British Journal of Social Work (2022) **52**, 1837–1858
doi: 10.1093/bjsw/bcab147
Advance Access Publication August 1, 2021

Trauma-informed Family Contact Practice for Children in Out-of-home Care

Susan Collings [1,*], Amy Conley Wright [1], Loyola McLean [2] and Sue Buratti[3]

[1]*Research Centre for Children and Families, School of Education and Social Work, The University of Sydney, NSW, 2006, Australia*
[2]*Brain and Mind Centre, The University of Sydney, Camperdown, NSW, 2050, Australia*
[3]*Therapeutic Services, Australian Childhood Foundation, NSW, 2153, Australia*

*Correspondence to Susan Collings, Education Building A35, The University of Sydney, Camperdown, NSW, 2006, Australia. E-mail: *susan.collings@sydney.edu.au*

Abstract

Trauma knowledge and skills are needed to support relational safety for children in out-of-home care and birth family contact is a particular area where trauma-informed approaches are critical. Mixed methods were used to understand the application of trauma-informed approaches to contact in New South Wales, Australia. A total of 118 caseworkers and 15 organisational leaders took part in an anonymous survey or semi-structured interview. Descriptive statistics and thematic analysis were completed. Results indicated that caseworkers were confident in their knowledge of trauma and ability to protect children at contact but not to explain trauma to carers or manage conflict between carers and birth relatives. Confusion about how to deliver trauma-informed practice hampered knowledge-to-practice translation. Staff training and supervision were used to build workforce skills but were not evaluated and no strategies to reduce vicarious trauma were identified. Strategies to promote psychological safety and improve cultural safety for Aboriginal children and families were in their infancy. The study demonstrates that the out-of-home-care sector needs a community of practice where it can test, implement and share promising strategies for improving relational safety and where adult and child trauma survivors are empowered to inform and lead new approaches to contact.

Keywords: birth family contact, cultural safety, developmental trauma, intergenerational trauma, out-of-home care, reflective practice

Accepted: June 2021

Introduction

Developmental trauma due to child maltreatment has profound effects on behaviour, mood, self-regulation and memory (Szilagyi, 2018). It is associated with long-term negative health and well-being outcomes (Felitti *et al.*, 1998). Trauma leads to child behaviours that damage the very caregiving relationships that promote healing and undermining placement stability. Focusing on assessment of behavioural symptoms fails to consider how support needs of relational networks around a child influence their well-being (Baylin and Hughes, 2016). Assessments that take account of underlying stressors in the child's life across multiple social contexts can assist professionals and carers to respond in ways that dampen the stressors that evoke these behaviours (Baylin and Hughes, 2016). Building understanding of these behaviours can enhance caregiving capacity.

Birth family contact attracts broad concern due to the potential for trauma rearousal (Boyle, 2017; MacDonald, 2020). In Australia, direct contact is used to keep children in permanent care (guardianship and kinship care, open adoption and long-term foster care) connected to birth family (Collings *et al.*, 2018). Court decisions about who children see, and when and where visits occur, prioritise physical safety over emotional needs but practices that do not promote children's psychological well-being can reactivate trauma (Collings and Wright, 2020). Rigid agency processes for contact and negative attitudes towards contact by caseworkers and carers can prevent birth parents having a chance to heal relationships with their children at visits (Ross *et al.*, 2017). A systemic, trauma-informed approach is needed to help all parties prepare for, manage and de-brief after contact (MacDonald, 2020).

Trauma-informed care in out-of-home care

Trauma-informed care is a holistic approach to human service delivery grounded in recognition of the prevalence and impact of trauma and proactive steps to rebuild safety and control for survivors and affected communities (Levenson, 2017). Consistently cited features of trauma-informed practice include interagency collaboration, service coordination, fostering safe environments and enhancing personal empowerment for clients (Fallot and Harris, 2008; Hanson and Lang, 2016). Initial trauma screening improves timely intervention and access to specialist treatment to reduce negatives long-term impacts (Szilagyi *et al.*, 2015; Sephr *et al.*, 2019). High-level leadership and commitment to hear and act on feedback from survivors are also recommended (Henry *et al.*, 2011; Bartlett *et al.*, 2016; Koury and Green, 2017). Time constraints, heavy caseloads and lack of management support are barriers to trauma-informed

practice (Kramer *et al.,* 2013; Bartlett *et al.,* 2016; Murphy *et al.,* 2017; Barto *et al*., 2018).

