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**Healthy Lifestyle Programs in Out-of-Home Care:
Implementing Preventative Trauma-Informed Approaches at Scale.**

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Abstract

From 2012 to 2014, we developed and subsequently evaluated The Healthy Eating, Active Living (HEAL) intervention—an obesity prevention and healthy lifestyle program designed for young people living in residential out-of-home care (OoHC). Based on quantitative (i.e., a randomized trial) and qualitative (i.e., semi-structured interviews) data and an iterative process of redevelopment, the program has evolved from taking a behavioural obesity prevention approach to now being underpinned by a trauma-informed care approach at a systems level. In this paper we outline the theoretical and empirical foundations of the HEALing Matters intervention that is currently being implemented at scale. In addition, we outline how our knowledge to translation framework informed the iterative improvement of our intervention with a focus on stakeholder and end-user engagement, partnership, and co-design along the way.

Implications

- There is a strong need for trauma-responsive health-focused programs and interventions within OoHC contexts.
- HEALing Matters addresses the need for trauma-informed approaches that encourage health behaviour change in young people living in OoHC.
- Policy, standards and recommendations must not only acknowledge, but prioritise, the impact of trauma on health-related lifestyle behaviours in order to identify strategies to help address this impact.

Keywords

Trauma-informed, out-of-home care, looked after children, translation, obesity prevention

In Australia, out-of-home care (OoHC) refers to placements designed for children and young people who are removed from their families by the State/government due to the presence of neglect, abuse and/or unsafe and unstable family environments (Australian Institute of Family Studies, 2018). More specifically, a child is removed from their current living arrangements because they are seen as being at 'imminent risk' of harm or danger. Most often, children are deemed to be at 'imminent risk' when exposed to family violence, substance use, mental illness, and physical, emotional and/or sexual abuse (e.g., Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Victorian Auditor General, 2014). Young people (also referred to internationally as 'children in care', 'looked-after children and young people', or are 'care-experienced') living in the OoHC system are widely considered to be one of the most vulnerable and disengaged groups in the community, have often experienced major trauma (Australian Institute of Health & Welfare [AIHW], 2018; Ainsworth & Hansen, 2005; Barber & Delfabbro, 2003), and exhibit a wide range of adverse physical and mental health outcomes (Ford, Vostanis, Meltzer, & Goodman, 2007; Nathanson & Tzioumi, 2007; Osborn & Bromfield, 2007; Skouteris et al., 2011).

Whether experienced in one's family environment or during periods of placement in OoHC, neglect, abuse and/or environmental instability expose young people to trauma (i.e., the experience of an event that is emotionally painful or distressing; Milne & Collin-Vézina, 2015) that can lead to a wide range of detrimental outcomes. Alarming, the majority of children in OoHC are exposed to multiple and chronic traumatic events (Ko et al., 2008; Milne & Collin-Vézina, 2015) with recent numbers suggesting that approximately 80% of children in residential care have experienced some form of interpersonal trauma (i.e., trauma involving physical, emotional, or sexual abuse and/or neglect; Fischer, Dölitzsch, Schmeck, Fegert, & Schmid, 2016). In addition, research has established that young people living in OoHC are at substantially increased risk of disordered or problematic eating, overweight and

obesity, and associated morbidities compared to typically developing peers in the wider community (e.g., Cox et al., 2014; 2015a; Hadfield & Preece, 2008). Indeed, internationally the rates of overweight and obesity increase significantly whilst young people are in care (see Skouteris et al., 2011). In addition, the effects of weight gain during OoHC are pervasive; individuals with lived experience in OoHC report significantly higher rates of obesity during their adult years than those without an OoHC experience (Schneider et al., 2009). Such findings serve to not only highlight the legacy of early abuse and neglect for long-term health outcomes (e.g., Miller, Chen, & Parker, 2011; Raby et al., 2011) but the need for trauma-responsive health-focused programs and interventions within OoHC contexts (Cox et al., 2017).

Despite the risk of overweight and obesity in OoHC and the number of young people being placed in OoHC continuing to escalate in Australia and around the world (Herrman et al., 2016), healthy lifestyle programs sensitive to the trauma and experiences of this vulnerable population remain largely non-existent (Cox et al., 2017a; 2017b; Skouteris et al., 2011). In Australia, despite well-intentioned policies and interventions that endeavour to improve upon the eating and physical activity habits of young people in OoHC, the vast majority of health improvement programs do not account for, and/or work with, the complex trauma and maltreatment many young people in OoHC have experienced and will continue to experience. Reasoning for this lack of trauma-responsive, health-related programs in the OoHC system in Australia and abroad is multifaceted, complex, and likely to vary across support services and systems, such as organisations delivering OoHC and government departments, and states and countries. One consistent factor, however, that we consider plays a major role across all OoHC systems and contexts, is the difficulty inherent in translating trauma-based scientific knowledge to practitioner-friendly programs in what is already a demanding and highly intense environment for care staff.

