NSW Health

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Integrated Trauma-Informed Care Framework:

My story, my health, my future

NSW GOVERNMENT

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Statement of commitment to Aboriginal children, young people, families and communities

Aboriginal people are the First Peoples of Australia and are recognised as having the longest, continuous cultures in the world.[1]

Aboriginal people share an ongoing legacy of resilience, strength and determination. Acknowledgment and respect for the strengths of Aboriginal people and their cultures and child rearing practices underpin this project. Aboriginal beliefs have always included strong cultural practices, ways of being and doing that promote health, wellbeing, family health and child safety.

NSW Health recognises that Aboriginal health encompasses not only the physical wellbeing of an individual, but also the social, emotional and cultural wellbeing of the whole community within which each individual is able to achieve their full potential as a human being.[2]

NSW Health acknowledges that individual and collective

experiences of trauma, including colonisation, Stolen Generations and assimilation have been and continue to be profoundly harmful. We also acknowledge that we, as a government agency, have a responsibility to recognise past harms, seek to remediate them, and prevent re-traumatisation.

Intergenerational impacts of colonisation and racism continue to impact Aboriginal people today.

Due to social and economic oppression, Aboriginal people, families and communities experience inequalities in health, education, employment and housing. These inequalities increase the risk of experiencing violence and can lead to poorer outcomes in health and social and emotional wellbeing. For example, Aboriginal children and young people are overrepresented in domestic and family violence statistics, the statutory child protection system and in youth justice settings. Despite these injustices NSW Health recognises Aboriginal peoples' strength and resilience and ongoing contribution to creating communities that are safe and respectful.

Early childhood experiences of trauma, particularly complex trauma, can have long lasting impacts on health and social and emotional wellbeing. Although the effects of childhood trauma can be severe and long lasting, healing can be mediated by Aboriginal-led interventions and culturally appropriate health services that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. Genuine appreciation and understanding of the impact of colonial power dynamics, racism and the importance of Aboriginal worldviews, and of the limitations of Western approaches in the understanding, identification, assessment and treatment of trauma, are central to demonstrating respect for the lived experiences of Aboriginal people.

NSW Health is committed to supporting the ongoing efforts of Aboriginal people and their communities in reducing the impact of the social determinants of health and the effects of individual and collective trauma legacies to improve the health and wellbeing of Aboriginal families and communities in NSW. NSW Health recognises the significance of family and community to identity, and is committed to Aboriginal families being connected and determining their own futures.

Acknowledgements

NSW Health acknowledges the lived experiences of all people who have experienced trauma and hope that this resource contributes to our collective vision for all communities and families to be healthy, safe and free from violence, abuse and neglect.

Many individuals and organisations have given their time and expertise to the development of this Framework.

NSW Health would like to thank, in particular, the children, young people, families and carers consulted for sharing their ideas on how health services can be trauma-informed, and what outcomes and experiences matter to them. We acknowledge and value their contributions as central to this work.

We would also particularly like to acknowledge CREATE Foundation, Barnardos, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), Royal Far West, Kinchela Boys Home Aboriginal Corporation, Children of the Bomaderry Aboriginal Children's Home Incorporated, Coota Girls Aboriginal Corporation, and Council for Intellectual Disability for their contributions and for enabling the participation of their clients and members. For their expert Aboriginal cultural guidance, we also acknowledge the Aboriginal Communities Matter Advisory Group and Rowena Lawrie, cultural supervisor to the Prevention and Response to Violence, Abuse and Neglect team.

The Ministry of Health would also like to acknowledge the contributions made by local health districts; specialty health networks; NSW Health pillars; including the Agency for Clinical Innovation; the Department of Communities and Justice; and the Association for Children's Welfare Agencies; and all members of the Integrated Trauma-Informed Care Framework Advisory Committee. Particular thanks go to Kylie Stark, Kevin Hadley, Chris Thomas, Melissa Russel, Jackie Jackson, Gemma Evans, Annie Flint, Sharon Midwater, Shirlena Gallagher, Courtney Namonye, Angela Rankin and VAN staff from Hunter New England Local Health District for their contributions.

Foreword

NSW Health plays an important role in ensuring that vulnerable children and young people receive the healthcare they need, when they need it, in a way that is sensitive to their needs and prior experiences.

I am pleased to introduce the NSW Health Integrated Trauma-Informed Care Framework: *My story, my health, my future*. The framework brings together elements of trauma-informed care and integrated care to enhance the experiences of clients and their families and carers accessing NSW Health services. It provides guidance to staff, as well as a platform for the changes required to implement this type of care.

Trauma is a significant factor contributing to poor health and wellbeing outcomes for children and young people experiencing vulnerability and disadvantage. Approximately two-thirds of Australians will experience a potentially traumatic event in their lifetime,[3,4] and an estimated half to two thirds of young people will be exposed to a traumatic event by the time they turn 16.[5,6]

The framework responds to issues identified in a NSW Health file review of a group of children in Out-of-Home Care with complex needs. The review found issues relating to a lack of coordination of health services and limited evidence that children's presenting issues were considered in the context of their trauma history. The review indicated that current service responses may perpetuate or exacerbate children's experiences of trauma.

The framework aims to mitigate the impacts of trauma, prevent the exacerbation of trauma, and promote healing. Preventing experiences of trauma (including prenatal exposure) is critical for improving outcomes. However, evidence also shows that identifying and responding early to children who have experienced trauma can protect against its long-term effects.[7,8] Health professionals have a role in preventing trauma as well as mitigating the impacts of trauma on children and young people.

The framework includes key principles for the whole of the public health system, whether you deliver frontline care, are designing new health facilities, or are helping shape policy. These principles challenge us to consider how we can ensure our clients feel safe and have agency and choice in their healthcare journey. In being person-centered, the framework also asks us to consider the context of people's lives and how a person's history, culture, gender, identity, and ability can impact on their access to and engagement with services. This takes kindness and understanding.

Although there are many examples of good practice in the NSW Health system, there are significant opportunities to enhance integrated practice and embed trauma-informed responses. System-wide change is needed to ensure that all clients and staff within NSW Health experience trauma-informed care, and that clients who require additional support are referred to specialist services.

The framework aligns with other important initiatives such as NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework and the First 2000 Days Framework. It also responds to recommendations made in the 2015 Independent Review of the Out-of-Home Care (OOHC) system in NSW (the Tune Review) and the Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission). I encourage you to use this framework to review, plan and deliver integrated and trauma-informed care to children, young people and their families and carers.

I would like to thank all those who shared their experiences and contributed knowledge to the development of the framework.

Susan Pearce
Secretary, NSW Health

Executive summary

Description	Detail
Who	The Integrated Trauma-Informed Care Framework is for all NSW Health staff, including clinical staff; executive and management staff; intake, administration and procurement officers; receptionists; office support; security personnel; educators; policy writers; staff in Pillar organisations and the Ministry of Health. Although children and young people are most commonly seen in Emergency Departments and child and youth focused services, they also use a wide range of more general health services, as do their families and carers. All services and staff in the NSW Health system have an important role in implementing integrated trauma-informed care.
What	Psychological and emotional trauma results from an event, series of events or set of circumstances that is experienced as physically or emotionally harmful or life-threatening, and overwhelms an individual's ability to respond. Adaptive responses to trauma may impact a person's access to and engagement with services, including health services, and may impact on overall physical and psychological health.[9] Integrated trauma-informed care brings together elements of trauma-informed care and integrated care to enhance the experiences of clients and their families, carers and staff. It aims to mitigate the impacts of trauma, prevent the health system exacerbating trauma, and promote healing.
Why	Potentially traumatic experiences are common in the general population, including for children and young people. Those in contact with the child protection system are known to have experienced trauma, and children in some other populations are also at an increased risk of having experienced adverse events.[10] The Tune Review highlighted trauma-informed practice and policy as keys to a successful service continuum for vulnerable children and families. Recommendation 9.8 from the Royal Commission Final Report also highlighted the importance of trauma-informed care, and proposed that: *The Australian Government and state and territory government agencies responsible for the delivery of human services should ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma-informed approaches.* Identifying and responding early to children who have experienced trauma can protect against its long-term effects.[11,12] Health staff and services have a key role in preventing trauma, as well as mitigating the impacts of trauma on children and young people. Although there are many individual examples of integrated and trauma-informed service provision within NSW Health, a system-wide approach is needed to support change across human services, including the NSW Health system.
How	The framework will guide system-wide change by outlining principles, implementation domains, strategic objectives and behaviour change required to provide integrated trauma-informed care. The principles of integrated trauma-informed care will be addressed across all domains of the NSW Health system, including governance and leadership, training and workforce development, policy, monitoring and quality assurance, engagement and involvement, financing, cross-sector collaboration, physical environment, quality service provision, and evaluation and technology.
Who will benefit	Children and young people with lived experience of trauma, including those in the statutory child protection system, and their families and carers are the intended beneficiaries. As a universal approach is required to reach this population, all NSW Health clients are also expected to benefit, particularly those with experiences of trauma. Staff are also expected to benefit from working in a trauma-informed system including through more positive experiences with clients, prevention of potentially traumatic workplace experiences and improvements in responses to staff experiencing trauma.

NSW Health Integrated Trauma-Informed Care Framework

Principles^

- Safety
- Collaboration
- Trustworthiness
- Integration
- Choice
- Empowerment
- Culture, gender, history and identity

Implementation Domains^

- Governance and Leadership
- Training and workforce development
- Policy
- Progress monitoring and quality assurance
- Engagement and Involvement
- Resourcing
- Cross sector collaboration
- Physical environment
- Service provision
- Evaluation
- Technology

Strategic Objectives

- Increase NSW Health's capacity to deliver integrated trauma-informed care to all children and young people, and their families and carers
- Embed trauma-informed principles and practices in service delivery
- Reduce risk of re-traumatisation of children and young people
- Improve cultural safety for Aboriginal people
- Ensure health care for children, young people, families and communities is accessible and culturally and gender sensitive
- Improve provision of continuity and person-centred care through better integration, especially for children and young people with complex needs

Practice Examples - Areas of Care

- All care
- Virtual care
- Management, planning and care coordination, including collaboration with partner agencies
- Health promotion
- Initial contact
- Screening and assessment inpatient/admitted patient care
- Crisis care and acute care
- Care in the community/ongoing care
- Trauma specific responses

Benefits

- Reduced risk of re-traumatisation
- Improved quality of life
- Improved health, wellbeing and safety outcomes
- Improved workforce experiences and outcomes
- Reduced trauma related health, social and emotional wellbeing disparities for priority populations

^ (adapted from SAMHSA, 2016)

Understanding trauma and integrated trauma-informed care

What is trauma?

Historically, 'trauma' has been understood within the health system as physical trauma. However, we now recognise the importance of psychological and emotional trauma as a health issue. For the purposes of this framework, trauma is the response to an event, series of events or set of circumstances that is experienced as physically or emotionally harmful or life-threatening, and which overwhelms an individual.