A constructive way to build trauma-informed practice is to identify actions required of systems, services and workers and then assess organisational progression towards these (Wall, Higgins and Hunter, 2016, p 5). Organisations need to be aware of the causes and consequences of trauma; to modify their approach to be sensitised to individual needs; to implement practices to rebuild safety, resilience and positive change; and to reorient their workplace culture towards holistic healing, recovery and empowerment for all clients and workers (Wall *et al.*, 2016, p 5). Staff training is used to equip workers to recognise and respond to trauma symptoms (Hanson and Lang, 2016). It can also increase awareness of vicarious trauma (Handran, 2015). Out-of-home-care workplaces, known as 'trauma-saturated professions', present increased vulnerability to secondary (or vicarious) traumatic stress whereby trauma symptoms transfer from clients to workers (Balu, 2017). Secondary trauma can result in compassion fatigue, worker burnout, defensive practice and high staff turnover, making it harder for caseworkers to have warm, connected relationships (Balu, 2017). When caseworkers are unaware of the impact of trauma saturation on their practice, it blocks their ability to make attuned decisions about a child (Baylin and Hughes, 2016). Staff training can reduce the incidence of secondary traumatic stress by ensuring self-care strategies and group processes such as supervision are in place (Hanson and Lang, 2016). Trauma-informed organisations give staff access to resources, support and encouragement to prioritise self-care, which promotes resilience and prevents burnout and secondary trauma (Handran, 2015).

Trauma awareness in the Australian context

In Australia, no discussion of trauma-informed practice can occur without acknowledgement of systems-induced intergenerational trauma inflicted on Aboriginal and Torres Strait Islander peoples (The term 'Aboriginal' is the preferred term for First Nations peoples of the state of New South Wales, where the study took place. We also use the terms Indigenous or Aboriginal and Torres Strait Islander peoples when referring to research about the First Nations peoples of Australia.) by the forced removal of children from families and communities during the twentieth century and its legacy for successive generations (Human Rights and Equal Opportunities Commission [HREOC], 1997). Indigenous children continue to be grossly over-represented in child protection statistics as families and communities struggle with the ramifications of system abuse (Libesman, 2014; Australian Institute of Health and Welfare [AIHW], 2018). To effectively respond to intergenerational

trauma on this scale is only possible within an ecological systems approach that respects the integrity and centrality of Kin, community and culture for Indigenous children, and that recognises and bolsters protective factors at the child, family and community level (Atkinson, 2013).

With growing calls for Indigenous self-determination and recognition that communities are best placed to drive solutions, some Australian child protection jurisdictions have transferred the placements of all Indigenous children to Aboriginal community-controlled organisations (Department of Health and Human Services, 2018). While New South Wales (NSW) has fallen short of this, the number of registered Aboriginal out-of-home-care providers has grown and represents fourteen of the sixty-five registered non-government out-of-home-care agencies in this state (NSW Office of the Children's Guardian, n.d.).

In Australia, national and state legislative and policy reforms have taken place within the last ten years to improve permanency for children (Collings *et al.*, 2018). Most out-of-home-care placements in NSW are now contracted to the non-government organisation (NGO) sector and incentivise guardianship and open adoption over long-term foster care. These changes require organisations to actively support carers to facilitate contact independently in preparation for permanency (Collings *et al.*, 2020; Wright and Collings, 2020). This has led to a massive culture shift in out-of-home care and created the impetus for self-examination of contact practice. The out-of-home-care system in Australia lacks shared understanding or common practices for responding to trauma and has focused largely on providing specialist clinical interventions to address children's trauma symptoms, although evidence from well-designed evaluations remains scarce (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre [ACPMH & PRC], 2013).

Using the stages proposed by Miesler and Myers (2013 cited in Wall, Higgins and Hunter, 2016, p 5), we have developed a model to assist the NSW out-of-home-care sector to assess and monitor progress towards a trauma-informed approach (Table 1). The left-hand side presents actions that signal progress along the continuum and the right-hand side indicates how the out-of-home-care sector can integrate these actions into contact practice.

Method

A mixed method study was conducted in NSW to understand the extent to which knowledge about trauma-informed practice has infused casework practices used to maintain contact between children in permanent care and families and what barriers exist to foregrounding trauma-responsive practices. The study, conducted in partnership with seven

Table 1. Model of trauma-informed practice for contact in out-of-home care

Stages of trauma-informed practice	Application to contact
Trauma aware—Seek information on trauma and its effects; build staff understanding of symptoms and behaviours	• General awareness about childhood trauma • Information and workforce training on trauma and secondary trauma
Trauma sensitive—Plan for organisational change at all levels; apply strengths-based approach; information and resources available to all clients and staff	• Staff/carer recruitment and training that addresses traumatic stress and interpreting children's trauma expressions • Reflective practice to incorporate strengths-based principles into discussions about contact • Normalise conversations about trauma
Trauma responsive—recognise and respond to traumatic stress; routine trauma history screening; promote resilience and protective factors	• Recognise features of intergenerational trauma and what safety looks like for contact between children and families • Use trauma screening to make timely referral to counselling and therapy • Help carers and birth family to recognise their resilience and resources for recovery
Trauma-informed—transform organisational cultural to focus on healing and recovery; collaborate with survivors, family members and other services; create physically and emotionally safe spaces for survivors based on their feedback; ongoing practice evaluation	• Leadership committed to holistic transformation to embed healing • Survivor-led solutions integrated into contact practices • Make sense of safety a priority in physical spaces where contact happens • Monitor and evaluate practice with input from workers, carers, families, children