In this paper, we describe the conception, modification and large-scale roll-out of Healthy Eating, Active Living Matters (i.e., HEALing Matters), a healthy lifestyle program developed for residential OoHC (i.e., placement in a residential building where care is provided by paid staff) and designed to strengthen the therapeutic and healthy lifestyle capacities of residential care staff responsible for providing care to young people (aged approximately 12-18 years). The paper begins by outlining previous work related to the program and the Australian policy context from which this work stems, highlighting the lengthy and gradual (i.e., slow) process of translating research to practice. The focus of the paper then turns to the underlying ethos and guiding principles of HEALing Matters, with a particular emphasis on the trauma-responsive approach we undertook and the necessity of this within the OoHC system for health-related programs. This includes a description of the program's key elements, and the consideration of matters of implementation and sustainability (which were guided by our knowledge to action framework). Finally, we provide an overview of the next steps we see as necessary for translating trauma-informed and health-based research into practice in OoHC in Australia and beyond.

Formative Work and Policy Context

Although in recent years, steps have been taken within the OoHC context towards creating a nurturing environment that promotes healthy growth and development (e.g., the National standards for out-of-home care [Department of Families, Housing, Community Services and Indigenous Affairs, 2011] and the Residential Care Matters: A Resource for Residential Care Workers [Commission for Children and Young People, 2013]), one health outcome that had been largely ignored globally, prior to our work in this area, was the prevalence of overweight and obesity. In particular, our preliminary research into the associations between placement in OoHC and health established that young people living in residential OoHC are at increased risk of disordered eating, overweight and obesity, and

associated morbidities compared to typically developing peers in the wider community (Cox et al., 2014; 2015a; Skouteris et al., 2011). Importantly, these early findings were the catalyst for a large body of additional and applied research (see Cox et al., 2015b; 2017a; 2017b) that included the development and subsequent evaluation of the Healthy Eating, Active Living (i.e., HEAL) program (Skouteris et al., 2014).

HEAL was a 12-month program (inclusive of 6-months maintenance) that aimed to provide young people in residential OoHC with practical opportunities (e.g., developing an individualized health plan, and participation in health-related activities such as cooking sessions, planting a vegetable garden and sports challenges) to improve their eating and physical activity habits. The program also targeted direct-residential care staff, providing professional development and resources to facilitate healthy lifestyle behaviour changes among the young people. HEAL was evaluated using a randomized trial in 48 residential care homes across three community service organisations (CSOs) in Victoria, Australia. Findings (both quantitative and qualitative) revealed trends towards decreased sugary drink consumption and lower BMI, increased healthy food consumption, improved participation in community sports, adolescent self-esteem and independent living skills (e.g., increased meal preparation by the young people), and increased availability in healthy snacks and meals provided by staff (Cox et al., 2017a; 2017b).

Despite these positive and encouraging findings, data also revealed a significant limitation of the HEAL program; it lacked a trauma-informed perspective in the training of residential care staff and delivery of the program content. We addressed this limitation (by reframing the professional development and resources to be delivered in a manner responsive to trauma [e.g., Emond et al., 2013; Bloom & Farragher, 2013; Harris & Fallot, 2001; Ko et al., 2008]) and termed the new program 'HEALing Matters' (i.e., Healthy Eating, Active Living Matters). This new version of the program is currently funded by the Australian

Government of Victoria's Department of Health and Human Services (DHHS) for state-wide scale-up. Departmental support of a large-scale roll-out of HEALing Matters highlights an important (but only very recent) government-level shift on the urgency and priority of healthy lifestyle programs in OoHC. Indeed, the Victorian Government's "Roadmap for Reform: Strong Families, Safe Young people" (DHHS, 2016a) calls for healthy lifestyle interventions to improve the health of young people living in OoHC by breaking the cycle of intergenerational vulnerability and dependency through health-related capacity building. In addition, the Victorian Government's 'Health 2040: Achievements and Next Steps' describes their prioritization of promoting healthy eating and physical activity for young people in OoHC by building skills and knowledge in nutrition, cooking and exercise (DHHS, 2016b).