Trauma can be experienced at an individual or collective level and may be in response to a single incident or be more complex, arising from sustained, cumulative or unresolved events. Trauma can also be intergenerational, where trauma flows through generations.

Adaptive responses to trauma may impact a person's access to and engagement with services and may impact on overall physical and psychological health throughout their lives.[13]

While the impacts of trauma may remain, people who have experienced trauma can heal. People heal from trauma in different ways and this healing takes time – for some people it may be a lifelong process. Addressing trauma in healthcare is an important part of supporting people to be able to live the life they want to live. Delivering integrated trauma-informed care is one way that health systems, services and staff can support healing.

Adverse childhood experiences

Adverse childhood experiences (ACE) are potentially traumatic events that occur in childhood. ACEs include 'aspects of the child's environment that can undermine their sense of safety, stability, and bonding.'[14] Research has shown that ACEs can have significant and lifelong implications, such as:

- increased risk of developing chronic diseases, such as obesity, diabetes, heart disease and cancer in adulthood.
- potentially impacting on a person's chances of succeeding at school and finding employment.
- increases in risk-taking behaviours such as smoking, over or under eating, and alcohol and other drug use, including prescription medications.[15]

The more adverse experiences, the greater the risk to the child's long-term health and wellbeing.

> "[Trauma is] pain that never goes away, not just on my skin."
>
> **– Young adult with an intellectual disability**

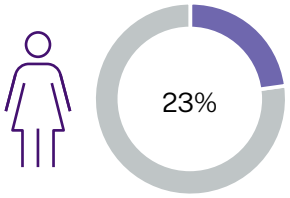
An estimated

57% to 75%

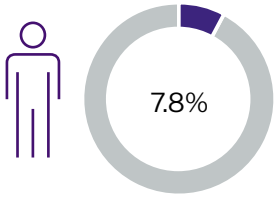
of **Australians** will experience a potentially **traumatic event in their lifetime**.[1]

Violence by an intimate partner

1 in 6 people
(16% or 2.9m)
experienced **violence**[3]
by an intimate partner[4]



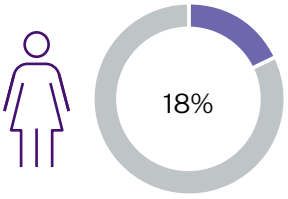
1 in 4 women
(2.2 million)



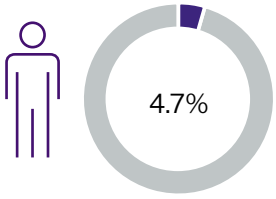
1 in 13 men
(703,000)

Sexual violence

1 in 9 people
(11.7% or 2.2m)
experienced
sexual violence[5]



1 in 5 women
(1.7 million)



1 in 20 men
(428,000)

Extensive research indicates **violence, abuse and neglect** and other **adverse childhood experiences (ACEs)**[8] have **serious outcomes** for women, children and men's **health**. These health and wellbeing outcomes are **cumulative** and may be **incrementally worse** for people experiencing **multiple types of abuse** or other **ACEs**.

Physical injuries

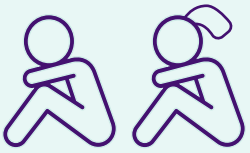
Mental health

1. Rossman, 2002 & Mills et al., 2011 cited in Bendall et al., 2018 2. Copeland et al., 2007 & McLaughlin et al., 2013 cited in Bendall et al., 2018 3. Physical and/or sexual violence since the age of 15. 4. Current and/or previous partner, girlfriend, boyfriend or date. 5. Sexual assault and sexual threat since the age of 15. 6. Physical and/or sexual abuse by an adult (18 years and over) before the age of 15. 7. Physical assault only witnessed before the age of 15. 8. In addition to violence, abuse and neglect, ACEs include parental substance abuse, mental health, separation, & incarceration.

An estimated

half to two thirds

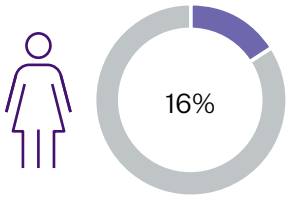
of young people have been exposed to at least one **traumatic event** by the time they turn 16.[2]



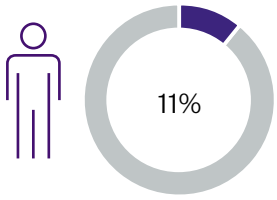
Child abuse (before the age of 15)

1 in 8 people (13% or 2.5m)

18 years and over experienced **child abuse**[6]



1 in 6 women (1.5 million)

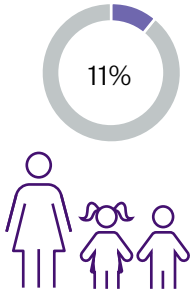


1 in 9 men (991,600)

Witness violence to parent

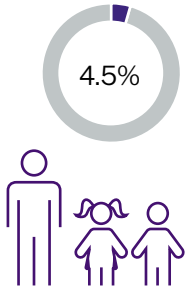
1 in 9 Australians (2m)

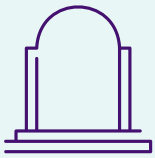
witnessed **violence**[7] towards their **mother by a partner**



1 in 22 Australians (819,000)

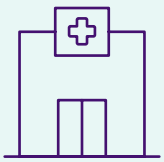
witnessed **violence**[7] towards their **father by a partner**





Death

Physical health



Chronic disease

Sexual and reproductive health

Behaviours associated with risk

Infographics: Costello & Backhouse, 2019a (with some adaptations). Data sources (other than for 1. & 2. already cited above): ABS, 2017 (Personal Safety Survey); various sources cited in Costello & Backhouse, 2019b (especially pp.109-111); 70/30 Campaign (WAVE Trust, 2018); and Burke Harris, 2018.

What is integrated trauma-informed care?

Integrated trauma-informed care brings together the elements of trauma-informed care and integrated care to improve the experiences of clients and staff. There are multiple overlaps between the principles of these two approaches and they are mutually reinforcing.

Trauma-informed care

Trauma-informed care is a systems-level initiative where organisations are oriented towards understanding, recognising and responding to trauma.[16] It is based on knowledge and understanding of trauma, how it affects people's lives, their service needs as well as how clients might present to services.

Trauma-informed care considers people's symptoms, responses and behaviours in the context of their past experiences, and emphasises physical, emotional and psychological safety for clients and staff. It aims to mitigate the impacts of trauma, avoid exacerbating trauma, and promote healing by considering how care is provided and creating a collaborative therapeutic environment.

Four assumptions underpin trauma-informed care.[17] These can be referred to as the four Rs and apply to all areas of an organisation.

- **R**ealise the impact trauma can have on families, carers, organisations, communities and individuals, and understand that all clients and staff may have their own experiences of trauma.
- **R**ecognise the signs of trauma, that relationships can be the basis for healing, and that the service-delivery setting plays a role in facilitating the foundation for trauma-informed care.
- **R**espond appropriately and effectively by applying the principles of trauma-informed care.
- Seek to prevent **R**e-traumatisation of clients as well as staff.[18]

A trauma-informed system uses trauma-informed care as a 'universal precaution',[19] presuming that every person — clients and staff — may have experienced trauma. It has benefits for clients and staff, including improved health outcomes and daily functioning, decreased trauma symptoms, reduced substance use and mental health symptoms, and decreased use of crisis intervention services, including hospitalisation.[20,21]

Integrated care

'Integrated care' is the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health in partnership with the individual, their carers and family'.[22] It places people at the centre of care, providing comprehensive wrap-around support for those with complex needs and enabling people to access care when and where they need it.

All trauma-informed care must be integrated, but integrated care is not necessarily trauma-informed. By highlighting integrated care as an explicit component of trauma-informed care, this framework seeks to emphasise the need for integrated ways of working in the provision of trauma-informed care. For more information on integrated care see the NSW Health Strategic Framework for Integrating Care.

Security in the emergency department – Casey's Story

People stared at Casey as she was escorted into the busy emergency department (ED) waiting area by two uniformed police officers. The staring made her feel anxious and self-conscious. She had been found walking on the railway tracks. Following triage, and still with the police escort and now also with security staff, Casey waited for the psychiatry registrar. With no phone reception inside, Casey, a teenager, was becoming increasingly loud and hostile towards nursing staff. She moved around the ED trying to get reception.

After an hour, Casey was in the care of a clinician and supported by two security staff. Casey's agitation grew as she was left waiting while security came and went to other jobs within the hospital. When her mother arrived, she immediately began asking why security staff were needed, taking down people's names and insisting on speaking to the security manager.

The security manager realised the situation was escalating and asked Casey whether she would like to move around the corner to a quieter and less public space. Casey seemed relieved at this suggestion. This room was used as a lounge for patients waiting to be picked up after surgery. It had recliner chairs and mobile reception, and a TV to keep patients occupied while waiting. It also afforded some privacy, with curtains separating each area.

Out of the view of the public, Casey immediately quietened down and turned to her phone, which now had reception. She had a cup of tea and a biscuit, and with the TV remote in hand, she sat back and worked the recliner chair so her feet were up. Forty minutes later, after being engrossed in the TV, she fell asleep. While Casey was sleeping, a social worker spoke to her mum, who said she was having trouble managing at home. They then discussed what supports might be put in place to assist her and the family. Soon after, the psychiatry registrar came and met with Casey and her mum, and Casey was able to go home after being assessed.

Staff were able to respond to Casey's concern about phone reception and help increase her sense of safety out of the public eye. They were able to give her choices like whether to eat or drink, watch TV, use her phone, sit or lie down. By responding to Casey in this way, security staff were able to prevent the situation escalating which would have been traumatising for both Casey and the staff. They also ensured that Casey received the health services required, and she was able to participate in her psychiatric assessment. Because of her experience, Casey may also be more likely to come back to the emergency department if she ever needs to.

The value of integrated trauma-informed care

Integrated trauma-informed care will help NSW Health provide strengths-based care in a safe and supportive environment for clients and staff.

While there are many examples of trauma-informed and integrated practice in NSW Health services, integrated trauma-informed care is not embedded across all NSW Health services or across all areas of the health system. It is critical that all NSW Health services prevent re-traumatisation and support healing, and that the system supports services to do so. The framework is also important in setting the foundations for the interagency work that is required to fully implement integrated trauma-informed care.

The diagnostic phase of the integrated trauma-informed care project identified the following key findings, which have informed development of the framework:

- **Trauma is not always viewed as a health issue that requires an immediate response.** This can result in people's experiences of trauma not being identified by the health system, particularly crisis-oriented services, and lead to missed opportunities to provide early intervention and holistic care. Some services may also consider people who have experienced trauma and have multiple complex needs as 'too difficult' to manage.
- **Experiences of trauma are common among the general population, including among health workers.** In addition to personal experiences of trauma, health workers may experience vicarious trauma during their professional practice. Vicarious trauma is not always recognised as a serious issue and health workers do not always receive the supervision and support required to respond to their needs.
- **The healthcare system is difficult to navigate, and inflexible referral and intake criteria create barriers to access.** Without appropriate support services, the impact of trauma, including adverse childhood experiences, can resemble other illnesses or diagnoses and can often be misunderstood.
- **Limited information sharing within Health and across agencies can also mean people re-tell their story and can experience unnecessary re-screening and assessments.** There is a need for greater trust, alignment and collaboration between agencies working with children and young people, and their families or carers.
- **Health workers do not always understand trauma-informed care** or know how to translate principles into practice.
- **There is a need to create cultural safety** within NSW Health and its services.

