



Family &
Community
Services



Taking Time | Framework

A trauma-informed framework for supporting people with intellectual disability



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Executive summary

The Taking Time Trauma-Informed Framework has been developed to guide service providers who support people with intellectual disability. It was informed by the literature, consultation with people with intellectual disability, and support from the consultation and governance groups established through Ageing, Disability and Home Care, Department of Family and Community Services (ADHC, FACS).

Trauma theory and other areas of knowledge are discussed in a literature review which is a companion document for the Framework entitled *Taking Time – A Literature Review: Background for a trauma-informed framework for supporting people with intellectual disability* (Jackson, Waters & Abell, 2015).

The Framework provides guidance for organisations to meet their obligations in accordance with the *United Nations Convention on the Rights of Persons with Disabilities 2008* and the *NSW Disability Inclusion Act 2014*.

The Framework is presented in eight parts:

1. Introduction
2. The Taking Time Framework
3. The Framework in Action
4. Supporting Information from the Research
5. Conclusion
6. Appendices
7. References
8. Acknowledgments

The vision and aims of the Framework are multiple and have a specific focus on people with intellectual disability including:

- reducing trauma and re-traumatisation
- facilitating healing from past trauma
- supporting the use of trauma-informed practice
- strengthening reflection on practice and self-care approaches
- improving appropriateness of the broader system's responses
- enhancing quality of life
- enabling society to gain from the contributions of people with intellectual disability
- facilitating a compassionate and responsive society that demonstrates the right to dignity for all.

Some of these aims are easier to grasp and achieve while others are more aspirational. No single paradigm, including trauma-informed practice, is sufficient to achieve these aims on its own. Consequently, this Framework draws on other theories that support the understanding of trauma and trauma-informed practice. Nonetheless, the Framework is predicated on the view, informed from research and practice, that trauma-informed practice can make a major contribution to achieving these aims and aspirations. It is also predicated on the view that the alternative – where an organisation is not aware of the implications of working with people who have experienced trauma – can sometimes be harmful.

A useful definition of trauma-informed practice is as follows:

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 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 9).

The key elements of the Taking Time Framework are:

Foundational values – values underlying trauma-informed practice for supporting people with intellectual disability

Guiding principles – as tools of the mind to inform practice, services and the system

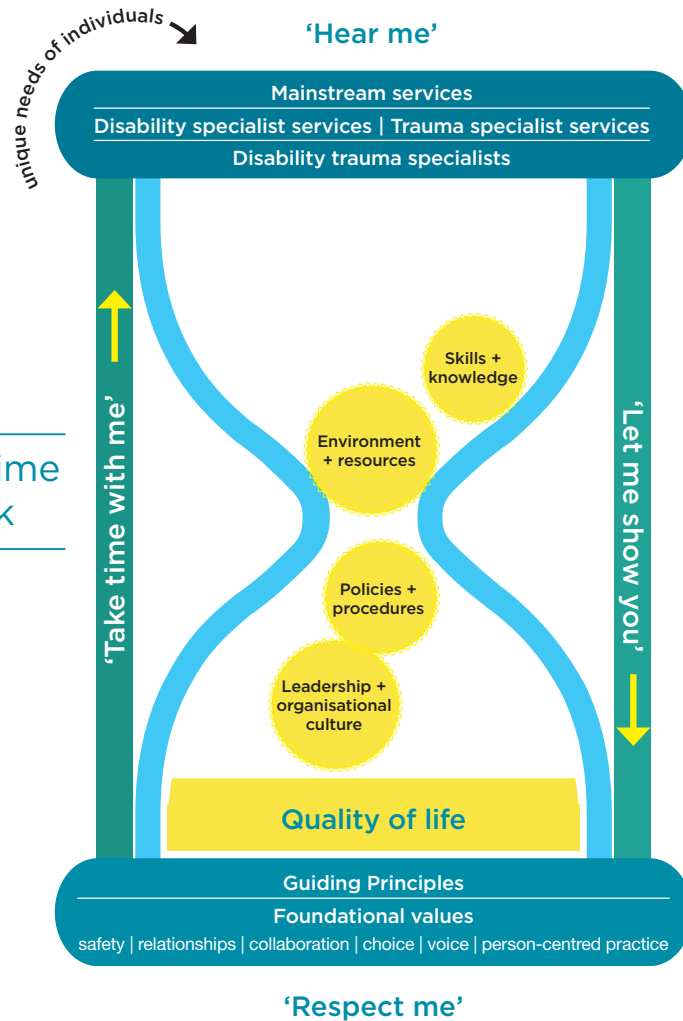
Knowledge and skills – to enable the principles to become action, which are embedded in an ongoing learning cycle

Environment and resources – what the physical and social environments provide to promote safety and the provision of appropriate resources to achieve this

Policies and procedures – enabling organisations' internal systems and documents to reflect the spirit, intent and actuality of trauma-informed practice

Leadership and organisational culture – what is required to ensure ongoing commitment at an organisational and sector level

The Taking Time Framework



The voices of people with intellectual disability are illustrated through the themes that arose when they were asked for their thoughts about trauma and what could be helpful. Those themes include:



The six foundational values underpinning this Framework are:

Safety - Relationships - Collaboration - Choice - Voice - Person-centred practice

The 15 guiding principles underlying this Framework's approach to trauma-informed practice are summarised as follows:

- 1.** Taking Time to understand and embrace each person's goals and aspirations, their unique strengths and support needs including communication, problem-solving and other cognitive processes.
- 2.** Understanding and recognising trauma and its impacts including the potential relationship with behavioural difficulties that may be experienced by the person.
- 3.** Creating opportunities for people to make or find their own meanings and to create the environment that supports them to communicate their feelings.
- 4.** Promoting a safe physical and emotional environment tailored for each individual.
- 5.** Being culturally respectful and informed and working towards cultural competence.
- 6.** Supporting the person's control, choice and voice to have or work towards genuine autonomy, self-determination, participation, and respect for human rights and freedoms.
- 7.** Sharing power and governance in a genuinely inclusive way.
- 8.** Valuing safe and genuine relationships in the process of recovery.
- 9.** Embedding a family-sensitive approach.
- 10.** Ensuring access to supported trauma-specific treatment (which may require adaptation and extra time for people with intellectual disability) delivered by appropriately trained professionals.
- 11.** Acknowledging recovery is possible for everyone and the importance of hope, fun, joy and peer support in the present and the future.
- 12.** Integrating practice that has a holistic view of the person and the recovery process, and facilitates communication among services and systems to support continuity.
- 13.** Acknowledging staff need to be and feel safe, and acknowledging the potential for vicarious trauma and need for self-care and organisational care.
- 14.** Acknowledging the need for transparent trauma-informed processes and systems that emphasise the importance of reflective practice.
- 15.** Adopting a trauma-informed organisational approach which requires a healthy organisational culture and positive leadership approach.

The Framework includes ideas for translation into practice at both service and system levels, and includes vignettes which provide examples in action within NSW. A number of organisations are in different stages of implementing trauma-informed practice from an individual, program or organisational perspective.

1 Introduction

1.1 Background to the Taking Time Framework

The reality and prevalence of trauma is recognised to varying degrees at every government level and throughout the range of human service delivery across Australia. Trauma and its multiple consequences are acknowledged by the United Nations as an international public health issue. It is, however, only relatively recently that ‘trauma-informed practice’ has become part of a lexicon in considering how best to respond to the impact of trauma from a policy, organisational, service delivery and personal perspective. Despite this, it is not in everyone’s vocabulary and, even when trauma-informed practice is the stated intent; it is easier said than done.

As described in the accompanying Literature Review (Jackson et al., 2015), there is evidence to suggest people with disability may be at increased risk of exposure to certain traumatic experiences. There is also recognition that facilitating recovery or healing from trauma, while informed by research, needs to be tailored to each individual. That being said, it is important to recognise not every person with disability or specifically intellectual disability has experienced or will experience trauma. The trauma-informed approach is not predicated on the universality of trauma, but on the value of prevention, early intervention and recovery. A continuing theme throughout this Framework is trauma can happen anywhere, but is not everywhere, and it can affect anyone, but does not affect everyone.

This Framework is informed by the *United Nations Convention on the Rights of Persons with Disabilities 2008* (the UN Convention) including principles of respect for inherent dignity and individual autonomy, non-discrimination, full and effective participation and inclusion in society, respect for difference, equality of opportunity, gender equality and respect for people’s evolving capacities.

The recently proclaimed *NSW Disability Inclusion Act 2014* (NSW) aims to make services more inclusive and accessible, and acknowledges the UN Convention and the human rights of all people with disability including specific groups such as Aboriginal and Torres Strait Islander people with disability, people with disability from culturally and linguistically diverse backgrounds, women with disability and children with disability. Although it does not overtly mention trauma, the Act has a general principle relating to protection from harm. Section 4(8) states: “People with disability have the right to live free from neglect, abuse and exploitation.” Disability Inclusion Act, 4 Stat. Austl. § 8 (2014). In recognition of the potential of any service system to support recovery or sadly exacerbate trauma, ADHC, FACS commissioned the Berry Street Take Two program to develop a trauma-informed framework, referred to as the Taking Time Trauma-Informed Framework. The overall aim is to promote a trauma-informed disability sector with a particular focus on supporting people with intellectual disability.

The name of this Framework was inspired by some of the themes arising from interviews with people with intellectual disability and their families. The need for 'taking time' is applicable to working with any traumatised population or individual where there are nearly always issues related to safety and lack of trust, based on past experience. Trauma can assault and distort a person's sense of time as it confuses memory of the past and the sense of the present. Time is not just needed for developing relationships, but also to take time to reflect on practice and to undertake the necessary assessments and reviews required to develop and maintain systems of trauma-informed practice. People with intellectual disability may particularly benefit from more time to process information and to cope with new experiences. These and other time-related themes are reflected throughout this Framework.

The Taking Time Framework provides both an organisational and practice perspective. It is informed by four interconnected processes: the literature review (Jackson et al., 2015); consultations through ADHC, FACS with people with intellectual disability and family; consultations and visits with disability services in NSW; and consultation with other stakeholders, particularly through project governance and consultation groups.

The governance group was a multi-agency group which assisted in identifying priority issues relating to the Taking Time Framework and implementation plan. It comprised senior representatives from FACS, NSW Department of Education, NSW Health Diagnostic Assessment Service, NSW Corrections, Mental Health Coordinating Council and NSW Council for Intellectual Disability. The consultation group also consisted of various representatives from ADHC and Community Services FACS, NSW Health, Education, non-government and private agencies.

It is hoped the process of dissemination and implementation activities that follow (e.g. development of an organisational self assessment toolkit) will further enable participation with people with disability to refine the Framework and to test its relevance, usefulness and authenticity.

As with any perspective, the trauma-informed paradigm is not the only one that should inform practice, organisational thinking or the broader service and policy systems. There are a number of other paradigms and perspectives that influence our work and ideas which, while consistent with trauma-informed practice, bring their own emphases and contributions.

The human rights perspective is a powerful one. The disability sector has provided leadership in the broader human services field on how to apply a human rights perspective, and to be vigilant to the implications of it being ignored or relegated to a lower degree of importance. Other relevant perspectives include person-centred practice, attachment theory, and developmental and ecological perspectives. This is not a complete list and will evolve with new research and practice findings. The Taking Time Framework has benefited from these and other perspectives, although trauma-informed practice has been its focus.

This Framework is predicated on the principle that the journey towards trauma-informed practice is ever evolving, and that its implementation will take time and reflection. Time is a rich concept in trauma theory and in disability as we look at history, the present and future. In this Framework, we explore these and related concepts, and consider the implications for organisations and workers supporting people with intellectual disability. In particular, despite having the concept of trauma at the forefront of this Framework, this is in fact a Framework that emphasises hope.

1.2 Who is this Framework for?

This Framework has been developed primarily for disability services supporting people with intellectual disability. It is hoped, however, that it may also inform the broader disability service sector and other sectors which support people with disability, such as education, child protection, childcare, aged care, social security, employment, mental health, general health, housing, services for Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, and people from culturally and linguistically diverse (CALD) backgrounds, including refugees. All services have an important role to play in supporting people with disability and, in doing so, through a trauma-informed lens.

As the Framework has both an organisational and practice focus, it is hoped it will be relevant for an organisation's management and leadership as they consider and reflect on trauma-informed practice and their organisation. It is also hoped workers within any organisation may find useful ideas and guidance in this Framework, and that the accompanying Literature Review will provide helpful information regarding trauma-informed practice.

1.3 Vision and aims

A framework is a conceptual map that brings together, in an accessible design, an organisation or systems approach to an area of practice or policy with a particular population (Marie Connolly, 2007). As such, a framework sets out to achieve the following:

- establish a vision
- clarify the approach to knowledge – to provide understanding of what underpins the work and how this informs the approach
- be grounded in the realities of practice
- be supported by research
- be embedded in principles and values central to the work
- provide a useful tool for practitioners and managers to deliver a theoretically informed intervention framework and a set of prompts to support best practice which articulates the link between practice philosophy and theory, practice interventions and outcomes.

This Framework explores each of these aims in relation to trauma-informed practice with people with intellectual disability.

The vision and aims of this Framework are:

Reduction of trauma and re-traumatisation of people with intellectual disability through trauma-informed service delivery

Supporting people with intellectual disability to heal psychologically from past trauma

Ongoing capacity to utilise trauma-informed practices and approaches effectively with people with intellectual disability and achieve improved outcomes in their quality of life

Ongoing capacity for workers to reflect on their practice and the service context

Ongoing capacity to care for self in undertaking work with a traumatised population

Improved capacity of the broader service system to work appropriately with people with intellectual disability who have experienced trauma

Enhanced quality of life for people with intellectual disability

A society that is more able to gain from the experience and contributions of people with intellectual disability

A compassionate and responsive society that demonstrates the right to dignity for all

1.4 Key terms

1.4.1 Disability

This Framework recognises the definition of disability as it appears in the UN Convention which recognises people with disability as:

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

A person has an **intellectual disability** when they meet the three criteria below:

- intellectual functioning: IQ measured at or below 70 (approximately two standard deviations below the mean), **and**
- significant limitations in at least one area of adaptive behaviour – communication, self-care, daily living, social skills, community access, self-direction, health and safety, functional academics, leisure and work, **and**
- these characteristics must be evident during the developmental period (American Psychiatric Association [APA], 2013).

1.4.2 Trauma

The term trauma can be overused or incorrectly applied, and often trauma as part of a person's lived experience is overlooked. In some cases, indicators of trauma may be incorrectly attributed to something else, such as 'symptoms' of a medical condition or disability. Therefore, it is important to clarify what it is and what it is not, and to identify a useful way of understanding trauma in the context of this Framework.

There are overlapping definitions of trauma with different emphases. The following definition of trauma from van der Kolk is one of the most commonly cited.

Traumatization occurs when both internal and external resources are inadequate to cope with external threat (van der Kolk, 1989, p. 3).

This definition highlights that trauma and its consequences through traumatising are not specific to the event, but to the individual's experience of the event (van der Kolk & McFarlane, 1996).

To explain this further:

- Traumatization can arise from a single event, multiple experiences or an ongoing situation (Terr, 1990).
- Traumatization can, but not always, consist of an interpersonal experience such as an assault or child abuse. Regardless of the type it can have interpersonal and lasting consequences. However, interpersonal trauma is more frequently associated with complex presentations.
- Traumatization can overwhelm a person's sense of control, connection and meaning (Herman, 1997).
- Traumatization is a subjective experience that can differ from one person to another (van der Kolk & McFarlane, 1996).
- Traumatization involves a high state of arousal that can impair integration across many domains of learning and memory (Cozolino, 2010).
- Traumatization is a potential risk to anyone, but some people are more likely to be exposed to a traumatic experience or more vulnerable to its consequences.
- Traumatization is something from which people can heal and recover to varying degrees with the appropriate support.

In contrast:

- Trauma is not experienced in the same way for everyone. The person's age at the time of the trauma, what has gone on before, and what supports are available during and after the trauma are some of the factors that can affect the impact of the experience.
- Trauma is not the same as stress, although it is on the continuum of stress-related responses. Some stress can be positive or tolerable, whereas toxic stress is equivalent to trauma (National Scientific Council on the Developing Child, 2014).
- Trauma is not post-traumatic stress disorder (PTSD), although that is one way of categorising symptoms experienced by some people who have been exposed to trauma.
- Trauma is not the only way of describing experiences that can be distressing or devastating to a person's health, development and wellbeing. Because an event may not be traumatic does not mean it does not have negative and destructive consequences.

1.4.3 Complex trauma

According to Herman (1997), key features of complex trauma include a more complex and tenacious set of symptoms, major personality changes and greater vulnerability to further harm, such as when self-inflicted and/or as a result of the behaviours of others. It is not a formal mental health diagnosis.

Complex trauma is usually a result of cumulative, repetitive and interpersonal assaults. It is particularly pernicious if it occurs in childhood and where the source of trauma is a person who has a caregiving and trusting relationship, and is meant to be a source of safety (Mental Health Coordinating Council [MHCC], 2013).

