Investigation into family and domestic violence and suicide

Volume 4: The need for trauma informed responses

Ombudsman Western Australia

About this Report

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The office of the Ombudsman acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of Australia. We recognise and respect the exceptionally long history and ongoing cultural connection Aboriginal and Torres Strait Islander people have to Australia, recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander people and pay respect to Elders past, present and emerging.

CONTENT WARNING

This report contains information about suicide, family and domestic violence and child abuse that may be distressing. We wish to advise Aboriginal and Torres Strait Islander readers that this report also includes information about Aboriginal and Torres Strait Islander women and children who died by suicide.

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Ombudsman Western Australia is one of the oldest Ombudsman institutions in the world. The Ombudsman is an independent and impartial officer who reports directly to Parliament. The Ombudsman receives, investigates and resolves complaints about State Government agencies, local governments and universities, undertakes own motion investigations, reviews child deaths, reviews family and domestic violence fatalities and undertakes inspection, monitoring and other functions.

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The office of the Western Australian Ombudsman takes pride in diversity and equal opportunity. The office stands with the LGBQTIA+ community. The Ombudsman's pronouns are he/him/his.

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Ombudsman Western Australia acknowledges Aboriginal and Torres Strait Islander people of Australia as the traditional custodians of this land. We recognise and respect the long history and ongoing cultural connection Aboriginal and Torres Strait Islander people have to Australia, recognise the strength, resilience and capacity of Aboriginal and Torres Strait Islander people and pay respect to Elders past, present and emerging.

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Contents

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Getting help and finding support

If a life is in danger, or someone you know is at immediate risk of harm, call 000.

If you, or someone you are with is highly distressed, feeling unsafe and thinks they are a risk to themselves, go to your nearest emergency department.

If you are worried about a person who refuses to go to an emergency department, and need urgent mental health assistance, please contact:

Mental Health Emergency Response Line: 1300 55 788 (Perth) or 1800 676 822 (Peel)

rapid response for after-hours mental health emergencies in the Perth and Peel metro areas, or connection to your local mental health service during business hours

Rurallink: 1800 552 003 (regional Western Australia, free call)

specialist after hours mental health telephone service for people in rural communities, 4.30 pm to 8.30 am, Monday to Friday and 24 hours Saturday, Sunday and public holidays, and for connection to your local mental health service during business hours

Suicide Call Back Service: 1300 659 467 or suicidecallbackservice.org.au

free phone, video and online counselling for people at risk of suicide, concerned about someone at risk, bereaved by suicide and people experiencing emotional or mental health issues

Child and Adolescent Mental Health Service Crisis Connect: 1800 048 636

phone and online videocall support for children and young people experiencing a mental health crisis as well as support and advice to families and cares, available seven days a week from 8.30 am to 2.30 pm across the Perth metro area

Australia-wide 24 hour mental health support lines

Lifeline: 13 11 14 or lifeline.org.au

24 hour telephone crisis support and suicide prevention online crisis support chat available from 7 pm to midnight AEST

13 YARN 13 92 76

the first national crisis support line for mob who are feeling overwhelmed or having difficulty coping, they offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal & Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week

Beyond Blue: 1300 22 4636 or beyondblue.org.au

immediate support available 7 days a week, through phone (24 hours), online chat (3 pm to 12 am) or email (response within 24 hours)

1800RESPECT: 1800 737 732 or 1800respect.org.au

24 hour phone and web chat counselling for people impacted by sexual assault, domestic or family violence and abuse

MensLine Australia: 1300 78 99 78 or mensline.org.au

phone, video and web counselling for men who want to take responsibility for their violence and have healthy and respectful relationships

StandBy Support After Suicide: 1300 72 77 47

a program focused on supporting anyone who has been bereaved or impacted by suicide at any stage in their life

Additional support services

Women's Domestic Violence Helpline: 1800 007 339

provides support for women, with or without children, who are experiencing family and domestic violence in Western Australia (including referrals to women's refuges)

Men's Domestic Violence Helpline: 1800 000 599

provides telephone information and referrals for men in Western Australia who are concerned about their violent and abusive behaviours

Crisis Care: 9223 1111 or 1800 199 008

provides Western Australia's after-hours response to reported concerns for a child's safety and wellbeing and information and referrals for people experiencing crisis

Sexual Assault Resource Centre: (08) 6458 1828 or freecall 1800 199 888

provides a range of free services to people affected by sexual violence

Derbarl Yerrigan Health Service: 9241 3888 or dhys.org.au

health and medical support for Aboriginal people, including counselling, Mon-Fri 9 am to 5 pm

SANE Australian Helpline: 1800 18 SANE (7263) or sane.org

phone, web chat or email counselling support for people affected by complex mental health issues, available from 10 am to 10 pm AEST

GriefLine: 1300 845 745 (landlines) or (03) 9935 7400 (mobiles) or griefline.org.au

free phone counselling and support for people experiencing grief, loss and trauma, 6 am to midnight AEST, seven days a week

Active Response Bereavement Outreach (ARBOR): 1300 11 44 46 or arbor.bereavement@anglicarewa.org.au

a free service offering short-medium term grief counselling, practical & emotional support, appropriate referral support, volunteer lived-experience peer support, and support groups to people recently impacted by losing loved ones to suicide

QLife: 1800 184 527 or qlife.org.au

3 pm to midnight, 7 days per week, telephone and webchat counselling for LGBTI people

Support services for children and young people

Kids Helpline: 1800 55 1800 or kidshelpline.com.au

24 hour telephone and web chat support for kids, teens and young adults from 5 to 25 years and their parents, carers, teachers, and schools

headspace: headspace.org.au/eheadspace

free telephone and online support and counselling for children and young people 12 to 25 years, their families and friends

Children and Young People Responsive Suicide Support (CYPRESS): 1300 11 44 46 or info@anglicarewa.org.au

support service for children and young people between the ages of 6 and 18 who have been bereaved by suicide

Translating and interpreting

If you are assisting someone who does not speak English, first call the Translating and Interpreting Service (**TIS**) on 13 14 50 and they can connect you with the service of your choice and interpret for you.

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1 Overview

Volume 1 of the investigation report, *Executive Summary*, outlines the role of the Ombudsman, the objectives and methodology of the investigation and a summary of the findings and recommendations.

Volume 2 of the investigation report, *Understanding the impact of family and domestic violence and suicide*, outlines the reasons why family and domestic violence increases the risk of suicide and self-harm in women and children, as identified in the research literature. It also explores what family and domestic violence looks like and feels like for victims and presents important context about family and domestic violence and suicide in Western Australia, including:

- definitions of family and domestic violence;
- coercive controlling behaviour;
- research examining the nature of family violence among Aboriginal and/or Torres Strait Islander people, families and communities; and
- research examining the impact of family and domestic violence upon children and adolescents.

Volume 3 of the investigation report, *Contact between victims of family and domestic violence who died by suicide and State government departments and authorities* details the Office's consideration of the deaths of 68 Western Australian women and children who were victims of family and domestic violence and died by suicide during the investigation period, and:

- includes an overview of state-wide WA Police data relating to family and domestic incidents between 1 January and 31 December 2017 (the investigation period);
- sets out how family and domestic violence is identified in the records of the WA Police Force, courts hearing restraining order proceedings, corrective services, hospitals and child protection services in Western Australia;
- details the instances where records show that the 68 women and children who died by suicide had experienced repeat or persistent violence;
- sets out patterns of contact, including the time between the victim's most recent contact with each agency prior to their death; and
- explores differences in the patterns and trends between the 68 women and children State government departments and authorities.

This volume of the investigation report, *Volume 4: The need for trauma informed responses*, identifies the current systemic responses to family and domestic violence provided by State government departments and authorities. It explores the need for agencies to continuously improve their focus on achieving safety for women and children and provide trauma informed services to better meet their needs.

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2 The Ombudsman's Child Death Review function

The Child Death Review function enables the Ombudsman to review investigable deaths. Investigable deaths are defined in section 19A(3) of the Ombudsman's legislation, the *Parliamentary Commissioner Act 1971,* and occur when a child dies in any of the following circumstances:

- In the two years before the date of the child's death:
    - The Chief Executive Officer (CEO) of the Department of Communities (Communities) had received information that raised concerns about the wellbeing of the child or a child relative of the child;
    - Under section 32(1) of the *Children and Community Services Act 200*4, the CEO had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child; and
    - Any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child.

- The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child.

In particular, the Ombudsman reviews the circumstances in which and why child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths.

The Ombudsman commenced the Child Death Review function on 30 June 2009.

In the Ombudsman's 2020-21 Annual Report, analysis highlighted a number of social and environmental factors that were associated with investigable child deaths. Reviews of investigable deaths often highlight the impact of these factors on the circumstances leading up to the child's death and, where this occurs, these factors are recorded to enable an analysis of patterns and trends to assist in considering ways to prevent or reduce future deaths.

The Office identified that family and domestic violence was identified in almost three quarters (74 per cent) of investigable child death reviews for the period 30 June 2009 to 30 June 2021. The following observations were also made:

- Where family and domestic violence was present:
    - parenting was a co-existing factor in nearly two-thirds of the cases;
    - alcohol use was a co-existing factor in over half of the cases;
    - drug or substance use was a co-existing factor in over half of the cases;
    - homelessness was a co-existing factor in over a quarter of the cases; and
    - parental mental health issues were a co-existing factor in over a third of the cases.[1]

[1] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, OWA, Perth, 2021, p. 70.

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3 The Ombudsman's Family and Domestic Violence Fatality Reviews

Following a State government working group process examining models for a family and domestic violence fatality review process, the (then) State government requested that the Ombudsman undertake responsibility for the establishment of a family and domestic violence fatality review function.

On 1 July 2012, the Office commenced its Family and Domestic Violence fatality review function. In the Ombudsman's 2020-21 Annual Report, analysis highlighted that:

> In 44 (61%) of the 72 intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or to other public authorities. In 13 (33%) of the 40 non-intimate partner fatalities involving alleged homicide finalised between 1 July 2012 and 30 June 2021, alleged family and domestic violence between the parties had been reported to WA Police Force and/or other public authorities.[2]

3.1 Previous own motion investigations

Following the establishment of the Ombudsman's Child Death Review and Family and Domestic Violence Fatality Review functions, the Office has undertaken a number of own motion investigations relating to suicide by children and young people and family and domestic violence fatalities.

The work of the Office in undertaking own motion investigations has consistently highlighted experiences of violence, abuse, and trauma in the lives of individuals who have gone on to die by suicide, and in the lives of individuals who have been killed as a result of family and domestic violence. This work has also highlighted the significant patterns of contact that many individuals affected by violence, abuse, and trauma had with State government departments and authorities prior to their deaths.

3.1.1 *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people* (the 2014 Investigation)

As part of the 2014 Investigation, the Office examined the deaths of 36 young people who died by suicide. The Office identified four groupings of young people, distinguished from each other by patterns in the factors associated with suicide that each group experienced.

Group 1 included 'twenty young people who all were recorded as having allegedly experienced one or more forms of child maltreatment, including family and domestic violence, sexual abuse, physical abuse or neglect. Most of the 20 young people in Group 1 were also recorded as having experienced mental health problems and suicidal ideation and behaviour:'

- all of these 20 young people allegedly experienced some form of child maltreatment including family and domestic violence, sexual abuse, physical abuse or neglect;
- 19 of these young people were recorded as having allegedly experienced child maltreatment in conjunction with other factors associated with suicide; and

[2] Ombudsman Western Australia, *Ombudsman Western Australia Annual Report 2020-21*, OWA, Perth, 2021, p. 133.

- as a group, these 20 young people had extensive contact with State government departments and authorities.[3]

The 2014 Investigation identified that 17 of the 20 young people in Group 1 were recorded as having allegedly experienced more than one form of child maltreatment and were therefore likely to have suffered cumulative harm. The Office highlighted research literature identifying that, when responding to child maltreatment, child protection authorities need to undertake holistic assessments to recognise cumulative harm. Accordingly, the 2014 Investigation made the following recommendation:

> Recommendation 9: The [then] Department for Child Protection and Family Support considers whether an amendment to the Children and Community Services Act 2004 should be made to explicitly identify the importance of considering the effects of cumulative patterns of harm on a child's safety and development.[4]

3.1.2 *Preventing suicide by children and young people 2020 Volume 3: Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people* (the 2020 Investigation)

In addition to the 36 deaths by children and young people examined in the 2014 Investigation, the 2020 Investigation examined records relating to an additional 79 children and young people who died by suicide following the 2014 Investigation. Collectively, these young people are referred to as the 115 children and young people.

The 2020 Investigation identified that:

- 70 of the 115 children and young people (61 per cent) were recorded as having experienced multiple factors associated with suicide;
- each of the 70 children and young people was recorded as having allegedly experienced some form of child abuse or neglect; and
- 64 of these 70 children and young people (91 per cent) were recorded as having allegedly experienced child abuse or neglect in conjunction with other factors associated with suicide, including suicidal ideation, mental health issues, substance and adverse family experiences.[5]

The 2020 Investigation highlighted that children and young people who experience cumulative harm and complex trauma arising from child abuse or neglect are at higher risk of suicide and other mental health issues. Accordingly, the 2020 Investigation made the following recommendation:

[3] Ombudsman Western Australia, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, 2014, p. 67-74.
[4] Ombudsman Western Australia, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, 2014, p. 116-122.
[5] Ombudsman Western Australia, *Preventing suicide by children and young people 2020 Volume 3: Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people*, 2020, p. 181.

Recommendation 6: That the Department of Communities provides the Ombudsman with a report within 12 months of the tabling of this investigation, detailing the proposed strategies to address the following issues raised in this report relating to:

- identifying and appropriately responding to children and young people and families who are the subject of multiple interactions raising concerns about their wellbeing;
- the Department's response to interactions raising concerns that a child or young person with a child protection history is at risk of harm as a result of self-harm or suicidal behaviours, including suicide attempts of a parent, carer or guardian; and
- identifying, and responding appropriately to, children and young people who are in care of the CEO of the Department (or who have left care of the CEO) who are exhibiting escalating self-harm and/or risk-taking behaviours;

including the measures by which the progress of these strategies will be monitored and evaluated.[6]

3.1.3 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities* (the 2015 Investigation)

As part of the 2015 Investigation, the Office examined the fatalities of 30 people who were killed where the relationship between the person who was killed and the suspected perpetrator was a family and domestic relationship. The Office's further analysis of these 30 fatalities identified that, for 24 individuals (80 per cent), there was a prior recorded history of family and domestic violence:

- for 16 of these individuals, there was a recorded prior history of family and domestic violence involving the person who was killed and the suspected perpetrator;
- for eight of the fatalities, there was a recorded prior history of family and domestic violence involving either the person who was killed and a third party, or the suspected perpetrator and a third party; and
- the Office also identified that, in 17 of the 30 fatalities (57 per cent), Violence Restraining Orders involving at least one of the people involved in the fatality were granted at some point in time.

The 2015 Investigation made 54 recommendations to State government departments and authorities. These recommendations related to victims, perpetrators, and children affected by family and domestic violence, and strategic planning and responses to Aboriginal family violence.

[6] Ombudsman Western Australia, *Preventing suicide by children and young people 2020 Volume 3: Investigation into ways that State government departments and authorities can prevent or reduce suicide by children and young people*, OWA, Perth, 2020, p. 236.

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4 Patterns and trends in victims' contact with State government departments and authorities prior to their death

4.1 Victims of family and domestic violence who died by suicide had significant contact with State government departments and authorities

In Volume 3, the Office analysed patterns of contact between the 68 women and children victims of family and domestic violence who died by suicide and State government departments and authorities, including:

- family and domestic violence related contact with the WA Police Force; and
- contact with health, corrective services and child protection services.

The Office identified that many of the 68 women and children had high levels of contact with State government departments and authorities.

This finding aligns with findings of the Queensland Domestic and Family Violence Death Review and Advisory Board, which highlights that 'in comparison with the service system contact recorded for domestic and family violence related homicides, cases that ended in a suicide death had greater contact with a range of services, suggest[ing] that there could be greater opportunities to intervene to help prevent these deaths.'[7]

4.1.1 Patterns in contact among the 68 women and children demonstrate significant demand for crisis services in the absence of available longer-term support

Western Australia's *Aboriginal Empowerment Strategy* identifies that 'government services generally fall into three basic categories, based on how intensive, urgent or reactive they are. Different sectors use different terminology for these categories (and different numbers of categories), however the table below shows the key basic characteristics:'[8]

[7] Queensland Domestic and Family Violence Death Review and Advisory Board, *2018-2019 Annual Report*, 2019, p. 40.
[8] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 32.

Table 1: Types of Government Services, as identified in Western Australia's Aboriginal Empowerment Strategy

Primary Preventative Universal Resilience	Secondary Restorative / Early intervention Targeted Stabilisation	Tertiary Reactive Mandatory / Statutory Crisis
Support wellbeing, foundational needs and capacities, inclusion, and protective factors, before issues arise	Reduce vulnerability and the risk factors leading to the need for crisis response	Provide safety and protection of self or others from identified risk
EXAMPLES • Parenting and early years • Youth recreation • Cultural programs and healing • Education and skills • Community infrastructure • Public health initiatives • Safe and stable housing	EXAMPLES • Youth Diversion • Youth diversion programs • Tenancy supports • Financial counselling • Rehabilitation facilities • Family counselling	EXAMPLES • Prisons • Hospitals • Children in out-of-home care • Women's refuges

Source: Aboriginal Empowerment Strategy[9]

In this context, the Aboriginal Empowerment Strategy identifies that prisons, hospitals, children in out-of-home care, and women's refuges are examples of tertiary, reactive, or crisis responses:

> These services are more cost-intensive, depend more on involuntary or coercive engagement, and involve higher risks. If current trends continue, demand for these "downstream" services is set to increase significantly in coming years.[10]

4.1.2 The underlying drivers of demand for crisis-oriented service provision are also inherently related to suicide prevention

Key Western Australian inquiries and strategic frameworks have highlighted the need to address the underlying drivers of demand upon crisis responses, including in the context of suicide prevention.

In the State Coroner's 2017 *Inquest into the deaths of 13 children and young persons in the Kimberley*, the Coroner elevated the voices of key stakeholders in the Kimberley. In identifying 'proximal causes' that 'trigger a suicide or suicidal attempt,' including 'alcohol and other drug use/misuse, relationship difficulties and/or family conflict/violence,' stakeholders identified that these factors are underpinned by issues such as 'historical trauma, racism, economic disadvantage and cultural breakdown rather than mental illness or alcohol abuse. The Coroner also identified other contributing factors such as family relationships, poor living conditions, boredom and hopelessness, highlighting a paper by the Kimberley Aboriginal Health Planning Forum which concluded that:'

> Suicide and self-harm are tragic symptoms not of mental illness, but of underlying inter-related social/historical/political factors which are not modifiable by the mental health interventions currently available in the Kimberley. To prevent

[9] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 32.
[10] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.

> further suicides a broad response which builds resilience and addresses causal factors, and is designed and implemented by local Aboriginal people, has to be the way forward. In addition, it should be noted that it would be unproductive to consider suicide in isolation from other related issues such as child sexual abuse, alcohol abuse/other addictive behaviours, jealousing, family/domestic violence and incarceration in prison. All these issues have vastly elevated rates across the Kimberley, and this is no coincidence. They each share very similar or identical causes and feed into each other in a relentless and perpetual cycle.[11]

The importance of addressing the underlying drivers demand upon crisis services has also been highlighted by Western Australia's Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 in Western Australia (**the Ministerial Taskforce**). The Ministerial Taskforce was established in early 2021 following the Chief Psychiatrist's review into the care of Kate Savage, a 13-year-old who tragically died while under the care of the Child and Adolescent Health Service.

In examining mental health related service provision to Western Australian infants, children, and adolescents, Ministerial Taskforce Chair Robyn Kruk AO set out 10 overarching and emerging directions that Taskforce believe are critical in securing better mental health outcomes for children and strengthening support for families, including to:

> Recognise the importance of providing appropriate interventions early in a child's life rather than allowing crisis situations to escalate.[12]

In reviewing the apparent suicides of Aboriginal and/or Torres Strait Islander adolescents, Queensland's Death Review and Advisory Board has also highlighted that high levels of service system contact were reactive to key issues in adolescents' lives:

> There was a high level of service system contact within the cases. … the service response was symptomatic and there was a distinct lack of early intervention or support programs to address underlying trauma in the young person's life or to provide any services in a culturally safe way.[13]

Western Australia's Aboriginal Empowerment Strategy notes that 'preventative and early intervention initiatives can bring about positive changes that reduce the need for crisis responses. Initiatives in this category proactively build up resilience, capability, healing, and independence – in short, self-determination.'[14] Accordingly, a key element of the Aboriginal Empowerment Strategy therefore requires the State government to invest 'in building strengths, prevention and earlier intervention' and:

i) Invest in initiatives that build strengths, reduce vulnerability through prevention and early intervention, and minimise the later need for crisis responses; and

ii) Improve the integration of services. [15]

[11] *Inquest into the deaths of 13 children and young persons in the Kimberley* (Coroner's Court of Western Australia, Coroner RVC Fogliani, 7 February 2019) 33.
[12] Ministerial Taskforce into Public Mental Health Services for Infants, Children, and Adolescents aged 0-18 in Western Australia, *Emerging Directions: The Crucial Issues For Change*, 2021, p. 6.
[13] Queensland Domestic and Family Violence Death Review and Advisory Board, *2018-2019 Annual Report*, 2019, p. 9.
[14] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.
[15] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 33.

