

ATTACHMENT SF 2

This is the attachment marked "**SF 2**" referred to in the witness statement of Angelina Sabin Fernbacher dated 21st July 2015.

TRAUMA INFORMED CARE AND PRACTICE: Towards a cultural shift in policy reform across mental health and human services in Australia

A National Strategic Direction

National Trauma-Informed Care and Practice
Advisory Working Group

Position Paper and Recommendations



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Trauma-Informed Care and Practice: towards a cultural shift in policy reform in mental health and human services in Australia

National Trauma-Informed Care and Practice Advisory Working Group

Position Paper and Recommendations

It wasn't until I finally entered a recovery-oriented, trauma-informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal...Someone finally asked me 'What happened to you?' instead of 'What's wrong with you?' Tonier Cain, survivor ¹

If the origins of so much dysfunction are to be found in the adverse experiences of childhood that the majority...apparently experience...then what exactly is the role of the mental health professional, the substance abuse counsellor, the domestic violence advocate? What should social service institutions focus their efforts upon? Can we stay comfortably settled in our offices or is advocacy for fundamental change a moral necessity?

Bloom, S & Farragher, B 2011,
Destroying Sanctuary: The Crisis in Human Service Delivery System,
New York: Oxford University Press ²

Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early childhood shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems.

Trauma survivors still experience stigma and discrimination and un-empathic systems of care. Clinicians and mental health workers need to be well informed about the current understanding of trauma and trauma-informed interventions

Professor Louise Newman,
Psychiatrist and Director
Centre for Developmental Psychiatry and Psychology, Monash University ³

Purpose

Trauma-Informed Care and Practice (TICP): a national strategic direction

This paper provides the research evidence for Trauma-Informed Care and Practice and the rationale for cultural and systemic reform in Australia and also presents recommendations for a strategic framework for implementation at both service and system levels. It additionally identifies the steps needed to embed trauma-informed principles into policy and the integration of evidence-based research into practice.

The position paper:

- encapsulates the principles of Trauma-Informed Care and Practice, and promotes the need for and benefits of their integration into mental health and human services practice and policy reform;
- delineates the contexts in which the implementation of trauma-informed care into practice would improve outcomes for consumers with trauma histories;
- establishes the breadth and depth of reform needed for the incorporation of trauma-informed care and practice across and within a diversity of human service sectors, cultures, systems, professional frameworks and models of service delivery;
- explores implementation integration of Trauma-informed Care and Principles (TICP Principles) into practice at the systems and service levels; and
- identifies the range of agencies and sectors to be engaged in establishing the TICP agenda including: State and Commonwealth Governments, policy makers, Mental Health Commissions, health and human service sectors as well as the broader community.

This position paper and recommendations are informed by the work of many international experts in the field, and their work underpins the recommendations outlined in the position paper.⁴

Position Paper Recommendations

Trauma-Informed Care & Practice (TICP) – A National Strategic Direction

Coordinated Government response

Process

- Whole of government policy reform – take-up/cross-portfolio
- Cross-government collaboration between Federal, State and Territory Governments as well as the CMO sector

Outcome

- Implementation of TICP across the broad range of human service sectors
- Incorporation of these recommendations for change to be accepted broadly across national mental health reform processes

Mental Health and Human Services

Aims

- To implement TICP principles into practice across and within mental health and human services and systems
- To embed TICP principles into the National Recovery Framework
- To integrate TICP principles into National Standards
- Inclusion of TICP in the national agenda in the next National Mental Health Commission Report Card

Process

- Engagement with State and Federal Mental Health and Human Service Ministers and senior policy makers
- Engagement with National and State Mental Health Commissions (prioritisation for policy, planning, research and sector funding)
- Integration of TICP principles into practice within the Royal Commission into Institutional Responses to Child Sexual Abuse
- Networking and collaboration with the international trauma-informed community
- Education and engagement of sector (Tools, Showcase Forum, Training)
- Implementation of research into practice – policy reform and practice standards, embedding Practice Guidelines

Outcomes

- Uptake and accepted practice for community managed organisations (CMOs), public and private agencies to integrate TICP into systems and services
- Workforce Development and capacity building in TICP
- Broad-based National Communications Strategy surrounding trauma

Section 1

Executive Summary

The experience of trauma and its impacts on individuals, communities and society as a whole are substantial. This paper recognises the prevalence of interpersonal trauma in our society; it acknowledges that a large percentage of those seeking help across a diversity of health and human service settings have trauma histories severely affecting their mental and physical health and wellbeing. The impacts of trauma characteristically persist long after the trauma has ended. Although exact prevalence estimates vary, there is a broad consensus that many consumers who engage with public, private and community managed mental health and human services are trauma survivors and that their trauma experiences shape their responses to service providers.⁵

This paper presents the position of the National Trauma-Informed Care and Practice Advisory Working Group (NTICP AWG) on developing a national approach to trauma-informed care and practice. Inherent in this is an understanding of the relationship between trauma, mental illness, co-existing conditions and complex psychosocial difficulties, particularly important in the context of dynamic changes to the service system environment in Australia including the introduction of the National Disability Insurance Scheme (NDIS) and Partners in Recovery. It incorporates the recommendations that the NTICP AWG present as necessary to facilitate a strategic approach towards a cultural shift in policy reform in mental health and human services in Australia. The paper is informed by extensive international and national evidence, and provides a platform from which the NTICP AWG will advocate for broad-based policy reform to embed trauma-informed principles of practice within and across jurisdictions and sectors.

Trauma-Informed Care and Practice

We can now connect the psychobiology of trauma to the social determinants of health. Never before have we had an integrative framework that allows extensive and specialised bodies of knowledge to be connected to each other within a human rights context as well as a public health challenge.

Bloom, S & Farragher, B 2013,
Restoring Sanctuary: A new operating system for trauma informed systems of care,
Oxford University Press

Australia's mental health and human service systems have, generally speaking, a poor record in recognising the relationship between trauma and the development of mental health conditions, co-existing difficulties and complex psychosocial problems, and responding appropriately to them. The lack of policy focus is reflected by a lack of awareness and education around trauma-informed approaches within practice and service settings.⁶ This position paper presents an approach described as 'Trauma-Informed Care and Practice' (TICP) to address these factors.

TICP exemplifies a 'new generation' of transformed mental health and human service organisations and programs that serve people with histories of trauma.

Responding appropriately to trauma and its effects requires knowledge and understanding of trauma, workforce education and training, and collaboration between consumers and carers, policy makers, and service providers and crosses service systems. It involves not only changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic.

TICP is a practice that can be utilised to support service providers in moving from a 'caretaker to a collaborator role'.⁷ When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services.⁸ By facilitating recovery through trauma-informed care, re-victimisation can be minimised and self and community wellness and connectedness can be promoted.

Transformational outcomes can happen when organisations, programs and services are based on an understanding of the particular vulnerabilities and/or 'triggers' that trauma survivors experience (that traditional service-delivery approaches may exacerbate) so that services and programs can be more supportive, effective and avoid re-traumatisation.

Trauma-Informed services understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible (Herman, 1992).⁹

Evolution of the national agenda in Australia

In 2007, the Senate Standing Committee on Community Affairs conducted an Inquiry into Mental Health in Australia. The final report: *Towards recovery: Mental health services in Australia*, was tabled in September 2008. In response to numerous statements (including representations and submissions from the Mental Health Coordinating Council (MHCC) and Adults Surviving Child Abuse (ASCA) particularly identifying the link between poor mental and physical health, complex need and a history of trauma; the Senate Committee called for Government recognition of adult survivors of childhood abuse, specifically emphasising the necessity for a nation-wide initiative for people with a diagnosis of Borderline Personality Disorder (BPD).