1.4.4 Vicarious trauma

Vicarious trauma is described as a transformation in a worker as a result of working with a person who has been traumatised. Vicarious trauma is a cumulative effect of working with trauma which can impact on many aspects of a person's life. It may consist of short-term reactions, or longer term effects that continue after the work has finished. Some effects of vicarious traumatisation parallel those experienced by the trauma survivor, and can lead to a person experiencing the symptoms of PTSD (MHCC, 2013, p. 65). It is recognised as one of the experiences that can lead to PTSD in the latest DSM-5 (APA, 2013).

1.4.5 Trauma-informed practice

A recent definition of a trauma-informed approach is as follows:

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 (SAMHSA, 2014, p. 9).

Trauma-specific approaches refer to therapeutic approaches with the aim to help a person manage and reduce trauma-related symptoms, and integrate their experiences of trauma so these no longer intrude on the present (Kezelman & Stavropoulos, 2012; Fallot & Harris, 2006; Jennings, 2008; MHCC, 2013).

In their definition of trauma-informed services, ASCA emphasises this is not about the treatment of trauma or the symptoms, but rather a recognition that trauma experiences are a possibility for anyone.

The possibility of trauma in the lives of all clients/patients/consumers is a central organising principle of trauma-informed care, practice and service provision. This is irrespective of the service provided, and of whether experience of trauma is known to exist in individual cases (Kezelman & Stavropoulos, 2012, p. 88).

1.5 Why trauma-informed practice?

There are numerous reasons why trauma-informed principles and practice are increasingly considered and implemented across a wide range of services in Australia and internationally, and why it is particularly being considered for supporting people with intellectual disability.

The following bullet points provide a series of suppositions, supported by the accompanying Literature Review (Jackson, et al., 2015), that builds the rationale for applying a Trauma-Informed Framework for services supporting people with intellectual disability.

- **Trauma happens** – There is increased recognition of the prevalence of trauma, including in countries such as Australia, to the extent that it is understood as a public health issue. This does not mean it happens to everyone, but that we need to recognise it when it does happen.
- **Trauma can affect the mind and body** – The impacts of trauma can be pervasive and affect multiple life domains. This can be the case for any age group, but the implications for children are even more dramatic because of their developing brain.
- **Time will tell** – Early life trauma can have a lifelong effect, especially if it remains unresolved. Early positive life experiences can heal and help children blossom. Adults can suffer the consequences of childhood trauma, especially at particular times of transition or stress. Adults can also experience trauma later in life as well as experiencing recovery.
- **Counting the costs** – There is increased recognition of the enormous social and economic cost of trauma to the individual and the community. These can include the implications of chronic mental health problems, reduced quality of life and life expectancy, lost productivity, demoralised workforce and high utilisation of costly tertiary services.
- **Some people are more at risk than others** – There is more recognition some groups within society, such as people with intellectual disability, can be at greater risk of exposure to trauma. There are other groups, specifically in the Australian context, that need to be recognised as more likely to be at risk of exposure to trauma, such as Aboriginals and Torres Strait Islanders, and refugees. The history of intergenerational trauma, community-wide trauma and current high exposure to trauma are compounding factors. Particular attention is required when more than one risk factor is present.
- **Some organisations are more at risk than others** – Organisations which predominantly work with traumatised populations are at increased risk of mirroring or pre-empting trauma reactions, especially if not trauma-informed. Attention to parallel processes, vicarious trauma and other trauma-related phenomena are a hallmark of trauma-informed organisational practice.

- **We don't always understand** – The consequences of trauma, especially complex trauma, are often misunderstood and can sometimes lead to blaming the person experiencing the trauma.
- **Square peg, round hole** – The consequences of trauma may not fit a neat diagnostic or other assessment framework, and so may not constitute eligibility for some services. Such consequences can also make it difficult for the person to trust services and so can also lead to difficulties for services to engage people most in need. This, in turn, can reduce the likelihood of the person being able to benefit from early intervention or preventative services, and so difficulties may be compounded until the point where more intrusive, tertiary services may be the only ones considered viable.
- **Never assume** – It is often assumed people with intellectual disability are a homogenous group of people with the same needs, wishes and abilities. Caution is needed not to assume people with intellectual disability will experience trauma and its consequences in the same way, or that they will benefit from the same responses as each other or anyone else. One size or one approach does not fit all.
- **We can make things better or worse** – There is increased appreciation that policies, organisations and practices can either support a person's recovery from trauma and/or increase risk of further harm.
- **Trauma can increase tenfold** – There is an ever-present risk of re-traumatisation or secondary trauma depending on how others respond. This can exacerbate the original experience of trauma or even be experienced as worse than the original trauma.
- **No-one is immune, including us** – Staff of any profession, level or role can be impacted by their experience of trauma either through their personal or work life. Although there are experiences and other attributes that can help build resilience, there is no guaranteed inoculation or immunity to trauma.
- **Time can heal, although not on its own** – We are able to change, grow, learn and recover, and to do so we need time, relationships and repetitive positive experiences.
- **We know more now than we did about how to help** – There is greater access to theory and research across different fields on the psychological, biological and neurobiological bases of trauma, and different pathways towards recovery (Jackson et al., 2015).

1.6 What does trauma-informed practice look like?

Fallot and Harris (2006) distinguish trauma-informed from trauma-specific as follows:

Human service systems become trauma-informed by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance. They seek 'safety first' and commit themselves to 'do no harm'.

By contrast, trauma-specific services have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery (p. 4).

Following are key features commonly considered distinctive to trauma-informed practice:

- All aspects of the service are organised to recognise and acknowledge trauma, its prevalence and its dynamics (Atkinson, 2013; Fallot & Harris, 2006; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; MHCC, 2013). In particular trauma-informed practice recognises that anyone may have experienced trauma which may or may not be known to others (Kezelman & Stavropoulos, 2012).
- It recognises that something has happened to the person rather than it being about what is wrong with the person (Bloom, 1997).
- It is responsive to the impact of trauma, emphasising physical, psychological and emotional safety for those who have experienced trauma and service providers (Bloom, 2005; Chadwick Trauma-Informed Systems Project, 2013; MHCC, 2013; SAMHSA, 2014).
- It works to create opportunities for those who have experienced trauma to rebuild a sense of safety, control and power over their own situation (Atkinson, 2013; Bloom, 2005; Elliott, Bjelajac, Fallot, Markoff & Glover Reed, 2005; MHCC, 2013).
- It recognises the importance of relationships as a means of promoting healing and recovery (Atkinson, 2013; Elliott et al., 2005; SAMHSA, 2014).
- It recognises the importance of the environment and aims to create environments where everyone feels physically, emotionally, morally and culturally safe (Atkinson, 2013; Bloom, 2005).
- It is grounded in and directed by an understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence (Bloom, 2005; MHCC, 2013).
- It acknowledges there are often particular trauma-related experiences and consequences for certain populations, such as people with intellectual disability (LeBel, 2011; MHCC, 2013).

2 The Taking Time Framework

The **Taking Time Trauma-Informed Framework** brings together a number of key elements as they relate to services supporting people with intellectual disability. The key elements of the Framework are listed below.

Key elements of the Taking Time Trauma-Informed Framework

Foundational values – values underlying trauma-informed practice for supporting people with intellectual disability

Guiding principles – as tools of the mind to inform practice, services and the system

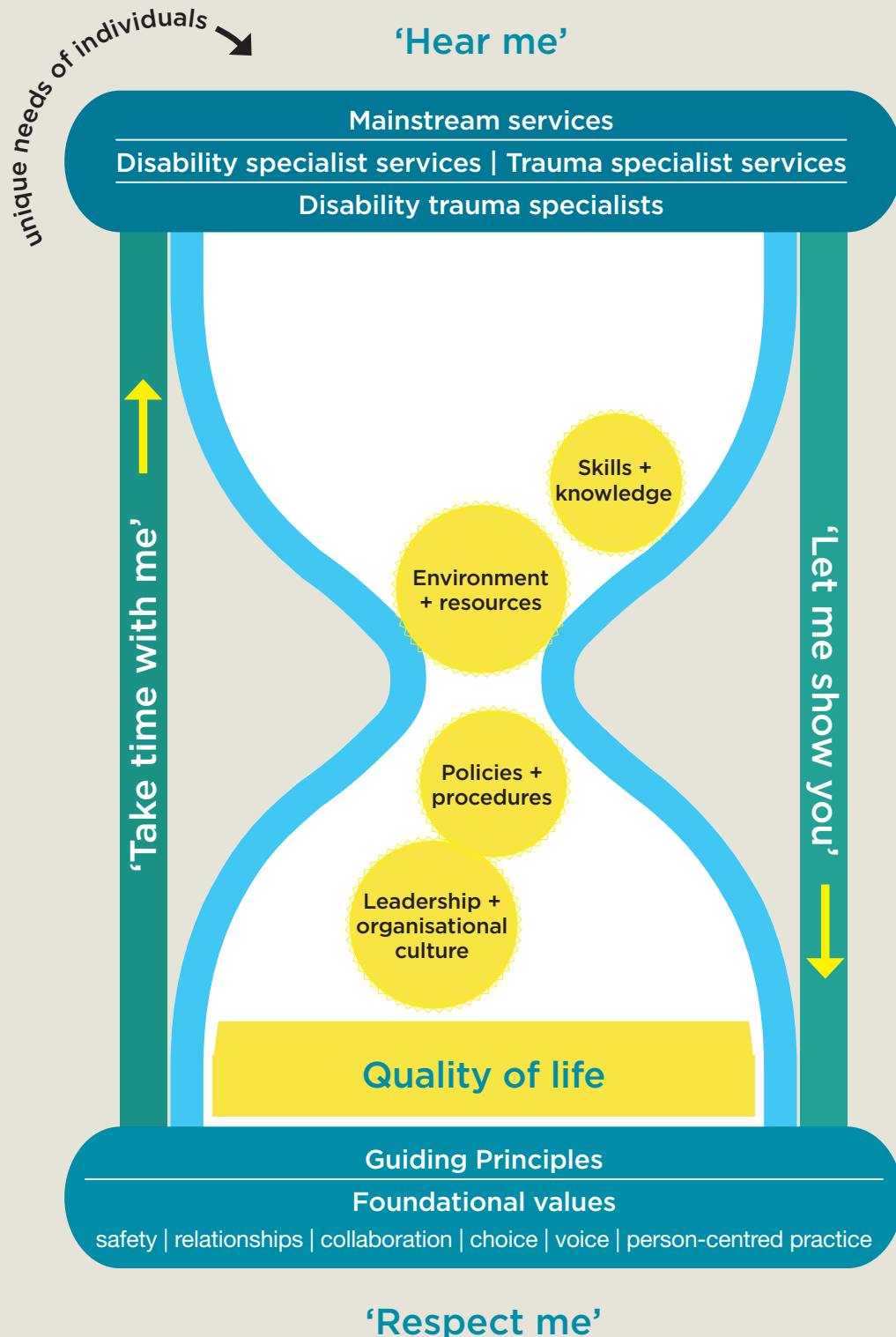
Knowledge and skills – to enable the principles to become action, which are embedded in an ongoing learning cycle

Environment and resources – what the physical and social environments provide to promote safety and the provision of appropriate resources to achieve this

Policies and procedures – enabling organisations' internal systems and documents to reflect the spirit, intent and actuality of trauma-informed practice

Leadership and organisational culture – what is required to ensure ongoing commitment at an organisational and sector level

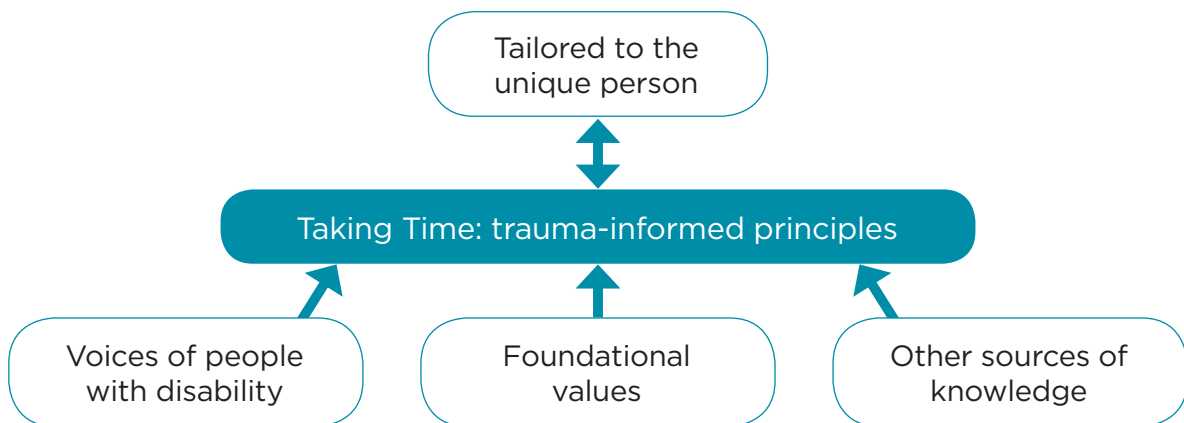
The Taking Time Framework



2.1 Developing the principles underlying the Framework

The principles for this Framework emerged from four sources:

1. hearing directly from people with intellectual disability about what they thought was important to guide workers to support people having a tough time
2. considering what the literature suggests are foundational values that inform all aspects of work at individual, service and system levels
3. considering other literature and other sources of knowledge regarding principles
4. considering how to ensure these are tailored to the uniqueness of each individual.



Consistent with Schon's (1990) 'reflection-in-practice' approach, principles aim to guide practice in the moment as well as more service-focused reflections, at a management and policy level.

Using Hornstein's (2014) phrase, these principles are 'tools of the mind' for guidance as the person who uses them brings them into their relationships with individuals, families and carers. These principles are not prescriptive, and cannot be given the wide range of possible service contexts in which they may be applied.

Trauma-informed services... must be based on principles, policies, and procedures that provide safety, voice and choice (MHCC, 2013, p. 27).

As is evident throughout this Framework, trauma-informed practice is not the only important perspective. 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. Where logical, we have incorporated these and other perspectives into this Framework, while acknowledging they are understood as separate and significant paradigms in their own right.

2.2 What is important?

The voices of people with intellectual disability

Learning from the people with intellectual disability and parents, a number of messages relevant to trauma-informed practice became clear. The details from these interviews are described in the Appendix, but some themes that arose include the following:



2.3 Foundational values of trauma-informed practice in disability support

Fallot and Harris' (2006) foundational principles have been highly influential in other trauma-informed frameworks such as the Adults Surviving Child Abuse (ASCA) (2012) guidelines (Kezelman & Stavropoulos, 2012); MHCC (2013) guidelines and the SAMHSA (2014) guidelines. These have been adapted for the purposes of this Framework with a stronger emphasis on relationships and the power of the person's voice. A sixth underpinning value is person-centred practice which was added as particularly relevant in the field of disability, although it has resonance for all human service areas.

The six foundational values for trauma-informed practice in disability support are:

- Safety** – ensuring physical and emotional safety
- Relationships** – maximising trustworthiness through relationships, task clarity, consistency and interpersonal boundaries
- Collaboration** – maximising collaboration
- Choice** – maximising choice and control
- Voice** – prioritising the person's voice being heard and heeded
- Person-centred practice** – ensuring the person's needs, goals and wishes guide practice

2.3.1 Safety

Safety is the foundational value on which all other principles depend. There is consensus that a trauma-informed approach must privilege safety (Jackson et al., 2015). This was reinforced in the interviews with people with intellectual disability, as well as through visits and meetings with disability services and other providers.

Bloom (2005) refers to four domains of safety in her Sanctuary Model – namely physical, psychological, social and moral safety. The Taking Time Framework includes a fifth domain of cultural safety (Bamblett, Frederico, Harrison, Jackson, & Lewis, 2012). This is also consistent with the Making Tracks trauma-informed framework for Aboriginal young people leaving care (Jackson, Waters, Meehan, Hunter, & Corlett, 2013).

A way to consider each of these elements of safety is to reflect on whether the opposite is present, as shown in the following table. We should ask what happens if the person with intellectual disability is protected from or exposed to physical, psychological, social, ethical/moral or cultural violence?