4.2 The research literature consistently identifies that victims of family and domestic violence act to resist violence perpetrated against them and protect their children

The research literature identifies that victims of family and domestic violence use a wide array of strategies to resist violence, and that the way in which victims respond to and resist violence depends upon the dangers and opportunities of their specific circumstances.[16]

Victims may resist violence utilising covert and overt strategies.[17] Overt resistance strategies used by victims can include openly challenging the perpetrator's behaviour; 'accessing formal and/or informal help' and/or separating from the perpetrator, which can involve 'a range of autonomous behaviors that directly challenge [sic]' a partner's control.[18] Covert resistance involves taking action without the perpetrator knowing about it, such as 'storing away personal objects or thinking about something else during an abusive incident.'[19] In this context, the research literature observes that 'victims are acutely aware that any defiant acts will be matched by an increase in the perpetrator's violence,' and that 'agency and service records serve as a testament that victims' acts of resistance are generally overlooked and unrecognised.[20]

Family and domestic violence researchers also identify that some protective strategies employed by victims may create the perception that a victim is also a perpetrator of violence or not responding in a way that may align with expectations, such as 'fighting back or defying the [perpetrator],' or using or abusing substances as an 'escape' or to numb physical pain.[21]

> Although these protective strategies act as coping and survival mechanisms for victims, they are frequently misinterpreted by laypersons and professionals who view the victim's behavior as uncooperative, ineffective, or neglectful.[22]

Researchers identify that for some victims use of force is 'not always defensive … often it is more aptly described as "violent resistance"', through which some women respond to a violent partner with violence to stop or reduce the violence, or in 'anger, frustration or retaliation.'[23] In resisting and responding to violence with the use of force, or in demonstrating behaviour that is likely to 'challenge our culture's dominant 'real' victim stereotype,' the actions of some victims are not seen in the context of broader violence:

> Significantly … victims of family violence might engage in defensive or retaliatory behaviours as a response to violence. Where police use an incident-specific lens

[16] For example, Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 28
[17] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[18] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 5.
[19] Hayes B, *Women's Resistance Strategies in Abusive Relationships: An Alternative Framework*, 2013, John Jay College of Criminal Justice, New York, p. 3.
[20] Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington, p. 27-28.
[21] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 28.
[22] Lien Bragg H, *Child Protection in Families Experiencing Domestic Violence*, 2003, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Washington, D.C, p. 29.
[23] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.

> and do not see the context of the violence, this may erode the legitimacy of a woman's [or victim's] 'victimhood'.[24]

Researchers identify that these factors influence police decision making.[25] In 2010, the Australian Law Reform Commission observed that, if police 'fail to identify the "primary aggressor" and the "primary victim" when attending a scene of family violence,' 'this may mean that victims are wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them.'[26] A Western Australian stakeholder observed that:

> The view put forward by the Western Australia Police is that, although understanding the nature of domestic violence is crucial to ensuring an effective response, ultimately members are only able to respond to the circumstances before them. In ambiguous circumstances, an understanding of who is likely to be the primary aggressor will be a useful guide. However, if the female is the one who clearly appears to be threatening to commit an act of family and domestic violence, the police are obliged to respond to the circumstance before them. According to police, this means that, just as it is not the role of police to take into consideration circumstances that may amount to a defence when considering whether to arrest for the commission of an offence, police are obliged to issue an order against the woman notwithstanding that she may have been subjected to acts of domestic violence many times in the past.[27]

The research literature consistently identifies that victims of family and domestic violence act to resist violence perpetrated against them and to protect themselves and their children, and/or seek help.[28] At times, victims' decisions about how they resist violence and attempt to protect themselves do not align with the expectations of outsiders or State government departments and authorities. This does not negate their experiences as victims of family and domestic violence, and does not mean that victims do not need, want, or are less deserving of help.

4.3 Perpetrators seek to avoid accountability for their violence and may manipulate institutions to maintain power and control over their victims

The research literature suggests that perpetrators of family and domestic violence will take steps to avoid being held accountable for their behaviour, including instances where perpetrators may present the violence as mutual or joint, both to avoid responsibility and to

[24] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 4.
[25] Women's Legal Service Victoria, *Policy Paper 1: "Officer she's psychotic and I need protection": Police misidentification of the 'primary aggressor' in family and domestic violence incidents in Victoria*, 2018, Monash University and Women's Legal Service Victoria, p. 3.
[26] Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2010, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[27] Centacare Safer Families Support Service, quoted by Australian Law Reform Commission, *Family Violence – A National Legal Response*, 2020, viewed 21 June 2021 <https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/9-police-and-family-violence-2/identifying-the-primary-aggressor/>.
[28] For example, Wilson D, Smith R, Tolmie J and de Haan I, *Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence*, 2015, Institute for Governance and Policy Studies, Victoria University of Wellington.

shift responsibility to the victim.[29] This includes where perpetrators describe violence as an 'argument' or 'retaliation' or allege that a victim is an unfit or incapable parent.[30]

Examples of strategies used by perpetrators to manipulate institutions and maintain control over a victim include:

- Threatening to call Child Protective Services … and making actual reports that his partner neglects or abuses the children.
- Changing lawyers and delaying court hearings to increase his partner's financial hardship.
- Telling police officers she hit him, too.
- Giving false information about the criminal justice system to confuse his partner or prevent her from acting on her own behalf.[31]

The Department of Communities identifies that collusive child protection practice entails significant risk of endangering women and children's safety, observing that:

> Men who perpetrate violence can be persuasive and subtle in the ways they downplay, deny, justify and rationalise their behaviour. Furthermore, they hold implicit beliefs—about women, relating to women and relationships—that enable them to feel right and vindicated regarding their behaviours and to perceive themselves as the victim in their interpersonal relationships.
>
> When you are trying to engage a perpetrator of family and domestic violence, it is very likely that he will try to get you to collude with his narrative about the violence, perhaps by:
>
> - presenting as calm, collected and reasonable;
> - presenting his (ex)partner as irrational, unreasonable or mentally ill;
> - lying about or omitting known facts, or presenting a partial picture;
> - claiming his partner is lying or fabricating evidence;
> - claiming 'the system' is out to get him;
> - speaking on behalf of his (ex)partner—especially if he is her carer;
> - claiming the violence is mutual;
> - acknowledging some wrongs while not accepting responsibility; or
> - attempting to use humour or other forms of charm to win you over.
>
> … If you collude, you might reinforce the perpetrator's violence-supporting narratives, at considerable cost to his family members.[32]

As identified in the Ombudsman's 2015 *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, it is critically important that all State government departments and authorities working with women and child victims of family and domestic violence are aware of the risk of being manipulated by perpetrators.

[29] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 12.
[30] Chung D, Green D, Smith G et al, *Breaching Safety: Improving the Effectiveness of Violence Restraining Orders for Victims of Family and Domestic Violence*, 2014, The Women's Council for Domestic and Family Violence Services, Perth, p. 11.
[31] Alabama Coalition Against Domestic Violence, *Why do Abusers Batter?*, Alabama Coalition Against Domestic Violence, cited by Ombudsman Western Australia *Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities*, 2015, p. 129.
[32] Government of Western Australia, *Perpetrator Accountability in Child Protection Practice*, 2013, Department for Child Protection and Family Support, Perth, p. 47-48.

5 Providing effective service responses to family and domestic violence and suicide

5.1 We know enough to begin incorporating understandings of the association between family and domestic violence and suicide into service responses

The Office notes that systematic reviews and the work of other Australian jurisdictions has demonstrated a significant association between family and domestic violence and suicide.[33] As one expert examining the connection between suicide among females and children experiencing family and domestic violence succinctly stated: 'We know enough to know we should be seriously concerned about this.'[34]

In Queensland, the Domestic and Family Violence Death Review and Advisory Board has reported that 'apparent suicides contribute the largest number of domestic and family violence deaths each year in Queensland.'[35] Highlighting 'the apparent correlation between domestic violence perpetration and suicide,' in 2017 the Queensland Domestic and Family Violence Death Review and Advisory Board identified that 'a more responsive service system which identifies and manages this elevated risk is needed:'[36]

> However, the Board recognised that while a heavy onus is often placed on front-line practitioners to manage these types of issues, a broader response which aims to provide the systems, structure and practice framework for staff, is required to ensure that more meaningful support is provided over the longer term.[37]

While cognisant of the research literature's questioning of this association and in acknowledgement of some of the limitations of this work arising from 'the degree of variability in the focus and methods employed,' the Office has also identified instances in other Australian jurisdictions where knowledge about the association between family and domestic violence and suicide has been incorporated into relevant strategies and frameworks.[38]

5.2 Proposals to criminalise coercive control

Increasingly, Australian researchers, advocates and professionals working in the field of family and domestic violence have called for legislative change to criminalise coercive control.[39] These calls were bolstered following the February 2020 murders of Queensland woman Hannah Clarke and her three young children, Aaliyah, Laianah, and Trey. Following

[33] MacIsaac M, Bugeja L and Jelinek G, 'The association between exposure to interpersonal violence and suicide among women: a systematic review,' *Australian and New Zealand Journal of Public Health*, 2016, vol. 41, p. 61.
[34] Prof. Vanessa Munro, quoted by Moore, A. 'Fatal truth: how the suicide of Alex Reid exposed the hidden death toll of domestic violence,' *The Guardian*, 24 March 2021, viewed 10 May 2021 <https://www.theguardian.com/society/2021/mar/24/fatal-truth-how-the-suicide-of-alex-reid-exposed-the-hidden-death-toll-of-domestic-violence>.
[35] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 25.
[36] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 15.
[37] Queensland Domestic and Family Violence Death Review and Advisory Board, *Domestic and family violence death of 'Frank'*, 2017, Queensland Government, Brisbane, p. 15.
[38] McLaughlin J, O'Carroll RE, O'Connor RC, 'Intimate partner abuse and suicidality: A systematic review,' *Clinical Psychology Review,* 2012, 32(8), p. 678.
[39] Bilston G, Cehtel Y, Chilcott B et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.

their deaths, the Queensland Women's Safety and Justice Taskforce 'conducted a wide-ranging review into the experience of domestic and sexual violence victims in Queensland's criminal justice system,' with the report of this review, released in December 2021, subsequently recommending a staged approach to criminalising coercive control in Queensland.[40]

Also in December 2021, in response to recommendations from its Joint Select Committee on Coercive Control, the New South Wales government 'committed to outlawing coercive control in current and former intimate partner relationships.'[41]

Scotland has recently criminalised coercive control, with the *Domestic Abuse (Scotland) Act 2018* being described as 'a new gold standard.'[42] Although the law has only recently come into operation, with 'women's experiences when reporting under the law [varying] from place to place,' researchers have identified that the laws 'are encouraging victims to come forward and report these crimes.'[43] The laws have also 'enabled authorities to punish behaviour with significant jail time that would otherwise have been difficult to prosecute.'[44]

There is ongoing debate surrounding the criminalisation of coercive control in Australia. Some researchers highlight the need for caution when considering the criminalisation of coercive control, noting that successful law reform would 'rely on victims' willingness and ability to involve police,' and police officers being equipped 'to identify the coercive and controlling behaviours,' and the key issue of 'how to prove coercion:'[45]

> Some of these critics are concerned that women could mistakenly be identified as primary aggressors if police aren't properly trained…
>
> Critics are also concerned that a new law could divert vital resources away from domestic violence prevention. They also worry that the male-centric and adversarial nature of the criminal justice system might make it an inappropriate forum to address an issue that overwhelmingly affects women.[46]

Proponents have highlighted that these issues, and concerns 'about the ability of the justice system to protect women … are not issues that are specific to a coercive control offense,'[47] arguing:

> When done right, the introduction of this new offence includes extensive consultation with the domestic and family violence sector; an iterative drafting process that acknowledges the local context in which the offence will operate; and an extensive lead-in period during which everyone – police, prosecutors, the

[40] Gramenz E, 'Task force recommends stages approach to criminalising coercive control in Queensland,' *ABC News*, 2 December 2021, viewed 12 December 2021 <https://www.abc.net.au/news/2021-12-02/queensland-report-coercive-control-released/100668654>.
[41] New South Wales Government, 'Government to criminalise coercive control,' *Media Releases,* 18 December 2021, viewed 19 December 2021 <https://dcj.nsw.gov.au/news-and-media/media-releases/2021/government-to-criminalise-coercive-control.html>.
[42] Brooks L, 'Scotland set to pass 'gold standard' domestic abuse law', *The Guardian*, 1 February 2018, viewed 15 October 2020, <https://www.theguardian.com/society/2018/feb/01/scotland-set-to-pass-gold-standard-domestic-abuse-law>.
[43] Yousaf H, quoted in 'New domestic abuse laws: More than 400 crimes recorded,' *BBC News*, 17 August 2019, viewed 15 October 2020 <https://www.bbc.com/news/uk-scotland-49374667>.
[44] Gearing A, 'Coercive control and domestic abuse: what might have saved Hannah Clarke and her children?', *The Guardian*, 29 February 2020, viewed 15 October 2020 <https://www.theguardian.com/society/2020/feb/29/coercive-control-and-domestic-abuse-what-might-have-saved-hannah-clarke-and-her-children>.
[45] Fitz-Gibbon K, Walklate S and Meyer S, 'Australia is not ready to criminalise coercive control – here's why,' *The Conversation*, 1 October 2020, viewed 12 October 2020 <https://theconversation.com/australia-is-not-ready-to-criminalise-coercive-control-heres-why-146929>.
[46] McGorrery P and McMahon M, 'It's time 'coercive control' was made illegal in Australia, *The Conversation*, April 20 2019, viewed 15 October 2020, <https://theconversation.com/its-time-coercive-control-was-made-illegal-in-australia-114817>.
[47] Bilston G, Cehtel Y, Chilcott B, et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.

> judiciary, other frontline responders, support workers, literally anyone whose work somehow relates to domestic and family violence – is trained about the new offence and coercive control more generally.
>
> The consequent change in thinking could lead to a cultural change that has long been missing in Australia's response to domestic and family violence. We need an entire system ready and willing to identify and appropriately respond to abuse without the incident-based blinders that currently obscure so much of it.[48]

Debate and differences of opinion surrounding the criminalisation of coercive control are not limited to academic, legal, or family and domestic violence researchers. Victim-survivors of family and domestic violence have a breadth of experiences, insights, and concerns that must be heard and harnessed in discussions about criminalising coercive control.

On 29 March 2022, the Western Australian Government commenced a community consultation process on the introduction of coercive control laws, through the release of its *Legislative Responses to Coercive Control in Western Australia: Discussion Paper* and accompanying fact sheet.[49]

In launching the discussion paper, the State government noted that:

> Considering new laws against coercive control raises complex legal, policy and social change issues. Legislative changes or other responses must benefit victim-survivors and not lead to adverse impacts, particularly for vulnerable members of the community.
>
> An important part of the consultation will consider what the current awareness of coercive control is in the community and how frontline responders can recognise these patterns of abuse. [50]

Relevantly, the discussion paper notes that Australian Attorneys-General and the New Zealand Minister for Justice agreed on 9 June 2021 to 'co-design national principles to develop a common understanding of coercive control and matters to be considered in relation to potential criminalisation':

> The national principles will be in two parts:
>
> 1. Part one will establish a common understanding of coercive control, including the impacts on women and vulnerable groups and best practice approaches to systems reforms.
>
> 2. Part two will address high level questions about the nature and scope of any criminal offence of coercive control and associated implementation issues.
>
> The MAG's Family Violence Working Group is leading the development of the national principles, in consultation with women's safety officials and the Women's

[48] Bilston G, Cehtel Y, Chilcott B, et al, 'Coercive control is a form of intimate terrorism and must be criminalised,' *The Guardian*, 6 October 2020, viewed 12 October 2020 <https://www.theguardian.com/commentisfree/2020/oct/06/coercive-control-is-a-form-of-intimate-terrorism-and-must-be-criminalised>.
[49] Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Discussion Paper,* 29 March 2022, Office of the Commissioner for Victims of Crime; Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Fact Sheet,* 29 March 2022, Office of the Commissioner for Victims of Crime.
[50] Government of Western Australia, 'Community to be consulted about tackling coercive control', *Media Statements*, 29 March 2022, accessed 29 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Community-to-be-consulted-about-tackling-coercive-control.aspx>.

> Safety Taskforce, which includes the Ministers for Women in all jurisdictions. The national principles will not consider the arguments for or against criminalisation.[51]

5.3 Some Australian jurisdictions include the association between family and domestic violence and suicide in strategic frameworks

5.3.1 The Victorian *Family Violence Multi-Agency Risk Assessment and Management Framework* highlights the prevalence of family and domestic violence among individuals who die by suicide

In March 2016, Victoria's Royal Commission (**the Commission**) into Family Violence delivered its report with 227 recommendations, including a recommendation to review and redevelop the state's Family Violence Risk Assessment and Risk Management Framework (**the Framework**), and to embed it in Victoria's *Family Violence Protection Act 2008*.[52]

Informed by a range of related reviews and engagement with 1300 stakeholders, the Framework's redevelopment resulted in the Victorian Family Violence Multi-Agency Risk Assessment and Management Framework (**the MARAM Framework**), which 'aims to address the gaps identified by the Commission'[53] and 'provides a system-wide approach to risk assessment and risk management.'[54]

> It creates the system architecture and accountability mechanisms required to establish a system-wide approach to and shared responsibility for family violence risk assessment and management. This is achieved by incorporating the Framework and accompanying principles and pillars into law, regulation, policy (through this MARAM Framework) and supporting materials and practice guides.[55]

The MARAM Framework highlights that in 'Victoria, one-third of people who die by suicide had a history of family violence,' and that 'family violence had been present for half of the women (identified as likely victim survivors) and one-third of men who died by suicide (identified as likely perpetrators).'[56] The MARAM Framework also incorporates a definition of family violence that highlights the connection between this violence and suicide which states that:

> Family violence perpetrated against Aboriginal people and communities includes a range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in families, intimate relationships, extended families, kinship networks and communities.
>
> It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide. Family violence experienced by people in Aboriginal communities acknowledges the spiritual and cultural perpetration of violence by non-Aboriginal people against Aboriginal partners which manifests as exclusion or isolation from Aboriginal culture and/or community.[57]

[51] Government of Western Australia, *Legislative Responses to Coercive Control in Western Australia: Discussion Paper,* 29 March 2022, Office of the Commissioner for Victims of Crime, p. 5.
[52] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[53] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[54] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 3.
[55] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 5.
[56] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 94.
[57] Victorian Government, *Family Violence Multi-Agency Risk Assessment and Management Framework*, 2018, p. 9.

The MARAM Foundation Knowledge Guide highlights the 'unique suicide risk factors' experienced by adolescent perpetrators of family violence which are 'compounded by increased risk of suicide for young people who have experienced family violence as victim survivors':

> The 2019 Commissioner for Children and Young People report *Lost, not forgotten* identified that:
>
> "… as children grow older and their trauma starts to manifest in challenging behaviour, disengagement from school, risk taking, violence or mental ill health, professionals lose empathy. The children become seen as the problem and referred to as 'difficult', 'needy', 'angry' and 'bad.'" [58]

In addition, the MARAM Foundation Knowledge Guide recognises the vulnerability the increased likelihood of suicide by children and young people who experience family and domestic violence … at all points along the journey from seeking safety to recovery and health' noting that:

> The risks of suicide are extremely high in young LGBTIQ people, particularly trans and gender-diverse young people. For LGBTIQ young people, this additional high risk is compounded by an increased risk if they have experienced family violence. …
>
> In Victoria, one-third of people who die by suicide had a history of family violence. Family violence had been present for half of the women (identified as likely victim survivors) …[59]

Importantly the MARAM Framework and Foundation Knowledge Guide requires specialist family and domestic violence staff to be 'trained to undertake Comprehensive assessment of risks, needs and protective factors for adult and children victim survivors' and acknowledges the limitations of traditional approaches to suicide risk assessment and encourages professionals to make use of:

> … emerging suicide prevention research and practice [which] places less emphasis on 'risk assessment', and more on identifying the drivers of suicidality and an individual's intent … [and] Also consider referrals to manage social distresses that increase suicide risk, such as employment, financial and housing issues and drug and alcohol addition/use. [60]

5.3.2 The Queensland *Suicide prevention framework for working with people impacted by domestic and family violence* acknowledges that 'suicides contribute the largest number of domestic and family violence deaths in Queensland each year' and that 'suicide is a risk factor across the entire spectrum of responses to people impacted by domestic and family violence'

The Queensland Government's *Suicide prevention framework for working with people impacted by domestic and family violence* (**the Queensland Suicide Prevention Framework**) was developed following a recommendation by the Queensland Domestic and Family Violence Death Review and Advisory Board (**the Board**), which is responsible for the systemic review of domestic and family violence deaths in Queensland:

[58] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 19 and 101.
[59] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 85 and 94.
[60] Victorian Government, *MARAM Practice Guides Foundation Knowledge Guide*, 2021, p. 101.