MHCC and ASCA were among those who strongly advocated for broad-based mental health and psychosocial supports for trauma survivors, contesting that (in the context of childhood trauma) BPD is but one of the possible impacts, and that using a particular diagnosis as a means to access services is not only using a too-narrow lens but is also stigmatising and discriminatory. Then, as now, we advocate for the availability of a wide range of flexible, holistic, trauma-informed recovery-oriented services as well as funding for trauma-specific services. Our efforts led to collaboration with other organisations sharing similar goals.

In September 2010, MHCC, ASCA, NSW Health Education Centre Against Violence (ECAV) and the Private Mental Health Consumer Carer Network Australia (PMHCCN) held a forum, the purpose of which was to discuss the development of a national agenda for promoting Trauma-Informed Care and Practice (TICP) across public, private and community-based mental health and human service systems. The all-day forum brought together individuals from several Australian states, including consumers and carers, federal politicians, the President of the NSW Mental Health Review Tribunal (at the time), senior clinicians, health

professionals and academics with expertise in mental health, disability and trauma across service sectors. It also included senior executives from a range of community-managed peak bodies and service providers experienced in working with the psychological impacts of trauma. The focus of the day was to identify existing research evidence about trauma and share experiences in practice.

The forum discussions established the need for development of a service-delivery culture embracing a TICP approach, as well as the need to advocate for trauma-specific services. A specific outcome in the report of the day's proceedings was the call to host a national conference on trauma. This would form part of an ongoing broader initiative towards a national agenda promoting that the principles of trauma-informed care be integrated across service systems throughout Australia.

The landmark Trauma Informed Care & Practice: Meeting the Challenge Conference 2011 delivered by MHCC in collaboration with ASCA, ECAV and PMHCCN was held in Sydney in June 2011, funded by the NSW Health Mental Health Drug & Alcohol Office (MHDAO). The Hon Mark Butler MP, then Minister for Mental Health and Ageing, Minister for Social Inclusion, opened the event with a video welcome. Over 240 people from every state in Australia and New Zealand attended on both days. The conference included a specially made video presentation from Kathleen Guarino, a high-profile professional working in the trauma field for the Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA.

The event was targeted at consumers, carers and people working in the mental health and human services sectors including public, private and community-managed agencies such as: drug and alcohol; primary and allied health; counselling; refugee; therapeutic and social support services; sexual assault and child protection, sexual health; disability; Aboriginal, culturally, linguistically and ethnically diverse organisations; as well as legal, advocacy education and research bodies.

Subsequently in October 2011, MHCC launched a microsite (hosted from its website) devoted to TICP. As well as widely promoting the microsite across member organisations and collaborating partners' networks we also encouraged people who had attended the original forum and the conference to join a TICP network. People were advised to visit the microsite for information about the work of the national TICP advisory working group (led by MHCC and ASCA) to: keep connected and share information; read about TICP news and events; seek training opportunities; find resources; and access research papers, video presentations and PowerPoint presentations including those of key speakers from the TICP conference in 2011. The TICP network continues to grow and now comprises some 210 people/ organisations.

Following these events, interest in trauma and trauma-informed care and practice have become topics high on the policy reform and workforce development agenda across service sectors. MHCC and ASCA along with other training providers facilitate numerous courses and professional-development opportunities targeted at different professional and practice groups across Australia. ECAV continue to provide consultation and training to clinicians employed within NSW Health inpatient and community-based treatment services across metropolitan, rural and remote areas.

MHCC has been inundated with enquiries about the provision of policy and organisational tools. There has been a marked increase in requests for specifically targeted professional development for the public, private and community-services workforce across numerous disciplines.

Other groups across service sectors and government have offered a range of trauma-related conferences, forums, seminars and ongoing training opportunities for a diversity of human service and health sectors including the criminal justice system.

The National Trauma-Informed Care and Practice Advisory Working Group (NTICP AWG) is encouraged by the groundswell of interest and energy around its national agenda.

National Trauma-Informed Care and Practice Advisory Working Group (NTICP AWG)

The NTICP AWG was formed by a partnership established in 2011 by the Mental Health Coordinating Council (MHCC), Adults Surviving Child Abuse (ASCA), NSW Health Education Centre Against Violence (ECAV) and the Private Mental Health Consumer Carer Network Australia (PMHCCN). The partnership has facilitated opportunities for public, private and the community-managed mental health sectors to understand and embrace the principles of trauma-informed care and practice thereby adopting a shift in organisational culture and service delivery for people engaging with mental health and other human services who are victims/survivors of interpersonal trauma.

Members of the National Trauma-Informed Care and Practice Advisory Working Group:

- Jenna Bateman, Mental Health Coordinating Council, NSW
- Dr Richard Benjamin, Eastern Mental Health Services, Rosny, TAS *
- Jo Campbell, Education Centre Against Violence ECAV, NSW ***
- Dr Sabin Fernbacher, Northern Area Mental Health Service, VIC*
- Corinne Henderson, Mental Health Coordinating Council, NSW
- Dr Cathy Kezelman, Adults Surviving Child Abuse ASCA, National
- Janne McMahon, Private Mental Health Consumer Carer Network Australia, SA **
- Jan Roberts, NSW Official Visitor, NSW *
- Alan Woodward, Lifeline Foundation for Suicide Prevention, National
- Dragan Wright, Creating Differently, private practitioner, trainer **

(* Public sector; ** private sector; *** public education; others listed are CMOs)

Advisors to the NTICP AWG are: Professors Louise Newman, Beverley Raphael and Warwick Middleton; Karen Willis (Rape Crisis).

The NTCIP AWG thanks Chris McCabe, ECAV for her participation and support on the AWG from 2010 to 2012.

Section 2

Language – understanding trauma

To understand the concept of ‘trauma’ a distinction needs to be made between event/s and a person’s reaction to the event/s.

Trauma may arise from single or repeated adverse events that can interfere with a person’s ability to cope or to integrate the experience. It is an experience of real or perceived threat to life, bodily integrity and/or sense of self. The impacts of traumatic experiences can be cumulative across the lifespan.

Definitions

Complex Need¹⁰ refers to individuals who present with an inter-related mix of diverse mental health and physical health issues, developmental and psychosocial problems. Many people with complex needs have histories of trauma (emotional, physical and/or sexual abuse), as well as other types of childhood interpersonal trauma including but not limited to chronic neglect and the effects of family violence.

Complex Trauma occurs as a result of traumatic stressors that are *interpersonal* – premeditated, planned and perpetrated by one human being on another. It is particularly damaging if it occurs in childhood.¹¹ These actions can be both violating and exploitative of another person.¹²

Complex, interpersonally generated trauma is severely disruptive of a person’s capacity to manage internal states. Complex trauma contrasts with ‘single-incident’ trauma (which relates to an unexpected and ‘out of the blue’ event such as a natural disaster, traumatic accident, terrorist attack or single episode of assault, abuse or witnessing of such an event). It is cumulative and repetitive.¹³ This is not to minimise the impact of single-incident trauma, or encourage a hierarchy of trauma in which one form of trauma is perceived as being more worthy of attention than another. A trauma-informed approach is always indicated regardless. However complex trauma is complex by its very nature and so demands different service and practice responses.

Complex Trauma survivors are likely to have histories of physical and/or sexual abuse as well as chronic neglect and/or protracted emotional abuse, witnessing domestic violence, and/or have been victims of interpersonal violence as a consequence of wars, genocide, civil unrest, refugee and combatant trauma. Such trauma frequently leads to diversity of mental health and of co-occurring problems such as poor physical health, substance abuse, eating disorders, relationship and self-esteem issues, suicidality and contact with the criminal justice system.