> "Choice makes me happy."
>
> **– Young adult with an intellectual disability**

Integrated trauma-informed care promotes child wellbeing and reduces harm to children and young people

We know that medical and healthcare procedures and treatment can be re-traumatising for children and young people, and being in a health setting may itself prompt emotions or memories associated with previous traumatic experiences. For instance, the physical environment of some health settings can create feelings of being powerless and unsafe. Common triggers include:

- sirens and other loud noises
- intense light and smells
- the sight of blood
- feelings of pain or discomfort
- waiting with other people who are distressed or in pain
- being asked to take clothes off
- being physically touched.

Children and young people who have experienced trauma often have complex health needs and may regularly access the health system. The health system can be overwhelming, and care is not always coordinated and integrated, meaning clients have to re-tell their story. These experiences can also lead to re-traumatisation.

Negative experiences with health services affect how children and young people engage with healthcare.[23] They may repeatedly miss appointments or only present when there is a crisis. Health workers need to actively engage hard-to-reach clients to ensure they get the health services they need.

> "I had to shield my kids when we had to go to the emergency department and ensure that they are not further traumatised, because if they see blood that's a trigger point for them, you know. If they've been in care, they see chaos, they see everything else, it isn't safe, so when you talk about safety, that's not a safe environment for them and it's not a calm environment either."
>
> **– Carer**

‘Eighty per cent of young people consulted said they would prefer the healthcare worker to know their history in advance, so the young person did not have to re-tell their story, which they found distressing.’

– CREATE Foundation

What happened: Sam and his mum’s journey

Sam went to school as usual this morning but within an hour he was in an ambulance, escorted by police because of aggressive and violent behaviour at school. No one accompanied him in the ambulance; and his mum won’t be able to come to the emergency department for a few hours. His dad is not around.

When Sam arrives at the emergency department he is distressed and lashes out. For the safety of Sam and the hospital staff, he is physically restrained and sedated. It takes five clinicians to do this because of his size and strength. When Sam wakes from sedation, he is scared and behaves aggressively towards the staff. He is physically restrained again as a result.

When Sam’s mum arrives, she declares she can no longer have him at home. Sam is too violent towards her and his brother. Although Sam is only 10 years old, he has been on medications for his mental health condition which have contributed to weight gain. Now he is adult-sized and his mother is unable to control him.

It was now after-hours and emergency department staff were left with no choice but to call the Child Protection Helpline and make a risk of significant harm report while staff tried to keep Sam calm in the emergency department.

What could have happened: integrated and trauma-informed journey

Sam went to school as usual this morning but within an hour he was in an ambulance because of aggressive, violent behaviour at school. The police were there but realising that Sam’s behaviour could be due to trauma, they did their best to appear non-threatening and spoke to Sam calmly, not making any sudden movements.

A teacher’s aide who Sam likes also came with him, but Sam was still very agitated. The ambulance called ahead to let the Emergency Department know that Sam would be arriving, that he was very distressed and may need some additional assistance. Following the call, the triage nurse checked Sam’s medical records and saw that he had significant engagement with the Child and Adolescent Mental Health Team, so she called them and let them know Sam was coming in by ambulance. She also contacted Sam’s school to ask them to contact his mum and stress the importance of her coming to the emergency department now. The school principal agreed to do so. When he got to the emergency department, the triage nurse saw immediately that Sam was a frightened little boy, despite his size, and so set him up in a quieter area of the emergency department.

The mental health clinician arrived quickly and the teacher’s aide stayed with Sam to support him until his mum got there. A member of the security team also sat nearby but out of sight. When Sam’s mum arrived, it was evident that she was also agitated and distressed, saying that Sam’s behaviour made everyone in the family feel unsafe and she didn’t know how she could continue to care for him at home.

The mental health clinician talked with Sam and his mum about what happened for Sam at school that had caused his reaction today and what might be triggering him at home.

Together they worked out a plan that included linking the family up with a community support service that could offer options like respite and individualised supports for Sam, his mother and for other family members. The clinician also listened closely when Sam said his medication made him feel bad. They agreed to adjust his medication and see if that was better for him. It had been a long day and the family’s situation was not resolved, but when Sam and his mum left the emergency department, they were feeling more hopeful.

Integrated trauma-informed care can support family functioning and parental wellbeing

Adults who care for children and young people may have their own history of trauma or current experiences of violence, abuse and neglect, which can impact on their parenting capacity.[24] Children and young people often experience vulnerability or trauma due to parental factors, such as untreated mental health conditions, alcohol and other drug use, and domestic and family violence. These child wellbeing and child protection concerns are often linked to a parent's own experiences of trauma, including adverse childhood experiences and intergenerational trauma.[25,26,27]

This does not mean that all parents who have experienced trauma have compromised parenting capacity, but it does mean that some parents may need additional services and supports to maximise parenting capacity and prevent trauma for the next generation. Health staff should understand that experiences of stigma and discrimination can be a significant barrier for accessing services, particularly for people worried about how they are viewed as a parent.

Health has a significant role in supporting adult survivors of violence, abuse and neglect or other forms of trauma. It is crucial that health services working with parents and carers are trauma-informed, as this will help to:

- support families early, particularly during the perinatal period and in early childhood
- address parental health and wellbeing concerns related to their trauma
- reduce possible re-traumatisation by health services
- support parents and carers to meet their child's health and wellbeing needs.

Jane, Baby Oliver and Leonie

I first met Jane when she was referred to our service for extended home visiting support following Jane and her husband Paul's first child, baby Oliver. In recent weeks Jane had become very depressed, presenting to the emergency department, where the Acute Mental Healthcare team and the Perinatal and Infant Mental Health Services had become involved.

Even though I was able to establish a good rapport with Jane, it wasn't until the fourth home visit, after I asked about the cuts on her arm, that she shared her history of trauma. Jane said she had never talked about her history with any service provider. I drew on all my family partnership, validation and empathising skills, focusing on what recovery might look like for Jane. We then focused and talked about Jane being a 'survivor of abuse', with me supporting her reflections and affirming her ability to have and make choices for herself and her baby.

It is so important to be able to sit with the client in their distress, show empathy, listen and validate their experiences of trauma. I really value the clinical supervision and guidance I received that enabled me to support Jane in this moment and to manage my own emotions afterwards.

Integrated trauma-informed care can improve the healthcare journey for priority populations

All children and young people can be vulnerable to experiences of trauma. However, some populations are more at risk due to socioeconomic, historical, and structural factors that contribute to ongoing disadvantage or discrimination. Implementing integrated trauma-informed care is likely to have greater benefits for these populations.

Children and young people who are at higher risk of poor health and wellbeing outcomes include, but are not limited to, those who:

- are Aboriginal
- are homeless or at risk of homelessness
- are sexually and/or gender diverse (lesbian, gay, bisexual, transgender, queer and intersex [LGBTQI+])
- are entering, in, or exiting Out-of-Home Care
- are under justice supervision
- are refugees or newly arrived migrants
- have physical or intellectual disabilities
- have chronic or complex conditions, including mental health or drug and alcohol concerns
- are a young carer
- have experienced violence, abuse or neglect
- live in rural and remote areas
- are pregnant or parenting or both.[28]

When providing integrated trauma-informed care, it is important to have an understanding of the background, context and history of priority populations and adapt service responses accordingly. This may mean, for instance, mobile outreach for hard-to-reach communities, developing resources in community languages or in Easy Read, actively involving consumers from priority populations in local service redesign and planning, working with peak bodies on targeted health promotion initiatives, regularly engaging with communities, using inclusive and non-stigmatising language, or consulting with or offering referrals to targeted health services, such as an Aboriginal Medical Service.[29] However, it is also important to remember that groups of people are not homogeneous and the experiences of people within population groups are unique to them. The client and their family or carer should always be at the centre of care.

Intergenerational trauma, health and healing

Australian governments have had many laws and policies that have harmed Aboriginal people and communities including those specifically intended to segregate, enforce assimilation or make decisions for Aboriginal people. This includes policies from the 1890s to the 1970s of removing Aboriginal children from their families to be assimilated into the non-Indigenous population. The children removed in this context are known as the Stolen Generations. Members of the Stolen Generations are alive today and may be Elders in their communities.

Under these policies, hospitals were places where Aboriginal women were segregated, not admitted to the birthing units, sometimes had to give birth in the laundry, and had their children taken away. These things are remembered, and these experiences are passed on through the generations.

Because of the health system's participation in these practices, hospitals are often places Aboriginal people associate with trauma. This contributes to present-day feelings of fear and mistrust.

> ***'...that still runs in their minds, so why should a lot of the kids now trust people ... that don't help their mothers and grandmothers, never helped them.'***
>
> (Kinchela Boys Home Survivor)

Providing healthcare in a way that works for many Aboriginal people and that improves Aboriginal health outcomes requires an understanding of this context, the trauma experienced by previous generations, as well as the intergenerational trauma experienced by many younger Aboriginal people today.

NSW Health must earn the trust of Aboriginal people, seek to establish safety, provide choice, and support agency, empowerment and healing, or health services will continue to contribute to structural disadvantages experienced by Aboriginal people.

Any experience of racism or discrimination in health services further compounds pre-existing trauma and intergenerational trauma. This undermines the ability of health services to participate in healing with Aboriginal people. Ensuring health services are racism and discrimination free will allow health services to best contribute to improvements in Aboriginal health and wellbeing outcomes.

When asked if young people wanted their healthcare worker to know their story in advance:

"To know the story in advance, I reckon, because it makes me feel less worried about the situation. If they bring it up again, that worry and grief and sadness comes flooding back. You can shorten it so all that stuff is not raised."

— Male, aged 13

The foundations of integrated trauma-informed care

What are the principles of integrated trauma-informed care?

Below are the key principles of integrated trauma-informed care. These principles provide an overarching framework to inform the development of NSW Health guidelines, policies and training, as well as the provision of care.