NGOs and the state government, reflects their commitment to practice improvement and knowledge creation. In the spirit of collaboration, staff within these organisations agreed to participate in the current study to set a baseline for trauma-informed contact practices in this state. An anonymous survey and semi-structured interviews were undertaken. Ethics approval was granted for the study by the University of Sydney (No: 2019/1032). Research questions were: (1) what knowledge and skills are needed by out-of-home-care organisations, caseworkers and carers to implement a trauma-informed approach? (2) how are trauma-informed principles applied to birth family contact? and (3) what are the barriers to applying these principles in NSW?

Sample group

A purposive convenience sampling method was used. Eight organisations that provide placement support for children on long-term orders in NSW were recruited through their current participation in a larger study called 'Fostering Lifelong Connections'. These included the governmental statutory authority and seven NGOs. Some organisations operated

state-wide and others in more geographically limited areas, but all offered services across both metropolitan and regional parts of NSW. The sample represents 10 percent of registered NGO out-of-home-care providers in the state but does not include Aboriginal community-controlled organisations. At the time, the larger study was initiated in 2017–2018, none chose to be involved. Two groups of participants were recruited for the current study: caseworkers with responsibility for implementing contact plans and senior management staff within these organisations.

Data collection

An anonymous online survey was distributed to all casework staff employed by the eight organisations who agreed to take part. The survey was purpose-designed by the research team and elicited worker beliefs, skills and training for birth family contact (instrument available from Author A on request). A total of 119 caseworkers and related personnel completed the survey between March and August 2020 (Table 2). Senior executive managers from the eight organisations were recruited to take part in a semi-structured interview. Interviews were conducted during April and May 2020 via videoconference or phone. A total of fifteen executive managers or senior delegates took part (Table 3). Interviews were up to one-hour duration and were transcribed, de-identified and uploaded to Dedoose^{TM} software for analysis.

Data analysis

Participants

Caseworkers and associated staff

Two-thirds of survey respondents were caseworkers ($n = 82$) followed by casework managers ($n = 18$) and the remaining were workers who held other relevant roles. The majority of respondents were female and from an Anglo Australian background (both 85 percent). A small number were Aboriginal (7 percent) or from a culturally or linguistically diverse background (8 percent).

Descriptive statistics

Basic descriptive statistics were used to measure worker skills and attitudes to apply trauma-informed principles to birth family contact.

Table 2. Survey respondents

Participant details	No. of participants (%)
Gender	
Female	101 (85)
Male	17 (14)
Aboriginal and Torres Strait Islander	
Yes	7 (6)
No	111 (94)
Both	1 (1)
Culturally and linguistically diverse	
Yes	10 (8)
No	109 (92)
Role	
Caseworker	82 (69)
Casework manager	18 (15)
Other (e.g. casework specialist, casework support, permanency planner)	19 (16)
Location	
Hunter New England	26 (22)
Central Coast	5 (4)
Illawarra/Shoalhaven	27 (23)
Mid and Far North Coast	16 (13)
Greater Sydney	22 (18)
Western and Far Western NSW	21 (18)
Southern NSW	2 (2)
Total	119

Table 3. Interview participants

Participant details	No. of participants (%)
Gender	
Female	12 (80)
Male	3 (20)
Organisation type	
Government	7 (47)
Non-government	8 (53)
Primary responsibility	
Client services	5 (33)
Operations	6 (40)
Practice development	3 (20)
Research and policy	1 (7)
Responsibility	
Statewide	4 (27)
Regional	11(73)

Results are presented for the three categories: (1) beliefs, (2) training and (3) confidence. Bar graphs report relative strength of agreement with statements (see Figures 1–3).

Overall, the group held highly positive views of birth family contact. The majority (85 percent) believed contact occurs when it is in children's

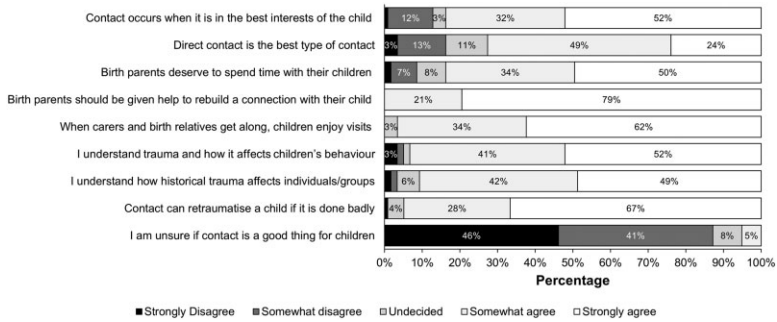

Figure 1: Caseworker beliefs about contact and trauma effects.

