reliving of trauma memories. They often come with strong feelings including terror and distress. They can also come with strong sensations and body movements. This is because our bodies often hold the memory of traumatic events. When we are reminded of traumatic events, the trauma can be reactivated and relived. When this happens, past experiences take over and it can feel as though they are happening in the present. The person behaves like they did when they were hurt before. Even when there are no communication barriers, it can be hard to put this sort of trauma re-enactment into words.

Triggers

Triggers can be common when people have experienced trauma. Triggers are distressing reminders of the traumatic event. People are pushed outside of the Window of Tolerance when triggered. The brain tries to help cope with the trigger by creating changes in the person's state of arousal. When triggered, a person might react from one minute to the next.

It is important to notice when a person has been triggered. Some people are triggered by a person shouting. Other people are triggered by others getting too close. Certain times of the day or night can be a trigger. Bedtime can be a trigger. The trigger can relate to what happens at that time of the day. For example, room checks. Some people are triggered on certain dates. For example, anniversary dates. People are often triggered by an experience that reminds us of past trauma. It may be tall women or men with beards. It can be contact with our family. It can be any situation that make us feel unsafe. If we know about the trauma, we will know about some of the person's triggers. But we might not be able to identify all of the triggers. If we know a person well, we might see a pattern to the triggers. If we do, we can try and reduce the triggers.

When triggered, a person may become jumpy. Or the person might get angry and pick a fight. The person might hit someone or themselves or destroy something. The person might scream or go silent and stop answering. It may not be obvious to others observing that something is wrong. However, the person who is triggered will feel lots of strong feelings. These include feeling frightened, agitated, anxious, distressed, and angry. Being triggered can cause people to react in ways that are hard to control.

People with disability who have experienced trauma may experience triggers every day. Some people with disability are very sensitive to loud noises and bright lights. That is because some disabilities can affect the way people process sensory input. This can make people with disability who have experienced trauma very sensitive to sensory triggers. Some people are triggered in group homes, residential settings or institutions. This is because these settings often have a lot of triggers, such as loud noises, strong smells, or lots of other people. These places might also remind people of past traumatic events that happened in similar settings. Some women with disability have been sexually assaulted by a person providing personal care. For example, bathing, dressing, or toileting. For many women with disabilities who have been sexually assaulted, personal care may be very triggering. The woman may rely on someone to provide personal care, but she may not be given any choice about who provides this care. Women who have been harmed by men, can sometimes find the presence of men triggering. This might happen in public places. For example, public transport, shopping centres, or hospitals. It might also happen in private places (e.g. at home) where men also live or visit. For example, if a male delivery worker or tradesperson attends the home to deliver or fix something.

Emotional Reactions

Our thoughts, feelings, bodies and behaviours are all connected. This is especially important to understand if someone has experienced trauma. Most of the time, people experience a thought first. This creates a feeling. A bodily response and then a behavioural response. For example:

Thinking about lunchtime (thought)   ➔ feeling hungry (feeling)
➔ hunger pangs/grumbling tummy (body) ➔ making lunch to eat (behaviour).
Or
Thinking about an exam (thought)   ➔ feeling anxious about failing (feeling)
➔ sweaty palms or headache (body) ➔ doing an extra hour of study (behaviour).

However, sometimes it can be very hard to notice the thought or feeling. Or the feeling can seem much bigger than it needs to. For example:

Thinking about lunchtime (thought) ➜ feeling panicked and fearful of starving (feeling) ➜ heart palpitations, rapid breathing (body) ➜ immediately making a big lunch to eat (behaviour).

This strong emotional reaction makes sense if the person has previously been starving. It also makes sense if a traumatic event prevented the person from accessing food. People who have experienced trauma often experience strong and sudden reactions. Sometimes the person may not notice the thought or the feeling, but just notice a body response. Sometimes the person may not notice the thought that occurred before the feeling, so the feeling might seem to come out of the blue. Anger, fear, sadness and frustration are common. It can be hard to manage or 'regulate' these feelings. Trauma makes it even harder to regulate emotions. People traumatised as a child often do not have the chance to learn how to manage or express strong emotions.

People who have experienced trauma can also have trouble naming and understanding feelings. The process of recognising and managing feelings can take a long time. People with disability may depend on other people to help understand strong or sudden feelings. This process can take even longer for children with disability who have experienced trauma. It is important that supporters understand that strong emotional reactions could be a response to a lot of frustration, communication barriers or traumatic triggers.

Complex Behaviour Support Needs

The phrase 'behaviours of concern' is commonly used within the disability sector. A 'behaviour of concern' is defined as a behaviour:

> **'of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion'**
> (Royal College of Psychiatrists, 2007, p. 10).

However, labelling behaviour as 'behaviours of concern' does not fit with the Convention on the Rights of Persons with Disabilities (CRPD). Behaviours that are labelled as 'behaviours of concern' can cause problems at home or in services. Of course, some people with disability and some people who have experienced trauma can and do engage in purposefully harmful or disruptive behaviour. However, many people act in ways that are labelled as 'behaviours of concern' in response to a prior experience of trauma, a current threat to safety, or because they are trying to cope with an unsafe environment person or situation (Ramcharan, Nankervis, Strong & Robertson, 2009).

Understanding trauma and how thoughts, feelings and behaviours are connected explains a lot of what is often labelled as 'challenging behaviour' or 'behaviours of **concern'.** Sometimes people express strong feelings through their behaviour. This occurs especially if communication barriers stop the person being able to explain the thought or feeling that came before the behaviour. Understanding the trigger to the thought, feeling, body response and behaviour helps to understand the reactions and behaviour. A person's behaviour is often not understood when the trigger is not noticed or understood. The person may even be punished for the behaviour. The person might be called 'impossible' or 'crazy'. However, if the trigger, thought, feeling, and body response are understood, other people are more likely to respond with empathy and compassion. The person will be more likely to be supported to manage the triggers, thoughts, feelings, body responses, and behaviours. It is important to be aware that sometimes supporters find a person's actions or demeanor to be challenging – not because the person intends to be challenging. But rather, because the person is doing what they can to survive or are making a legitimate protest to stop something harmful from happening.

Knowledge Base
- Behaviours

- Some complex behaviours are labelled 'behaviours of concern'
- Systems have often tried to control behaviour labelled as 'attention-seeking' or 'behaviours of concern'
- It is important to think about possible reasons for behaviour
- A person can be labelled as 'uncontrollable', 'manipulative' or 'psycho' if the reason for the behaviour is not understood
- Labels hurt people and often make things worse
- Often a diagnosis is given based on a person's behaviour
- The person's behaviour then becomes the main reason for treatment
- The behaviour might be treated by restraining the person, or medicating the person
- People can be wrongly punished for their complex behaviour support needs and support may be withdrawn
- It is important to change this response to people who have strong feelings and complex behaviour support needs.

Behaviours are ways people communicate that there is something wrong in the environment – it could be an abusive support worker, a non-responsive caregiver, or other problematic factors external to the person with disability. It needs to be listened to and understood.
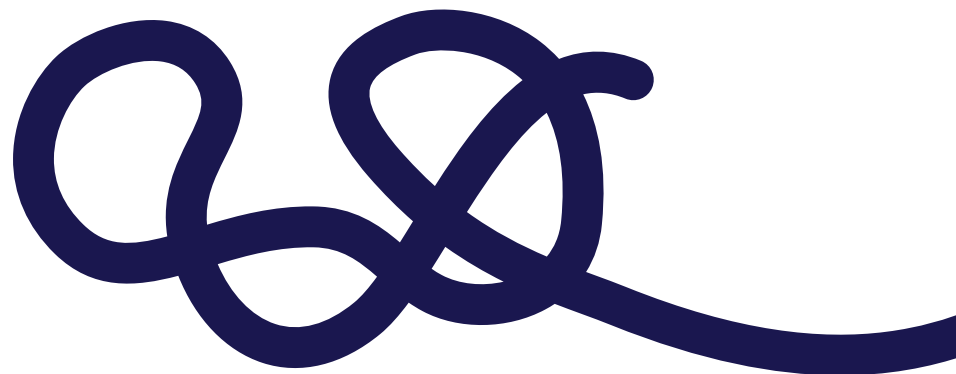
Resilience and Recovery

Resilience has been defined as "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar et al., 2000). Resilience is not related to a person's capacity. It is complex and depends on the presence of different risk and protective factors. These include biological, social, psychological and cultural factors. The different elements of a trauma-informed approach can help to foster resilience.

> **'Healing is not just about recovering what has been lost or repairing what has been broken. It is about embracing our life force to create a new and vibrant fabric that keeps us grounded and connected ... keeps us strong and gentle ... gives us balance and harmony, a place of triumph and sanctuary for ever more'.** (Milroy, 2013)

Different people have different goals for recovery and are able to acknowledge and celebrate the strengths of having survived. However, many people can and do recover from trauma. Recovery from traumatic experience is a process. It depends on a lot of different factors. A key factor is the support people receive. People need that support to process the parts of trauma where they felt hurt and betrayed by other people. They also need it to help build healthy relationships.

Our brain can develop and change in structure and function because of our experiences. This means that our brains can also help us recover from trauma (Doidge, 2007). We call this neuroplasticity. The brain responds to social experiences. Social experiences shape it. The good news is that neural growth and change continue through life. Positive experiences change the brain. Positive interactions support the person to build healthy connections between the nerves in the brain and to recover. This can foster healthy development, functioning and secure relationships.

A trauma-informed approach not only helps people recover from trauma, but also helps people live a life that is more than the experience of trauma. It can help people move towards a more holistic recovery and stronger

engagement with themselves and the community. This enables the person to acknowledge their own strengths, feel supported by the community and more able to contribute to it. And move beyond solely defining themselves as a victim of trauma. To even gain a sense of pride around their survival. Develop a new identity and feel empowered. Some people may even become politically active and try to prevent trauma in their community as a part of their recovery (Ginwright, 2018).

The ability to grow through the experience of trauma is sometimes called post- traumatic growth. Tedeschi and Calhoun (2013) identified five main areas of posttraumatic growth:

a. Better ability to relate to others;
b. Seeing new opportunities, priorities or pathways in life;
c. Developing a greater appreciation for life;
d. Better understanding of the considerable personal strengths and abilities that enabled survival; and
e. Creating meaning about the purpose of life and survival (e.g. spiritual or existential meaning)
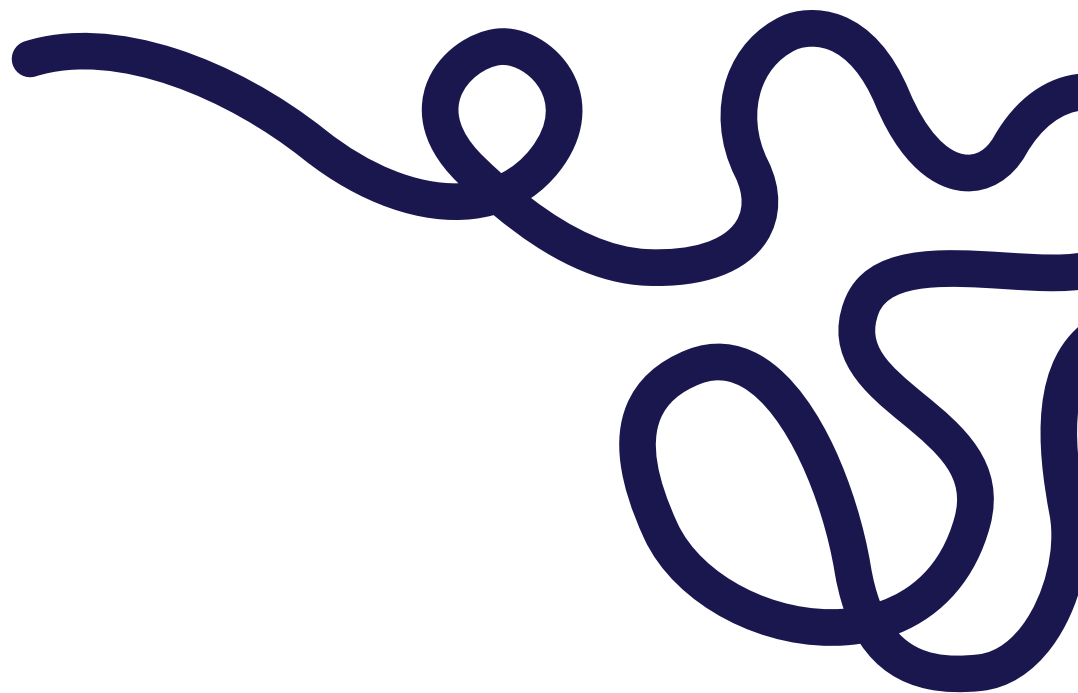
Survival and Coping Strategies

Knowledge Base
– You can help people with disability recover from trauma

- Many people can and do recover from trauma
- Trauma changes the brain but recovering from trauma can also change the brain
- People need good support and good experiences to recover from trauma
- People need to feel connected with others through community and culture
- People who have experienced trauma need empathy, understanding and respect
- Positive daily interactions (conversations, compassion and care) with people can support recovery – it doesn't matter how big or small the interaction
- Supporters can help people with disability to recover from trauma and reduce the risk of more harm
- Everyone can work together to stop people, institutions and systems from causing more trauma and harm
- People can grow through the experience of trauma

The human ability to survive and adapt is amazing. It is important to think about the possible trauma experiences of a person receiving support. People and services can focus on what is wrong with people. This is not helpful. Surviving is a strength, which is good to be acknowledged. This does not mean ignoring the negative impacts of the trauma. It means working with the impacts and needs in a respectful and aware way.

People who have experienced trauma have had things happen that should not happen to anyone. Each person copes as best as possible. Ongoing trauma can overwhelm a person's capacity to cope. It forces a person to adapt to be able to survive. These adaptations are called coping strategies. Coping strategies become familiar. They become default or automatic responses during more stress and trauma. People adopt coping strategies to help manage strong feelings and changes in arousal. These coping strategies enable a person to survive trauma. They are strengths that have protected the person.

However, some strategies do not stay helpful long-term. While the strategies may have been protective before, they often become risks or have negative health impacts. For example, some people cope by using alcohol, drugs, self-harm, suicidality, anger and aggression. Other people might use withdrawal, avoidance and dissociation. People **often use these** behaviours to communicate their needs. This should be listened to. When coping strategies that are no longer protective are identified, it is important to support people to find other ways to cope. It is critical to not remove coping strategies until the person has new resources to cope. Remember that the person uses coping strategies to stay safe in a dangerous world. Coping strategies are there for a reason. There are other ways we can support people to manage pain and distress. But it takes time, patience and support. Coping strategies can be hard to change. We all go back to old patterns under stress or trauma. Supporters can play an important role in supporting people to build new resources that help with coping and recovery from trauma.

Practice Tip
– Coping Strategies

Here are some ideas for understanding and supporting helpful coping strategies:
· Be mindful of the possible trauma a person may have experienced
· Recognise the person's resilience and strength to survive
· Acknowledge the coping strategies that have helped a person survive
· Understand that the person's behaviour is communicating something
· Support new ways or coping strategies that are less harmful to meet the need that other coping strategies are meeting
· Be patient and support the person to practice each new skill before removing old coping strategies

Social Beings and Healthy Relationships

Humans are social beings who are affected by the social environment. Humans are wired to connect with others. Negative relationships and interactions can change how we form connections with others. Negative relationships and interactions can even change how the brain works. Damaging interactions cause negative changes in the brain. These changes in the brain can change the way people think, feel and behave.

Trauma is often the result of a person or people harming another person (i.e., a negative relationship or interaction). When a person has been abused or violated, the person can learn not to trust or feel safe with other people. This can make it hard for the person to trust supporters. Some people do not trust the 'system'. This is because some people with disability have been betrayed by other people and systems before. Some have been abused by people who were supposed to provide care or support. Being neglected or abandoned can happen. So can bullying and other violations. People who have experienced trauma can sometimes expect to be hurt again because this happened before. This can mean that the person withdraws and avoids connection. This is a coping strategy that enabled survival. However, this coping strategy can lead to the person feeling isolated and lonely.

Positive interactions can enhance wellbeing. Good interactions can lead to positive thoughts, feelings and behaviours. Positive interactions can also change the brain and repair damaged neural pathways. Positive interactions can support the person to gain skills in managing strong emotions. Positive and healthy relationships can help resolve the impacts of past negative experiences, including trauma. It is very hard to heal from trauma in isolation. Relationships are an important part of being healthy. This is because healthy relationships can support recovery in many areas of life. In healthy relationships people can learn skills they missed out on earlier. This includes the ability to regulate emotions and arousal. Having a healthy relationship and having positive interactions with a supporter can greatly enhance wellbeing.

· improve brain functioning and well-being
· increase safety
· build trust
· foster connection
· support development of self regulation
· support people to explore their past and present experience
· reduce the risk of re-traumatisation
· build healthy interdependency or dependency between people
· promote self-determination

Cultural Sensitivity

"A practice which respects, supports and empowers the cultural identity and wellbeing of an individual and empowers them to express that identity and have those needs met"
(Department of Health, 2004)

Any framework for people with disability who have experienced trauma must be culturally sensitive. We are all products of our own culture. This means that we grow up with a set of norms. We adopt these norms, and they become part of us. We are often not aware of our norms. This can cause us to believe that our way is the only way. Sometimes this makes us judge another culture. Sometimes we believe that our culture is better than others. When we are culturally sensitive, we understand and accept the differences between our culture and another one. Cultural sensitivity means being aware of similarities as well as cultural differences.

As we understand more about another culture, we become more respectful of its values and norms. This helps us value the differences. As we become culturally sensitive, we can adapt the way we communicate. We can also behave in a way that fits better with another culture. This makes us more empathic and attuned to our differences. The more we understand our biases and educate ourselves about other cultures the more culturally sensitive we become.

Training programs such as the Culturally Informed Trauma Integrated Healing Approach (We Ali-li Pty Ltd) are highly valuable resources for developing understanding of cultural attunement and sensitivity. Training like this can build understanding and skills in using traditional healing and wellbeing approaches to working with all people, but particularly with First Nations people who have experienced trauma.

> **Knowledge Base**
> – Cultural Sensitivity and Attunement
>
> · It is important to be sensitive to how culture might impact a person's needs and experience of disability and trauma
> · Being culturally sensitive does not mean being a cultural expert
> · It means being open to understanding difference and attuning to that difference
> · It means reflecting on your own beliefs, values and assumptions
> · It reduces the risk of discrimination
> · A person's culture can be a significant resource for recovery

Trauma-Informed Framework

"Trauma Informed Practice is not about the treatment of trauma or the symptoms, but rather a recognition that trauma experiences are a possibility for anyone"
(Kezelman & Stavropoulos, 2012)

A trauma-informed practice framework applies to everyone providing a service or support. It does not only relate to services or people who provide trauma counselling. Counselling for people with complex trauma experiences is trauma specific treatment. While both trauma-informed and trauma-specific services have a place, they are not the same. Being trauma-informed refers to the ways in which people needing support are treated more broadly, and the context of that support. A trauma-informed context **supports** recovery and can optimise trauma-specific clinical treatment. This means that not only clinicians need to be trauma-informed. As many people experience trauma, traumatised people come into contact with a wide range of services. This means that all people providing services

or support need a basic knowledge of how trauma impacts the way people function. This is regardless of their role, qualifications or skill base.

Gaining and implementing this knowledge reduces the risk of further traumatising trauma survivors. It also leads to smoother and less stressful interactions for everyone.

Knowledge Base
– Trauma-Informed Practice

· Is not clinical treatment
· Recognises that many issues are trauma-related
· Requires people to be trained to be able to act on this awareness
· Follows the principle of `do no harm'
· Understands the effects of stress and trauma on the brain and body
· Considers what trauma has happened to a person and not what is `wrong' with a person
· Regards `symptoms' as expressions of coping strategies
· Is sensitive to the person's comfort levels and to the way in which a service is delivered, not just what the service is
· Works with the person rather than doing something 'to' or `for' the person

Trauma-informed support means seeing the person who has experienced trauma as the expert. It means working with each person's strengths. Not focussing on what is wrong with a person or trying to 'fix' the person. Being trauma-informed changes how we think and respond to people. It does this in every interaction. It helps us notice what is going on for someone. We can then support the person to recognise their strengths as well. And to build on their strengths to support resilience and recovery. It includes always thinking about the possibility of trauma in someone's life. It is about recognising possible trauma and understanding its impacts. It is about understanding the way different people cope with trauma. It is about understanding how trauma responses and adaptations can become barriers to connection and participation. This understanding supports us to respond to the person in a more helpful way.

At the core of trauma-informed practice are two fundamental overarching principles. The first is to focus on assisting people to recover from trauma. It does this through nurturing resilience through greater social support and self-efficacy. It also promotes a compassionate environment, which optimises safety for everyone.

Secondly, trauma-informed practice seeks to reduce or prevent retraumatisation when this is possible. Retraumatisation is the experience of further trauma from being triggered or otherwise re-exposed to past trauma material. Often people with trauma experience have complex needs. People with prior trauma face many barriers to having their needs met. Many people engage with a range of services, at the same time, and over time. People with prior trauma are often very sensitive to stress and trauma. This means that everyone supporting people who have experienced trauma needs to be informed about trauma. Trauma-informed strategies recognise trauma and possible triggers for retraumatisation (Bateman, Henderson, Kezelman, 2015). Recognising trauma and triggers helps to embed strategies to reduce the harm caused by the trauma and triggers. Section 2 of these guidelines provide more information on strategies to reduce the harm caused by trauma and triggers. When providing trauma-informed support to people with disability we must attend to five core trauma-informed principles. These are drawn from the work of Fallot and Harris (2009).

Principle 1 - Safety:

Being and feeling safe is a basic need. Trauma experiences are experiences of not being safe. Previous trauma creates barriers to feeling safe. Many people with disability who have experienced trauma do not feel safe. Many are not safe. Supporting a person's safety includes understanding the person's perception of their own safety. It also includes understanding other people's perception of the person's safety. It is important to not dismiss a person's safety concerns. But also, to not be too cautious and not take any small risks. We must also consider the person's 'dignity of risk'. This means considering each person's right to take reasonable risks that are essential for their dignity, self-esteem and self-determination. There are five main dimensions of safety to consider:

- **Personal safety**

Personal safety includes physical and emotional safety. People who have experienced complex trauma often do not feel safe in their own bodies. This is because trauma can make it hard to manage thoughts, feelings or behaviours. Negative thoughts, feelings and behaviours can take over. To be safe, we need to be in a safe environment. We also need to be aware of our trauma responses and develop strategies to manage them. First, we need others to understand our trauma responses. They can then support us to manage our trauma responses.

Some people with disability continue to live in places that are not safe. Many people with disability experience ongoing abuse, neglect, violence and exploitation. Sometimes people are punished for their trauma responses. These include having strong feelings and using strategies to try and cope that are sometimes labelled as 'behaviours of concern'. All these things can stop people feeling and being safe.

- **Interpersonal safety**

This means feeling safe with other people. People who have experienced trauma have often been hurt by other people. This may have happened in caregiving or intimate relationships. Many people who have experienced trauma have also experienced discrimination and stigma. Some have been bullied. Others have been abandoned. Some people have been excluded. Many people may be isolated from others or feel isolated. Interactions with other people may not feel safe. Trauma makes it hard to trust other people. Many people with disability have a lot of people who provide support. This means there are a lot of relationships to manage. Trauma makes it harder to manage lots of relationships. These many different relationships can mean that environments such as group homes do not feel safe for people who have experienced trauma.

- **Environmental safety**

Every person needs to feel safe in their surroundings. This means that the environment needs to be free from harm. Some people with disability who have experienced trauma have been in institutions. Some of these institutions were dangerous or not safe. Some people were abused and violated in institutions. Some people do not have a place to call home or move homes a lot. Some may have a place to live but not a place that they chose. The residential environment may not feel safe.

Some environments have too much sensory input. This can be hard for people with disability who experience barriers to processing sensory input. There may be lots of sudden loud sounds. The lights might be too bright. There may be strong smells. Intense sensory input can be overwhelming. Environments that have too much sensory input can feel overwhelming.

Some environments do not support people to find things to do. People may have limited access to activities. Some people may not be able to access a supporter in the environment (e.g. prison). People are forced to do things in some places. Some people are restrained. This is a way some places try and 'control' behaviours. Other people are intruded on and their boundaries are violated. Many people experience repeat trauma because of this. There may also be a lot of triggers in these environments.

Change is hard for most people. Most of us like our routines. Constantly changing environments can make people feel not safe. It can take a long time to feel safe in new environments. This can happen even if the change is a good one. It can take time to get used to a new place and new people.

· **Systemic safety**
This refers to safety in systems and services. Some systems promote the needs of the system, over the needs of the person. This makes the system feel not safe. Some systems and services do not focus on what the person needs. Because of this, a person might be forced to go against their beliefs and values. The person's privacy might not be respected. Decisions may be made without asking the person. Processes may be too hard, unfair or not transparent. There may not be an accessible complaint process. People with disability who have experienced trauma must feel supported by the system to feel safe within it.

· **Cultural safety**
Cultural safety is defined as: **"The identification a person makes with factors that are derived from the culture, belief systems or worldviews that allow them to feel safe while being with those whom they have gone for help"**
(Atkinson, 2002).

People cannot feel safe if their cultural needs are not met. People, services and systems may not be culturally sensitive or appropriate. For example, it may not be appropriate for some women to access support from a male supporter. It may not be appropriate or safe to make direct eye contact or talk about certain past events. These things may not feel culturally safe for some people.

The following case study is an example of the importance of personal, interpersonal, environmental, systemic and cultural safety. Niles' decline in his wellbeing is directly related to the absence of safety on each of these dimensions.

Content Warning

This case study contains information that may be upsetting for some people. This is because it talks about violence, abuse, neglect or exploitation of people with disability. If you have any difficult feelings after reading it, you may want to reach out for support. You may have your own support system you can access.