Trauma-integrated care principles[30]	
Principle	**Description**
 Culture, gender, history and identity	Services are responsive to a client's culture, gender, religious background, sexual orientation and ability, and recognise and address historical trauma, genocide and institutional racism. Services also leverage the healing value of traditional cultural connections. It is understood that each individual and family is unique. Care and treatment should address unique needs and preferences. However, it is also recognised that some population groups may be at increased risk of experiencing trauma, and trauma experienced within particular groups may be contextually different or manifest differently.
 Safety	Service providers and clinicians work with clients to ensure they feel physically, culturally, religiously, socially and psychologically safe.
 Trustworthiness	Service providers and clinicians are transparent, and seek to build and maintain trust among clients, staff and other services. Being trustworthy involves being reliable, accountable, respecting boundaries, and not sharing information that is not yours to share.[31] It takes time and effort to build trust particularly where trust has been broken.
 Collaboration	Staff recognise the importance of healing through relationships where power and decision making are shared. Collaboration occurs directly in client interactions and more broadly in service management.
 Empowerment	The strengths and agency of children and young people, and their families, carers and significant others are recognised, built upon, and validated both in direct service provision and organisational management. Client voices and opinions are included in the development of resources, policies and procedures. Clients and staff are supported to develop new skills as required — for example youth leadership training and training for staff in child and youth participation.
 Choice	Service providers and clinicians aim to strengthen the experience of choice for children and young people, and their families, carers and significant others.
 Integration	Care is seamless, effective and efficient, responding to all of a person's health needs in partnership with the individual, their carers and family.[32] It is person-centred, primary care based, continually improved and requires collective accountability and sharing of information.

Implementation domains for organisational change

The domains[33] below are the key areas of NSW Health within which the principles of integration and trauma-informed care must be embedded in order to facilitate change and achieve the framework objectives.

Domain	Description
Governance and leadership	Governance and leadership support and investment in implementing integrated trauma-informed care. There is clear responsibility to lead and oversee the work, and client voices are included in governance arrangements.
Training and workforce development	There is ongoing training in integrated trauma-informed care and opportunities for professional development, including for those in non-client facing roles.
Policy	There are written policies and protocols establishing an integrated trauma-informed approach, including consideration of staff who have experienced trauma and vicarious trauma. Principles are embedded into practices and procedures. Policy development, implementation and review processes are trauma-informed and include the voices of children and young people, and their family and carers.
Progress monitoring and quality assurance	There is ongoing assessment, tracking and monitoring of the implementation of integrated and trauma-informed principles and use of evidence-based, trauma-informed clinical tools. Quality assurance processes and procedures are used to maintain a high level of trauma-informed care at every stage of the process of service delivery.
Engagement and involvement	Children and young people, and their families and carers, including those who have experienced trauma and those in priority populations, have genuine and significant involvement, voice, choice and agency in their care and throughout NSW Health.
Resourcing	Allocation of resources, including funding and human and physical resources, supports the provision of integrated trauma-informed care.
Cross-sector collaboration	Collaboration across sectors and agencies is built on a shared understanding of the principles of integrated trauma-informed care and a commitment to work together to improve the experience of children and young people and their families and carers in the services provided by NSW Health, partner agencies and non-government organisations. Collaboration occurs at all levels of the organisations, including in the development of policy and in direct client care.
Physical environment	The physical environment promotes all the principles of integrated trauma-informed care.
Service provision	Practitioners are trained to use the latest evidence and provide interventions that are age-appropriate, culturally appropriate, integrated and trauma-informed. A trusted, effective referral system is in place to facilitate access to more specialised treatment where necessary. Referrals are actioned efficiently and 'warm referrals'* and other supports are provided when needed.
Evaluation	Measures and evaluation design reflect an understanding of trauma and the principles of integrated care and trauma-informed care. Children and young people and their families and carers are involved in evaluating health policies and services. Activities designed to implement integrated trauma-informed care are evaluated. Evaluations are conducted in a trauma-informed way.
Technology	Technological solutions are used to support the provision of integrated trauma-informed care and the principles of trauma-informed care are considered in the development of all technological solutions.

Gadhu Family Health: Southern NSW Local Health District

Gadhu Family Health is purpose built and designed to promote the safe provision of services for Aboriginal families. The centre delivers antenatal, postnatal, child and family, and allied health services for women carrying an Aboriginal baby, children aged 0-5 years and their families.

Co-location of the services supports integration between Aboriginal Maternal Infant Health Services, the Building Strong Foundations program and New Directions Service. Women can also access a child health and/or immunisation clinic and chronic disease management support.

Access to the services is provided through existing referral networks, such as maternity services, sexual assault services, sexual health services, paediatric clinics and child protection counselling services. Referrals can be made verbally or through a centralised intake process. Women can also 'drop in' to Gadhu for a cuppa and to access support.

Providing integrated and trauma-informed care, the service maximises choice for the person and gives control over the healing process back to families. Respect underpins all their work and staff prioritise safety, choice and control at all levels of care. Families are transitioned seamlessly between the services. Active strategies are also in place to prevent women from having to re-tell their stories. Strategies include: a shared workspace to promote collaboration, co-writing notes and use of shared documentation, and formal fortnightly meetings to discuss the support needs and preferences of women accessing the service.

The work is led by Aboriginal health workers who have been delivering culturally appropriate, trauma-informed and healing practice for several years.

"You need to communicate when you're doing the handover; they need to communicate to the patient, which is these vulnerable kids, because if you don't explain what's happening then, that's when they panic. So you need to have that communication consultation and the handover process."

– Carer

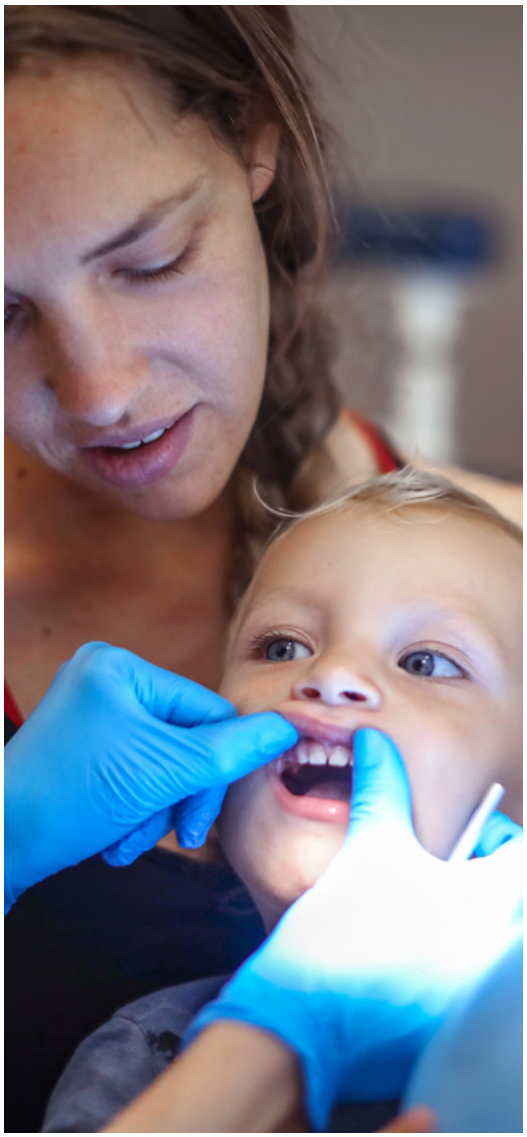
Moving towards integrated trauma-informed care as a system

Strategic objectives and priorities

The Integrated Trauma-Informed Care Framework is the first step towards achieving the system-wide changes required to ensure that all children and young people and their families and carers receive integrated trauma-informed care. To this end, the framework aims to achieve the following objectives and strategic priorities.

OBJECTIVES	 ❶ Increase NSW Health's capacity to deliver integrated trauma-informed care to all children and young people, and their families and carers	 ❷ Embed trauma-informed principles and practices in service delivery	 ❸ Reduce risk of re-traumatisation of children and young people
STRATEGIC PRIORITIES	1.1 Streamline management and reporting structures to promote integration and trauma-informed care.	2.1 Apply the principles of trauma-informed care to development, review and evaluation of policy, strategies and procedures.	3.1 Provide education, training and development to equip NSW Health workers with the right knowledge and skills.
	1.2 Establish mechanisms for resourcing trauma-informed care.	2.2 Embed trauma-informed care in relevant policy and operational guidelines to drive practice.	3.2 Design and modify physical environments to facilitate integrated Trauma-Informed Care.
	1.3 Embed a robust system for monitoring and reporting.	2.3 Ensure quality and safety of services through robust LHD/SHN clinical governance processes and systems that reflect integrated trauma-informed care principles.	3.3 Provide services in accordance with the principles of Integrated Trauma-Informed Care.
	1.4 Ensure Leadership (clinical and executive) drives change.	2.4 Reduce vicarious trauma of NSW Health workers through professional support and learning including clinical supervision.	3.4 Provide guidance and training on recording and managing information and balancing confidentiality of clients.

4 Improve cultural safety for Aboriginal people, families and communities	5 Ensure healthcare is accessible and culturally and gender sensitive for children, young people, families and communities	6 Improve provision of continuity and person-centred care through better integration, especially for children and young people with complex needs
4.1 Put in place formal processes to routinely involve Aboriginal children and young people and their families and carers in local redesign implementation and service planning.	5.1 Formal processes are in place to routinely involve children and young people and their families and carers in local redesign implementation and service planning, particularly those from priority populations.	6.1 Establish integrated electronic clinical system.
4.2 Develop cultural competence in working with Aboriginal people and supporting cultural safety with Aboriginal clients.	5.2 Develop cultural competence in working with diverse clients and ensure services are safe and accessible for clients from diverse backgrounds.	6.2 Support work with interagency partners at all levels.
4.3 Establish formal pathways for Aboriginal cultural consultation.	5.3 Enhance availability and accessibility of client feedback mechanisms.	6.3 NSW Health services and staff work together to identify trauma, provide initial responses, make referrals and coordinate care.
4.4 Support NSW Health's Aboriginal workforce in a trauma-informed way.	5.4 Ensure workforce planning and management reflects the diversity of the community and takes into account local priorities and needs.	6.4 Put in place mechanisms to facilitate interagency collaboration at all levels.



Integrated trauma-informed care in oral health: 'Grin and Grow'

The Grin and Grow program provides timely access to clinical treatment and preventative oral healthcare for children in OOHC across Murrumbidgee and Southern NSW Local Health Districts. The service is available for children from 12 months of age (or earlier if required) to 18 years.

Most children in OOHC have experienced trauma, and the Grin and Grow program aims to educate oral health clinicians to be trauma-informed and aware that being close to a child, touching and looking in their mouth can be triggering for a child who has experienced trauma.

We ensure our service is trauma-informed by:

- educating clinical staff on trauma-informed care, including understanding trauma and its impacts
- prioritising appointments for children in OOHC
- providing a centralised referral process where referrals are submitted to the Oral Health Intake Centre by the OOHC coordinator and contact made to the carer within 24 hours to arrange an appointment
- providing children with information and a dental pack that includes a sensory object (squishy toy), toothbrush and toothpaste
- providing an initial appointment, which is examination and oral health promotion–focused and, where possible, avoiding invasive treatments. This is important to build a sense of safety and rapport with the child
- strengthening relationships with the Department of Communities and Justice and funded service providers by building a pathway for better communication and exchange of information
- identifying and acknowledging the over-representation of Aboriginal children in OOHC; consulting with Aboriginal Health in developing the Grin and Grow program; providing culturally appropriate resources for Aboriginal children and their carers; and educating and training staff in cultural appropriateness through programs such as Respecting the Difference.