Interpersonal violence has been defined by the World Health Organisation (WHO) as *the intentional use of physical force, or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has a likelihood of resulting in, injury, death, psychological harm, mal-development or deprivation* (Krug et al., 2002 p 5). This definition includes victimisation perpetrated against intimate partners, parents, siblings, children, other relatives, friends, acquaintances, colleagues and strangers.¹⁴ It should be noted that interpersonal violence is often gendered, with marginalised groups being at

greater risk, including but not limited to LGBTQI people and Aboriginal and Torres Strait Islander people.

Trauma particularly that which arises from interpersonal abuse and/or neglect in childhood, as well as victimisation in adulthood, can lead to serious long-term consequences and many survivors adopt extreme coping strategies which can persist into adult life (as an attempt to manage overwhelming traumatic stress). These strategies include suicidality, substance abuse and addictions, self-harming behaviours, dissociation, and re-enactments of past abusive relationships. Trauma can be trans-generational for individuals and/or affect whole communities.

Trauma-Informed Care and Practice (TICP) is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. A trauma-based approach primarily views the individual as having been harmed by something or someone (Bloom, S 1997:2000, p 71).¹⁵ TICP is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services.

A distinction needs to be made between a trauma-informed approach (which is indicated in all service settings) and that which is needed to treat trauma in a clinical context (although such an approach is likewise underpinned by trauma-informed principles).

Key principles of trauma-informed care include safety, trustworthiness, choice, collaboration and empowerment. A TICP framework recognises the impact of power differentials in service settings, maximises self-determination, supports autonomy and empowers individuals to learn about the nature of their injuries and to take responsibility in their own recovery. Non trauma-informed services often mirror the power and control experienced in the abusive relationships that caused the past trauma making recovery difficult and the risk of re-traumatisation real.¹⁶ This is often at its most problematic in acute settings where people may be involuntarily detained and subject to coercive treatment.

TICP is informed by an understanding of the particular vulnerabilities and 'triggers' that survivors of complex trauma experience, with services delivering better outcomes, minimising re-victimisation and ensuring that self and community wellness and connectedness can be promoted.

TICP is a paradigm shift in service delivery culture, and an integral part of recovery-oriented practice. It acknowledges and clearly articulates *that no one understands the challenges of the recovery journey from trauma better than the person living it.*¹⁷ This requires that practitioners are attuned to a person's experience and to the dynamics of trauma and acknowledge, respect and validate that experience.

Trauma-specific refers to treatment approaches and trauma-informed services which directly address trauma in its various forms.

Principles of Trauma-Informed Care & Practice ¹⁸

- integrate philosophies of quality care that guide assessment and all clinical interventions
- are based on current literature
- are informed by research and evidence of effective practices and philosophies
- are led by consumers and survivors
- are culturally safe and inclusive

The **eight foundational principles** that represent the core values of trauma-informed care and practice are:¹

Understanding trauma and its impact. Understanding traumatic stress, and how it impacts people, and recognising that many challenging behaviours and responses represent adaptive responses to past traumatic experiences.

Promoting safety. Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place particularly in relation to responding to suicidality, and provider responses are consistent, predictable, and respectful.

Ensuring cultural competence. Understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity, providing opportunities for consumers to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

Supporting consumer control, choice and autonomy. Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

¹ These principles were identified and adapted on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, D J Reed, B G Mazelis, R & D'Ambrosio, B 2003, 'Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA, Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study', Delmar, NY: Policy Research Associates, literature on therapeutic communities), Campling, P 2001, 'Therapeutic communities. 'Advances in Psychiatric Treatment, 7: 365–372; and the work of Maxine Harris and Roger Fallot: Fallot, R & Harris, M 2009, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol.' Washington, DC: Community Connections and 'The Sanctuary Model' as developed by Sandra Bloom and colleagues, Bloom, S L & Sreedhar, S Y 2011, 'The Sanctuary Model of Trauma-Informed Organizational Change, Reclaiming Children and Youth: From Trauma to Trust', 17(3):48-53; Bloom, S L & Farragher, B 2011, *Restoring Sanctuary: A New Operating System for Trauma-Informed Organizations*, New York: Oxford University Press.

Sharing power and governance. Promoting democracy and equalisation of power differentials; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures.

Integrating care. Maintaining a holistic view of consumers and their recovery process and facilitating communication within and among service providers and systems.

Healing happens in relationships. Understanding that safe, authentic and positive relationships can aid recovery through restoration of core neural pathways

Recovery is possible. Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

Key Features of Trauma-Informed Care and Practice Systems

<i>Systems without Trauma Sensitivity</i>	<i>Trauma-Informed Care Systems</i>
Consumers are labelled and pathologised as manipulative, needy, attention-seeking	Are inclusive of the survivor's perspective
Misuse or overuse of displays of power – keys, security, demeanour	Recognise that coercive interventions cause traumatisation/re-traumatisation – and are to be avoided
Culture of secrecy – no advocates, poor monitoring of staff	Recognise high rates of complex post-traumatic stress disorder (PTSD) and other psychiatric disorders related to trauma exposure in children and adults
Workers believe their key role is as a rule enforcer	Provide early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness
Little use of least restrictive alternatives other than medication	Recognise that mental health treatment environments are often traumatising, both overtly and covertly

<i>Systems without Trauma Sensitivity</i>	<i>Trauma-Informed Care Systems</i>
Institutions that emphasise 'compliance' rather than collaboration	Recognise that the majority of mental health staff are uninformed about trauma, do not recognise it and do not treat it
Institutions that disempower and devalue staff who then 'pass on' that disrespect to service recipients	Value consumers in all aspects of care
High rates of staff and recipient assault and injury	Respond empathically, be objective and use supportive language
Lower treatment adherence	Offer individually flexible plans or approaches
High rates of adult, child/family complaints	Avoid all shaming/humiliation
Higher rates of staff turnover and low morale	Provide awareness/training on re-traumatising practices
Longer lengths of stay/increase in recidivism	Are institutions that are open to outside parties: advocacy and clinical consultants
Poor access to training and education	Provide training and supervision in assessment and treatment of people with trauma histories
Culture that focuses on symptoms and diagnoses without reference to a life journey	Focusing on what happened to the client rather than what is 'wrong with you' (i.e. a diagnosis)

<i>Systems without Trauma Sensitivity</i>	<i>Trauma-Informed Care Systems</i>
Ignore disclosures and fail to address safety issues	Ask questions about current abuse
Do not take responsibility for how a person will cope once discharged from care/hospital	Address the current risk and develop a safety plan for discharge
Avoid focus on experience of trauma and minimise importance of trauma on presentation	Presume that every person in a treatment setting may have been exposed to abuse, violence, neglect or other traumatic experiences

Chart adapted from: Falot, R & Harris, M 2009, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol', Washington, DC. Community Connections; Jennings, A, 2004, 'Models for Developing Trauma-Informed Behavioural Health Services: Strategies Emerging from the States', *Psychosocial Rehabilitation Journal*, Spring, pp 1–15.

Section 3

International evidence: the literature

a. Defining trauma (see also p. 8)

Trauma shapes and informs our interactions with ourselves and others. It has a profound impact on our body, mind and spirit. Healing from trauma is possible for all. The experience is transformative.

The Transformation Center, 2012 ¹⁹

While trauma can be experienced as a result of single or multiple traumatic events of any aetiology, this paper focuses on complex trauma – the multiple impacts of interpersonal trauma/violence including those on a person’s psyche and ‘sense of self’. Complex trauma is the product of overwhelming stress that is interpersonally generated.