You can also get support through the Disability Gateway by phoning 1800 643 787 between 8am-8pm Monday to Friday

Case Study – Niles and Tessa*

Niles lost sight in his right eye as a consequence of a firearm injury. The damage included permanent cognitive issues and medical conditions, such as seizures, that require medication. He also required surgery to fix a medical plate [in his skull]. His mother, Tessa, made a submission [to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability] about her son's experience as a prisoner with disability and her battles on his behalf:

"I saw him in a state I find hard to write [about] – in a wheelchair, his left eye bulging and moving round and he could not see. He was pushing his wheelchair into a wall and there were three guards present before Niles was taken to the hospital. He was vomiting and dizzy, no observations were done – bloods especially, with his condition. I [tried] all avenues to get help.

[The prison guards] called him a 'retard' and he was put out in the yard while in his wheelchair without a helmet. At that time Niles had no plate put in [to repair his skull] so anybody could have hurt him".

Following the procedure to fit a plate to Niles's skull, Tessa said, he was sent back to prison before it was safe. She said Niles should not have been forced to return to prison without authorities considering the advice of his medical practitioners. "His neurosurgeon said he should never had been taken from rehab," Tessa said, as doing so would give Niles "a 10 per cent chance of survival."

Tessa told us she believes that Niles was 'poisoned' with seizure medication while in prison, by guards both under- and over-medicating him. The resultant toxicity of medications in his system was so damaging that he became legally blind in his remaining eye.

"[The] stress of being in jail is no good for his health. The environment is not calming [and Niles] is just treated like nothing, like nobody. Well, he's my son – he's somebody's – and [he has] a lot of support and a family who love him".

*Names changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Principle 2 - Trustworthiness:

Different traumas especially from childhood can create barriers to trusting others and yourself. People who have experienced trauma have often been betrayed by people or systems. Sometimes this happens over many years. Trauma makes it hard to develop trusting relationships. Choosing not to trust makes people feel that they can prevent further trauma and betrayal.

A person needs to be able to work out what other people are thinking to be able to trust other people. Physical, attitudinal, communication and social barriers can lead to misunderstandings. Trauma can lead to misreading cues or gestures. It can mean that **innocent situations** or people feel dangerous. It can also mean that benign cues are seen as threats.

People who have experienced trauma need to be supported by trustworthy people. You can show that you can be trusted by being and showing that you are reliable, predictable, consistent and attuned. The more a person experiences an attuned response the fewer barriers there are to building trust. Healthy boundaries are very important too. It is always important to negotiate boundaries. Boundaries should not be too rigid or too loose. If we have healthy boundaries, we can support other people to have safe boundaries too.

The following case study provides an example of breaches in trustworthiness. In this example, both the service provider and prosecutors could have improved practice by demonstrating greater trustworthiness.

Content Warning

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Case Study – Jane and Maree*

"Ten years on from the initial sexual abuse, our daughter ... still suffers from PTSD [post- traumatic stress disorder], distrust issues, life threatening psychogenic seizures, anxiety and depression requiring medication and many fears".

Jane, Maree's daughter, is autistic. Jane was excited at the idea of living independently. But ... she had many issues with the day staff. Her behaviour management plan was never followed and instead she was subjected to humiliation, intimidation and bullying. Maree complained to the day service staff and eventually to the general manager. Her emails went unanswered and she felt that staff avoided her.

Jane told her she had been sexually abused by a staff member. Maree told us that when she called the agency the next morning they asked, 'Oh you think that happened? Do you want us to get the police involved?' Maree was adamant that she did. Two weeks later Jane was interviewed by the police.

Maree told us that in the 20 months it took for the case to go to trial, Jane was in a constant state of anxiety and the agency offered her no support. Jane developed a fear of new people supporting her. When new support people were introduced, she was scared of them and told Maree they were hurting her. Jane's behaviour escalated and police were called.

Maree recounts in her submission that the staff member was found guilty and sentenced to prison. The prosecutor was surprised because it is 'quite rare for a person with a disability to win a case of abuse, as they are not considered reliable witnesses. However, the conviction was overturned on appeal. Maree told us she felt that a factor in this outcome was that Jane had to engage with a series of prosecutors who lacked understanding of autistic people, while the defendant had one lawyer for the entire process. Maree says that Jane was left angry, fearful, anxious and distrusting, and behaved accordingly.

*Names changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Principle 3 - Choice:

A child has much less choice and control than an adult. Many people with trauma were silenced as children. Some people continue to be silenced as adults. The same applies to people with disability. All people need to be heard and have choices. Trauma silences and removes choice from people. It challenges dignity and removes power. For a long time, certain systems have been known to not provide people with enough choice. That is not acceptable. There are all sorts of choices. Choices about where to live. Choices about who to live with. Choices about when to come and go. Choices about what to eat and when. All people need to have choices about their own lives.

The following case study is an example of the importance of choice when supporting people with disability who have experienced trauma.

Content Warning

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Case Study – Ben, Will and Jenny*

Will and Jenny are guardians of their foster son, Ben, who is autistic and has language difficulties and physical disabilities. Ben lives in a group home … [where] bullying and harassment between residents has happened… They attributed the increased risk of violence and abuse [in the group home] to poor management and supervision by the supported independent living (SIL) provider, and poor selection of residents… The provider told residents' families that it would work with the relevant state department to select new residents and would advocate on behalf of the current residents to ensure the new resident was compatible. [Will and Jenny told the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*] that a situation where neither the residents nor their guardians are directly involved in the selection process is unacceptable to them. They say it infringes the rights of people with disability to have the opportunity to choose their place of residence and who they live with.

*Names changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Principle 4 - Collaboration:

Collaboration means consistently communicating a sense of `doing with' rather than `to' or `for' other people. It also means always considering the ways in which this is conveyed. Collaboration means working together. Trauma involves secrecy and one person or system having 'power over' another person. People who have experienced trauma need to play a key role in working out their own support needs. All people are the expert in their own lives. This means the person receiving support is the expert, not the professionals or services providing the support. Collaborating with people with disability who have experienced trauma is essential. This means including the person in choosing who should and should not provide support. It means collaborating with the person regarding what, where and when support is provided. Many people with disability who have experienced trauma have complex needs. Being trauma-informed means collaborating with the people and services that support the person. It means genuinely working together and removing barriers to collaboration. It also means ensuring well-coordinated support across services.

The following case study is an example of barriers to collaboration with medical practitioners.

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Case Study – Jennifer*

Jennifer has a disability and is also a support person for a friend with disability. In her submission to [the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability] she said she has seen for herself, during recent inpatient hospital treatment, that health professionals '… will leave out relevant information when seeking patient consent for treatment. They have also shown that they will neglect to inform the patient of their health progress if they feel it may reflect badly on medical procedures they have used. Further doctors will threaten patients with involuntary treatment orders if the patient questions their practices or tries to ask for clarifying information about their treatment.' Jennifer stated that in her experience medical staff will often dismiss the concerns or questions of patients with disability in the belief that 'they know better'. She said they routinely fail to provide clear information at a patient's communication level. She also said that unless a patient has someone aggressively advocating for them, medical practitioners will 'simply railroad a disabled patient into their own goals'.

*Name changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Principle 5 - Empowerment:

Trauma takes away a person's power. It affects a person's sense of agency or sense of control. It also affects how a person feels about themselves. Supporting a person to feel empowered helps the person build a stronger sense of self. This means helping to remove any barriers the person faces. It means supporting people to manage strong emotions. This means providing a person with the right information to make informed decisions. It means providing opportunities for the person to make decisions for themself. And supporting the person to build the skills and resources needed to make decisions. With these skills, resources and opportunities, a person can make more decisions for themself. Empowerment promotes dignity and upholds human rights.

Independence is an important part of self-determination or being free to do what you want. But people with disability face many barriers to

being independent. Sometimes it is believed that a person cannot make decisions for themselves. A person's right to make decisions for themselves may have been taken away. This is very disempowering. Not having access to money can also be disempowering. It can be hard to find a job and earn money. Not having money keeps people dependent. Dependency can make a person more likely to be abused and exploited. It can mean that a person is expected to comply or go along with everything. It can mean excess control by caregivers and the system. Activities can become demands. The person can be forced to do things. When a person with disability is forced to comply, it can be very harmful. It can change the way the person engages or does not engage with a service. Being trauma-informed means providing opportunities for empowerment to help a person to become more independent.

The following case study highlights the impact of disempowerment. Prospective employers can promote empowerment by making reasonable adjustments in the workplace or flexible workplace arrangements. The Disability Employment Service could support empowerment through proactive engagement with prospective employers.

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Case Study – Hugh*

Hugh has a university degree and experience in Information Technology (IT). He estimates that during the past five years he has applied for approximately 14,300 jobs. Hugh has an acquired brain injury and autism spectrum disorder and as a result he requires a flexible working environment. **"I am upfront about the nature of my disability and the type**

of reasonable adjustments that I require," he said in his submission [to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability]. These adjustments include working in a space where he's not surrounded and distracted by other workers and having control **"over the intensity of the workload"**. In other words, part-time, flexible hours working from home would be ideal. Hugh is adamant that **"there is no reason I cannot perform IT work remotely"**.

Even though he has adapted his CV and cover letters following advice from various employment service providers, Hugh rarely gets to the next stage. When he has been interviewed, he has felt "intimidated by a management structure that refuses to acknowledge" his flexibility requirements.

Being unable to find employment means he has been "forced to rely on the disability support pension for many years … despite my willingness to engage in employment". Needless to say, "the impact of applying for so many jobs over such a lengthy timeframe has been demoralising".

Hugh has had five Disability Employment Services (DES) providers over the past five years, and he questions their role. He said he has found them "inadequate and ineffective, they have not helped me at all". He … believes they are failing people with disability, particularly people with acquired brain injuries and autism. He would like to see them work more proactively to influence employers to understand the needs of people with specific disabilities.

*Name changed and some details removed to protect people's identities. Narrative based on a submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

For more information on trauma-informed principles, see **Talking about Trauma: Guide to Conversations and Screening for Health and Other Service Providers** (Blue Knot Foundation, 2017) professionals.blueknot.org.au/resources/publications/talking-about-trauma-series/ and Talking about Trauma: Guide to Everyday Conversations for the General Public (2017) professionals.blueknot.org.au/resources/publications/talking-about-trauma-series/

The Need for Culturally Sensitive Disability & Trauma-Informed Services

"Creating a trauma-informed culture in and of itself could help staff and clients make better recoveries than has previously been possible" (Bloom, 2011:15).

Some services prioritise the needs of the service (sometimes to increase their profit margins) over the needs of the people using the service. This creates a problematic power imbalance between the service, workers, and the people who access the service. This power imbalance increases the possibility that people accessing the service may experience abuse or violence. Abuses of power thrive when organisations are not accountable and there are poor responses to unethical worker behaviour and a culture of secrecy. Trauma-informed services address this power imbalance and in doing so, reduce the risk that people seeking support will be harmed (Isobel and Edwards, 2017). This not only promotes better outcomes for people accessing the service but greatly benefits workers as well. It has also been shown to be cost-effective for the service with reduced absenteeism, presenteeism and turnover, and better risk mitigation strategies (Kezelman, Hossack, Stavropolous & Burley, 2015). Having more trauma-informed services, with better collaboration and coordination between and across services also contributes to creating trauma-informed communities and societies.

We are all human beings. As human beings we share a common fragility and all need support from time to time. Any one of us can experience trauma at any point in our lives. It is important that we all work towards developing a culturally sensitive disability trauma-informed approach. Such an approach can support all people to recover from trauma,

regardless of their ability, gender, culture, age, faith, or sexual orientation. It can help us recognise trauma responses in the context of a person's cultural background. This helps us listen to people and understand their perspective. And respond in ways that better support and help people. It helps us understand strong emotions, different levels of arousal and behaviours. Instead of focussing on what is wrong with a person, we can think about what trauma happened to the person. Being disability trauma-informed and culturally sensitive helps us understand that a person is not being difficult. It helps us try to understand what the behaviour is saying and what it may mean. It gives us strategies to de-escalate situations. It stops us labelling and treating people unfairly and causing more harm. It allows us to create a more compassionate, fair and inclusive society for all.

Service Tip
 - Benefits of a Trauma-Informed Approach

The primary focus of a trauma-informed service is on the people accessing the service. The benefits for people receiving trauma-informed services remain the primary driver for trauma-informed change. Additionally, there are benefits for workers, volunteers, the service itself, and the community more broadly. These are secondary but still important to list.

Benefits for People with Disability who have Experienced Trauma:
· Receive better support and assistance
· Needs are better met
· Supported to overcome barriers to participation, accessibility and inclusion
· More likely to achieve better personal outcomes
· Less likely to be retraumatized
· Provided with greater opportunities to recover
· Supported to build internal resources, self-regulate, stay within Window of Tolerance
· Supported to de-escalate, avoid crises, minimise behaviours labelled as 'behaviours of concern'
· Supported to actively develop own support network
· Have a greater voice and choice – heard, listened to and able to make informed decisions
· Able to forge better relationships with workers through true collaboration

- Empowered and provided with opportunities for self-determination, greater independence
- Fosters enhanced feelings of safety and trust
- Supported to participate and self-advocate, as appropriate
- Greater engagement with supporters

Benefits for Workers:
- Greater worker health and wellbeing
- Enhanced interactions between workers and people accessing service
- Less likely to experience vicarious trauma and/or identify it early and manage it better
- Reduced stress, burnout, absenteeism and presenteeism
- Better able to meet the needs of people accessing the service
- Experience greater work satisfaction and stay committed longer
- Improved work culture, relationships with management

Benefits for the Service:
- Better services enhancing outcomes for people accessing service
- Work Health and Safety benefits
- Enhanced risk mitigation and management
- Better worker retention – reduced staff turnover
- Less stress on service and greater team cohesion and culture
- Fewer complaints and enhanced complaints process and responsiveness
- Support is transparent and predictable, using best practice principles
- Enhanced support coordination, within and across services
- Less reliance on seclusion, physical and chemical restraint and coercive practice
- Cost-effective (i.e., fewer injuries, less turnover, reduced sick leave)

Vicarious Trauma, Burnout and Grief

"Vicarious trauma is the negative transformation in the helper that results [across time] from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them"
(Pearlman & Caringi, 2009).

It is not possible to consistently provide trauma-informed services to people with disability without support. Vicarious Trauma (VT), burnout and grief are all very common experiences amongst supporters. Services that employ support workers and advocates must provide ongoing and effective support to workers, volunteers and caregivers to identify and respond to these common experiences.

Vicarious trauma (VT) is a risk for anyone who is exposed to trauma material. It is a 'normal' part of working with trauma material or people with trauma experiences. VT does not happen because a person has a weakness. Rather it is to be expected when working with people who have experienced trauma.

The effects of VT are similar to those of Post-traumatic Stress Disorder (PTSD). People can experience intrusive symptoms such as flashbacks or nightmares. They can also experience numbing, shut down, difficulty relaxing or dissociation. Another feature is avoidance of people, places or other reminders of the trauma. VT can also change a person's thoughts or cognitions. It can disrupt a person's core beliefs and world view. VT can also affect a person's feelings of safety, trust, self-esteem, sense of control, meaning and hope as well as their relationships.

Even though VT develops from exposure to traumatic material over time, it can also be affected by other factors. These include the sort of work a person does, the support they receive and their workload. Coping strategies and the context in which the caregiver, support worker or advocate provides support may also make a difference. The main challenge with VT is recognising and managing it (Pearlman & Caringi, 2009). The good news is VT is recognised more frequently and acknowledged to be a serious issue. Many workplaces now see VT as a Work Health and Safety issue.

The following case study provides an example of what vicarious trauma could look like for a supporter and how it could arise.

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Case Study - Georgia and Cindy

Georgia was a very active member of her local community. She regularly volunteered in the canteen at her daughter's school. She coached a local netball team and distributed meals to elderly residents with her local church group. One day at church, Georgia was introduced to a new member of the congregation. This woman, Cindy had an extensive trauma history and physical disability. Cindy needed support with transport and shopping. She had recently completed an intensive drug rehabilitation program. Georgia had struggled with substance use herself in the past. Georgia offered to support Cindy and help with transport and shopping needs. Over the next few weeks, Cindy shared details of her experiences of abuse, neglect and substance use. At times, Georgia felt distressed and overwhelmed by the trauma Cindy had experienced. Georgia felt increasingly tired and irritable. Sometimes, she visualised Georgia being hurt, or dreamed about the abuse happening to herself. Georgia started to feel less safe or able to trust people like she used to. For the first time in 20 years, Georgia started to think about using alcohol again.

*This is not a real person's story.

It is important to note that being exposed to other people's trauma, resilience and recovery can also have positive impacts. These include developing a greater appreciation for safety and healthy relationships. It might include being inspired by supporting people to recover and witnessing positive stories of survival. It might mean being more aware of the human condition, everyday experiences of abuse, neglect and violence, but also of resilience. This is called vicarious resilience. Just as trauma survivors can experience post traumatic growth, people who work with trauma survivors and trauma material can grow from the experience as well. Many develop a renewed identity, world view and priorities. In this way embracing work with people with experiences of trauma can become a source of strength and resilience.

It is important to understand the difference between VT, burnout and compassion fatigue. Burnout can be experienced by any caregiver or worker in any workplace or environment. It is not about working with trauma material. Rather it reflects the general stressors in the workplace or role of caring (Brown, 2009). Burnout presents as physical and emotional exhaustion. Compassion fatigue is the emotional impact of helping others. This can happen without trauma exposure (e.g. aged care workers). This used to be called secondary traumatic stress. It is always important for supporters to support their own wellbeing. It is only when people providing support are healthy and well that the people receiving support get the best quality support possible.

It is also important to recognise that many supporters may also experience grief. Grief is "an intense emotional state associated with the loss of someone (or something) with whom … one has had a deep emotional bond" (Reber, 1985). Sometimes people experience grief after someone they care about has experienced a traumatic event. The person may not have died but may have been fundamentally changed by the traumatic event. For example, when someone experiences a traumatic accident that has resulted in permanent injury or disability, such as an acquired brain injury. Sometimes parents, friends, siblings and other family members grieve as they come to accept the impact of the traumatic event on their loved ones. It can be especially hard for family and friends to provide support to others as they are processing their own grief.

Further Resources

There are many resources available to help build knowledge around trauma and trauma-informed practice:

- Blue Knot Foundation (BKF) provides information and training on complex trauma, trauma-informed practice and vicarious trauma available from their website. professionals.blueknot.org.au/professional-development-training/ This includes a range of guidelines for organisations and service providers, as well as members of the public. professionals.blueknot.org.au/resources/publications

- The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) have many resources for understanding trauma amongst Culturally and Linguistically Diverse (CALD) communities. Information can be accessed from their website https://www.startts.org.au/

- We Al-Li Pty Ltd have produced resources and provides training for a Culturally Informed Integrated Healing Approach (CITIHA) specifically for supporting First Nations people from trauma. Further information can be accessed from their website https://wealli.com.au/

- 1800RESPECT provides information and support specifically for people who have experienced sexual assault or domestic and family violence. Information can be accessed from the website https://www.1800respect.org.au/

- National Disability Services (NDS) have created resources specifically for trauma- informed support for people with disability that are available on their website https://www.nds.org.au/zero-tolerance-framework/considering-additional-risk

- Some organisations have also developed trauma-informed resources for supporting people with specific disabilities. For example, Taking Time is a trauma- informed framework for supporting people with intellectual disability produced by Berry Street and funded by the NSW Department of Family and Community Services. This can be accessed from [https://learning.berrystreet.org.au/focus- areas/berry-street-education-model](https://learning.berrystreet.org.au/focus-areas/berry-street-education-model)

Summary

Guidelines for Practice – Core Knowledge Requirements for Disability Trauma-Informed Practice

To ensure the provision of high-quality disability trauma-informed practice, caregivers, support workers and advocates should hold knowledge in the following areas:

1. Disability, Human Rights, Social Justice and Barriers to Inclusion

· Be aware of the United Nations Convention of the Rights of Persons with Disabilities 2008
· Understand the Social Model of Disability
· Know about the attitudinal, physical/environmental, language/communication, social and system barriers faced by people with disability
· Recognise the importance of social justice within the disability rights movement
· Be aware of the prevalence of disability in Australia
· Understand the rates of abuse, neglect, violence and exploitation experienced by people with disability
· Understand the role of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
· Understand the intersection of trauma and disability and the needs of people with disability and experiences of complex trauma
· Understand the complexity and challenges of the disability support service system
· Understand issues of grief and loss for people with disability

2. Process of Trauma and Recovery

· Understand the different types of trauma
· Understand the impacts of childhood trauma
· Understand attachment dynamics
· Understand the importance of risk and protective factors
· Understand that different groups of people are more likely to experience complex trauma
· Recognise the importance of positive relationships and interactions for recovery from trauma
· Understand trauma and the stress response
· Understand the difficulties many people with trauma experiences have in regulating their strong emotions
· Understand the Window of Tolerance model and changes in arousal
· Understand flashbacks, dissociation and triggers

3. Impacts of Trauma

· Knowledge of the multiple domains of functioning (e.g. physical, emotional, social, spiritual etc.) that can be impacted by trauma
· Recognise and value coping strategies and their role in survival
· Understand how trauma impacts on support seeking behaviour and needs
· Understand the relationship between thoughts, feelings, body responses and behaviour
· Recognise the relationship between trauma, coping strategies and 'behaviours of concern'

4. Resilience and Recovery

· Hold hope for recovery from trauma
· Know that recovery from trauma is possible and that the brain can change
· Understand the concepts of resilience and post traumatic growth
· Recognise the importance of connection and relationship to promote recovery from trauma

5. Cultural Sensitivity

· Recognise intersectionality between gender, ability, culture and trauma
· Understand a person's issues and needs in the context of the person's culture including cultural needs
· Recognise the need for attunement to cultural differences
· Recognise that choices or practices may appear to be unhelpful but only because they are different to the 'norm' or what we are used to
· Be aware of the importance of being curious and open to difference
· Be aware of the importance of being tolerant of and embracing difference

6. Trauma-Informed Goals and Principles

· Be aware that fostering recovery from trauma is a primary goal of trauma- informed practice
· Be aware that minimising retraumatisation is a primary goal of trauma-informed practice
· Understand the primacy of safety and the multiple domains of safety
· Understand the importance of trustworthiness in building healthy relationships with people with trauma experiences to support recovery
· Understand the importance of choice for people who have experienced trauma
· Understand the importance of collaboration and sharing power with people with trauma experiences to support recovery from trauma
· Understand the need for people who have experienced trauma to be empowered to support recovery


7. Impacts on Supporters

· Know about the concepts of vicarious trauma, burnout and grief
· Be aware that vicarious trauma is the result of exposure to trauma material
· Understand how vicarious trauma, burnout and grief can impact on the quality of support

Skills Development

This section is for individual caregivers, support workers, and advocates. It details the areas of specialised skill development that are often needed for supporting people with disability who have experienced complex trauma. It identifies not only the outcomes to be achieved through trauma-informed support but also how to change existing practices to ensure trauma-informed support. It has been written in easy-to-understand language to cater for a wide range of supporter backgrounds and life experiences. Throughout this section, 'Practice Tips' have been provided in highlighted boxes. 'Service Tips' have also been provided to highlight what services can do to support trauma-informed practices. At the end of this section is a summary of core disability and trauma-informed practices needed by any person who supports people with disability who have experienced trauma.
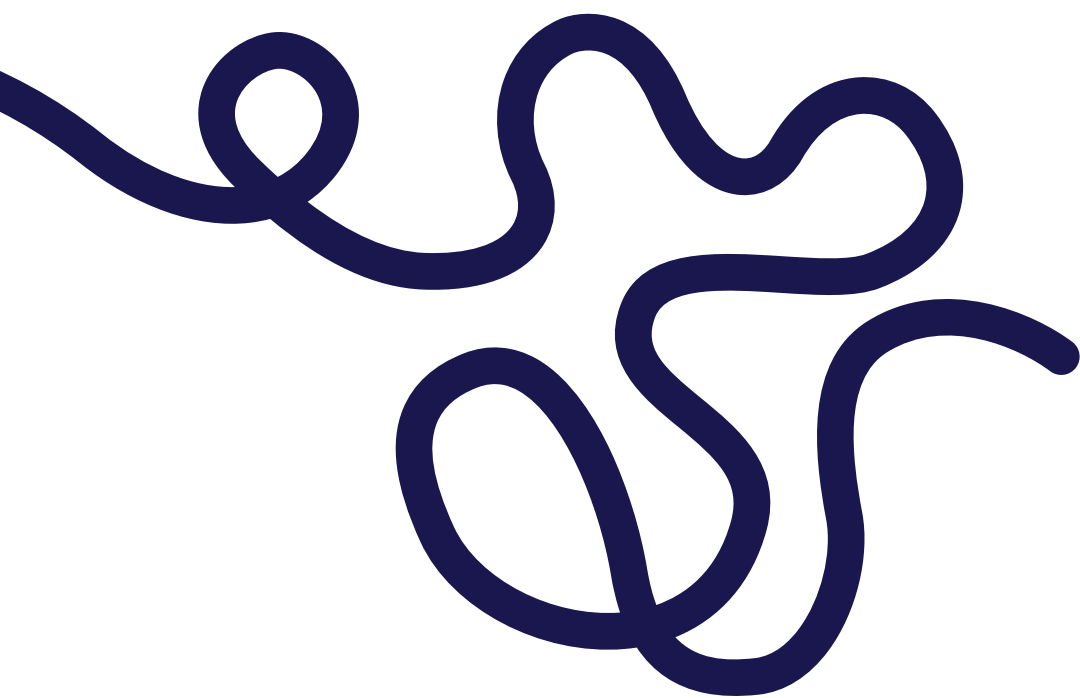
General Skills for Supporting People

Caregivers, support workers, and advocates are in roles to provide social and emotional support to people with disability who have experienced trauma. Good support is important for people who have experienced trauma (Barol, 2001). It can help a person to build or restore a person's sense of safety (if the person has previously felt safe). Sometimes it can support people through triggers and flashbacks. These are trauma responses. Sometimes the triggers or flashbacks come with strong emotions like fear or anger. The triggers or flashbacks can also cause concerning thoughts such as wanting to die or hurt someone. Sometimes the triggers or flashbacks may result in worrying behaviours such as lashing out at others or self-harm. A number of basic skills are needed to provide this kind of support. These are attunement, empathy, compassion and reflection.