Integrated trauma-informed care in practice

What do the integrated trauma-informed care principles mean for working with clients?

Trauma-informed care is about how services are provided, not just what the service entails. As healing from interpersonal trauma occurs within relationships, the wider relational context in which healing takes place is critical.[34] Everything about a child or young person's contact with a health setting can make a positive difference, from the physical environment, to the way they are greeted and the subsequent interactions with the clinicians providing care.

Children and young people who reported positive experiences with health workers highlighted the importance of clear communication, friendliness and rapport. Conversely, negative experiences were associated with health workers not listening or understanding their needs.

> ***"When I went to a doctor, the person I saw was very nice but the receptionist was very rude and said weird things like 'it's stupid that you hurt yourself like that'."***
>
> **(Male aged 12)**

Children and young people said that health workers who were truthful and empathic were more trustworthy. Having a trusted support person present, like a family member, carer or caseworker also helps children and young people feel safe. Young adults with a disability said that a healthcare worker's acceptance of their wish to have a comfort object with them was important for building trust and their sense of safety.

Culture, **gender** and **history** shape our **identity** as unique individuals. Discrimination based on culture, religion, ability, gender or sexual orientation is harmful and undermines trauma-informed care. Cultural safety is critical for providing trauma-informed care. It is imperative that children, young people and their families and carers are given time to tell health workers what is important culturally to them.

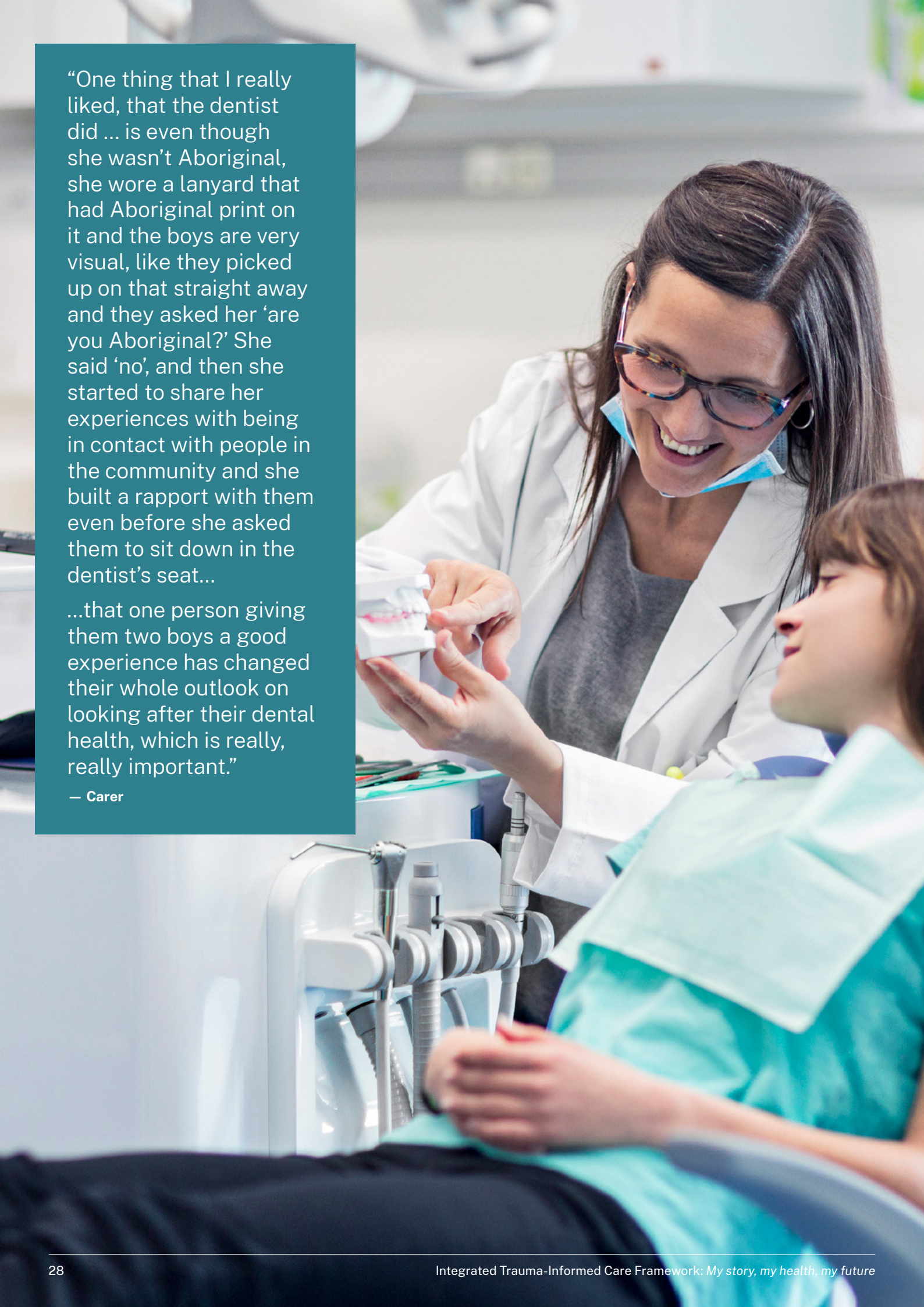
> ***'We all live our lives differently and have different beliefs, so just having a broad general idea of different customs and how people behave accordingly, that's important as well.'***
>
> **(Aboriginal carer)**

Children and young people of **diverse gender and/or emergent sexual orientation** may experience trauma due to their fear or experience of rejection by their family, as well as from being bullied or isolated from peers and educators. In health settings, **safety** includes accepting a person's gender identity. Trauma-informed care requires an understanding of the impact that stigma has on children and young people.

People who have come to this country as refugees said that it is important for health care workers to be aware that the cultural practices of different groups may differ from Australian health practice and that a lack of understanding and ability to communicate about this can be a barrier to building rapport and trust.

Actively affirming, respecting and using a person's chosen name and pronouns (e.g. he, she, they), and de-stigmatising and normalising diverse experiences and identities of gender and sexual orientation will actively contribute to a safe and therapeutic clinical environment. Members of the Stolen Generations said that health workers who take the time to reach a deeper understanding of identity, that is, where an Aboriginal person comes from — their Country and mob — are experienced as more respectful than those who do not. Respect, trust and safety are linked to understanding of a person's identity.

Healthcare workers can build rapport around simple things that establish a connection.



"One thing that I really liked, that the dentist did ... is even though she wasn't Aboriginal, she wore a lanyard that had Aboriginal print on it and the boys are very visual, like they picked up on that straight away and they asked her 'are you Aboriginal?' She said 'no', and then she started to share her experiences with being in contact with people in the community and she built a rapport with them even before she asked them to sit down in the dentist's seat...

...that one person giving them two boys a good experience has changed their whole outlook on looking after their dental health, which is really, really important."

— Carer

Tips from children and young people, and their families, carers and support workers

During community consultations, children and young people with experiences of trauma and their carers made the following recommendations for health staff:

- ***Make us feel welcome.*** Simple welcoming behaviours like smiling, making eye contact, and talking to children and young people, not only the adult, are helpful.
- ***Don't make us tell our story over and over.*** Requiring clients to retell their story can be re-traumatising. Check the health records, and speak to other services involved.
- ***Speak honestly to us.*** Honesty is critical to building trust and creating safety. Make sure clients understand what you are saying and ask clients what they want.
- ***Minimise wait times.*** Children and young people with complex needs may need special provisions to reduce long wait times for services and appointments. Waiting a long time for services or in an emergency department may reduce feelings of control and remind people of experiences of violence, abuse or neglect where the perpetrator took control away from them.
- ***Involve families and carers in planning.*** Recognise the knowledge and experience families and carers bring and actively involve them in care planning (where appropriate).
- ***Help us access other services.*** The health system is difficult to navigate, and care is not always coordinated. Support clients to access other appropriate services.
- ***Treat us as a partner.*** Collaboration and partnership with children, young people, families and carers is critical for trauma-informed care. Listen and respond to the needs of children and young people, especially if they tell you they don't feel safe.
- ***Keep our GPs in the loop.*** Families value the support of their GPs. It's critical for health workers to work closely with a family's GP so that care is integrated and holistic.
- ***Know how the system works.*** It is helpful for Health workers to better understand the Out-of-Home Care (OOHC) system. Visit www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/OOHCH-Program.aspx or www.facs.nsw.gov.au/families to find out more.
- ***If you aren't sure if a child or young person is in OOHC, ask them about their living arrangements.*** If they are in OOHC, build a relationship with their carers, caseworker and their NSW Health OOHC Health Pathway Coordinator.
- ***Own your own emotions and look after yourself.*** Children and young people take their cue from adults. If you or their parent or carer is scared or distressed, this is likely to scare or upset the child or young person.
- ***Explain what's happening and why.*** Routine things like shift changeovers or staff washing their hands before a procedure may frighten or confuse children if they don't understand what is being done and why. Check in and explain each step prior to a procedure, provide choice and listen. Not feeling in control can be a trigger for people with experiences of trauma.
- ***If appointments are running late, let the child or young person and their carer know.*** Provide information about how long they will have to wait, and offer choices, if possible. Can they go for a walk and come back?
- ***Understand that children are experts at survival.*** When children or young people are stressed, they may react unexpectedly or not share information. That is part of their survival skill set. Be patient and allow time for them to share. This may take a number of appointments. People with experiences of trauma may find it difficult to trust new people.
- ***Children feel safer with someone they know and trust.*** Ask the child who they trust and whether they would like that person to attend appointments with them. Choice is empowering. Talk to the child's caseworker to better understand the child's experiences and needs.
- ***Children and carers who are stressed may not remember details about healthcare afterwards.*** Consider writing a one page summary with the child or young person, using language they understand and will recall later, setting out who they saw and why, what happened in the appointment and what the child or young person or their carer needs to do to follow up after the appointment.
- ***Children may not feel safe in hospitals or health services.*** Children and young people removed or assumed into care while in hospital or following a medical appointment may not feel safe in our services. They may fear speaking because they are scared of being removed again.

While young adults with a disability are aware that **choice** is a right, if they feel intimidated or there is a clear power differential between them and the clinician, they may not feel able to exercise that choice and may simply defer to the clinician's expertise and feel unable to participate in decisions about their own health. They should for example, have a choice about the gender of doctor who treats them. Establishing rapport, providing choice and empowering people with an intellectual disability in a healthcare setting needs to take into account that the power imbalance with the health care worker can be intimidating for people with disability.

"One participant said he only goes to the doctor with his parents. He said the doctor is busy and a 'very clever man' as he uses really big words, doesn't make eye contact and only talks to his parents as they understand quicker and they just go home and talk about what happened instead."

— Young adult with an intellectual disability

"My health is me, it's mine, work with me, not the person sitting next to me."