Society generally understands trauma as an unusually intensive and unwanted experience that involves actual or perceived danger to oneself or another. As interpersonal violence/trauma often occurs in secrecy and is steeped in shame, survivors often struggle to have their experience validated. Trauma occurring in the context of interpersonal violence, either covert or overt, often results in complex and chronic psychological and physiological injuries.

There is now a wealth of research related to the effects of complex trauma on the developing brain not just in infancy but right through the life cycle. Research has also identified the capacity for the brain to repair and so for those affected to recover and these research findings have substantial implications for mental health and human service responses. ²⁰

b. Prevalence

A 2007 Australian University–initiated study of over 21,000 older Australians found that over 13% of those surveyed reported having been either physically or sexually abused in childhood or both. ²¹ These figures do not include those who have been emotionally abused or neglected or forced to live with domestic violence.

According to the most recent ABS figures (2005) the proportion of women and men who experienced physical abuse before the age of 15 was 10% (779,500) and 9.4% (702,400) respectively. Women were more likely to have been sexually abused than men before the age of 15. 12% (956,600) of women reported that they had been sexually abused before the age of 15 compared of to 4.5% (337,400) of men, although there is strong evidence that figures are much higher due to unreported or uncorroborated evidence.

According to the AIHW (2009), the breakdown of substantiated childhood abuse in Australia is: physical abuse 23%; neglect 29%; emotional abuse 38% and sexual abuse 10%. However one study (Palmer, Brown, Rae-Grant & Loughin, 2001) identified that most survivors reported a combination of abuse types: physical, emotional and sexual (45%), physical and emotional (21%), sexual and emotional (17%), with sexual only (11%) and emotional only (6%).

Statistics suggest that two out of three patients presenting at emergency, inpatient or outpatient mental health services have underlying complex trauma secondary to childhood physical or sexual abuse.²² If emotional abuse, chronic neglect and the impacts of witnessing domestic violence or growing up with significant family violence, substance abuse and poverty are also included, the percentage is even higher.²³ Extensive studies in the USA have found that 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas.^{24 25}

The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences.²⁶ Shirley Havenga, Chief Executive Officer, Community Psychiatric Clinic, in Seattle, writes: *Trauma is an almost universal experience of public mental health and substance abuse consumers; the need to address it has become essential for the growth and recovery of trauma survivors.*²⁷

The literature clearly shows that childhood trauma is widespread across all socio-economic, ethnic and cultural boundaries, although it has been hard to gather statistics in some communities due to secrecy, shame, fear and isolation.

The high reported levels of trauma of people in mental health facilities often remain unrecognised, and consumers who have been previously traumatised are also vulnerable to re-victimisation and re-traumatisation in care.²⁸ Research conducted by Mueser et al., (1998) assessed the lifetime prevalence of traumatic events and current patients with PTSD and severe mental illness (e.g. schizophrenia and bipolar disorder) receiving public mental health services in the UK and USA. The findings suggest that PTSD is a common comorbid disorder in severe mental illness that is frequently overlooked in mental health settings.²⁹

c. Re-victimisation

Those who have experienced abuse/trauma/violence in childhood are often at risk of further re-victimisation and re-traumatisation later in life. Child maltreatment is associated with adolescent violence, adult violence towards non-familial individuals, and violence towards intimate partners.³⁰ Studies show that witnessing or experiencing violence in childhood significantly increases the risk of becoming a victim or a perpetrator in later life.³¹

Women who experience childhood abuse are, as an adult, one and a half times more likely to experience violence as, and twice as likely to experience sexual violence than, those who have not.³² Female survivors of child abuse commonly experience re-victimisation, e.g. coercive sexual experiences, rape, or marrying physically and sexually violent men.³³ Child abuse victims are not only more likely to be victims of rape but also to be involved in physically abusive relationships as adults.³⁴

d. Populations at risk

Many groups of people who have experienced community violence are at risk of repeated victimisation, including but not limited to Aboriginal people, refugees and culturally and linguistically diverse (CALD) minorities, older Australians, people with disabilities, and people who are lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI).³⁵

Statistics show that Aboriginal and Torres Strait Islander children are more likely to be the subject of substantiated reports than other children. Across Australia, Indigenous children are more than 6 times as likely as other children to be the subject of substantiation as a result of criminal proceedings.³⁶ The NSW Ombudsman reported that 10% of all reported child sexual assault victims in NSW were Aboriginal even though Aboriginal children comprise only 4% of the total population of children (2012).³⁷

Women with Disabilities Australia (WWDA) identify women with disabilities as one of the most 'marginalised' groups experiencing abuse. International studies indicate that women with intellectual disabilities are 10 times as likely to be sexually assaulted as other women (2002).³⁸

(i) Gendered dimensions

The majority of people who are victims of abuse are women, children of both sexes and vulnerable men. These crimes are often 'gendered crimes'. Trauma-informed services need to be gender-responsive, necessitating the creation of an environment – through site selection, same-sex amenities and accommodation, staff selection, program development and program content and materials – which reflects an understanding of the realities of, for example, women's and girls' lives and their particular challenges and strengths. Likewise services must reflect recognition of the social and cultural pressures on boys and men that often lead to particular difficulties and outcomes.

Holistic trauma-informed services aim to understand every aspect – physical, emotional, and spiritual – of a person's self, as well as the environmental and socio-political aspects that provide context to one's lived experience.

There is growing recognition of the complex needs of women with co-existing substance abuse and mental health disorders. Recent research indicates that 55% to 99% of women with co-occurring disorders have experienced trauma from abuse and that abused women tend to engage in self-destructive behaviours. These women are often not well served by services in their communities. Many of these services separate substance abuse and mental health programs, despite research which shows that integrated, trauma-informed treatment services increase the likelihood of recovery.³⁹

Similarly, trauma-informed services for men must display non-judgemental acceptance that trauma is also pervasive in men's lives. Services must understand that there are distinct gender differences in how men experience and respond to trauma and exhibit the symptoms of trauma-based disorders. Account must be taken of the impact of male socialisation on recovery from trauma and/or addiction (Covington, Griffin & Dauer, 2011).^{40 41}

(ii) Cultural dimensions

An understanding that the trans-generational transmission of trauma is at the core of Aboriginal people's experience through the processes of colonisation and neo-colonisation needs to inform practice. Trauma-informed care and practice services and systems need to emphasise the high risk of re-traumatisation for Aboriginal and Torres Strait Islander people particularly in acute mental health settings which traditionally poorly reflect and respect Aboriginal worldviews or adequately embed Cultural Safety. Aboriginal and Torres Strait

Islander Cultural Safety is a practice and service framework that aims to provide positive and emotionally safe experiences for Aboriginal people in mainstream systems (Durey, 2010).⁴²

Knowledge, information and data from and about individuals and groups integrated into programs transform standards and cultural competence and evidence-based practices and approaches. To match the individual/group culture increases both the quality and appropriateness of health care, and improves health outcomes (Whaley & Davis, 2007).⁴³

Studies on the prevalence of trauma and abuse among CALD women, whether experienced in childhood or adulthood, are scarce; studies concerning CALD men are non-existent. An International Violence Against Women (IVAW) survey indicated that CALD women *report lower levels of physical violence than women from English-speaking backgrounds*, but that *a similar proportion from both groups experienced sexual violence during the 12 months preceding the survey* (Keel et al., 2005).⁴⁴ Research has identified factors that not only influence CALD (also referred to as NESB, or non-English-speaking backgrounds) women's perceptions of what constitutes violent behaviour, but also contribute to a reluctance to report childhood abuse or current violence (Ouzos & MacKay, 2004).⁴⁵ Lenore (2003) suggests *reasons that women from NESB backgrounds are unlikely to report are varied and include personal, cultural and religious, informational and language and/or institutional and structural*.⁴⁶ This refers to cultural norms regarding issues such as: the position of women from CALD cultures with diverse religious beliefs relative to men in their communities; issues surrounding marriage and virginity; their dependence on same-culture medical and other service-delivery agents; fear of confidentiality; and retribution, stigma and parenting issues.