Types of safety	What might the <i>absence of safety</i> look like for a person with intellectual disability?	What might the <i>presence of safety</i> look like for a person with intellectual disability?
Physical	<ul style="list-style-type: none"> • Exposed to violence from others, e.g. physical and/or sexual abuse • Lives, learns or works in a violent environment • Does not have a safe or secure place to live or play • Nowhere to go or no one to tell if feeling unsafe • Medical and physical care needs unrecognised and/or neglected • Invasive, unnecessary medical procedures, e.g. sterilisation • Invasion of personal space and property • Restricted access to food • Restricted access to outdoors and activities • Unable to physically access support services 	<ul style="list-style-type: none"> • Is not exposed to violence • Feels safe in their home, school and work environment • Feels safe to play and have fun • Has a place they can call home that provides safety and comfort • Has any support needs effectively met • Knows who to talk to if feeling unsafe • Has health needs effectively met • Services utilised are physically accessible

Types of safety	What might the <i>absence of safety</i> look like for a person with intellectual disability?	What might the <i>presence of safety</i> look like for a person with intellectual disability?
Psychological	<ul style="list-style-type: none"> • Exposed to emotional abuse, e.g. verbal abuse, threats and rejection • Emotional neglect and sense of being abandoned • Inconsistent and confusing messages and expectations • Rejection on the basis of disability • Discrimination • Bullying 	<ul style="list-style-type: none"> • Healthy relationships which affirm self-esteem, value and belonging • Access to attachment figures and key relationships • Capacity to address discrimination and bullying with appropriate support if required
Social	<ul style="list-style-type: none"> • Isolation • Exclusion • Multiple placements or accommodation changes • Too many changes, e.g. staffing changes, rosters and routines • Sense of rejection and experience of discrimination when accessing services • Information in alternative formats is unavailable and communication needs are not supported 	<ul style="list-style-type: none"> • Connected to family, friends and community • Experiences belonging, respect and reciprocity • Feels welcome and accepted when engaging with services • Information is available in alternative formats to meet a range of communication and language needs

Types of safety	What might the <i>absence of safety</i> look like for a person with intellectual disability?	What might the <i>presence of safety</i> look like for a person with intellectual disability?
Ethical, moral	<ul style="list-style-type: none"> • Being forced or influenced to go against own beliefs, values and ethics • Not consulted in relation to planning and service delivery approaches that impact on them • Not involved in a meaningful way in decision-making about aspects of their life 	<ul style="list-style-type: none"> • Encouraged and supported to act according to own value base • Recognising the sense of reward from acting in accordance with belief systems • People with disabilities involved at every level of the organisation • Services support people with decision-making as required to maximise their participation, choice and control
Cultural	<ul style="list-style-type: none"> • Subjected to racial taunts or other forms of racism or racial violence • Prevented from participating in cultural activities, routines and community • Disrespect or lack of opportunity to develop or strengthen identity 	<ul style="list-style-type: none"> • Is supported to explore, understand and identify with their culture • Supported to experience culture and connection as a source of protection, dignity and comfort

2.3.2 Relationships

Relationships are key to recovery and healing. Herman (1997) and Perry (2005) note recovery from trauma can only occur within the context of relationships, not in isolation. Bronfenbrenner (1979) emphasises the complex web of relationships, and Perry (2005) states that recovery from trauma requires a ‘therapeutic web’ of people to provide nurturing day-to-day experiences.

Perry (2005) emphasises redressing longstanding experiences of trauma requires repetitive, persistent, nurturing experiences, mediated through relationships. We need to create frequent, predictable opportunities for the person to experience the opposite of the trauma, and for his or her brain to be shaped by these new experiences. When a person has a new experience or performs an action for the first time, synapses are formed. As these experiences and actions are repeated, the synaptic connections are strengthened (Perry, 2002). Providing positive, reparative, relational experiences can help form or strengthen these synaptic connections associated with the experience of relationships, reward and self-regulation.

To understand and cope with relationships we need to be able to sense what other people might be thinking. We ‘read’ or attempt to read people – their faces and gestures – and make quick, often accurate (but sometimes inaccurate) assumptions about what they might be thinking or feeling. We do this all the time, checking our assumptions with questions, looks and gestures. It is a large part of communication with others. This is not always straightforward when supporting people with disability as physical gestures may not be spontaneous or within a person’s control, and tone of voice and speech may be impacted. The particular cognitive impairment may also impact on a person’s ability to understand someone else’s verbal and non-verbal cues.

The experience of trauma, especially early relational trauma, can also disrupt a person’s ability to read other people or make them more susceptible to misreading benign cues as threat. Getting to know and understand the person in his or her own right is essential in order to avoid assumptions and potentially misread his or her cues. Perry’s (2005) concept of a therapeutic web is useful as it may be important to establish a relationship not only with the person with disability, but also the people in their support network to assist in understanding their needs and wishes.

In supporting our ability to form relationships to promote healing and recovery, we can be our own best resource. Our training, access to supervision and support, and the extent to which we are mindful of our need for self-care helps us to be relational and to promote engagement and attunement.

2.3.3 Collaboration

A key question is to consider whether we are effectively collaborating with people with disability.

Fallot and Harris (2006) propose a series of questions for organisations aspiring to be trauma-informed relating to collaboration with the consumer. For the purposes of this Framework in supporting people with intellectual disability, these questions include:

- What is the level of involvement of people with intellectual disability in planning and evaluating the service? What supports are in place to enable genuine participation?
- Is there a role for those who have previously experienced trauma to be advocates or supports to their peers?
- Is there overt respect for the person's life experience including positive and traumatic experiences that enable the person to put their experience in context in order to have meaning?
- How involved are people with intellectual disability in planning and setting priorities about their goals?
- Is there a model of doing 'with' rather than 'to' or 'for' people with intellectual disability, i.e. person-centred approach?
- Is there overt communication of the belief that the person is the ultimate expert on their own experience?
- Is there an appropriate level of information-sharing between the service and the person in a way that is meaningful for them?

In addition to creating and maintaining supportive relationships with people with intellectual disability, trauma-informed organisations strive to ensure there is collaboration between staff and with other organisations. The Making Tracks framework emphasises the importance of partnership with other organisations as well as with the service user as a key aspect of practice (Jackson et al., 2013).

2.3.4 Choice

Multiple studies have found that a person's degree of self-determination predicts higher quality of life (e.g. Lachappelle, Wehmeyer, Haelewyck, Courbois, Keith, Schalock & Walsh, 2005; Nota, Ferrari, Soresi & Wehmeyer, 2007).

- Self-determination status is positively correlated with more positive post-secondary school outcomes, including employment, independent living, and social inclusion for young people with disabilities.
- Young adults who are more engaged in personally-valued recreation activities are better able to be self-determining, suggesting a reciprocal relationship between recreational activities and self-determination.

Adults with disability rank self-determination more highly than professionals, parents or other family members rate it for the person with an intellectual disability. Research also shows a person's IQ level is not predictive of their capacity for self-determination, i.e. lower IQ does not mean less capacity for self-determination (A National Gateway to Self-Determination, n.d.).

The importance of people with disability having choice and control over their own situation and pursuing their own goals has been recently re-emphasised through the *NSW Disability Inclusion Act 2014*.

2.3.5 Voice

Ensuring people have a voice in their own situation and are supported to be active participants is a key value of the disability rights movement. It is strongly inferred in the *Disability Inclusion Act 2014* through a number of principles relating to active participation, inclusiveness and recognition of capacities including some which may change with age and their right for dignity.

To raise awareness of discrimination and marginalisation, and to have a voice in the decisions affecting their lives, it is crucial the past and present endeavours of people with disability are recognised and acknowledged. Sometimes the term empowerment can presume the person has no power until someone else gives it. While this may be the case in some situations, it is also important to recognise the individual's personal power from the outset and ensure there are as few barriers as possible limiting the exercise of that power in the context of a healthy and safe society.

Hearing the voice of the individual is a key principle in trauma-informed practice as the experience of trauma can rob the person of their voice and sense of power, as well as their control and dignity. Traumatic experiences can overwhelm those aspects of a person's existence which usually give them "a sense of control, connection, and meaning" (Herman, 1997, p. 33).

An example of both sharing power and self-determination that demonstrates the power of the individual and collective voice is the self-advocacy approach where people with intellectual disability form groups which:

... raise issues about policy, practice, and equality for people with an intellectual disability. Self-advocacy groups have a strong focus on training, support, lobbying, education, and coming together for conferences. Its key-defining characteristic is that it is 'done' by people with an intellectual disability (Bigby & Frawley, 2010, p. 161).

2.3.6 Person-centred practice

A person-centred approach is a foundational value in working with people with disability:

People with disability, their families and carers are to be at the centre of decision-making about how the specialist disability system supports them, not just as the focus but as the key determiners of how available resources are used (ADHC, 2010, p. 20).

Various definitions of person-centred planning share an emphasis on the need to tailor services, approaches, planning and implementation to the needs and context of the individual. At its core, a person-centred approach is an individualised approach which draws on the strengths, needs and desires of the person with disability (Corfield & Brearley, 2011).

The figure below provides a summary of how trauma-informed practice principles apply in the context of person-centred practice.

Person-centred planning	Trauma-informed practice principles
Person at centre	<ul style="list-style-type: none"> • Support to gain/regain a sense of control over daily lives • Acknowledge strengths and build competencies that will strengthen sense of autonomy • Service systems are set up to keep individuals (and their carers when applicable) well-informed about all aspects of treatment • Individuals have ample opportunities to make daily decisions and actively participate in healing process • Understanding a person’s typical capacity may be temporarily compromised by trauma • Listening through multiple forms of communication to the individual about who they want involved in their life
Wider social network is involved as full partners	<ul style="list-style-type: none"> • Promote and maximise opportunities to engage fully in the wider community • Acknowledge that trauma isolates and healing from trauma occurs through relationships

Person-centred planning	Trauma-informed practice principles
Partnership between the person, their family and the service provider	<ul style="list-style-type: none"> • Collaboration around achieving goals for individuals, family and community • Vigilance about potential for services and systems to act in ways that may re-victimise the individual
Whole of life is considered	<ul style="list-style-type: none"> • Consider the different domains of individual functioning, e.g. physical, social, emotional, sexual • Acknowledge opportunities and potential risks at different stages of the life cycle
Continuous listening, learning and action	<ul style="list-style-type: none"> • Commitment to growth and change • Looking for potential barriers that may get in the way of hearing what an individual is communicating through words or behaviour • Acknowledge the fluid nature of decision-making • Refrain from assumptions • Ensure time and space for reflection • Open to new ideas and information

2.4 Guiding principles of the Taking Time Framework

The information from the Literature Review and the perspectives of the people with intellectual disability and parents, along with the foundational values, strongly resonate with many guiding principles found in a variety of trauma-informed practice frameworks (e.g. Kezelman & Stavropoulos, 2012; Atkinson, 2013; Bloom, 2005; Chadwick Trauma-Informed Systems Project, 2013; Fallot & Harris, 2009; Guarino et al., 2009; Hummer, Dollard, Robst & Armstrong, 2010; Jackson et al., 2013; MHCC, 2013; and The Bouverie Centre, 2013).

There are 15 guiding principles underlying this Framework’s approach to trauma-informed practice.

Taking Time: Trauma-Informed Framework guiding principles

- 1.** Taking Time to understand and embrace each person's goals and aspirations, their unique strengths and support needs including communication, problem-solving and other cognitive processes.
- 2.** Understanding and recognising trauma and its impacts including the potential relationship with behavioural difficulties that may be experienced by the person.
- 3.** Creating opportunities for people to make or find their own meanings and to create the environment that supports them to communicate their feelings.
- 4.** Promoting a safe physical and emotional environment tailored for each individual.
- 5.** Being culturally respectful and informed and working towards cultural competence.
- 6.** Supporting the person's control, choice and voice to have or work towards genuine autonomy, self-determination, participation, and respect for human rights and freedoms.
- 7.** Sharing power and governance in a genuinely inclusive way.
- 8.** Valuing safe and genuine relationships in the process of recovery.
- 9.** Embedding a family-sensitive approach.
- 10.** Ensuring access to supported trauma-specific treatment (which may require adaptation and extra time for people with intellectual disability) delivered by appropriately trained professionals.
- 11.** Acknowledging recovery is possible for everyone and the importance of hope, fun, joy and peer support in the present and the future.
- 12.** Integrating practice that has a holistic view of the person and the recovery process, and facilitates communication among services and systems to support continuity.
- 13.** Acknowledging staff need to be and feel safe, and acknowledging the potential for vicarious trauma and need for self-care and organisational care.
- 14.** Acknowledging the need for transparent trauma-informed processes and systems that emphasise the importance of reflective practice.
- 15.** Adopting a trauma-informed organisational approach which requires a healthy organisational culture and positive leadership approach.

2.5 Tailoring the Framework to the unique person

The *Disability Inclusion Act 2014* has a general principle that: "People with disability have the right to respect for their cultural or linguistic diversity, age, gender, sexual orientation and religious beliefs" (s.4(6)).

To enable this right to be fulfilled to the fullest extent, additional principles are included in the Act specific to Aboriginal and Torres Strait Islander people with disability, people with disability from CALD backgrounds, women with disability, and children with disability.

Consistent with a human rights and trauma-informed perspective, it is crucial to tailor any practice or principle to the individual person. The Act and literature in general both pay attention to the person's age/developmental stage, cultural identity and gender, but this is by no means a complete list. A person's sexual preference or identity, faith and personal values are other important areas to consider.

The reality is that no list can limit the possible areas that an individual may consider to be the most important to them. In this publication, we will discuss development, culture and gender in more detail, but listening to what is important to each person and acting accordingly is the overarching principle. This is consistent with all of the foundational values described earlier, namely safety, relationships, collaboration, choice, voice and person-centred practice.

2.5.1 Developmental

The ASCA guidelines highlight the importance of a developmental perspective. This includes recognising human development across the life span and involves different developmental tasks, challenges and opportunities (Kezelman & Stavropoulos, 2012). It is relevant for any age group, but has particular resonance for children and for anyone going through developmental transitions.

Trauma-informed practice recognises trauma has a differential impact on people of different ages. For example, the consequences of trauma on the developing brain of infants and young children may not only affect their day-to-day functioning, but also their future developmental trajectory.

A developmental perspective also recognises any major transition, such as starting school, leaving school, leaving home, changing jobs, retirement or moving into an aged care facility can be periods of increased stress. Although this stress may be tolerable, if the person has previously experienced trauma, they may be ill-equipped to manage these transitions (Jackson et al., 2013). For example, if an adult has previously experienced institutionalisation and then moved into the community, they may find a later transition to an aged care facility deeply distressing and traumatic or comforting and reassuring – depending on their previous experience.

A person's developmental age may not be the same as their chronological age. This can be due to developmental delay or disability, but may also be a result of the impact of trauma. That being said, practice should be age-respectful as well as developmentally informed (Jackson et al., 2013).

2.5.2 Culture

Each culture provides distinctive understandings of human suffering and of healing. Each culture provides explanations for the occurrence of illness, models of bodily structure and function and personality, and forms of dealing with illness. These understandings are grounded in a culture's cosmology, epistemology and set of beliefs and values (Minas & Klimidis, 1994, p. 140).

Cultural identity covers various aspects of identity including shared beliefs, values, attitudes, behaviours and practices. Culture applies to all people, not just those who come from a minority culture. However, it is those who belong to a cultural group or background subject to racism or other forms of systemic attack who are often most aware of their cultural identity (Bamblett et al., 2012; deVries, 1996).

Certain cultural groups in our society have been exposed to more overt individual and systemic trauma throughout history and community, such as the Aboriginal and Torres Strait Islander community. They have been exposed to the trauma associated with invasion, colonisation and forced removal from their families, communities and land, as well as racism. They are over-represented on almost every measure of concern relating to health, education, socio-economics, child protection and youth justice/corrections involvement (Bamblett et al., 2012). In particular, the impact of Stolen Generation policies has been damaging to aspects of culture and community connectedness which are core elements to building resilience (Atkinson, 2013).

Refugees and asylum seekers are another group who have been highly exposed to trauma both at the point of origin, through the journey and upon their arrival in Australia (Kaplan, 1998).

Maintaining connection with one's cultural identity – through language, cultural practices, religious beliefs and community connection – is recognised as having a protective role in developing a positive sense of self, building resilience and increasing the range of external supports that are available to improve quality of life. Increasingly, it is becoming understood that, in terms of facilitating recovery from trauma and attachment disruption, the role of culture can buffer individuals from trauma and is instrumental in facilitating recovery from relational, intergenerational and community trauma (Atkinson, 2013; Bamblett et al., 2012).

Culture plays a key role in how individuals cope with potentially traumatizing experiences by providing the context in which social support and other positive and uplifting events can be experienced. The interactions between an individual and his or her environment/community play a significant role in determining whether the person is able to cope with the potentially traumatizing experiences that set the stage for the development of PTSD (deVries, 1996, p. 400).

According to Atkinson (2013), the role culture plays in healing is increasingly recognised. She notes that hard evaluative data is rarely available, but that evidence takes many forms. In particular she comments on the many services and practitioners who are beginning to document practice wisdom. In her call for culturally informed approaches, it is noted that culture plays a role in the type of trauma that individuals may experience, the risk for continued trauma, how individuals handle and express their experiences and which type of care is most effective (Guarino et al., 2009).

One powerful means of recognising culture is the development of Indigenous-specific approaches to care (Atkinson, 2013, p. 9).

2.5.3 Gender

The ASCA (2012) guidelines highlight the importance of being respectful and attuned to issues of gender. Gender may influence the experience and perception of trauma. Some traumatic experiences are often gender-based such as sexual violence (in the context of both heterosexual and same-sex relationships), domestic violence and homophobic violence. Trauma-specific practice also recognises the importance of power and power differences, and this can be exaggerated or reduced depending on the perception of gender, power and control (Kezelman & Stavropoulos, 2012; MHCC, 2013).

Much has been documented in relation to the struggle for acceptance and equality for LGBTI people and families, but less has been written in relation to people with disability and their sexual identity and preferences. How do people with intellectual disability grapple with issues in relation to gender identity? How do they express their struggle and their preferences and how can we hear and support them? What avenues of support are available as they work through the relevant issues? A submission by Family Planning NSW (2014a) notes:

The health and wellbeing of LGBTI people and people with disability continues to be disproportionately poorer than the general population and heterosexism, homophobia and transphobia dominate as leading causes of social exclusion and discrimination (Family Planning NSW, 2014a, p. 5).