Deep Listening and Attunement

Deep listening or attunement means being aware of and responding to every aspect of another person. The person's past, present and future. To hear the words as well as the emotions underneath the words. To listen quietly. This includes listening to what is being said as well as what is not said, or what is simply implied. Many First Nations people have practiced deep listening for a long time. The word 'Dadirri' means 'deep inner listening'. It comes from the Ngan'gikurunggurr and Ngen'giwumirri languages of the First Nations people of the Daly River region in the Northern Territory.

Deep listening is an important skill for everyday life. It is even more important when there are communication barriers to providing support. Sometimes people cannot find the right words to communicate or do not use words to communicate. People communicate in lots of other ways. Through looks, posture, silence, breathing. It is important to notice these other ways and to listen deeply. For more information on deep listening,

see https://www.miriamrosefoundation.org.au/dadirri/ or https://wealli.com.au/training/we-al-li-core-training/dadirri-the-ancient-tradition-of-mindfulness/

Empathy

Empathy is the ability to understand and feel what another person is feeling (Bellet & Maloney, 1991). It is different to sympathy. Sympathy is more like feeling sorry for someone. Sometimes sympathy can feel patronising because it is not heartfelt. Empathy has two components. It involves understanding the feeling and also feeling the feeling. Sometimes people can also feel another person's physical reaction, like feeling sick in the stomach or tense in the head.

Sometimes people are scared of empathy. A person might be concerned that they will become overwhelmed with emotion. Empathy can be tiring too. Some people switch off empathy to try and protect themselves. Empathy has its limits and should have boundaries. It should be used to develop an understanding of another person and their needs. Empathy on its own is often not sufficient to create meaningful change. For example, feeling deep empathy for a person who has recently suffered a trauma, will not resolve the trauma impacts. It will not locate suitable housing or medical attention. It will not prevent the trauma from happening again. But it will help the person to feel understood and less isolated.

Compassion

Compassion is the capacity to recognise the suffering of others and to also take action to support the people who are suffering. In this way, compassion more actively works towards creating solutions to suffering, unlike empathy. When supporting people with disability who have experienced trauma, a compassionate response includes noticing that the person is suffering. For example, noticing the person is experiencing a flashback, strong overwhelming emotions or feeling isolated. And then doing something to decrease this suffering. Like helping to soothe and reassure the person after they experienced a strong emotion. Or showing the person how to reduce flashbacks. Or removing barriers to social isolation.

Language

No person is just their disability. Nor is the person just their trauma. Every person is much more than that. Each person has hopes, dreams, and needs. Each person wants to connect and participate. Each person is a member of the community. Language helps us do that. Many people prefer person-first language (e.g. person with disability or person who has experienced trauma). But some people prefer identity-first language (e.g. disabled person or traumatised person). It is important to ask the person what language is preferred. This shows respect and demonstrates inclusivity

Some words can trigger people who have experienced trauma. There is no way of knowing for certain which words might upset a person. It is important to keep the possibility of triggering in mind. It helps to be as sensitive as we can to each person's experience, even if we do not know all the details. This can help us choose what to say and how to say it. It is about being aware of the possibility that certain words or phrasing can be triggers and trying to avoid them.

The person may not know all the details of the trauma experienced and that is okay. It is important to not drill into a person's trauma experience. Or demand to know all of the details about what happened. It is also important to not use graphic language. There is no way of being sure which words might upset a person. It is about being aware that some words may

upset the person and doing what you can to avoid using those words. Many people with disability who have experienced trauma have worked hard to recover. Many have overcome barriers to participation and autonomy. For many, this is an ongoing life goal.

The following case study provides an example of the power of language and how it can disrupt support and relationships.

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Case Study – Haji*

Haji identifies as non-binary. This means their body is male but gender is female. Haji prefers to use the personal pronoun of "they/them" instead of "he/him" or "her/his" to reflect their gender diversity. Haji is also blind. They were sexually assaulted last year and sought counselling to recover from the trauma.

"The counsellor was a really lovely person and I could tell she knew a lot about trauma and sexual assault. But she kept referring to me as a male. I tried to explain that I was non-binary, but I don't think she really understood that. Every time she made reference to me being a man or my masculinity, it drove a wedge through my ability to feel comfortable or understood by her. She also used to use the phrase 'Can you see how or 'What do you see as being ….'. I know it seems like a little thing, but that really irritated me. One session, after I had just made a report to police about the assault, I just snapped. I said 'actually, maybe you don't realise, but I'm blind, I actually can't see anything'. I never went back after that. I still feel a bit

uncomfortable about it today. I wish she had just stopped to think about these things and talk to me about her use of language. It would have been so easy for her to just say 'Can you understand how ...' or 'What do you believe or think ...'. I think it would have made a really big difference for me".

*This is not a real person's story.

Communication

People with disability want to be seen, heard, understood and respected. This is no different to people without disability. Communication is not only about language. It is about non-verbal communication too, such as body posture, gesturing, and eye movements. Communication can include touch and hugs. Drawing or sharing artworks. It is about comfort and caring and being with another person. It is about building safety and trust. It is about what I can learn from you...and what you can learn from me. It is about being with someone, regardless of what is happening. It is about being with someone even when the person is angry and sad. Or when the person is scared and lashing out. It is about reaching out to someone who is withdrawn and isolated. Supporting people with disability who have experienced trauma often needs creative approaches to overcome communication barriers. It requires the caregiver, support worker, or advocate to listen to what the person needs to support communication. It means adapting ways of communication to meet the needs of others.

Good communication starts by making authentic or real connections with people. For example, being open and honest. By showing respect, empathy, and compassion. By treating each person with dignity. Being polite, friendly and sensitive to another person's needs. Using the language that the person prefers. Creating a good space for communication can take time. It is important to be patient. This includes respecting silence.

A number of strategies can support good communication outside of sensitivity to language preferences. Inviting the person to communicate about things that are not threatening like the weather or sport can help practice communication for other topics. Sometimes it is about trying

different ways of communicating, such as drawing, speaking, gesturing, or writing to find a more comfortable way of communicating. Being an active listener means paying attention to the other person. It is important to clarify what the person has said and understood. This can help to prevent miscommunication. **Some people summarise** what has been communicated regularly. This means reflecting back what was understood. If you think there might be a miscommunication, talk about it. Notice if the person seems confused or offended by something you said or did and ask them about it.

There are a couple of things to avoid. Try not to shout unless the person needs you to raise your voice to hear you. Be careful to not be too intrusive by asking too many personal details that you do not need. Or asking too many questions at once. Also, do not be patronising. No one enjoys being patronised. For example, telling the person they are amazing because they have disability or have experienced trauma. The person may be amazing because of who they are. That is different.

Practice Tip
– Improving Communication

Here are some ideas for creating space for communication:
- Be sensitive to what the person needs
- Treat the person with dignity
- Be open and honest
- Be calm and polite, comforting and respectful
- Show empathy and compassion – not pity
- Always greet the person. Always say goodbye when you leave
- Use person-first language when speaking and writing unless the person requests disability-first language. This shows respect
- If the person cannot speak, acknowledge the person in an appropriate way e.g. shake hands
- Be patient - the person might need time to communicate
- Respect silence

Here are some ideas for helpful communication strategies:

· Use language that validates the person's survival and strengths, that does not focus on what the person cannot do or does not have

· Invite conversation or communication but do not take over

· Speak directly to the person

· If you do not understand what the person is saying, ask the person to say it again or write it down – whatever is the best way for the person to communicate

· If a person does not or cannot respond, check in with them, ask if they need more time

· Engage in active listening – pay careful attention

· Summarise what you have understood regularly to check that you have understood – reflect back or clarify what has been said

· Try to understand the real issue – the person's needs behind what is being said or done

· If you notice that the person is upset by or reacts to something you have said or done, check in with the person

Here are some communication disruptors to try and avoid:

· Avoid shouting - only speak more loudly if the person asks you to

· Avoid asking too many questions

· Avoid imposing anything on the person. The person can decide for themselves

· Avoid being intrusive - this applies to both a person's trauma and their disability

· Avoid being patronising
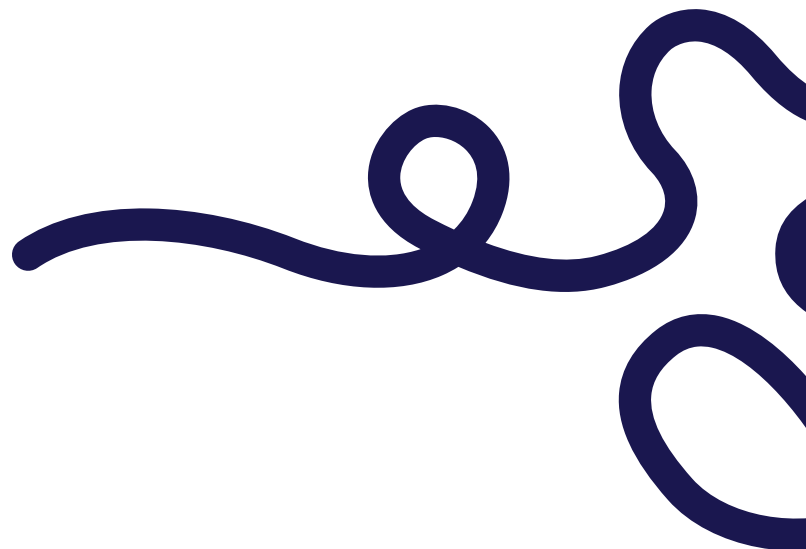
Accessibility

> **"At the time, I didn't know any services or education on where to get help. I still live in pain from this".**
> (Ralph* Submission made to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability).

People with disability can experience barriers to accessibility. These may include attitudinal, physical/environmental, communication, social or systemic barriers. Different groups of people experience additional barriers to accessing services and different parts of the community. These barriers can become even more complex for people with disability who have experienced trauma. It might be hard to access services if a person, their family or their community have felt betrayed by services before. In this situation not trusting those services is expected. Many First Nations people have been betrayed by systems and services in the past.

The disability sector can be very difficult for anyone to navigate. Even service providers may struggle with knowing what services available and what services are will meet a person's needs. Accessing services without local knowledge or language is especially difficult. So too is accessing services when you feel stigmatised or discriminated against. Judgement, intolerance and misinformation can be barriers for different groups of people to access the support they need. Supporters can play an important role in removing accessibility barriers.

Being Reflective

People who support others are able to provide better quality support when they notice how they are thinking and feeling. This is called being reflective. It is sometimes also called 'reflective practice'. Being reflective helps to work out over time, why we respond to certain people or issues in certain ways. It means exploring our assumptions and judgements and how these might affect the support we provide. A reflective approach helps people learn about themselves as well as other people. It helps us to better understand and respond to others. It helps us attune to other people's culture, diversity and needs. Reflective practice supports insight that perspective depends on a person's values, biases and previous experiences. It makes people more aware of their personal prejudices,

attitudes, and values. As well as those held by other people. It helps to prevent an 'us' and 'them' mentality, which can contribute to 'othering' people with disability.

Reflection can be done by yourself or can be done with others, such as a friend, work colleague/s, or supervisor. It is about learning from mistakes and doing things better next time. Being reflective means that supporters can examine and adjust their practice and responses over time. Or know when some time out from providing support is needed. It supports continuous learning, collaboration and learning from others, including the people with disability who receive support. For professional support workers and advocates, it also supports professional inquiry and development. Most importantly, reflective practice supports better outcomes for people with disability who have experienced trauma.

Practice Tip
– Steps to Being Reflective

Here are some ideas about how to start being reflective:

Step 1:
Think about how you would like to provide support.
What do you see as being good support?

Step 2:
Think about how you actually provide support.
Does it match how you would like to provide support? Or is it different? What bits are different?

Step 3:
Think about your feelings, emotions and thoughts when you assist, support or advocate for a person?

Do you feel proud, frustrated, angry, sad, nervous, obligated, guilty, privileged, pleased etc?

Do you think you are wasting your time, or do you think your support is valued, worthwhile and meaningful?

Step 4:
Think about your values, beliefs, attitudes and assumptions about providing support.

Do you value feeling needed? Do you believe only you can understand the person you are supporting? Do you believe others will think you are mean, uncaring or selfish if you don't provide support?

Step 5:
Knowing these things, how can you support in a better way?

How does thinking about how you would like to provide support, how you actually provide support, your thoughts and feelings, and your values/ beliefs/attitudes/assumptions impact on how you provide support?

(adapted from Schon, 1983).

Person-Centred

The disability sector developed the frame of person-centred practice. It forms the foundation for working with people with disability. The term 'person-centred practice' is used all the time. But it is important to understand what it really means and to work in a truly person-centred way. Person-centred practice focusses on the needs of the person. It means genuinely putting the person's safety, comfort and wellbeing first. It can be tempting to assume that we know what a person needs to feel safe. Person-centred practice is about finding out from the person what makes the person feel safe or comfortable. And doing what works for the person.

Person-centred practice means communicating with the person. To get to know the person and ask about their needs and wants. Involving the person in making decisions around who should and should not provide support. It is about understanding what is important to the person. To understand the person in the context of their whole life. It also means planning with the person around how to support them to achieve their goals. To work with the person to help them achieve a meaningful life. With as much independence as possible.

Person-centred practice strongly aligns with trauma-informed practice. Both approaches consider what happened to the person. Not what is wrong with the person. The person is not seen as broken and no one is seen as needing to be 'fixed'. The person receiving support is held as the expert in their lives. Person-centred practice is not focussed on the needs of the service or the system. Some services are only built for the system. This can result in the person's needs or thoughts being ignored. In services and systems that are not person-centred ideas and processes are imposed on the person.

Practice Tip
– Person-Centred Practice

Here are some questions to ask yourself to help you practice in a person-centred way:
· What matters most to the person?
· What are the person's current needs?
· What barriers does the person face?
· What opportunities are available?
· How can the person's needs be prioritised?
· How can the person's needs be best achieved?
· What does success look like to the person?
· How can success be achieved with the person?
· How can the person be supported to make decisions?

When we can answer these questions, we can set clear goals with the person. Supporters can decide with the person what actions need to be taken. We can focus on the person's strengths and skills. This empowers the person. Together we can support the person to participate fully in life and their community.

Cultural Sensitivity

When we are culturally sensitive, we are aware of differences between people. We are also aware of the similarities. The bottom line is to remember that we are all human beings. We share a common humanity. As human beings we can all be vulnerable, and we share a common fragility. Knowing this means we can engage with one another without judgement. The reality is that no one culture is better than another one. No culture is right or wrong. Using this lens means we are open to learning from and understanding about other people. When we do this, we treat others with respect and we can start to value diversity.

Being culturally sensitive does not mean that we need to be experts in other cultures. Rather it means being empathic and curious. This approach can help us understand more about people from other cultures. When we understand that, we can respect the differences. Sometimes people choose to do things differently. This does not mean that the person is making a bad decision. The decision might just be different to that made by people from a different culture or with a different lived experience. When we respect other cultures, we change what we do and say. This helps us align with the norms of other cultures. This is important because behaviour has different meanings in different cultures. Our culture affects the way we experience things. When we find out about the different ways we experience things, we understand other people better. This helps us better understand what a person does and why. When we understand the norms of another culture, we can adapt our behaviour to honour the norms of the other culture. This shows that we respect the values of the other culture. We can become comfortable in another culture, while still honouring our own.

It is good to reflect on our culture. Doing this helps us understand the role our culture plays in our life. This helps us recognise our judgements and unconscious biases. It makes us curious to learn more about other cultures. Cultural sensitivity embodies sensitivity to diversity, not just of culture but of other differences. It is not only important to attune to each person's culture but also to their ethnic background, gender, disability, sexual preference, linguistic background and lived experience of trauma over time.

Practice Tip
– Culturally Sensitivity Practice

A welcoming physical environment that feels safe to people of different cultures is important. Individual practice that demonstrates cultural sensitivity is also critical. Here are some things you can try to demonstrate cultural sensitivity:

Reflecting:
· How are you privileged in ways that others may not be?
· In what ways does your cultural membership influence your values, beliefs and assumptions?
· What can you learn from other cultural groups?

Demonstrating:
· Awareness of the importance of the culture of the person receiving support, including age, gender etc.
· Awareness that different words and languages have different meanings in different cultural groups and trying to use suitable language
· Understanding and commitment to maintaining the cultural integrity of local traditions by providing opportunities to access these traditions
· Community respect and inclusion
· Respect for people from different cultures

Recognising:
· That a person's culture can be a significant resource for recovery
· That cultural supervision is important and should be accessed when needed

Creating Supportive and Trauma-Informed Relationships

Some people do not trust other people or feel safe in relationships after experiencing violence, abuse, neglect, or exploitation. Some people who have experienced trauma expect people to hurt them. Not trusting other people can help to keep a person safe from other people and further harm. But it also keeps people isolated and alone. Caregivers, support workers, and advocates can all play a big role in supporting a person to experience positive and healthy relationships. This can lead the person to change their beliefs about relationships. If a person can change these beliefs, the person can change their relationships. This includes a person's relationship with themselves.
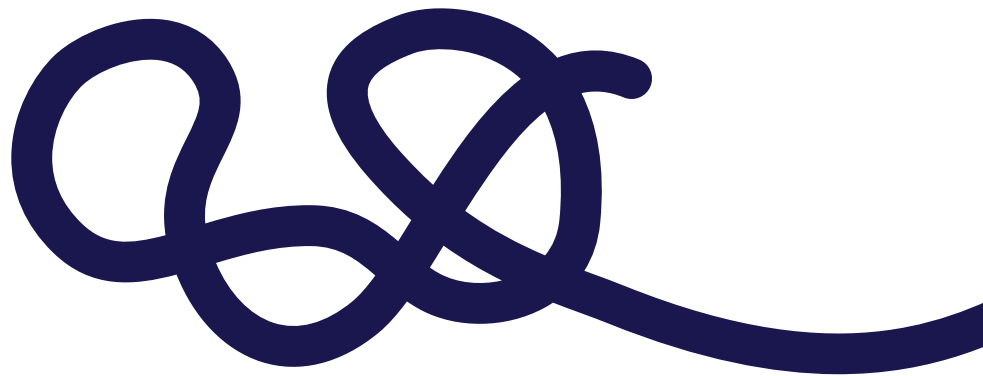
Supporting Healthy Relationships

When people experience genuine, honest, authentic and healthy relationships, they can start to feel safe. Healthy relationships are about building safe connections. People who have experienced trauma can learn to trust and feel safe again. Each relationship of safety and trust makes another safe and trusting relationship more likely. It means that the person starts to trust other relationships too.

Consistent and predictable relationships are safe relationships. This includes a safe relationship or space for when a person becomes dysregulated. Positive interactions and relationships can help the person build skills in managing strong emotions. This assists the person to grow their Window of Tolerance and supports the person to stay inside their window. This is how a person learns to self-regulate.

Healthy relationships provide a person with a new relationship experience. A relationship in which the person can feel secure and supported. Modelling healthy relationships and practicing healthy boundaries supports building other healthy relationships. Learning about how to build healthy relationships is a normal part of childhood and adolescence. This can support making good relationship decisions later in life. This is why programs such as "Respectful Relationships" (for more information see https://www.education.vic.gov.au/about/programs/Pages/respectfulrelationships.aspx) and "Love Bites"(see https://www.napcan.org.au/Programs/love-bites/), to name a couple, exist. It can help people work out who is safe and trustworthy and who is not. Supporters can even help people change their attachment style.

A positive or supportive relationship does not mean doing everything for the person. It also does not mean making the person do everything for themselves if that is not within the person's capacity. A healthy relationship includes interdependence. This means working together to achieve outcomes. This allows moments for independence and being dependent on another person when needed. Healthy interdependence promotes self-determination. Establishing and maintaining healthy relationships takes time. Ups and downs are to be expected. All relationships get rocky at times. One argument or disagreement does not make a bad or unhealthy relationship. Even if it is a really big argument. A healthy and positive relationship includes being able to resolve conflict or disagreement. It includes being able to acknowledge conflict. It requires patience and being able to apologise when needed. Learning how to repair a relationship is an important relationship skill.

> **Practice Tip**
> – Healthy Relationships

Here are some ideas about how to start building safe and trusting relationships:
- Be authentic, genuine and not fake
- Be consistent and predictable
- Model, build and practice healthy boundaries
- Support emotional regulation, even when it is hard to do this
- Be patient, there will be ups and downs
- Resolve conflict when it arises
- Build healthy interdependency that promotes self-determination

A Word on Boundaries

> **`Boundaries are particularly salient with clients who have been subjected to violations, exploitations, and dual relationships'** (Kinsler, Courtois, Frankel, 2009 p.127).

People who abuse other people violate the other person's boundaries. These include physical, sexual, emotional or psychological boundaries. Trauma creates significant barriers to building healthy boundaries. This includes healthy boundaries with friends, partners and professionals. Boundaries can be too rigid. When this happens, the relationship starts to feel controlling and punishing. The relationship may lack compassion, understanding or empathy. Sometimes boundaries can be too weak as well. When this happens, the relationship can feel confusing and unsafe. There may be a lack of clarity of roles, purpose and predictability in the relationship. It can be hard to know where the boundary is in a relationship. Boundaries are important for both people in a relationship. Boundaries are very different when you are a friend or family member versus a professional.

Maintaining healthy boundaries is an important way of building safety for others. But it can be easy to breach boundaries and sometimes hard to notice when that happens. This is because relationships are dynamic and fluid, which means they change all the time. When we form a relationship

with someone, we are not always aware of why we feel or think certain things about the other person. This happens for both people in the relationship. We start to behave in relationships based on prior experiences in relationships and because of assumptions and expectations we have about other people. It is important to understand the complexity of relationship dynamics. It helps with maintaining boundaries, looking after yourself, preventing burnout and managing vicarious trauma. These issues are discussed in further detail later in this section.

For more information on the complexity of relationship dynamics, including transference and countertransference, see:
https://mywellbeing.com/for-therapists/transference-and-countertransference

https://www.healthline.com/health/mental-health/transference

https://www.psychologytoday.com/au/basics/transference

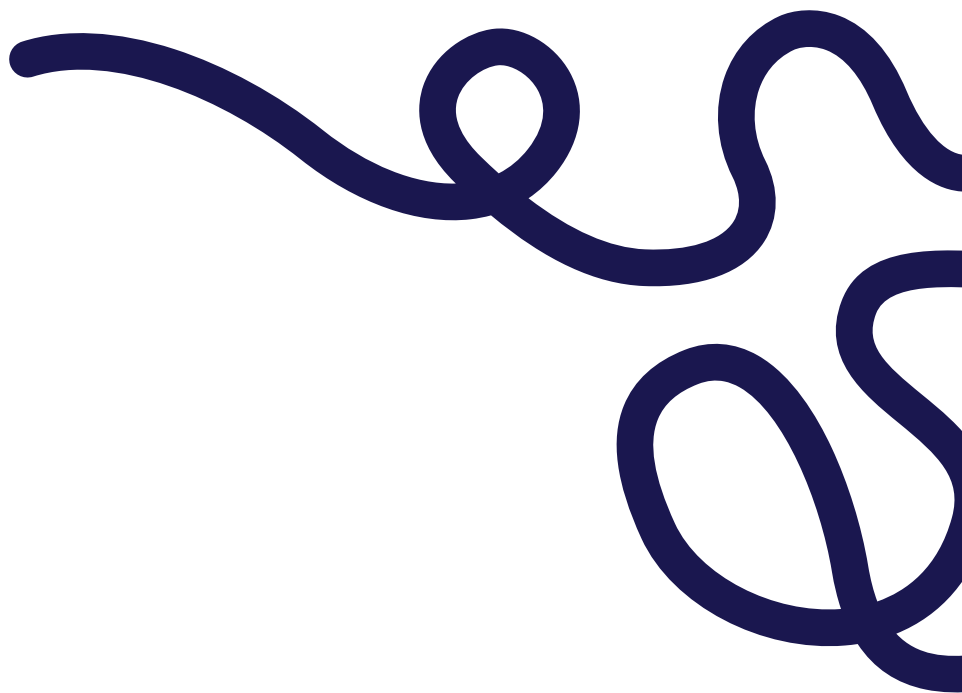https://www.goodtherapy.org/blog/psychpedia/transference

https://www.verywellmind.com/transference-2671660

The following case study provides an example of the complexity of relationship dynamics when providing support.

Case Study – Yasmina*

Yasmina is a 50-year-old caregiver who lives with depression. She cares for her 16-year- old daughter who has depression. She also provides care for her 82-year-old mother who has mobility difficulties and is in the early stages of dementia. She works full-time and is active in many local community groups. Yasmina grew up in a household where women usually were the caregivers. When Yasmina was a child, her mother struggled to understand her depression. Or know how to support her needs.

Yasmina resented her mother and yet felt obliged to care for her: "When I needed her as a child, she showed me little in the way of compassion and understanding… Now that she's older and feeling frail, she expects me to provide her all the compassion and understanding in the world… I struggle to say 'no' to her… I feel like it is my duty as a daughter to provide her care… That I somehow owe her this… Even though I am a 50- year-old woman, I feel like a suicidally depressed and sulky teenager whenever I'm in her presence… I feel responsible for everything".

Yasmina also felt confused by her responses towards her daughter: "You'd think I would be the best possible support for my daughter given that I had very similar experiences as a teenager… But every time she reaches out to me for help, I feel angry and resentful… What kind of a mother reacts with anger when their daughter feels suicidal… I hear my mother's words come out of my mouth… How is it that I became the uncompassionate caregiver here?"