> The Board reviewed two deaths (suicides) that occurred within women's shelters due to overdose of prescribed medication during 2016-17.
>
> As a result of this review, the Board recommended that a targeted suicide prevention framework, which accounts for the detection of, and response to, vulnerable individuals be developed and implemented within domestic and family violence shelters…
>
> In responding to this recommendation, the Queensland Government expanded the scope, to be applicable to all specialist practitioners working with people impacted by domestic and family violence. This decision was made in acknowledgement that suicide is a risk factor across the entire spectrum of responses to people impacted by domestic and family violence (including perpetrators), not only a risk for victim/survivors when they are in shelters.[61]

The Queensland Suicide Prevention Framework 'aims to guide practitioners who work with people impacted by domestic and family violence (including both victim/survivors and perpetrators) in Queensland, to effectively support people who may be at risk of suicide.'[62] Importantly, the Queensland Suicide Prevention Framework states:

> Domestic and family violence specialist workers are not expected to be researchers in suicide prevention. This Framework is intended to be used as a guide to inform best practice suicide prevention responses and referral to mental health researchers, to ensure clients and their children/dependants can access the support they need.[63]

The Queensland Suicide Prevention Framework identifies that suicide risk screening 'is used to identify whether there is risk of suicide present and should always be considered as part of routine risk screening processes when working with people impacted by domestic and family violence.' If the screening process identifies that there may be risk of suicide, it specifies that 'a thorough suicide risk assessment needs to take place by a clinician or relevant professional to inform appropriate safety strategies, referral options and treatment.'[64]

> Risk of suicide is not a static event, and may fluctuate as circumstances change for a person. Ongoing suicide risk screening is particularly important during periods of elevated risk, such as separation from a partner. For victim/survivors, this may also include contact with a violent perpetrator, or further exposure to domestic and family violence, and for perpetrators, it may include risk of the victim/survivor leaving the relationship or loss of control.[65]

[61] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 1-2.
[62] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 3.
[63] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 3.
[64] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 6.
[65] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, p. 9.

The Queensland Suicide Prevention Framework also:

- provides guidance about talking to people impacted by family and domestic violence, noting that 'research suggests that direct questions about suicidal thoughts or behaviours are appropriate and do not increase the risk of suicide,' and that 'questions should gauge the presence of suicide intent, as well as if the client has a plan for suicide;'[66]
- details warning signs and risk factors which 'may indicate a person has elevated suicide risk and requires a thorough assessment;'
- identifies response and referral pathways, and when these should be used;[67] and
- provides information about working with diverse and/or high-risk groups.[68]

5.4 There is some recognition of the association between family and domestic violence and suicide in Western Australian strategic frameworks

5.4.1 *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* identifies that 'family and domestic violence towards children, young people, and adults is a primary cause of … suicide and self-harm'

On 22 July 2020, the State Government launched *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* (**Path to Safety**), Western Australia's strategy for reducing and responding to family and domestic violence.

The Path to Safety framework for change has 'four focus areas:'

- work with Aboriginal people to strengthen Aboriginal family safety;
- act immediately to keep people safe and hold perpetrators to account;
- grow primary prevention to stop family and domestic violence; and
- reform systems to prioritise safety, accountability and collaboration.[69]

> Path to Safety will be supported by three action plans 'that set out what needs to be done to achieve the long-term vision of all Western Australian's living free from family and domestic violence.' The First Action Plan, running from July 2020 to June 2022, initially focuses on 'actions to address the significant impact of COVID-19 on family and domestic violence in Western Australia.'[70]

Path to Safety identifies that 'family and domestic violence towards children, young people, and adults is a primary cause of … suicide and self-harm.'[71]

[66] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 9.
[67] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 13.
[68] Queensland Government, *Suicide Prevention Framework for working with people impacted by domestic and family violence*, 2021, p. 18.
[69] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence*, 2021.
[70] Government of Western Australia, *Western Australia's Strategy to Reduce Family and Domestic Violence*, 2021.
[71] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, Government of Western Australia, p. 17.

Recommendation 6: The Department of Communities, in consultation with key government and non-government stakeholders, considers this investigation and incorporates the findings of the investigation into strategic initiatives aimed at reducing the incidence and impact of suicide and self-harm associated with family and domestic violence, including incorporation into Path to Safety beyond the First Action Plan.

5.4.2 The Western Australian Suicide Prevention Framework acknowledges 'the role that addressing historical and current trauma and the social determinants of health have in suicide prevention'

Authored by the Mental Health Commission, the *Western Australian Suicide Prevention Framework 2021-2025* (**the WA Suicide Prevention Framework**) was developed for use 'as a guide by government, non-government, communities and private organisations, so that a coordinated approach can be taken to suicide prevention activity across Western Australia.'[72]

The WA Suicide Prevention Framework acknowledges 'the role that addressing historical and current trauma and the social determinants of health have in suicide prevention' including 'childhood trauma, family violence, poverty, insecure housing, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use [and] … the impact of colonisation and systemic racism [on Aboriginal people].'[73]

The WA Suicide Prevention Framework also recognises that 'addressing the social determinants that drive hopelessness and have a marked impact on an individual's social connections, mental health and suicidality' is seen as 'the most pressing activity for suicide prevention in the near and long term' in some communities.[74]

The WA Suicide Prevention Framework further highlights the need for holistic supports for people experiencing vulnerability, including victims of family and domestic violence, noting that:

> Suicidal behaviour is complex, and there are many reasons why someone may be having suicidal thoughts. The early identification and providing people with a range of support and/or treatment options can reduce the risk of someone taking their life …
>
> [Proposed action] 4.5 Increasing access to appropriate mental health and support services for the specific needs of targeted vulnerable populations and including those relating to family and domestic violence, homelessness, alcohol and other drug use and/or trauma.[75]

[72] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 9.
[73] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[74] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 43.
[75] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 31.

In identifying that 'some populations and groups are more vulnerable to suicide and suicidal behaviour,' the WA Suicide Prevention Framework identifies that this includes:

- Aboriginal and/or Torres Strait Islander people;
- persons who have experienced abuse, historical or current trauma, conflict or disaster;
- refugees and migrants;
- prisoners and others in contact with the justice system;
- individuals who have made a previous suicide attempt and people suicide bereaved;
- LGBTI persons;
- children and young people; and
- rural and remote communities. [76]

5.4.3 The Department of Communities has released a draft Aboriginal Family Safety Strategy for consultation

Under Focus Area 1 of the State Government's *Path to Safety,* the first priority of the Department of Communities, informed by 'the voices of Aboriginal people who advocated strongly for a separate, stand-alone strategy' was to 'work with Aboriginal people and communities to co-design and implement a dedicated Family Safety Strategy.'[77]

Relevantly, Path to Safety identified 'the need for cultural healing' and that Aboriginal women and children's 'experiences of violence are compounded by service system responses that often fail to meet their needs'.[78] It noted that:

> In 2017, the Department reviewed the cases of 433 children in care (approximately 10% of children living in Out-of-Home-Care at that time), which included 226 Aboriginal children, 89% of these Aboriginal children had lived experiences of family violence.[79]

Path to Safety also highlighted that:

> Aboriginal people experience ongoing harm and trauma resulting from dispossession of land and identity, the Stolen Generations and systemic discrimination. These drivers of inequality and disadvantage are key to understanding Aboriginal people's disproportionate experience of family violence and why healing and cultural security need to be at the centre of responses for all Aboriginal people and communities. …
>
> We have listened to our stakeholders who told us that Aboriginal people, and particularly Elders and leaders, want to work in partnership with Government to lead the creation of strategies to address the drivers of violence and responses to family and domestic violence in their communities.

[76] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 48.
[77] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[78] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[79] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.

> The Aboriginal Family Safety Strategy will be co-designed and delivered with Aboriginal people to prevent and respond to family violence in ways that are culturally secure and responsive to the experiences of Aboriginal people across our State. At the centre of the approach will be recognition of and response to the diversity of WA's Aboriginal people. This diversity is experienced in terms of culture, kinship systems, roles of women and men, experience of trauma and geographical context. Taking a whole-of-community public health approach, the Aboriginal Family Safety Strategy will address the needs of victims and the accountability of the perpetrators to change behaviour.
>
> Access to cultural knowledge, protocols and a strong sense of identity, including women's and men's business, can prevent violence and improve wellbeing. In some cases, Aboriginal people's experiences of dispossession, racism and trauma have disrupted and eroded cultural practices that can prevent or stop violence. Recognising and building upon the existing strengths, resources and resilience of Aboriginal people and communities is critical to improving Aboriginal family safety and wellbeing.[80]

On 17 March 2022, the State Government released a draft of the Aboriginal Family Safety Strategy (**the Strategy**), developed by the Department of Communities in partnership with Dr Victoria Hovane, a Ngurin Ngarluma, Jaru, Gooniyandi woman, registered psychologist and managing director of Tjallara Consulting.[81] The draft strategy:

> … acknowledges that family violence is not part of Aboriginal culture, and has an aim of ensuring that all Aboriginal people in WA live safe and healthy lives free of family violence and that we are all part of that solution. …
>
> The Aboriginal Family Safety Strategy draft has been developed in close consultation with Aboriginal people and organisations to design a new approach that will keep children and families safe and allow them to heal.[82]

The draft Aboriginal Family Safety Strategy is underpinned by the values of 'self-determination', 'shared responsibility', 'culture and identity', 'cultural leaders, Elders and Traditional Owners' and 'respect'. [83] It also contains four key focus areas:

1. **Heal:** Ensure healing guides the delivery of family violence services and practice.[84]

2. **Recognise and support:** Recognise the unique roles and responsibilities of men and fathers and support them to build strong communities and support safe families.[85]

[80] Department of Communities, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030*, 2020, p. 11 and 30.
[81] Government of Western Australia, 'Aboriginal Family Safety Strategy released for comment', *Media Statements*, 17 March 2022, accessed 17 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Aboriginal-Family-Safety-Strategy-released-for-comment.aspx>.
[82] Government of Western Australia, 'Aboriginal Family Safety Strategy released for comment', *Media Statements*, 17 March 2022, accessed 17 March 2022 <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/03/Aboriginal-Family-Safety-Strategy-released-for-comment.aspx>.
[83] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 7, 22-23.
[84] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, Department of Communities, Government of Western Australia, Perth, 2022, p. 25.
[85] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, Department of Communities, Government of Western Australia, Perth, 2022, p. 29.

3. **Transform:** Transform our service provision and reform our systems.[86]

4. **Build on and build up:** Use culture to build on foundations and build up futures through early intervention and prevention.[87]

Importantly, the draft Aboriginal Family Safety Strategy makes provision for 'ongoing monitoring and evaluation … to ensure continuous improvement, make progress and demonstrate change … [using those] data and metrics that are valued by Aboriginal people and communities.' [88]

The draft Strategy also recognises the need for a 'whole-of-Government approach to governance and [for its] implementation … [to] ensure actions are coordinated and building off one another'. [89]

5.4.4 The Family and Domestic Violence Response Team Model in place at the time of the investigation, is currently being redesigned

As part of Western Australia's approach in assessing and responding to family and domestic violence, FVIRs are provided to a multi-agency team comprising representatives from WA Police, the Department of Communities, and non-government organisations for triage, assessment, and further action. This model, known as the Family and Domestic Violence Response Team (**FDVRT**) model, became operational in February 2013.[90] It was therefore in place approximately four years prior to the commencement of the investigation period, when 711 (56 per cent) of the 1,276 FVIRs relating to the individuals who died by suicide were recorded.

The Department of Communities FDVRT Operating Procedures state:

> The FDVRT model aims to improve the safety of child and adult victims of family and domestic violence through a collaborative approach that focuses on timely and early intervention following a police call out to a family violence incident.[91]

In August 2020, the Department of Communities released the findings of the Family and Domestic Violence Response Team Review Report (**the Review Report**), summarising key themes and findings of a review undertaken into the operation of FDVRTs. The Review Report identified that 'the review of the FDVRT model was conducted as a result of the Ombudsman Western Australia (OWA) findings in relation to various child death and family and domestic violence (FDV) fatality reviews that identified recurring issues with the FDVRT model. In addition, known issues have been identified through operational and contract management feedback.'[92]

[86] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 35.
[87] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 41.
[88] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 49.
[89] Tjallara Consulting Pty Ltd, *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030 – Draft for consultation*, 2022, Department of Communities, Government of Western Australia, Perth, p. 50.
[90] Department of Communities, *Family and Domestic Violence Response Team Operating Procedures*, 2017, Government of Western Australia, Perth, p. 4.
[91] Department of Communities, *Family and Domestic Violence Response Team Operating Procedures*, 2017, Government of Western Australia, Perth, p. 5.
[92] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, Subiaco East, p. 6.

The Review Report highlighted a number of findings, including that 'there is an urgent and critical need for a focussed team to support and guide the FDVRT with appropriate governance, monitoring, and compliance processes.'[93]

In July 2021, government stakeholders including the Minister for Police, Hon Paul Papalia and the Minister for Prevention of Family and Domestic Violence, Hon Simone McGurk met with the Director General, Communities to discuss interagency Family and Domestic Violence responses.'[94] During this meeting:

> … a Communities and WA Police Force recommendation to commence a project (the Project) to redesign the Family and Domestic Violence Response Teams service model was endorsed.
>
> Integral to the design of a new Family and Domestic Violence Response Teams Model is the formal inclusion of the Department of Justice in the process. Communities have established an interagency committee and project team consisting of Communities, WA Police Force and [Department of Justice] representatives to oversee the Project.
>
> The Project aims to design and implement a new integrated Family and Domestic Violence Response Teams service model that enables front line staff to deliver timely and coordinated intervention and support, to keep victims and their children safe, and hold perpetrators accountable.
>
> All agencies have agreed that a family and domestic violence informed approach will provide practical and culturally appropriate responses to family and domestic violence. As such, the Project will apply the nationally and internationally recognised Safe and Together Model, developed by the Safe and Together Institute.
>
> Embedding Safe and Together principles within operational practice will support Family and Domestic Violence Response Teams to focus on analysing the perpetrator's pattern of behaviour and view the perpetrator as the source of the harm to children and family functioning.[95]

During the Investigation, the Department of Communities advised the Office that:

> The FDVRT Project will be guided by the Aboriginal Family Safety Strategy, which is currently in development, and apply the principles and critical components of the nationally and internationally recognised Safe and Together model. Over the past two months, the project team has met fortnightly to develop a project plan which outlines the agreed principles and considerations which will guide the Project. This draft project plan was reviewed and endorsed by the committee on 2 September 2021.[96]

[93] Smith P, *Family and Domestic Violence Response Team Review*, 2020, Thirdforce Consultancy Services Pty Ltd, Subiaco East, p. 8.
[94] Personal Communication, Department of Justice, 4 November 2021 and Personal Communication, Department of Communities, 29 October 2021.
[95] Personal Communication, Department of Justice, 4 November 2021.
[96] Personal Communication, Department of Communities, 29 October 2021.

In December 2021, the Department of Communities most recently informed the Office that:

> … the project team have finalised the design of the enhanced Family Domestic Violence Response Team (FDVRT) service delivery model.
>
> The project team includes representatives from Communities, Justice and Police who have worked consultatively to implement the agreed deliverables, including;
>
> - The inclusion of Justice Officers in the co-located FDVRT
> - Development of a Central Support and Coordination Team to provide governance of the model and ensure ongoing continuous improvement across the structure, policy, process and training. This is a tripartite arrangement, staffed by representatives of Communities', Police and Justice.

Recommendation 7: The Department of Communities, Western Australia Police Force and the Department of Justice, in consultation with key government and non-government stakeholders consider this investigation and incorporates the findings of this investigation in the redesign of the Family and Domestic Violence Response Team Model including, but not limited to:

- the association between family and domestic violence and suicide, for women and children;
- the association between family and domestic violence and suicide for Aboriginal and Torres Strait Islander women and children; and
- the need to see and speak to children and adolescents who are exposed to family and domestic violence when engaging with families and assessing risk, including those alleged to be the perpetrator or instigator of parent-child conflicts.

5.5 Trauma greatly influences emotional, physical, and social wellbeing, and is an enormous driver of service need

5.5.1 For Aboriginal and/or Torres Strait Islander individuals, suicide prevention is inherently related to healing from trauma

Healing is 'an essential part' of the Aboriginal Empowerment Strategy, which identifies that 'Aboriginal people have said very clearly that healing and trauma must be addressed for social and economic outcomes to improve:'

> Healing is about addressing trauma. Trauma can be experienced at the individual level (such as abuse, neglect, or family separation), the household level (for example witnessing violence or self-harm), or the societal level (including dispossession and dislocation, racism, social exclusion, and the experiences of the Stolen Generations).

> Without healing, trauma can be passed on to others as intergenerational trauma, and new traumas may be created through cycles of disadvantage. The healing process allows individuals, families and communities to address the effects of past and ongoing trauma, and reduce its impacts on future generations.[97]

Aboriginal and/or Torres Strait Islander experts identify that addressing trauma is crucial to addressing suicide among Aboriginal and/or Torres Strait Islander people; 'any sustainable response must go to the deeper, underlying historical causes of hopelessness and despair, which contributes to suicide:'[98]

> These deeper causes include intergenerational trauma. Poverty, racism, social exclusion, substandard housing, and economic marginalisation of our communities are the legacies of colonisation.
>
> Indigenous suicide is different because it cannot be separated from the historical and related present-day situation of our peoples. Indigenous people from around the world share both similar histories and high rates of child, youth and other suicide …
>
> Our communities and cultures are sources of identity, values and practices that can help protect against suicide. Such strengths provide the foundation for a mix of short, medium, and longer-term action to turn the trajectory of Indigenous child and youth suicide deaths around.[99]

5.5.2 The Office identified that trauma was a driver of service need among the 68 women and children who died by suicide

The research literature identifies that trauma and 'exposure to traumatic life events such as child abuse, neglect and domestic violence is a driver of service need,' and that 'policies and service providers must respond appropriately to people who are dealing with trauma and its effects in order to ensure best outcomes for individuals and families using these services.'[100]

Having identified that individuals with recorded histories of family and domestic violence demonstrated persistently higher levels of contact with State government departments and authorities, the Office identified that trauma was a driver of service need among the individuals who died by suicide.

5.5.3 High frequency utilisers of social support services have often been impacted by trauma

The research literature identifies that people impacted by trauma 'characteristically present at a wide range of services. They often have severe and persistent mental health and coexisting substance abuse problems and are frequently the highest users of the inpatient, crisis and residential services.'[101]

[97] Government of Western Australia, *Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, Department of Premier and Cabinet, Perth, p. 11.
[98] Dudgeon P, Hirvonen T. and McPhee R, 'Why are we losing so many Indigenous children to suicide?' *The Conversation*, 29 March 2019, viewed 23 December 2021, <https://theconversation.com/why-are-we-losing-so-many-indigenous-children-to-suicide-114284>.
[99] Dudgeon P, Hirvonen T and McPhee R, 'Why are we losing so many Indigenous children to suicide?' *The Conversation*, 29 March 2019, viewed 23 December 2021, <https://theconversation.com/why-are-we-losing-so-many-indigenous-children-to-suicide-114284>.
[100] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 3.
[101] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 4.

> A large percentage of those seeking help across a diversity of health and human service settings have trauma histories severely affecting their mental and physical health and wellbeing. The impacts of trauma characteristically persist long after the trauma has ended. Although exact prevalence estimates vary, there is a broad consensus that many consumers who engage with public, private and community managed mental health and human services are trauma survivors and that their trauma experiences shape their responses to service providers.[102]

Researchers identify that individuals with experiences of trauma are across many human and social support service sectors, including:

- **Mental Health Services:** research has found that 'nine out of 10 people accessing mental health services have experienced trauma at some stage in their life.'[103] The Blue Knot Foundation highlights that the 'single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma.'[104]

- **Child protection systems:** researchers identify that 'children and families in the child welfare system 'experience high rates of trauma and associated behavioral health problems.'[105] The Australian Institute of Family Studies identifies that children and young people in care are likely to have been exposed to trauma and identifies them as 'one of the most vulnerable, disadvantaged and traumatised populations in the Australian community.'[106]

- **Police:** Experiencing trauma has been linked with increased rates of criminal behaviour:

> Research has demonstrated the interconnection between histories of violence and abuse, traumatic experiences, and criminal behaviour. This does not mean that violence and abuse in life creates or causes criminality in a simplistic or linear way, or that those who commit crime can merely 'blame it on' their previous experiences of violence, abuse, or neglect. Still, it does mean that there are complex interconnections between people's life experiences, opportunities, choices and chances, and their personal histories, including trauma histories. As one researcher observes: 'child abuse and neglect, poverty, sexual molestation, and witnessing violence are, among others, the most common risk factors for posttraumatic reactions, aggression, and antisocial behaviour.'[107]

[102] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 4.
[103] New South Wales Agency for Clinical Innovation, *Trauma-Informed Care and Practice in Mental Health Services*, 2021, viewed 21 October 2021 <https://aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services>.
[104] Middleton W, cited by Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, Blue Knot Foundation, p. 30.
[105] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[106] Campo M and Commerford J, *Supporting young people leaving out-of-home care*, 2016, Australian Institute of Family Studies, Child Family Community Australia, p. 2-7.
[107] Randall M and Haskell L, 'Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping', *Dalhousie Law Journal*, 36(2), 2013, p. 516, citing Ardino V, *Offending Behaviour: The Role of Trauma and PTSD*, 2012.

- **The juvenile and criminal justice system**: 'Studies of people in the juvenile and criminal justice system reveal high rates of mental and substance use disorders and personal histories of trauma.'[108] Further, the Australian Institute of Family Studies has stated that:

> [C]hildhood trauma exposure has been linked to involvement with the criminal justice system. A large study exploring adverse childhood experiences of serious, chronic and violent juvenile offenders and juveniles referred to the justice system for single non-violent offences found that every additional adverse childhood event experienced increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35%, even when other known risk factors for violent behaviour were accounted for (Hahn Fox et al., 2015).[109]

- **Homelessness:** AIHW identifies that 'half (54%) of [the] children and young people who received homelessness and child protection services [in 2016-17] were [also] experiencing family and domestic violence,' noting that this figure is higher than 'the 44% of children and young people' who are 'only' receiving homelessness services.[110]

- **Alcohol and other drugs treatment programs:** research identifies that over 80 per cent of individuals entering substance use treatment programs 'report having experienced a traumatic event in their lifetime,' and that the 'vast majority have experienced multiple traumas.'[111] Researchers further identify that post-traumatic stress disorder has a strong comorbidity with substance use problems.[112]

5.5.4 Trauma informed approaches acknowledge and attend to the effects of trauma: this has significant implications for service provision

The Office reviewed a diverse and 'rapidly growing research base' leading to new understandings of trauma, and identified that correspondingly, this research 'also has major implications for service-provision.'[113] In this context, the Office identified that there has been increased attention to the concept of trauma informed approaches 'to help services attend to the effects of trauma, and its links to health and behaviour, so as to create safe spaces that limit the potential for further harm.'[114]

In undertaking this work, the Office has consulted with State government departments and authorities, and key stakeholders in the family and domestic violence sector. The Office has heard that, while awareness of the need to account for trauma in service provision is becoming more prevalent in Western Australia, more knowledge is needed to understand how this may be used to enact meaningful change.