The issue of gender and sexuality for people with disability has been influenced by unhelpful assumptions ranging on a continuum from being perceived as asexual through to being perceived as sexual 'predators'. There has been a struggle for recognition that people with disability are sexual beings with the same needs and rights as everyone in relation to the expression of their sexuality within appropriate and safe boundaries.

People with intellectual disability have the same range of sexual desires and aspirations as people without disability (Family Planning NSW, 2014b). There are additional needs for some people with disabilities in relation to issues of sex and sexuality including:

- Education and information in relation to sexuality in an accessible format such as sex education, reproductive health, contraception and understanding boundaries, including the right to say 'no' and what is appropriate sexual behaviour. The tailoring of resources and education will vary depending on the requirements of the individual and the nature of the disability.
- Access to appropriate medical care related to sexual health.
- Support for participation in safe sexual activity where desired.
- Clarification in law regarding issues of consent, such as in relation to reproductive health and sexual health. Particular attention needs to be paid to the practice of involuntary or coerced sterilisation (Family Planning NSW, 2014a & b).

Addressing these and other needs may reduce the vulnerability of people with disability to sexual exploitation, violence and unwanted pregnancy, any of which could result in or exacerbate trauma.

The Literature Review accompanying this Framework documents the gendered nature of violence against women and the particular risks for women with disability (Jackson et al., 2015). For example, the review cites the work of Women With Disabilities Australia (WWDA, 2007) that demonstrates:

- women with disability experience violence, particularly domestic violence and violence in institutions, more often than men with disability
- gender-based violence, including domestic violence, sexual assault/rape can cause disability
- women and girls with disability are often at greater risk than men with disability, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation
- women with disability are more vulnerable as victims of crimes from strangers and people known to them, yet crimes against women with disability are often not reported to law enforcement agencies
- women with disability are more exposed to practices which qualify as torture or inhuman or degrading treatment, such as sterilisation, forced abortion, violence, forced medication and chemical restraint.

The gendered nature of violence needs to be considered in all service settings at a policy and practice level including when providing trauma-informed support for people with intellectual disability. This involves considering a range of factors including the extent to which staff are aware of the nature of violence against women with disability and the potential impact of this on the individual. For example, are staff aware of

indicators of violence and other trauma? What approaches do staff take when they observe indicators or receive a disclosure of violence?

Consideration also needs to be given to whether there are policies and procedures in place providing adequate support and care for women who have experienced violence, both past and currently. This could include the provision of a female support worker, where possible and when requested, forging links with domestic violence crisis and support services, and with sexual assault services in the local area. Much has been documented in relation to women with disability's access or lack of access to these services, and it is important to consider access is often 'more than just a ramp' (WWDA, 2007).

This is not to say that men cannot suffer violence, but recognises the prevalence and nature of gendered violence as a too common reality.

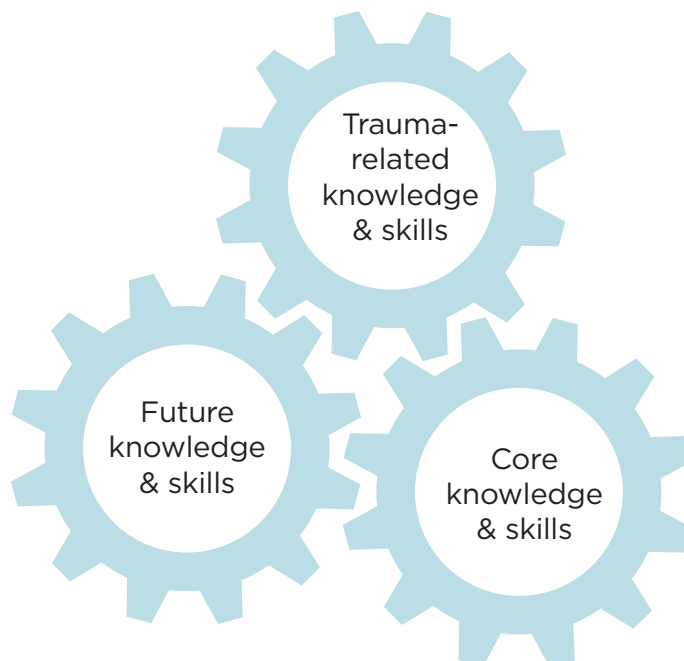
2.6 Knowledge and skills

2.6.1 Knowledge and skill development

Any framework requires giving attention to requisite knowledge and skills in order for it to be understood and implemented. This involves:

- considering the knowledge and skills required as foundational or core to the worker's role
- what, if any, are the new areas of knowledge and skills specific to the Framework?
- what is the approach to continuing to learn as research and practice continues to challenge our ideas and strongly held views?

The following diagram portrays the inter-connectedness between these areas of knowledge.



2.6.2 Core knowledge and skills

Each service and role within it requires a particular knowledge base and skill set. This will vary markedly based on the nature of the service, the discipline and role of the worker, their undergraduate or postgraduate education and access to on-the-job training within their organisation.

A useful exercise in implementing a trauma-informed framework is to review the core knowledge and skills within a service, and ascertain if there are areas of potential conflict or confusion, or areas that may directly contribute to trauma-informed practice.

An example of a potential area of conflict or confusion is where staff are trained in a particular use of coercive practice without the benefit of a trauma-informed lens. An example of a potential area of mutual contribution is if the service has access to a multidisciplinary team that can help inform the assessment of the impact of trauma on an individual.

2.6.3 Trauma-related knowledge and skills

As outlined earlier there is a distinction between trauma-specific and trauma-informed services. In line with this, not every worker is required to know how to provide trauma therapy, although a trauma-informed service would ensure that a person had access to trauma-specific treatment, either from within the organisation or through referral, when required (SAMHSA, 2014). If there are trauma-specific roles within the service it is imperative staff are trained and supervised to undertake recovery-focused work consistent with evidence-informed practice.

In implementing a trauma-informed framework it is recommended that a review is undertaken of staff and management's knowledge and skill level on each of the foundational values and guiding principles in this Framework. This comparison exercise can inform a training needs analysis for each individual worker as well as for the service more broadly.

2.6.4 Future knowledge and skills

Any body of knowledge will change over time. Therefore each organisation should be encouraged to have a quality improvement strategy for keeping abreast of the latest knowledge, both through contemporary research and evidence-based literature, as well as being informed by the voices of the people who use the service and other stakeholders. This will inform an ongoing quality improvement strategy to maintain and build capacity not limited to trauma-informed practice, but also embracing an evolving approach fundamental to sustaining best practice.

2.6.5 The importance of language

Caithness and Moore (2011) discuss the importance of shared language across diverse disciplines and roles as a means to providing a multidisciplinary response. Different professions may use the same term to mean different concepts. In the context of this Framework, terms such as integration, arousal and passive may have different connotations for a disability service or a trauma service or depending on whether the professional is an occupational therapist, speech pathologist, social worker or psychologist.

The use of certain terms or language is often contestable and dynamic in the disability/mental health/trauma fields with some terms becoming unacceptable or outmoded quite quickly, or those accessing services having particular preferences. It is recognised some of the terminology in this Framework may become out-dated more quickly than the concepts themselves. Examples of changing language include 'challenging behaviours' to 'behaviours of concern', and 'trauma-informed care' to 'trauma-informed practice'. Indeed, it is likely the term 'trauma' will become more contested over time.

2.6.6 Knowledge and skill strategy

As with all strategies aimed at developing knowledge, skills and competencies, multiple and flexible approaches are necessary. This includes, but is not limited to initial and ongoing training. Training would include topics regarding trauma theory, but enabling opportunity to explore these concepts with other theories and approaches relevant to the work.

A training and professional development strategy should include whole-of-organisation training for all staff including practitioners, administration and back-of-office staff, and management. The strategy is likely to also involve some training focused on staff in particular roles with people with disability.

Access to supervision is pivotal to not only learning and reflecting on the relevant knowledge and skills, but also particularly important in reflecting on this knowledge in practice. Supervision is also key to enabling staff from any discipline or in any role make sense of their experiences in implementing trauma-informed practice and to minimise vicarious trauma.

2.6.7 Different types of knowledge

The following table provides an overview of the different types of knowledge aspired to at different levels. The level refers to the degree of knowledge, not a hierarchy of knowledge. For example, certain roles within the disability sector require a detailed level of knowledge about assessment of people who have behaviours of concern, and to develop a plan to help them and others respond to these behaviours. In comparison, a wider range of roles within the disability sector and other sectors are expected to know how to engage people with disability and how to collaborate with other services.

The disability sector and people with disability may take a leadership role in providing public education about how to communicate with people with particular types of disability and to increase the accessibility of certain places and sites.

This table was adapted from Frederico, Jackson and Dwyer (2014) in order to be applicable to working with people with intellectual disability and to those who have experienced trauma. It provides a guide to what knowledge and skills may be required in different roles. This is an ever changing, non-exhaustive list as many fields and roles can be added.

Examples of different levels & types of knowledge in the areas of disability and trauma

DISABILITY FIELD

Personal knowledge	Specialist knowledge	Professional knowledge shared across fields	General knowledge
Who am I? Living with intellectual disability How does it feel? What do I want? What don't I want? What do I think about? How can I communicate my wishes, ideas and feelings? What am I good at? What do I need help with? What is helpful? What have I experienced? My gender My age My culture	Assessment of cognitive functioning and development Functional analysis and other assessments Development of behaviour support plans Complex presentations such as disability and mental health and/or substance abuse Specialist responses Application of certain roles under legislation Person-centred planning Specialist medical and allied health assessments, e.g. speech, OT, physiotherapy Formulation Education about working with people with disability Advice on accessibility	Types of services available Disability service system Referral processes Collaborative practice Relevant legislation Person-centred practice Applying somatosensory, speech and other interventions informed by specialists Culturally informed practice	Human rights Human development Cultural knowledge and awareness Attitude and awareness of how to respond to someone with a specific disability Requirement to make places and systems more accessible

TRAUMA FIELD

Personal knowledge	Specialist knowledge	Professional knowledge shared across fields	General knowledge
Who am I? Living with the experience and memories of trauma What have I experienced? How does it feel? What do I want? What don't I want? What do I think about? How can I communicate my wishes, ideas and feelings? What am I good at? What do I need help with? What is helpful? What was I like and what was my life like before the trauma? My gender My age My culture	Assessment of development and impact of trauma Development of individual therapeutic plans Trauma-specific therapy Complex mental health presentations and formulation Specialist medical and allied health assessments, e.g. speech, OT, physiotherapy Planning other therapeutic approaches Psycho-education How to consult and support trauma-informed organisations and practice	Trauma-informed approaches Psychological or emotional first aid Identifying vicarious trauma and accessing support services Types of services available Referral options Collaborative practice Applying somatosensory, speech and other interventions informed by specialists Culturally informed practice	Human rights Human development Presence of trauma Signs of traumatisation Support systems Preliminary psychological or emotional first aid Cultural knowledge and awareness Public awareness of psychological distress

2.7 Environment and resources

As reflected in the guiding principles, trauma-informed practice requires an environment where everyone feels safe. This can be easier said than done in some contexts, especially if there are insufficient resources or the environment itself is inherently unsafe. A trauma-informed lens may lead to someone looking anew at a familiar environment, such as a community residential unit, office, classroom or secure facility, and asking questions such as:

- What is in this place that may help the person feel safe?
- What is in this place that may lead to the person feeling unsafe?
- Are there particular areas in this place that may feel more unsafe for different people, such as based on impairment, age, culture or gender?
- Does this place feel safe to service users, their families and/or carers, other community members and staff?
- What can be done to enhance the sense and reality of safety?
- Have we asked the residents or other service users what makes them feel safe?
- Have we asked family members or friends what might be helpful for us to know?

We feel safe or unsafe not only through emotions, but also through all of our senses. A useful approach to enhancing safety is to consider the place from a sensory perspective. Consulting with a trauma-informed occupational therapist can be advantageous in considering the sights, sounds, smells, touches, tastes and movements that are encouraged or discouraged by the environment. This does not only involve the building and lands, but also other resources and belongings, such as the furniture, furnishings, colours, textures, areas of low stimulation, and areas for multisensory experiences, privacy or communal activities.

A trauma-informed approach reminds us the unfamiliar can feel unsafe, even if it is benign or benevolent. This emphasises the importance of reflection when a person is transitioning from one environment to another. For example, asking the person what they need, and encouraging them to have their own belongings that are familiar and potentially comforting for them. This may include the shampoo they are used to (smell), their favourite clothing (colour and texture), their favourite foods (taste and texture), the level of lighting in the room (sight), the type of bedding (texture and weight) and their favourite music (sound and rhythm).

Enabling appropriate access to resources to support the environment is not just a matter of pleasing the individual, which is a worthy goal in itself, but may also be a key element to help them feel calm and settled in an otherwise scary world.

Trauma-informed practice also requires investment in resources such as staff time with the person and their family; allocation of resources for staff training and thoughtful communication with all stakeholders; and access to services such as therapy and behaviour support. A trauma-informed organisation takes steps to maximise its capacity to allocate the required resources to meet the needs of the people it supports. This may require creative and collaborative approaches in a sector where resources are limited.

2.8 Policies and procedures

Most organisations have established policies and procedures for their day-to-day operation, as well as governance and quality improvement processes. A common challenge is to have sufficient written documentation to help staff, management and others know the expectations and agreed ways of doing things, without having too much detail that is overly prescriptive, cumbersome to implement or difficult to review and change in light of changing dynamics within the organisation.

It is not suggested specific policies and procedures for trauma-informed practice are required. Rather it is recommended a trauma-informed perspective, along with human rights and other important perspectives, is used as a lens through which to focus on, create and then review all policies and procedures. This may be more obvious in some areas such as policies on restrictive practices, access to support for the person with disability, their family members and staff after a critical incident, or in a staff wellbeing policy.

However, a trauma-informed lens can also inform policies and procedures relating to:

- information sharing
- performance management
- client records
- accessibility of the service
- accommodation vacancy management
- meal times and other routines in residential or day programs
- referral criteria and processes
- planning for the completion of service delivery with the person with disability
- how to enlist people with disability and their families/carers into different aspects of the organisation
- transparency of the service
- the process of eliciting feedback and input.

Four useful and interrelated questions when reviewing any policy or procedure are:

1. Does the absence of a documented policy or procedure add, or potentially add, to confusion, uncertainty and inconsistency?
2. Have people with disability, families and carers been consulted in the development of policies and evaluation of programs and service delivery?
3. Is there too much detail that is adding, or potentially adding, to confusion and could be simplified?
4. Are the policies and procedures sufficient to avoid potential trauma or re-traumatisation and other adverse situations where possible and are they sufficient to assist all involved when a crisis occurs?

An example of a policy or practice to be considered is whether or not there should be a formal process of screening for trauma history or current trauma experience. A number of the trauma-informed frameworks suggest that screening for trauma is a key principle (e.g., Kezelman & Stavropoulos 2012; Chadwick Center for Children and Families, 2013; Falot & Harris, 2006; MHCC, 2013; and SAMHSA, 2014). This is to ensure a person who has experienced trauma is identified as soon as possible and receives the appropriate response.

Some services clearly need to screen for trauma as part of their criteria for acceptance, such as child protection, trauma-specific therapy services and disaster recovery services. However, it is an interesting question to consider whether or not there should be specific screening about trauma as part of the intake or assessment process in other services such as disability services. It is possible the screening questions themselves could trigger a trauma reaction, and it is likely the person will not be forthcoming about trauma history until a trusting relationship has been established. Rather than a focus on screening trauma, this Framework emphasises the need to be open to recognise trauma or its ramifications for the person, and to never assume a person has not experienced trauma.

One of the litmus tests for a trauma-informed organisation is whether its policies and procedures are useful at a time of potential or actual crisis – to avoid, reduce or respond and then review – or are they dropped as soon as a crisis occurs?

Involving people with disability and their families/carers in a meaningful and non-tokenistic way in the creation and review of policies and procedures is occurring in some organisations, but for many it is a work in progress. The benchmark is consumer and carer participation in an active and ongoing way where their voices are heard in an authentic process.

2.9 Leadership and organisational culture

2.9.1 Focus on leadership

Any change or transition process requires effective leadership. The Sanctuary Model is a well-articulated example of a model where the leadership of trauma-informed practice requires the whole management team to invest in the process. Depending on the organisational structure, this may include the governing board, CEO and management team.

Experience has taught that courageous leadership is always the key to system change and without it, substantial change is unlikely to occur (Bloom, 2005, p.69).

There are different models of leadership. As with the other key elements, it is recommended these be considered in the light of trauma-informed practice. Important questions are:

Does the model of leadership:

- provide safety for all?
- support a relational approach including trustworthiness?
- demonstrate collaboration?
- create genuine opportunities for choice and for each person's voice to be heard, and support person-centred planning and practice?

Leadership does not always imply only the most senior people in an organisation, although it should definitely include them. People with personal authority, role authority and/or professional authority (Obholzer, 1994) can play a powerful leadership role in building or sustaining – or undermining – a positive, trauma-informed organisational culture and championing organisational change.

2.9.2 An organisational culture

The seven Sanctuary Model commitments are sometimes referred to as seven cultures (Bloom, 2005). They represent the importance of creating an organisational culture that is safe, open to communication and emotionally intelligent, and which shares power and involves dynamic learning, mutual responsibility and a focus on growth. Two other elements of a positive, trauma-informed culture created and sustained by leadership are supporting reflective practice and ongoing attention to congruence.