Yasmina's mother feels "like I'm such a burden on her… I hate feeling reliant on other people… She was such a demanding child to parent… I had nobody to help me… I did my best to support her… I can feel when she is angry and frustrated with me… It feels just like it did when she was a teenager… She'd hold me responsible for everything that was wrong in her life… I guess it's just a woman's lot in life to be the caregiver".

*Identifying details have been changed to protect privacy

Boundaries can also depend on the circumstances or activity. Sometimes, supporting or caregiving necessitates close contact with another person's body. Sometimes it means access to another person's private and confidential information. These situations can make a person feel very unsafe and vulnerable. Trust is essential. In some communities, a person might be both a professional support worker or advocate and a friend or family member. This is particularly the case in small, close knit communities such as some rural and remote communities. Blind and Deaf people may also be both professional and peer or familial supporters. People from First Nations, CALD or LGBTIQ+ communities may also hold dual roles as a professional supporter and friend or family member.

Boundaries for Professionals

Organisations that employ support workers and advocates should have a clear policy and procedure around professional boundaries. Most professionals know and understand the difference between a professional and a personal relationship. For example, providing alcohol or illicit drugs to a person receiving professional support or assistance would constitute a breach of professional boundaries and may be criminal.

Maintaining any sort of sexual relationship or sexual contact with a person receiving professional support is also a serious professional boundary breach. Lending money or giving and receiving gifts may also be viewed as problematic in some organisations.

Professional boundaries also extend to relationships with other members of the person's family. It is important to uphold these boundaries to prevent intentional or unintentional abuse of power and authority. Professional boundaries are also important to protect the professional. Boundaries help to maintain a reasonable balance between work and other life activities. They also help you to look after your own needs. Many well intentioned and committed workers are tempted to 'rescue' people who receive support. However, overstepping this boundary can undermine the person's self-determination and path to independence. Supportive supervision can help prevent this common and easy to breach boundary. Regularly working longer than agreed working hours or additional hours without payment are other examples of common boundary violations. These can cause resentment to the person receiving support, poorer quality support, burnout and high staff turnover. These concerns and the role of supervision are discussed in more detail later in these guidelines. It is essential that all professional support workers and advocates also check any relevant organisational policies that provide clarity regarding roles and boundaries, if they exist. Identifying the correct person in the organisation to ask about professional boundaries is also important. This will help minimise mistakes.

Boundaries for Family and Friends

When you are a partner, friend or family member who is providing support, boundaries will look a little different. For example, you may be supporting your partner and be in a sexual relationship with the person at the same time. You may be a family member or friend who regularly socialises and drinks alcohol with the person receiving support. Gift giving or receiving, and money lending may be normal in the relationship. Partners, friends and family members play important roles. It is important to notice when the role **as a caregiver** disrupts the role as a friend, partner or family member. For example, when a friend does not want to socialise with a person at the same time as they are a primary caregiver. Or when there are lots of arguments because the primary caregiver is struggling with providing support or needing a break. Family and friends have needs in the relationship also. Sometimes this can mean that respite, extra support or time out are needed.

Negotiating boundaries and healthy relationships during adolescence can be particularly challenging. Developing relationship skills and testing boundaries is a normal part of adolescent development. People with disability or who have experienced **trauma** face additional barriers to negotiating boundaries and developing relationships. Parents, caregivers and families often play a pivotal role in assisting children and young people with disability to navigate through adolescence. This time can cause tension in the family as a young person works toward greater independence, tests boundaries, increases risk-taking behaviour and are more readily influenced by their peers.

In short, it is important to always negotiate boundaries with the person, whether they are adults, children or young people. Boundaries need to be flexible enough to change with need. Boundaries need to be agreed, but only if the person understands the boundaries. The purpose of relationship boundaries is to uphold safety and build trust. Boundaries should never be used as punishment.

Trauma-Informed Skills for Supporters

Mastering deep listening, empathy, compassion, reflective practice and developing communication skills are very important. So is creating supportive relationships and maintaining healthy boundaries. However, from time to time, some very specific trauma-informed skills are needed to support people to feel safe, manage arousal, strong emotions, and some specific behaviours.

Supporting Safety

People need to be safe and feel safe. All people need to be physically and psychologically safe. Some people have never felt safe. And do not know what it feels like to be safe. Learning what safety feels like can take time. A person can find it hard to feel safe when the environment is not safe. A person may live in a place such as a group home or prison that is not safe. Sometimes a person is not financially safe and does not have access to enough money or food to survive. Some people may have relationships that are not safe either. Some people may experience ongoing abuse and violence. Some people may not have a safe place to sleep. These are all basic needs for feeling and being safe. It is important to try and meet these basic needs. It is very hard to recover from trauma when basic safety needs are not met. Sometimes, it may not be possible to meet all these needs immediately. But people can still be supported to feel safer some of the time.

Screening for Trauma

> **"In a trauma-informed system, trauma is viewed not as a single, discrete event, but rather as a defining and organizing experience that forms the core of an individual's identity. The far-reaching impact, and the attempts to cope with the aftermath of the traumatic experience, comes to define who the trauma survivor is."** (Fallot and Harris, 2009).

Given how often people with disability experience trauma, it is important that services have a consistent process for screening for trauma. This is to make sure the right information and supports are provided to the right people. Screening for trauma should not be invasive or re-traumatizing. For more information about safe screening, see Talking about Trauma: Guide to conversations and screening for health and other service providers (Blue Knot Foundation, 2017)
From professionals.blueknot.org.au/resources/publications/talking-about-trauma-series/ and Talking about Trauma: Guide to everyday conversations for the general public (Blue Knot Foundation, (2017) www.blueknot.org.au/resources/blue-knot-publications/talking-about-trauma-guide-to-everyday-conversations-for-the-general-public/

Practice Tip
– Responding to an Abuse or Trauma Disclosure

Here are some ideas about how to respond to an abuse or trauma disclosure:
· Be supportive and validating. This can reduce shame, self-blame and isolation
· Accept the person's experience without judgement
· Listen and be attentive
· Stay calm and not distant
· Reassure the person and validate their feelings
· Use attentive body language
· Offer choices about what to do next e.g. continuing or taking a break
· Try to keep stress levels manageable – yours and theirs
· Refer appropriately as needed. This may include:
· Medical services to treat an injury or gather forensic evidence;
· Counselling services (e.g. sexual assault or domestic violence service);
· Police or legal services (e.g. to make a police report or access legal advice);
· Emergency accommodation services;
· Financial support services;
· Independent advocacy service to assist with making a complaint to the NDIS Quality and Safeguard Commission or other oversight mechanism or to assist with accessing other referrals.

Anchoring

It is possible to support people to build safety by using an 'anchor'. An anchor can help a person when they are triggered. It can also help a person who is hyper or hypoaroused.

An anchor is also useful when a person has strong emotions or complex behaviours. An anchor is a person or place to go to when triggered. Caregivers, support workers, and advocates can all be that anchor person. An anchor must be a trusted person. This is a person who can be there for another person who is stressed or outside their Window of Tolerance. An anchor person can provide a safety net and support the other person to understand and express what is happening to them. This can also help de-escalate a tense situation and bring calm. This strategy is useful in a crisis or to prevent a crisis. A place of calm can also be an anchor. It can be a place a person has been to or a place in their imagination. Companion animals can also be excellent anchors.

Developing Resources and Coping Strategies

All people have some protective factors. Protective factors are things that help to keep you safe and healthy. Things such as having supportive family or friends. Or being able to speak up and communicate your needs. Protective factors are important and should be encouraged and strengthened. Many people have also developed different coping strategies to help manage dysregulation. It is a good idea to ask the person what coping **strategies have worked** in the past. It can be useful to explore these with the person when the person is calm. That way the person will have some strategies to use when feeling triggered or traumatised. Then encourage the use of those coping strategies (if useful and effective) when needed.

Sometimes, coping strategies become less effective over time or in certain situations. Sometimes, coping strategies become harmful over time. For example, substance misuse and self-harming. It is important to first recognise that the coping strategy has helped the person to survive. Secondly, it helps to identify which coping strategies need to be replaced. And finally, people may need support to develop and practice new coping strategies. This should always be done before trying to remove a pre-existing coping strategy.

Supporters can support people to develop their own resources and coping strategies. Resources can be internal, like inner strengths. It is important to develop some strategies that the person can do themselves easily and quickly, like self-soothing strategies. Resources can also be external such as caregivers, companion animals and calming environments. Examples of useful coping and self-soothing strategies are discussed in the following pages.

Practice Tip
– Protective Factors and Coping Strategies

Here are some examples of protective factors:
· Identify the person's protective factors
· Explore how these protective factors have helped keep the person safe and survive trauma
· Strengthen and encourage these protective factors (e.g. encourage contact with positive supports, support self-advocacy etc.)

Here are some ideas about how to build coping strategies:
· Recognise that coping strategies are 'strengths' that supported survival
· Help identify when coping strategies are harmful
· Provide information and education about coping strategies
· Explore alternative coping strategies that are not harmful
· Support efforts to practice new coping strategies
· Encourage letting go of coping strategies that are no longer helpful

Supporting Emotional Regulation

Part of being safe is learning how to manage strong emotions. Being able to do this on your own is called self-regulation. Many people with trauma experiences experienced barriers to learning how to manage strong emotions as a child. They may have used dissociation, self-harm, isolation or emotional numbing instead. Some people with disability may have experienced barriers to developing self-regulation too. Managing strong emotions can be hard. It is hard for many people. Developing self-regulation can support a person to expand their Window of Tolerance. This means the person can manage triggers and flashbacks better. This helps reduce the trauma response. And if triggered, the person will be better able to manage strong feelings and changes in arousal. When this happens, the person will be able to learn and take on new information. The person will also learn to build healthy boundaries. Supporters can support regulation. The following strategies can help people manage trauma memories, triggers and strong emotions:

Noticing Personal Responses and Reactions

> **"Individual advocates [and supporters] need to be able to see … what they are doing to either diffuse or aggravate distress in the [people they are supporting]"**
> (Director of Individual and Group Advocacy NSW, People with Disability Australia)

It is important for everyone to be aware of their own reactions. It is possible to contribute to another person's dysregulation intentionally or unintentionally. Reflecting on what actions, statements or responses may have led to an escalation in distress is critical. A change in tone of voice. An eye roll, sigh, or turn up of the nose. These very small or subtle reactions can trigger a person or escalate distress. There may even be a desire to punish the person for their trauma reaction. This is not helpful and tends to make things worse.

It is important to always support a person to reduce the intensity of their reactions. This is not the same as shutting down the person's emotions. Everyone has the right to feel angry or upset sometimes. The aim is to help reduce the strength of the emotion, so it does not overwhelm the

person. When a person has a very strong emotional response or becomes activated, their nervous system is overwhelmed. It is possible to assist other people to regulate and settle their nervous system, feel calmer, and think more clearly and flexibly (Rothschild, 2010). Supporters need to be able to monitor and regulate their own emotions and responses to be able to support others to do the same. This reduces the risk that a person will become more distressed and will help to de-escalate the situation.

Noticing Early Warning Signs and Identifying Triggers

It is important to notice the early warning signs of a person becoming dysregulated. That is, being overwhelmed by strong emotions and or being hyper- or hypo-aroused. There may be signs. These signs are signals of distress that may indicate that a crisis is on its way. These can include restlessness, pacing, agitation, sweating, tightness in the chest or shortness of breath. Other signs are withdrawal or shut down. A person's usual behaviour and responses may change. Some people may need help to identify their own early warning signs.

Some people might be aware of some of their triggers. It is good to ask a person about possible triggers before they present. We might not always be able to identify a person's triggers, and definitely not straight away. You can sometimes work out what triggered a person by paying attention to what happened just before the person became distressed or while the person is distressed. Just noticing and trying to look at what is going on from the other person's perspective can be helpful. That way we might be able to see what the other person sees or feels.

Co-Regulating

Supporters can support a person who has become dysregulated through co-regulation or calming together. To do this you need to be in a calm state yourself first. Then you use your own skills in regulation to help another person manage their emotions. This is a really important part of supporting a person to achieve a regulated state. Co-regulation might include sitting with someone quietly and calmly until the person regulates. It might also include touch. For example, holding the person's hand or hugging the person. Touch should only be used if the person permits it. Permission may be verbal (e.g. "I need a hug

from you" or "Can you please hold my hand?") or behavioural (e.g. outstretched arms, not pushing away). Touch should only be used if it is not distressing for the person or it is appropriate in the context of the relationship with the person. Companion animals are also very good co-regulators.

Somatic Strategies

Shifting usual body patterns can change the way a person feels or thinks. This is because a lot of trauma is stored in the body. There are lots of ways to work with the body. These are called somatic strategies. These strategies include movement, postural changes and the way a person responds to sensory cues or things in the environment that stimulate one of the five senses. Some people find holding themselves or hugging themselves can be a helpful self-soothing strategy. For more information about this strategy see [Peter Levine's Self Holding Exercises for Sufferers of PTSD – PART 1 – The Art of Healing Trauma (new-synapse.com)]. Some people close their eyes and try to notice where in their body (such as head or stomach) they are feeling the most distress. Then they place their hand on that part of the body. Some people might gently rock backward and forward to self-soothe. Some people like to give parts of their body a massage. Some people like to move their body by jumping, walking, stretching, or jogging on the spot to self-soothe. Some people find certain smells (e.g. lavender) or drinking some teas (e.g. camomile) soothing. Some people like to have a warm bath to soothe. It is important to remember that everyone is different. While some people feel calm with these self-soothing strategies others may find some of them triggering. This is why it is important to explore a range of strategies with the person **before** the person needs support to regulate strong emotions.

Here are some ideas about how to respond to strong emotions:
· Identify the person's protective factors
· Explore how these protective factors have helped keep the person safe and survive trauma
· Sit with the person and their difficult feelings
· Support the person to express their feelings - not everyone can do that and that is okay
· Support the person to express themselves in whatever way they can
· When it is appropriate, ask the person what helped them to feel calm in the past
· Accept the person's feelings. This shows that you accept the person too
· Acknowledge their pain, validate and normalise their feelings
· Check in with the person that you have understood
· Gently suggest what may help. Wait for the person to respond. If they do not agree, respect their decision.
· Do not use platitudes - it is better to sit in silence and just be there with a person
· Ask how can I help/support you right now?

Managing Changes in Arousal

Grounding strategies can support a person to manage changes in arousal. They also support safety and emotional regulation. These are strategies that supporters can learn to help support people. Grounding techniques can help when a person is so distressed that they feel detached or as if they are not real or in a dream. Sometimes when we are distressed, we can feel as though we are in a different situation to the present – such as reliving a traumatic experience from the past. We can also use grounding techniques when we experience a flashback. Flashbacks throw us back into experiences and memories from the past. Grounding techniques help bring us back into the present. They can bring us back into our bodies as well. They are designed to help people focus on the present and direct attention away from past memories or distress. Sometimes a person needs to practice grounding strategies to make them work well. There are a range of different grounding strategies to use:

Present Minded ('Here and Now') Grounding

Sometimes a person might appear confused about where they are. The person might feel like the traumatic experience is happening right there and then, instead of in the past. Or the person might feel like they are in a dream and feel a bit numb. If this happens, one simple grounding strategy is to alert the person to the current surrounding and remind the person that they are safe now. This grounding exercise can support a person to feel safe. It helps the person come back into the present moment. There are different ways to do this. Different people find different ways helpful. Some will need to be modified for a person with disability. Some may not be possible.

Practice Tip
– Here and Now Grounding Strategy

When a person needs help to come back to the present moment and direct attention away from past distress or memories, you can:

· Reassure the person that it is okay - they are safe and it is just a flashback or anxiety
· Reassure the person that this is to be expected
· Remind the person that it is what happened was in the past, and is not happening now
· Reassure that the worst is over – they survived the trauma and it is in the past
· Reassure the person that they are experiencing a memory – it can't hurt the person now
· Put the lights on and encourage the person to open their eyes (if this happens in the dark)
· Encourage the person to look around the room, notice colours, objects, nearby people - anything to help the person notice the present moment and stop thinking about the past trauma
· Encourage the person to listen and notice any sounds, such as traffic noise, birds, outside, rain, or voices
· Remind the person to notice their body - to feel the gentle pressure of clothes on their skin, the hair against their neck, the floor beneath their feet etc.

- Encourage the person to use grounding statements (e.g. I am Fred. I am 45 years old. This is the present and that was the past. I am safe. Today is...)
- Encourage the person to take some time out from a stressful situation

Then support the person to orient to the future by:
- Focusing on what the person is going to do next, such as e.g. eat, go home, or read a book
- Planning to do something nice for themselves, such as e.g. take a bath, walk, or listen to music

Physical Grounding

Sometimes it helps if people can sense their feet firmly on the ground. This can help the person to feel the earth's support. It can also help a person to feel physically stable and in the present moment. This can help the person feel psychologically stable and secure too.

Practice Tip
– Physical Grounding Strategy

Suggest this if the person has the capacity to do the following steps. Ask the person to:
- Put both feet firmly on the ground
- Feel the ground under their feet
- Feel the grounding into the body
- Pay attention to their feelings in their body
- Examine: What is the sense in your body?
- Be curious and non-judgmental
- If the person cannot feel anything or is not aware of their feelings and senses that is okay - it is about noticing that

Breathing and Mindfulness Grounding

Breathing connects us into our bodies. It helps us regulate our energy and arousal. When we exercise or exert ourselves, we breathe faster and harder. When we are scared, upset, anxious or feeling threatened we often breathe fast. We may also breathe shallowly. Our body begins to panic when we do this. Trauma survivors often over-breathe (i.e. rapid and shallow breathing). The rate of breathing affects the heart rate, blood pressure and causes different body experiences. This can make us feel dizzy and shaky.

When we are distressed or feeling anxious it can help us to focus on our breathing. Breathing slowly helps slow other processes in the body. Breathing slower and deeper helps stop the panic. It also lowers arousal. When we relax, we breathe slower and deeper. This, in turn, reduces tension and stress. Slowing breathing can help turn off the 'fight/flight' response – our survival response to stress. Sometimes people need support from another person to help them focus on their breathing.

Practice Tip
– Mindful and Controlled Breathing

Mindful breathing:
· Ask the person to breathe deeply into their belly
· If able, suggest that the person places their hand on their tummy just above their belly button
· Suggest that the person breathe so that their hand is pushed up and down
· Ask the person to imagine a balloon in their tummy. Then blow the balloon up with each breath in. Then let the balloon down with each breath out.

Controlled breathing exercises:
· The following controlled breathing exercises can help if a person starts to feel tense, anxious or panicked. It is useful to try and do this before any difficult situations arise. Not everyone will be able to do this, but it is useful if the person can.
· Ask the person to focus on their breathing
· Suggest that the person try to breathe evenly
· Ask the person to lengthen each breath

- It can help to make the breath out slighter longer than the breath in (e.g. in for the count of 3 and out for the count of 5
- 'Box breathing' is another technique to help relieve stress or anxiety - breathe in for 4, hold for 4, breathe out for 4, hold for 4 and repeat
- Focus on taking deep breaths and pushing the breath out forcefully, making a whoosh sound
- If the person finds breathing techniques difficult, suggest lying down and placing a small pillow or piece of clothing on the stomach. Ask the person to watch the pillow or clothing slowly rise up and down with each breath
- Doing this every day, if possible, can help lower stress levels
- Focusing on breathing is particularly effective when the person is grounded - ask the person to feel the earth under their feet, the seat they are sitting on. Looking out of a window, stepping outside into the fresh air. These strategies can make breathing techniques work better
- If panic sets in quickly and if the person cannot breathe through it, ask the person to try breathing in and out of a paper bag

Sensory Grounding

Connecting through our senses helps us become more aware of our body. This helps connect us to our body and manage our emotions better. As we connect with positive sensations, we can help calm ourselves. When we are aware of and feel connected to our body, it helps us to be in the here and now. It helps us feel grounded. This in turn can help us connect. These strategies can be modified to suit individual needs and preferences.

Practice Tip
– Five Senses Grounding

A Helping Hand

Before the person needs grounding:

- If the person is able, ask the person to trace their hand on a piece of paper
- Label each finger as one of the five senses
- Represent each finger as something safe - something that is meaningful to the person (e.g. thumb represents sight and index finger represents hearing)
- If the person is able, after they have finished drawing this, ask the person to memorise it - not everyone can do this and that is okay.
- You can also suggest that the person puts the drawing somewhere they can see it, like on the fridge door

When the person is triggered ask the person to breathe deeply and slowly. Then suggest to the person that they put their hand in front of their face. Ask the person to stare at each finger in turn. Suggest that they try to do the five senses exercise from memory (Najavits, 2002).

Comfort Box

Before the person needs grounding, and if the person is able:

- Locate something that the person finds calming to look at (e.g. a picture, something sparkly or shiny, or a snow dome etc.)
- Locate something that the person finds calming to listen to (e.g. a small music box, a tuning fork, a rain stick, favourite iPod tracks etc.)
- Locate something that the person likes to touch (e.g. a piece of velvet or satin, a plush toy etc.)
- Locate something that the person likes to smell (e.g. a bottle of essential oil, dried lavender, cinnamon etc.)
- Locate something that the person likes to taste (e.g. a mint, chocolate etc.)
- Place all these items in a box - some people like to also decorate the box
- When triggered encourage the person to access their box and use the five senses to explore each item until they can return to the Window of Tolerance

Five Senses Grounding

When triggered, if the person is able, ask the person to:
· Name 3 things they can see in the room
· Name 3 things they can feel (e.g. back on chair)
· Name 3 things they can hear right now (e.g. birds outside)
· Name 3 things they can smell right now or 2 things they like the smell of
· Touch 3 things in the room and describe what they feel like (e.g. cold, hard, rough etc.)

Inner Experience Grounding

Noticing what is going on inside our bodies is another helpful grounding technique. This means noticing our inner experience. This technique can be helpful for some people. Others might find it more challenging.
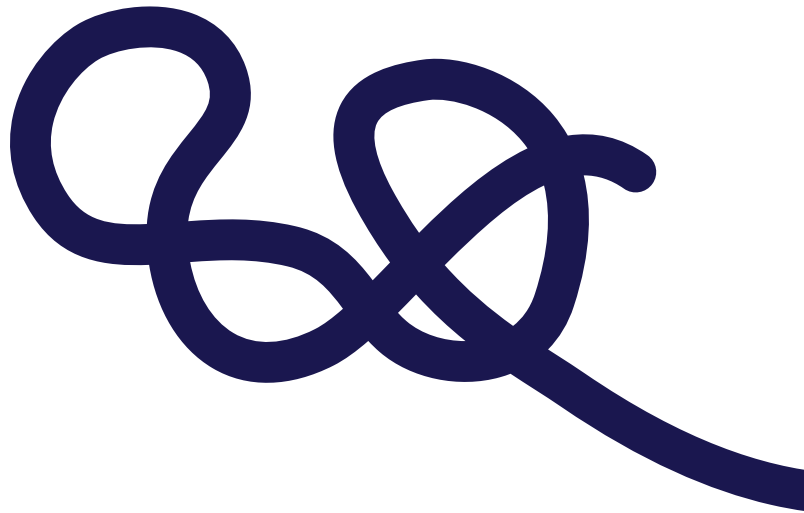
Here are some questions to ask to support people to notice their inner experience:

Step 1:
Noticing similarities

· Is it like previous experiences or situations?

· What feelings are the same as before?

· Is there a pattern of trauma responses – like going back to past experiences?

· Are there any others?

Step 2:
Beginning to notice difference

· What is different about this experience? Does it need a different response?

· Can the person begin to tell the past from present?

· Can the person separate inner fears or beliefs from external realities?

There is no 'one size fits all' strategy. All grounding strategies are designed to help a person who is overwhelmed to return to their Window of Tolerance. Some strategies work better than others for different people. Some strategies work better when a person is feeling hyperaroused. Some strategies work better when a person is feeling hypoaroused. Grounding strategies can be modified depending on whether the person is hyperaroused or hypoaroused.

Practice Tip
– Summary of Grounding Strategies for Hyperarousal and Hypoarousal

To Support All People Who are Outside Their Window of Tolerance:

· Recognise that being hyperaroused or hypoaroused is a distress or fear response

· Validate the person's response ('I can see you are...')

· Offer support ('Would you like me to support you to ...?')

· Suggest that the person takes a 'rest' break. Suggest that they might want to stretch, walk around or take some time outside

· Help the person to be aware of their surroundings and to tune into their senses

If a person becomes hyperaroused (i.e. visibly agitated, sweating, dilated pupils, raised voice, rapid pace of speech, face changes colour):

· Here and Now Grounding - Turn the person's focus to the current task or need

· Physical Grounding - Suggest that the person gently stamp their feet on the ground or engage in a physical activity like going for a brisk walk (if safe to do so) to discharge some energy

· Breathing and Mindfulness Grounding - Suggest that the person takes some long, slow breaths

· Sensory Grounding - Suggest that the person has a calming object with them – something that is meaningful to them and helps the person soothe through using one of their senses e.g. photos, soothing music or friend's voice, essential oils, favourite scent, woolly socks, teddy bear etc.

· Inner Experience Grounding – Notice what is happening in the body (e.g., sweating, shaking, feeling hot etc.) Notice the similarities and differences etc.

If a person becomes hypoaroused (i.e. 'zones out', glazed eyes glaze, on autopilot,'shut down'):

· Here and Now Grounding – Turn the person's focus to the present, remind them that they are safe, give them time and space. Speak calmly and slowly to help bring the person back to an awareness of where they are ('I am xx; it's Tuesday morning; we're sitting in a café...')

· Physical Grounding - Suggest a simple stretch (the focus should be on an external movement rather than on an inner sensation)

· Sensory Grounding - If the person has lost the sense of their body, suggest that they rub their arms and legs to help them feel where their body starts and ends

· If the person is sitting down, suggest that they stand up for a moment (and stand up with them) - Emphasise movement not sensation

· Suggest the person wraps themselves in a blanket or towel and feels it around them

· Direct attention outwards not inwards by conducting five senses grounding

Behavioural Support

Some disabilities and trauma can make it hard for the person to talk about their feelings. Sometimes it can also be very hard to figure out what a person with disability is trying to communicate through actions or demeanour alone. This can cause frustration for everyone. Both the person with disability and supporters. Communication barriers can sometimes cause aggression or violence. Sometimes they may lead to withdrawal. Sometimes they might lead to self-harm. Self-harm can be a way to express emotions like frustration and fear.