Although a step in the right direction, health focused initiatives for OoHC (including the ones mentioned above) are rarely trauma-informed and instead are based largely on policy standards that simply suggest to people to 'be healthy'. So, while there is no shortage of policies, nationally or internationally, calling for health-focused programs to improve the health and wellbeing of young people in OoHC (e.g., DHHS 2016a; 2016b; Department for Children, Schools and Families & Department of Health, (n.d.); Department of Health, 2009), the same cannot be said for policies also calling for health-focused programs to be responsive to the multiple traumas and stressors that young people in OoHC have been exposed to. In addition, and despite a recent international trend (especially in the UK and US) towards providing therapeutic and trauma-informed OoHC systems (e.g., Kramer, Sigel, Connors-Burrow, Savary, & Tempel, 2013; Connors-Burrow et al., 2013; Kerns et al., 2016; Lang, Campbell, Shanley, Crusto, & Connell, 2016), there remains a lack of obesity prevention and healthy lifestyle programs designed for OoHC. Instead, when it comes to health policies and programs in OoHC, they are more often than not aligned with general population health

information (that often struggles to go beyond the public health echo chamber) that fails to take into account the complexities associated with abuse, maltreatment and trauma.

HEALing Matters

It is well established that trauma from abuse and neglect experienced by children and young people negatively impacts on their development and behaviour (Ford, Vostanis, Meltzer, & Goodman, 2007; Nathanson & Tzioumi, 2007; Osborn & Bromfield, 2007; Skouteris et al., 2011). These findings have led to development of service delivery models that consider the way individuals working with children in care can apply trauma-informed principles and practices to the day-to-day interactions and long-term planning for children in OoHC. One such example is the implementation of Therapeutic Residential Care (TRC). In Victoria, Australia (the context for HEALing Matters), TRC has been implemented based on the premise that a therapeutic environment can address the harmful effects and support recovery from trauma, while helping young people achieve improved life outcomes (DHHS, 2016c). This is done by recognising that day-to-day interactions between young people and residential care staff provide opportunities to overcome and heal the impact of past trauma and disrupted attachment (DHHS, 2016c).

In contrast, to date, initiatives to improve health and wellbeing outcomes (such as overweight and obesity) for young people in OoHC have focused on "problem oriented" and "illness- focused" approaches (e.g., American Academy of Pediatrics, 2002; Webster, 2010; Department of Health [Australia], 2011; Department for Children, Schools and Families & Department of Health [UK], n.d.). While these are an integral part of a holistic health care plan, effective prevention must aim to reduce the likelihood and onset of chronic disease while ensuring the program, and care staff responsible for delivering the program, are responsive to the trauma young people in OoHC have experienced (e.g., Barton, Gonzalez & Tomlinson, 2012). In moving away from a solely behavioural approach to obesity prevention,

HEALing Matters recognizes that food and physical activity can be powerful ways of demonstrating trust, predictability and the provision of support and care that is attuned to the needs of young people in OoHC.

The primary aim of HEALing Matters is to improve upon the healthy eating and physical activity habits of young people in residential OoHC by: (1) upskilling residential care staff's health literacy; and (2) simultaneously engaging with the young people in a trauma-responsive manner. In doing so, HEALing Matters builds on residential care staffs' basic theoretical knowledge and familiarity with general models of therapeutic care (attained via compulsory training courses required for residential OoHC staff) to help develop a 'home' environment more conducive to healthy behaviour change and maintenance, and ultimately the attenuation of overweight and obesity rates in OoHC.

Importantly, HEALing Matters supports residential care staff, and the agencies they are employed by, in meeting government mandated requirements for the provision of healthy food and access to sport and recreation activities in residential OoHC. Specifically, HEALing Matters is designed to assist care staff to better understand how food and physical activity can be used to strengthen relationships and provide young people in their care with a sense of value and belonging, whilst also fostering healthy lifestyle habits. The online package, that provides professional development modules and a knowledge exchange platform, also provides resources and support to facilitate healthy behaviour changes among both residential care staff (e.g., increased frequency in providing healthy snack and meal options) and the young people they care for (e.g., increased participation in community sports programs). Developed by health and psychology researchers at the Monash Centre for Health Research and Implementation (MCHRI) and guided by the MCHRI Knowledge to Action Framework (described below), the program has been informed by extensive end-user, CSO and stakeholder engagement.