best interests (85 percent) and only 13 percent were unsure if contact is a good thing for children. There was high level support for direct contact with almost three quarters (73 percent) in agreement that it is the best type. Notably, all respondents believed that birth parents should be given help to rebuild relationships with their children, and 95 percent believed that relationships between birth relatives and carers impacted on children's contact experiences. A similar percentage (93 percent) believed that poorly managed contact could harm children and recognised trauma has both direct impacts on child behaviour (93 percent) and historical impact affect groups as well as individuals (91 percent).

Almost two-thirds of respondents believed they had received adequate training about the purpose of contact (64 percent). However, they were less satisfied with the training received on how to develop and implement a contact plan or supervise contact visits (52 percent and 47 percent, respectively). In both cases, approximately half of respondents were dissatisfied with the preparation they had received in these areas. Only one in three respondents were satisfied with the preparation they had received to engage children and birth family at contact and over 20 percent were undecided about how to rate training in this regard. Low levels of satisfaction with training to facilitate dialogue or resolve disputes between birth relatives and carers (29 percent and 25 percent, respectively) and to deal with problems related to contact (37 percent) were also recorded. While two-thirds of respondents agreed they had received adequate training on trauma-informed practice, only 39 percent felt equipped to apply this knowledge to contact.

A mixed picture emerged of confidence to adopt a trauma-informed approach to contact. Caution is needed in interpretation due to the high level of 'undecided' ratings with the ability to keep children safe at contact the only category in respondents were overwhelmingly confident (91 percent). Almost two-thirds only 'somewhat agreed' that they could explain trauma, attachment and child behaviour to adults and, while most

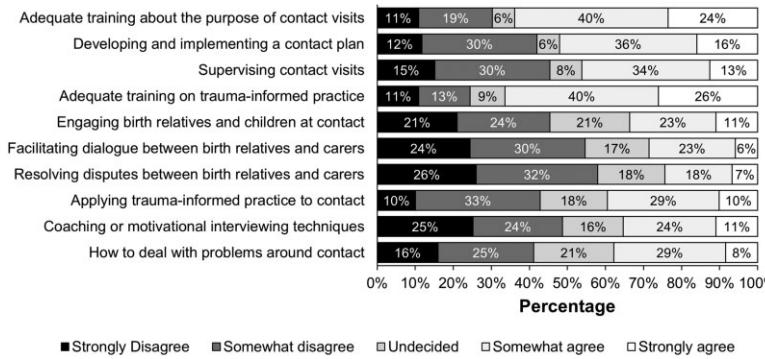

Figure 2: Caseworker perspectives on adequacy of training.

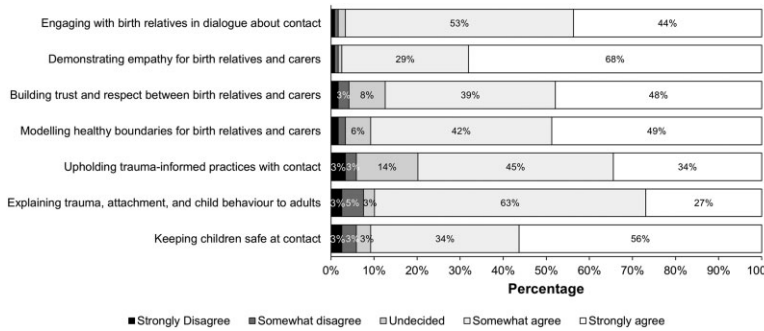

Figure 3: Caseworker confidence in applying trauma informed approach to contact.

(79 percent) believed they could uphold trauma-informed practice with contact, only one-third 'strongly agreed' that this was the case. The same pattern is evident with communication skills. While two-thirds 'strongly agreed' that they could demonstrate empathy for birth relatives with carers, under half were as confident that they could build trust and respect between these two groups or engage birth relatives in a dialogue about contact. While the overwhelming majority believed they could model healthy boundaries (90 percent), under half were highly confident that this was the case.

Based on these results, caseworkers believe contact is in the best interests of children and birth relatives but may view children's safety in narrow physical terms rather than a felt sense of safety, which includes dimensions of relational and cultural safety. Training about the effects of child maltreatment on development and attachment does not equip them to explain how visits may retrigger trauma and the variety of

trauma expressions. Confidence to engage with birth relatives and carers, particularly when problems arise, is more limited.