When the supporter focusses on the behaviour as a 'behaviour of concern', the frustration gets worse. Or if the supporter believes the person is deliberately trying to cause trouble, they will be unable to provide empathic or compassionate support. It is important to always think about the possible cause of a new behaviour. New behaviours can sometimes arise when someone is being abused or harmed or is triggered and re- enacting a past traumatic experience. Supporting people from a trauma-informed framework means that it is important to consider whether behaviours that have been labelled as 'behaviours of concern' are in fact a trauma response. It may or it may not be. If the person experienced an obvious or known

trauma trigger just before the behaviour, it may be a trauma response. If the person was punished because they were not able to identify, express or manage strong emotional responses, the behaviour may be a trauma response. Viewing the behaviour through a trauma-informed lens can help everyone be more patient and less frustrated. It also helps to improve communication and understanding. If the behaviour is understood as a response to emotional dysregulation or an attempt to communicate distress, the response to the behaviour changes. It becomes more useful.

Practice Tip
– Using a Trauma-Informed Lens to Understand Complex Behaviour Support Needs

No trauma-informed lens	Possible Interpretation through a Trauma-informed lens
Regularly engages in difficult or challenging behaviour	Regularly experiences strong trauma responses
Behaving badly on purpose	The behaviour has meaning and is trying to communicate something
Is manipulative	Uses coping strategies to survive
Is oppositional	Does not feel safe with what is being suggested
Abuses drugs and alcohol	Tries to manage distress and regulate feelings through substance use
Is noncompliant and avoids groups	Does not feel safe or feels overwhelmed in groups
Is jumpy, agitated or paces	Feels unsafe and needs to constantly check for danger - hypervigilant
Does not comply with boundaries	Does not understand boundaries or is trying to get needs met
Is lazy, unmotivated or does not pay attention	Experiences a freeze trauma response or shuts down when overwhelmed
Cannot be trusted and lies all the time	Does not feel safe telling the truth or has survived by not speaking the truth

Behaviour support practitioners can help with understanding complex behaviour needs. They can develop a positive behaviour support plan to help guide how to interpret and respond to certain behaviours. For more information on accessing this support, see [The Positive Behaviour Support Capability Framework | NDIS Quality and Safeguards Commission (ndiscommission.gov.au)](ndiscommission.gov.au)

Practice Tip
– Trauma-Informed Support for Complex Behaviour Support Needs

When confronted with a behaviour labelled as a 'behaviour of concern', it can help to ask the following questions:

Understanding the Behaviour

- What was the cause of the behaviour?
- What happened just before the behaviour that may have triggered the response?
- What is being communicated by the behaviour?

Assisting Emotional and Behavioural Regulation

- What can support the person to return to their 'Window of Tolerance'?
- In what other ways can the person communicate their needs?

Managing Your Own Reactions

- Be aware of how the behaviour makes you feel
- Manage your own reactions
- Take time out or seek support if you are feeling angry, scared, frustrated or distressed by the behaviour

Trauma-Informed Skills to Minimise Harm and Re- Traumatisation

Use of Restrictive Practices, Restraints and Seclusion

Under the United Nations Convention on the Rights of Persons with Disability, the use of restrictive practices, restraints and seclusion can be a serious breach of human rights.

Restrictive practices, restraints and seclusion have often been used to manage the actions or demeanour of people with disability. This has been done in the name of controlling what are labelled as 'behaviours of concern' and managing complex behaviour support needs. They have been regularly overused and misused and are now recognised as a serious infringement of human rights. People who have experienced trauma are likely to be re-traumatised when restrictive practices, restraints and seclusion are used. This is because these strategies are disempowering, often replicating the experience of previous trauma. These practices sometimes trigger past trauma for some people. Some people experience further trauma because of these practices. These practices are sometimes used in schools, private homes, hospitals, prisons, and residential settings.

Restrictive practices include physical, mechanical, environmental and chemical restraints. Sometimes people physically restrain or hold down people with disability. Such restraint can be acutely traumatising and re-traumatising. Restraint can trigger prior feelings of being trapped, coerced and disempowered. Many people felt trapped during past abuse. Sometimes medication or drugs are used to chemically restrain people with disability. Some people with disability are forced to do things they do not want to do. Some people in control punish people with disability. Some people may take things away as a punishment or stop people with disability from seeing or speaking to their family and friends. Sometimes

authority figures may take away a person's mobile phone to stop them calling for help. Sometimes people are forced to comply with strict rules. Strict rules and coercive control take choices away from people. It is important to support people to make choices for themselves. Being restrained is no less abusive if it is called a restrictive practice. Misusing restrictive practices is not ethical and may even be illegal in some situations.

The use of seclusion is also re-traumatising. This is because it locks people away, separates them from others, and replicates feelings of isolation. Seclusion restricts engagement with others and human connections, which are so critical for health and wellbeing. This includes being able to co-regulate when distressed.

Practice Tip
– Understand Restrictive Practices from a Trauma-Informed Framework

Example of Restrictive Practice	Possible Re-Traumatisation
Seclusion Kept locked in a room/prison cell away from others Not permitted to play with other school children at lunchtime	Similar to past abuse where locked away, alone or kept apart against will Made to feel different from other children because of the abuse or kept isolated on purpose to enable ongoing abuse
Chemical Restraint Sedated against will	Similar to abuse when drugged Feels like dissociative episode
Mechanical Restraint Strapped or tied down to a bed or chair	Similar to past abuse when strapped or tied down Unable to defend against abuse

Physical Restraint Held down by medical/prison staff or police Hand held to stop gesturing to communicate or signal for help; silenced	Similar to when held down to enable abuse Similar to not being able to signal for help or being silenced to prevent disclosing abuse
Environmental Restraint Being locked in a yard/building	Similar to when could not escape or detained during past abuse
Not allowed phone	Similar to when could not call for help when needed
Closed/locked doors	Similar to when trapped and unable to escape
Taking money or removing access to money/pay	Similar to when financially abused – no money or money taken away
Not providing treatment, food or medication when needed	Similar to when denied water, food, treatment during neglect or past abuse

Trauma-informed practice reduces the use of restraint and seclusion practices in disability services (LeBel, Huckshorn and Caldwell, 2010). Environments that emphasise control tend to isolate people. People with disability and especially people with trauma experiences can be isolated and feel alone. This makes abuse and exploitation more likely. Trauma-informed services and people minimise the use of coercion. Instead, they work collaboratively with people with disability as equal partners, responding to people's needs. Sometimes, a restraint is needed to ensure a person's safety but should <u>always</u> be a last resort. A restrictive practice should also <u>never</u> be more restrictive or used for longer than is necessary to prevent or contain danger. For more information on the national framework for reducing and eliminating the use of restrictive practices, see [National Framework for Reducing and Eliminating the Use of Restrictive Practices in the](#) [Disability Service Sector | Department of Social Services, Australian Government](#) [(dss.gov.au)](#) or [https://www.ndiscommission. gov.au/regulated-restrictive-practices](#). National Disability Services (NDS) also has information available on their website that explains how to

recognise restrictive practices at https://www.nds.org.au/zero- tolerance-framework/considering-additional-risk

The following case study provides an example of the use of some restrictive practices. It also highlights how understanding a behaviour (e.g. food as a soother) can be used to change behaviours without the use of restrictive practices.

Content Warning

This case study contains information that may be upsetting for some people. This is because it talks about violence, abuse, neglect or exploitation of people with disability. If you have any difficult feelings after reading it, you may want to reach out for support. You may have your own support system you can access.

You can also get support through the Disability Gateway by phoning 1800 643 787 between 8am-8pm Monday to Friday

Case Study – Lena*

When Lena arrived for her first shift as a disability support worker in a day centre, she expected it to be as advertised. 'On paper the roster of programs looked fantastic,' she told us. Participants, some with high needs, could choose different activities – for example, cooking, sewing, woodwork and drama. 'They should have been enjoying their life, but they weren't.'

Instead she was confronted with 32 people, some restrained, some wearing face guard masks and some lying on the floor. There were only two staff and Lena was told to 'get on with it the best you can'. The restraints were 'the old fashioned chairs with belts on them … and people that were ambulant … would be strapped in'. The masks were forced on people to stop them spitting. Lena was shocked because 'the newer restraint laws would definitely have been in'.

All of the residents displayed complex behaviours including physical violence, compulsive eating and absconding. All doors, windows and the

kitchen roller door were locked. The man Lena supported was a compulsive eater. Food soothed him, and he knew the staff kept their chocolates in the office. One day the supervisor found him in the office and yelled at him to get out. When the man did not leave immediately, the supervisor grabbed him and physically removed him. Lena supported the same man at a community centre during the day where the kitchen was open and lunch boxes were left out. With Lena's gentle support he learned not to touch food that didn't belong to him.

Lena also recounted supporting a woman living in a residential facility for 30 men and women. Half of the residents lived with disability and half had been recently released from prison. Doors weren't locked. For people with no support, it was a place of last resort, 'before homelessness'.

The home kept 85 per cent of the residents' support pension for food, toiletries, and health expenses. Residents were supposed to be given the remaining 15 per cent but this woman was lucky to get $10 a week. Food was served at strict times and toiletries were restricted. Lena says, I had to go every week and ask for soap … tampons … shampoo.

Laundry was done only twice a week, so clean clothes were an issue. Rooms weren't cleaned. The residents' cigarettes were taken and kept in reception which was only open during the day.

* Name changed and some details removed to protect people's identities. Narrative based on a private session with the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Dignity of Risk

Self-determination includes the right to take reasonable risks that are essential for dignity and self-esteem. This is called the 'dignity of risk'. Supporters need to uphold each person's dignity and self-esteem. Being overly cautious or risk averse when managing risks can compromise a person's self-esteem and dignity. Sometimes supporters have a responsibility to act when there is an immediate safety risk. This is called a 'duty of care'. In weighing up a duty of care, the dignity of risk must also be considered. Duty of care must always be upheld if there is an unacceptable level of risk to the person's immediate safety. Policies (when they exist) need to be clear on when it is acceptable to override the person's choice. Weighing up duty of care and dignity of risk is particularly challenging for decisions regarding children and young people where **there may be statutory obligations to report** significant risk of harm. Support workers and advocates should consult with supervisors, mentors or managers when making these difficult decisions.

Parents and caregivers must constantly make decisions about providing children with new experiences and opportunities to grow and learn. In making these decisions, caregivers need to weigh up any potential risks to the child. For example, allowing the child to play a sport in which they might get injured. If the caregiver worries about risk too much, it can prevent the child from many new experiences or opportunities. Children and young people need opportunities to grow and develop. If the parent does not accurately consider risk, the child may be regularly hurt or injured. Weighing up the dignity of risk can be especially challenging when considering children and young people with disability.

The following case study is an example of when duty of care and dignity of risk are poorly managed.

Content Warning

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Case Study - Mohammad*

Mohammad has an intellectual disability and was sexually abused as a child. He is 39 years old. He was convicted of an offence and imprisoned for four years.

"When I first went to prison, I felt really scared. I found it hard to talk to anybody. One Friday afternoon I tried to tell the prison psychologist that I was feeling scared. I told her that I used to cut myself on purpose and hit my head against the wall when I was upset as a kid. I told her that being in prison made me feel like a kid again. She asked me if I was going to be able to keep myself safe over the weekend. I told her I didn't know how to do that. I thought she meant keep myself safe from the other prisoners. It turns out she was asking if I was going to kill myself over the weekend. I was put in isolation over the weekend. I had to wear a suicide prevention gown. I couldn't even wear my underwear. I felt naked. I didn't like it. It was like when I was abused as a kid. I couldn't leave the cell all weekend because they thought I might kill myself. I missed out on seeing my mum who came to visit me that weekend".

*This is not a real person's story.

Minimising Trauma and Re-Traumatisation

`[M]any survivors have been retraumatized by [workers] who had inadequate understanding and skills to treat complex trauma-related problems...'
(van der Hart, Neijenhuis & Steele, 2006:224)

Being trauma-informed is the best way to minimise the risk of additional trauma and re-traumatisation. People are often re-traumatised when their experiences of abuse and trauma are not acknowledged. People are also re-traumatised when the impacts of what happened to the person are minimised. Some people try to speak out about what happened but are silenced or ignored. Some are not believed. A trauma-informed approach is open to the possibility of trauma. It acknowledges the effects of trauma and each person's experience.

Services and people who are not trauma-informed are not aware of people's triggers. No effort is made to reduce their exposure to possible triggers. No additional support is provided in highly triggering environments or contexts. Flashbacks and behaviours are often not understood. This often means that people are labelled and blamed. It leads to people being dismissed and silenced. People and services that are not trauma-informed often negate, deny, minimise or disbelieve people's experiences. Many do not listen to what a person is saying. Some people disempower the person who experienced trauma and behave as if they are the expert and know better. Everyone needs and deserves to be heard and to have their feelings validated. This is especially important for people who have been excluded and not previously acknowledged. Instead of being supported to be calm and regulate their emotions, a person who has been traumatised may be punished for their biological responses to the trauma. This is very re-traumatising. These are common experiences for people with disability who have experienced trauma.

Practice Tip
– Minimising Trauma and Re-Traumatisation

Here are some ideas about how to minimise trauma and re-traumatisation:

- Be aware that trauma is a possible cause for a person's reaction or needs
- Adopt a position of belief when disclosures of abuse are made
- Be careful to not silence, deny or minimise a person's lived experience of trauma
- Validate and normalise feelings of distress resulting from trauma
- Seek to understand a person's triggers and attempt to remove potential triggers from their environment (e.g. remove triggering posters, meet in safe locations, limit the number of times the person is required to recount their trauma experience etc
- Provide additional support to a person or prepare the person for when they need to go to very triggering environments
- Support the person to manage arousal and emotional reactions when triggered
- Limit the use of restrictive practice, restraints and seclusion
- Provide additional support to the person to help them manage the trauma impacts if restrictive practices must be used
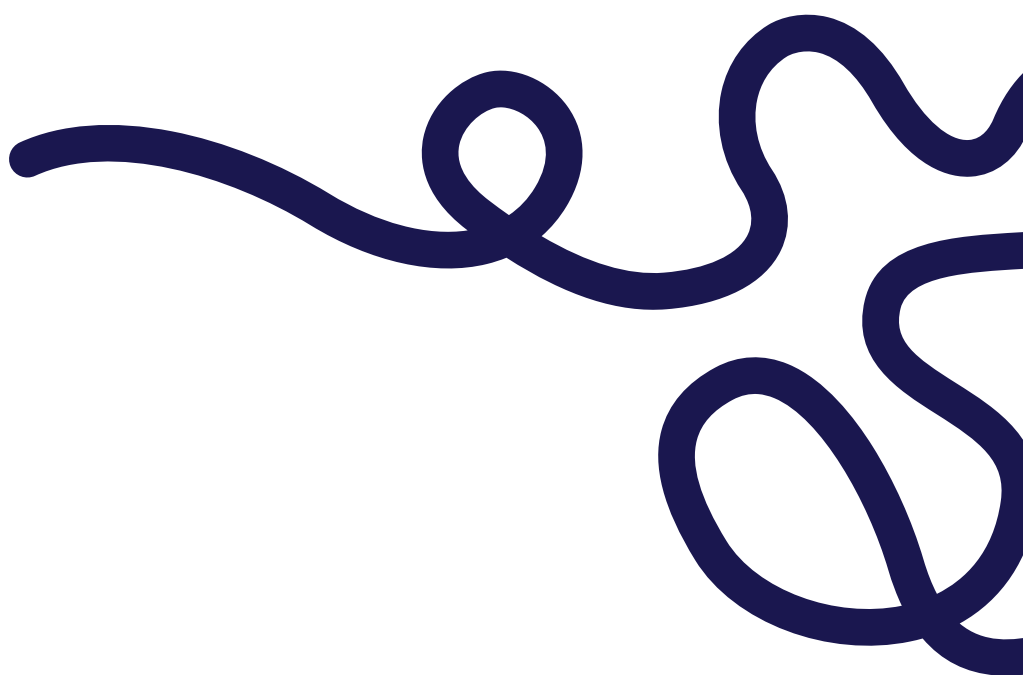
Advocacy

**"Good advocacy must include playing an educative role...
teaching how to navigate the systems in which [we] are currently
enmeshed... and how to navigate similar systems in the future.
A good advocate should also always aim for redundancy in their
client's life"** (Director of Individual and Group Advocacy NSW, People
with Disability Australia)

Advocacy is a process of working with and for people. It can mean
speaking, acting and writing for a person. However, it does not mean
disempowering the person and taking over. Advocacy supports self-
determination and values the person for who they are. Advocacy fosters
autonomy, dignity and upholds each person's human rights.

Self-advocacy is the action of speaking up for yourself. It includes telling
other people about your thoughts and interests. It means being able to
ask for what you need and want. When barriers that prevent people with
disability from being heard are removed, people with disability can engage
in self-advocacy. However, many people with disability who have trauma
experiences need supporters who can represent the person and their
rights, preferences and wellbeing. At times caregivers and support workers,
will take on the role of speaking up for the person or supporting them to
advocate for themself. Yet in some contexts or situations the person will
need to access advocacy that is independent of their service provider or
service system. Ensuring the person can access an independent advocacy
organisation is necessary to avoid any possible conflicts between the
interests of the person with disability and the interests of the service
or system. Caregivers are often very effective advocates. However, an
independent advocate may be needed for complex issues - including
in situations where the caregiver's perspective might differ from the
perspective of the person with disability.

Professional advocates often have experience in supporting people with
disability to express their perspectives, make complaints or navigate
complex systems. Much funded advocacy is focused on upholding the
rights of individual people with disability. In contrast, systemic advocacy
seeks to change policy and systems. Changes to policy and systems can
affect large numbers of disempowered and stigmatised people. That is
why the Royal Commission into Violence, Abuse, Neglect and Exploitation of

People with Disability is so important. It is looking at how to improve things for people with disability who have experienced abuse, violence, neglect, and exploitation. It is about changing the future for people with disability who have experienced trauma.

Referrals

Good trauma-informed services work towards making the service redundant for the people accessing the service. This includes providing access to sufficient knowledge, resources and support to enable independence and self-reliance. Outgrowing or no longer requiring support is cause for celebration. Some people may only need to engage for a short time with the service. Others may need a longer period of engagement to meet their needs.

People's needs also change across the life course. And people often have many different needs. This means that one service can rarely provide all the supports a person needs through their life. Sometimes, a service that was once suitable is no longer the best option to meet a person's particular need. Sometimes, a person may want to access a different service. At other times, a new service is needed to fill gaps in the services a person is receiving.

When the person has agreed that they will be finishing up with a service, that service is responsible for ending the service smoothly and ethically. This may mean working with the person to determine how best to wind down their engagement with the service. It may also involve introducing the person to another service or making a referral. It is critical to ensure that the person has ongoing support when one service ends, and another starts.

It is important that services develop clear and accessible referral pathways. It may be helpful if the supporter is actively involved in assisting the person to access a new service or supporter. However sometimes a person may not want this, either because they want to make a fresh start with the new service or to have more control over the process. It is important to always take the person's wishes about changing services or supporters into account. When referring to other services, always make sure that the person is aware and consents to the information that is relayed to the other service.

· Key performance or service indicators that add up number of occasions of service or the length of engagement do not accurately measure the quality or success of service
· This is because people's needs are often complex and change across the life course
· Services are responsible for ending service smoothly and ethically
· This may include ensuring appropriate referrals have been provided and accessed
· Workers should be supported to facilitate referrals in a trauma-informed manner
· Services should develop clear and accessible referral pathways

Coordinated Support

Coordinated support is critical for anybody receiving support for complex needs, especially when people have experienced trauma. Coordinated support is sometimes also called 'Care Coordination'. People receiving services under the National Disability Insurance Scheme (NDIS) may also receive 'Support Coordination' services (for more information, see https:// www.ndis.gov.au/participants/using-your-plan/who-can- help-start-your-plan/support-coordination).

Coordinated support is critical for people with prior trauma experiences to minimise the risks of additional trauma and promote recovery. Services need to have processes in place to enable adequate coordination of support. People with disability who have experienced trauma can have a range of complex needs. This means that a number of different people or services may be providing support. It is essential that the person receiving support is involved in making decisions around the coordination of support. This is a fundamental requirement of both person-centred and trauma-informed practice (i.e. collaboration principle). This includes involvement in decisions about who to include or not include in the person's support network. The person should also take part in determining the timing of the support and how it is provided. Shared decision-making must always include the person receiving support. This helps ensure that the support

best meets the person's needs. Coordinated support requires collective decision making, involving all the services and individuals providing support. It also requires accurate and timely communication and the coordination of information and resources as well as of people.

Each person or service in the support network may play very different roles in providing that support. Everyone involved in a person's support network needs to understand the person's needs. This shared understanding provides a holistic picture of each person's **support network. This** enables all service providers to understand their different roles and responsibilities. It assists with understanding and valuing the different contributions each person or service in the support network makes. It also means that gaps can be identified and addressed as best they can. Each person with disability who has experienced trauma needs and deserves harmonious and streamlined services. This requires service providers developing respectful and harmonious working relationships. The person receiving support should not ever be impacted by interagency disagreements. These need to be addressed and resolved by service providers without affecting the services a person receives. Coordinating effective support requires good communication. This means open, transparent and timely communication with all people in the support network, including the person receiving support.

It can be challenging to integrate, and coordinate supports across different systems, such as education, health, justice, and disability systems. Often systems work in siloes. This can lead to compartmentalised support. This can negatively affect a person's experience of support, and the person's wellbeing. It can mean that some of the person's needs are not met or are inadequately met. Service providers need to work together to minimise the potential for fragmented service delivery. To prevent this, it is optimal for one person to be the support coordinator. That person can ensure everyone's commitment to address, minimise and overcome any barriers or issues. Jurisdictional issues and funding limitations often complicate support arrangements. It can be especially difficult to coordinate support between services that are trauma-informed and those that are not trauma-informed. The safety, wellbeing and support needs of the **person accessing services is always** a priority. This means that it is important for trauma-informed services to try to inform other services about the benefits of a trauma- informed approach. This can help other services to understand the trauma-informed process better.

Coordinating support requires good planning. This is particularly important when people are transitioning from one service to another. For example, when moving from one residential arrangement to another. It is also essential to coordinate support well when a person is transitioning between various stages of support or different stages of the life cycle. For example, transitioning from school to the workforce, or from independent living to an aged care facility. These types of transitions bring significant change and need to be managed sensitively, with good communication and collaboration. This is because they often involve changing accountability and responsibility within the support network. Sometimes they involve new service providers who need to be integrated into the person's support network. It is important that these changes are discussed and agreed, so as to prevent gaps in support.

Service Tip
– Coordinated Support

· All decisions should be made with the person receiving support
· It is the responsibility of those providing support to ensure that support is well coordinated
· All service providers and individuals involved in the support network should be clear about the different roles and responsibilities of each person or service in the support network
· Ideally one person helps to coordinate all services and individuals delivering support
· It is important to value and respect the different roles and contributions of all individuals and services within the support network
· Open, timely and transparent communication leads to the best outcomes
· Integrated and coordinated support is especially important across different systems and services

Partnerships

No service, no matter how substantial, can deliver all of the support and services that people need. For this reason, it is important that services develop relationships and partnerships with other services. Both within and across sectors and systems. The greater the quality of the partnership, the greater the outcomes for people accessing support. Building and nurturing networks and partnerships can take time. However, they enable greater choice for the people seeking support.

Interagency partnerships and collaborations can be invaluable. The more barriers within different service systems are broken down the smoother processes can be for the people receiving support. Participation in service networks, interagency forums and sharing of resources (where appropriate) greatly aid the development of effective partnerships. Partnerships also help to build capacity within the broader system. Partnerships require ongoing collaboration, ideally involving government at all levels, and different sectors and systems. Service systems are complex and difficult to negotiate even for service providers. Service providers play a critical role in supporting people seeking support to navigate through them and for their needs to be met.

Service Tip
– Partnerships

· Services should develop partnerships with other services within and across the sector
· Partnerships support workers to build knowledge and resources
· Partnerships assist people who receive support and their caregivers to receive well-coordinated support and navigate the system

Preventing Abuse and Trauma

Everyone is responsible for preventing further abuse and trauma. Respecting each person's privacy is important to prevent further harm. This means only seeking information about other people that is truly needed. It also means maintaining confidentiality around any information you receive. A person with disability may need to access a variety of services because of a variety of different needs.

This means that the person can depend on a number of different people for assistance, support and advocacy. It is important to always seek the person's consent before you release any personal information to a third party.