2.9.2.1 Reflective practice

A focus on leadership does not equate to an emphasis on managerialism or support the move toward more risk-averse practice. Indeed, that trend can reduce the ability of leadership to support time for reflection and learning (Gibbs, 2001; Ruch, 2007).

Schon (1990) believes a skilled practitioner or leader is a reflective one. He wrote that the 'artistry of knowing' is not about facts, but about recognising the ever changing nature of our own tacit and explicit theories, and being able to reflect on our knowledge and experience and that of others to consider each situation from different perspectives. Osterman (1990) noted "reflection as concentration and careful consideration, and reflective practice is the mindful consideration of one's actions, specifically, one's professional actions" (p.134). Furthermore Osterman (1990) discussed reflective practice as "a challenging, focused, and critical assessment of one's own behavior as a means towards developing one's own craftsmanship. While reflection is certainly essential to the process, reflective practice is a dialectic process in which thought is integrally linked with action" (p.134).

Far from leisurely speculation, critical reflection provides an opportunity to challenge assumptions.

These include assumptions regarding interpersonal communication and dialogue, professional helping and workplace cultures, and regarding knowledge, learning, research and the place of emotions (Fook & Askeland, 2007, p. 12).

When working with marginalised and disadvantaged groups, it is particularly important to explore our own values and assumptions. For example, what are our views about people with intellectual disability as unique individuals, sexual beings, parents and as consumers seeking full participation in decision-making at both personal and organisational levels? How do these views influence our practice? Only with a considered, open and sustained focus on our practice, and the space to question and challenge these in a respectful process, can practice be transformed.

Reflective practice can be a valuable attribute of an organisation as a counterpoint to the focus on policies and procedures. It does not negate the need for these, but enables an accompanying recognition of the complexity, unpredictability, ambiguity and uncertainty "that characterises human behaviour and people's lives" (Ruch, 2005, p. 115). Reflective practice does not assume every problem can be solved by a policy or other form of document, and acknowledges there is risk inherent in the work. Leadership that applies and supports reflective practice is particularly relevant in a trauma-informed context as it pays attention to potential issues, such as parallel process and vicarious trauma.

2.9.2.2 Organisational congruence

Congruence is comprised of consistency – demonstrating the values, principles, process and actions over time and across all roles and relationships; reciprocity – mutual interactions where what we expect from one person towards another is the same throughout the service; and coherence – the cohesiveness or degree to which the behaviours of a person, group or system have an overall sense of wholeness and integrity (Anglin, 2002).

The ability to achieve congruence is not a static phenomenon where once achieved the task is over. It is “an ideal state or goal, but is never fully achieved” (Anglin, 2002, p. 65). As such, leadership plays a pivotal role in striving towards congruence and in emphasising it as a goal. Congruence is an important consideration in trauma-informed practice. Along with reflective practice it helps instill the need to be attuned to the person with disability as well as ourselves and each other. It recognises we are in an imperfect environment and to accept mistakes will occur from which much can be learnt in a transparent, respectful and non-blaming environment.

Congruence and these other aspects of leadership are key elements in the Framework, but are also important in the implementation of other frameworks.

3 The Framework in Action

To implement a framework is just as much, if not more, of a challenge than developing or deciding which one to use. It requires the normal processes of transition or change management including a communication plan, an implementation plan, adapting or developing new systems and structures, training and support, and maintaining inspiration. The Taking Time Framework builds in recognition of the importance of leadership, policies, the environment and knowledge as part of the process of change. Some additional elements to support the translation of trauma-informed practice into reality have been developed.

3.1 Suggestions for implementation at a service level

The following 12 suggestions have been largely influenced by the ASCA guidelines (Kezelman & Stavropoulos, 2012) into trauma-informed practice, but supplemented with our own experience of implementation. Which steps are required will depend in part on the organisational readiness for implementing a trauma-informed framework. As such, some of these suggestions may not be necessary for certain organisations. It is recognised a number of organisations have already begun, or are well underway, in the process of becoming trauma-informed.

1. Don't do it on your own – what access to knowledge is required?

It is useful to undertake a preliminary mapping exercise of who in your field of work and/or location may be appropriate and available to consult, educate and support the process of becoming trauma-informed. In other words, are there other organisations that have already become or are in the process of becoming trauma-informed?

Being able to tap into the experience of other trauma-informed service providers, including trauma-specific practitioners, can provide a helpful resource when aiming to be a trauma-informed organisation. For example, discussions can be unsettling for workers, consumers and their families, and so it is helpful to have prepared a way of being able to reflect safely on this potentially new information from the outset.

Similarly, when completing a self-assessment tool, having a 'critical friend' who can provide both support and challenge throughout this process can be invaluable.

2. Where are we before we start?

It is important to do a stocktake or review of the current situation before making large-scale changes. This may demonstrate the strengths in the organisation that can support change, as well as identifying areas requiring additional support.

For example, an organisation may undertake a review of the service, such as through a self-assessment and consumer assessment tool to ascertain whether the board of management or governance group, management, staff and others are aware of the value of trauma-informed practice, the prevalence and consequences of trauma for their population, and areas requiring immediate attention.

This process can challenge assumptions and will raise awareness and lead to fruitful discussions for the management, workforce and the consumer group.

3. Ensure a sustained leadership commitment

Any implementation process will wax and wane if there is not a clear and consistent message from leadership that there is a strong commitment to the process and outcomes. This includes learning along the way and making adjustments accordingly, but being clear and steadfast about the intent, expectations and processes of communication and support for change.

4. Commit to a consumer-driven system and process

This includes, but is not limited to one of the cornerstone principles within the disability field of person-centred planning. As many disability services have consumer participation processes in place, they may be able to build on these, but if these processes are not already present, this will need to be a priority focus of attention.

5. Provide or enable an introductory education strategy

This step should be based on key principles of trauma-informed practice for the workforce, board of management, consumers, family members and other key stakeholders. This will provide a common language and an informed base for the next steps.

6. Provide or enable an ongoing training and education strategy

This step will provide the workforce with the knowledge and skills required. An example of this is to undertake a training needs analysis, such as that developed by the Chadwick Trauma-Informed Systems Project (Chadwick Center for Children and Families, 2013).

7. Establish a service charter of trauma-informed practice

This would be based on a genuine consultation process following the opportunity for education and training for all stakeholders and be endorsed by the board of management or governance group. It could be informed by this Framework or other models of trauma-informed practice.

The service charter should articulate key messages about how the organisation recognises the impact of trauma, and how it aims to stop the cycle of harm and focus on recovery and resilience. It will place trauma-informed practice in the broader organisational context. Some organisations which have a service charter in place may use this Framework as part of their review of the charter.

8. Emphasise a recovery orientation

This step builds on the foundational values of safety, relationships, collaboration, choice, voice, and person-centred practice. Consider what does the situation look like when these values are present, and what does it look like when they are not present or not sufficiently present?

9. Promote understanding of the impacts of trauma and the importance of coordinated services

This occurs through the more detailed education program and can be more tailored to the service charter and the specific services provided by the organisation or network.

It also reflects the value of seeking collaboration with other organisations that are frequently supporting the same people as a means of providing collegial support through the process of implementation and as a benchmarking exercise. This is also discussed later regarding system level implementation.

10. Commit to all forms of diversity

This is a foundational value and principle for the service, and includes how difference is understood, recognised, celebrated and protected – as for all disability services.

11. Recognise culture and connection to a community or cultural group

In addition to the issue of diversity, this step is a key element of building resilience. In the context of Australia, particular attention is required for Aboriginal and Torres Strait Islander people who are over-represented in the disability population and who have an increased probability of having experienced trauma. Another group at particular risk of both disability and trauma are refugees and asylum seekers.

12. Incorporate a message of optimism and hope into all interactions between services and people with disability and their families/carers

This includes creating opportunities for conversations at many levels and through various means depending on the communication needs and preferences of the individuals. For example, the hope of healing from the experience of trauma may be different to whether or not the person feels hope in relation to their disability, but one may influence the other.

3.2 Suggestions for implementation at a system level

As NSW is going through a process of major transition in relation to multiple systems, including the disability field, it is valuable to provide opportunities at a system, service and individual level to acknowledge this can lead to increased stress, sense of threat, uncertainty, loss of relationships, and loss and confusion about roles. A trauma-informed system would pay attention to this in order to assist those experiencing major changes to avoid inadvertently projecting these pressures onto others. Trauma-informed approaches are alert to the potential of a parallel process occurring between a stressed workforce and the stress/distress experienced by the people they support.

The following table is also informed by the ASCA guidelines (Kezelman & Stavropoulos, 2012) and has been adapted and clarified as they may apply to the service system supporting people with intellectual disability.

Guidelines	Suggestions for implementation
<p>Promote collaboration and coordination across systems of care which serve people with trauma histories, and include a life-span perspective</p>	<p>It is often apparent there are too few or too many services involved in the lives of people who have specific needs. This is particularly the case if they have multiple needs that require different disciplines or types of service response. Promoting a service system, that places the person and those people important in their life at the centre, is part of the disability policy framework.</p> <p>A trauma-informed system would recognise not only the value of collaboration, but also some of the constraints that can interfere when the sector itself is under pressure and strain. A life span perspective is part of the developmental approach acknowledging that, throughout key transitions beginning in childhood and throughout life, the service needs of the person may change. Suggestions include:</p> <ul style="list-style-type: none"> • When an organisation is going through the process of implementing trauma-informed practice, invite colleagues in other services to general training or information sessions. • Invite services that may also be involved with the people you support, but from other fields, and create opportunities for discussion about the extent to which trauma-informed principles and practice are influencing that sector. • Establish local trauma-informed communities of practice. • Introduce trauma-informed practice as a theme or part of a charter or terms of reference in local networks and other collaborations. • Enlist consumers who are interested and their relevant services, and provide some case studies of trauma-informed or not trauma-informed practice to assist recognition of what it is and what it is not. • Establish a joint process with another organisation to support each other in the process and to help create a benchmark to each organisation's process. This will not only support each of the services, but also help create a groundswell of interest in the broader field.

Guidelines	Suggestions for implementation
<p>Policies and procedures</p>	<p>As discussed, particular attention is required to review policies and procedures in the light of trauma-informed practice. A number of the Appendices may support this process.</p> <p>However, at a system level, it is equally important to consider the statewide or regional policies that have implications for people with intellectual disability from a trauma perspective. It is not simply a review to see which policies mention trauma, but also to ensure they are consistent with trauma principles.</p>
<p>Facilitate involvement of people with intellectual disability in systems which serve them, and articulate and uphold trauma-informed rights</p>	<p>As services are aiming to encourage and enable greater consumer participation and action, so is the sector. Although the disability sector has shown leadership in this regard compared to some other sectors, it is obviously an ongoing area requiring attention.</p>
<p>Education and training</p>	<p>As discussed, it is helpful to consider different types of knowledge and what is needed to support each role or type of service as ‘knowledge holders’ in order to advance trauma-informed practice for people with intellectual disability. This is also in recognition of other bodies of knowledge that are important to integrate with trauma and related theories.</p>
<p>Identify and review funding requirements</p>	<p>At a government level, in terms of purchasing or funding services, consideration should be given to whether funding requirements acknowledge the complex realities for people who have experienced trauma. As the system attempts to become trauma-informed, there should be a realistic expectation of appropriate funds needed for managing change including, but not only, related to training.</p> <p>For example, it may also include needing to ensure access to trauma-specific services when required. Funding may be required for research, given the limited data available regarding the prevalence of trauma for people with disability and likely effects on/for them. Trauma-informed practice may not require additional funds in order to make a difference, but it may point to particular gaps in funding.</p>

Guidelines	Suggestions for implementation
<p>Promote education in trauma, especially differences between single-incident and complex trauma, via links with universities, colleges and training organisations</p>	<p>To develop and maintain a trauma-informed workforce requires commitment at the undergraduate and postgraduate level. Indeed, from a public health and education perspective, there is value in secondary school level education about some of the principles.</p> <p>A commitment to knowledge creation through research and dissemination through education, training, conferences and publications is required for there to be a sustained paradigm shift.</p>
<p>Respect culture, ethnicity, gender, age, sexual orientation, disability and socio-economic status</p>	<p>Tailoring the implementation of the Framework to the individual is not only an issue for each service, but also for the sector and system as a whole. Aboriginal community-managed organisations, organisations supporting communities from culturally and linguistically diverse (CALD) backgrounds, gender-specific organisations, and child, adult and aged care services are just some of the potential partners in trauma-informed practice.</p>

4 Supporting Information from the Research

The Literature Review accompanying this Framework provides a detailed discussion of the research findings regarding different aspects relating to trauma and trauma-informed practice (Jackson et al., 2015). This chapter focuses on summarising the literature regarding consequences of trauma, some of the mediating factors that influence the impact of trauma and research specific to trauma-informed practice.

4.1 Consequences of trauma

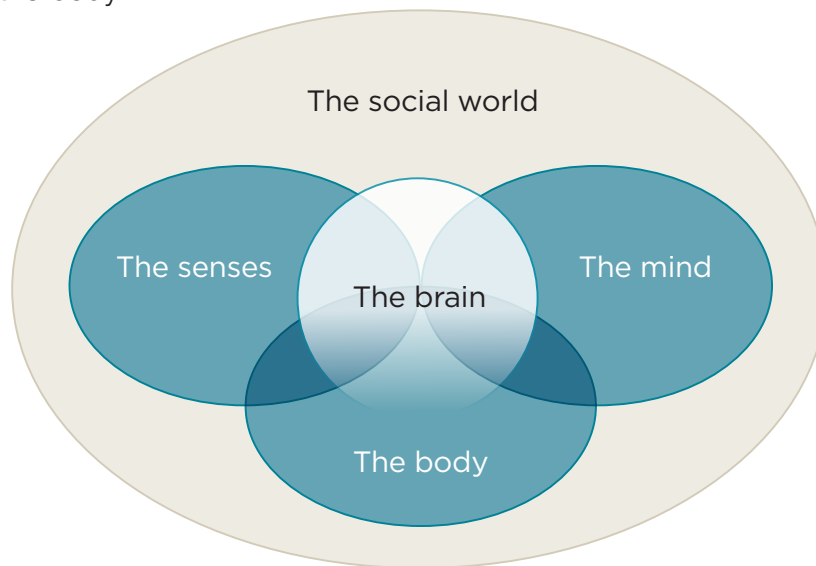
Research suggests a wide range of potential physical, cognitive, emotional, social and behavioural consequences of exposure to trauma for people of all ages. While people with disability are likely to have certain strengths and access to supports, traumatic experiences can derail anyone's usual capacity to cope, and this may have additional implications for people with intellectual disability (Razza, Tomasulo, & Sobsey 2011).

The majority of studies do not include participants with intellectual disability. Nonetheless, two suppositions have been made. First, people with intellectual disability are likely to experience similar consequences of trauma as others. Certainly, there is no reason to assume they would experience fewer or less severe consequences. Second, people with intellectual disability may already have difficulties mediated through the brain, such as memory or cognitive problems which traumatic experiences may then exacerbate.

In order to better understand the implications when a person is confronted with overwhelming trauma, we consider the person and their situation from a holistic perspective. The figure below is an attempt to portray the overlapping nature of the person's brain, senses, mind, body and interactions with the social world, while acknowledging each area has distinct features. They are intertwined and many of the effects of traumatisation that could impact one area have implications for, or create difficulties in, other areas.

- **The brain:** There is an increasing body of research that strongly suggests a number of key areas in the brain that mediate stress responses and are implicated in the exposure to trauma.
- **The senses:** Senses are mediated through the brain and the body and are a primary means for taking in information including information regarding threat.
- **The body:** The range of bodily functions that have been implicated in the effects of trauma is substantial and primarily mediated through the brain.
- **The mind:** Although the mind is inextricably linked to the brain, it is more than the sum of the parts of the brain and this is particularly important when considering the implications of potential trauma and recovery.

- **The social world:** No person can survive in isolation from the rest of the world. An infant is inherently dependent on the social world beginning with the parent/carer who provides for their daily needs including skin-to-skin contact. As we grow, our social world expands and changes, but continues to be a necessity of living. Our ability to interact in the social world is mediated through the brain, the senses, the mind and the body.



The following series of five tables briefly describes the research in relation to each of these areas and the impact of trauma.

The brain	
Potential impacts of trauma	Examples of research
<p>Changes in structures, systems and electrochemical reactions in the brain. For example:</p> <ul style="list-style-type: none"> ● reduced volume and size of structures such as hippocampus and corpus callosum, increased noradrenalin (norepinephrine) ● atypical cortisol levels ● increased responsivity of the amygdala to threat-related stimuli. 	<p>Bogdan, Williamson & Hariri, 2012; Chugani, Behen, Muzik, Juhasz, Nagy & Chugani, 2001; De Bellis, Baum et al., 1999; De Bellis, Keshavan et al., 1999; De Bellis, 2005; Hull, 2002; Perry, 2002; Perry & Pollard, 1997; Teicher, Dumont, Ito, Vaituzis, Giedd & Andersen, 2004; Twardosz and Lutzker, 2010; van der Kolk, McFarlane & van der Hart, 1996.</p>

The implications for these impacts on the brain can include: memory problems, poor concentration, repetition of traumatic memories, exaggerated startle response, communication problems, difficulties in finding words to describe emotional experiences (alexithymia) and dysregulated emotional arousal.