Community services experience ongoing difficulties in engaging bilingual workers who can provide culturally appropriate services and who understand childhood abuse and sexual abuse related issues within a cultural context. This aspect is particularly problematic in small or isolated communities with little access to any support services. Trauma-informed services must integrate cultural knowledge into programs and be culturally safe so as to minimise re-traumatisation.

e. Presentation

Characteristically, survivors of childhood abuse exhibit early onset of mental health difficulties and a tendency towards chronicity, lowered self-esteem and sense of hopelessness (Henderson & Brown, 1988; Harris, 1988; Romans et al., 1992).⁴⁷ Many traumatised people adopt extreme coping strategies in order to manage anxiety and overwhelming emotional distress including: suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, and dissociation. Many coping strategies become risk factors for later physical health issues.

The 2007 Australian University-initiated study of over 21,000 older Australians (referenced earlier), found child abuse survivors are almost two and a half times as likely to have *poor mental health outcomes, four times more likely to be unhappy even in much later life and more likely to have poor physical health*.⁴⁸ The same study found that physical and sexual abuse increases the risk of having three or more medical diseases, including cardiovascular events in women, and in social and lifestyle aspects, a higher prevalence of broken relationships (lower rates of relationships in later life cause lower levels of social support and

an increased risk of living alone) and an increased likelihood of smoking, substance abuse and physical inactivity.⁴⁹

A study of 384 survivors of childhood abuse found that survivors of child abuse tended to be depressed, have low self-esteem and have problems with family relationships.⁵⁰

f. Mental health impacts

No single diagnostic term has been agreed upon internationally which captures the complexity of presentations related to complex trauma.

Seventy-six per cent of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have three or more psychiatric disorders.⁵¹

Survivors of abuse often carry a number of mental health diagnoses concurrently, including: post-traumatic stress disorder (PTSD), borderline personality disorder, schizophrenia,⁵² depression or other affective disorders, anxiety disorder, psychotic and dissociative disorders, somatoform disorder, and sexual impairment disorders. The effects of childhood trauma are wide ranging, and people with trauma histories frequently present with multiple coexisting conditions and problems including: substance abuse,⁵³ eating disorders,^{54 55} self-harming behaviours,^{56 57} and suicidality,^{58 59} frequently have interactions with the criminal justice system,^{60 61} and/or experience homelessness.⁶²

Child sexual assault is associated with two and a half times the rates of mental disorder,⁶³ including being two to three times more likely to have an anxiety, mood or eating disorder; four times more likely to attempt suicide and sixteen times more likely to have a sleep disorder.⁶⁴

Trauma survivors may experience symptoms of Complex PTSD, including intrusive re-experiencing of the trauma in nightmares or flashbacks, inability to recall part of the trauma and emotional numbing as well as hyper-arousal.

As previously noted, many survivors carry a diagnosis of Borderline Personality Disorder (BPD). BPD is one of a group of 'personality disorders' listed in the DSM-5 (2013). It is characterised by 'significant self and interpersonal functioning impairments' and distressing emotional states with a set of symptoms including: difficulty in empathising and relating to other people; aggression; poor impulse control; suicidality; and self-harming behaviours such as substance abuse, eating disorders, cutting and self-mutilation. Some researchers have estimated that up to 75% of individuals diagnosed with BPD have experienced sexual abuse in childhood (Linehan, 1993).⁶⁵ This diagnosis is often stigmatising with little recognition of a person's lived experience of trauma.

Dissociation is a set of trauma-related phenomena ranging from altered awareness and out-of-body experiences to a lack of integration of information within the cognitive system. People experiencing dissociation can present with: vagueness; excessive daydreaming; de-personalisation; de-realisation; disengagement from the immediate environment; altered body perception; emotional numbing; amnesia for traumatic experiences; and at the extreme end of the spectrum can manifest Dissociative Identity Disorder (DID). Dissociative symptoms are common in adults with a history of child sexual abuse (CSA).⁶⁶ Several

studies established that 60–83% of patients with DID have a history of prolonged sexual abuse and in many cases, physical and emotional abuse as well.⁶⁷

No one set of symptoms or outcomes can fully characterise survivors' experience. Professionals who focus on symptomatology alone may fail to recognise or address the underlying trauma. A 1998 study of 62 patients meeting diagnostic criteria for Dissociative Identity Disorder (DID) demonstrated that 29% of these highly traumatised individuals had previously been treated for 'schizophrenia', 73% satisfied full diagnostic criteria for Borderline Personality Disorder, 71% met criteria for a current somatisation disorder, 94% had had, or did have, major depression, and 90% satisfied diagnostic criteria for Post-Traumatic Stress Disorder.⁶⁸ (Note: the diagnostic criteria referred to applies to the DSM-IV, 1994. The DSM-5 was subsequently published in May 2013, and does not substantially alter the criteria for the conditions mentioned).⁶⁹

g. Other health impacts

People with a lived experience of trauma often present to a health practitioner, commonly a GP. Many will not have connected their current problems and behaviours with their prior trauma, nor will their health practitioner. Failure to recognise underlying trauma can impact both treatment and outcomes.

One study found that 29.3% of women with a sexual abuse history reported at least six somatic symptoms compared to 15.8% of other women.⁷⁰ Survivors of child maltreatment are at increased risk of hepatitis, diabetes, heart disease, cancer, a stroke, are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms.⁷¹

Gastrointestinal (GI) problems may be second only to depression as the most frequent long-term consequence of child sexual abuse. One study found that as many as 71% of adolescent girls and adult women who experience sexual abuse for more than two years may later develop GI disorders. Survivors of sexual abuse are also at risk of higher rates of: irritable bowel syndrome; chronic abdominal pain; diabetes; obesity; arthritis; asthma; recurrent surgeries; poor reproductive outcomes; digestive problems; hypertension; and insomnia.⁷²

Likewise women with a history of child sexual abuse experience higher rates of: venereal disease; pelvic inflammatory disease; respiratory problems and neurological problems; breast diseases ranging from fibrocystic changes to cancer; and yeast infections. They are also one and a half times more likely to have bladder infections.⁷³

Research shows that physical and psychological problems are common for survivors during pregnancy. The physical and emotional demands of labour and delivery also pose particular challenges for this group of women. Some women report extreme distress during breastfeeding, with bodily contact and the sensations of breastfeeding evoking memories of sexual abuse (Prescott, 2002).⁷⁴ These feelings may result in emotional distancing from the infant, intense feelings of guilt, self-blame and a sense of powerlessness.

A large community-based study of 634 women in British Columbia, Canada, sought to determine the association between interpersonal violence and substance use and postpartum depressive symptomatology. Findings suggested that women with past or

current interpersonal violence or personal or partner substance-use problems should be considered for targeted screening for postpartum depression.⁷⁵

h. Interpersonal difficulties

Abusive behaviours and assault, whether physical, sexual or psychological can create long-term interpersonal difficulties. Many victims encounter problems in adult relationships and sexual functioning due to distorted thinking patterns and emotional distress, and find themselves in re-enactments of past abusive relationships.⁷⁶ Such difficulties include fear of abandonment, hypersensitivity to criticism, challenges with trust and intimacy and problems dealing with conflict.

i. Resilience

Resilience refers to the capacity of human beings of any age to survive and thrive in the face of adversity. Research has demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's wellbeing.⁷⁷ One of the strongest predictors of a child's subsequent recovery relates to maternal and family dynamics.