HEALing Matters is underpinned by the ethos that the environment and interpersonal relationships that exist between residential care staff and the young people are crucial in not only the recovery process but also in initiating and maintaining healthy lifestyle choices (Emond, McIntosh, & Punch, 2013). From this perspective, residential care staff are positioned as the primary drivers of healthy change. This understanding of residential care staff as imperative to the improvement of overweight and obesity levels in OoHC is supported by our previous work that reported low overall health literacy of residential care staff (Cox et al., 2015b). Importantly, HEALing Matters includes a ubiquitous focus on the symbolic meaning of food and the processes around it (e.g., Emond et al., 2013). By doing so, HEALing Matters endeavours to encourage residential care staff to move away from a conceptualization of food as a commodity or tool for reinforcement and punishment (Cox et al., 2017c) and instead, to understand food and food processes as important factors in a young person's recovery and development. Similarly, participation in both structured and unstructured physical and/or recreation activities provides an everyday opportunity to help young people feel connected, to form new relationships and gain a sense of belonging (Gilligan, 1999, 2000; Penedo & Dahn, 2005). Thus, HEALing Matters also covers strategies to help residential carers build physical activity in the everyday routines of the young people they care for while being sensitive to factors that may influence physical activity engagement for young people in OoHC, such as a lack of self-efficacy or poor psychological well-being due to the exposure of trauma (Quarmby & Pickering, 2016)

The HEALing Matters program consists of: 1) an e-learning training/professional development component; 2) additional resources (e.g., video and printable recipes, links to community sport and recreation bodies, and module glossaries); and 3) an online community discussion board that provides residential care staff with the opportunity to participate in a network of practice and knowledge exchange, and also ask questions about the content; **the**

discussion board is moderated and answered by health and psychology researchers. Each domain is divided into 3-4 X 15-minute segments to allow for learning to take place in small, or larger, time frames depending on the individual preference of each carer. Below we describe the large-scale roll out of HEALing Matters and how this, and the process of redevelopment, was informed by the MCHRI Knowledge to Action Framework.

The MCHRI Knowledge to Action Framework

Concerns about the gap between science and practice are well documented, with the 17-year gap between discovery research and translation into practice widely touted (Morris et al., 2011). Despite clear evidence that knowledge cannot be translated in a simple linear way into practice, understanding how to identify, manage and mobilise different types of knowledge that exist within and across organisations remains a challenge (Morris et al., 2011). The complex process of knowledge translation has been described by the Canadian Institute of Health Research, as “*a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system*” (2016, “Knowledge Translation – Definition”, para. 4). This difficulty in translating knowledge into practice has led to the proverbial “*valley of death*” that characterises a lack of research to deliver the impact needed for sustained and timely improvements in health and social care outcomes (Butler, 2008).

To transcend this valley, an understanding of “how” to translate knowledge and implement system-wide, evidence-based strategies is vital. Robust theories to inform the implementation journey are therefore needed. The field that focuses on the “how” to do this, is known as implementation science. Whilst a comprehensive, overview of existing theories is beyond the scope of this paper, Nilsen (2015), and then extending on this work more recently Damschroder (2019), show how implementation science is linked to three classes of

theories: (1) process theories that inform and guide the mechanisms of change and the process of implementation; (2) determinant theories that reveal the moderators of implementation outcomes, that is, what influences the implementation outcomes; and (3) evaluation theories that guide how to assess the process of implementation to improve the chance of a program/intervention working in the “real world” (e.g., the RE-AIM evaluation framework, see Shaw et al., 2019).

In terms of process theory, several frameworks have utility for implementation science, including the *Knowledge to Action Framework* (KTA, Graham et al., 2006). The KTA framework informed the Monash Centre for Health Research and Implementation (MCHRI) knowledge translation framework, the ‘MCHRI Knowledge to Action Framework’ (see Figure 1; Robinson et al., 2018). In addition, the *Consolidated Framework for Implementation Research* (CFIR, Kirk et al., 2015) has also informed the MCHRI framework; stakeholder engagement is embedded throughout the translation cycle given that consumer, community and stakeholder needs and the barriers to their health and social care improvement influence an intervention’s implementation and therefore knowledge of these needs and barriers, by engaging and working collaboratively with key stakeholders, is fundamental to implementation success. Indeed, the MCHRI framework can be distinguished from other frameworks because it acknowledges the importance of consumer and community involvement, genuine partnership, and co-design in every stage of implementation; in so doing, this framework is aligned with the United Kingdom’s National Institute for Health Research (NIHR) mandate that research is to be conducted “with” or “by” the people most affected by the research rather than by researchers “to” or “for them” (2012). That is, consumers are equal partners with researchers because their lived experiences qualify them to be the best experts of their own lives (CIHR, 2019; NIHR 2012) and hence, they can contribute significantly, in partnership with researchers, to the rigour needed to create and

translate evidence into “real world” solutions (Huang, Lipman, and Daniel Mullins 2017).