The senses

Potential impacts of trauma	Examples of research
Vision problems	Meltzer et al., 2003; Nathanson & Tzioumi, 2007; Widom et al., 2012
Hearing problems	Nathanson & Tzioumi, 2007
Tactile sensation problems	Tobin, 2011
Sensory processing and integration problems	Biel & Peske, 2009; Cermak & Croza, 1998

The implications for the impact of trauma on the senses can include the person's capacity to process information through the different senses, to feel comfortable and calm and to self-regulate in terms of their physiological and emotional arousal.

The body

Potential impacts of trauma	Examples of research
Dysregulated heart rate	Allen, 1995; Nunn, 2004; Perry, 2000; Shonkoff & Phillips, 2000
Heart disease	Anda et al., 2008; Dong et al., 2003
Skin diseases	Besiroglu et al., 2009
Poor lung functioning	Widom et al., 2012
Diabetes	Widom et al., 2012
Liver disease	Dong et al., 2003
Irritable bowel problems	Heitkemper et al., 2011
Appetite problems or obesity	DePanfilis, 2006; Knutson et al., 2010
Sleeping problems	DePanfilis, 2006; Heitkemper et al., 2011
Oral health problems	Widom et al., 2012
Migraines	Tietjen et al., 2010
Autoimmune diseases	Dube et al., 2009
Cancer	Brown et al., 2010

Many of these potential health problems for people who have experienced trauma have clear implications for the person's health and well-being, especially in relation to longevity and quality of life. However, they are also compounding risk factors where the person experiencing one or more of these may be at risk of other health problems, as well as mental health and psychosocial difficulties.

The mind	
Potential impacts of trauma	Examples of research
Cognitive development and learning problems	Barrett et al., 1996; De Bellis, 2005; Mills et al., 2011; Perry & Pollard, 1997; Spratt et al., 2012; Widom et al., 2013
Executive functioning	De Bellis, 2005; Nikulina & Widom, 2013
Affect dysregulation	Marquis et al., 2008; Maughan & Cicchetti, 2002
Difficulties in modulating arousal (e.g. hyperarousal)	van der Kolk, 1996
Problems with attention and concentration	van der Kolk, 1996
Symptoms consistent with mental health problems including, but not limited to, PTSD	Goldstein et al., 2009; Horwitz et al., 2001; Hussey, Chang, & Kotch, 2006; Lobbestael, Arntz, & Bernstein, 2010; Lowell, Renk, & Adgate, 2014; Mazzeio & Espelage, 2002; Norman et al., 2012; Taussig et al., 2013; Thompson et al., 2012; Tietjen et al., 2010; Widom et al., 2013; van der Kolk & McFarlane, 1996
Speech and language problems	Coster & Cicchetti, 1993; Grant & Gravestock, 2003; Snow, 2009; Spratt et al., 2012; Sylvestre & Merette, 2010
Shattered meanings (e.g. loss of trust, sense of self, shaken belief system and loss of hope)	Flynn, Cicchetti, & Rogosch, 2014; McFarlane & Yehuda, 1996; van der Kolk, 1996

Many of the problems that can be caused or exacerbated by trauma that are understood as related to the mind have social connotations, particularly attachment problems, social anxiety and aggression. These are included in the next table, but could be equally placed in the previous one.

The social world	
Potential impacts of trauma	Examples of research
Attachment problems	Horwath, 2013; Lowell et al., 2014
Difficulties in sibling or peer relationships	Flynn et al., 2014; Taussig et al., 2013
Limited social supports in adulthood	Sperry & Widom, 2013
Social anxiety and poor social skills	De Bellis, 2005; Flynn et al., 2014; Iffland et al., 2012
Future occupational status	Widom et al., 2013
Aggression towards others	Horwath, 2013; Hussey et al., 2006; Knutson et al., 2005; Kotch et al., 2008; Manly et al., 2013; Marquis et al., 2008; Widom et al., 2013
Early sexual activity and sexual risk-taking behaviours	Beckett, 2011; Haydon, Hussey, & Halpern, 2011; Kaplan, Pelcovitz, & Labruna, 1999; Norman et al., 2012; Wilson & Widom, 2008; Wilson & Widom, 2010
Sexual exploitation through prostitution	Beckett, 2011; Brawn & Roe-Sepowitz, 2008; Wilson & Widom, 2008; Wilson & Widom, 2010

4.2 Mediating factors

Not everyone who is exposed to a traumatic experience will be traumatised, and not everyone who is traumatised will experience all of these consequences.

Research has provided insight into some of the mediating factors that help explain why some people are more at risk of particular consequences than others. Some of these are static and not open to change, such as historical factors and gender. Other factors are dynamic, and therefore open to being strengthened or reduced to support the person in their attempt to cope. Examples of dynamic factors include the way the person understands what has happened and their access to support.

One of the most well recognised mediating factors is the person's age. Although trauma can occur and be harmful at any age, there are additional vulnerabilities to the developing brain of an infant and young child (Kezelman & Stavropoulos, 2012; Perry, 2006).

Perry et al. (1995) listed a number of mediating factors relating to the degree in which a child may experience severe consequences as a result of exposure to trauma. Apart from the specific reference to the child's age, these factors have relevance to people of any age, comprising:

- the child's functioning and history prior to the trauma, such as earlier history of adversity and their responses over time
- the child's age, given that neurobiological response patterns appear to change with age
- the specific cognitive meaning or interpretation of an event, in other words how the child and others understood the event or experience
- the nature of the trauma (e.g. different types of child maltreatment or a one-off event compared to ongoing trauma)
- the presence of exacerbating factors such as loss of a parent or attenuating factors, such as positive relational support and early intervention.

This list of mediating factors is not to suggest an older person, with no prior history of trauma who experiences a one-off traumatic event, may not be completely traumatised by the experience and suffer serious consequences. It is, however, more likely that at least some of these factors will be present for people who suffer lasting consequences, especially in the context of complex trauma.

Some authors have noted cognitive impairment as one of the risk factors for prolonging the intensity or duration of the consequences of traumatisation (Garbarino & Kostelny, 1996; Perry, 1999).

Gender is another factor implicated in mediating the consequences of trauma. However, the literature demonstrates it is not all one-direction (Perkonigg & Wittchen, 1999; Perry, 1999; Yule & Canterbury, 1994). For example, females were more at risk of some consequences such as anxiety, depression and dissociation, and males were more at risk of other consequences such as hyperarousal and aggression (Yule & Canterbury, 1994).

Some factors described in the literature as possibly supporting a person to cope with a traumatic experience include their active attempts to cope with stress, their cognitive capacity, their self-efficacy and self-confidence, and temperamental characteristics such as being more active than passive (Garbarino & Kostelny, 1996).

Van der Kolk, van der Hart and Marmar (1996) wrote of the positive impact of hope and optimism and the capacity to imagine the future. Salmon and Bryant (2002) noted that a person's capacity to understand their own thought processes can be of assistance in coping with trauma, but also noted the capacity for abstract reasoning can lead to catastrophic thinking where they fear the worst.

Herman (1997) wrote many traumatic events involve losses that need to be mourned. If this mourning process does not occur, then this can be an exacerbating factor for ongoing traumatisation.

Research suggests it is not just the presence of positive relationships and prosocial supports, but the perception of such support that can influence the degree of impact of trauma (Greenburg & Keane, 2001). For children, their parents' coping capacity, particularly the parents' emotional state, was one of the most influential factors on the child's capacity to cope with the trauma experience (Cohen et al., 2010; Garbarino & Kostelny, 1996; Yule & Canterbury, 1994).

4.3 Research on trauma-informed practice

Across Australia and internationally, human services are adopting trauma-informed practice in a diverse range of child and adult services, ranging from out-of-home and residential care for children and young people, to gender-specific alcohol and other drug treatment services.

The accompanying Literature Review (Jackson et al., 2015) only located one example of a trauma-informed approach for the needs of people with disability (LeBel, 2011; LeBel, Huckshorn, & Caldwell, 2010). A number of other trauma-informed models and frameworks also provide insight and are applicable when considering trauma-informed practice for people with intellectual disability. These are summarised in the following table with a more detailed table in the Literature Review.

Authors	Description of trauma-informed framework
Kaplan (1998) Australia	A guide that focused on trauma and torture survivors who were refugees and asylum seekers.
MHCC (2013) Australia	A National Strategic Direction for Trauma-Informed Care and Practice (in mental health and human services): position paper and recommendations. Informed by the National Trauma-Informed Care and Practice Advisory Working Group and international literature and research.
Atkinson (2013) Australia	Summarises trauma research specific to Indigenous Australian children and their families. Describes service providers who deliver trauma-informed and trauma-specific services for Indigenous children.
ASCA – Kezelman & Stavropoulos, (2012) Australia	a) Practice Guidelines for Treatment of Complex Trauma (clinical) b) Practice Guidelines for Trauma-Informed Care and Service Delivery
Jackson et al. (2013) Australia	Making Tracks: A trauma-informed framework for services supporting Aboriginal young people in the process of leaving the out-of-home care system
The Bouverie Centre (2013) Australia	Guidelines for trauma-informed family-sensitive practice for adult health services. Includes some common fears of workers and some helpful tips for workers.
LeBel (2011) US	A PowerPoint presentation focusing on trauma-informed practice with adolescents with disability focused on preventing restraint and seclusion. Developed to reflect components of the National Association of State Mental Health Program Directors (NASMHPD) to prevent violence and coercion in care settings.
The National Center on Family Homelessness, Guarino et al. (2009) US	This document was written for the Department of Health and Human Services (USA). The focus was to provide a toolkit for homelessness services, shelters and related programs. The toolkit contains: 1. <i>Trauma-Informed Organizational Self-Assessment</i> 2. <i>User's Guide: to assist programs in implementing the Self-Assessment</i> 3. <i>How-To Manual for Creating Organizational Change: identifies concrete steps for change.</i>

Authors	Description of trauma-informed framework
Jennings (2008) US	Describes all the services and models considered to be evidence-based or 'promising practice' for trauma-informed and trauma-specific mental health services.
The Sanctuary Model, Bloom (1995, 1997, 2003, 2005, 2006) US	Represents a trauma-informed whole-of-system approach designed to facilitate the development of structures, processes and behaviours of staff that assist in counteracting trauma and aiding trauma recovery. Has been applied to a range of settings in the US and to a smaller extent in Australia.
Harris & Fallot (2001) Fallot & Harris (2006, 2009) US	Harris and Fallot's publications support the change process of introducing and implementing 'trauma-informed systems of care' and are frequently cited by other models.
Chadwick Trauma-Informed Systems Project (2013) US	This was a series of guidelines for applying a trauma lens to a child welfare practice model. It includes the essential elements of a trauma-informed child welfare system and notes that trauma-informed is one, but not the only perspective.
SAMHSA (2014) US	A trauma-informed framework for the behavioural health specialty sectors, such as mental health and alcohol and other drug treatment services

There is growing evidence of the efficacy of trauma-informed practice, although few studies have yet focused on people with intellectual disability. Examples of positive outcomes attributed to trauma-informed practice include:

- reduced trauma symptoms
- reduced substance use
- reduction in mental health symptoms
- improved housing stability
- decrease in use of crisis services
- cost effectiveness
- increased collaboration with consumers and other services
- greater self-efficacy
- improved staff morale
- reduction of restrictive practices, such as restraint and seclusion
- consumers reporting increased sense of safety and a more significant voice (Azeem et al., 2011; Donovan et al., 2003; LeBel, Huckshorn, & Caldwell, 2010; MHCC, 2013; Rivard et al., 2005).

There is as yet little evidence base in relation to trauma-informed practice directly with people with disability, although there are clearly promising indications. There is no evidence to suggest trauma-informed practice is harmful. As reflected earlier, there is a substantial body of research pointing to the need to respond appropriately to reduce the prevalence of trauma and its many consequences, and minimise re-traumatisation and re-victimisation in the community as well as service settings. As trauma-informed practice service provision continues its evolution, its benefits are likely to become more comprehensively researched and outcomes data increasingly available.

In the meantime, the research messages support the conclusion that trauma-informed practice is relevant and potentially very helpful for organisations working with populations who are at particular risk of traumatisation, such as those with intellectual disability.

5 Conclusion

The Taking Time Trauma-Informed Framework was designed to support the development, implementation and review of trauma-informed practice for systems and services supporting people with intellectual disability in NSW, Australia.

The project governance group articulated the following rationale for the development of the Framework:

- People with intellectual disability are at increased risk of being exposed to trauma.
- People with intellectual disability are likely to suffer serious and long-term consequences of trauma.
- There is value in articulating the philosophies, values and belief systems relating to service provision for people with intellectual disability.
- An appropriate level of knowledge in relation to trauma is critical, and associated with this is the need to consider how knowledge is shared and disseminated.
- People with disability, and in particular people with intellectual disability, would benefit from a trauma-informed framework tailored to their experiences.

The Framework is targeted towards services providing support for people with intellectual disability of all ages accessing disability services in NSW. Key stakeholders include policy-makers, program developers, managers and workers in the disability field. In addition, it is hoped this Framework will be of relevance and assistance to other services that are not disability-specific, but support people with intellectual disability.

There is no 'one size fits all' approach to trauma-informed practice. Trauma itself varies in its nature, intensity, frequency and duration, and individuals experiencing trauma are not a homogenous group. We require more than a general understanding of the theory of trauma or the principles of trauma-informed practice. To be truly effective in our work, we need to tailor and apply these principles in a way that meets the needs of various populations. In so doing, we must hear their voices, and enable their active and genuine participation.

We know that people with disability are particularly vulnerable to certain types of trauma. The Literature Review informing the Taking Time Framework explores the nature and prevalence of trauma and its impact on people with disability. It also highlights the diversity within disability across a wide range of domains including, but not limited to, culture, type of disability, gender, age, developmental stage, sexuality and environment (Jackson et al., 2015).

The Framework aspires to bridge the gap between theory and practice in a number of ways.

We hope it generates discussion and reflection, encouraging the establishment and strengthening of ongoing communication across various sectors in relation to trauma-informed approaches to supporting people with intellectual disability.

We hope it provides an additional language to help communication about trauma and its consequences, so that people with intellectual disability, their social supports and the service system can learn from each other about trauma and healing.

We hope it affirms existing knowledge and expertise, and highlights the similarities and cohesiveness with person-centred approaches already embedded in disability services.

We hope it respectfully challenges and prompts reflection on individual and organisational practice and encourages the incorporation of new knowledge and awareness in relation to trauma-informed practice.

We hope it highlights the value of workers' roles and emphasises the importance of their own safety, self-care and wellbeing.

We hope it builds on, engages and motivates practitioners in their work.

The Framework has been informed and enriched by the participation of people with intellectual disability, who spoke poignantly about what helps them feel safe and supported. It is hoped the implementation process will provide further opportunities to develop positive and collaborative initiatives for participation.

Ultimately, our hope for this Framework is that it will support and enhance the journey towards trauma-informed practice for services and systems working with people with intellectual disability. The indicators of enhanced practice are many and varied. In summary, we would hope the Taking Time Framework supports and promotes:

- increased knowledge in the disability services and related fields about trauma and its impact on the lives of people with intellectual disability
- increased awareness of key elements of trauma-informed practice within specific service contexts
- increased confidence to reflect on practice and greater awareness of ways to further develop practice
- a commitment to a system-oriented approach to working with people with intellectual disability
- a commitment to reflective practice, the striving for congruence, learning and collaboration
- improved capacity to practice self-care and reduce vulnerability to vicarious trauma for workers

- increased knowledge about culturally-informed practice and greater readiness to seek secondary consultation
- appreciation of the diversity within disability, and awareness of the nature and impact of trauma for particular groups such as children, women, Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and LGBTI people, and capacity to provide support in a respectful and appropriate way that acknowledges each unique person
- awareness of particular challenges for people with disability at different stages of the life cycle, for example, reproductive health, sexuality, grief and loss, and ageing, and capacity to provide support in a respectful, culturally appropriate way.

It will indeed 'Take Time' to implement trauma-informed practice across service systems working with people with intellectual disability. However, in the development of this Framework, we saw evidence this is already occurring to some extent. This will always remain a work in progress as we begin, enact, review and revise our work in a cyclical fashion.

The name of this Framework was inspired by comments in the interviews, as they related to the need for time for people to trust others, and the need for staff, services and systems to recognise the importance of taking time in supporting people with intellectual disability. This includes, but is not limited to, the need to enable recovery and for the process of healing to take time.

Time is a valuable metaphor for considering what is important, and what is and what is not in our control. Time is also a key concept in understanding trauma as it crosses time.

Traumatisation can be understood as the past intruding on the present and posing a risk for the future. Recovery can be understood in part as helping someone integrate the past with the present in terms of memory and understanding, so they can find hope in the future. The integration process itself takes time. Regardless of whether a service is providing trauma-specific treatment or striving to be trauma-informed while providing services such as health, housing, and education, the process of engagement, assessment of needs and intervention requires time. It is important systems acknowledge this and make time based on the needs of the individual as opposed to a 'one size fits all' approach.