For a child who has been abused, their relationship to the perpetrator/s, their interpretation of the abuse, whether or not they disclose the experience and when, whether they were believed or not, and how quickly they report their experience/s can affect short- and long-term consequences. Children who are able to confide in a trusted adult, and who are believed, generally experience less traumatic effects than children who do not disclose the abuse, and/or are not believed. Moreover, children who disclose soon after the abuse may be less traumatised than those who live with the secret for years provided they receive a supportive, validating response.

John Briere (2002) writes that the impacts of abuse and/or neglect differ enormously depending on a complex interplay of factors including but not limited to the following variables: disposition; resilience; bio-psychological factors; family environment and other supports; peers; security; positive parent/child attachment; and previous history of support or abuse, including duration, frequency and nature of abuse. However, recovery is possible and many people go on to lead fulfilling lives.⁷⁸

In cases of familial abuse, the presence of a supportive, non-offending parent is strongly correlated with resilience⁷⁹ as is the presence of another caring adult. A calm, practical, positive, validating and supportive approach by the person to whom the abuse is disclosed may greatly reduce the impact of the abuse.

The importance of the initial response suggests that efforts to prepare and assist parents and caregivers to acknowledge and support any child who discloses abuse are likely to have significant benefits.⁸⁰ Similarly, the response to disclosure by adult victims is critical given the number of years with which many people have lived with undisclosed trauma. Failure to respond appropriately, not only personally but also institutionally can have a devastating effect on these adults, their families and others close to them.⁸¹ The historical and current ways in which institutions respond will be further explored within the Australian Royal Commission into Institutional Responses to Child Sexual Abuse.

A study by Collishaw et al. (2007), found that positive relationship experiences across childhood, adolescence and adulthood predict resilience.⁸² However, a review of 65 studies conducted in over 10 countries between 1986 and 1992 concluded that, almost without exception, the impact of childhood sexual (and indeed all forms of) abuse is harmful, although personal resilience and the presence of a supportive relationship can ameliorate some impacts.⁸³

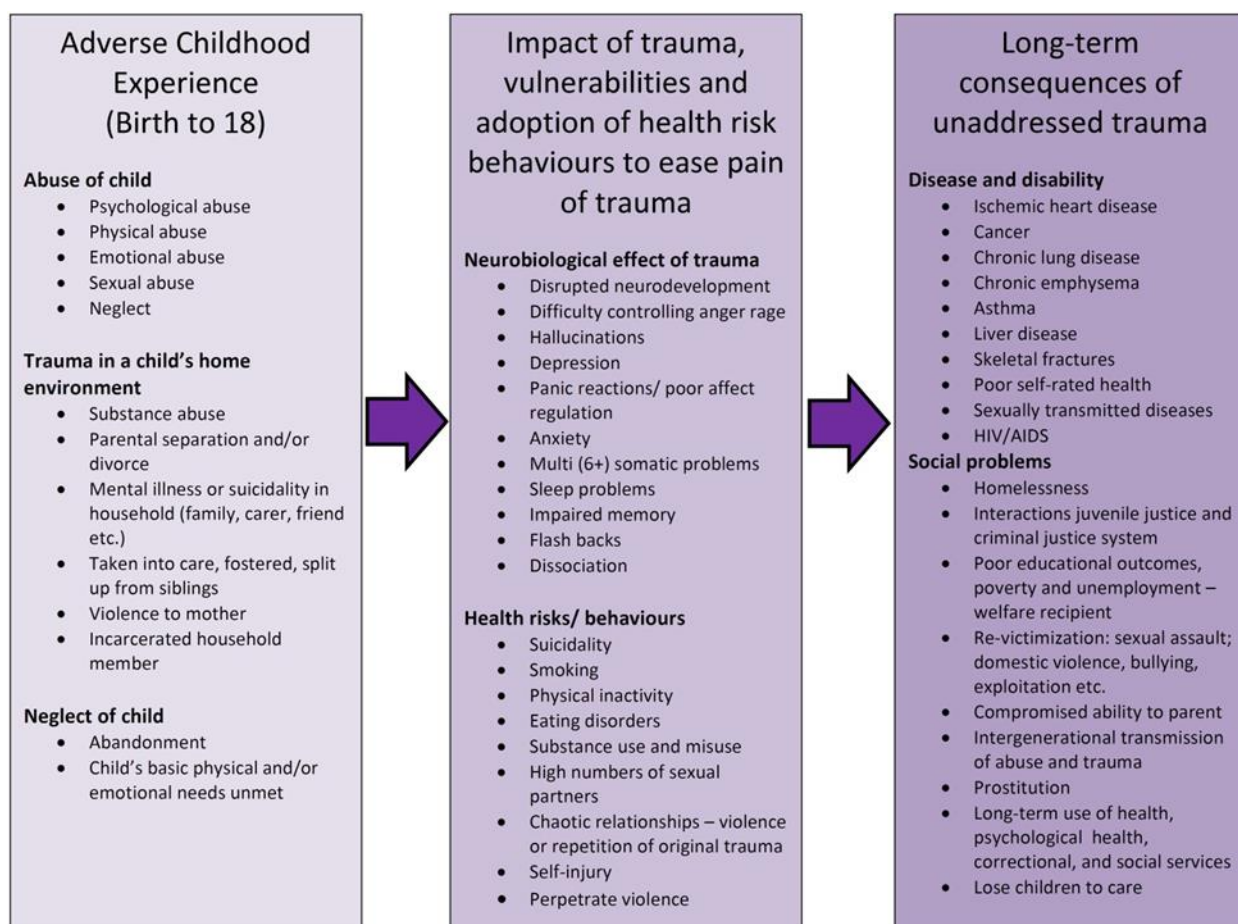
The Damaging Consequences of Violence and Trauma and the Adverse Childhood Experiences (ACE) Study Chart

The chart following shows the sequence of events related to unaddressed childhood abuse and other early traumatic experiences. Without interventions to interrupt the cycle, intergenerational transmission will perpetuate ACEs.

The children of parents whose trauma histories are unresolved often experience intergenerational impacts.⁸⁴ When children experience insecure attachments to their caregivers as a result of trauma it can affect their future relationships. Potential difficulties in adult relationships for subsequent generations can be ameliorated when parental trauma is resolved. *When adults have had difficult childhoods, but have come to create a coherent narrative, they have made sense of their lives* (Siegal, 2006). The children attached to these adults can have secure attachments and do well.⁸⁵

The following chart shows the short- and long-term impacts of adverse childhood experiences. Without intervention, adverse childhood experiences result in long-term disease, disability, chronic social problems and early death.⁸⁶

Chart adapted from The Damaging Consequences of Violence and Trauma (NASMHPD.org). Chart originally created by Ann Jennings, <http://www.TheAnnInstitute.org>. Source reference: Adverse Childhood Experiences Study (CDC and Kaiser Permanente, see <http://www.ACEstudy.org>) Data supporting the model can be found in the *Adverse Childhood Experiences Study* (Center for Disease Control and Kaiser Permanente).⁸⁷



The Adverse Child Experiences (ACE) Study has established that, in the USA, adverse childhood experiences are major risk factors for disease and early death as well as poor quality of life. The greater the number of adverse experiences, the higher the prevalence of negative outcomes, with the coping mechanisms adopted in childhood and persisting into adulthood becoming risk factors for later disease and disability.