Some people with disability face mobility barriers every day. This can make it hard to move out of harm's way. Some people who experience communication barriers cannot easily tell others about what is happening. This makes further harm or re-traumatisation more likely. Everyone has a responsibility to speak out against violence, abuse and neglect when another person cannot do that for themselves. Some abuses might be subtle. Like talking about a person's habit or mistake to tease or embarrass that person. Some abuses might be obvious. Like hitting or withholding treatment to hurt someone. If you witness abuse or unethical behaviour towards a person with disability, do what you can to stop the abuse. Think about what you can do and who you can ask for help. For more information on how to respond if you witness abuse or unethical behaviour towards a person with disability see https://www.nds.org.au/resources/zero-tolerance

Practice Tip
– Speak Up If Something Does Not Look or Feel Right

If you see something happen or are asked to do something to a person with a disability that does not seem or feel right:

· Try to get the person with disability away from any immediately unsafe situation or person
· Try to speak to the people involved about your concern if it is safe to do so

· Talk to a person you trust about what you witnessed, such as a supervisor or a friend
· Call the National Disability Abuse and Neglect Hotline on 1800 880 052 and seek advice

Consider reporting to police if what you witnessed was criminal
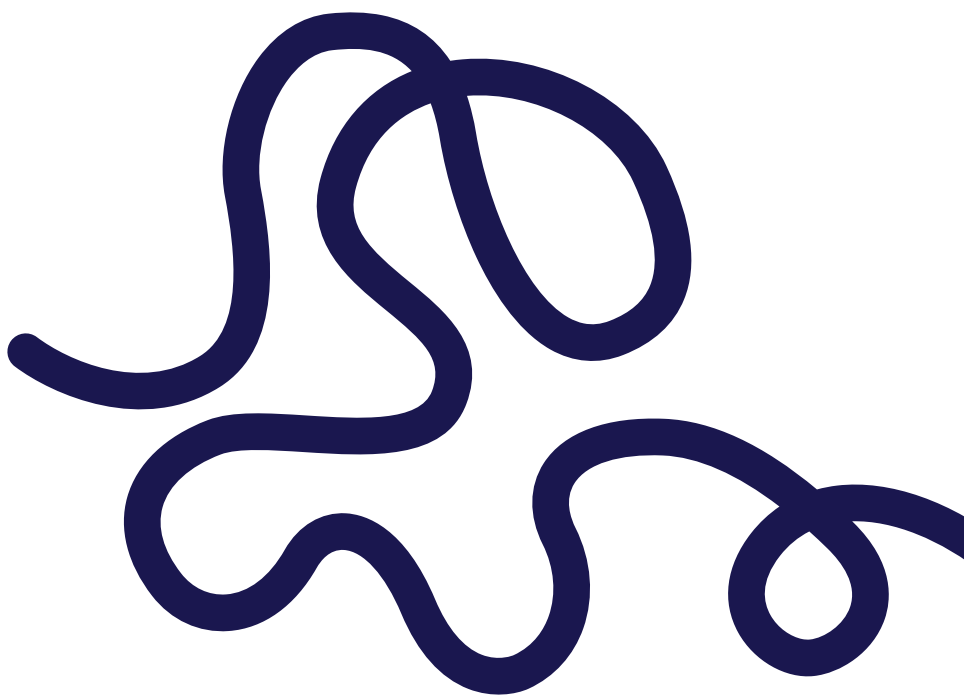
Making a Complaint and Reporting

When a person experiences abuse, neglect, exploitation or violence within a service, the **person has the right to make a complaint to** the service. Some services have a very clear, fair and accessible complaints process. Other services do not. At times, an independent advocate may be useful to support people to make a formal complaint. Or to further the compliant if a satisfactory response has not been received. For more information on how to make a complaint about an NDIS provider, see [How to make a complaint about a provider | NDIS Quality and Safeguards Commission (ndiscommission.gov.au).](https://ndiscommission.gov.au)

Sometimes, a person may disclose something that is criminal. For example, child abuse and neglect, or theft, or physical and sexual assault. It is important to be aware of your legal responsibility to report criminal behaviour. Some professionals, such as police or psychologists, must report certain alleged criminal offences if they become aware of them. All citizens may be at risk of prosecution if they become aware of an alleged criminal offence but fail to act or report the offence. This is why it is important to know **the laws in your state or territory.** For example, there are laws about reporting child abuse and neglect in each state and territory of Australia. For more information on the legislation in your state or territory click on this link [https://www.aihw.gov.au/reports- data/health-welfare-services/child-protection/child-protection-legislation-by- jurisdiction](https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/child-protection-legislation-by-jurisdiction) or visit the National Office for Child Safety at childsafety.pmc.gov.au for support services.

Reporting violence, abuse, neglect and exploitation and violence against adults is a little more complicated. What you must and can report can depend on where you live, your work role, whether the person can report themselves or whether the person wants to report or not. Adults generally have the right to choose for themselves as to whether they report something criminal that has happened to them. If an adult is capable of making their own decisions and does not want to report violence, abuse, neglect or exploitation, that decision should be respected. If an adult does want to report to police, that decision should also be supported.

Practice Tip
– Strategies for Making a Statement, Submission or Giving Evidence

Here are some ideas for supporting someone to prepare to make a statement, submission or give evidence:

· Develop and practice coping resources to help manage emotions and arousal (see suggested strategies earlier in this section)
· Gather as much knowledge as possible about the environment and process that will be used
· Practice or prepare what information will be provided
· Let people know about likely triggers and stress responses and additional supports or modifications needed – taking extra breaks, dimming the lighting, physical movement, vocalisations, ceasing proceedings in the event of dissociation etc.

Here are some ideas for accessing support while making a statement, submission or giving evidence:

· Bring a support person, companion animal or self-soothing items (see sensory grounding earlier in this section)
· Take advantage of opportunities that might make it easier – such as giving evidence from a safe location through audiovisual technology, asking to make a statement with a police officer specialised in sexual assault or domestic violence, reading from a prepared statement, providing a written submission etc.
· Manage the pace – some people want to take it slow, some people want to get through the process quickly
· Take breaks to use coping resources

Here are some ideas for support after making a statement, submission or giving evidence:

· Check in on whether the person is grounded and feeling safe (see suggested grounding strategies earlier in this section)
· Help the person to talk and process how they feel – happy, relieved, disappointed, angry
· Ensure access to follow up support as needed
· Encourage the person to celebrate the achievement, regardless of the outcome

· Orient to next tasks – going home, eating lunch, seeing friends etc.

Providing a police statement, giving evidence in legal proceedings, or making a submission to the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability can be scary. Many people require support to do this. Supporters may be asked to assist with this process.
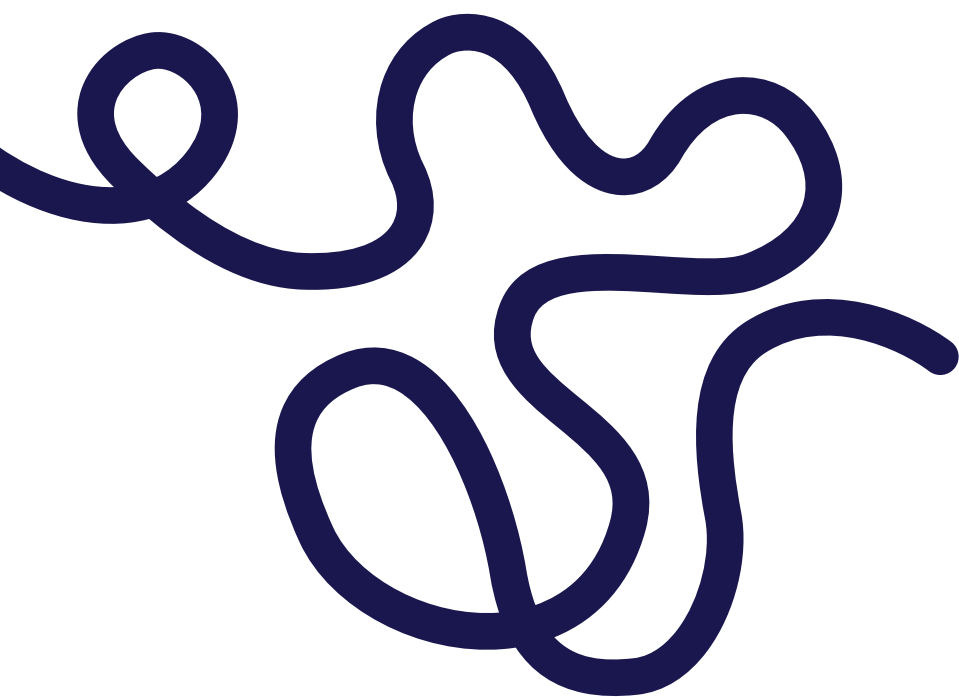
Trauma-Informed Principles into Practice

When we become trauma-informed, we support people to recover from trauma and reduce or eliminate the risk of re-traumatisation. We do this by embedding the core trauma-informed principles in everything we do. The following provides practice and service tips show how we can embed each of the five core trauma-informed principles when providing support:

Principle 1 - Safety

When supporting a person to feel safe, we need to think about safety from the person's perspective. This includes being sensitive to a person's trauma history and its impacts. We need to consider all the different domains of safety, including personal, interpersonal, environmental, systemic and cultural. We need to consider both physical and emotional safety in each of these domains. A person's sense of safety can change easily. It changes with different people and experiences. It changes over time.

- **Personal safety**
  Many people with disability who have experienced trauma feel unsafe within themselves. Some people experience a lot of triggers. These triggers can be hard for the person. We can help the person understand their triggers. And support the person to manage strong reactions and help them to feel safe, sometimes for the first time, as well as again. It is important to always manage your own stress levels and reactions. This is because you cannot support another person when you are not managing your own reactions. Supporters can support people to build the resources needed to feel safe.

- **Interpersonal safety**
  The first step to creating interpersonal safety is to respect the person's personal space. Be patient and allow time for trust to gradually build. Empathy, compassion and attunement are critical in building interpersonal safety. Seek permission to approach or touch the person. Engage with the person authentically. Uphold boundaries. Be mindful of

non-verbal communication, such as tone of voice, hands on hips, and eye contact.

· **Environmental safety**
Make sure there are safe spaces and ready exits. The environment must be accessible for people and appropriately accommodating. For example, having access ramps and enough room for a wheelchair to manoeuvre through. Or being accessible for companion animals. Or in a location that feels inclusive and welcoming. Consider the amount of stimulation in the environment and manage it. Like lowering the lights, reducing sounds, removing posters or pictures that might be overstimulating or triggering.

Supporters can play a big part in supporting a person through changes in their environment as these can prevent people from feeling safe. A good starting point is to ask the person what they need and want. It can help to talk with the person about what might help to feel calm and safe. A good guide is finding out what helped the person before. It can help to have familiar things in a new environment. Things that gently stimulate the different senses can also help. Examples include soap (smell), favourite foods (taste), suitable lighting (sight), familiar music (sound), favourite clothing (touch).

· **Systemic safety**
Making systems feel safer means thinking about the needs of the individuals accessing the system. Asking the person what they want. And making sure that processes are fair and transparent. This can also mean having an accessible complaint process or supporting a person to make a complaint about a system or service. It can also mean advocating to change the system or service.

· **Cultural safety**
We must understand what is and is not culturally appropriate or safe for each person. If a person tells you that something is not culturally safe, listen to what the person is saying. Do what you can to change things. It is important to always ask the person about their cultural safety needs.

Practice Tip
– Establishing Safety

Here are some ideas for how to establish safety:

· Is the person free from physical harm?
· Find a private space to meet the person - does the person feel comfortable in this space?
· Manage your own responses - they can help the person to feel safe or not
· Show the person that you want to understand their needs
· Focus on your non-verbal communication as well
· When the person is speaking or communicating, do not look away or interrupt
· Listen compassionately - tune in and be present
· It is okay to say: 'I don't know what to say'
· Support the person to feel in control
· Value the person
· Support the person to express their feelings and regulate them

Supporters cannot consistently practice in a trauma-informed way without trauma-informed services and systems that encourage and enable their practice. Trauma-informed services support workers to implement the safety principle by embedding the principle within service-wide policy and procedure.

Service Tip
– Embedding the Safety Principle

Procedure

- Intake assessments require trauma screening, as is appropriate
- The physical environment is in good working order and complies with Work Health and Safety (WHS)
- Lighting is appropriate
- Exits are clear and operational
- Safety is taken seriously by workers
- Workers receive regular training to update safety knowledge and skills
- Adequate equipment to ensure safety, such as duress alarms, hoists, fully functioning equipment are provided
- Restrictive practices are rarely, if ever used
- When restrictive practices are required, they are used appropriately and safely and as a last resort
- Efforts are made to increase emotional safety for people accessing the service, such as privacy and confidentiality
- People who access the service are supported to increase emotional regulation skills
- Coping strategies are recognised as a strength that have enabled survival
- Services are culturally sensitive and safe
- Advocacy is provided when needed
- There are areas in the workplace for workers to attend to their own needs or manage dysregulation
- Appropriate language is used in the workplace
- Empathy and compassion is encouraged in the workplace
- Workers and people who receive support feel safe providing feedback to the service
- Workers are accountable
- Workers receive adequate supervision

Policy

- There are policies in place to support emotional and physical safety, such as anti-bullying or harassment, staff security, home visits, behaviour in the workplace etc.
- Policies are culturally sensitive and promote or support cultural safety
- The organisation has a trauma-informed service charter (see Appendix A for example) that highlights the importance of safety and access to safe supports
- Feedback and critical incidents are used to inform policy changes regarding safety needs
- Policy clearly guides the appropriate use of restrictive practices
- Policies are regularly reviewed and updated to improve safety

Principle 2 – Trustworthiness

Many people with disability who have experienced interpersonal trauma have had their boundaries violated. This means that they have been betrayed. When our boundaries have been violated, we find it difficult to trust other people and services. Patience is needed to develop trustworthiness. Being reliable, consistent, and predictable is essential. Upholding confidentiality and maintaining privacy demonstrates trustworthiness. Supporters need to be attuned to the needs of the people receiving support. This means being able to read any cues that may mean the person does not trust you or is suspicious of the service. It is important to acknowledge to the person that trust can take time. It needs to be earned and can be easily broken.

Practice Tip
– Establishing Trustworthiness

Here are some ideas for how to establish trustworthiness:
- Foster respectful boundaries
- Honour privacy and confidentiality
- Be open and transparent – no secrets or whispering
- Be enthusiastic and genuine
- Be clear about what you are going to do and provide accurate information
- Do what you say you will do. If you cannot do it, be honest and tell the person
- If you make a mistake, own it and apologise
- Be consistent and reliable

Trustworthiness extends beyond an individual relationship between the supporter and the person receiving support. Trustworthiness is easily damaged when the supporter is required to operate within a service or system that is not trustworthy. Trauma-informed services support workers to implement the trustworthiness principle by embedding the principle within service-wide policy and procedure.

Service Tip
– Embedding the Trustworthiness Principle

Procedure
· Workers are suitably qualified
· Workers receive regular training, including disability trauma-specific training
· Appropriate boundaries are maintained
· Workers are supported to maintain high quality support by receiving supervision, debriefing, mentoring and/or support managing vicarious trauma
· Workers and work practices are reliable, predictable and consistent
· Workers engage authentically with people receiving support
· The organisation has clear and accessible complaints process
· People who use the service provide honest feedback to the organisation

Policy
· There are an appropriate number of policies to guide workers, not too few and not too many
· Workers are adequately oriented to policies and uphold these policies
· Policies are accessible and sufficiently clear for workers
· Position descriptions exist and provide role clarity
· Policies are consistently applied across the organisation
· Consequences of policy breaches are understood by workers and consistently applied
· There is a policy regarding privacy and confidentiality
· The organisation has a trauma-informed service charter that highlights the importance of accessing trustworthy supports
· Policies are regularly reviewed and updated to improve trustworthiness

Principle 3 – Choice

Many people with disability have not had much choice in life. People with trauma experiences also had no choice about the abuse or violence they experienced either. Fostering choice is not just about offering choices. It is being creative with options. It is about providing new opportunities.

Practice Tip
– Fostering Choice

Here are some ideas for how to foster choice:
- Support as much choice as possible
- Acknowledge the person's point of view
- Honour the person's interests even if they are different to yours
- Provide the person with the information they need to make informed choices and consent
- If a person's choice needs to be overridden, be compassionate and person- centred when you explain why their choice was overridden

Supporter efforts to provide choice to the people receiving support can be negated by inflexible service delivery and systems. Trauma-informed services support workers to implement the choice principle by embedding the principle within service-wide policy and procedure.

Service Tip
– Embedding the Choice Principle

Procedure
- The organisation supports workers to work creatively to maximise choice to people who access the service
- Alternative responses to restrictive practices are routinely offered
- The organisation supports advocacy to enable greater choice

Policy
- The organisation has a trauma-informed service charter that highlights and upholds individual choice
- Policies are not overly prescribed and promote opportunities for autonomy
- Policies are regularly reviewed and updated to promote choice

Principle 4 – Collaboration

Collaboration means doing something '*with*' a person rather than doing something '*for*' or '*to*' the person. We engage more effectively with people when we cooperate with them. Always work to minimise any power imbalances between you - the person providing support and the person receiving support. The person receiving support is the expert in their own life. They must be involved in decision making regarding their needs and the support they receive. Collaboration also means liaising with the person's entire support network. It means working together through effective communication and information sharing. Care and support are more effective when they are coordinated.

Practice Tip
– Promoting Collaboration

Here are some ideas for how to promote collaboration:
· Do not assume that the person cannot make their own decisions
· Accept the person's decisions, even if you do not agree with them
· Do not assume that the person cannot act for themselves
· Try and recognise when the person may need your support in making decisions or acting for themselves
· Follow the person's lead and go at their pace
· Be welcoming and inviting - support the person to feel comfortable
· Do not try and control the relationship – power in the relationship should be shared equally
· Promote mutual relationships
· Be flexible, responsive and accessible
· Involve the person in making decisions about who should and should not provide them with support.

True collaboration takes time and effort. Supporters cannot consistently provide opportunities for collaboration without trauma-informed services and systems supporting the use of collaborative processes. Trauma-informed services recognise the value of true collaboration. They support workers to implement the collaboration principle by embedding the principle within service-wide policy and procedure.

- Principle Procedure
- The person receiving service is involved in decision making and identifying their own needs
- Service is individualised according to need
- Support coordination is provided as needed
- Cultural experts and supports are consulted as needed
- Efforts are made to avoid siloing of services
- Systems are in place to gather and utilise feedback from people who access the service
- Processes are in place to seek stakeholder engagement
- Workers are sufficiently resourced to engage in meaningful interagency liaison and warm referrals

Policy
- Policies acknowledge and promote person-centred practice, support coordination and collaboration
- The organisation has a trauma-informed service charter that highlights the importance of collaboration and collaborative support
- Policies are regularly reviewed and updated to improve collaboration

Principle 5 – Empowerment

Trauma often stems from and causes disempowerment. Trauma can erode self-esteem and a person's sense of their own capacity. Empowerment supports recovery from trauma. Supporting a person to build self-determination is very important. It might include supporting a person to find a job. To find stable housing. To live independently. To remove the barriers that prevent their full participation in the community. To provide opportunities to learn and develop transferable skills and strategies. It requires a careful balance between advocating for a person when they want and need you to. But also, not doing something for the person if the person can do it independently. Rescuing a person fails to promote the person's own strengths and capabilities and can undermine their process of empowerment.

Practice Tip
– Fostering Empowerment

Here are some ideas for how to foster empowerment:

- Support the person to choose what they want to do and when
- Do not decide for the person
- Provide the person with the information they need
- When a person has the right information, they can make informed decisions
- Do not force your decisions on anyone
- Support the person to have personal control

It is extremely difficult to empower others when you feel disempowered yourself. Trauma-informed systems must not disempower those who work within or receive support from the system. Trauma-informed services must empower its own workers to empower others. This can be done by embedding the empowerment principle within service-wide policy and procedure.

Service Tip
– Embedding the Empowerment Principle

Procedure

- Coping strategies are viewed as strengths that enabled survival
- 'Behaviours of concern' are viewed and responded to through a trauma-informed lens
- Opportunities to increase personal resources (e.g. emotional regulation skills, arousal management skills, access to supports etc.) are routinely provided
- Advocacy is provided appropriately when needed
- Efforts are made to remove barriers to inclusion

Policy

- Policies acknowledge individual strengths and efforts to survive trauma (e.g. coping strategies)
- Policies promote resilience and vicarious resilience amongst workers
- The organisation has a trauma-informed service charter that highlights the importance of empowerment
- Policies are regularly reviewed and updated to improve empowerment

Summary

Guidelines for Practice – Set of Core Trauma-Informed Skills

To ensure the provision of high-quality disability trauma-informed practice, supporters should follow these guidelines for individual practice:

1. Engages Authentically with Each Person
- Engages genuinely with each person (e.g. acknowledges when mistakes are made, does not make false promises etc.)
- Attunes to the person and listens deeply to the person's needs and experiences
- Empathises with each person
- Provides compassionate support to each person
- Sensitive to person's preferred language
- Adapts communication to best meet person's needs and preference
- Supports person to overcome barriers to inclusion
- Holds non-discriminatory attitudes
- Uses non-judgemental language
- Treats everyone with respect, dignity and unconditional positive regard
- Supports each person's human rights
- Supports each person's right to live free from violence, abuse, neglect, and exploitation
- Respects each person's right to privacy and confidentiality
- Holds hope for recovery from trauma

2. Provides Person-Centred, Reflective and Culturally Sensitive Practice

· Asks the person for personal preferences
· Respects each person's individuality
· Collaborates with the person to set the agenda for what is needed or desired
· Fosters personal control and safety for the person
· Reflects on the values, beliefs, assumptions and responses that may contribute to or compromise support
· Applies person-centred and reflective practices to support cultural sensitivity
· Respects difference and attunes to it
· Recognises grief and losses and what they may mean for the person

3. Supports Healthy Relationships with Each Person

· Models healthy relationships
· Supports the development of safe and trusting relationships
· Maintains appropriate boundaries
· Respects personal boundaries (e.g. keeping a safe distance with the person receiving support, not getting too close)
· Seeks permission to use touch
· Attentive to body language and non-verbal cues

4. Values Coping Strategies as Strengths and Supports People to Build Resources

· Supports the person to acknowledge own life experience and survival as a strength
· Supports the person to reinforce and build on their strengths
· Acknowledges success and achievements and barriers overcome
· Draws on strengths and resilience
· Acknowledges initial protective role of coping strategies
· Supports person to identify when coping strategies are no longer effective and may cause harm
· Supports person to develop new coping strategies
· Fosters resourcing through supporting the person to feel safe, regulate strong emotions and manage changes in arousal

5. Supports People to Regulate Emotions

· Provides person with information to understand stress response and strong emotions
· Assists person to notice early warning signs of emotional dysregulation
· Assists person to identify triggers and manage response to them
· Supports person through co-regulation
· Explores somatic strategies to support person to emotionally regulate

6. Supports People to Manage Changes in Arousal

· Provides information about stress, the trauma response and the window of tolerance
· Assists people to return to their Window of Tolerance
· Supports people to build strategies to recognise and manage changes in arousal
· Supports people to use a range of grounding and self-soothing strategies as needed

7. Supports People to Understand and Manage Complex Behaviour Support Needs from a Trauma-Informed Perspective

· Interprets behaviours labelled as 'behaviours of concern' through a trauma-informed lens when appropriate and understands behaviour in the context of past or current trauma
· Considers possible cause or function of the person's behaviour
· Considers what the person's behaviour is communicating
· Supports the person to emotionally and behaviourally regulate
· Provides information about trauma and 'behaviours of concern'
· Supports the development of safety plans and strategies as required
· Manages own responses to complex behaviour support needs to prevent escalation or harm

8. Fosters Autonomy, Dignity and Human Rights
· Recognises that every person has the right to feel safe and supported
· Actively supports opportunities for each person's self-determination and autonomy
· Actively decreases barriers each person faces to independence
· Supports each person with advocacy as needed
· Supports self-advocacy or systemic advocacy when appropriate
· Fosters person's connections – support system, family, friends, community
· Supports each person's capacity to participate
· Supports each person to engage in society in a role that is meaningful for the person
· Supports each person's accessibility needs

9. Supports Safety for Each Person
· Works with the person to identify barriers to emotional and physical safety
· Identifies strategies that have worked for the person in the past (e.g. supports, safety planning, anchors etc.)
· Averts crises when needed
· Recognises a person's safety rituals (e.g. checking the environment regularly)
· Provides informed consent and safeguards each person's confidentiality
· Regularly checks each person's safety needs and supports each person to increase safety

10. Demonstrates Trustworthiness to Each Person
· Does not promise anything that cannot be guaranteed
· Admits mistakes or gaps in knowledge or skills
· Is reliable, consistent and predictable
· Maintains respectful boundaries always
· Is open, honest and transparent
· Provides clear accurate timely information about services and support

11. Supports Each Person to have Choice
· Offers as much choice as possible
· Is creative with opportunities for choice
· Works with each person to develop other options
· Provides accurate information to enable each person to make informed choices
· Does not coerce any person to make a particular choice

12. Provides Opportunities for Collaboration with Each Person and Other Services

· Actively involves each person, as appropriate, in developing own support network, making decisions about supports
· Actively works with the person during the support process
· Shares information with other services collaborating with and building interagency relationships and partnerships
· Collaborates with all caregivers, support workers and advocates who provide support to the person
· Maps the person's support network and contributed to effective support coordination and referrals
· Identifies gaps in support with the person and seeks to address them

13. Supports Each Person to be Empowered

· Provides adequate information to enable the person to make informed decisions
· Advocates for the person and/or supports self-advocacy as appropriate
· Empowers the person through collaboration and resourcing
· Provides the person with supportive feedback and reinforces the person's strengths

14. Minimises Harm

· Removes potential triggers from the environment whenever possible
· Minimises the risks of re-traumatisation
· Is aware of possible risks
· Does not replicate abuse dynamics (e.g. maintaining secrecy, power over, silencing etc.)
· Remains open and accessible to each person's changing needs and choices
· Minimises the use of restrictive practices, restraints and seclusion
· Provides additional support to the person when restrictive practices, restraints or seclusion must be used
· Weighs up the person's dignity of risk with duty of care
· Acts on duty of care when required
· Prevents abuse and trauma whenever possible

Support for the Supporters

This section provides information on what supports people need when providing trauma-informed support to others. "Practice Tips" for individual supporters to use to support themselves are provided. Service responsibilities for providing trauma-informed workplaces and support to supporters are highlighted in "Service Tips".

Creating Trauma-Informed Disability Services

`A program cannot be safe for clients unless it is simultaneously safe for staff and administrators' (Bloom, 2006:2)

Supporters cannot consistently provide trauma-informed support without the services and systems within which they operate also being trauma-informed. This requires the development of a trauma-informed culture that operates across services and systems. Individual services can develop a trauma-informed culture when everyone involved with the service is involved in creating this culture. This includes workers and people who access support from the service. Trauma-informed change starts with attending to the philosophies and vision that permeate the service. It requires trauma-informed principles (as discussed in Sections 1 and 2) to be embedded at both a systemic and service level.