[108] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[109] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 7.
[110] Australian Institute of Health and Welfare, *Family, domestic and sexual violence in Australia: 2018,* 2018, p. 65.
[111] Mills K, 'Trauma and substance use,' Presentation at the Western Australian Network of Alcohol & other Drug Agencies WA AOD Conference, March 2018, viewed 21 October 2021 <https://cracksintheice.org.au/pdf/webinar-trauma-substance-use.pdf>.
[112] Forbes D, 'Substance use and mental health consequences of trauma and implications for assessment and treatment,' 2018, Western Australian Alcohol and Other Drug Conference, 21 March 2018.
[113] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxx.
[114] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

6 The need for trauma-informed, culturally secure family and domestic violence services in Western Australia

6.1 Trauma and its impact

6.1.1 Trauma

The research literature identifies that trauma is 'both the experience of, and a person's response to, an overwhelmingly negative event or series of events'[115] that are emotionally disturbing or life-threatening:[116]

The Blue Knot Foundation, Australia's National Centre of Excellence for Complex Trauma, identifies that trauma 'is a state of high arousal in which severe threat or the perception of severe threat overwhelms a person's capacity to cope. It comprises a range of events, situations and contexts. These include natural disasters, accidents, betrayal in interpersonal relationships, and diverse forms of abuse.'[117]

6.1.2 Trauma survivors display extraordinary strength and resilience, and recovery from trauma is possible

Researchers have identified that 'we know far more' about trauma and post-traumatic symptoms 'than we do about resiliency' arising from family and domestic violence.[118] Increasingly, researchers have found that recognising an individual's strength is vital in responding to trauma:

> … a list of symptoms tells us little about the tremendous strengths and resources battered women draw on to recover from domestic violence. The pain individuals experience from domestic violence should not be minimized. Yet, it does not have to be the centerpiece of one's identity. Standing alongside the entire range of debilitating effects of trauma, most survivors display a stunning capacity for survival and perseverance. Growth and pain, therefore, are not necessarily mutually exclusive, but instead are inextricably linked in recovery from trauma.[119]

Acknowledging the strengths and perseverance of trauma survivors is also an important component of recovery from trauma. Orygen, the National Centre of Excellence in Youth Mental Health, has highlighted the importance of ensuring that the strengths of young people, their families and carers are 'recognised, built on, and validated [and] … used to empower them in the development of their treatment.'[120]

[115] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[116] Centre for Health Care Strategies, 'Understanding the Effects of Trauma on Health,' 2017, p. 1.
[117] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 45.
[118] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 2012, 18(11), p. 1280.
[119] Anderson K, Renner L and Danis F, 'Recovery: Resilience and Growth in the Aftermath of Domestic Violence,' *Violence Against Women*, 2012, 18(11), p. 1280.
[120] Orygen National Centre of Excellence in Youth Mental Health, *Clinical practice in youth mental health: What is trauma-informed care and how is it implemented in youth healthcare settings?*, 2018, p. 2.

The Blue Knot Foundation emphasises that elevating the voices of survivors of trauma and incorporating messages of 'optimism and hope' is vitally important when providing recovery and support services to survivors of childhood abuse, including family and domestic violence:

> Feedback from adult survivors of child abuse suggests that a sense of optimism regarding the process of recovery is far from common within many areas of existing service provision (this is when childhood trauma is recognised at all). Indeed, the experience of many survivors is that an opposite message is conveyed. This is not only a harmful message to transmit, but in light of the now solid research findings to the contrary, an illegitimate one. Resolution of trauma, including of adverse childhood experiences, is now shown to be possible, and best-practice trauma informed care should consistently convey this message in all respects and at all levels.[121]

Researchers highlight that recovery from trauma is possible, and that 'many people go on to lead fulfilling lives.'[122] Research identifies that impacts of even the most severe trauma 'can be resolved,' and that 'negative intergenerational effects' of trauma 'can be intercepted … when mental health and human service delivery … reflect the current research insights.'[123]

The research literature documents the need to overcome the societal myth that survivors of childhood abuse are 'damaged' and 'not capable of living a normal life.'[124] Noting that:

> [M]any survivors manage to live their lives and succeed in a range of professions and all strata of society. In so doing, they show great strength and courage. Despite the impacts of childhood abuse, adult survivors resist the effects in many ways, and find strategies to help with healing and developing a new sense of self.[125]

The Blue Knot Foundation further highlights the concept of post-traumatic growth, whereby 'a person develops greater inner strength as a result of their journey through trauma' and, in doing so, 'develop[s] beyond recovery':[126]

> … if you are a survivor or are supporting a survivor, the concept of post traumatic growth may seem unachievable at the moment but knowing that it is possible can also be empowering.[127]

[121] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 15.
[122] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[123] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxviii.
[124] Henderson C, and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 52.
[125] Henderson C, and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 52.
[126] Blue Knot Foundation, *Healing and Resilience*, 2021, viewed 20 October 2021 <https://blueknot.org.au/resources/coping-strategies-impacts-and-healing/healing-and-resilience/>.
[127] Blue Knot Foundation, *Healing and Resilience*, 2021, viewed 20 October 2021 <https://blueknot.org.au/resources/coping-strategies-impacts-and-healing/healing-and-resilience/>.

6.1.3 The concept of resilience is crucial to understanding how individuals are affected by trauma

In recognising that individuals 'demonstrate a range of reactions to traumatic events, tragedy and stress, researchers have tried to understand why some people succeed in the face of hardship and risks where others experience ongoing distress or illness.'[128] In this context, researchers identify resilience as 'a crucial construct in understanding the traumatic stress response because both trauma and resilience are interdependent processes that influence one's overall health.'[129]

Resilience refers to 'the capacity of human beings of any age to survive and thrive in the face of adversity.'[130] Increasingly, researchers have sought to understand 'what helps resilient individuals overcome adversity in the hope that the trait may be fostered in others.'[131]

> Resilience has been defined as 'a dynamic process encompassing positive adaptation within the context of significant adversity.' Resilience is not a personal trait that individuals do or do not possess (thus, the term 'resiliency' is best avoided because it connotes an individual characteristic), but rather a product of interacting factors—biological, psychological, social, and cultural—that determine how a child responds to traumatic events.[132]

Research identifies that the impacts of abuse, neglect, and other potentially traumatic events 'differ enormously depending on a complex interplay of factors.' These factors include 'disposition; bio-psychological factors; family environment and other supports; peers; security; positive parent/child attachment; and previous history of support or abuse, including duration, frequency and nature of abuse.'[133]

Resilience can exist – and be cultivated – in individuals and communities. For children in particular, 'cognitive development/problem solving skills,' 'self-regulation,' and 'relationships with caring adults' can assist in developing key elements of resiliency.[134]

Researcher Michael Ugnar, an expert resilience theory, is 'cautious when naming the magic elements' that make an individual resilient,[135] and instead highlights the responsibilities of families, communities, and governments to provide resources that foster resilience:

> *"In the context of exposure to significant adversity, resilience is both the capacity of individuals to* **navigate** *their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to* **negotiate** *for these resources to be provided in culturally meaningful ways."*

[128] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[129] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 35.
[130] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[131] Administration for Children and Families, 'Resilience,' U.S. Department of Health and Human Services, Washington, 2021, viewed 19 October 2021 <https://www.acf.hhs.gov/trauma-toolkit/resilience>.
[132] Bartlett, J. and Steber, K., 'How to Implement Trauma-informed Care to Build Resilience to Childhood Trauma,' *Child Trends,* Bethesda, 2019, viewed 19 October 2021 <https://www.childtrends.org/publications/how-to-implement-trauma-informed-care-to-build-resilience-to-childhood-trauma>.
[133] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[134] Substance Abuse and Mental Health Services Administration, *Childhood Resilience*, 2019, viewed 19 October 2021 <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/childhood-resilience>.
[135] Ugnar M, *2014 Thinker in Residence Report by Michael Ugnar*, 2014, Commissioner for Children and Young People Western Australia, Perth, p. 7.

> This definition shifts our understanding of resilience from an individual concept, popular with western-trained researchers and human services providers, to a more relational understanding of well-being embedded in a social-ecological framework. Understood this way, resilience requires individuals have the capacity to find resources that bolster well-being, while also emphasizing that it's up to families, communities and governments to provide these resources in ways individuals value. In this sense, resilience is the result of both successful navigation to resources and negotiation for resources to be provided in meaningful ways.[136] [original emphasis]

Ugnar has identified that in general, resilience 'is a process' rather than the 'static trait of an individual.' Described 'as the interaction between a child's personal strengths and the child's environment,' resilience 'will almost always depend on the child's ability to seek and find what he or she needs … It is up to the child's community to provide the child with the protective factors that help him to cope with stress.'[137]

6.1.4 Complex trauma/toxic stress

In defining trauma, researchers differentiate between simple and complex trauma. Simple trauma is the term used for single-incident trauma involving experiences or events 'that are life threatening and/or have the potential to cause serious injury'[138] and are generally unexpected. Simple trauma can include experiences such as being in a car accident, house fire, natural disaster, fighting in a war, or experiencing assault in adulthood.[139] Researchers further identify that 'there are also generally supportive and helpful community responses to the people who have experienced [simple or single incident] trauma.'[140]

> [S]ingle incident trauma such as accidents or natural disasters are more likely to be public events. Other people know about or share the trauma so there is more community acceptance. This can provide validation and reduces secrecy and shame. Single incident events usually have a clear beginning and end. Once the event is over, survivors can reach a place of safety and may be able to seek help and recover.[141]

Complex trauma is often ongoing and interpersonal, occurring in relationships that are meant to be safe:

> **Complex Trauma** occurs as a result of traumatic stressors that are interpersonal – premeditated, planned and perpetrated by one human being on another. It is particularly damaging if it occurs in childhood. These actions can be both violating and exploitative of another person.[142]

[136] Resilience Research Centre, *What is Resilience,* 2021, viewed 19 October 2021, <https://resilienceresearch.org/about-resilience/>.
[137] Ugnar M, *2014 Thinker in Residence Report by Michael Ugnar*, 2014, Commissioner for Children and Young People Western Australia, Perth, p. 7.
[138] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[139] Blue Knot Foundation, *What is Complex Trauma*, 2021, viewed 11 October 2021, <https://blueknot.org.au/resources/understanding-trauma-and-abuse/what-is-complex-trauma/>; Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[140] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[141] International Society for the Study of Trauma and Dissociation, *Trauma and Complex Trauma: An Overview*, 2020, viewed 11 October 2021 <https://www.isst-d.org/public-resources-home/fact-sheet-i-trauma-and-complex-trauma-an-overview/>.
[142] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.

As interpersonal violence or trauma 'often occurs in secrecy and is steeped in shame, survivors often struggle to have their experience validated,'[143] with individuals 'often feel[ing] disconnected from the support of others:'[144]

> [C]omplex trauma is characteristically the product of overwhelming stress that is interpersonally generated. Its multiple impacts include those affecting a person's 'sense of self'. As interpersonal violence and abuse often occur in secrecy and are steeped in shame, survivors often struggle to have their experience recognised and validated by others. Trauma occurring in the context of interpersonal violence, either covert or overt, often brings about complex and chronic psychological and physiological injuries.[145]

Complex trauma is also known as 'toxic stress' in the research literature. The Australian Childhood Foundation has highlighted that for children:

> **Toxic stress** results from intense experiences that target the child directly and carry with them intentional messages of intimidation, fear, shame and abuse of power. It is overwhelming of the child's internal psychological, emotional, relational and physiological resources. It too can be sustained over a period of time. However, the intensity with which it occurs can also mean that a brief or one-off experience of it can significantly affect a child and young person. Examples of toxic stress are child sexual abuse, physical abuse and bullying. As a result, children and young people's physiological systems remain activated without relief. It causes sustained disintegrative effects in both the structure of the brain and communication between the body and brain. The destructive effects of toxic stress can be reduced by co-ordinated and deliberate interaction between young people and a network of supportive and trained adults. Often, therapeutic and individually tailored support plans are imperative in reconfiguring the child or young person's ongoing response to future developmental challenges.
>
> Toxic stress results from significantly adverse and pervasive experiences for children and young people, including
>
> - child abuse;
> - chronic neglect;
> - family violence;
> - rejection or bullying by peers; and,
> - racial discrimination and/or harassment.
>
> Because the brains and bodies of children and young people are so malleable, high impact stress and toxic stress are faster to manifest. They leave deeper tracks of damage. In these circumstances, children's brain and body systems will be harmed, affecting the way they react and relate to others and their physical environment.

[143] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 14.
[144] Thomas L, *What is trauma?*, Australian Childhood Foundation, 2019, viewed 11 October 2021, <https://professionals.childhood.org.au/prosody/2019/03/what-is-trauma/>.
[145] Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 6.

> High impact and toxic stress reduces the capacity of the thinking part of children's brain to shape the way they react to challenges in their environment. As a result, children and young people appear to behave instinctively and sometimes inappropriately, without knowing why. They are also not able to easily influence their feelings when faced with perceived threat or increases in their experience of stress.
>
> It impairs the growth and activity of the connecting structures between the left and right hemispheres of the brain. As a result, children find it difficult to know, name and express their feelings. They can find it difficult to read social cues and respond in social exchanges. It increases children and young people's base arousal level such that they live in a constant state of vigilance and heightened alarm. As such, vulnerable children and young people are easily triggered by seemingly minor issues. Their responses are often seen as 'out of the blue' or 'over reactions' to situations.
>
> High impact stress and toxic stress lock down children and young people's capacity to adapt to change in their environment. They are more likely to use fixed and repetitive behavioural routines in situations where they feel distress and unease. These routines involve movements and actions that feel familiar and comforting to them – even if they are destructive or harmful to others.
>
> These children and young people lack the adaptability and flexibility necessary to respond differentially to varying situations and contexts. They have a limited range of coping strategies. Whilst these strategies may have been effective in assisting them to survive in unsafe situations, they are often inappropriate responses in situations where there is an absence of danger.[146]

6.1.5 Intergenerational trauma

Trauma can also extend from one generation to the next. In 1966, researchers identified 'high rates of psychological distress among children of holocaust survivors,'[147] with subsequent research showing that 'not only traumatic experiences, but also resilience patterns can be transmitted to and developed by the second generation.'[148]

> When people who have experienced or witnessed trauma have not had an opportunity to heal from that trauma, it can be transferred to the next generation. This is known as intergenerational trauma.[149]

When trauma is transferred across a number of generations, 'it is known as transgenerational trauma' and extends beyond individuals to families and communities.[150]

[146] Tucci J, Mitchell J, Lindeman M et al, *Strengthening Community Capacity to End Violence: A Project for NPY Women's Council*, 2017, NPY Women's Council and Australian Childhood Foundation, p. 17-18.
[147] Menzies P, 'Intergenerational Trauma and Residential Schools,' *The Canadian Encyclopedia*, 2020, viewed 12 November 2021, <https://www.thecanadianencyclopedia.ca/en/article/intergenerational-trauma-and-residential-schools>.
[148] Braga L, Mello M. and Fiks J, 'Transgenerational transmission of trauma and resilience: a qualitative study with Brazilian offspring of Holocaust survivors,' *BMC Psychiatry*, 2012, 12(134), doi:10.1186/1471-244X-12-134.
[149] Blue Knot Foundation, *Intergenerational Trauma: Fact Sheet*, 2021, p. 1.
[150] Blue Knot Foundation, *Intergenerational Trauma: Fact Sheet*, 2021, p. 1.

In Australia, transgenerational trauma impacts Aboriginal and Torres Strait Islander people who have experienced trauma because of 'colonisation, including the associated violence and loss of culture and land, as well as subsequent policies such as the forced removal of children. In many Indigenous families and communities, this trauma continues to be passed from generation to generation with devastating effects.'[151]

6.1.6 Trauma can have long-term impacts upon individuals

Researchers identify that the long-lasting adverse effects of an event 'are a critical component of trauma,'[152] noting:

> These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic events and the effects.[153]

As a result of advances in diverse and numerous fields,[154] there is a growing body of evidence showing that experiencing trauma or traumatic events can have significant impacts upon individuals, raising their risk of long-term physical and behavioural health issues.[155]

In the field of neuroscience, a multidisciplinary science examining the structure and function of the nervous system, scientists have examined a continuum of automatic, survival-based behaviours that are innate, hard-wired and automatically activated in response to the perception of threat:

> *Arousal* is the first step in activating the defense cascade; *flight or fight* is an active defense response for dealing with threat; *freezing* is a *flight-or-fight* response put on hold; *tonic immobility* and *collapsed immobility* are responses of last resort to inescapable threat, when active defense responses have failed; and *quiescent immobility* is a state of quiescence that promotes rest and healing. Each of these defense reactions has a distinctive neural pattern mediated by a common neural pathway.[156]

The Australian Childhood Foundation has also highlighted that, with respect to children experiencing toxic stress:

> Children and young people affected by high impact stress and toxic stress find it difficult to make meaning from their experiences. They have few or no effective internal maps to guide their actions. As a result, they react rather than respond.
>
> Their beliefs about themselves are determined by the very people who violate them. They hold onto ideas about relationships which are not helpful to them in their communication with peers and other adults like teachers. They can find it

[151] Australians Together, *Intergenerational Trauma*, 2021, viewed 12 November 2021 <https://australianstogether.org.au/discover/the-wound/intergenerational-trauma/>.
[152] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[153] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[154] Shonkoff J and Garner A, 'The Lifelong Effects of Early Childhood Adversity and Toxic Stress,' *Pediatrics*, 2012, 129(1), p. e232, viewed 11 October 2021, <http://www.pediatrics.org/cgi/doi/10.1542/peds.2011-2663>; Centre for Health Care Strategies, *Understanding the Effects of Trauma on Health*, 2017, p. 1.
[155] Centre for Health Care Strategies, *Understanding the Effects of Trauma on Health*, 2017, p. 1.
[156] Kozlowska K, Walker P and McKeabm L, et al, 'Fear and the defense cascade: Clinical implications and management,' *Harvard Review of Psychiatry*, 2015, 23 (4), viewed 12 October 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495877/>.

> difficult to see adults as supportive. They are cautious about being hurt and are more likely to stay closed to the development of new connections or relationships.
>
> They do not easily understand or engage with consequential learning. Their brains are so over-activated that they are able to take in very little and not learn new information easily. In particular, their memory systems continue to remain under stress. They fail to consolidate new learning. Their working memory for even the easiest set of instructions can be severely compromised.
>
> Children and young people affected by high impact stress and toxic stress experience the present with little reference to their past, even though their behaviour, feelings and physiology are affected by their experiences of violation. They do not have access to the qualities that make them who they are. They have a transient sense of their own identity. Their future is without plans or a sense of possibility.[157]

6.1.7 Adaptive coping mechanisms may serve trauma survivors in the short term, but can compromise health and wellbeing in the long term

Scientists highlight that, unlike animals, humans are often not 'able to restore their standard mode of functioning once the danger is past,' and that people 'may find themselves locked into the same, recurring pattern of response tied in with the original danger or trauma.'[158]

The research literature suggests that experiencing trauma can result in the development of neurological and psychological symptoms,[159] and '[i]n the absence of treatment, [these] trauma-related difficulties and their effects tend to persist into adolescence and adulthood and become difficult to reverse'.[160] The brain's 'remarkable adaptiveness'[161] and the ability of the nervous system 'to change its activity in response to intrinsic or extrinsic stimuli by reorganizing its structure, functions, or connections'[162] can mean that, 'if the initial trauma is not resolved and the person has not recovered, he/she can be repeatedly "triggered" into survival responses by seemingly minor stressors.'[163] These adaptive coping mechnisms:

> … emerge in response to adversity [and] are rooted in the biological imperative to survive life-threatening situations and cope with the aftermath of trauma. Often formed during childhood, these adaptations are embedded in neural networks, functioning outside of conscious awareness and operating even after the trauma exposure has ended. The brain stores trauma memories as part of a protection strategy. When memories quickly (and sometimes frequently) intrude into the present as upsetting thoughts, emotions, sensory memories, bodily sensations, or flashbacks, the original sense of fear, as well as the associated self-protective, survival strategies are activated. Adaptive behaviors such as aggression, spacing-out, avoidance, and distrust become automatic responses to the slightest cue of danger. For example, trauma survivors' sensitivity to loud noises,

[157] Tucci J, Mitchell J, Lindeman M et al, *Strengthening Community Capacity to End Violence: A Project for NPY Women's Council*, 2017, NPY Women's Council and Australian Childhood Foundation, p. 18.
[158] Kozlowska K, Walker P and McKeabm L, et al, 'Fear and the defense cascade: Clinical implications and management,' *Harvard Review of Psychiatry*, 2015, 23 (4), viewed 12 October 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4495877/>.
[159] For example, see: van der Kolk B, *The Body Keeps Score: Brain, mind and body in the healing of trauma*, New York, 2014; Schore A, 'Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder', *Australian and New Zealand Journal of Psychiatry*, 2002(36), p. 9-30; Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice.
[160] Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice, p. 1.
[161] Rosenzweig J, Jivanjee P, and Brennan E, et al, 'Understanding Neurobiology of Psychological Trauma,' *Pathways Research and Training Centre*, 2017, p. 2. <https://www.pathwaysrtc.pdx.edu/pdf/projPTTP-neurobiology-tip-sheet.pdf>.
[162] Mateos-Aparicio P and Rodriguez-Moreno A, 'The Impact of Studying Brain Plasticity,' *Frontiers in Cellular Neuroscience*, 2019, viewed 12 October 2021 <https://www.frontiersin.org/articles/10.3389/fncel.2019.00066/full>.
[163] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, 2018, p. 11.