In this Framework we acknowledge time is precious and should not to be wasted, but in fact given to others. Taking time may be one of the few things that, by the act of taking, we are actually giving.

6 Appendices

Appendix 1: Quality of life domains

Appendix 2: Key principles for addressing trauma in the lives of Aboriginal and Torres Strait Islander peoples

Appendix 3: Cultural Competence Continuum – Aboriginal Cultural Competence Framework

Appendix 4: Six core strategies – An example in practice

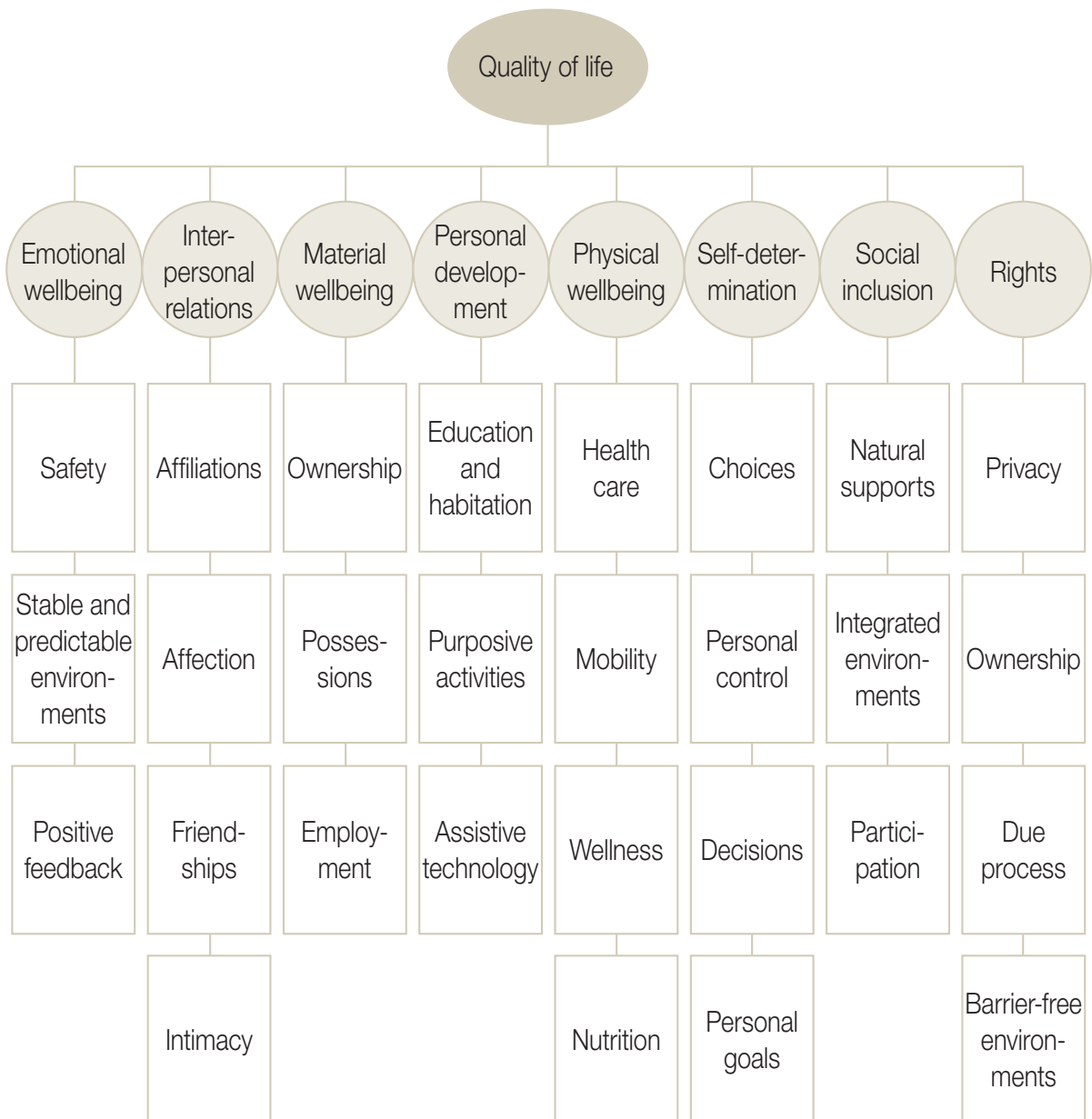
Appendix 5: Approach to knowledge in developing this Framework

Appendix 6: Voices of people with intellectual disability

Appendix 7: Learnings from disability services

Appendix 1: Quality of life domains

Quality of life domains (adapted by Bigby & Frawley 2010 from Schalock et al. 2002)



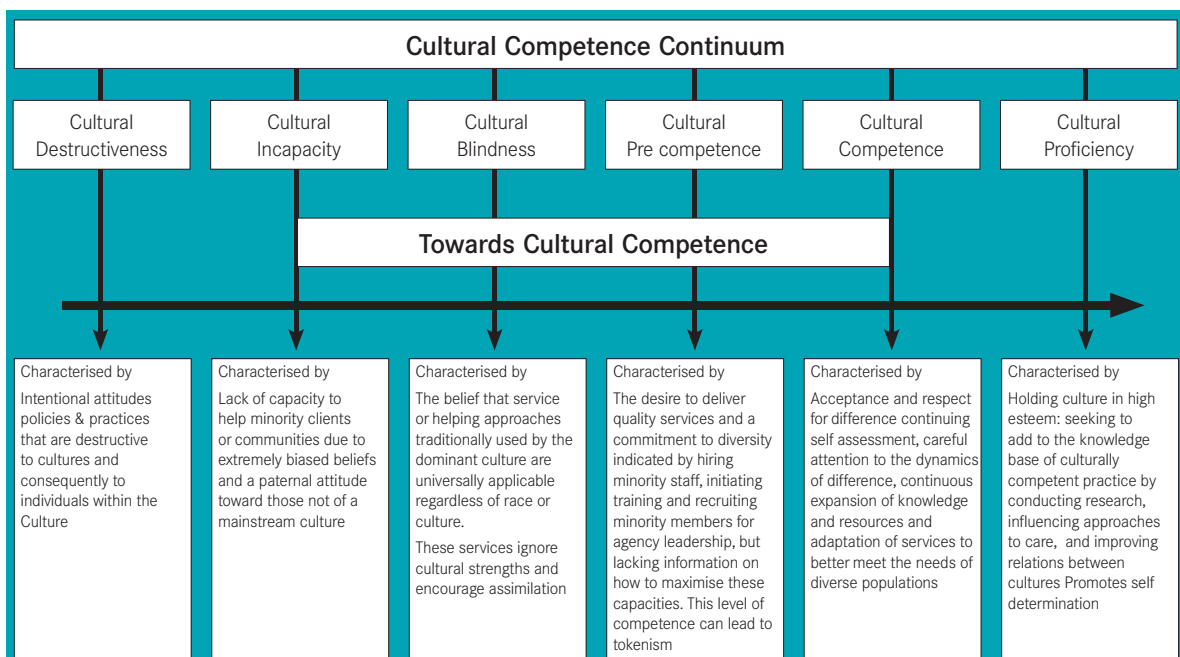
Appendix 2: Key principles for addressing trauma in the lives of Aboriginal and Torres Strait Islander peoples

Core characteristics of Indigenous healing (as cited by Caruana, 2010)

- Indigenous ownership, design and evaluation of services (Aboriginal and Torres Strait Islander Healing Foundation Development Team, 2009) – Informed by an Indigenous, not a Western, world view, and using culturally sensitive screening and assessment tools (Archibald, 2006; Castellano, Archibald, & White, 2007, p.69).
- Holistic and multidisciplinary approach – That is, addressing mental, physical, emotional and spiritual needs, with a focus on familial and community interconnectedness, as well as connections to the environment and the spiritual realm (Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009; Archibald, 2006; Quinn 2007).
- Centrality of culture and spirituality – Cultural renewal is seen by some as an essential precursor to healing (Aboriginal and Torres Strait Islander Social Justice Commissioner 2008; Quinn 2007). According to Phillips (2003, p. 142), ‘culture is treatment’.
- Informed by history – That is, being cognisant of the historical source of trauma, rather than focusing too strongly on the individual pathology.
- Adopting a positive, strength-based approach – This recognises and promotes the resilience of Indigenous people (Kelly, Dudgeon, Gee, & Glaskin, 2009).
- Preventative and therapeutic strategies – Rather than reactive responses that merely seek to reduce symptoms.
- Commitment to healing – As a process that takes considerable time, rather than as an event.
- Commitment to adaptability, flexibility and innovation – Programs must be inclusive to ensure they reach people who may not have strong cultural ties (Feeney, 2009; Wilczynski, Reed-Gilbert, Milward, Fear, & Schwartzkoff, 2007) and to incorporate localised practices (Archibald, 2006).
- Utilisation of particular approaches best suited to the Indigenous context – Such as narrative therapy (Archibald, 2006; McCabe, 2008), group processes (Koolmatrerie & Williams, 2000), and the combination of Western and traditional practices, such as the use of traditional healers, or ngangkari (Archibald, 2006; Milroy 2008).

Appendix 3: Cultural Competence Continuum – Aboriginal Cultural Competence

The chart, presented in the Aboriginal Cultural Competence Framework (VACCA, 2008) adapted from material by Terry Cross, presents the continuum for cultural competence used in some states in America where they have introduced cultural competence standards.



Appendix 4: Six core strategies – An example in practice

National Association of State Mental Health Program Directors (NASMHPD) ‘Six Core Strategies’

(Adapted from Azeem et al., 2011)

1. Leadership towards organisational change

- Senior management created the goal of reducing restraint and seclusion, and making this a high priority. They shared this vision with all staff through multiple communication channels.
- Created a Trauma Reduction Team to monitor goals and targets, and implement strategies/monitor progress.
- Informed staff through regular meetings, training, monthly meetings to evaluate progress.
- Integrated the strategies into the day-to-day work.
- Recognised and rewarded throughout the organisation – celebrated successes.

2. Use of data to inform practice

- Collected and analysed data is shared at staff meetings regularly with clinical teams, communicated with staff in other means.
- Created healthy competition between teams.
- Non-judgmental reviews – supportive for people with disability, such as of critical incidents, etc.

3. Workforce development

- The organisation created a therapeutic environment based on trauma-informed practice.
- Staff educated at orientation, and regular education about neurological, biological, psychological and social effects of trauma.
- Principles of recovery-oriented care, person-centred care, respect, dignity, partnership and self-management.
- These principles also presented in position descriptions, competencies and performance reviews.
- Trained not to use jargon and labels such as borderline, manipulative, attention-seeking and noncompliant. This is emphasised in reports and clinical meetings.

4. Use of restraint and seclusion reduction tools

- Prevention principles, tools and assessments included in individualised treatment plans.
- Staff re-trained in preventative measures – awareness raised of person’s trauma history, formulating and using safety plans, use of comfort rooms, occupational therapy techniques, de-escalation, etc.
- Therapeutic communication between families, consumers and staff, to identify triggers etc.
- Sharing ‘near misses’ and what worked across the organisation.

5. Improve consumer’s role

- Involve consumer, case manager, family and others in safety planning, goal setting and participation in meetings.
- Regularly survey and address complaints in a timely manner.

6. Psychological first-aid techniques

- Immediate post-event and psychological first aid provided in 48–72 hours.
- Non-punitive and supportive.
- Looked at emotional support for consumer and staff, and changes to treatment plan.
- Look at root cause analysis.

Appendix 5: Approach to knowledge in developing this Framework

A philosophical approach to knowledge explicitly or implicitly underpins any framework. The epistemological position about the nature of knowledge helps put the framework and its application in context (Willig, 2008).

This Framework is primarily drawn from a social constructionist perspective, which posits that human experience, including perception, is mediated through history, culture and language. Our perception is not a direct reflection of the environment or the event, but as how they are experienced and understood. “This does not mean that we can never really know anything; rather, it suggests that there are ‘knowledges’ rather than ‘knowledge’” (Willig, 2008, p. 7).

A social constructionist perspective emphasises the subjective nature of knowledge and the value we place on different types of knowledge. This approach to knowledge seems highly suitable to the development of this Framework, as we aim to better understand the experience of people with intellectual disability who have experienced trauma and the experiences of the services working with them.

While there is a growing evidence base informing trauma-informed principles and practice, this is not in the context of people with disability. In developing this Framework the approach recognises the lack of explicit research in this field. Where evidence does exist, it is not of greater value than the lived experiences of people with intellectual disability and their families.

Social constructionism is a useful lens through which to consider trauma, given that the focus of healing from trauma is often described as ‘meaning making’. In other words, the emphasis is on helping the person make sense of what happened. The objective reality is not as important as subjective experience (van der Kolk & McFarlane, 1996).

This approach to knowledge reinforces the emphasis on portraying different realities, acknowledging that the reality for the person with intellectual disability is distinct from that of their family, peers or workers.

Appendix 6: Voices of people with intellectual disability

How can anyone understand the reality for someone else, let alone someone who has experienced trauma? This is even more of a problem for those in our society who historically have had difficulties in being heard, who have been marginalised and who experience additional challenges in having their experiences recognised and acknowledged, such as people with intellectual disability.

To inform this Framework, ADHC, FACS conducted – directly or through a worker known to the interviewee – a series of questions adapted to each person relating to trauma and trauma-informed practice. This process was conceptualised through the deliberations of the ADHC, FACS and Take Two project team, drafted by Take Two and finalised and implemented by ADHC, FACS.

The following plain-language definition, created by the team, was provided at the outset of each interview, as a starting point for the conversation:

Things happen that can make people feel scared, angry and hurt and not know what to do. Sometimes these feelings keep coming back – we call this trauma.

A summary of the interview responses and analysis is provided below.

1. What are some examples of this (trauma) that you have seen on TV or in the movies?

Examples of trauma seen on TV or in movies included:

- interpersonal trauma, such as kidnapping, physical and emotional abuse, violence, loss of significant people and loss of identity
- health-related events, such as being hurt and stopping breathing
- single traumatic events such as accidents and bushfires.

Alcohol and drug use was also mentioned, although it is unclear if this was seen as a possible manifestation of trauma or a traumatic event. The direct comments included:

- “In *Home and Away*, someone was kidnapped with her boyfriend from their house, Oscar was having problems and hit a girl, and he was taking exercise and stopped breathing in the bush.”
- “In *Home and Away*, someone got hurt. They had a fight. Also in *The Incredibles*, Mr Huff has a sore neck because Mr Bob punched him.”
- “Alcohol use, drug use, accidents, car accidents, bushfires.”
- “Loss – of significant others, of own identity. Acute stressful/traumatic events.” (parent)

2. What are some other things that can happen which may worry, frighten or hurt people?

Other situations mentioned by the participants included interpersonal trauma, as already mentioned above, including violence, loss of a family member, discrimination and feeling different or less important than others. There were also single-event traumatic events that may not be interpersonal such as car accidents.

The sense of getting lost is a poignant example for someone who may become very frightened in that situation. Similarly, feeling different or less than others is an illustration of how a person's perception of 'self' can add to the experience. As with the earlier question, there were also examples of how people may show their fears, such as through meltdowns, tantrums, feeling sad and moaning. The direct comments included:

- "People getting bashed, making them feel sad and stuff, people who have been in car accidents."
- "Meltdowns, unplanned tantrums. Smashing plates, moaning, and being "hypo"."
- "Family – losing someone from your family, getting lost."
- "Verbal/physical assault. Discrimination. Bullying/harassment. Feeling "different" or less than others." (response from a parent)

The responses to these two questions seem to reflect a reasonable understanding of trauma and of the applicability of the plain-language statement, albeit a limited sample.

3. What are some ways in which people can show – in words and actions – that they are hurt, scared, angry and having a tough time?

The responses to this question demonstrated some awareness that externalising behaviour can reflect internal feelings.

Carers'/parents' responses can be summarised as: physical injuries, verbal behaviours, physical behaviours towards self and others, and facial expressions. The comment that they would not be having fun could reflect the internal experience of a lack of joy or happiness.

Some direct comments were:

- “When they cry, when they throw stuff, when they yell at you, when they are upset – they are crying a lot and they won’t be having fun.”
- “Broken arms or broken legs. Swearing, yelling at them. Crying. Screaming.”
- “Following people around town, hurting them (hitting, physically hurting them or verbal abuse). Facial expression, looking sad. Saying hurtful things.”
- “Behavioural outbursts, anxiety, agitation, aggression, violence against self and others.” (response from a parent)

4. If you were trying to help someone who was having a tough time, what would you do?

In putting themselves in the role of helping others, participants’ comments ranged from very practical such as calling emergency services, through to being playful and keeping other people safe.

Common themes were the importance of talking to people, staying with people and use of physical touch.

Examples of direct comments from participants with disability were:

- “Stay with them and play with them, and look after them – sit down with them and rub their back.”
- “Talk to them – about what’s happening at home, or if they are having a bad day at school or lost a pet, ask them what’s wrong. Touch them lightly, gentle rub and ask are you ok?”
- “Call 000. Ambulance or police or fire truck.”

Parental responses were more on a systems level, with an emphasis on resources for service development and remuneration for those working with children. This included recognition of the costs associated with trauma.