A trauma-informed disability service has a workplace culture in which everyone feels valued and safe. This includes workers as well as people who receive supports. The culture fosters person-centred, recovery-oriented and disability informed practice. Innovation is encouraged and diversity is embraced. Workers are genuinely enrolled in a process of continuous learning. The expertise of lived experience of disability and trauma is acknowledged and genuinely valued.

Services maintain a trauma-informed culture through careful recruitment, induction, and ongoing training of workers. Workers are the most critical asset of any service and are nurtured as such. Training is provided for both individual workers and teams. Training is designed to increase understanding and application of trauma-informed principles and to build awareness of vicarious trauma. Training is ongoing and provides

professional development opportunities for all workers every year. Training is relevant to each worker's role and responsibility and reflects current research and practice knowledge.

Trauma-informed services have mechanisms for monitoring for consistent adherence to trauma-informed policy. Regular work review, feedback and performance improvement support are important for supporting workers and maintaining quality services. Supportive supervision, opportunities for debrief, and support in identifying, responding to and mitigating the risk of vicarious trauma are critical. A culture that actively supports the supporters' wellbeing is central.

Service Tip
– Critical Components for Trauma-Informed Organisations for People with Disability

· Promotes each person's recovery from trauma
· Minimises the likelihood that a person accessing the service will be re-traumatised
· Supports each person to feel and be physically and emotionally safe
· Supports each person to overcome barriers to inclusion
· Fosters each person's opportunities for self-determination or autonomy
· Supports the person to build a meaningful, participating life according to their wishes
· Treats the person with respect and dignity, and upholds their human rights
· Supports the person to live free from abuse, neglect, violence and exploitation
· Respects the privacy and confidentiality of each person
· Is person-centred – supports the person to identify and meet their needs
· Is accessible and inclusive to all people accessing the service
· Supports the person's right to assistance
· Supports the person's opportunity for choice and control
· Respects all forms of diversity and each person's individuality
· Understands a person's presentations and needs in the context of their lived experience of trauma and disability
· Honours the person's unique attributes and culture
· Understands that a person's cumulative trauma can become the core of who they are

- Supports the person to learn more about trauma and its impacts
- Acknowledges each person's strengths and coping skills
- Supports each person to identify and build on their strengths and develop new coping strategies and resources
- Changes organisational approaches from 'managing symptoms and behaviour' to working with people
- Reduces hierarchy and power imbalances between the people who access the service, workers and the broader system

The process of creating a trauma-informed service is complex and requires ongoing attention that extends beyond the scope of these guidelines. Many services require extensive training, mentoring and organisational consultancy to achieve these outcomes. It is an iterative process over time for which patience, commitment and support are needed. For further information and resources to achieve trauma-informed organisational change see:

Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery by Blue Knot Foundation professionals.blueknot.org.au/resources/publications/practice-guidelines/

Organisational Guidelines for Trauma-Informed Service Delivery (Updated 2020) by Blue Knot Foundation professionals.blueknot.org.au/resources/publications/organisational-guidelines-for-trauma-informed-service-delivery/

Talking about Trauma Guide to Conversations and Screening for Health and Other Service Providers by Blue Knot Foundation professionals.blueknot.org.au/resources/publications/talking-about-trauma-series/

Trauma Informed Care and Practice Organisational Toolkit – New Edition 2018 by the Mental Health Coordinating Council (MHCC) https://www.mhcc.org.au/2018/11/trauma- informed-care-and-practice-organisational-toolkit-ticpot-new-edition/

Trauma-Informed Organisational Change Manual by School of Social Work, University of Buffalo https://www.tfec.org/wp-content/uploads/Organizational-Change-Manual- University-of-Buffalo.pdf

Trauma-Informed Organisational Toolkit for Homeless Services by the National Centre on Family Homelessness https://www.air.org/sites/default/files/downloads/report/Trauma- Informed_Organizational_Toolkit_0.pdf

Trauma-Informed Oregon https://traumainformedoregon.org/resources/resources-organizations/

The Importance of Family and Friends

Carers Australia (2020) estimate that approximately 861,000 people in Australia are primary caregivers for a family or friend. The majority are women (around 70%) and on average they provide more than 20 hours per week of caregiving. The average age of a primary caregiver is 54, but 10% of caregivers are also young people (under the age of 25). Over one third of primary caregivers live with disability themselves. Some caregivers are also professional support workers and advocates.

Family and friends are important to most people. They can help us to feel a sense of belonging, love and acceptance. Familial and peer caregivers often play an important role for loved ones with disability. This support is especially important for children and young people. Family and friends often play a big role in supporting participation and inclusion. They routinely play a central role in the coordination of support and system navigation. Most caregivers are committed to providing good assistance and support. Family and friends need support too. Sometimes well-meaning caregivers may cause harm that they did not mean, because they did not understand enough about trauma or safe disability practices. Some caregivers cannot access adequate information and support for themselves. This can be very upsetting especially if it causes their loved one harm.

Some people with disability who have experienced trauma have several supporters. The whole support team needs to work together. This includes familial and peer caregivers. Some caregivers may understand a person's behaviour and needs, and others may not. This can cause tension in the team and can be confusing for the person receiving support. When a team develops a shared language and understanding, the team can work together and support one another. Familial and peer caregivers need to be included in decision making and need access to support themselves. Some disability organisations can support familial and peer caregivers. Organisations like Carers Australia can provide support to caregivers (see [Carers Australia | The voice for carers across Australia](#)).

**Practice Tip
– Familial and Peer Caregivers**

Here are some ideas for how familial and peer caregivers can access support:
- Connect with services and people who can share information about disability, trauma and caregiving
- Attend seminars, workshops and training if available
- Find an independent advocacy service that can help
- Find a respite service to help when needed
- Join a group or online forum for caregivers
- Maintain supportive and understanding friendships
- Call a telephone support service such as, the Carer Gateway (ph: 1800 422 737) or Lifeline (ph: 13 11 14)
- Find out about financial support options such as Carer's Allowance or the Utilities Support Scheme
- Talk to someone such as a friend or counsellor about how you are feeling

It is imperative that peer and familial caregivers are adequately supported. This starts with recognising and valuing the need for peer and familial support. It means providing family and friends with services and resources to support them with managing burnout, grief, Vicarious Trauma (VT) and also attend to their own needs. The wellbeing of peer and familial caregivers is a shared responsibility. This responsibility should be shared with not only the individual caregivers, but also their communities and the services that provide support to people with disability.

- Recognise the value of peer and familial caregivers and their expertise
- Involve peer and familial caregivers in decision making and coordinating supports
- Provide resources, such as access to equipment or training as needed to enhance caregiving
- Provide information about burnout, grief, vicarious trauma and looking after yourself
- Assist with accessing support groups, respite, independent advocacy, counselling etc as needed

Peer Workers and Mentors

A peer worker or mentor (in this context) is a person who has a lived experience of disability and/or trauma. Or a person who has experience with supporting a friend or family member with disability and/or trauma. Many trauma-informed organisations value a peer workforce. Services for people with psychosocial disability often employ psychosocial recovery coaches and peer advocates.

Peer workers or mentors are well placed to build strong relationships of connection and learning together. Peer workers can share their lived experience, including their lived experience of recovery. This includes sharing what worked and did not work for them.

Peer workers can understand the impacts of different experiences as well as possible barriers to recovery and participation. Because peer workers have been there, they are able to hold hope for others when the person cannot hold the hope for themselves. A peer worker can bring a unique and equal experience. It is a relationship with no power imbalance. Peers can be great advocates for a person with disability who has experienced trauma, or for a change in approach. Peer workers often enable a person to build a more meaningful and participating life.

Volunteers and peer workers should receive adequate induction, training and support. Just like any other worker in a service. This includes proper management processes, as well as debriefing and supervision to support the health and wellbeing of peer workers. A peer workforce is a professional workforce in its own right. It brings its own richness, expertise and skills to support people accessing services.

Managing Burnout

Being a supporter can be very demanding. It is important that supporters are aware of how they are feeling when they are responsible for meeting another person's needs. Many people who provide support to others experience burnout. This happens when the person experiences too many demands. Burnout can make people feel physically and emotionally exhausted. It is hard to provide good support when feeling this way. It is important to notice this feeling. Feeling this way makes sense given the challenges of caregiving. When supporters are feeling burnt out, they might need to take a break or get some support themselves. Supporters might find specific equipment can make caregiving easier and assist with burnout also. For more information on managing burnout, see https://www.powells.com/book/-9781984817068

> **Practice Tip**
> – Managing Burnout
>
> **Here are some ideas for how to start managing burnout:**
> · Know that it is common and understandable
> · Take a break if possible
> · Explore whether specific training or equipment may make caring easier
> · Explore whether others can help provide support
> · Explore options for reducing workload/responsibilities

Dealing with Grief

It is also important to notice when supporters are feeling grief around a person's experience of trauma. Sometimes people blame themselves for not being able to prevent trauma. They can feel angry or not want to believe that the trauma occurred. Sometimes supporters can feel very sad that a person they love has been affected so much by trauma. That they have been changed by the trauma. Supporters may feel sad or resentful about needing to become a primary caregiver and its impact on their own life and dreams. Supporters can also experience grief as they witness a person's decline in wellbeing because of their disability, aging or poor health. It is important that supporters receive support when feeling this way. Some supporters find it helpful to talk with others such as counsellors or friends about feeling this way.

Practice Tip
– Dealing with Grief

Here are some ideas to start the process of resolving grief:
· Notice when experiencing self-blame, anger or disbelief
· Know that grief is normal and understandable
· Know that grief can be overcome
· Talk with others about it
· Consider grief counselling
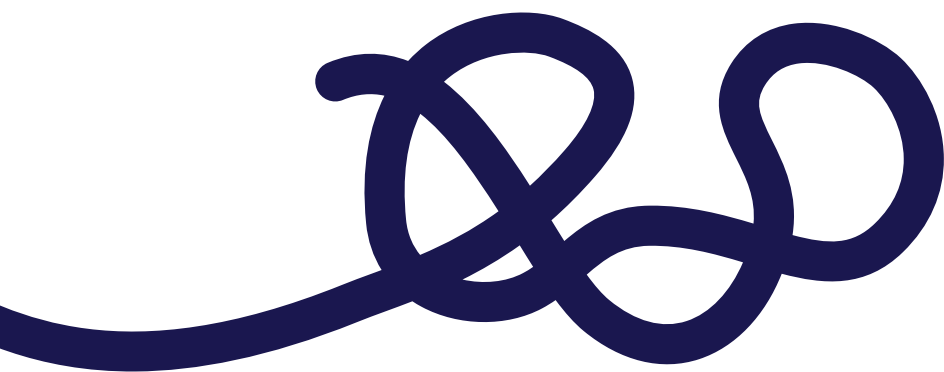
Managing Vicarious Trauma

Vicarious Trauma (VT) is a recognised risk for anyone who supports people with trauma experiences. This includes caregivers, family, friends, support workers or advocates. VT is a critical Worker Health & Safety (WHS) concern for all services in which workers are exposed to other people's trauma stories and impacts through the course of their employment. Workers' health and wellbeing is core to trauma-informed practice and workplace culture. Each service needs to develop a shared understanding of VT and how to identify the early warning signs. This includes supporting workers to implement strategies for minimising the risk as well as managing the impacts of VT, if and when they occur. A basic understanding of trauma-informed principles, VT and a focus on worker wellbeing should form part of the induction process.

It is important to be alert to the early warning signs of Vicarious Trauma (VT). They can be subtle or obvious. Anyone who is exposed to traumatic material or other people's trauma stories is at risk of experiencing VT. Feeling impacted by exposure to trauma material is not a sign of weakness or a fault. If anything, it highlights a person's humanity. It is important that supporters, and the services that support them, are alert to the early warning signs. When supporters are alert to the early signs, it is easier to pick up that something is wrong. Then a range of different strategies can be used to manage the risk and impacts of VT.

Vicarious trauma presents with a range of different signs. Some people experience intrusive thoughts about a trauma story or person's trauma response when they experience VT. These might be experienced as flashbacks or nightmares. Sometimes people might feel emotionally numb, or shut down (hypoaroused), or dreamlike and dissociative. Some people might have difficulty relaxing or sleeping. Some people may want to avoid people, places or things that are reminders of someone's trauma or a person who has experienced trauma. Often, people notice a change in how they view the world or themselves or others. For example, starting to feel like the world is not safe. Or that other people cannot be trusted. Or needing more control over other people or themselves. Some people might experience a loss of hope, meaning and purpose. Some people start finding it harder to be empathic or compassionate towards others. Or feel the need to switch off their empathy to protect themselves.

💡 Practice Tip
– Managing Vicarious Trauma and its Impacts

You can start to manage vicarious trauma and its impacts when you notice when you are:

· Being jumpy, and on high alert
· Being anxious and agitated
· Experiencing strong emotions that you cannot manage
· Withdrawing and isolating yourself
· Experiencing strong emotions that you cannot manage
· Withdrawing and isolating yourself
· Feeling helpless and hopeless
· No longer enjoying things you once enjoyed
· Feeling as if the world and people are not safe
· Questioning your place in the world
· Being more cynical or feeling depressed
· Overreacting to violence (e.g. on television)
· Finding it hard to be empathic or compassionate
· Struggling with relationships or have a lot of conflict with others
· Having trouble sleeping
· Misusing substances
· Focusing on other people's trauma stories
· Not being reliable at work – coming in late, being less productive, not turning up

Here are some tips to start to manage vicarious trauma:
· Reduce your exposure to trauma by reducing the number of people you support, how much time you provide support or the type of support you provide
· Share the load when you can
· Identify any symptoms early
· Take action to address the symptoms early
· Monitor your symptoms
· Monitor how effective your strategies are to minimize the symptoms
· Have a regular routine or practice of attending to your own needs to support wellbeing
· Seek support for the emotional side of your role as a caregiver, support

worker or advocate - talk about your feelings and responses
- Reflect on your work - journaling can help reflection
- Reach out to trusted friends and colleagues
- Receive supervision from an experienced trauma-informed supervisor

Sometimes people experience some of these things, but it does not disrupt their lives. However, if these things are experienced as distressing or unpleasant, take action to try and reduce the impacts. It can be very hard to provide good support to others when experiencing the negative impacts of VT. Sometimes the symptoms might be acute and start suddenly after a particular event. Sometimes it can be hard to notice them. The symptoms of VT might start gradually. This can make them hard to notice. There are a number of reasons why early signs might be missed.

Knowledge Base
– Why a Person may not Identify the Early Signs of Vicarious Trauma

- Not notice symptoms
- Ignore the symptoms
- Too busy
- Working too hard or so busy that you cannot stop and let yourself feel
- Attribute what is happening to other factors
- Attribute what is happening to other things such as the weather or other stressors
- Not aware of VT
- Having an unconscious desire to not recognise VT symptoms

Supporter Wellbeing

People who provide care or support to others can sometimes prioritise the needs of others over their own needs. It is important that supporters safeguard their own wellbeing (Allman, 2015). Caring for ourselves is vital for our health and quality of life. It also puts supporters in a better space to meet the needs of people with disability who have experienced trauma. Supporter wellbeing is a shared responsibility. The ability for supporters to attend to their own wellbeing needs depends on familial, peer, and community support. For those people who provide support as a part of their employment, it is also a shared responsibility with their employer. It is important for all workers to be emotionally healthy and well so they can best support people who access the service. Supporter wellbeing must be encouraged. Services may do this in a range of ways. These include having leaders and managers who model looking after their wellbeing needs, promote the value of supporter wellbeing through training, provide flexible working arrangements, encourage the use of leave entitlements to attend to supporter wellbeing needs, and even fund regular wellbeing activities for workers when possible.

Different supporters have different wellbeing needs. We all need to find what works for us and need to regularly take care of our own wellbeing needs. Effective wellbeing strategies helps in all areas of life, including work and relationships. When providing support to others, it is important to take plenty of breaks. It is also important that the supporter accesses good support for themself. This can be mentoring, debriefing, or supervision. It could also be having supportive friends or respite when needed. It is also good to have a variety in daily tasks. It is important to take time off when sick or tired. Rest and restorative sleep can make a big difference. So does a healthy diet and exercise. Taking time for holidays and family and friends is very important. Finding a balance between work and leisure is needed for all. Socialising and doing enjoyable activities that help to feel calm and refreshed is important. It can be helpful to develop a wellness plan that attends to many domains of functioning such as physical, emotional, environmental, professional, social and spiritual domains.

💡 Practice Tip
– Develop A Routine of Attending to Your Own Wellbeing Needs

Strategies to attend to your own wellbeing needs to be realistic and achievable. Looking after your own wellbeing does not always involve doing more. Some people need to do less in their busy lives to attend to their wellbeing needs. There are many different activities that supporters engage in to support their own wellbeing. The below is a list of some of these strategies. Consider regularly using <u>some</u> of the below activities to support your own wellbeing:

Physical
· Have a shower or bath
· Take care of your diet
· Exercise regularly
· Drink plenty of water
· Yoga or stretching
· Take time off when sick
· See a GP for your medical and health needs
· Take a break from technology such as phones, computers, or tablets for at least an hour a day
· Sleep at least seven hours a night
· Get a massage
· Play sport

Emotional/Psychological
· Engage in reflective practice every day
· Keep a journal
· Learn a new skill
· Start a new hobby
· Engage in a mindfulness practice
· Volunteer
· Be curious
· Notice your dreams, thoughts, self-talk, imagination or feelings
· See a therapist
· Read fiction
· Practice saying 'no' more often
· Get a pet

- Do something just for fun
- Notice your achievements
- Keep a gratitude journal
- Set goals
- Laugh out loud
- Listen to music
- Visit the art gallery
- Ask someone to help care for others
- Explore your barriers to doing less or attending to your own wellbeing needs

Environmental
- Decorate your workspace/room/home
- Enjoy nature
- Do some gardening
- Go for a walk outside
- Sit quietly in the sun
- Look after the environment by recycling, pick up rubbish, activism etc.
- Get some fresh air
- Have a spring clean

Professional
- Get regular supervision
- Do some training
- Set professional development goals
- Set limits with colleagues/co-workers
- Leave work on time
- Take on a new work project that excites you

Spiritual/Cultural
- Give to charity
- Connect with your cultural community
- Memorialise loved ones who have died
- Make and share a culturally important dish
- Reflect on your values and purpose
- Carry out a cultural practice
- Find or practice faith

Social/Relationship

· Take time for intimacy with others
· Spend time with people who make you feel good
· Spend time with your partner/children/parents etc.
· Join a social group such as a book club, bush walking, or cooking group
· Nurture your personal relationships
· Make new friends
· Organise a social event

(adapted from Norton, 1996)

Part of looking after yourself is about being self-aware. Supporters need to be aware of their own responses, levels of arousal, emotions and body reactions. It is important that supporters regularly check in with themselves around their reactions. To see if their reactions are reasonable and expected, or out of the ordinary. This requires being mindful, non-judgemental and aware of one's own values and attitudes. It is so easy to let judgements creep in. This includes judgements about oneself. Like feeling guilty for taking a break or wanting to do something for yourself.

The emotional needs and feelings of supporters are important. Many supporters have their own lived experience of trauma or disability. If supporters do not receive adequate **assistance and support, they can be** at greater risk of vicarious trauma and burnout. This can lead to extra stress and conflict. Addressing these can help resolve the stress and conflict. For more information on supporter wellbeing, see https://www.vu.edu.au/sites/default/files/state-of-self-care-in-australia-mitchell-institute.pdf

Debriefing

Everybody needs to debrief sometimes. Debrief, in this context, means having a conversation with another person about a particular event or how that event makes a person feel. This provides an important opportunity to get something "off your chest" in a safe way. It provides an opportunity to reflect on how the event may have impacted a person. And to identify what to do to resolve it. It also helps the person needing to debrief to feel supported. Debriefing is conducted formally in some services but can also be used informally by talking with a colleague. Debriefing should be viewed in services as an essential aspect of providing trauma-informed support.

Debriefing is a very important process for familial and peer caregivers too. Many caregivers access debriefing from telephone-based services such as the Carer Gateway or Lifeline. Many caregivers may also attend caregiver support groups or online forums to access debriefing. Some friends and family members are also very helpful at providing opportunities to debrief.

It is important to remember that debriefing should be constructive. It is a time for reflection to improve the quality of support or caregiving. Debriefing should not be used as an opportunity to complain about or belittle a person. Doing this is not trauma- informed and is very unhelpful. It reinforces unhelpful beliefs and attitudes that make caregiving harder, not easier.

The following case study demonstrates how effective debriefing can help to manage frustrations and improve support.

Case Study - Neil*

Neil is a 24-year-old man who provides support to his 55-year-old mother who has motor neurone disease and depression.

If I'm really honest, some days I resent having to do things for my mother. I love her and I want to care for her, but I get frustrated with her too sometimes. I used to have a mate who also was a caregiver. Sometimes we would get together and start to talk about our frustrations. But this often got a bit out of hand. Then we'd start making fun of my mother and complaining even more about having to provide support. I found I actually started resenting her even more. Then we had lots more arguments. Many years later, I found a support group for caregivers. We still talked about our frustrations with caregiving, but it was different. Instead, we focused on the other person's feelings too. And talked about frustration being normal. The group helped me to notice that most of my frustration was more about my life circumstances and with the system. Rather than with my mother. This made things better. The resentment reduced and my relationship with my mother improved. She was frustrated too. So in a way, our shared frustrations actually brought us closer together.

*This is not a real person's story.

Practice Tip
– Debriefing

Here are some ideas for getting started with debriefing:
· Engage in regular debriefing
· Use debriefing to explore an event and thoughts and feelings associated with providing support
· Be constructive with debriefing
· Help the other person know what you need from debriefing (e.g. "I don't need a solution, I just need to talk about it", "Something has really upset me and I just want to work out what it was" etc.)
· Access debriefing from people you trust or provide debriefing that helps
· Debrief with people who do not make you feel angrier and more upset or less capable

Supportive Supervision

All supporters would benefit from regular access to ongoing supportive supervision. This is different to debriefing or line management. Supervision is useful for developing the insights needed to reflect and maintain accountability. Supportive supervision provides a space for reflection, challenges thinking, and shapes practice. It supports people to be open and flexible to new ways of looking at and doing things. Supportive supervision should be funded as an essential activity required to maintain a healthy productive workforce. Effective supervision also optimises outcomes for the people who access the service. If the organisation offers a clinical service, clinical supervision with a suitably qualified trauma-informed supervisor is paramount. This supports clinicians to manage the potential effects of working clinically with traumatised people. However, other workers also require supervision when working with people who have experienced trauma. Trauma-informed supervision should be provided to all support workers and advocates who support people with disability and lived experience of trauma. Supervision provides opportunities for workers to identify and work through any challenges around implementing and embedding trauma-informed principles. It also supports workers to explore barriers to achieving outcomes for people with disability. Supervision can be individual or group and provided internally or externally or both.
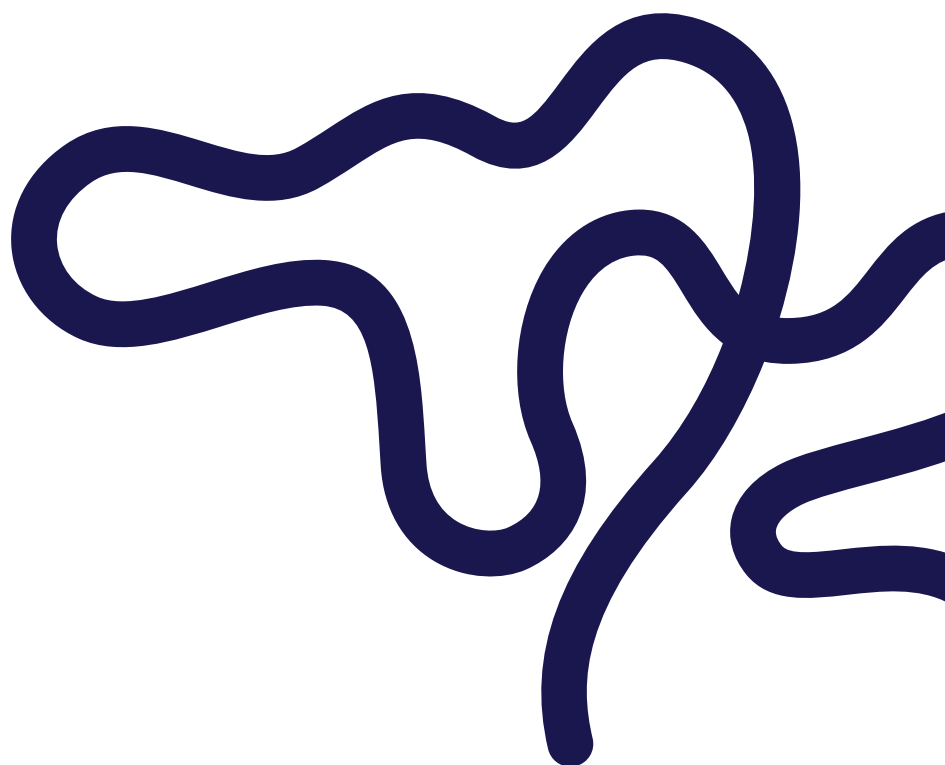
Practice Tip
– Supportive Supervision

Here are some ideas for getting started with supportive supervision:

· Ask your employer if supervision is provided
· Seek funding from your employer to pay for professional supervision
· Find someone who has experience being a support worker or advocate, as well as, as a supervisor if possible, and ask them to provide supervision to you
· Arrange with a group of peers who also provide advocacy or support to meet regularly as a group for peer supervision
· Attend supervision regularly if possible
· Take a moment to prepare the questions, concerns, achievements you would like to discuss in supervision
· Reflect on your work as a support worker or advocate in supervision
· Talk with your supervisor about what you need in supervision

Summary

Guidelines for Practice – Core Organisational Supports for the Supporters

To ensure high-quality disability and trauma-informed practice, organisations and services must provide adequate support to enable supporters to be able to provide trauma-informed support. Trauma-informed practice should not be the sole responsibility of individual workers or caregivers. Adequate support necessitates adequate funding and resourcing.