By emphasising engagement and coproduction at each step in the framework, we aim to

ensure that our research—and the translation of it—are not only responsive to both

stakeholder and end-user needs but are also impactful (Robinson et al., 2018).

In line with the MCHRI Knowledge to Action Framework, and in addition to our formative work, knowledge generation and evidence synthesis (see, Cox et al., 2014; 2015a; 2015b; 2017a; 2017b; 2017c; Skouteris et al., 2011; 2014), the redesign of HEALing Matters also involved a team of multi-disciplinary experts and Community Service Organisation (CSO) collaborations. This included consultation with Eating Disorders Victoria, Nutrition Australia, the DHHS (State Government of Victoria, Australia [including Sport and Recreation Victoria and Prevention, Population Health and Place, and the Health and Wellbeing Division]) and the Victorian Centre for Excellence in Child and Family Welfare. Throughout the redevelopment and codesign of the program’s content, young people with lived experience were also consulted; this was accomplished via collaboration with the CREATE Foundation, a consumer body representing the voices of young people with an OoHC experience.

This multi-disciplinary and highly collaborative process permitted us to engage key stakeholders to identify scope, priorities, gaps, needs and optimal processes to drive evidence translation and program sustainability and represents true codesign (i.e., genuine partnership). For example, to address the previously mentioned limitation of the HEAL program, the lack of a trauma-informed philosophy, we formed international and local collaborations with experts and key stakeholders able to provide targeted information and assistance relevant to this limitation. This included working with colleagues from Stirling University who are regarded as international leaders in the provision of therapeutic care to young people in OoHC. Consequently, HEALing Matters is now delivered within a framework informed by

attachment (Bowlby, 1982), trauma (Emond et al., 2013; Bloom & Farragher, 2013; Harris & Fallot, 2001; Ko et al., 2008), and resilience (Rak & Patterson, 1996) theories. In doing so, HEALing Matters recognizes that food and physical activity are a powerful way of demonstrating trust, care, predictability, flexibility, and attuned parenting, demonstrating the translation of research into practice.

Implementation Strategies and Scale-Up

The MCHRI Knowledge to Action Framework (see Figure 1, Robinson et al., 2018) also provides a structure for evaluating the implementation process within the RE-AIM evaluation framework used to specify how to maximize reach, effectiveness, adoption, implementation and maintenance of a program/intervention in a real-world setting (Glasgow et al., 2019). The RE-AIM evaluation framework focuses on the translation of research findings into practice and policy and has been applied extensively to health promotion interventions (Glasgow et al., 1999, 2019; McKenzie, Naccarella, Stewart & Thompson, 2007). In relation to HEALing Matters specifically, the implementation and scale-up state-wide, and across multiple CSOs, presents challenges and potential barriers across the five RE-AIM domains (i.e., reach, effectiveness, adoption, implementation and maintenance) that will need to be assessed and accounted for. For example, CSOs are likely to demonstrate variability, both between and within organisations, in terms of their input and leadership at each level of administration, the implementation climate, the extent to which collaboration occurs, and the organisation's priorities around health and wellbeing. As mentioned above, an e-learning platform was deemed the most suitable delivery method for HEALing Matters. This approach was selected not only because of the advantages such a model possesses (see below), but also because the e-learning platform affords us the opportunity to evaluate the implementation of HEALing Matters across the five RE-AIM domains. For example, the e-learning platform allows for the collection of online meta-data and activity (such as the

frequency of resources being accessed and the time it takes to complete a module) and for us to utilize quality monitoring and user feedback tools that will be used to inform our evaluation of reach, effectiveness, adoption, implementation and maintenance. By utilizing the RE-AIM framework, therefore, we aim to assess the impact of these factors and ultimately inform implementation and scale-up of OoHC healthy lifestyle programs broadly.