> odours, physical proximity to others, and touch can instantaneously activate adaptive reactions.[164]

In examining how people experience trauma, the Blue Knot Foundation identifies that the basic experience of trauma can involve experiencing 'the destruction of the predictable foundation of everyday life which the non-traumatised person takes for granted.'[165]

Where an individual's normal coping responses 'provide a sense of control, connection, meaning and safety,'[166] trauma interferes with a person's ability to cope:[167]

> Trauma overwhelms a person's ability to cope when faced with threat, or when they believe there is a serious threat confronting them ...
>
> Trauma is a state of high arousal which interrupts connection ('integration') across a wide range of functioning. It disrupts the capacity for systems of the body to work together. This can negatively affect a person's physical and psychological health in many ways.[168]

Researchers identify that people who experience trauma may develop ways of coping that allow them to survive and function day to day,[169] and 'manage the psychosocial and physiological disruption which trauma causes.'[170]

> Children, like adults, develop coping strategies to protect them from being overwhelmed and help them manage the physiological and psychological effects of the dysregulated arousal, emotions and behaviour which occur with trauma. Such coping strategies are often creative and effective in the short to medium term, but risky and can damage health in the longer term.[171]

Coping strategies may assist a person to manage dysregulation and overwhelming stress arising from trauma in the short term. Often though, the long-term effects of trauma prove to be 'pervasive and cannot be compartmentalised.[172] Accordingly, over time, the coping strategies used by a person who has experienced trauma, may decrease in their effectiveness, and cause trauma-organised 'profound neurobiological adaptations' which may be injurious to their health.'[173] For example, coping strategies such as 'alcohol and drugs, self-harm, over- or under-eating or over-working'[174] can impair individuals wellbeing and health later in life:

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[164] Rosenzweig J, Jivanjee P, and Brennan E, et al, 'Understanding Neurobiology of Psychological Trauma,' *Pathways Research and Training Centre*, 2017, p. 2. <https://www.pathwaysrtc.pdx.edu/pdf/projPTTP-neurobiology-tip-sheet.pdf>.
[165] Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, Milsons Point, 2018, p. 14.
[166] The Sexual Trauma & Abuse Care Centre, *Neurobiology of Trauma*, 2016, viewed 11 October 2021, <http://stacarecenter.org/wp-content/uploads/2015/09/The-Care-Center-Neurobiology-of-Trauma-Nov-2016.pdf>.
[167] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.
[168] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 7.
[169] The National Child Traumatic Stress Network, *Complex Trauma: Effects*, 2021, viewed 11 October 2021, <https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects>.
[170] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 34.
[171] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 45.
[172] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi
[173] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. xxxi
[174] Blue Knot Foundation, *What is Complex Trauma,* 2021, viewed 11 October 2021, <https://blueknot.org.au/resources/understanding-trauma-and-abuse/what-is-complex-trauma/>.

> Many traumatised people adopt extreme coping strategies in order to manage anxiety and overwhelming emotional distress including: suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, and dissociation. Many coping strategies become risk factors for later physical health issues.[175]

Researchers identify that research 'can now connect the psychobiology of trauma to the social determinants of health,' or the conditions in which people 'grow, live, work and age' which shape their health.[176] The most prominent, comprehensive, and systematic study examining this connection is the Adverse Childhood Experiences (**ACE**) study conducted in the United States:

> This longitudinal study draws on over 17000 participants, and with reference to various categories of 'adverse' childhood experience and household dysfunction, explores the extent to which such experience affects subsequent adult health.
>
> Cohort members of the ACE study are predominantly white middle-class, have generally had some college experience, and do not show any obvious markers of social disadvantage. Yet the two major findings of this study are that adverse childhood experiences are 'vastly more common than recognised or acknowledged', and that they powerfully impact both mental and physical health 'a half-century later'.
>
> In fact the ACE study charts the translation of traumatic childhood experience into both emotional disorder and organic disease later in life. The study establishes 'that time does not heal some of the adverse experiences [found to be] so common in the childhoods of a large population of middle-aged, middle class Americans. One does not 'just get over' some things …
>
> A further key finding of the ACE study is the extent to which adult health problems on the part of those who had adverse experiences as children stem from strategies, coping mechanisms and behaviour which were initially protective attempts to deal with the adversity experienced.[177]

The epidemiological results of the ACE study 'are authoritative in their magnitude' and correlate decisive links 'between adverse childhood experiences and subsequent adult health problems.'[178] Further research has repeatedly replicated the findings of the ACE study. For example, research has identified that a history of childhood trauma is '[t]he single most significant predictor' of subsequent contact with the mental health system.'[179]

[175] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 17.
[176] Commission on Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health*, 2008, World Health Organisation, Geneva, p. 1.
[177] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[178] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[179] Kezelman C, 'Unresolved childhood trauma and physical and mental health,' *New Paradigm (The Australian Journal on Psychosocial Rehabilitation)*, 2018 (Winter), p. 46.

The ACE study established that 'personal solutions' in the form of 'coping mechanisms to deal with childhood trauma are converted over time into adult health problems,' as initially protective attempts to deal with adversity 'lose their protective function,' and 'actively undermine adult well-being.'[180] In this context, the ACE study and subsequent research has located the 'roots of major public health problem[s]' in the experiences of trauma and adverse events in childhood.[181]

6.1.8 Adaptations arising from trauma may influence behaviour and lead to difficulties engaging with service systems

Dr Sandra Bloom, former President of the International Society for Traumatic Stress Studies and Chair of the Campaign for Trauma-Informed Policy and Practice in the United States, has highlighted that 'many people who present to social service and health organisations, especially 'high utilisers', will have a trauma history, and this may lead to difficult or discordant interactions.'[182]

Dr Bloom describes how 'clients presenting in mental health, substance abuse, and other social service settings' are likely to be impacted by exposure to chronic stressors and significant experiences of childhood adversity, and that this also influences behaviours and responses in service provision settings:[183]

> … they have been repeatedly exposed to danger and now may have difficulty keeping themselves safe… Clients who have been repetitively hurt within the context of close, interpersonal relationships, often have difficulty discerning who can be trusted and who cannot because failures of trust characterise their interpersonal history…
>
> As a result of the exposure to chronic stress, clients are frequently chronically hyperaroused, responding to even minor stressors as major stressors… One of the responses to chronic hyperarousal in our clients may be an increase in aggression toward self and/or others. Repetitively traumatised clients have significant difficulties in managing distressing emotions…
>
> Under recurringly traumatising conditions, it is difficult to maintain a clear and healthy sense of identity. As a result, clients often appear contradictory: they often do not act on what they think, or their actions contradict what they say. Their strongly held moral beliefs may not consistently guide their actions. As a result of their toxic experiences with other people, clients frequently lack good communication skills and have difficulty in being both direct and diplomatic. As a result, their communication style may be indirect and covert and may end up creating more problems than it solves …[184]

[180] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[181] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 40.
[182] Bloom S (2019) and Mautner et al (2013) cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[183] Bloom S, 'Trauma-informed systems transformation: Recovery as a public health concern', 2007, cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 61-62.
[184] Bloom S, 'Trauma-informed systems transformation: Recovery as a public health concern', 2007, cited by Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 61-62.

Where Dr Bloom highlights the 'weight of accumulated trauma experiences that people carry when they enter social services settings,' Western Australian researchers Dr Peter Smith and Lisette Kaleveld also highlight that this can include traumas 'from their distant as well as immediate history:'[185]

> For example, often workers will not be aware that prior to presenting at their service a client perhaps had been asked to leave the homeless shelter, denied funds from Centrelink or had not slept properly or eaten well for days. Their first interaction with a new service may involve extensive paperwork or demands to provide information about personal histories (that may include covering past traumas).
>
> It is therefore understandable that the person's ability to regulate their emotion at this point may be compromised. If anything about the present interaction is triggering, things do not go their way, or a person has just had enough, they may vent their anger at the worker in front of them. The symptoms and behaviours that trauma survivors present may result in their being turned away (MHCC, 2013), which may be then experienced as abandonment which might exacerbate any trauma history.[186]

As survival responses 'operate outside conscious awareness,' and 'people still affected by trauma experience continuing high sensitivity to seemingly minor stressors or "triggers;"' a traumatised person can therefore 'often be repeatedly triggered:'[187]

> To the observer who does not know or remember this, a person may seem overly reactive for no apparent reason. It can be easy to misinterpret their reaction/s, and respond inappropriately in attitude and behaviour.[188]

The research literature highlights that changes related to trauma and the brain's stress response can drive the behaviour of traumatised individuals. When considered without context, this can result in authorities misperceiving traumatised individuals:

> Traumatized individuals tend to be hypervigilant and hypersensitive to perceived threats, and they tend to overreact to such threats, often violently. This extreme reaction becomes the focus of police attention. For example, a traumatized person may mask anxiety with an extreme bravado, which police view as arrogance or a lack of caring instead of the psychological defense mechanism that it is (Arroyo, 2001). Also, the brain's impaired regulation of the stress response makes it difficult, if not impossible, for traumatized individuals to calm themselves down, even when it would be in their best interest to do so, which makes them seem more aggressive (Van der Kolk et al., 2009). In addition, associated difficulties such as substance abuse can also become a focus of police attention, with no thought about whether underlying psychiatric difficulties might have contributed to such substance abuse.[189]

[185] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[186] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 20.
[187] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 11.
[188] Kezelman C and Stavropoulos P, *Talking about Trauma: Guide to conversations and screening for health and other service providers,* 2018, p. 11.
[189] Dudley RG, *Childhood Trauma and Its Effects: Implications for Police*, 2015, National Institute of Justice, p. 11.

In this context, researchers identify that 'challenging behaviours' can be adaptive responses to trauma.[190] For example, a 'mistrust of authority figures and wariness of professional helpers,' rather than being interpreted as 'hostility, lack of motivation or resistance to services', may be viewed as a normal, 'protective reaction when an individual feels vulnerable.'[191] In this sense, trauma informed approaches serve to 'normalise symptoms and behaviours that have traditionally been pathologised and viewed as examples of personal and social deviance.'[192]

6.1.9 Trauma exposure is widespread: millions of Australians have experienced abuse and violence

The research literature identifies that trauma is widespread – 'traumatic experiences are common, with people often having multiple adverse experience across their life.'[193] Trauma:

> … occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders.[194]

General population research conducted by the World Health Organisation over 24 countries, with a combined sample of almost seventy thousand participants, identified that over 70 per cent of respondents reported experiencing a traumatic event, with over 30 per cent reporting four or more traumatic events:[195]

> 70.4% of respondents in 24 countries overall, and 82.7% of those in the United States, had experienced at least one type of traumatic event; in Canada, the prevalence is approximately 76% of adults (Van Ameringen et al., 2008). Exposure to traumatic events may cause post-traumatic stress disorder (PTSD), but also a range of other negative mental and physical health outcomes, impacts on daily living and coping, cognitive processes, and even neurobiological changes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The types of experiences that may be traumatic include, but are not limited to, accidents and injuries (e.g., natural disasters, car accidents), interpersonal violence (e.g., intimate partner violence, child maltreatment), collective violence (e.g., war, genocide, and the ongoing effects of colonialism), and others such as the death of a loved one (Benjet et al., 2016). Overall, trauma is a serious threat to individual health and well-being worldwide, and significant efforts are expended to understand, prevent, and address the problem (SAMHSA, 2014).[196]

[190] Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet,' delivered 17 September 2021.
[191] Levenson, J. 'Trauma-Informed Social Work Practice,' 2017, *Social Work*, 62(2), p. 105-113, viewed 18 October 2021 <https://doi.org/10.1093/sw/swx001>.
[192] Henderson C and Bateman J, *Reframing Responses Stage Two: Supporting Women Survivors of Child Abuse An Information Resource Guide and Workbook for Community Managed Organisations*, 2010, Mental Health Coordinating Council, p. 79.
[193] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[194] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[195] Benjet C, Bromet E and Karam E et al, 'The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium,' *Psychological Medicine*, 2016, 42(2), p.327-343.
[196] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

According to the Blue Knot Foundation, 'one in four adult Australians experience trauma during childhood.'[197] The Australian Institute of Family Studies also identifies that 'exposure to adverse, potentially traumatic events in childhood is not uncommon,' highlighting the findings of the ACE study in identifying that, of 17,337 respondents, 64 per cent had experienced at least one adverse experience and approximately 12 per cent had experienced four or more in the first 18 years of life.[198]

The Personal Safety Survey (**PSS**) undertaken by the ABS, provides statistics for family, domestic, sexual violence, physical assault, partner emotional abuse, child abuse, sexual harassment, stalking and safety in Australia. The 2016 PSS identified that:

- two in five Australian adults (39 per cent of Australians, or 7.2 million people) had experienced violence since the age of 15;
- one in six women (17 per cent of Australians, or 1.6 million people) and one in sixteen men (6.1 per cent of Australians, or 547,600 people) experienced partner violence since the age of 15;
- over one in 10 adult Australians (13 per cent, or 2.5 million people) experienced abuse as children under the age of 15. This includes an estimated 1.6 million people (8.5 per cent) who experienced physical abuse and 1.4 million (7.7 per cent) who experienced sexual abuse; and
- one in eight women (13 per cent, or 1.2 million people) and one in ten men (10 per cent, or 896,700 people) 'witnessed' violence towards their mother by a partner before the age of 15.[199]

The AIHW identifies that family, domestic, and sexual violence is 'a major health and welfare issue. It occurs across all ages, and all socioeconomic and demographic groups, but predominantly affects women and children,' and can inflict physical injury, psychological trauma, and emotional suffering … [lasting] a lifetime and can affect future generations.'[200]

6.1.10 Not all individuals exposed to potentially traumatic events experience trauma

Responses to traumatic experiences 'vary widely, with not all exposure leading to negative outcomes. It is the individual response to the experience that determines whether it is considered traumatic or not.'[201]

To understand the concept of trauma, researchers identify that a distinction needs to be made between event/s and a person's reaction to the event/s,[202] explaining that 'some individuals experience traumatic events and go on with their lives without lasting effects while others have more difficulty and experience ongoing traumatic stress reactions:'[203]

[197] Blue Knot Foundation, 'Breaking Free,' Blue Knot Foundation, Milsons Point, September 2019, p. 12.
[198] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[199] Australian Bureau of Statistics, 'Personal Safety, Australia,' ABS, Canberra, 2017, viewed 21 October 2021 <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release#experience-of-abuse-before-the-age-of-15>.
[200] Australian Institute of Health and Welfare, *Family, domestic, and sexual violence in Australia: 2018*, Australian Government, Canberra, 2018, p. vi.
[201] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 6.
[202] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 8.
[203] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 13.

> While life-threatening events are clearly traumatic, overwhelming stress can also occur in the absence of direct threats to survival…
>
> It is important to note the role of *perception*. Trauma is determined from the perception of threat rather than by the magnitude of the event/s. This means that it can arise from seemingly minor 'triggers'. This important point has many implications…
>
> The role of perception reveals why contrasting experiences can be traumatic, and why some experiences may be traumatic for some people and not for others.[204]

An individual's experience and perception of a particular event 'determines whether it is traumatic or not,' and how an event is experienced may be linked to a range of factors including the individuals' cultural beliefs, availability of social supports, or the developmental stage of the individual: [205]

> Not all children or adults who are exposed to potentially traumatic events experience long-term health problems. This may be due to protective factors, which help shield individuals from the lasting effects of trauma. Protective factors include: parental knowledge of child development; healthy parent-child attachment; social connections; and social and emotional competence.[206]

6.1.11 Services can unintentionally re-traumatise individuals

Researchers identify a broad consensus that 'many consumers who engage with public, private and community managed mental health and human services are trauma survivors,' with 'trauma experiences shape[ing] their responses to service providers:'[207]

> People impacted by trauma characteristically present to multiple services over a long period of time and care is often fragmented with inadequate coordination between services, and poor referral pathways and follow-up protocols which results in a 'merry go round' of unintegrated care. This risks retraumatisation and compounding problems as a result of unrecognised trauma. Such escalation and entrenchment of symptoms is psychologically, financially and systemically costly. Understanding that trauma underpins the way in which many people present who attend a diversity of service settings necessitates substantially new ways of operating.[208]

[204] Kezelman, C. and Stavropoulos, P. *Talking about Trauma: Guide to conversations and screening for health and other service providers,* Blue Knot Foundation, Milsons Point, 2018, p. 7.
[205] Ferrara N, *In Pursuit of Impact: Trauma- and Resilience-Informed Policy Development*, 2018, Lexington Books, Lanham, p. 13. Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 8.
[206] Centre for Health Care Strategies Inc. 'Understanding the Effects of Trauma on Health,' CHCS, Hamilton, 2017, viewed 19 October 2021 <https://www.chcs.org/media/Fact-Sheet-Understanding-Effects-of-Trauma-1.pdf>.
[207] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 1.
[208] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 1.

Research also highlights that systemic responses to trauma and its effects provided by 'public institutions and service[s] … intended to provide services and supports to individuals are often themselves trauma-inducing.'[209] Services may retraumatise a people as a result of:

- society which continues to ignore abuse and minimise its effects; which pathologises and blames the victim rather than providing informed support; [and]
- use of coercive interventions (e.g., seclusion and restraint, forced involuntary medication practices), and philosophies of care based on control and containment rather than empowerment and choice. The result is often unintentional retraumatisation in already vulnerable populations.[210]

The New South Wales Mental Health Coordinating Council identifies that 'trauma survivors often experience services as unsafe, disempowering and/or invalidating' and may withdraw from seeking support, particularly when services fail to understand how their past trauma has shaped their 'behaviours and reactions … and the way people approach potentially helpful relationships.'[211]

The challenges faced by Individuals experiencing trauma can be 'exacerbated' by responses received from human service sectors,[212] with the United States' Substance Abuse and Mental Health Services Administration (**SAMHSA**) and the Blue Knot Foundation identifying that many public institutions can be re-traumatising:[213]

> While confronting to contemplate, the re-traumatisation of already traumatised people by and within diverse services of the health sector is highly prevalent. Research establishes that service practices which lead to retraumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. In fact research which supports this disturbing claim is growing. Recognition of the reality that `[t]rauma has often occurred in the service context itself' is a major impetus for introduction of `trauma-informed' practice.'[214]

How services are provided 'can have important impacts on health and well-being,' particularly for individuals experiencing trauma. 'When serving survivors of trauma and violence, a lack of understanding of the complex and lasting impacts of these experiences may lead to harm and to missed opportunities to provide effective care.'[215]

[209] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 2.
[210] Bateman K, Henderson C, and Kezelman C, *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia – a national strategic direction*, 2013, Mental Health Coordinating Council and Adults Surviving Child Abuse, Sydney, p. 3.
[211] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 20.
[212] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 24
[213] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 3.
[214] Kezelman, K. and Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Blue Knot Foundation (formerly Adults Surviving Child Abuse), NSW, 2012, p. 86.
[215] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.

6.2 Trauma informed approaches to service provision

There is a diverse and 'rapidly growing research base leading to new understanding of trauma and new possibilities for recovery from it. Correspondingly, it also has major implications for service-provision:'[216]

> Research has established that trauma is a major public health problem. Yet within current systems it is frequently unrecognised, unacknowledged, and unaddressed. Many of those affected have been inadvertently re-traumatised in systems of care lacking the requisite knowledge and training around the particular sensitivities, vulnerabilities and triggers of trauma survivors.[217]

In recognition of the prevalence, impacts, and growing awareness of trauma, there has been increased attention to the concept of **trauma informed approaches** 'to help services attend to the effects of trauma, and its links to health and behaviour, so as to create safe spaces that limit the potential for further harm.'[218]

Fundamentally, trauma informed approaches involve 'a paradigm shift in service delivery culture to acknowledge and clearly articulate the importance of trauma in understanding and responding to client presentation.'[219]

6.2.1 Trauma informed approaches or services are distinct from trauma specific clinical interventions

Researchers identify that trauma informed interventions 'occur at two levels: trauma-specific interventions and trauma informed models of care.' [220]

Trauma specific clinical interventions 'refer to clinical services or programs designed to treat and ameliorate the actual symptoms and presentations of trauma.'[221] Trauma specific interventions include diagnostic and treatment services 'designed to treat the actual sequelae of sexual or physical abuse trauma … [such as] grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help make to render painful images more tolerable, and behavioural therapies which teach skills for the modulation of powerful emotions.'[222]

Trauma informed approaches or services 'do not directly treat trauma or the range of symptoms with which its different manifestations are associated,' however, they are 'informed about, and sensitive to, trauma related issues' and incorporate key trauma principles into organisational care.[223]

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[216] Kezelman, K. and Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* Blue Knot Foundation (formerly Adults Surviving Child Abuse), NSW, 2012, p. xxx.
[217] Kezelman, C. 'Trauma informed practice,' *Mental Health Australia*, Deakin, 2014, viewed 26 October 2021 <https://mhaustralia.org/general/trauma-informed-practice>.
[218] Wathen C, Schmitt B and MacGregor J, 'Measuring Trauma- (and Violence-) Informed Care: A Scoping Review,' *Trauma, Violence & Abuse*, 2021, p. 1.
[219] Wall, L. Higgins, D. and Hunter, C., *Trauma-informed care in child/family welfare services*, Australian Institute of Family Studies, Melbourne, 2016, p. 12.
[220] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[221] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 4.
[222] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15-16, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[223] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, Blue Knot Foundation, NSW, p. 88; Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, p. 9.