Organisational leaders

As participants were senior staff within their organisations, limited demographic information was collected to preserve anonymity. Most were women (80 percent) and eight participants were from NGOs, two-thirds (66 percent) being mid- to large-sized organisations that employed at least 100 caseworkers. Four worked for the state government department which employs over 2,300 caseworkers (removed for blind review). Over half (53 percent) occupied client service or practice focused positions. Some organisations had a state-wide presence and others were regional. Within this sample, the majority (75 percent) had regional responsibility.

Thematic analysis

Inductive thematic analysis involved open coding and constant comparison (Braun and Clarke, 2014). New codes were generated iteratively and then checked to refine codes and remove duplicates. The process was repeated until no new codes could be identified. Categories were created to organise codes into enablers or barriers to the application of trauma-informed practice related to contact. Four themes emerged: (1) lack of consensus on terminology; (2) building trauma awareness; (3) dimensions of safety; and (4) signs of culture change. Quotations are attributed using a numerical identifier.

Lack of consensus on terminology

Across the group, participants felt greater clarity was needed on what trauma-informed practice involved and the sector needed consistent terminology. As participant 4 stated, 'I don't think we've got a common language and a common understanding around what we call this.' This issue was not simply semantics but reflected a deeper concern about how well the sector could undertake the complex repair work with children and families who had suffered profound and often intergenerational trauma without a common language.

All participants were acutely conscious that trauma had a significant impact on the children they worked with. Several noted that it had consequences on behaviour and, as participant 10 noted, it could impact 'On all aspects of their life'. Several participants spoke of having 'a therapeutic framework' (participant 2) but gave no further detail of what

this constituted or whether the organisation itself provided therapy or referred to specialists. Participant 6 noted that there is a 'distinction between trauma-informed interventions and trauma-informed practice'.

Most participants described trauma-informed practice in terms of awareness, and two participants also referred to a holistic approach that 'recognises the impact of trauma on a person's behaviour and experience and responses to intervention … in absolutely everything that we do' (participant 13) or as 'service delivery that stops pathologising and labelling' (participant 5).

Several participants noted that 'trauma informed' had become synonymous with 'good' practice and greater precision would align it to specific activities. Participant 13 said that, 'it's a fairly amorphous concept that in an ideal world would manifest in a whole heap of different ways'. Two participants expressed cynicism about overuse of the term, fearing that fundamental questions about how organisations pivot and, moreover, what policies are needed to drive sector-wide culture change are left unanswered. As participant 1 stated bluntly: 'They're certainly very good at using the term. It's permeated the lexicon, for sure.'

Building trauma awareness

Training was the most common organisational mechanism used to build trauma awareness of staff and carers. All participants said their organisations ensured workers understood abuse and neglect as physiological stressors and the impacts of early trauma on behaviour and attachment. However, organisational size and resources varied greatly. Large organisations established caseworker competencies and offered formal induction which 'is very, very intensive for the new starters and then there's a whole bunch of other training they do' (participant 1). Smaller organisations took a more informal approach in which 'they'd be buddied up with another worker [to] get to know the families' (participant 3) and supplementary induction and/or external training. Overall, training was not delivered by trauma experts or incorporated into staff induction.

Participants saw training as essential to helping carers understand that trauma had shaped their child's learning and behaviour. NSW has mandatory training for registered foster and kinship carers and offers free ongoing education and peer support (available at My Forever Family) but there is no obligation to take up these opportunities. With no monitoring in place, it is left to the discretion of caseworker to decide which carers need this additional support.

Participants realised that stable and attuned caregiving was the primary resource to rebuild relational safety for children in out-of-home care. Participant 3, summing up this perspective, described carers as 'the agents of change'. They also recognised that retaining a skilled carer

workforce was a tall order as carers are not qualified therapists or counsellors and bring to their role personal values and experiences. As participant 12 explained:

> Probably the biggest challenge is skilling up our carers to understand trauma. They've raised their own children in a particular
>
> way and it's helping them understand that that's not necessarily the way to manage that child.

Several participants said that evidence of a past culture in out-of-home care when it was acceptable to make harsh judgments about birth parents still persisted. Participant 11 explained that 'we've got a whole cohort of carers where we told them that they needed to be afraid of natural parents, they weren't to have any contact with them.' Several organisations used carer recruitment to reset expectation around ongoing family contact by 'having those honest discussions upfront and weaving that through the training' (participant 8). Residual negative attitudes by workers still persisted, too: 'they came in thinking that they were rescuing kids from bad people. It is still a challenge to change that perspective and bias' (participant 1).

Supervision and reflective practice were the chief organisational strategies identified by participants to embed trauma-informed practice. All participants said their organisation provided supervision and most said they encouraged reflective practice. In reality, however, the crisis-driven nature of their work could reduce their effectiveness. Participant 6 noted, 'they need to be questioning themselves [but] I don't think people allow themselves the time and space', suggesting that organisations need to create reflective 'time and space' within busy workloads and make external clinical supervision available. No participants mentioned strategies or procedures in place to ensure caseworkers could speak candidly during supervision or whether confidential employee assistance programs (EAP) were available and if so, how these were promoted to staff.