- “Particularly in relation to children – develop services and allocate resources for intensive intervention. Recognise that childhood trauma leads to lifelong loss of production and cost to the community. Pay therapists/others managing these children a remuneration that maximises the likelihood of them remaining in the service as changes in therapists can be (further) traumatic.” (response from a parent)

5. Have you seen examples of workers (helpers/staff/carers/teachers) being helpful when someone is hurt, sad or angry?

The examples given of helpful strategies in practice are consistent with earlier comments of what would be considered helpful. For example, the earlier suggestion of the use of touch is shown here through a comment about giving a hug. The comments also reflect the need to actually ask what would be helpful rather than making assumptions.

All these suggestions highlight the importance of relationships to facilitate healing and recovery. Direct comments included:

- “Me, I get angry a lot. They try to look after me and help me. They try to help me calm down. They said go sit down and watch a movie and that helped. Be playful and don’t bash them. If they are angry and want to be alone, walk away. Listen to them. Ask them if they’re ok and stuff. People were bashing him and he got angry and calls them names. Our teacher helps him a lot – she asks him if he is ok. She says don’t swear and come and play.”
- “Taking them to hospital. I like going to hospital sometimes.”
- “Ask how you doing, give a hug if very upset and talk about the problem.”
- “Development of relationships and all that this entails inclusive of mutual trust, respect and friendship. Changes and improvement in these children is a long-term process that requires consistency and patience. Good therapists willing to put in the time, effort and patience have been the ones who have most success with our daughter.” (response from a parent)

6. What are some of the things that workers can do to help people be safe and feel comforted?

This question sought to discover if there were specific strategies about safety and comfort.

The responses were consistent with the other questions relating to ways of being helpful such as the theme of staying with people, talking with people, playfulness and the importance of relationships. Interestingly there were some potential contrasting responses in this question, such as reassurance compared to telling them to snap out of it and use of medication compared to exercise. At least one and probably more of the participants were commenting on what they actually see in practice. The direct comments included:

- “Stay with you. Look after you – sit with you and play games.”
- “Talk to them, ask them if they are frustrated, check if they are scared, reassure them that they will be ok – tell them to stop complaining, redirect them to snap out of it.”
- “PRN, chill-out room, exercise.”

- “Once again I feel more than anything creating a trusting and mutual caring relationship is critical. Traumatized children seem to take time to open up and until a mutual relationship is established this seems unlikely to occur.” (response from a parent)

7. What would make it worse?

This question elicited a poignant list which included yelling, holding them down, not talking, ignoring and pushing too hard. These comments appear to reflect use of power and control as a major theme particularly in the context of others influencing their feelings directly (e.g. ‘telling me not to be scared’ or in a general sense ‘make them cry’). Some direct comments were:

- “Yell. Not look after you and leave you alone. Making them angry, make them cry, make them sad – yelling at them when they’re not doing anything.”
- “Holding them down. Door shut in the calm room.”
- “Not talking about it, ignoring it, talking about their own problems, telling me not to be scared, and telling me to stop whingeing.”
- “Pushing the child too hard too soon without an established relationship.” (response from a parent)

8. What do workers need to know and how can they learn this?

The examples provided in response to this question emphasised knowing what to say and how to say it. The parent’s response below continues the focus on strengthening the system and workforce capability.

- “Write in a book. Talking. How to talk to them and say, “It’s ok”, “You’ll be alright”.”
- “To be open, to talk to one person at a time – trained in trauma, work with people who have had trauma.”
- “Make sure the kids are safe, make sure they are ok, make sure they are happy and not angry and stuff. They should ask the kids. If they are angry and hurting people then they are not happy and the teachers would then go and see if they are ok.”
- “Education, experience and mentoring for senior, established and experienced therapists. Multidisciplinary responses ensuring involvement, input and suggestion for all members of the team.” (response from a parent)

9. Do you have any ideas about rules that workers should follow for people to feel safe?

Responses to this question appeared to tap into more detailed responses, including use of safe distance, fire safety, specific rules such as not jumping out of windows, no laughing, no phone, and establishing a non-threatening environment.

- “Safe distance – arm distance. Obey and know about fire exits. Make sure others act nicely, don’t hurt others. No phone policy – causes fights.”
- “No swearing, no moaning, no hitting, no laughing, no injuries, no jumping out of windows.”
- “Don’t yell at them, they’re not doing anything wrong. If they are angry see that they are ok and help them. Stay with them and look after them.”
- “... common sense? Establishment of a non-threatening environment which is comfortable, age appropriate and safe for the individual client.” (response from a parent).

10. What should the bosses do to make sure their service helps people feel safe and supported?

This question aimed to seek thoughts about an organisation’s leadership role.

The responses seem to reflect that this is how it was understood. Again issues of ensuring safety were noted as well as having specific policies, such as no bullying. Support for workers was also mentioned. Use of meetings, but also more overt use of control such as lock-down were raised.

- “Have a safe environment, training for staff, have no-bullying policies and procedures, have a meeting to talk about it with all staff and clients.”
- “Keep people safe when they are angry and keep the teachers and kids safe. Like in lock-down.” (She gave an example of being moved to a different class when a classmate was unsettled and aggressive.)
- “Talk to the workers, say, “It will be alright”. Talk to the people they are helping.”
- “Sleeping.”
- “Obviously seek the relevant funding, ensure appropriate personnel are employed and encourage mentoring/learning by less experienced personnel with more experienced.” (response from a parent).

11. Is there anything else we need to know?

The responses to this question were varied. They ranged from use of first aid, communication, through to specific feedback about services provided.

- “Everyone should have first aid if they are working with people with trauma – for injury help.”
- “Writing in the book. Talking, saying, “it’s ok”.”
- “Nothing that I’m sure you don’t already know. Traumatic events in children pose the risk to adversely influence lifelong functioning. To be honest, the services our 10-year-old has received have been crap. Haphazard, no clear goal, intermittent and often ending/ceasing abruptly leading to more harm than good. The reality is in children like this you can either:
 - “Provide resources now and attempt to make them productive members of society, or
 - “Spend \$\$\$\$\$\$ +++++ later as these kids grow up to be non-functioning adults and all this entails inclusive of criminal activity, unemployment, incarceration, drug misuse, etc. etc. etc.” (response from a parent)

Additional to the voices directly presented, the comments raise some themes that generally are consistent with trauma-informed practice as earlier described. These include:

- moving the focus from what might be ‘wrong’ with an individual towards understanding ‘what has happened to them’ – hearing their story
- importance of safety
- importance of relationships
- importance of communication
- needing to be careful about use of power and control
- importance of the environment
- importance of daily interactions
- importance of touch and human contact
- meaning that can be attributed to behaviours.

Participant comments also suggest that, in some aspects of practice, there may be different views about what is helpful. This illustrates that, although there is some agreement among the participants, there was also difference, which in itself is an important principle. As some comments by one of the participants reflected ideas contrary to being trauma-informed (e.g. the use of coercion), this is an illustration of the need to educate not only the workforce, but also the consumer group regarding the principles and ideas underlying trauma-informed practice.

Appendix 7: Learnings from disability services

Following are some de-identified examples of experiences of trauma for people with intellectual disability and/or their family/carers, as portrayed during visits and other conversations by the project team to disability services in NSW.

These vignettes reflect the severity of some traumatic experiences, the age range that can be affected and some of the consequences. They illustrate the reality of trauma, re-traumatisation and victimisation within this population.

- A 12-year-old boy who had experienced early years of extreme family violence and neglect, and who showed behaviours of rage and distress that confounded his family and school.
- A young adult who as a baby had been born with foetal alcohol syndrome, and was then dropped, shaken and starved.
- A middle-aged man in a group home who was being bullied and harassed by another resident and felt he had nowhere else to go.
- People who had lived in the same residential setting for over 50 years relocating to new accommodation.
- Some residents known to have experienced major traumatic events prior to their entry into supported accommodation services.
- The families of people living in residential settings not knowing how they would manage when a family member was living in a different accommodation setting.
- A middle-aged woman experiencing profound sadness on Mother's Day and at Christmas time related to the forced removal of her baby decades ago.

Examples of Trauma-Informed Practice in Action

Although the Taking Time Trauma-Informed Framework is new, the principles and concepts that underpin it are not. This is reflected in a number of examples of applying trauma-informed practice in services supporting people with intellectual disability in NSW. Through the course of undertaking visits and phone interviews with services during this project, a number of examples of trauma-informed practice became apparent. The following is a sample of some of these initiatives.

A whole of organisation approach – Sanctuary Model

A non-government organisation that provides children and family services as well as disability services in NSW has made a commitment to being a whole-of-organisation trauma-informed service. They are in the process of the Sanctuary Model certification process (Bloom, 2005).

The Sanctuary Model has commitments to non-violence, emotional intelligence, inquiry and social learning, social responsibility, open communication, shared governance, growth and change.

The Sanctuary Tool Kit consists of a set of practical tools that support a shared language and approach. A key tool is the SELF framework – an acronym for safety, emotion, loss and future. It is a cognitive behavioural approach to recovery that can be used in multiple ways by providing non-pejorative, non-jargon language that is shared with consumers, staff and management.

Other tools in the Sanctuary Model include community meetings which occur daily, and the use of individual safety plans for consumers, staff and others as well as psycho-education (Bloom, 2005).

Following are a couple of quotes from a senior manager explaining different aspects of the Sanctuary Model in practice at every level:

- “Strengths are the SELF model and ensuring that the foundations to make the model work are in place. This includes regular supervision and team meetings. Community meetings are generally at the beginning of the day, but sometimes you can see people in the office checking in with community meetings throughout the day. Seeing staff powerfully engage mindfully. We do community meetings in Board meetings too.”
- “Seeing the principles in action staff engaging in psychoeducation with clients and carers. Understanding the impact of trauma on clients and staff. The story of how a property manager approached a recent property damage report highlights this...the staff member went out to the home and inspected the damage. Her response was: “What has happened to this kid for her to do this? Well this is likely to happen again so how can we fix this to make her safe in the future?””

A whole-of-school approach

ADHC, FACS is working in collaboration with a mainstream secondary school and its feeder primary schools to implement an initiative in a regional NSW town to develop a trauma-informed approach. The intention of the approach is to build compassion and empathy towards difference, of which disability is one example. This involves working towards building a ‘calmer classroom’ approach which is a trauma and attachment-informed approach within schools (Downey, 2007).

This approach also offers a suite of programs and services within the school. Examples include:

- plans to bring mindfulness practitioners into schools
- introducing an emotions-based social skills program through the children’s hospital
- transitioning towards the development of self-regulation plans rather than behaviour support plans.

An element of this initiative involves teaching children and young people about brain development and functioning such as the stress response and fight, flight and freeze reactions. This initiative hopes to incorporate strategies for supporting staff with recognition of the impact of vicarious trauma. Consultations with the broader system, in relation to students with disability and case reviews, may also be incorporated. There is the potential to build in some capacity to evaluate this initiative through pre- and post-measurements of stress levels.

Leaving care workshop

A one-day workshop with workers from government and non-government sectors was held, including out-of-home care services and disability services, to explore ways to support young people with disability transitioning from care using a trauma-informed perspective. This included reflection on what works, what doesn't work and exploring ways of developing therapeutic relationships with the young person using the ASCA guidelines as a framework (Kezelman & Stavropoulos, 2012).

Mindfulness

Mindfulness is an integrative process that promotes well-being in body, mind, and relationships (Siegel, 2009, p. 139).

There are a number of elements to mindfulness but in general it is understood to involve focusing attention on emotions, thoughts and sensations in the present moment, as well as elements of affect regulation and a relational process 'where you become your own best friend' (Siegel, 2009, p.145).

ADHC, FACS has developed a mindful parenting group for parents of children with disability which includes a training manual for potential facilitators. Current work includes working directly with schools to explore what a trauma-informed approach might look like in each setting.

The ADHC, FACS Play Therapy Initiative

Play therapy is a non-judgmental, non-directive and non-interpretative psychological intervention that offers young people an opportunity to 'play out' their feelings using toys rather than words in a safe therapeutic environment.

Play therapy is predominantly a non-directive treatment modality that allows the child to explore and process whatever emotions are arising for them at the time. At times, however, structure and direction is necessary, and ADHC, FACS has used the Play Therapy Dimensions Model to assist with decision-making in relation to the level of directedness within therapy. Mediums used in this therapy included art materials, clay, puppets, drama, music, dance and movement, metaphoric storytelling, creative visualisation and sand play.

This ADHC, FACS initiative found 78% of participants experienced a statistically significant improvement in strengths and difficulties (SDQ) (Goodman, 1997), suggesting that play therapy is effective in reducing emotional and behavioural difficulties for children and young people with intellectual disability.

Tailored consultation and training: Working with Trevor

An 18-year-old man, Trevor (a pseudonym) has autism and a mild intellectual disability. Prior to finding stable housing, he had been living in motels for approximately eight months. Residential support staff found some of Trevor's behaviours concerning and requested assistance to develop a behaviour support plan.

ADHC, FACS staff collected information in relation to Trevor's history, and applied a trauma lens to their understanding of Trevor to explore possible meanings behind some of his behaviours. Staff were introduced to a genogram and an ecomap for Trevor, his family and his world. A timeline was developed to assist an understanding of Trevor's history and staff were supported to uncover potential strengths that had not been previously identified.

This work was informed by principles underpinning the Neuro-sequential Model of Therapeutics (NMT) (Perry, 2006), after the ADHC, FACS staff had participated in a case-based training series with the Child Trauma Academy and Berry Street Take Two. This approach also included an understanding of sensory processing and a process of checking in with staff to ask: "What's coming up for you?"

In this way staff were supported to identify and acknowledge their own fears and concerns, and to feel supported and affirmed in their work. A trauma-informed individualised safety plan was developed for Trevor. This included exploring safe levels of communication, safe places, safety strategies and working together as a team.

Trauma-informed attitudes

Staff in a residential setting spoke about the importance of understanding the impact of trauma for the people living there. This included exploring the meaning behind particular behaviours, but also being alert to genetic factors and medical issues which may influence a person's presentation. They noted that the multidisciplinary approach is particularly useful in this regard. One staff member summed up the importance of a holistic response: "My discipline is not the most important discipline...it's about what the client needs."

- "It is a multidisciplinary approach. All staff are aware of the impacts of trauma and the different needs of the kids we care for. Safety is paramount. We try to address trauma by using the principles of Circle of Courage. This approach identifies belonging, mastery, independence and generosity. These are seen as the four universal growth needs which apply to children and youth in any culture or learning environment."

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Who are we?

Berry Street Take Two program

The Berry Street Take Two program, through its Practice Development and Training Team with the support of other Take Two staff, has worked in partnership with Ageing, Disability and Home Care, Department of Family and Community Services (ADHC, FACS) to develop this Framework.

The Take Two program is a therapeutic service for children and young people who have experienced trauma of abuse and neglect, most of whom are in contact with the child protection system. Take Two has been in operation since 2004 and has clinical teams in major metropolitan and regional centres throughout Victoria, as well as a statewide Aboriginal Team. It provides clinical work with children and young people, their families and carers. In addition to its clinical services, Take Two has a research and information management team and a practice development and training team. Both teams work within Victoria and other states and territories, as well as some international projects.

Take Two is a program of Berry Street which is one of the largest child welfare organisations in Victoria. Other Take Two partners include La Trobe University Department of Social Work and Social Policy, University of Melbourne's Mindful Centre for Training and Research in Developmental Health, and Victorian Aboriginal Child Care Agency.

Statewide Behaviour Intervention Service, ADHC, FACS

The Statewide Behaviour Intervention Service (SBIS) is a specialist service within the Clinical Innovation and Governance (CIG) Directorate of ADHC, FACS. SBIS provides support for people with disability and complex behaviour support needs, those in their networks, and associated services (government and non-government) across the state.

SBIS provides support to:

- address behaviours of concern
- plan within complex systems
- decrease risk of placement breakdown
- improve health and well-being
- increase capacity within the service system.

This is achieved through four main areas of work:

- individual behaviour support – primary, secondary, and tertiary support
- information and training
- research and practice development
- systems consultation and review.

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The opportunity to ‘take time’ – to research, reflect and develop a trauma-informed framework for supporting people with intellectual disability – was made possible by NSW ADHC, FACS.

ADHC, FACS recognised the potential for trauma to impact on the lives of people with intellectual disability and the need for a trauma-informed approach to promote healing and recovery and prevent re-traumatisation. This recognition prompted ADHC, FACS to engage with Berry Street Take Two to develop this Framework.

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Consultation with consumers or service users, in this case people with intellectual disability, was crucial to the development of this Framework. We wish to express our gratitude to the people with disability and their families who participated in interviews and those who supported them to tell their stories and share their thoughts. The comments from the participants are rich, thoughtful and bring life to this Framework. We also extend our sincere thanks to the staff who shared their stories and knowledge, and the agencies that opened their doors to us for site visits.

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The Governance Group was a multi-agency group which assisted in identifying priority issues relating to the Taking Time Framework and Implementation Plan. It comprised senior representatives from FACS, NSW Department of Education and Communities, NSW Health Diagnostic Assessment Service, NSW Corrections, Mental Health Coordinating Council and NSW Council for Intellectual Disability. The Consultation Group also consisted of various representatives from ADHC, FACS, Health, Education, non-government and private agencies.







Family &
Community
Services