Our e-learning approach also aligns with the other training approaches offered by peak social welfare advocacy bodies in Australia, such as the Centre For Excellence in Child and Family Welfare (CFECFW, see <https://www.cfecfw.asn.au/online-learning/>). This shift towards more online-based training for OoHC residential staff is largely due to its potential for higher levels of efficiency, flexibility (i.e., users can choose when and where they access the training content), accessibility (i.e., every residential house is equipped with at least one computer in order to support mandatory reporting requirements) and cost effectiveness (i.e., face-to-face training is a significant cost to an organisation) (Derouin, Fritzsche & Salas, 2005; Means et al., 2009). Furthermore, e-learning provides residential care staff with the opportunity to explore new information at their own pace and in a private setting (and through this autonomous training, may also lead to improvements in self-management). Importantly, and in line with Anderson's model (2008) for how to effectively integrate e-learning, HEALing Matters is designed with a strong appreciation for residential care staff's prior experiences and work context. Specifically, learning is reflective, often via Socratic questioning, authentically and actively constructed. Consideration has also been given to possible challenges associated with using an e-learning platform, including, slow or outdated software, low digital literacy of users, and insufficient time to complete the training within participants allocated workload (Benson & Powell, 2015). To help overcome these challenges, we have: (1) ensured the HEALing Matters portal is supported across a range of Internet browsers and devices (e.g., desktops, tablets and mobile phones); (2) implemented

real-time IT support to address technical difficulties; and (3) ensured that there is managerial support at each CSO to monitor the completion of the training modules.

Summary and Conclusion

Researchers and policy makers often fail to engage with stakeholders and end users and instead rely solely on their own academic expertise and/or linear dissemination strategies for knowledge translation; such strategies are more likely to fail compared to strategies that are codesigned and iterative (Robinson et al., 2018). Designed in line with the MCHRI Knowledge to Action Framework, and stemming from years of formative work (e.g., Skouteris et al., 2011), HEALing Matters is one of the first programs to link trauma-responsive research with a healthy lifestyle program, aimed at reducing overweight and obesity, directly in OoHC practice settings and at scale. HEALing Matters, and the large body of research that has proceeded it (see, Cox et al., 2014; 2015a; 2015b; 2017a; 2017b; 2017c; Skouteris et al., 2011; 2014;) therefore, demonstrate strong advancements in the application of research on trauma-responsive strategies and the different health-related outcomes such strategies should, and can, be applied to.

In Australia, there is a paucity of health strategies and interventions that specifically target weight status in young people in OoHC, as part of either an overall health assessment or the provision of care more generally, and there remains no standardized recommendations about the food or physical activity environments provided to young people in OoHC. While we acknowledge the well-meaning of healthy eating and physical activity policies, they currently lack a trauma responsive lens. We maintain that such guidance must be viewed in light of the unique and demanding environment that exists in OoHC and the often intensive needs of the young people living there, such as, sub-clinical disordered eating patterns that do not meet the criteria for a formal diagnosis (e.g., restrictive eating, binge eating, emotional eating, compulsive eating or pica, eating non-food items) or problematic food-related

behaviours (e.g., food contamination, hoarding or stealing food; Casey, Cook-Cottone, & Beck-Joslyn, 2012). Consider as an example a young person who has been neglected; they may never have experienced consistent meal times and/or have had limited exposure to a wide variety of foods, especially fruits and vegetables. For this young person, guidance like “children and young people are supported to eat well and access nutritious food”, is too simplistic to be translated into increased consumption of these foods. Instead, health behaviour change in OoHC must be done at a pace the young person is comfortable with and with a strong understanding of their history and current situation; an understanding rarely achieved outside of trauma-response programs.

HEALing Matters is one example of a program that aims to address the need for trauma-informed approaches when encouraging health behaviour change in young people living in OoHC. However, much more can, and must, be done to ensure carers and CSO staff are supported in helping young people achieve and maintain a healthy lifestyle, and to ensure young people are upskilled in this area. This should include policy, standards and recommendations that not only acknowledge but prioritize the impact of trauma and maltreatment on health-related lifestyle behaviours and to identify strategies to help address impact. Improvements in trauma-informed knowledge and competencies will not only increase staff’s readiness to provide care that is trauma responsive but opportunities to position child health on level terms with other child welfare focuses such as safety and stability. Because, *“If we keep on doing what we have been doing, we are going to keep on getting what we have been getting”* (Wandersman et al., 2008, pp 171).

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Figure 1. *Monash Centre for Health Research and Implementation (MCHRI) Knowledge to Action Framework* (Robinson et al., 2018).