In Australia, this understanding of the relationship between adverse childhood experiences, identified in the ACE study, and poor health and social outcomes needs to inform policy and practice. We cannot begin to address the totality of an individual's healthcare, or adequately promote health and/or prevent disease (both tenets of health-care reform) unless we address the trauma that underlies many chronic physical and mental health conditions. Nor can we begin to bring down the spiralling costs of health care.

j. Economic cost

The costs of unrecognised and untreated complex trauma are enormous. This is not only in terms of reduced quality of life, life expectancy and lost productivity, but in significant increases in the utilisation of medical, correctional, social and mental health services.⁸⁸

Total estimated cost of child abuse and neglect in the United States (2012) including costs across all aspects of mental and physical health care, social care and law enforcement totalled over between \$US80 billion⁸⁹ and \$US124 billion across numerous studies in the US.⁹⁰

The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at \$161 billion in 2000.⁹¹ The human costs are incalculable to the victims and their children, family and community.



Source reference: Adverse Childhood Experiences Study (CDC and Kaiser Permanente, see <http://www.ACEstudy.org>)

Taylor et al.,⁹² estimated that the annual cost of child abuse and neglect for all people ever abused in Australia was \$4 billion in 2007, while the value of the burden of disease (a measure of lifetime costs of fear, mental anguish and pain relating to child abuse and neglect) represented a further \$6.7 billion and could be as high as \$30.1 billion. The report also estimated that the lifetime costs for the population of children in Australia reportedly abused for the first time would be \$6 billion, with the burden of disease representing a further \$7.7 billion and could be as high as \$38.7 billion, including the monetary value of the pain and suffering that survivors' experience.^{93 94}

Section 4

Systems

Trauma-specific interventions are one piece of the puzzle, but I am talking about something much broader. We must adopt a systemic approach which ensures that all people who come into contact with the [health system] will receive services that are sensitive to the impact of trauma. They must be able to receive such services regardless of which 'door' they enter or whether they ever find their way to a trauma-specific treatment program. We can begin by recognizing the primacy of trauma as an overarching principle. Being trauma informed means realizing that the vast majority of people we come in contact have trauma histories. Trauma must be seen as the expectation, not the exception in mental health service systems.

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National Council for Community Behavioral Healthcare, Washington DC

1. Current systems' responses

People impacted by trauma characteristically present at a wide range of services. They often have severe and persistent mental health and coexisting substance abuse problems and are frequently the highest users of the inpatient, crisis and residential services. Their challenges are often exacerbated by inadequate responses from the community across mental health and human service sectors.

This document centres on promoting a TICP policy focus and providing the knowledge as to how the evidence can be incorporated into systems and service delivery.

As previously stated, Australia's mental health system has, generally speaking, a poor record in recognising the relationship between trauma and the development of mental health problems, and hence in responding in an informed manner. This has serious implications for survivors' health and wellbeing.

There may be several reasons for current systems' responses including:

- a mental health system based on a 'diagnose and treat' approach which fails to identify or acknowledge the lived experience underlying presentations and their impacts. The current paradigm emphasises diagnosis and treatment by symptom cluster, and does not lend itself to looking at the underlying problem. A clinical assessment informed by a set of Diagnostic and Statistical Manual (DSM) criteria means that the substantive issue of what happened to the person to have affected them so profoundly does not inform service or practitioner responses. In fact it is often relegated to 'interest value' only or not recognised at all;
- resistance by medical professionals to believing the accounts of people disclosing abuse histories without substantiation from other parties/sources and therefore minimising or failing to validate lived experience;
- a society which continues to ignore abuse and minimise its effects, which pathologises and blames the victim rather than providing informed support

and which fails to bring perpetrators and those complicit in covering it up to justice; and/or

- the use of coercive interventions such as seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment, rather than empowerment and choice, often cause unintentional re-traumatisation in already vulnerable populations.⁹⁵

This is illogical given that recognition and integration of experienced trauma is fundamental to the recovery process. While a history of abuse may be mentioned in case notes, a sole focus on symptomology often means that consumers do not receive the holistic care needed to meet their complex needs, so they can find pathways to recovery.

As the impacts of trauma are cumulative, current victimisation and trauma compounds the effects of prior trauma. As previously mentioned, many consumers are at risk of ongoing victimisation (in domestic and family settings).⁹⁶ The effects of violence perpetrated by patients and staff, including in inpatient mental health facilities, also need to be acknowledged. Safety, a core principle of TICP, needs to be made a high priority.⁹⁷

2. Re-traumatisation in services

The following factors relate to re-victimisation in service delivery contexts.

- The symptoms and behaviours with which a trauma survivor may present at a diversity of mental health and human service sectors may result in their being turned away. Many service agencies and programs are specifically targeted towards particular groups, conditions or difficulties and access for people experiencing a number of co-existing problems may ultimately lead to re-victimisation/discrimination because they end up falling through the service gaps.
- Certain presentations are too often regarded as the product of personal weakness or lack of 'will power', rather than being understood as the outgrowth of initially self-protective childhood attempts to cope with adversity. The multiple co-existing diagnoses with which trauma survivors are often labelled including substance abuse and self-harming behaviours attract additional judgements. Viewing a person through a narrow lens which fails to recognise that these symptoms and behaviours can all reflect complex adaptation to early trauma perpetuates such perceptions and substantially affects outcomes.
- Risk of sexual harassment and sexual assault within mental health inpatient settings, especially for female consumers ('Zero Tolerance for Sexual Assault Report', Victorian Mental Illness Awareness Council, 2013;⁹⁸ Davidson, 1997⁹⁹). It is critical that mental health services provide physically safe environments for consumers by monitoring and addressing any forced or unwanted sexual activity.
- Some diagnoses are especially stigmatising, putting people with them at particular risk of victimisation. In some services, and for some practitioners, a diagnosis of BPD for example implies that the individual's personality is flawed, and that there is little hope of recovery. The features of BPD include emotional instability, intense and

unstable interpersonal relationships, a need for relatedness and a fear of rejection. This means that people with BPD often evoke strong emotions in those around them.

Pejorative terms to describe persons with a diagnosis of BPD, such as difficult, treatment resistant, manipulative, demanding, narcissistic and attention seeking are often used, and this may become a self-fulfilling prophecy as negative responses trigger further self-destructive behaviour. The use of the term BPD is inherently re-traumatising to those people so labelled.

- Many consumers who self-harm and present to emergency departments are labelled, condemned and discriminated against because they are considered attention seeking and not deserving of care. They are often treated in a punitive manner that fails to acknowledge or understand the trauma which underlies these 'coping strategies'.
- The medical model is the basis of our primary care system. It works on the basis of symptoms, signs, diagnosis and treatment while focusing little on a person's lived experience. There are many potential triggers for consumers as medical professionals go about their everyday work, especially within a system in which medical practitioners are not alert to trauma dynamics and the potential for re-traumatisation. This lack of awareness around possible triggers can inadvertently lead to re-traumatisation in a general practice or service setting.
- In a medical centre, apparently innocuous events such as being touched or stood over can reactivate the power differential reminiscent of that which occurred at the time of the original abuse. Similarly physical examinations, many of which are intrusive and highly personal, such as having to get undressed (and the feelings of exposure and lack of safety in doing so) can elicit and reactivate experiences of prior trauma and the attendant traumatic reactions. The same can apply to dental procedures when instrumentation in the mouth can trigger traumatic memories.
- Fear of invasive procedures can cause people to avoid seeing their GP altogether for what can be crucial screening tests and procedures and so put them at risk for greater morbidity and mortality.¹⁰⁰
- Acute units often display power hierarchies that exacerbate the risk of re-traumatisation, e.g. use of coercive practices including involuntary detention, seclusion and restraint and enforced medication.

Yet few medical and/or dental practitioners are informed about the possibility of trauma and its dynamics in patients presenting not only with mental health conditions but with a diversity of physical issues as well. Trauma is rarely identified, and may be undeclared and unacknowledged by the patient as well as the practitioner.