– Young adult with an intellectual disability

Signs of trauma for non-clinical, client-facing staff

Client-facing, non-clinical staff, such as reception and security staff, might observe client behaviours that clinical staff don't see.

These workers have the opportunity to identify possible signs of trauma and respond appropriately. Children and young people who have experienced trauma will present differently. It's important to remember that any behaviour or response that seems out of context could be a sign of trauma.

When unexpected behaviours or responses are present, consider 'what has happened to this person?' not 'what is wrong with this person'.

While not precise, some things you see or hear *may* indicate trauma, such as:

Young children (ages 0–5)

- startling easily
- being difficult to calm
- reluctance to explore their surroundings
- overfamiliarity with strangers
- internalising behaviour such as being extremely quiet and rarely or never crying
- not meeting developmental milestones.

Adolescents (ages 13–18)

- fighting
- risky behaviours, hurting themselves or damaging property
- refusal to follow rules, or talking back frequently
- inability to follow direction
- ignoring attempts at engagement or communication
- frequent acute care presentations associated with drug or alcohol use
- bravado, disengagement or dissociation (fight, flight or freeze).

School-age children (ages 6–12)

- difficulty paying attention
- being quiet or withdrawn
- fighting with peers or adults
- hurting themselves or damaging property
- behaviours common to younger children (thumb-sucking).

All age groups

- unusual parent/carer and child interactions — for example what the parent or carer says about the child or how they respond to them, could also be indicative of trauma.

This is not a diagnostic tool and it is important to remember that these behaviours can be present in the absence of trauma.

Staff roles and responsibilities

Although staff may not always be able to achieve the practices below, these are some examples of integrated, trauma-informed practice for staff in different roles.

All staff

- Adopt 'universal precautions' for integrated trauma-informed care.
- Adopt the 4 Rs of trauma-informed care (see page 12).
- Consider and apply the principles of integrated trauma-informed care in everything you do.
- When a client behaves or responds in an unexpected way, consider 'what has happened to this person?' not 'what is wrong with this person?'.
- Identify barriers to integrated trauma-informed care and provide feedback.

Client facing non-clinical staff

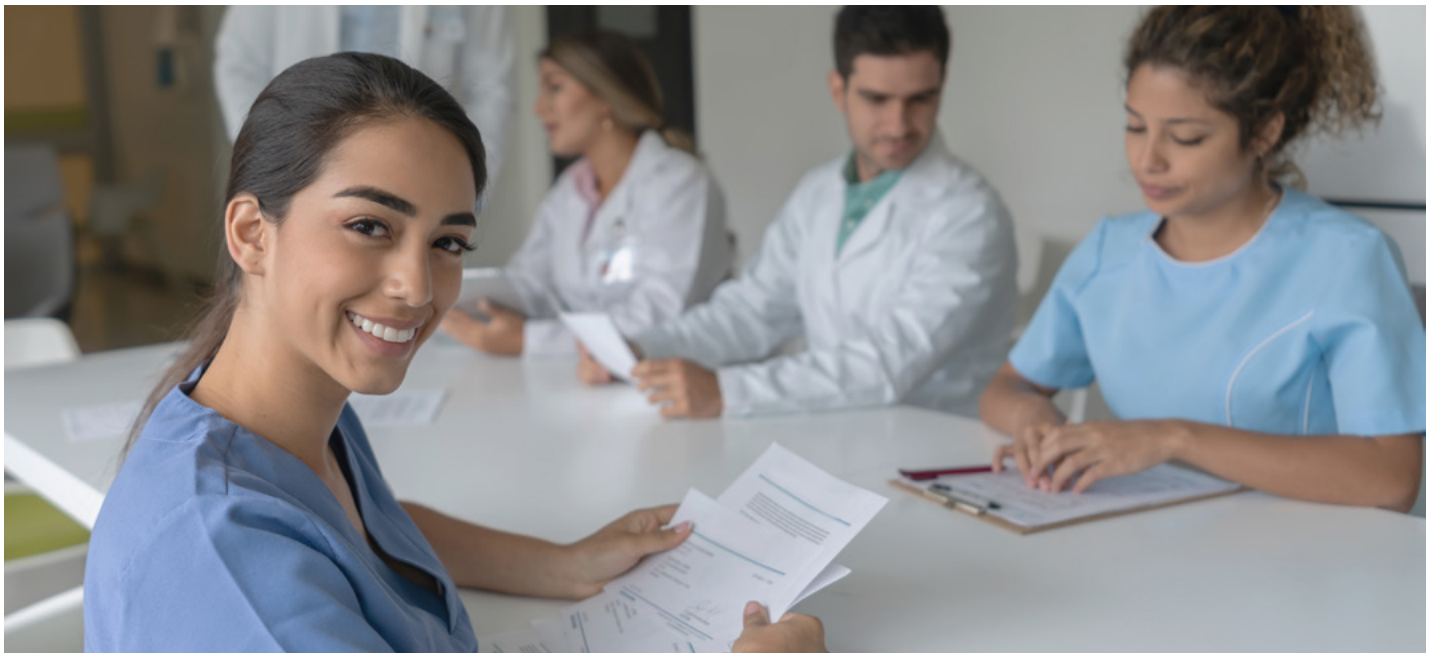
(e.g. security, front desk, referral support, reception, office support, office administration)

- Introduce yourself and greet people with a welcoming smile and warmth.
- Know the signs of trauma.
- Provide a nurturing, calm and predictable environment.
- Reduce unexpected movements and don't stand over children or young people.
- Create spaces that are welcoming and safe for children and young people, and their families and carers, and for people with diverse identities and cultural backgrounds. For example include artworks and reading materials from different cultures, have comfortable chairs or couches to sit on, reduce unnecessary noise and where possible ensure families and children are able to wait away from other adults.
- Communicate in a way the client, including those with a disability or their chosen representative, can understand.

Clinical staff

(e.g. emergency department, oral health and general practice)

- Introduce yourself by name and explain your role.
- Understand signs of trauma likely to be seen in your area of practice.
- Seek regular feedback from your client: explain each step prior to a procedure, provide choice, and listen.
- Use supervision.
- Reflect on your practice and consider cultural safety.
- Communicate in a way the client, including those with a disability or their chosen representative, can understand.
- Consider who should be involved in care and work with them. This includes security staff.
- Read available notes before the appointment and consult where necessary so that the child or young person does not have to retell their story.



Executives, board and sponsors

- Provide executive sponsorship of integrated trauma-informed care.
- Lead cultural change and service development.
- Demonstrate commitment to integrated trauma-informed care by:
    - ensuring all local policies and procedures reflect the principles of integrated trauma-informed care
    - modelling trauma-informed practice
    - supporting client engagement
    - monitoring and reporting on implementation of integrated trauma-informed care
    - establishing governance of local integrated trauma-informed care initiatives
    - improving workplace diversity
- Address barriers to integrated trauma-informed care.

Managers

- Model integrated trauma-informed care and practice.
- Support staff to embed trauma-informed approaches and ensure a safe supported workplace.
- Respond appropriately to disclosures.
- Support and encourage routine supervision.
- Recognise that staff may have their own experiences of trauma.
- Work with staff to build a safe environment: culturally, physically and emotionally.
- Support attendance at training around trauma, trauma-informed care, vicarious trauma and culturally appropriate care.
- Work with staff to establish systems that promote integrated and trauma-informed practice.
- Address or escalate barriers to integrated trauma-informed care implementation.
- Work collaboratively with other managers to support effective integrated trauma-informed practices between services.
- Encourage and support interagency collaboration.

Policy makers and other ministry/pillar staff

- Ensure that policies are trauma-informed and incorporate the principles of trauma-informed care and integrated care.
- Ensure that children and young people are involved in the policy cycle (monitoring, review and evaluation) in a trauma-informed way.
- Encourage, support and engage in interagency collaboration.
- Develop funding models to support integrated trauma-informed care.
- Develop integrated trauma-informed care key performance indicators or benchmarks.
- Promote and support research in integrated trauma-informed care.

Trainers, educators and human resources

- Ensure training packages are trauma-informed and include information about integrated care, trauma-informed care, vicarious trauma and vicarious resilience.
- Apply the principles of trauma-informed care during training.
- Employ the principles of trauma-informed care in advertising, onboarding, employment and offboarding processes and procedures.
- Employ the principles of trauma-informed care in the management of performance and industrial relations matters.
- Recognise and respond to the effects of vicarious trauma on staff.

Yonas and Murray – Security staff in an inpatient setting

It was a call not unlike other calls that security have received before. However, as it was the paediatric unit, I decided to attend myself, as my staff often appreciate support when responding to incidents that involve children.

On arrival, I could hear screaming, crying and thumping coming out from the room but I couldn't see anything. My three security staff and I were on standby. There was a clinician inside the room, and the cries and screams of this child were gut-wrenching.

The clinician wasn't having any success connecting with the child and motioned for me to enter the room. I quietly asked the clinician whether I could try to help calm him. She agreed and looked relieved.

The clinician said, 'He's a self-harmer'. This was said in front of the distressed child. All I could think of was how to help him.

I am not a doctor, nurse or psychologist, but I am human and I couldn't stand by listening to the distress in this child's voice and watching him hit himself in front of me.

I went over to the boy. I squatted down so our heads were at the same height and I asked him calmly and quietly what was happening. I didn't expect I would get him to respond. He responded by saying he wanted to die. I put my arm around him to stop him hitting himself and then walked him back to his bed. I sat with him. His father soon arrived, and I handed him to his dad, who cuddled him.

On the way out of the room I stopped to ask the clinician if she was okay and we talked about what had happened.

This small act of kindness and understanding impacted on everyone involved. For the child, the benefit of this approach cannot be overstated, as a terrible time of distress presented a small opportunity for healing. As an organisation, there were benefits, because we didn't have to get too many staff involved. For the staff, they did not have to watch a child continue to suffer in such severe distress.