1. **Invest in a Trauma-Informed Service Culture**
   - Create workplace cultures in which people feel and are safe
   - Foster a service culture that is person-centred, recovery-oriented, culturally sensitive and disability and trauma-informed
   - Foster a culture of continuous learning and mutual support
   - Facilitate effective team processes and regular team meetings
   - Encourage individual and team contribution as well as innovation
   - Create a culture that is inclusive and embraces diversity
   - Acknowledge the expertise of people with the lived experience of trauma and disability
   - Attend to the philosophy and vision that underpins the entire service ensuring it is consistent with being trauma-informed
   - Embeds trauma-informed principles at a systemic and service level

2. **Build a skilled and informed workforce, including workers, peers and volunteers**
   - Educate all workers and volunteers around trauma, trauma-informed support and vicarious trauma
   - Provide training and support around healthy personal and professional boundaries

- Build a diverse workforce including people with disability, with a lived experience of trauma, and with different communication and work styles
- Promote shared decision making and problem solving
- Promote ethical conduct and risk management processes
- Assess individual and collective performance around trauma-informed principles
- Provide accessible comprehensive resources to enhance knowledge and practice

3. Support the Supporters

- Understand the possible impacts of trauma and working with people with trauma experiences
- Acknowledge grief and loss amongst supporters
- Provide information about vicarious trauma, burnout, grief and supporter wellbeing needs
- Foster and facilitate opportunities for supporter wellbeing
- Monitor and respond supportively to burnout
- Encourage peer support, debriefing and mentoring
- Recognise the risks of VT and support the supporters to mitigate the risks
- Assist supporters to manage the impacts of vicarious trauma
- Foster healthy boundaries between supporters and the people who receive support
- Provide regular supervision to all workers - individual and group
- Encourage collaborative processes including professional and personal development opportunities as appropriate
- Review workloads and offer supports, task variety, sufficient breaks to offer high quality support
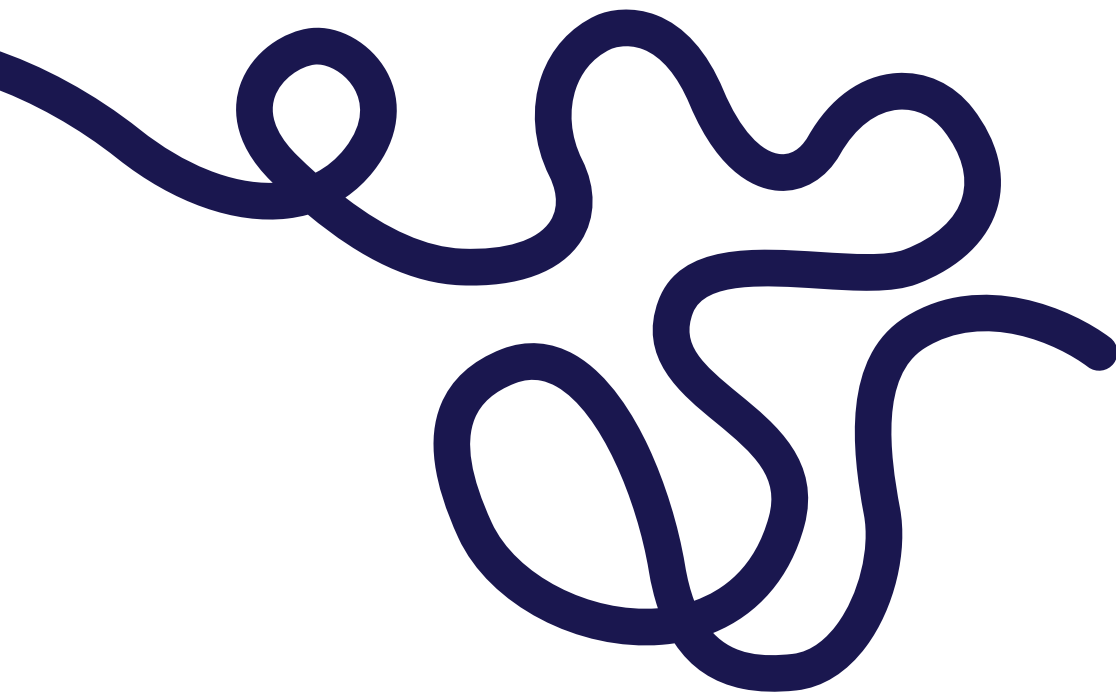
Future Directions

Future Directions

"We need to work on equality and [be more] inclusive in Australia… We need more disability advocates like myself… We also need politicians to listen to us". (Submission to the Royal Commission into Violence, Abuse Neglect and Exploitation of People with Disability)

Every person with disability deserves to be treated with respect and dignity regardless of their gender, sexual preference, faith, culture, values or ability. Every person with disability has the right to live in an inclusive society that supports the independence and self-determination of people with disability. Every person with disability has the right to live free from violence, abuse, neglect and exploitation. Every person with disability who has experiences of trauma deserves to be able to access services that support recovery and do not re-traumatise the person.

Violence, abuse, neglect and exploitation of people with disability is abhorrent and unacceptable. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability provides an opportunity to identify and acknowledge this. This is a pivotal time to provide systems change. We need to work together to achieve societal change in attitudes, responses and accessible services for people with disability who have experienced trauma. People with disability and experiences of trauma are coming forward to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. People with disability are speaking out and we must listen to each person, hear each person, believe each person and work with each person to build a different world. One of tolerance, understanding, acceptance, compassion, empathy and inclusion.

People with disability who have experienced trauma need people of influence to champion disability trauma-informed practice across the entire disability sector. Many advocates, including people with disability, caregivers, and people who work in the disability sector, have worked tirelessly for many years raising awareness of the need to improve the lives

of people with disability. Now is the time for culturally sensitive disability and trauma-informed practice. Changes of this nature and scale will take time. Substantive change needs coordinated and committed action and strong leadership from governments, institutions, services, communities and individuals to embrace this call and enact long overdue and complex change.

The development of these guidelines is but one step in this process. We hope that they will be taken up and used as part of this larger process. These guidelines have been informed by the lived experience of many people with disability who have experienced trauma. They have also been informed by extensive consultation with the many advocacy, support and other services from within the disability sector with which people with lived experience engage every day. Many of the people with lived experience with whom we have spoken have identified being traumatised and retraumatised in systems and services and while receiving support from others. The services with whom we have consulted have identified a system and services, which have often worked tirelessly to provide better supports to people with disability, but whose resources have not been adequate, or have not been able to meet the enormous gaps in demand and need. These guidelines build upon the foundational work conducted by many disability advocates over many years. We want to acknowledge their leadership, their drive and their commitment, and walk alongside them and other services as we all collaborate to provide a better world for people with disability and experiences of trauma.

It is hoped that all people with disability who have experienced trauma will benefit from these guidelines. That they will build an understanding of trauma and promote new skills and strategies that more effectively support people living with the impacts of trauma. It is hoped that all services that support people with disability who have experienced trauma will be able to evolve their service provision to ensure that high quality culturally sensitive disability trauma-informed support is consistently provided to all.
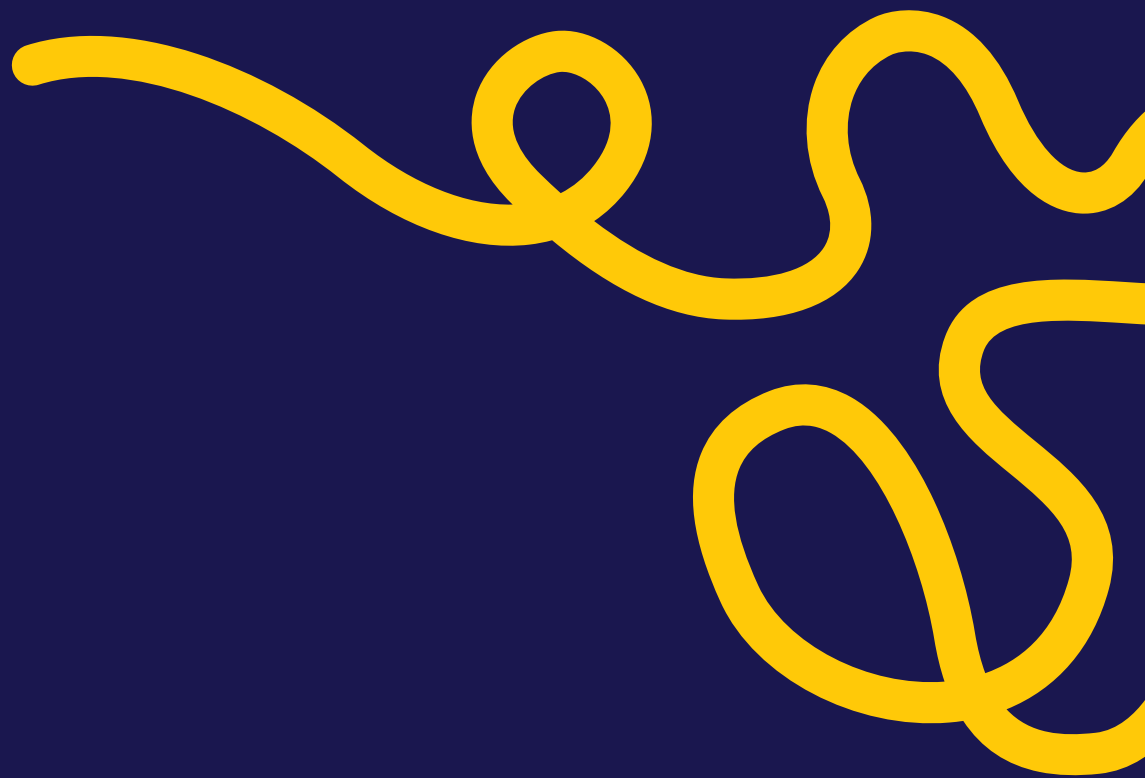
The implementation of broader violence prevention strategies is needed to meaningfully reduce the rates of trauma and violence in Australia. Particularly for trauma and violence against people with disability. The next steps to furthering the development of a high-quality integrated support system for all people with disability who have experienced trauma

will entail the development of systems that can ensure a truly trauma-informed disability-informed culturally sensitive system for every person seeking support.
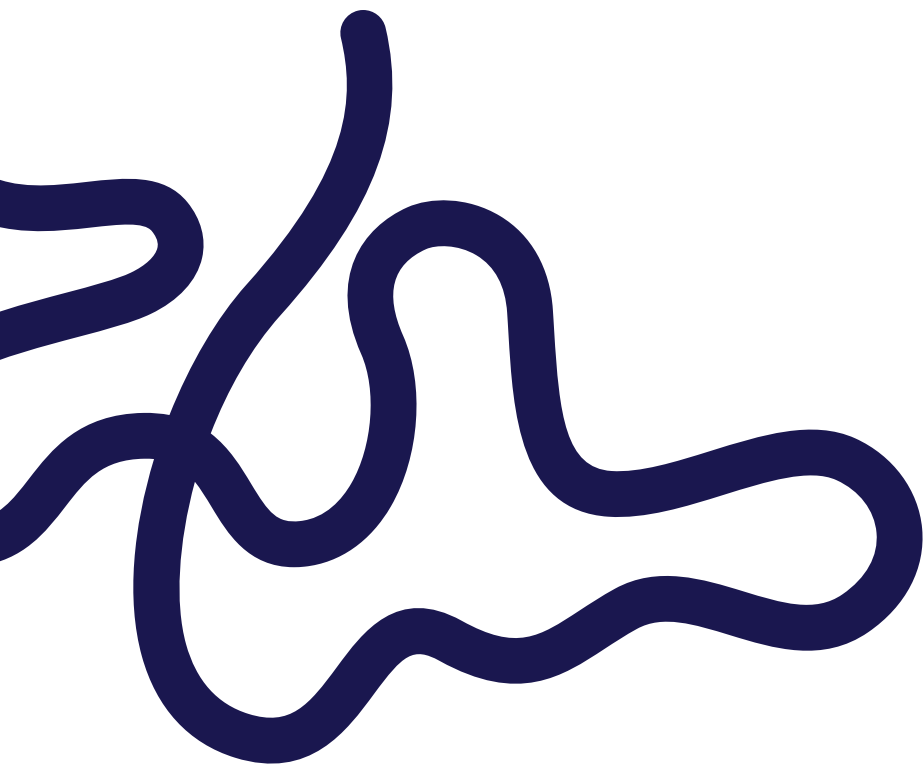
> **"My hope for future is that people with disabilities are valued in the community and genuinely treated equally."**
> (Submission made to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 20 February 2020)
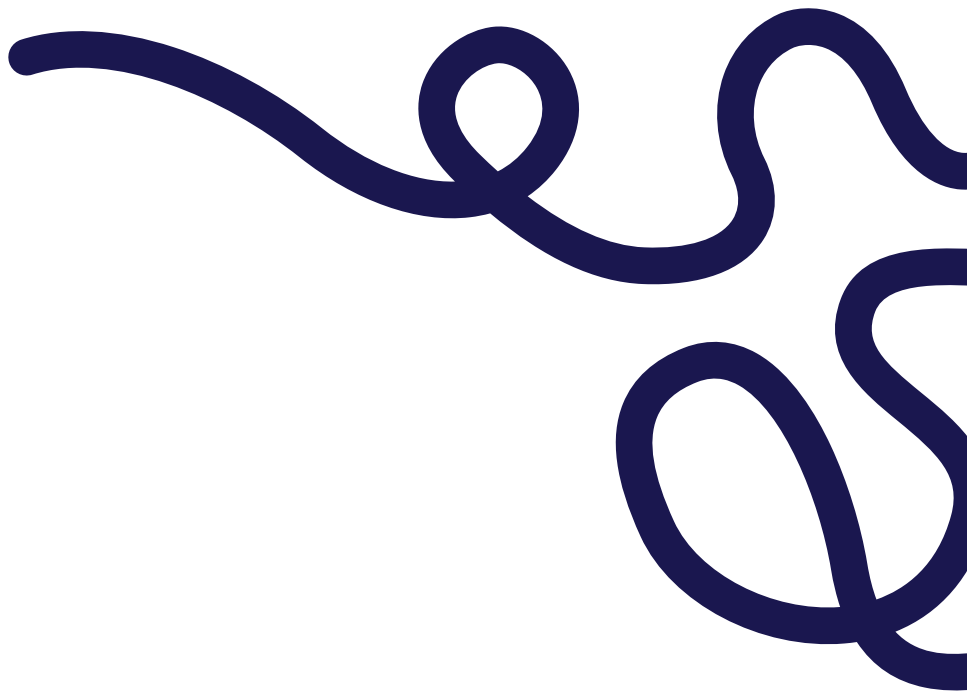
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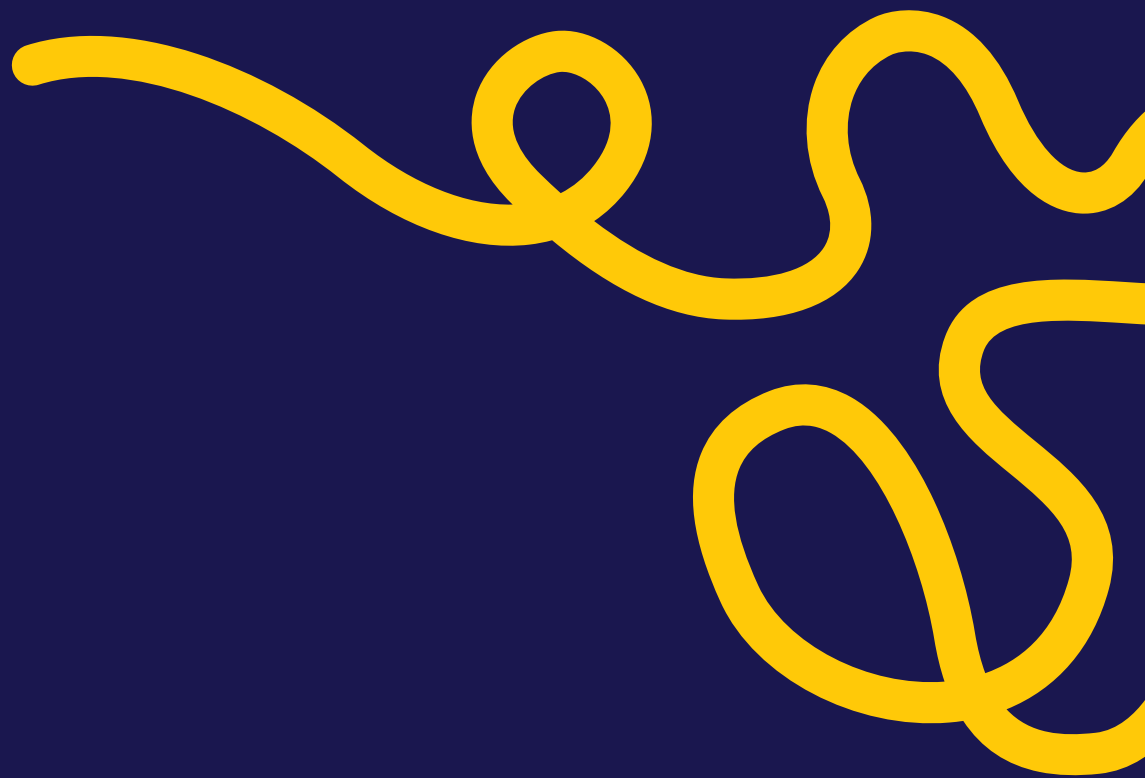
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Appendix
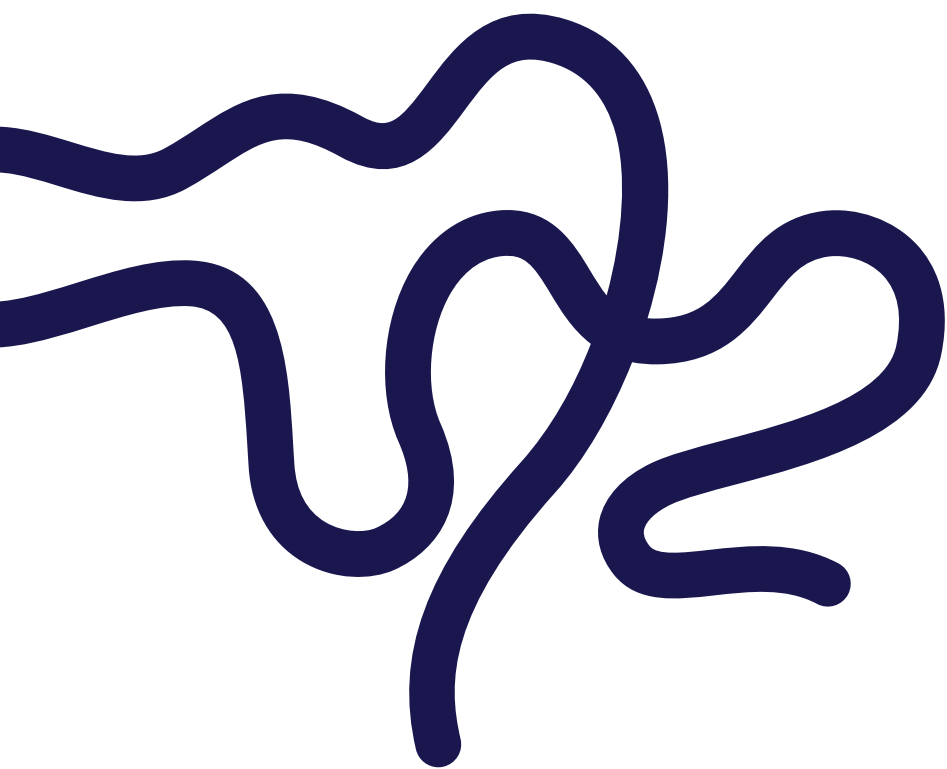
Appendix A – Example of Trauma-Informed Service Charter

This is a sample only of what a trauma-informed service charter could look like. Each service is unique and will need to develop its own service charter. A service charter is an important document but is meaningless if the operations of the service do not consistently adhere to the charter or service policies and procedures are not also consistent with a trauma-informed framework.

<Insert service name> recognises that trauma is more common amongst people with disability than people without disability and that many people with disability have experienced trauma in the context of receiving support from others. As a leading service in the provision of *<insert service provision>* to people with disability, *<insert service name>* is a *trauma-informed* service in its orientation and operation.

<insert service name> recognises that unresolved trauma can have substantial impacts across the life cycle, but that with the right support, recovery is possible. If recovery rather than re-traumatisation is to occur *<insert service name>* must embed trauma-informed principles comprehensively throughout its operations, programs and services. *<Insert service name>* to empower recovery and build resilience for people with disability who have experienced trauma.

The *<insert service name>* Service Charter reflects trauma-informed principles as follows:

I: PHILOSOPHY & VISION

1) Trauma-informed practice is <insert service name>'s guiding orientation

2) *<insert service name>* promotes a recovery orientation according to the five-core trauma-informed principles of `safety', `trustworthiness', `choice', `collaboration' and `empowerment'

3) *<insert service name>* promotes an understanding of the prevalence and impacts of trauma on individuals, families, communities and society

4) *<insert service name>* actively collaborates with other organisations and services to prioritise the co-ordinated care within and between services and sectors which best meets the complex needs of people with disability and their supporters

5) *<insert service name>* commits to meaningful respectful engagement with people with disability and proactive incorporation of their lived experience and expertise at the core of everything it does

6) *<insert service name>* acknowledges and respects all forms of diversity and strives to attune to and meet the needs of diverse communities across Australia

7) *<insert service name>* is committed to building a service and programs that are culturally sensitive, including but not limited to meeting the needs of First Nations People, culturally and linguistically diverse communities, people from LGBTIQ+ communities, from rural and remote communities and the aged care sector

8) A message of optimism and hope is incorporated into all interactions between *<insert service name>*, the people who access the service and those who support them, personally and professionally, and in all advocacy work and service provision

2: MAPPING TO PRACTICE

(A) SYSTEM LEVEL

1) *‹insert service name›* coordinates services and care between and among systems and sectors

2) *‹insert service name›* incorporates a life-span perspective, and recognises the transgenerational impacts of trauma

3) All policies and procedures comply with trauma-informed principles

4) People with disability are at the core of all systems activities and trauma- informed rights are articulated and upheld

5) Education, training programs and all services embed trauma-informed principles and processes

6) All workers are informed about disability and trauma, its impacts and dynamics and trained in trauma-informed principles so the risk of re-traumatisation is minimised

7) Individual and collective performance are measured by sensitivity to the needs of people with disability who have experienced trauma

8) Ongoing education and training around disability trauma informed practice, and a continuous improvement orientation is central to ‹insert service name›'s service culture and operations.

9) ‹insert service name› pursues funding opportunities to advance trauma- informed agendas

10) ‹insert service name› promotes and advocates for education around disability and trauma at all levels and across a diversity of systems and services

11) Respect for all forms of diversity and attunement to diverse cultures, backgrounds and orientation are foundational principles

(B) SERVICE LEVEL

Step 1:
‹insert service name› identifies key formal and informal activities and settings to ensure they embed the core trauma-informed principles *(as per Section I, Pt 2 above)*

Step 2:
‹insert service name› asks key questions about all activities and settings to quality assure their operation in a trauma-informed manner

Step 3:
‹insert service name› prioritises goals to advance and consolidate trauma-informed practice on a regular basis

Step 4:
‹insert service name› identifies specific objectives and responsible people to champion and embed trauma-informed principles
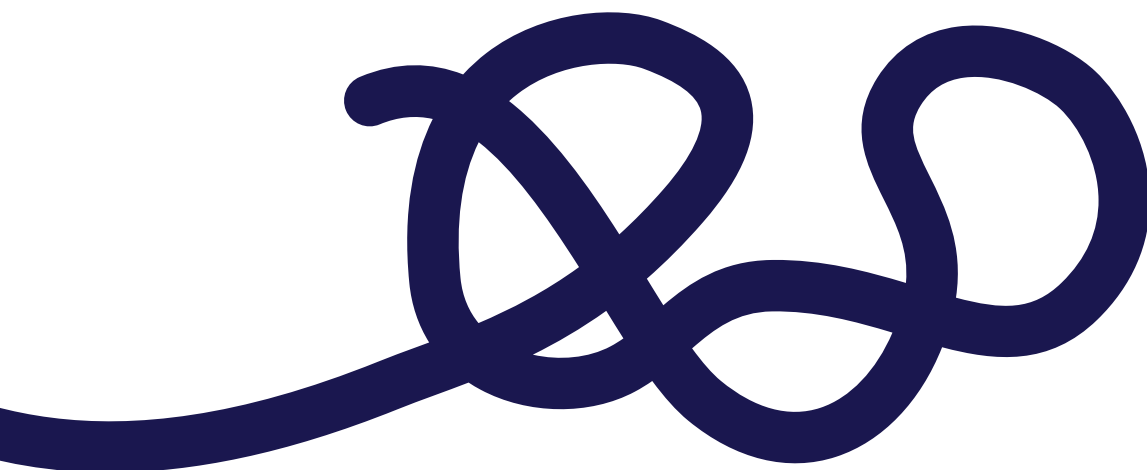
DOMAIN 1A SAFETY

Physical, emotional and environmental safety are an underpinning priority

DOMAIN 1B TRUSTWORTHINESS

Trustworthiness is maximised through task and role clarity, consistency, and setting *appropriate interpersonal boundaries*

DOMAIN IC CHOICE

Choice and control are maximised in principle and in practice for all people who access the service

DOMAIN 1D: COLLABORATION

All relevant activities maximise collaboration and sharing of power with people with disability as much as possible

DOMAIN 1E: EMPOWERMENT

Empowerment and skill-building is a priority at all times

SERVICE POLICIES

<insert service name> embeds the above principles in formal policies and informal practice and monitors them to ensure they are effectively implemented