A small number of organisations used group supervision to provide peer learning but, without specialist support, this could entrench poor practice pointing to a broader workforce issue of secondary trauma. Although participants realised that their workers interact regularly with children and families affected by trauma, no participants referred to organisational strategies to address a risk of vicarious trauma. This is a concerning oversight given that caseworkers regularly interact with individuals who may exhibit dysregulation. Self-care not only benefits individual staff but it also ensures that they are emotionally equipped to support clients. Without recognition that vicarious trauma is endemic in child welfare, well-intentioned efforts fall short of being trauma informed.

Dimensions of safety

There was widespread recognition of historical and intergenerational trauma for families, particularly Aboriginal families, who felt 'the disconnection and the trauma that generation upon generation have experienced, and the lasting impacts on people trying to parent their kids now' (participant 14). Government representatives were acutely aware that historical child removal practices coloured their current interactions with families: 'One of the first challenges is for us to appreciate many of those families we've had dealings with as an agency over the years' (participant 13).

Participants were asked about organisational processes for embedding cultural safety and several referred to matching of Aboriginal caseworkers and families. A few noted that it was important to recognise the diversity of Aboriginal nations and clans and consult with families about their preference for having a caseworker from their own community or not. NGOs tended to only accept placements of Aboriginal children if no Aboriginal community-controlled organisation was available, and two participants said they actively involved local community to support the child's cultural needs. One of the participants mentioned that Aboriginal staff were at risk of intergenerational trauma reactivation and organisations had a specific responsibility to protect them from distress and reputational damage of working in out-of-home care.

Participants recognised that children in out-of-home care needed to experience relational safety but the main focus for organisations was placement stability and less on how well contact achieved relational safety. The majority of participants, reflecting a sector-wide shift towards permanency, recognised that contact supported children in permanent care to sustain lifelong family connections. As participant 10 stated:

> It's this massive shift that we have to do in the sector about valuing so many different people's roles for these children. Maybe they won't ever be cared for by their parents but what can we do that's next best thing to maintain that relationship?

Most organisations had implemented practices to involve carers in contact as early as possible. As participant 11 explained, 'children need contact with their families and if carers aren't able to support that, they're going to get all these mixed messages'. This was often driven by pursuit of guardianship and open adoption orders which would require carers to show they recognised the importance of family and community for child well-being and were willing to take over responsibility for contact. Despite this, few participants gave explicit examples of casework practices to help parents connect in safe and healing ways with their child at visits.

Overall, participants recognised that psychological safety was optimised by normalising contact: 'the more natural you can make it, the more children are going to feel like this is just a normal part of life' (participant 4). This may include shifting visits from offices to playgrounds and parks. Two participants said that it was possible to replicate this even with supervised contact, often directed by the court to address a risk to physical safety. As one stated 'We've tried to really create a more child friendly environment for contact—we've got an outdoor yard and some play equipment or trying to do activities that are engaging for children and the parents' (participant 13). In contrast, other participants shared anecdotal examples such as unfamiliar contact worker driving children to visits which could undermine psychological safety: 'You can't be putting children in a car with strangers to drive them off to the most anxiety-provoking thing they're going to do all month' (participant 10).

Balancing children's needs for emotional safety and supporting family relationships represented a key challenge at visits. Participant 15 illustrated the danger of focusing exclusively on relationships at the expense of psychological safety:

> Sometimes the questions should be 'Should the kids have contact'? I heard [caseworkers] talk about forcing the kids into the contact even though the father had not acknowledged his wrongdoing.

Signs of culture change

All participants said their organisation adopted a strengths-based approach which respected the beliefs, traditions and resilience of families, consistent with trauma responsive practice by drawing on and building up a family's protective factors. As participant 12 explained:

> I am an absolute believer that you can balance the children's needs to be safe coming from an empathic position as to what's getting in the way. You can absolutely hold both positions really respectfully with parents.

In terms of organisational culture change, participants reflected on how engaging and safe their physical spaces were. Participant 7 noted that 'a lot of our offices are quite nice places to visit' whereas other participants saw their offices as corporate and potentially retraumatising:

> We've got multiple families in these corporate spaces that all have their own trauma [which] is at the level of systems abuse for already vulnerable people. (participant 2)

Participants accepted that their organisations did not always get it right. As participant 3 noted, 'I don't think we're experts. I think that we all have to continually learn about [trauma-informed practice], because there's always new research.' In relation to Aboriginal families,

participant 15 explained that 'It's about standing in their shoes and understanding where they're coming from rather than applying the white mainstream lens to the work that we do.' Despite this openness to learning new ways of working with families, it was not clear what formal process was used to incorporate emerging evidence or the voices of families into practice. No organisation referred to a structured consultation process with service users such as families and young people.