Practice examples

The practice examples below provide guidance to client-facing staff on how to move towards integrated, trauma-informed practice. Key areas of care have been selected, which are points at which clients, families and carers may come into contact with the NSW Health system. If the framework is implemented correctly, these are points at which client experiences and outcomes will be directly improved. It is important to recognise that many staff are already practising in this way, and that where they are not, this may be due to system limitations, which the Framework and Implementation Plan will work to address.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
All care e.g. All healthcare contexts and settings All care refers to every interaction with a health service in every setting or context. Every interaction with a health service presents an opportunity for healing and can impact on future engagement with health services. It is therefore important that each and every interaction is trauma-informed. Some people may experience fear due to prior negative experiences of health services or intergenerational trauma. Every interaction with a health service should serve as an opportunity to heal from these experiences. This includes where health services are provided virtually or via telehealth.	Signs and symptoms of trauma go unrecognised.	Staff are alert to signs and symptoms of trauma.
	Trauma is not understood as underpinning behaviour: 'what is wrong with them?	Trauma is considered as a potential explanation for behaviour: 'What has happened to you?'.
	Clients are the recipients of information or care plans. Clinicians determine the best treatment option.	Focus is on what matters to the client and information is provided in a way the client can understand and can use to make decisions.
	Injury or illness is treated in isolation.	The whole of a person, not just the injury or illness, is treated.
	Parents or carers are the focus of communication.	Children and young people are engaged, not just their family or carer.
	Communication between health services and other agencies is limited.	Clinicians consider who else should be involved or might hold important information, and include them in communications and planning.
	Working in a culturally responsive way may be seen as the domain of specialised services only.	Specialised services are consulted or referred to where required, but all services provide culturally appropriate care. Clinicians work with children and young people and their families and carers to identify whether culturally specific services may be preferred (if available). Clients are treated with compassion and are free from stigma and discrimination.
	Telehealth or virtual care is chosen as the modality of care without consideration of the client's circumstances or wishes.	Clinical judgment is used to determine whether telehealth or virtual care is suitable for a particular client giving considerations to the presence of violence, abuse or neglect and any known trauma history, in conjunction with the client's preferences.
	Phone numbers and contact details may be difficult to find and calls may go unanswered with no voicemail option. Significant delays may be experienced before calls are answered.	Phone numbers and contact details are easily identified, phone numbers are always answered or have a voicemail option that clearly outlines when calls will be returned. Calls are picked up or returned in a timely fashion.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Virtual care e.g. telehealth, virtual care clinics, virtual hospital	Clinicians may progress with the appointment as they would in-person.	Be guided by the patient regarding the depth of the appointment. They may prefer to just talk or test the connection at first.[37]
	The virtual nature of the encounter may lead clinicians to be less cognisant of the client's feelings and experience of the encounter.	"Proceed according to patient comfort level; obtain consent for examinations, minimize removal of clothing, and proceed with follow-up discussions once the patient is clothed."[38]
		"...[A]void personalizing language such as ... *"show me your [body part]"*[39]. Consider instead: "In order to help us treat you, it would be useful for me to examine the arm. Would you mind rolling up the sleeve so that I can see the rash?"[40]
	Clients are advised to make sure they have a private space to have their appointment.	Clinicians are aware that those present may not always be visible and are guided by body language and other cues as to how to navigate sensitive subjects.
	It is assumed that the client is in a safe and private space during the appointment.	Ways which the client can indicate they no longer feel they have sufficient privacy are established.
		Clients are reminded of the service modalities available, and of their rights to change service modality, including changing back to face-to-face services.
	Limited consideration is given as to the impact of technology on the patient experience, relationship and communication.	The clinician sits far enough away from the screen so the patient can read their body language and establish the appearance of eye contact.[41]
	Talking about a client's personal space may be seen as rapport building.	Clinicians are "sensitive to the patient's feelings in revealing their home or living space and do not make comment about it."[42]

The application of trauma-informed principles to virtual care has the potential to increase engagement in care, and provide opportunities for protective, healing connections.[35] However, health workers must take appropriate steps to promote the safety of clients who are experiencing violence, abuse and neglect. For example, it can be harder for survivors/victims to access a private space from which to safely make and receive phone calls or video calls.

In addition, the delivery of services via telehealth can leave a "trail" and provide increased opportunities for perpetrators of violence to monitor victims' activities and conversations within the home, and an increased risk of technology facilitated abuse. Use of virtual care modalities should recognise and seek to mitigate against these risks.

It is also important for clinicians to be mindful that during times of heightened public anxiety and isolation, such as during the COVID-19 pandemic, clients may experience trauma and re-traumatisation. This can impact both access and response to care.[36]

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Management, planning and care coordination, including collaboration with partner agencies e.g. All healthcare contexts and settings Management, planning and care coordination is crucial to integrated trauma-informed care. It can help establish choice, give clients back control, reduce the likelihood of re-traumatisation and ensure care is focused on what is important to the client.	All clients manage and coordinate care on their own.	Assistance with case management and care coordination is provided where this is necessary to support the client.
	Children and young people needing specialist medical or therapy services are given a referral letter and advised to make an appointment	There is prompt follow-up by support services after a referral is received. The clinician asks older children or young people what information they would like shared about them, so they do not have to re-tell their story.
	Missed appointments are seen as a failure of the client.	Consideration is given to factors contributing to missed appointments and how the client journey could be improved. Services allow for missed appointments while clients 'test out' and develop trust in workers and services. Services also call or message clients to remind them about an appointment.
	Healthcare is provided as a discrete service, disconnected from other services the child or young person might be accessing.	Healthcare is provided as part of a coordinated, holistic care plan that has been developed with the child or young person, and their family, carer and other agencies involved. Collaborative multidisciplinary and multi-agency care is undertaken with appropriate case conferencing and case management to support seamless care.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Health promotion e.g. Open days, community events, posters, social media and resources Health promotion refers to any action taken to maximise health and wellbeing. Health promotion may be the first opportunity to build trust with an individual or community and can impact whether people will be comfortable using your service.	Health promotion resources and activities provide standard information to everyone in the same way.	Priority populations, children and young people, families and carers are involved in the development of health promotion initiatives. A person's cultural, historical, gender, religion, ability, and identity are considered, with location, design and content taking these into account.
	It is not seen as a worker's role to receive or respond to disclosures.	Staff are prepared to receive disclosures and respond appropriately (see trauma-specific responses).
	Trauma is seen as the domain of specialised services only and unrelated to other health conditions.	All health promotion activities take into account the relationship between trauma and health and wellbeing.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Initial contact e.g. Reception, emergency department entry and triage, community health front desk.	The role of reception and triage are seen as process-oriented only, with the same service delivered to every client.	Initial contact is used to build rapport, with all staff providing a welcoming environment and attending to safety factors, building trust through open and honest communication.
	It is not seen as the role of staff at initial contact to build trust, provide choice or help establish safety.	Where possible, the client is provided with choices including those which may help them to manage their exposure to triggers.
	Clients exhibiting signs of trauma are described as 'difficult', 'aggressive' or 'uncooperative'.	All staff are aware that all clients may have experienced trauma and consider trauma as a potential explanation for behaviour.
		If signs and symptoms of trauma are identified by non-clinical staff, they are flagged with a clinician.
	Security personnel are used only to respond to incidents or maintain a presence to prevent incidents.	Security measures are re-conceptualised, focusing more on soft security and de-escalation.
		Security personnel are included in planning and safety huddles. They are provided with clinical information required to optimise their approach to clients.

Initial contact is the point at which the child, young person, family or carers access a health service. It may be virtual, over the phone or in person, and includes the service provider, clinician, receptionist, security and other front of house staff they first meet.

It is critical that initial contact is trauma-informed, as this can influence a person's experience of the healthcare service received. In some cases, poor initial contact experiences can result in clients not receiving the service required.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Screening and assessment e.g. All healthcare contexts and settings Screening and assessment is an area that can make a significant difference to children and young people. In particular, over-assessment and repeated screening can be frustrating and cause children and young people to have to tell their story multiple times. If done well, screening and assessment can ensure people get responses that will be most helpful to them. However, if screening and assessment is not trauma-informed or the system lacks integration, this can result in re-traumatisation and may result in clients not receiving the services they need.	This may be done in the first instance as standard practice for all clients.	Clinicians review documentation to identify what screening and assessment information is available and identify known history of trauma. Clinicians consider their role and the service setting and use their clinical judgement in guiding the pace and timing of screening and assessment. Clinicians consider if and when to take a trauma history given available information.
	Clinicians show discomfort or impatience when a client is not speaking or is taking their time.	Clinicians are patient and manage their physical and verbal reactions.
	Clinicians have limited consideration of the need to build trust and safety to facilitate accurate responses.	Clinicians focus on establishing a relationship and environment where the client feels safe to disclose experiences of trauma and participate fully in screening and assessment.
	Limited information is given to the client regarding the purpose of screening and assessment.	Clinicians explain the purpose of the assessment in a way the client can understand, including what the information will be used for and, if it is a general screening question, that it is asked of everyone.
	Screening and assessment findings may not be available to other clinicians who need them, resulting in repeated screening and assessment.	Care plans and results are documented and tracked, and an appropriate level of detail is available to other services as needed.
	Screening and assessment tools are one-size-fits-all.	Clinicians consider, in consultation with the client, whether culturally appropriate assessment and screening tools are available and appropriate.
	Each clinician does their own isolated screening and assessment.	A multidisciplinary team approach is used where appropriate, and relevant information is shared with the team with the knowledge of the client.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Crisis and acute care e.g. Emergency departments, ambulance attendance, obstetric, psychiatric and paediatric emergency care Integrated trauma-informed care in crisis and acute care is critical, as presentations to these services are often highly stressful and may remind people of previous presentations due to violence, abuse or neglect. Additionally, many acute care occasions of service relate to direct experiences of violence, abuse and neglect. Care in these scenarios can easily become disconnected from other aspects of a person's healthcare. In some services, the physical environment also presents particular challenges.	The focus is only on treating the immediate injury or presenting issue(s).	Safety, including cultural and psychological safety, is considered in the context of providing urgent care. Consideration is given to the whole client and their context. Additional information is sought from other health services and agencies as required to provide appropriate care.
	Communication occurs with parents or carers only.	Communication with children and young people is age appropriate and regular, and seeks to reassure, validate and recognise the traumatic experience, and keeps the client informed of progress and explains delays. Staff ensure the child or young person understands and consents to procedures, even where the responsible adult has consented on their behalf. Choices are provided even where these may be limited. Environmental factors that may re-traumatise clients are reviewed and exposure reduced. Examples include, flashing lights, loud noises and the presence of other distressed clients.
	Limited consideration is given to the whole context in which care is provided.	Transition between clinicians is seamless. Security personnel are involved in planning and safety huddles.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Inpatient / admitted patient care e.g. Paediatric ward, mental health unit, labour and post-natal ward Similar to acute or crisis care, in many cases inpatient occasions of service can be particularly stressful. They also often follow on from an acute or crisis event that may have been particularly traumatic. If services are not integrated or trauma-informed, the period of care and exposure in these settings may also be prolonged, increasing the potential for harm.	Blood is drawn and procedures are undertaken at bedside.	Treatment rooms or other spaces are used for procedures, so a child's bed is maintained as a safe space.
	There are mixed wards with adults and children and different genders.	Children and young people's safety is paramount. Generally, children and young people are not accommodated in wards with adults, and for older children and young people, different genders are accommodated separately. However, bed allocation involves critical decision making to provide a physically and emotionally safe environment for all clients. Staff use their judgement in relation to individual situations and circumstances.
	Limited information is provided to clients about what is happening and when.	Communication with children and young people and their family and carers is age-appropriate, regular, reassures, validates and recognises their experience, and keeps the client informed of progress and explains delays.
	The focus of communication is on parents and carers.	Staff speak directly to children and young people. Security personnel are involved in planning and safety huddles.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Care in the community / outpatient care e.g. child and family health, youth health, allied health and oral health services For some clients, care in the community or outpatient care may be the only contact that they have with NSW Health services. These service contexts are easier to make integrated and trauma-informed than acute care or in-patient settings. They can be used to build trust with clients and help to ensure that when urgent care or inpatient care is required, clients are more likely to access it and feel comfortable doing so.	Clients are expected to arrive at the service without any prior relationship building. They are also expected to research for themselves to better understand the services available.	Trust is built and relationships formed before appointments — e.g. a phone call the day before to confirm an appointment, providing information packs, videos and contact numbers to answer any questions.
	Each clinician works with the client individually and with limited coordination.	A multidisciplinary team care approach, including social care support networks, is provided. Partnerships are built in the community (internal and external to NSW Health)
	Clinicians focus on only addressing the issue which has brought the child or young person to the service.	Clinicians work with clients to build on and develop their strengths to promote health and healing.
	There is limited focus on the context in which services are provided.	Flexibility is available in how services are provided including outside the health centre and clients are given choices on where they receive services.
	Culture, gender history and identity are not considered.	Services work with the local community to build and promote cultural safety and receive feedback on their services.