> A 'trauma informed' system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. A 'trauma informed' system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in 'traumatology'.[224]

Researchers identify that the provision of both trauma specific clinical interventions and trauma informed approaches are essential in addressing the consequences of trauma, noting that 'the provision of trauma informed services must also be supported by trauma specific services, which provide specific interventions to address the consequences of trauma.'[225] Similarly, trauma specific services require a trauma informed 'environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services.'[226]

The Office's focus on trauma informed approaches relates to the broader organisational or service system responses that are **trauma informed**, rather than trauma specific clinical interventions. However, growing awareness of trauma and its impacts have led to calls from researchers for the need for both trauma informed and trauma specific services.[227]

6.2.2 Understanding trauma informed approaches to service provision

Trauma informed approaches describe a framework for human service delivery that is 'based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.'[228]

The research literature identifies that trauma informed approaches aim to 'normalise symptoms and behaviours that have traditionally been pathologized,' with the approach asking 'what has happened to you?' rather than, 'what is wrong with you?'[229]

[224] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[225] Kezelman C, 'Trauma informed practice,' *Mental Health Australia*, 2014, viewed 26 October 2021 <https://mhaustralia.org/general/trauma-informed-practice>.
[226] Jennings A, *Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services*, 2004, p. 15, viewed 1 August 2022, <https://www.theannainstitute.org/MDT.pdf>.
[227] Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 2.
[228] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[229] Queensland Government, *Trauma-Informed Care and Practice: A guide to working well with Aboriginal and Torres Strait Islander Peoples*, State of Queensland, Brisbane, 2019, p. 3.

Internationally and in Australia, researchers have undertaken significant work in conceptualising and articulating trauma informed approaches to service provision. A central theme underpinning this work is the principle that 'recognition of trauma is core to accommodating the service needs of service survivors:'[230]

> Trauma-Informed Care and Practice (TICP) is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics … TICP is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services.[231]

SAMHSA has examined and articulated the concept of trauma and trauma informed approaches, identifying that trauma informed approaches are grounded in a set of four 'R's' or key assumptions:

> A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**.[232] [original emphasis]

The Blue Knot Foundation has identified that trauma informed services:

- attune to the possibility of trauma in the lives of everyone seeking support
- apply the core principles of safety, trustworthiness, choice, collaboration and empowerment (Fallot and Harris, 2001)
- accommodate the vulnerabilities of trauma survivors including people from diverse backgrounds
- minimise the risks of re-traumatisation and promote healing
- emphasise physical and emotional safety for everyone
- recognise coping strategies as attempts to cope
- collaborate with clients, and affirm their strengths and resources
- recognise the importance of respect, dignity and hope
- focus on the whole context in which a service is provided and not just on what is provided.[233]

[230] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 29.
[231] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 9.
[232] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 9.
[233] Blue Knot Foundation, 'Building a Trauma-Informed World,' Blue Knot Foundation, Milsons Point, 2021, viewed 4 November 2021 <https://blueknot.org.au/resources/building-a-trauma-informed-world/>.

6.2.3 Key principles of trauma informed approaches

Frameworks articulating trauma informed approaches to service provision identify a set of key principles underpinning these approaches. 'Although at times there might be subtle variations in terminology, and a degree of overlap between the principles, there is general congruence' around five key principles of trauma informed approaches.[234] These principles include:

SAFETY — **Ensuring physical and emotional safety**

Trauma informed approaches promote safety by:

- recognising the social, interpersonal, personal and environmental dimensions of safety. Understanding safety as defined by those served is a high priority;
- establishing a safe physical, psychological and emotional setting where basic needs are met for staff and the people they serve;
- ensuring staff are attentive to signs of consumer discomfort or unease, and understand these signs in a trauma informed way; and
- provider responses are consistent, predictable, and respectful.

TRUSTWORTHINESS — **Maximising trustworthiness through task clarity, consistency, and interpersonal boundaries**

Trauma informed approaches maximise trustworthiness by:

- providing clear information about what will be done, by whom, when, and why;
- maintaining appropriate boundaries; and
- conducting organisational operations and making decisions with transparency, and with the goal of building and maintaining trust.

CHOICE — **Maximising consumer choice and control**

Trauma informed approaches maximise choice and support autonomy through:

- ascertaining how much choice a consumer has over what services they receive;
- ensuring consumers get a clear and appropriate message about their rights and responsibilities;
- building in choices that make a difference to consumer-survivors (e.g. 'when would you like me to call?' 'Is there some other way you would like me to reach you or would you prefer to get in touch with me?');

[234] Smith, P. and Kaleveld, L. *Addressing Trauma in Western Australia*, Western Australian Association for Mental Health, Perth, 2020, p. 24.

- understanding the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice;
- supporting clients in cultivating self-advocacy skills; and
- empowering staff to do their work as well as possible with adequate organisational support and in an environment in which they also feel safe.

COLLABORATION **Maximising collaboration and sharing power**

Trauma informed approaches:

- place importance on partnering and the leveling of power differences between staff and clients, and among organisational staff;
- promote collaborative, strengths-based practice that values the person's expertise and judgement,
- demonstrate that healing happens in relationships and in the meaningful sharing of power and decision-making;
- cultivate a model of doing 'with' rather than 'to' or 'for'; and
- build a significant role for consumers in the planning and evaluation of an agency's services.

EMPOWERMENT **Prioritising empowerment and skill building**

Trauma informed approaches foster empowerment by:

- recognising and building upon an individuals' strengths and experiences;
- understanding that recovery is possible for everyone, regardless of how vulnerable they appear and instilling hope by establishing future oriented goals;
- providing opportunities for consumer and former consumer involvement in the planning and evaluation of services; and
- fostering a belief in the primacy of the people served, in resilience, and in the ability of individuals, organisations, and communities to heal and promote recover from trauma.[235]

[235] Adapted by Ombudsman Western Australia, from: Fallot R and Harris M, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, 2009, Community Connections, Washington DC, p. 7-10.; Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8; Kezelman, C. Stavropoulos, P, *Talking About Trauma: Guide to Everyday Conversations for the General Public*, 2017, p. 12-23; and Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 11.

6.2.4 Trauma and violence informed approaches acknowledge the impact of systemic inequalities and violence

In acknowledging that violence and abuse occurs within broader structural systems and inequalities, researchers have identified that frameworks for trauma and violence informed approaches 'expand the concept of trauma informed practice to account for the impact of systemic and interpersonal violence and inequalities have on a person's life.'[236]

> **Trauma-informed care (TIC)** creates safety for service users by understanding the effects of trauma, and its close links to health and behaviour; it is not about eliciting or treating people's trauma.
>
> **Trauma- and violence-informed care (TVIC)** expands on this to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. It shifts the focus to a person's experiences of past and current violence so problems are seen as residing in both their psychological state, and social circumstances.[237]

Researchers identify that in expanding the concept of a trauma informed approach, trauma and violence informed approaches bring into focus 'both historical and ongoing interpersonal violence and their traumatic impacts and helps to emphasize a person's experiences of past and current violence so that problems are not seen as residing only in their psychological state,' but also 'in social circumstances.'[238]

Principles underpinning trauma and violence informed approaches are similar to those principles identified for trauma informed approaches. These principles include an 'understanding of trauma and violence,' the creation of 'emotionally and physically safe environments for clients and service providers,' fostering opportunities for 'choice, collaboration, and connection,' and the provision of a 'strengths-based and capacity building approach to support client coping and resilience.'[239] In identifying the difference between trauma informed and trauma and violence informed approaches, researchers identify that the latter 'brings an explicit focus' to:

- broader structural and social conditions, to avoid seeing trauma as happening only "in people's minds"; e.g., discriminatory systems will break the bonds of trust that need to exist in a service context;
- ongoing violence including "institutional violence", i.e., policies and practices that perpetuate harm ("system-induced trauma"), e.g., making people retell their trauma to satisfy the needs of the system, rather than those of the person; [and]
- the responsibility of organizations and providers to shift services at the point of care supported by policies and systems that enable these shifts.[240]

[236] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[237] Wathen C and Varcoe C, *Trauma- & Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations & Providers*, 2021, Gender, Trauma & Violence Knowledge Incubator @ Western University and Equip Health Care, London, Canada, p. 1.
[238] Varcoe C, Wathen C, Ford-Gilboe M, et al, *A VEGA Briefing Note on Trauma-and Violence-Informed Care*, 2016, VEGA Project and PreVAil Research Network, Ontario, Canada, p. 1.
[239] Ponic P, Varcoe C and Smutylo T, *Trauma-(and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations: Victims of Crime Research Digest No. 9*, 2018, Department of Justice, Ottawa, viewed 8 November 2021, <https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html>.
[240] Varcoe C, Wathen C, Ford-Gilboe M, et al, *A VEGA Briefing Note on Trauma-and Violence-Informed Care*, 2016, VEGA Project and PreVAil Research Network, Ontario, Canada, p. 1.

The research literature highlights that this shift in language also allows for 'a more expansive understanding of people's experiences of violence and trauma,' as, particularly in the case of complex trauma, 'histories of violence typically include interconnected experiences of interpersonal and systemic violence.' Further, 'for many victims, interpersonal violence is ongoing; it can be intergenerational and linked to broader historical contexts.'[241]

6.2.5 Trauma informed, culturally strong healing approaches

The research literature highlights the importance of trauma informed approaches respecting diversity and ensuring cultural competency, identifying that a trauma informed approach 'understands how cultural context influences perception of and response to traumatic events and the recovery process,' and uses interventions respectful of and specific to cultural backgrounds,[242] leveraging the healing value of traditional cultural connections.[243]

In highlighting that trauma-informed approaches 'need to be responsive to cultural, historical, and gender issues,' researchers also highlight that this includes 'the provision of gender-responsive services, or considering gender-specific needs when interacting with individuals.'[244]

Select frameworks, such as SAMHSA's trauma informed approach, also include cultural, historical, and gender issues as a principle of trauma informed approaches. However, some researchers have identified that issues of 'culture and culturally sustaining practices' should instead be 'an overarching principle for which all other principles must be seen through.'[245]

In the Australian context, the Healing Foundation (the national Aboriginal and Torres Strait Islander organisation established to address the ongoing traumas of the Stolen Generations and forced childhood removals) has advocated for the adoption of trauma aware, healing informed approaches that:

> … emphasise the fundamental importance of collective healing processes grounded in Aboriginal and Torres Strait Islander cultures and perspectives, recognising the ongoing suffering of colonisation, the mass impacts of genocidal practices such as the Stolen Generations, and the realities of ongoing racism and interpersonal violence. According to the Healing Foundation: Trauma-informed practice is a strengths-based approach to healing that: is based on an understanding of, and responsiveness to, the impact of trauma; emphasises physical, psychological, and emotional safety for people seeking help and for the helpers; and creates opportunities for people affected by trauma to rebuild a sense of control and empowerment. It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities.[246]

[241] Ponic P, Varcoe C and Smutylo T, *Trauma-(and Violence-) Informed Approaches to Supporting Victims of Violence: Policy and Practice Considerations: Victims of Crime Research Digest No. 9*, 2018, Department of Justice, Ottawa, viewed 8 November 2021, <https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html>.
[242] Henderson C, Everett M, Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, p. 8.
[243] Substance Abuse and Mental Health Services Administration, *SAMHSA'S Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014, SAMHSA, Rockville, p. 11.
[244] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.
[245] Davis M, 'A Focus on the Trauma Informed Principle Cultural, Historical, and Gender Issues,' *Trauma Informed Oregon*, 30 July 2021, viewed 4 November 2021 <https://traumainformedoregon.org/a-focus-on-the-trauma-informed-principle-cultural-historical-and-gender-issues/>.
[246] Salter M, Conroy E, Dragiewicz M et al, *'A deep wound under my heart': Constructions of complex trauma and implications for women's wellbeing and safety from violence (Research Report, 12/2020),* 2020, ANROWS, citing Healing Foundation, *A resource for collective healing for members of the Stolen Generations*, 2014, <https://healingfoundation.org.au/resources/a-resourcefor-collective-healing-for-members-of-the-stolengenerations/>.

The Healing Foundation further identifies 'eight elements of a quality healing program'

1. Developed to address issues in the local community
2. Driven by local leadership
3. Have a developed evidence base and theory base
4. Combine western methodologies and Indigenous healing
5. Understand the impact of colonization and transgenerational trauma and grief
6. Build individual, family and community capacity
7. Proactive rather than reactive
8. Incorporate strong evaluation frameworks[247]

An example of a 'community centred, culturally strong, trauma-informed' framework for strengthening community capacity to end violence has been developed by the Ngaanyatjarra Pitjantjatjara Yankunytajatjara (**NPY**) Women's Council together with the Australian Childhood Foundation.[248] As noted by the Australian Human Rights Commission Report *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, this practice framework:

> … contains a strong commitment to resourcing communities with the tools to build and develop their own strategies based in their knowledge systems, stories, ceremonies, healing practices and spiritual beliefs to challenge violence and find safety in their lives.
>
> The Framework is useful in understanding what forms of working practices are considered trauma-informed and appropriate for Indigenous organisations to deliver.
>
> The Framework consists of eleven stages of actions and strategies which should be approached gradually and with care by practitioners in a linear order.
>
> Each stage of the Framework has a set of actions, strategies and practical information for the family violence practitioner to guide and evaluate their work.[249]

[247] Aboriginal and Torres Strait Islander Healing Foundation, *Healing Informed Organisations*, 2015, p. 11.
[248] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney p. 141.
[249] Australian Human Rights Commission, *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future Report*, 2020, AHRC, Sydney, p. 141-142.

The stages of the NPY Women's Council framework for strengthening community capacity to end violence are as follows:

Source: Australian Childhood Foundation and Ngaanyatjarra Pitjantjatjara Yankunytajatjara Women's Council[250]

6.2.6 Trauma informed approaches recognise trauma, but do not prevent it

However, some academics in the field of social work, feminism and activism have identified that, through employing biomedical and psychiatric constructions of trauma, this approach may avoid 'the social and political roots of a problem, the experiences and effects of oppression and shared forms of trauma.'[251] If conceptualised or used synonymously through a medical lens, such as through the narrow lens of post-traumatic stress disorder, such approaches risk 'individualising' constructions of trauma:[252]

> … which can blame and pathologise the individual rather than acknowledge and address the broader structural inequalities which cause trauma, such as colonisation and/or gender-based violence.[253]

Similarly, in developing guidelines for implementing trauma informed practice, Blue Knot Foundation President Dr Cathy Kezelman has identified 'a striking anomaly needs to be noted. Increased recognition of child abuse is not the same as effective and systematic addressing of it' as:

> … The challenges posed by trauma relating to child abuse are not, then, solely 'clinical', 'personal', 'psychological' or the preserve of 'the helping professions'. They are social, national and political in the broadest sense. Both because of its prevalence and ongoing effects, child abuse in its various forms comprises a major public health problem, and widespread recognition of this by policy-

[250] Tucci J, Lindeman J, Shilton M and Green L, Strengthening Community Capacity to End Violence: A Project for NPY Women's Council, 2017, Australian Childhood Foundation and NPY Women's Council Foundation, Alice Springs, p. 27.
[251] Mckenzie-Mohr, Coates & McLeod, 2011, p. 136, cited by Funston L, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, 2019, University of Sydney, Sydney Digital Theses, Sydney, p. 32.
[252] McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 136.
[253] Women's Health Victoria, *Spotlight on Trauma-informed practice and women*, 2019, p. 1.

> makers, as well as by the public, comprises one of the major challenges that needs to be met.[254]

Trauma informed approaches offer a framework for better responding to the needs of those who have experienced trauma. However, trauma informed practice 'is ultimately not a violence prevention or social justice framework.'[255]

Literature concerning trauma informed approaches generally does not include 'explicit reference to social change, legislative change, social policy recommendations or community development strategies.'[256] In this context, researchers highlight that 'an orientation toward primary prevention must occur alongside secondary prevention efforts,' including trauma informed approaches.[257] These efforts require broader change.

6.3 Victims and witnesses of violent crime have diverse and varied needs for support

6.3.1 Our understanding of victims' needs has evolved in recent years

In recent years, a number of Australian reviews and inquiries have been conducted into the needs and experiences of victims. Most notably, these have included the Royal Commission into Institutional Responses to Child Sexual Abuse, and the Victorian Royal Commission into Family Violence. The reports of these inquiries have provided new perspectives on victims' experiences, support needs, and the re-traumatisation that can arise from inadequate systemic responses.

Accordingly, the evidence base on victims' needs and experiences has expanded in recent years, broadening understandings of victimisation and trauma beyond:

> … an understanding of crime as an isolated or confined experience from which victims of crime are well equipped to recover; that victims experience crime with few pre-existing issues; and that victims of crime are always able to identify and articulate what they need from the system.[258]

It is now well-recognised that victims of crime have diverse needs and experiences of victimisation, and may have multiple and/or complex support requirements – all of which occur in the broader context of their life circumstances, historical interactions with support services and pre-existing vulnerabilities, as noted in a 2020 review of Victoria's victim support services system:

- The way in which a person responds to the experience of victimisation can depend on personal factors - such as age, gender, abilities, health, ethnicity, culture, socioeconomic status, social networks and previous experiences and

[254] Kezelman K and Stavropoulos P, *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* 2012, p. 44.
[255] Funston, Leticia, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, University of Sydney, Sydney Digital Theses, p. 34.
[256] Funston L, *In the Business of Trauma: An intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis]*, 2019, University of Sydney, Sydney Digital Theses, p. 32, and McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 142.
[257] McKenzie-Mohr, S. Coates, J. and McLeod, H. 'Responding to the needs of youth who are homeless: Calling for politicised trauma-informed intervention,' 2012, *Children and Youth Services Review,* 34(1), p. 142.
[258] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, November 2020, p. 12, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>.

interaction with the justice system; the type and seriousness of the crime; and the nature of the victim's relationship with the offender.

- Most people have an emotional reaction to victimisation, with increased stress and persisting psychological, social and physical effects associated with more serious or violent offences.

- Effects of victimisation can be wide-ranging – for example, the RCIRCSA [Royal Commission into Institutional Responses to Child Sexual Abuse] found that victims of child sexual abuse experienced impacts in multiple spheres, such as mental health, physical health, including substance misuse; interpersonal relationships, including difficulties with trust and intimacy; connection to culture, spirituality and religious involvement; sexual identity, gender identity and sexual behaviour; and education, employment and economic security.

- While the effects of property crimes are typically not as severe and long-lasting as violent personal crimes, victims of property crime can nevertheless suffer emotional, psychological and physical health effects, sometimes to a severe degree.

- Emerging crime types, such as online fraud, can have "a devastating impact on victims and their families". For example, victims of online fraud often experience significant emotional and psychological impacts, with feelings of shame, distress, sadness and anger often reported, as well as loss of trust in others. A 2016 Australian study reported that multiple online fraud victims indicated that they had seriously contemplated suicide as a result of their victimisation.

- Many victims of crime never report to police with under-reporting even more pronounced for specific cohorts and types of offences. For example, some studies indicate that as many as 90 per cent of Aboriginal women do not disclose experiences of violence.

- The effect of crime victimisation can compound, as well as be compounded by, pre-existing vulnerabilities in those already experiencing disadvantage or marginalisation, such as refugees, women escaping family violence, Aboriginal and Torres Strait Islander peoples, and people with disabilities.

- Prior experiences of victimisation – for example, childhood sexual abuse and childhood physical abuse – can be predictive of secondary victimisation, which in turn compounds and exacerbates the impact of crime in a multiplicative way.

- The link between victimisation and offending is one of the strongest empirical associations in criminological literature. A 2012 review of the literature on the 'victim-offender overlap' identified studies reporting that more than half of victims of crime become offenders and vice versa.

- The link between victimisation and offending can be even more pronounced for some crime types and cohorts. For example, a 2014 literature review of the profile and needs of incarcerated women noted high rates of histories of childhood victimisation (particularly sexual abuse) and subsequent victimisation as adolescents and adults (including sexual assault and family violence). Similarly, an Australian study found that victims of child sexual

> abuse were "almost five times more likely to be charged with an offence than their peers in the general population."[259]

6.3.2 Victims of violent crime want individualised information and support services that are proactive and trauma informed

Research into victims' experiences has also identified the diversity of victim support needs. The Royal Commission into Institutional Responses to Child Sexual Abuse highlighted that:

> At various times, depending on the circumstances, victims and survivors seek support from a range of mainstream and specialist services to help manage the detrimental impacts of abuse on their mental health. They may also need support for legal, education, housing, health, employment and financial issues, and for assistance with reporting abuse. The services used by victims and survivors span several sectors and can be difficult to navigate. The need for support often extends to secondary victims, such as family members, carers and friends and others ...[260]

Victims may require both practical supports and emotional or psychological supports, as highlighted by the Australian Institute of Criminology:

> For victims of violent crimes, it is frequently assumed that what is most needed is emotional and psychological support. However, an American study on female victims of violent crime indicated that practical support, such as the provision of daycare, housing, education, food and job training was regarded as being more helpful than the provision of emotional support from family and friends, professional counselling, medication, and support from self-help groups and medical providers. It is important to note that emotional support was not regarded as unhelpful, but rather that it was not as relevant to the practical needs of the victim. This result may reflect a misdirected emphasis on the provision of services to victims of violent crimes.
>
> A study sponsored by the National Institute of Justice in the United States concluded that service providers often fail to adequately address the more concrete/tangible needs of victims, focusing instead on providing emotional/psychological support. In addition, an Australian qualitative study suggested that the three most important aspects of providing support services for victims of domestic violence were that they remain free, anonymous and flexible, with the added component that that they address the longer term effects of the crime, as well as providing immediate crisis support. [references omitted][261]

[259] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, 2020, p. 21-23, viewed 27 May 2022, <https://cij.org.au/cms/wp-content/uploads/2020/11/strengthening-victorias-victim-support-system-victim-services-review-centre-for-innovative-justice-november-2020.pdf>.
[260] Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report Volume 9: Advocacy, support and therapeutic treatment services*, 15 December 2017, p. 9-10.
[261] McGregor K, Renshaw L, Andrevski H, *ACT Victims of Crime Referral Project: Final Report (AIC Reports Technical and Background Paper 55),* 2013, Australian Institute of Criminology, p. 9.