Discussion

This study draws on evidence from eight organisations that have embarked on a research-to-practice improvement journey and created a community of practice to support further development in the contact practice space. It sought to understand the current workforce knowledge and skills in trauma-informed practices and principles that underpin the application to contact. The results of this study show that individual organisations are at different stages of adapting to achieve this goal and serves as a useful baseline for sector progression toward trauma-informed approaches to contact in NSW. A proposed model for assessing and monitoring progress towards trauma-informed practice in the area of contact (see Table 1) can inform international practice improvements (MacDonald, 2020).

The study asked what barriers exist to trauma-informed practice in the area of contact and these results indicate that further development is needed in building awareness of safety as a multidimensional concept and in agency processes to create safety at contact that move beyond risks to physical safety and harm mitigation. Caseworkers rated their competency to protect children at contact far higher than their ability to deal with problems between carers and birth relatives. Previous research suggests that vicarious trauma reduces caseworkers' ability to make attuned and responsive decisions (Henry *et al*., 2011; Baylin and Hughes, 2016). It is possible that caseworkers focus attention on solving tangible safety issues, such as where contact takes place and who attends, at the expense of more complex questions of how to rebuild relational safety for children exhibiting serious trauma symptoms and for adult family members where intergenerational trauma is re-activated in encounters with out-of-home-care agencies.

Another barrier to trauma-informed contact is a procedural approach, leftover from the legal process in which the primary aim of contact is to assess parental capacity and retain parent–child attachment. Earlier research argued that the NSW out-of-home-care sector urgently needed practice-informed guidance on how caseworkers can collaborate with carers and birth families to make contact physically safe and psychologically enriching for children in guardianship and open adoption (Collings

and Wright, 2020). The findings confirm this, exposing shortcomings in workforce skills and confidence to communicate with and resolve problems between children's carers and birth relatives that arise over contact. Irrespective of whether contact is facilitated by carers or supervised by staff, organisations need to design processes to unpack assumptions about the purpose of contact. This would permit a more creative and co-operative dialogue between all parties about how to best protect a child's emotional safety and offer them genuine relational opportunities. A more trauma-informed contact practice would, for example, give children and adults a chance to have a meaningful conversation with a caseworker after each visit. Organisations would have a structured process for incorporating this feedback into practice reflection so caseworkers can articulate and challenge their own reactions, including resistance, and to act on the feedback.

Consistent with earlier Australian research (ACPMH/PRC, 2013), these results show there is recognition by several out-of-home-care organisations in NSW that traumatic stress challenges placement stability and carers need support to manage its impacts on children's behaviour. Although organisations in this study had taken steps to increase the capacity of caseworkers and carers to identify and respond to trauma expressions, there remain substantial gaps in evidence-based knowledge translation. The results highlight that this is a barrier to good contact practice and confirm the need for sector-wide agreement on consistent language to describe trauma-informed practice (ACPMH/PRC, 2013). Trauma screening improves understanding of trauma manifestations and early identification and treatment of trauma-related conditions which are critical for positive child outcomes (Szilagyi *et al.*, 2015; Sephr *et al.*, 2019). Despite this, no organisation had a screening process in place at the time of the study. This is a missed opportunity to build carer awareness of their child's triggers and help to gain skills to co-regulate with their child to address them. It also suggests that behavioural difficulties may be attributed to other causes, delaying necessary treatment and threatening placement stability.

Workforce knowledge and skills needed for trauma-responsive contact practice cannot be divorced from broader systemic factors that hamper workforce sustainability and worker well-being. Child protection and out-of-home care exist in a complex ecosystem that imposes restrictions on the way organisations operate. Macro factors such as legislative and policy frameworks, institutional and policy requirements, and political decisions about resource allocation can constrain efforts to operationalise trauma-informed principles in practice. The study was undertaken in the wake of massive system transformation in NSW which included changes from unit cost to outcomes-based funding for out-of-home-care placements. Birth family contact is a flashpoint for the workforce challenges this introduced. Above all, out-of-home care is recognised to be a

trauma saturated system in which staff face chronic time constraints and stress due to the crisis nature of their work with traumatised children and their families (Bartlett *et al*., 2016; Balu, 2017; Murphy *et al*., 2017). Caseworker dissatisfaction with training was highlighted as a particular issue in this study and may well point to system problems of resource allocation and workforce capacity to manage complex caseloads, and the effectiveness of management responses to these broader issues (Kramer *et al*., 2013). Despite evidence of widespread commitment to professional training, issues of caseworker burnout and subsequent attrition remain a sector-wide concern.