Area of care	Practice examples	
	Not integrated or trauma-informed	Integrated trauma-informed practice
Trauma-specific responses e.g. All healthcare contexts and settings	Clinicians fear saying or doing the wrong thing so are tentative in their response or deflect the issues.	Limitations on privacy and confidentiality are explained early and in a way the client can understand. Clinicians listen calmly and patiently, free of distractions, allowing a child or young person to be heard in their own words.[43] Clinicians know that 'listening supportively is more important than what you say'.[44] Clinicians reassure the client, recognise their bravery and manage their own emotions.[45] When what a child or young person has said needs to be passed on to someone else, this is explained.
	Mainstream services focus on referring clients on to specialised services and provide a limited response to trauma.	Clinicians know what services are available, work with the client to identify if specialist services are required, offer warm referrals and ensure clinical documentation is respectful. Clinicians work on the goals established by the client together and review regularly to ensure the process is working for the client's needs and wishes.

A trauma-specific response is the response of a clinician to disclosures of trauma, violence, abuse or neglect. It can also occur where there is a high degree of suspicion that these may be present. It includes both the immediate response as well as referrals to specialised services where required.

Disclosures of trauma or violence, abuse or neglect are a time of great vulnerability for clients. It often takes significant courage to disclose such experiences and it is critical that clients receive a trauma-informed response from staff regardless of their role. Failure to implement trauma-informed care at such times may leave a client feeling re-traumatised, helpless and unwilling or unable to disclose to someone else.

"In a different situation when I was worried and crying, it was because I wasn't sure what was going on. Someone told me something was going to happen, and then something else happened instead. Plans changed and I wasn't told anything about it, or they didn't explain why. I started to think they might have even lied to me.

I would like the person who is telling me to be straightforward. Don't sugar coat it, just tell me what is going to happen."

– Male, aged 13

Trauma-Informed Birthing – Gina's Story

Recently arrived from overseas and feeling very alone, Gina had hoped for a natural birth. The midwives were kind but none of them spoke Spanish so Gina had to work hard to understand what they were saying to her. After a few hours, labour had not progressed and Gina's baby was showing signs of distress. The midwives alerted the duty doctor Hannah and the decision was made to deliver the baby by caesarean section.

Suddenly there was urgency in the way the staff were speaking and moving. Gina was barely aware of the midwife talking to her but understood that something was very wrong. Gina was taken to theatre where the number of strangers in gowns and masks made Gina even more upset and she began to panic. In her anxious state Gina was having more difficulty understanding English.

When Hannah arrived she noticed that Gina seemed to be extremely scared and upset and she was not taking in what anyone said. She also realised that Gina seemed to be having difficulty understanding what was being said and requested that a telephone interpreter be called. It crossed Hannah's mind that there might be more going on for Gina than they knew but they didn't have time to find out because this baby was coming. Hannah knew that what she could do was help Gina feel safer and try and give her back some control.

Moving quietly to Gina's side, with the phone on speaker, she smiled and took Gina's hand in hers. With the assistance of the interpreter Hannah said 'hello Gina, how are you feeling? My name is Hannah. I'm a doctor. This must feel very strange and scary to you. You and I are going to deliver your baby very soon but first I will explain what is happening. Are you warm enough? Would you like a blanket?' In a calm voice, Hannah explained what would happen, stopping to check with Gina that she understood and asking whether she had any questions.

Gina became calmer, had almost stopped crying and was paying close attention to what Hannah was saying. Hannah talked to Gina throughout the delivery describing what she was doing and checking that Gina was okay. The baby boy was born healthy and was placed on Gina's chest.

That evening, Hannah went over to see Gina on the ward. She asked whether Gina would like her to contact the interpreter and Gina said she thought they could manage if Hannah spoke slowly. Hannah checked what Gina remembered, why her baby was delivered by C-section and went over things with her again, reassuring her that she and her baby were healthy. Later Hannah reflected on how working with Gina through the birth had improved the experience for Gina, the baby and for herself.

> "I think that the most positive experience is when they have taken what I say seriously and they believe what I'm saying."
>
> **– Female, aged 10**

Next steps

Implementing the framework

The Ministry of Health will work with NSW Health stakeholders and other key agencies to identify specific projects and programs of work to implement the Integrated Trauma-Informed Care Framework. These initiatives will be reflected in the implementation plan drafted by the Ministry of Health. A communications plan and accompanying resources will also be developed to facilitate the implementation of the Integrated Trauma-Informed Care Framework.

Monitoring progress and evaluating outcomes of the framework

The framework is unique and, to the best of our knowledge, integrated trauma-informed care has never been systematically implemented across an entire public health system. For this reason, monitoring its implementation and evaluating the outcomes and benefits of the framework will be critical.

Over time, as implementation progresses and community needs change, elements of the framework may need to be amended to reflect learnings. A 'knowledge to action cycle' will be adopted to ensure continuous learning and the translation of knowledge into action with the aim of ensuring that the direction of the framework remains appropriate. A monitoring and evaluation framework will be developed by the Ministry of Health in consultation with NSW Health stakeholders and other agencies to support this process.

> "I think the man with the needle, if he said it's not going to be very bad, it's just going to be quick and like your brother pinching you, and it will be in and out. Here it is going in and here it is going out. That would have made it perfectly fine."
>
> **— Male, aged 12**

Definitions

Adverse childhood experience	Potentially traumatic events that occur in childhood (0-17 years). For example: experiencing violence, abuse, or neglect such as witnessing violence in the home or community or having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability and bonding, such as growing up in a household with substance use, mental health problems or instability due to parental separation or household members being in jail or prison.[46]
Children and young people	Anyone aged between 0-17 years.
Client	The term client refers to individuals who are using or have used NSW Health services. In some cases this includes family members or carers who rely on NSW Health services to support their family member or person in their care. In the Framework the term client encompasses the terms patient, consumer, families and carers.
Collective trauma	Psychological reactions of a group of people to one or more traumatic events impacting on that group. The size of the group may differ but could include an entire society.
Complex trauma	Trauma arising from repeated exposure to traumatic incidents over a period of time, including both experiencing and witnessing traumatic incidents. Complex trauma is most often associated with histories of multiple traumatic stress exposures and experiences, along with several disturbances in primary relationships. Complex trauma is often severe and pervasive.
Health	Health encompasses not only the physical and mental wellbeing of an individual, but also the social, emotional and cultural wellbeing of the whole community within which each individual is able to achieve their full potential as a human being.[47]
Integrated care	Integrated care is the provision of seamless, effective and efficient care that responds to all of a person's health needs in partnership with the individual, their carers and family.[48]
Integrated trauma-informed care	Integrated trauma-informed care brings together elements of trauma-informed care and integrated care to improve the experiences of clients and staff.
Intergenerational trauma	Intergenerational trauma is a form of trauma transmitted across generations. In Australia, intergenerational trauma is often experienced by the children, grandchildren and future generations of Aboriginal people harmed by government policy, such as the Stolen Generations. For Aboriginal people in particular, the pain and distress of dispossession, past government policies and practices that fractured Aboriginal families and communities, and continuing social and economic marginalisation, continue to affect further generations.
Priority Populations	Groups of people who experience multiple challenges that heighten the likelihood, impact or severity of trauma, as well as experiencing additional barriers to seeking support.[49]

Secondary trauma or re-traumatisation	Refers to experiences that occur after initial trauma as a result of that event or the subsequent actions or inactions of others.[50] This could be brought on by painful medical treatment, adversarial legal action, a child being removed from their family, people's lack of understanding, disbelief, denial, blame, or even poor professional practice.[51] Secondary trauma can have the same impact on a person as the initial exposure to the experience.
Staff	Refers to all individuals that work in NSW Health organisations and services including those providing services on a voluntary basis.
Trauma	Trauma is the response to an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful or life threatening and overwhelms an individual. Adaptive responses to trauma may impact a person's ability to access and engage with services and may impact on overall physical and psychological health.[52]
Trauma-informed care	Trauma-informed care is a systems-level initiative where organisations are oriented towards understanding, recognising and responding to trauma. It is a framework for human services delivery based on knowledge and understanding of how trauma affects people's lives and their service needs.[53] Sometimes trauma-informed care is referred to as a model of care; however, for the purposes of the current document, a systems-level definition is appropriate.
Trauma-specific response	A trauma-specific response is the response of a clinician to disclosures of trauma, violence, abuse or neglect. It can also occur where there is a high degree of suspicion that these may be present. It includes both the immediate response as well as referrals to specialised services where required.
Universal precautions	Universal precautions are based on an assumption that every individual who comes into contact with the health system has experienced trauma. At every interaction of the healthcare experience, precautions are taken to minimise the risk of re-traumatisation to the individual.[54] The term universal precautions is generally used in medicine in relation to infection control measures but has been adapted for use in relation to trauma-informed care.
Vicarious trauma	Vicarious trauma is the transformation or change in a worker's inner experience as a result of responsibility for and empathic engagement with traumatised children or adults. This can result in feelings of compassion, but also responsibility, coupled with varying degrees of helplessness and control.[55]
Vicarious resilience	Vicarious resilience is the idea that while workers are affected by the traumatic stories they hear, they are also bolstered and strengthened by the abilities and recovery shown by the people they work with, finding inspiration and perspective.[56]
Violence, abuse and neglect	An umbrella term used to describe three primary types of interpersonal violence that are widespread in the Australian community. It refers to domestic and family violence, sexual assault and all forms of child abuse and neglect. It also refers to children and young people displaying problematic sexual behaviour or engaging in harmful sexual behaviour, who often have their own experiences as victims of abuse and neglect.[57]
Violence, abuse and neglect (VAN) services	NSW Health services that provide dedicated responses to violence, abuse and neglect generally or a specific form (e.g. sexual assault). Violence, abuse and neglect responses may also be provided by other health services, but this is not their primary responsibility.
Warm referral	Refers to using methods of helping a client connect more easily with another service provider. Contacting the new service provider using a speaker phone while the client is with you, introducing the client to the service and helping them make an appointment is one example of a warm referral.

Appendix

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