Qualitative research undertaken through interviews of victims of violent crime in Victoria identified several key themes relevant to improving victim support services in that State, including that:

> Victims of crime often cannot differentiate between the various services and agencies with which they interact in the aftermath of a crime. …
>
> Victims of crime need a timely response … Depending on the nature of the crime experienced, however, some had urgent needs that were not able to be addressed immediately. These often included practical and safety needs–- such as where a crime meant that a victim could not immediately return to their home or where the offender posed an ongoing risk. Other immediate needs included information and psychological first aid; taxi vouchers and transport; support to coordinate and attend medical appointments; and childcare. Where victims of crime were not able to work because of the crime, it was important to instigate rapid processes to access interim … payments or support through Centrelink. …
>
> Victims of crime want information provision that is individualised. …
>
> Victims of crime want support that is proactive and trauma-informed …
>
> Victims of crime want a single point of contact to help them navigate the system, although this did not always need to be an individual worker. Rather, they wanted to know that there was one 'place' which would provide them with the information which was relevant to them at the time; holistically assess and respond to their needs; and would not require them to re-tell their story. …
>
> Victims of crime want to know what is happening with their case …
>
> Victims of crime want support to navigate legal issues …
>
> Families [of victims of crime] are not well-supported … [and] there is a need, in some cases, to work with the whole family. This includes ongoing individual assessments of family members to understand the extent to which they may be impacted by their loved one's experience of victimisation over time.[262]

Victims of crime additionally face barriers to accessing appropriate services and care, including after the conclusion of court proceedings, parole applications and the period after an offender is released.[263] Some of these barriers include:

- that the evidence-base 'about the effectiveness of support interventions … [in] successful[y] meeting victims' needs' is limited, and still developing;[264]
- victims are often in need of 'the missing middle in social services,' not often meeting the acute clinical service criteria for entry into public mental health services;[265]
- a 'shortage' in appropriately qualified mental health professionals;[266] and

[262] Centre for Innovative Justice, *Strengthening Victoria's Victim Support System: Victim Services Review: Final Report*, 2020, p. 32-41,
[263] Department of Justice, *A report on the statutory review of the Victims of Crime Act 1994 (WA)*, Government of Western Australia, May 2021, p. 27.
[264] Ministry of Justice (UK), *Evidence and Practice Review of support for victims and outcome* measurement, November 2021, NatCen Social Research, p. iii.
[265] Craven R, 'The missing middle in social services, *The Mandarin*, 31 January 2020, <https://www.themandarin.com.au/124281-the-missing-middle-in-social-services/>; Orygen, *Defining the missing middle*, <https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle/orygen-defining-the-missing-middle-pdf?ext=>.
[266] Institute for Social Science Research, *Final Report: National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, 2020, The University of Queensland, p. 7, 16, 22, 43.

- victims' vulnerability to further re-victimisation when accessing services provided by organisations that are outside the scheme of regulation and oversight provided 'unregulated private health facilities … not covered by the definition of "Health Service" or "Hospital" in the *Private Hospitals and Health Services Act 1927*' which are currently the subject of the Education and Health Standing Committee Inquiry into the Esther Foundation and unregulated private health facilities.[267]

6.4 Vicarious trauma

6.4.1 Workers providing services to people who have experienced trauma may experience 'vicarious trauma'

> The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.[268]

Researchers identify that workers supporting survivors of trauma are 'at risk of being negatively impacted' by their work.[269] The changes a person may experience after routinely and repeatedly being exposed to first-hand or secondary trauma in the course of their employment, are referred to as 'vicarious trauma'.[270]

> [Vicarious trauma] … is related to concepts such as 'emotional exhaustion', 'burnout', 'compassion fatigue', 'secondary traumatisation' and 'counter-transference', but some key differences exist between some of these concepts. It can also be expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'.[271]

> Vicarious trauma is a cumulative effect of working with trauma, which can affect many aspects of a person's life. It may consist of short-term reactions, or longer-term effects that continue long after the work has finished. … some effects of vicarious traumatisation parallel those experienced by the primary victim/survivor.[272]

The research literature identifies that those who work to support others with trauma can experience a range of detrimental effects over time, including changes in the way they perceive the world:

[267] Legislative Assembly, Education and Health Standing Committee, Parliament of Western Australia, *Inquiry into the Esther Foundation and unregulated private health facilities: Terms of Reference*, 7 April 2022.
[268] Remen R, *Kitchen Table Wisdom: Stories that Heal*, 1996, Penguin, New York, cited by Dixon ,. 'When Compassion Hurts: An Introduction to Vicarious Trauma and Resilience,' NSW Health Youth Forum Presentations, 2019, p. 1.
[269] Office for Victims of Crime, *What is Vicarious Trauma*, 2021, viewed 22 October 2021 <https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma>.
[270] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 1.
[271] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 2.
[272] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 2.

> Connected to these experiences, vicarious traumatisation may also involve a change in a person's beliefs about themselves, the world, and other people within it. This is known in the psychological field as changes in their 'cognitive schema', and may involve:
>
> - feeling that the world is no longer a 'safe place' (for themselves and/or others);
> - feeling helpless in regard to taking care of themselves or others;
> - feeling their personal freedom is limited; and
> - feelings of alienation (that their work within the field of sexual assault sets them apart from others).[273]

Vicarious trauma can arise in response to a number of high stress professions, including among first responders working in policing, paramedic, fire and other emergency services; social workers; mental health professionals; victim support workers; child protection workers; lawyers and paralegal staff; and others working during war and natural disasters.[274]

Research has shown that professionals working with survivors of childhood abuse and other forms of interpersonal violence produce the highest scores of 'traumatic stress' and may experience a higher level of 'disrupted beliefs'.[275]

Vicarious trauma can also be experienced by researchers working 'on topics that are permeated with trauma,' fatality review jurisdiction staff, criminologists and others whose work requires 'empathetically reviewing stories of profound loss and trauma and … the worst of humankind.'[276]

Vicarious trauma research points out that these responses are normal human reactions to circumstances involving repeat exposure to distressing events. Further, researchers note that those who experience vicarious trauma should not be 'pathologised' or 'viewed … as medically or psychologically abnormal'.[277]

[273] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3.
[274] Barrratt P, Stephens L, and Palmer M, *When Helping Hurts: PTSD in First Responders*, 2018, p. 5; Dixon A, 'When Compassion Hurts: An Introduction to Vicarious Trauma and Resilience,' 2019, NSW Health Youth Forum Presentations, p. 3. and Office for Victims of Crime, *Introduction to Vicarious Trauma for Law Enforcement*, 2021, Department of Justice, Office of Justice Programs, Washington.
[275] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3.
[276] National Center for Fatality Review and Prevention, *Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma*, 2016, p. 4; Moran R and Asquith N 'Understanding the vicarious trauma and emotional labour of criminological research,' *The Emotion and Emotional Labour of Criminological Researchers*, 2020 13 (2).
[277] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3; Henderson C, Everett M, and Isobel S, *Trauma Informed Care and Practice Organisational Toolkit (TIPCOT) – An Organisational Change Practice Resource – Stage 1, Planning and Audit*, 2018, Mental Health Coordinating Council, p. 10-11.

6.4.2 Organisations can support and protect their staff against vicarious trauma or increase the risk of its occurrence

Whilst exposure to trauma is 'the clearest predictor' of vicarious traumatisation, research highlights that caseloads (i.e. the extent of trauma exposure), are also predictive of the likelihood of vicarious trauma occurring in a workplace.[278]

Researchers identify that the culture in which work is undertaken is important in determining whether and how individuals experience vicarious trauma:

> Research shows that when the possibility of vicarious trauma is not recognised or acknowledged, people may be more detrimentally affected because there are few if any efforts to prevent or reduce this harm …
>
> "The values and culture of an organisation set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally." (Bell et al., 2003, p. 466)
>
> … An organisational culture that normalises the effects of working with trauma can be a start to providing a supportive environment for workers to address those effects in their work and wider lives. It may also give 'permission' or encouragement for workers to take care of themselves.[279]

In exploring how vicarious trauma can be mitigated or addressed, researchers identify that organisational approaches are crucial, and that 'emphasising individual coping strategies or "resilience"' should be avoided as they 'could be a form of "victim-blaming"' and misunderstand the causes of vicarious trauma:[280]

> As mental health professionals dedicated to the fair and compassionate treatment of victims in society, we have been strong in vocalizing concerns that those who are abused and battered not be blamed for their victimization and their subsequent traumatic response. Yet when addressing the distress of colleagues, we have focused on the use of individual coping strategies, implying that those who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, selfcare, or supervision … In light of findings that the primary predictor of trauma scores is hours per week spent working with traumatized people, the solution seems more structural than individual. (Bober & Regehr, 2006, p. 8).[281]

Research highlights that organisations can create a supportive environment for individuals working in fields that routinely involve exposure to trauma, people affected by trauma, and traumatic material.

[278] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 5.
[279] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 3, 8-10.
[280] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 7.
[281] Bober and Regehr, 2016, p. 8 cited by Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 7.

Researchers and stakeholders in the sexual assault and fatality review fields identify ways in which organisations can create a supportive environment for professionals in these fields. These may also be relevant to the diverse areas in which people work with individuals who have experienced trauma, and their stories. These include:

- **increased knowledge about vicarious trauma:** identifying and understanding vicarious trauma and related reactions, identifying and cultivating expertise, and sharing this knowledge and opening dialogue about vicarious trauma;
- **ensuring appropriate and diverse caseloads**: given that the level of exposure to trauma is a predictor of vicarious traumatisation levels, the number of cases workers see within a given time period needs to be appropriate;
- **providing effective supervision for all**: effective supervision is said to be an essential component of the prevention and healing of vicarious traumatisation. Responsible supervision creates a relationship in which a worker feels safe to express their fears, concerns and feelings of inadequacy;
- **access to debriefing**: debriefing and peer support were identified in a study of domestic violence counsellors as the most important strategy for dealing with the after-effects of a difficult counselling session;
- **staff and peer support**: the literature on both vicarious traumatisation and burnout emphasises the importance of social support within the organisation. Maintaining collegiality and avoiding social isolation is fundamental for workers; and
- **safety and comfort in the work environment**: being threatened by a client or other person at work is strongly correlated with compassion fatigue. As well as safety issues, workers' comfort is also important.[282]

6.4.3 People working with and witnessing the strength of trauma survivors, workers may experience 'vicarious resilience'

Just as individuals affected by trauma display resilience and strength, the witnessing of clients 'overcoming adversity and demonstrating an immense capacity to heal' can have a positive effect on people working with individuals affected by trauma.[283]

Vicarious resilience is embedded in resilience theory and is described as 'the growth that helping professionals experience through witnessing the experiences and triumphs of victims under adverse circumstances.'[284] It is a strength-focused concept that originated with therapists working with trauma victims:

> They noticed that among the psychotherapists working with torture survivors, some made specific reference to the inspiration and strength they drew from working with clients.[285]

[282] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 8-10, and National Center for Fatality Review and Prevention, *Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma*, 2016, Okemos, p. 7-8.
[283] Blue Knot Foundation, 'Managing Wellbeing and Recognising Vicarious Trauma: Professional Development Training Booklet,' 2021, p. 15.
[284] Jun J, 'Vicarious Resilience: Cultivating Internal Strength Through External Support,' *American Journal of Nursing*, 2020, 120(11), p. 13.
[285] Hernandez-Wolfe P, 'Vicarious Resilience: A Comprehensive Review,' *Revista de Estudios Sociales*, 2018, 66, 9-17, p. 10, doi: 10.7440/res66.2018.02.

Qualitative research studies have documented the presence of vicarious resilience in working with professionals who work with survivors and family members of those who have experienced severe trauma. This research has identified a number of positive factors associated with working with survivors, including 'changes in life goals and perspective, client-inspired hope, increased recognition of clients' spirituality as a therapeutic resource, increased capacity for resourcefulness, increased self-awareness and self-care practices, increased consciousness about power and privilege relative to clients' social location, and increased capacity for remaining present while listening to trauma narratives.'[286]

Working in fields that frequently interact with trauma survivors or traumatic experiences 'can mean making a positive and lasting impact' on issues of profound importance.[287] Vicarious resilience 'does not ignore the important phenomenon of compassion fatigue,' burnout, or vicarious trauma; 'instead, it offers a counterbalance, a positive resource to be attended to and nurtured.'[288]

6.5 Western Australian strategic frameworks identify the need for trauma informed approaches to service provision

Key Western Australian strategy documents in the area of suicide prevention, family and domestic violence, engaging with young people, empowering Aboriginal and/or Torres Strait Islanders, and workforce development recognise the significance of trauma and its impact upon individuals and communities. These strategy instruments also emphasise the need for services to adequately understand and appropriately respond to trauma.

6.5.1 *Path to Safety: Western Australia's Strategy to Reduce Family and Domestic Violence 2020 – 2030* identifies that Western Australian responses to family and domestic violence will be trauma informed

Path to Safety sets out a whole-of-government and community plan for reducing and responding to family and domestic violence. Path to Safety highlights a series of guiding principles, including that 'effective solutions are locally tailored, culturally safe, and **trauma-informed**:'[289]

> All Strategy initiatives will maintain a focus on responding to people's diverse and intersecting experiences, providing-trauma informed supports, and supporting effective, local solutions.[290]

Similar to actions set out nationally in *Australia's National Plan to Reduce Violence against Women and their Children 2010-2022* and its Fourth Action Plan, Path to Safety also highlights trauma informed service provision for victims and perpetrators of family and domestic violence:

[286] Killian K, Engstrom D and Hernandez-Wolfe P et al, 'Development of the Vicarious Resilience Scale (VRS): A Measure of Positive Effects of Working With Trauma Survivors,' *Psychological Trauma: Theory, Research, Practice, and Policy*, 2017, 9(1), p. 23.
[287] Morrison Z, *'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field (ACCSA WRAP No. 4)*, 2007, Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies, p. 11.
[288] Jun J, 'Vicarious Resilience: Cultivating Internal Strength Through External Support,' *American Journal of Nursing*, 2020, 120(11), p.13.
[289] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 6.
[290] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, Department of Communities, Perth, p. 25.

> To create safety for women and children, and to support them to recover and thrive, we will grow the capacity of earlier intervention and crisis response services to …
>
> - Deliver services that are person-centred, risk and trauma informed and accessible.[291]

With regard to perpetrator accountability and behaviour change, Path to Safety identifies that:

> Over the life of the strategy we will build an effective web of accountability through increased collaboration between services and agencies, streamlined responses and routine exchanges of risk relevant information, mechanisms to identify episodes of family and domestic violence and enact consequences for the perpetrator and pathways to suitable interventions …
>
> This will be underpinned by ensuring that service options for perpetrators also recognise and respond to the impacts of trauma.[292]

6.5.2 The WA Suicide Prevention Framework specifies the need for trauma informed supports

The WA Suicide Prevention Framework identifies that 'persons who have experienced abuse [or] trauma' are vulnerable populations 'who have been identified as having a higher risk of suicide and suicidal behaviour as a result of barriers they may experience due to social, economic, cultural, geographical, environmental and individual factors.'[293] Acknowledging the role of 'addressing historical and current trauma and the social determinants of health have in suicide prevention,'[294] the WA Suicide Prevention Framework identifies that:

> Action on suicide prevention is more effective when integrated with broad responses to the social and cultural determinants of poor health and wellbeing. This includes childhood trauma, family violence, poverty, insecure housing, displacement, experiences of discrimination, lack of education opportunities, isolation, loneliness and alcohol and other drug use. For Aboriginal people the impact of colonisation and systemic racism also needs to be acknowledged.[295]

The WA Suicide Prevention Framework identifies that 'competent and confident assistance for people who are suicidal' is a priority under the framework, and highlights that 'embedding culturally secure, trauma-informed and compassionate procedures and responses into [Emergency Departments] as well as crisis and support services' are activities required to achieve this priority.[296]

[291] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, p. 35.
[292] Government of Western Australia, *Path to Safety: Western Australia's strategy to reduce family and domestic violence 2020-2030,* 2020, p. 40.
[293] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 6-7.
[294] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[295] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 24.
[296] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 31.

With regard to Aboriginal and Torres Strait Islander people, the WA Suicide Prevention Strategy identifies a series of activities that 'aim to support the healing and restoration to wellbeing and mental health, both individually and collectively for Aboriginal people.' In addition to facilitating the development of 'a Western Australian Aboriginal Suicide Prevention Strategy prioritising a culturally secure [social and emotional well-being] approach to suicide prevention with dedicated regional plans,'[297] the WA Suicide Prevention Strategy highlights the following recommended activity:

> 11.7 Embed culturally secure, trauma-informed and compassionate procedures and responses into crisis and support services.[298]

6.5.3 *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025* identifies that services to young people must be trauma informed, and emphasises the need for all staff delivering services to young people are appropriately trained

In December 2020, the Mental Health Commission released the *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025* (**YPPA**), guiding the 'State Government, the Mental Health Commission and other agencies, the mental health and AOD [alcohol and other drugs] sector, and other stakeholders across the community, in supporting and responding to the mental health and AOD needs of young people aged 12 to 24 years.'[299]

In highlighting the contribution of stakeholders to YPPA, the Mental Health Commission identified:

> "Distress is a natural response to interpersonal adversity (e.g. abuse and trauma), young people don't have the agency to address or deal with this"
>
> Understanding and addressing trauma, and providing trauma informed care is important in preventing the emergence and/or increase in severity of mental health issues.[300]

YPPA identifies that young people with mental health and/or alcohol and other drug issues, and young people in general, 'come into contact with many different sectors and services, including AOD, mental health, health, justice, community, education and social service sectors:'[301]

> This intersectional relationship between sectors means that coordinated approaches for young people are critical and most effective. Services need to be trauma informed, so they can respond appropriately, particularly regarding trauma experienced by young people throughout their childhood.[302]

[297] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 37-38.
[298] Mental Health Commission, *Western Australian Suicide Prevention Framework 2021-2025*, 2020, p. 38.
[299] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020.
[300] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 20.
[301] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 36.
[302] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 36.

YPPA emphasises the need to ensure that staff (including those outside the mental health and AOD sector),[303] are trained in delivering appropriate services to young people, highlighting that 'staff training in recovery oriented and trauma-informed care is crucial.'[304] YPPA further highlights 'trauma-informed training,' expanding 'delivery of trauma-informed care and practice training in the mental health community sector and to human services agencies' as an area for immediate action.[305]

6.5.4 Western Australia's *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025* identifies that implementation of trauma informed care is necessary across health and human service systems, not just within mental health and alcohol and other drug settings

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* identifies the requirement to develop a comprehensive mental health, alcohol and other drug workforce planning and development strategy. Western Australia's *Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020-2025* (**the Workforce Strategic Framework**) 'aims to guide the growth and development of an appropriately qualified and skilled workforce that will provide individualised, high quality mental health and [alcohol and other drugs] services, and programs for the Western Australian community.'[306]

The Workforce Strategic Framework identifies that 'trauma-informed care' is an 'approach which recognises and acknowledges trauma and its prevalence amongst people using and delivering services, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery, in order to prevent further trauma and support healing.'[307]

The Workforce Strategic Framework identifies nine principles that underpin the framework. Principle seven of the Workforce Strategic Framework relates to trauma informed care:

> **Trauma-informed and family-inclusive methods are common practice.**
>
> Implementation of trauma-informed care is necessary across health and human service systems, not just within mental health and AOD settings.
>
> **Trauma-informed care:** recognises that past trauma experiences affect a person's present perspectives and responses. Trauma-informed approaches commit to and act upon core principles of safety, trustworthiness, choice, collaboration and empowerment.

[303] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 43.
[304] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 42.
[305] Mental Health Commission, *Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025*, 2020, p. 43.
[306] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, p. 5.
[307] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, 2020, p. 48.

Trauma-informed services:

- are informed about, and sensitive to, trauma related issues;
- are attuned to the possibility of trauma in the lives of all clients;
- commit to and act on the core principles of safety, trustworthiness, choice, collaboration and empowerment;
- emphasise physical and emotional safety for all – clients, practitioners and service providers; and
- collaborate with clients, and affirm their strengths and resources; and recognise the importance of respect, information, hope and possibilities for connection.[308]

6.5.5 Health Service Providers have begun implementing a trauma informed approach, including through the *Western Australian Women's Health and Wellbeing Policy*; *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* and *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*

The Department of Health developed the *WA Women's Health and Wellbeing Policy* 'to demonstrate the WA health system's commitment towards achieving the shared vision and strategic priorities of the *National Women's Health Strategy 2020 – 2030*'.[309] Included as a priority in the policy is 'the delivery of safe, trauma informed services for women experiencing gender-based violence'. [310] The Policy 'aims to drive continuous improvement in the health, safety and wellbeing of women and girls in WA' and:

> … is an initiating document to guide the development of new policies, programs, research, and service planning and delivery to drive equitable, accessible and appropriate services … [and recommends] 'that the WA Department of Health, Health Service Providers and health services develop implementation plans to deliver the recommended actions of the Policy …[311]

The *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* aims to 'strengthen the integration of mental health care within all regional health services' … and:

> … aligns with the *WACHS Strategic Plan 2019–24* priorities of addressing disadvantage and inequity, building healthy and thriving communities in collaboration with our partners, and providing a safe and secure workplace.[312]

Additionally, the *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024* acknowledges the 'people who have experienced complex trauma' as a vulnerable group in country Western Australia and defines 'trauma-informed care' as follows:

[308] Mental Health Commission, *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025*, 2020, p. 29.
[309] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia.
[310] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia, p. 24.
[311] Health Networks, Department of Health, *WA Women's Health and Wellbeing Policy*, 2019, Government of Western Australia, p. 7-8, 10.
[312] WA Country Health Service, *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024*, 2019, Government of Western Australia, p. 3.