Strategies to improve cultural safety for Aboriginal families were in their infancy. There were some promising examples of pathways to leadership for Aboriginal staff to improve retention and of engaging with community to support children's cultural connections. However, while there was broad recognition that intergenerational trauma permeated across Aboriginal communities, processes to nurture cultural safety for Aboriginal staff were not well developed. These workers are vulnerable to retraumatisation not only because they may face community hostility for working within an oppressive system, but because the issues they encounter during their work can reactivate their own traumatic histories. Aboriginal caseworkers are very likely to be among a small handful of workers in any one organisation and likely to continue to make up a minority of the mainstream sector, which removes an essential source of cultural support for this group. Non-Aboriginal organisations need to work creatively with their Aboriginal community-controlled counterparts to design support structures for this group and, more broadly, to engage local communities more fully in meaningful dialogue about cultural safety for the children and families with whom they work.

Next steps

While this study indicates a high level of support for direct contact, caseworkers did not feel skilled to handle interpersonal dynamics between carers and birth relatives. Carer recruitment and training now establish an expectation that carers will support children's family relationships, although there was some evidence that a legacy of negative views about birth relatives still remains. With clear evidence that children enjoy contact when adults from both sets of families get along (Boyle, 2017), more work is needed to improve caseworker skills and confidence to scaffold these fragile relationships (Wright and Collings, 2020). Out-of-home-care caseworkers may benefit from training in how to model a secure attachment template for these adults. In a related area, workplace training and information on burnout and vicarious stress are needed to build staff skills to reflect on their responses with families and

to normalise help seeking. Worker burnout inevitably leads to less optimal decision making and poorer outcomes for vulnerable children. It also increases a risk of staff turnover, undermining consistency for families. Introducing relaxation and mindfulness activities into meetings and supervision could be easily adopted to improve practice here. Participants were not explicitly asked about EAP and interviews did not surface any information about their availability, so it is unclear how commonplace these services are.

Change is already underway within the out-of-home-care sector in NSW to improve trauma awareness. The authors are working with the eight out-of-home-care sector partners who took part in this study and other expert stakeholders, including people with lived experience of care, on the 'Fostering Lifelong Connections' project. The project uses action research to design and test relationship-building strategies and experiment in real time on adaptations as feedback from caseworkers, families and children emerges about their acceptability. Being driven by collective agreement on the need for practice improvement in the area of contact, this project lays fertile ground for a community of good practice to flourish. Reflective practice should become standard so that workers learn skills to process their own reactions and transform insights from personal and professional experience into practical strategies with families.

Finally, organisations should consider introducing routine trauma screening to identify behavioural and other support needs of children and families at the earliest opportunity. This will also support outcome monitoring frameworks and enhance the ability of the sector to collect reliable data about the impacts of new practice on children.

Limitations

A convenience method was used to recruit participants, all employees of out-of-home-care organisations who were involved in a larger study about contact, which introduces potential sample bias. Interview participants were senior staff members who may have been disinclined to criticise their organisation, but the frank responses make this unlikely and inclusion of an anonymous survey reduced a risk of bias and strengthened reliability of the results. As no Aboriginal community-controlled organisations were involved in the larger study, the results do not reflect how they have responded to the trauma-related needs of their staff, carers and children. It is likely that some have adopted culturally safe practices that would benefit the out-of-home-care sector more broadly. Future research is needed to explore and evaluate practices used by Aboriginal-specific organisations to support culturally safe connections for children in permanent care.

Conclusion

Traumatic stress from child maltreatment has profound and enduring impacts on children's relationships, including with birth family and carers. Contact between children and birth relatives can be critical for healing and recovery but it can also reactivate trauma. The out-of-home-care sector needs to become a collaborative, trauma-informed practice community where promising practices for contact are able to surface and be trialled and where adult and child trauma survivors are empowered to inform and lead these new approaches. Among the key tasks of this community would be to agree on child-centred language, relational concepts and respectful terminology to describe the terrain of trauma-informed practice within the current legal, policy and practice space. Building evidence to support these practices and promoting and embedding this knowledge across all sectors that engage with children in care, including educational settings, would ensure a holistic approach to children's social and emotional well-being.

Acknowledgements

We gratefully acknowledge assistance from colleagues at the Research Centre for Children and Families. Dr Betty Luu assisted with survey instrument design and data analysis, and Laura Metcalf and Bonnie Blythe contributed to an evidence review on trauma-informed practice. We also thank the young people and family who are part of the Expert Reference Group convened whose insights on how to support children to thrive in safe and healing relationships were invaluable to preparatory work undertaken for this article.

Funding

The Fostering Lifelong Connections study was funded by an Australia Research Council Linkage Program Grant (LP180101332). Additional funding was received from the Faculty Research Support Scheme, Faculty of Arts and Social Sciences, The University of Sydney.

Conflict of interest statement. None declared.

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