> Many people accessing mental health, alcohol and other drug services have experienced trauma in their lives. This can be as a result of early childhood abuse or neglect, assault, domestic violence or other traumatic experiences. TIC is delivered from a stand point of understanding the prevalence of trauma and of its impact upon a person's physical, emotional and mental health. This can impact an individual's behaviour and ability to engage with services, understanding that their response to this and some interventions can re-traumatise the individual.[313]

The *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026* was 'developed to provide strategic direction, leadership and best practice for North Metropolitan Health Service in response to the public health issue of family and domestic violence' and:

> … recognises the impacts of colonialism, inter-generational trauma, structural disadvantage, the destruction of culture, loss of cultural identity and the pervasion of racism and normalisation of systemic disadvantage faced by Aboriginal people as a driver of and context for their experience of violence.[314]

Further, the *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026* also highlights 'the high likelihood that victims of FDV have experienced trauma' and the importance of staff 'respond[ing] in a trauma-informed way'.[315] The Strategy describes 'trauma-informed care' and 'trauma informed health services' as follows:

> Trauma-informed care seeks to create safety for consumers by understanding the effects of trauma and its close links to health and behaviour … Trauma-informed care [also] involves understanding how trauma shapes a person's world view and functioning. Trauma-informed care will incorporate principles of safety, trust, collaboration and choice in service delivery. …
>
> A trauma informed health service includes incorporating trauma-informed policies such as allowing sufficient time (length of session) and continuity of care to engage with a consumer, spaces to have private and confidential discussions, and if possible, decisions made in collaboration and respectful of a consumer's choice. It also requires clear roles for staff and referral pathways both internally and externally. A key factor in supporting a consumer who discloses FDV is to provide them with information and support in response to their needs. Responses need to be culturally appropriate, culturally secure, and flexible to better meet the needs of consumers. [316]

6.5.6 The Aboriginal Empowerment Strategy identifies that healing trauma is an essential part of the strategy, emphasising trauma informed service delivery

The Aboriginal Empowerment Strategy, developed in partnership with the Aboriginal Advisory Council of WA, sets out how the Western Australian government 'will direct its efforts towards a future in which all Aboriginal people, families and communities are empowered to live good lives and choose their own futures from a secure foundation:'

[313] WA Country Health Service, *WA Country Health Service Mental Health and Wellbeing Strategy 2019-2024*, 2019, Government of Western Australia, p. 22.
[314] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 6 and 12.
[315] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 16.
[316] North Metropolitan Health Service, *North Metropolitan Health Service Family and Domestic Violence Framework 2021-2026*, 2021, p. 16 and 22.

> The Strategy outlines a high-level framework for future state government policies, plans, initiatives and programs that contribute to better outcomes for Aboriginal people …
>
> … sets out the State's approach to meeting its commitments under the National Agreement on Closing the Gap …
>
> [and] consists of 10 strategic elements grouped into four themes, and a set of core principles. Together, these set the high-level direction for the WA Government, its agencies and staff to work towards achieving the Strategy's goal.[317]

As identified in section 5.5.1, the Aboriginal Empowerment Strategy identifies that healing trauma is a central and essential part of the strategy, noting that 'Aboriginal people have said very clearly that healing and trauma must be addressed for social and economic outcomes to improve.'[318] The Aboriginal Empowerment Strategy also identifies that services to Aboriginal and/or Torres Strait Islander people are to be 'family-focused, **trauma-informed** and directed to building strengths and reducing vulnerability,'[319] with its Policy Guide identifying that 'the Strategy's principles emphasise trauma-informed service delivery and guard against the creation of future traumas.'[320]

Trauma informed approaches to service delivery are also highlighted explicitly for Aboriginal and Torres Strait Islander children and young people. Western Australia's *Commitment to Aboriginal Youth Wellbeing*, the Government's response to the State *Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley*, and the 2016 Parliamentary Inquiry, *Learnings from the Message Stick: the report of the Inquiry into Aboriginal youth suicide in remote areas*, 'outlines how the Government of Western Australia proposes to work towards reducing the rate of suicide and enhancing the wellbeing of young Aboriginal people.'[321]

Commitment 5, 'building capacity in health and mental health services' identifies that 'induction and ongoing training of staff in cultural competency and trauma-informed care' is included as a key approach to building capacity in health and mental health services to 'deliver services to Aboriginal people that are flexible, responsive and culturally safe.'[322]

6.5.7 The Office did not identify detailed public sector guidance about what it means to be trauma informed

The Office identified that these strategies and frameworks recognise the importance of understanding trauma and identify the importance of trauma informed service delivery.

However, the Office did not identify a unified whole of government service approach or framework for creating shared definitions and understandings of trauma informed practice, its implementation and evaluation.

[317] Department of Premier and Cabinet, 'Aboriginal Empowerment Strategy – Western Australia 2021-2029,' 2021, viewed 3 October 2021, <https://www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/aboriginal-empowerment-strategy-western-australia-2021-2029>.
[318] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Strategy Overview*, 2021, p. 7.
[319] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Strategy Overview*, 2021, p. 14.
[320] Government of Western Australia, *The Aboriginal Empowerment Strategy Western Australia 2021-2029: Policy Guide*, 2021, p. 11.
[321] Government of Western Australia, *Commitment to Aboriginal Youth Wellbeing*, 2020, p. 5.
[322] Government of Western Australia, *Commitment to Aboriginal Youth Wellbeing*, 2020, p. 24-25.

6.5.8 The term trauma informed is frequently used, but not always accompanied by clearly articulated definitions or approaches

In other countries and in Australia, some agencies are 'moving towards a trauma-informed paradigm for considering health and human service delivery systems:'[323]

> A systems approach to trauma-informed care means that implementation goes beyond individual practitioner and service organisation change to extend to whole systems that people who have experienced trauma are likely to interact with. A system, for example, could include the justice, homelessness or child welfare systems …
>
> Systemic change is important because it enables people to receive services that are sensitive to the impact of trauma regardless of whether they enter through any particular service setting or intervention.[324]

Researchers acknowledge that the implementation of trauma informed approaches at 'the systems level' is challenging 'due to the complex, dynamic nature of service systems.'[325] While the term 'trauma informed' is common, and used frequently across a range of service settings, some researchers highlight that 'there is not a common understanding of [trauma informed care],' or of how to implement it in different service settings. This 'causes confusion and difficulties in integrating and coordinating service delivery across sectors.'[326] Examining challenges faced by systems and services in implementing trauma informed approaches, with the Australian Institute of Family Studies identifies:

> With the lack of an overarching framework in Australia, there is a danger of inconsistent or piecemeal development of trauma-informed models and practices that do not share a consistent language or framework for implementing trauma-informed systems of care in child/family services…
>
> Challenges to implementing a trauma-informed approach to care include: a lack of clearly articulated definitions (e.g. of trauma-specific interventions vs the concept and principles of trauma-informed care); translating trauma-informed care to specific practice and service settings; consistency across service settings and systems; care-coordination; a lack of guidance for facilitating complex system change; and a lack of evaluation of models of trauma-informed care.[327]

'In Australia, there is a demonstrated growing desire for, and provision of, training for trauma-informed care and practice among mental health professionals, child welfare services and other human service practitioners.'[328] In Western Australia, this desire is reflected in the aforementioned strategy frameworks, many of which have incorporated the voices of stakeholders including organisations, communities, and individuals with lived experience of family and domestic violence, suicide, and trauma.

[323] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 12.
[324] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 12-14.
[325] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 38.
[326] Domestic Violence Victoria, 'DV Vic Submission to Mental Health Royal Commission,' 2019, p. 19.
[327] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.
[328] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 41.

The research literature identifies that, while take-up of the idea of trauma informed approaches has been enthusiastic, 'leadership on framing trauma-informed care and collaborative initiatives to design, implement and evaluate organisational and systemic approaches are essential.' [329]

Recommendation 8: The Mental Health Commission, in collaboration with relevant State government departments and authorities and stakeholders, develop and disseminate a common understanding of what constitutes a trauma informed approach for Western Australian State government departments and authorities. Including, but not limited to:

- a definition and key principles of a trauma informed approach;
- domains of implementation (including, but not limited to, an organisation's strategic leadership, policy, training for staff, and evaluation);
- consideration of vicarious trauma in the service delivery context;
- this approach being intersectional, and elevates the voices and experiences of Aboriginal and/or Torres Strait Islander people; and
- a timeline for undertaking this work.

6.5.9 Some State government departments and authorities are incorporating trauma informed approaches into select service provision settings

In examining trauma informed approaches to service provision, and in consulting with State government departments and authorities, the Office identified that some work is already being done to incorporate trauma informed approaches to service provision in Western Australia.

The Department of Communities advised the Office that it utilises the Sanctuary Framework, a framework employed in residential care and secure care settings, facilities which are usually used by children who are in the care of the CEO:

> Many child protection interventions seeking to protect and support children and young people, such as removal from home and placement with strangers, as well as appearances in court, may increase a child or young person's trauma. This is a common experience of many of the children and young people within Residential and Secure Care.
>
> **Healing from Trauma with the Sanctuary Model**
>
> The Sanctuary Model is a trauma informed model for creating an organisational culture that provides an environment within which healing from traumatic experiences can be addressed. The Sanctuary Model (originated in the USA in the 1980's it was created by Dr Sandra Bloom and her colleagues) is comprised of four pillars …[330]

[329] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 36.
[330] Government of Western Australia, *Residential Care (CIC) and Secure Care Services Residential Framework*, 2020, Department of Communities, p. 2.

The Department of Communities' 'Therapeutic Care Guide,' a guide for use in out-of-home care settings, identifies observable measures through which staff may reflect upon therapeutic care practices, and identify gaps in knowledge, skill, and understanding.[331]

The Department of Justice advised the Office that work incorporating trauma informed care is being incorporated into several settings, including:

> **Women's Strategic Direction**
>
> …The [Women and Young People] directorate continues to [develop] a suite of documents which provide stakeholders with a clear understanding of the Departments intent with regard to the management of women in our care and expectation for the minimum standard of trauma informed practice within our facilities and services. These documents will provide an overarching philosophy, strategic direction, business planning framework and operational model for the prison facility's which comprise the Western Australian Women's Estate. The Women's Strategy project will articulate a clear direction of the Departments expectations and intended outcomes for the management of women held in prison custody within Western Australia both within the Women's Estate and in regional precincts.
>
> **Bindi Bindi Mental Health Unit at Bandyup Women's Prison**
>
> In 2015, a comprehensive survey of the mental health and substance use problems of prisoners recently arrived in prison in WA included a survey of reception prisoners at Bandyup Women's Prison (BWP)…The study found significantly higher prevalence of mental disorders, social disadvantage and needs among women compared to men.
>
> National data indicated the overwhelming majority of women in prison are victims of violence an experience experts attribute to their offending and criminalisation. Many prisoners have co-occurring mental health and AOD problems and cannot be admitted to any AOD rehabilitation prison unit until their mental health is stable. …
>
> As part of the WA Recovery Plan, Capital funding of $2,377,000 was requested and approved as part of the Government's COVID-19 stimulus to undertake capital works at Bandyup Women's Prison (BWP) to convert unit 1A into a Mental Health Unit to support the mental health needs of women and provide opportunity for women from across the state to transfer into the facility for the purpose of stabilising and addressing their mental health needs. The Unit provides a safe, secure, culturally appropriate and structured living environment with support facilities and services for women in custody with a mental illness requiring treatment.
>
> … The Unit's operating model is based on a number of key principals including individual, Trauma-informed and culturally sensitive care which realises the need for services to be guided by the women's needs not systematic requirements, the widespread impact of trauma and the need to tailor culturally sensitive services for women.
>
> Bandyup's Mental Health Unit is staffed by a multidisciplinary team of specialists and prison officers who work collaboratively and holistically with the women to provide the required care and support for improved wellbeing and

[331] Government of Western Australia, *Therapeutic Care Guide: Residential and Secure Care*, 2020, Department of Communities, p. 2.

> reintegration. Prison Officers nominate to work in the unit and are provided operational specific training for the unit to support trauma informed service delivery.
>
> **Working With Female Offenders six (6) module e-learning program**
>
> This is a 6 module e-learning package directed at all staff working with women. Module 2 specifically deals with a trauma informed approach however trauma informed practice is a key message throughout the entire package … WWFO e-learning package was launched in August 2021 to staff working within the women's estate and is currently being rolled out to all prison staff across WA. …
>
> **Vicarious trauma and the impact of the work on staff**
>
> The Departments Training Academy includes modules covering Trauma informed practice for prisoners and staff welfare as a component of the Prison Officer Entry Level Training Program and Vocational Services Officer course. Vicarious trauma and the impact of work on staff is the mandate of Employee Welfare, The Directorate monitor staff absenteeism, Workers Compensation and staff welfare to identify trends, however area managers are tasked with sourcing and providing appropriate training where required.[332]

6.5.10 Operationalising what it is to be trauma informed will vary across settings and systems

Researchers exploring the operation of frameworks for trauma informed approaches emphasise that 'a shared understanding about the overall philosophy and purpose of trauma-informed care [or practice]' and appropriate support 'to realise this paradigm shift' is crucial.[333] Trauma informed approaches 'must be based on principles, policies, and procedures that provide safety, voice and choice.'[334]

However, principles of trauma informed practice are not prescriptive, 'and cannot be given the wide range of possible service contexts in which they may be applied.'[335] In this context, the research literature highlights that an aspect of trauma informed approaches is that they 'must be culturally relevant' to the population served.[336]

> … The core idea behind trauma-informed systems is that they are relational, and human... It will also be difficult for others to prescribe. Each service, organisation and individual will need to work through how they can embrace the principles of trauma informed care, and then apply them in non-static ways to best meet the needs of the person in front of them.[337]

In identifying that the principles and practices of a trauma informed approach must be translated in a way that is relevant for unique service settings, researchers also identify that the nature of a trauma informed approach transcends isolated policies or procedures and

[332] Department of Justice, personal communication, 12 November 2021.
[333] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39-41
[334] Mental Health Coordinating Council, *Trauma Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia,* 2013, p. 27.
[335] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 18.
[336] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 13.
[337] Smith P and Kaleveld L, *Addressing Trauma in Western Australia*, 2020, Western Australian Association for Mental Health, p. 8.

may instead be used 'as a lens through which to focus on, create and then review all policies and procedures.' [338]

In this context, the Office also notes that, for many presenting issues, populations, and service provision contexts, trauma informed approaches are not the only important perspective requiring consideration. For example, in the context of supporting people with intellectual disability, Berry Street, an independent family service organisation in Victoria, identifies that:

> Perspectives that are culturally informed, developmentally informed, person-centred, family sensitive and have a human rights perspective are examples of other key complementary approaches to inform any system, service or workers supporting people with intellectual disability… they are understood as separate and significant paradigms in their own right.[339]

While the adoption of trauma informed approaches therefore requires leadership, guidance, and visibility about how this is being implemented, what it means to practice a trauma informed approach will vary in different settings. Accordingly, researchers identify that, to some extent, variability in how trauma informed approaches are 'translated into practice or operationalised in different settings' is expected:[340]

> As a 'paradigm shift' for organisations or systems that have not traditionally applied a trauma lens – and in some cases whose very purpose works against the principles of trauma informed care (for example, custodial settings) – the principles and practices of trauma-informed care need to be translated in such a way as to be meaningful and feasible in that setting. An organisation, system or setting that is built on statutory authority and legislated coercive powers, for example, will by necessity practice trauma-informed care in a very different way to a community health centre. This does not signal an inherent problem with the concept of trauma-informed care itself, and indeed reflects the challenges of operationalising an overall principle or ethos across multiple service systems. Wall and colleagues (2015) noted that being trauma informed involved a shift for services from being "trauma-blind" to trauma sensitive and on to trauma-informed. It is important not to see this continuum or process as a "typology" of level of being trauma-informed, but as a way of acknowledging that being aware of trauma in client populations is not sufficient to change systems and organisational cultures.[341]

Translating trauma informed approaches into practice also involves considering the needs of distinct workforces, and how staff in different settings engage with individuals, information, and are exposed to trauma.

[338] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 39.
[339] Jackson A and Walters S, *Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability*, 2015, Berry Street, Melbourne, p. 18.
[340] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.
[341] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.

In identifying that the implementation of a trauma informed approaches is a 'paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time,' researchers have identified a continuum of implementation for organisations increasing their awareness of trauma. This continuum of implementation begins 'with becoming trauma aware and … [moving] to trauma sensitive to responsive to being fully trauma informed:'[342]

1. **Trauma aware:** where staff understand trauma and how individuals may have behavioural presentations in response to traumatic experiences.

2. **Trauma sensitive**: where an organisation's work practice can operationalise some concepts of a trauma-informed approach.

3. **Trauma responsive**: where the individual and organisational response enables changes in behaviour and strengthens resilience and protective factors.

4. **Trauma-informed**: where the culture of the whole system reflects a trauma-informed approach in all work practices and settings.[343]

Te Pou o te Whakaaro Nui (**Te Pou**), New Zealand's National Centre of Mental Health Research, Information and Workforce Development, has undertaken work including a review 'to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness, and factors supporting implementation.'[344] As part of this research, Te Pou has highlighted that specific strategies for implementing trauma informed approaches 'are common in the literature,' and can be grouped in to four broad areas, including:

1. Transferring knowledge to practice by realigning organisation processes and systems needed for the workforce and people accessing services.

2. Identifying barriers to implementation.

3. Addressing workforce wellness and safety.

4. Developing workforce skills and confidence needed to support people with experience of trauma.[345]

As trauma 'affects a large proportion of the population' and survivors 'are clients in a broad range of human services,' organisations across all settings 'should consider how trauma-informed approach could benefit stakeholders,' and how such an approach would operate in its own unique context.[346]

In conducting research commissioned by the Royal Commission into Institutional Responses to Child Sexual Abuse, researchers identified 'the first question for organisations and service settings to ask is':

[342] Missouri Department of Mental Health, 'Missouri Model: A Developmental Framework for Trauma Informed Approaches,' 2019, p. 1, viewed 11 November 2021 <https://dmh.mo.gov/media/pdf/missouri-model-developmental-framework-trauma-informed-approaches> and Blue Knot Foundation, 'Foundations for Building Trauma Awareness: Professional Development Training Booklet', delivered 17 September 2021.
[343] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, p. 38.
[344] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, 2018, p. 8.
[345] Te Pou o te Whakaaro Nui, *Trauma-Informed Care: Literature Scan*, 2018, Te Pou (New Zealand's National Centre of Mental Health Research, Information and Workforce Development), Auckland, p. 45.
[346] Wall L, Higgins D and Hunter C, *Trauma-informed care in child/family welfare services*, 2016, AIHW, p. 2.

> Given what we know about the impacts of trauma on the people we serve, what can we change in our policies, protocols, hiring practices, training, physical environment and general practice to ensure that, in performing our core business, we do not, at a minimum, retraumatise our service users (or clients, patients or students), and hopefully work with them in a strengths-based and future-oriented way?[347]

Recommendation 9: Taking into account the outcome of Recommendation 8, the Western Australia Police Force; the Department of Justice; the Department of Health; and the Department of Communities each:

- consider how a trauma informed approach may be incorporated into their operations; and
- work to improve their organisation's understanding of trauma.

[347] Quadara A and Hunter C, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, 2016, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 39.

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Major Investigations and Reports

Title	Date
A report on giving effect to the recommendations arising from An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	October 2022
A report on giving effect to the recommendations arising from the Investigation into the handling of complaints by the Legal Services and Complaints Committee	September 2022
A report on the steps taken to give effect to the recommendations arising from Preventing suicide by children and young people 2020	September 2021
An investigation into the Office of the Public Advocate's role in notifying the families of Mrs Joyce Savage, Mr Robert Ayling and Mr Kenneth Hartley of the deaths of Mrs Savage, Mr Ayling and Mr Hartley	July 2021
Preventing suicide by children and young people 2020	September 2020
A report on giving effect to the recommendations arising from Investigation into ways to prevent or reduce deaths of children by drowning	November 2018
Investigation into ways to prevent or reduce deaths of children by drowning	November 2017
A report on giving effect to the recommendations arising from the Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities	November 2016
Investigation into issues associated with violence restraining orders and their relationship with family and domestic violence fatalities	November 2015
Investigation into ways that State Government departments and authorities can prevent or reduce suicide by young people	April 2014
Investigation into ways that State Government departments can prevent or reduce sleep-related infant deaths	November 2012
Planning for children in care: An Ombudsman's own motion investigation into the administration of the care planning provisions of the Children and Community Services Act 2004	November 2011
The Management of Personal Information - good practice and opportunities for improvement	March 2011
2009-10 Survey of Complaint Handling Practices in the Western Australian State and Local Government Sectors	June 2010

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