Health professionals often unwittingly take on an abusive role when they fail to recognise that the power differential inherent in the relationship between patient and clinician can mirror past abusive relationships.

3. System failures

Trauma survivors often experience services as unsafe, disempowering and/or invalidating. Frequently, after failing to find a service provider who understands their behaviours and reactions in the context of their trauma history, they withdraw from seeking assistance. It needs to be noted that the pervasive impacts of trauma can include *the way people approach potentially helpful relationships* (Fallot et al., 2009).¹⁰¹

Failure to provide trauma-informed services and expertise as well as poor or inequitable access to trauma-specific services exacerbates mental and physical health issues for consumers and escalates the risk of suicide and deliberate self-harming behaviours. Responsive and effective crisis management must be matched by affordable, accessible, ongoing care delivered in a manner maximising consumer self-determination.

Currently in Australia:

- complex trauma and its effects are often unrecognised and misdiagnosed;
- generally mainstream services are unable to address trauma victims' needs;
- people impacted by trauma present to multiple services over a long period of time and often experience poor access;
- care is often fragmented with inadequate coordination between services and poor referral pathways and follow-up protocols;
- a 'merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma; and
- escalation and entrenchment of symptoms is psychologically, financially and systemically costly.¹⁰²

Understanding that trauma underpins the presentations of many people who attend a diversity of service settings necessitates substantially new ways of operating. Many trauma survivors have not connected their current problems and behaviours with their past traumatic experiences and nor have their health or mental health workers. The cost of inadequate service responses individually and in health, welfare and economic terms is immense.

4. Requisites for implementing Trauma-Informed Care and Practice across service settings

Trauma-Informed services, whether in mental health or human service contexts, and whether in public, private or community based settings must be based on principles, policies, and procedures that provide safety, voice and choice. And, as is consistent to all good care, it must be individualised and personalised.

Services must focus first and foremost on an individual's physical and psychological safety, and particularly respond appropriately to suicidality. They must also be flexible, individualised, culturally competent, promote respect and dignity, hope and optimism and be based on best practice. Recent research indicates that the most effective approaches for supporting recovery from trauma are well-integrated psychological/therapeutic health

services that also reflect the centrality of trauma in the lives and experiences of consumers.¹⁰³

It is also important for services to screen for trauma – an activity which few services currently undertake. This deficiency means that often trauma is not identified and hence not addressed. Training in trauma screening should be provided to all mental health professionals otherwise there is a risk of triggering and re-traumatisation. This training will need to include knowledge as to how to create safety and containment and have the ability to manage disclosure and referral processes. Training needs to be developed so that it can be utilised across service settings, i.e. public, community and private.

The multiple symptoms and behaviours with which trauma survivors present can cause confusion among clinicians and treating teams and consumer histories may list several diagnoses and levels of need. Current models of care in public and primary health care settings mostly focus on diagnosis and many complex trauma survivors carry multiple diagnoses.

Services that embed the principles of trauma-informed care and practice will not only move away from the sole focus of diagnoses but also help resolve inconsistencies in diagnosis and facilitate holistic care based on each person's lived experience.

5. Benefits of introducing TICP – International Evidence

Outcome studies in the USA provide substantial evidence related to the benefits for consumers and workers, as well as the cost-effectiveness of introducing trauma-informed care policies and practice.¹⁰⁴

- Trauma-informed service settings, with trauma-specific services available, have better outcomes than 'treatment as usual' for many symptoms. We know from a variety of studies¹⁰⁵ and pilot programs¹⁰⁶ that settings utilising a trauma-informed model report a decrease in psychiatric symptoms and substance use.
- Some of these programs have shown an improvement in consumers' daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms. These findings suggest that integrating services for traumatic stress, substance use and mental health leads to better outcomes.¹⁰⁷
- Early indications suggest that trauma-informed care may have a positive effect on housing stability. A multi-site study of trauma-informed care for homeless families found that, at 18 months, 88% of participants had either remained in existing temporary housing or moved to permanent housing.¹⁰⁸ An outreach and care coordination program that provided family-focused, integrated, trauma-informed care to homeless mothers in Massachusetts found that the program led to increased residential stability¹⁰⁹
- Trauma-informed care may lead to a decrease in crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalisation and crisis intervention following the implementation of trauma-informed care.¹¹⁰

- Trauma-informed, integrated services are cost-effective. They have improved outcomes but do not cost more than standard programming.¹¹¹
- Qualitative results find that providers report positive outcomes in their organisations.¹¹²
- In implementing trauma-informed care, providers report greater collaboration with consumers, enhanced skills and a greater sense of self-efficacy among consumers, and more support from their agencies. Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events and more effective services.¹¹³
- Qualitative results indicate that consumers respond well to trauma-informed care. Within the DC Trauma Collaboration study, consumers reported an increased sense of safety, better collaboration with staff, and a more significant “voice.” Eighty-four per cent of consumers rated their overall experience with these trauma-informed services using the highest rating available.¹¹⁴ Survey results suggest that consumers were very satisfied with trauma-informed changes in service delivery.¹¹⁵

Interesting to note in its Strategic Plan, *Leading Change: A Plan for 2011–2014: Roles and Action*, the Substance Abuse and Mental Health Services Administration (SAMHSA)¹¹⁶ has identified a core purpose as reducing the pervasive, harmful and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, mental health and related systems and addressing the mental health needs of people involved in or at risk of involvement in criminal and juvenile justice systems.

6. Rationale for embedding TICP into Australian service systems

During every incarceration, every institutionalisation, every court-ordered drug-treatment program, it was always the same: I was always treated like a hopeless case.

Tonier Cain, survivor

Tonier Cain is a success story. Today, she is a team leader with the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration USA (SAMHSA) National Center for Trauma-Informed Care (NCTIC).

But for every Tonier Cain, hundreds of thousands of people pass through mental health and human services programs with unacknowledged painful trauma histories every day. The good news is that people with trauma histories can and do recover.

The recognition of trauma is core to accommodating the service needs of trauma survivors. Trauma must be seen as the expectation, not the exception. The NTICP AWG advocate for a systemic approach which ensures that all people in Australia who come into contact with services of any nature, receive care that is sensitive and responsive to the impact/s of trauma. This must occur regardless of the ‘door’ through which they enter or whether they access to a trauma-specific treatment program.

Roger Fallot (2009), clinical psychologist and Director of Research and Evaluation at Community Connections, states that trauma-informed services must *incorporate knowledge*

about trauma in all aspects of service delivery; be hospitable and engaging for survivors; minimize re-victimisation; and facilitate recovery. ¹¹⁷

In Australia, a trauma-informed response must be coordinated across multiple service systems including but not limited to emergency and acute services, mental health care, primary healthcare, substance abuse and domestic violence services. All too often trauma survivors cycle in and out of systems without ever receiving the services they need to support them towards recovery.

7. A Trauma-Informed Recovery-Oriented approach

Recovery orientation has been adopted as an overarching philosophy to guide mental health practice and is embedded into policy and standards nationally. An understanding of trauma is integral to a recovery-oriented approach. In fact developing and implementing trauma-informed systems of care is one of the first steps towards becoming recovery oriented. ¹¹⁸

The fundamental shift in philosophy, culture, practice and understanding needed to adopt recovery-orientation parallels that needed to move to a trauma-informed approach. As we work to minimise systems barriers to recovery so too must we also work to reduce the possibilities for re-traumatisation and harm within service systems and practice.

Trauma-informed approaches like recovery orientation are person centred and involve sensitivity to individuals' particular needs, preferences, safety, vulnerabilities and wellbeing, recognise lived experience and empower consumers to participate in decision making.

Victorian Department of Health, 2011 ¹¹⁹

In addition, trauma-informed care involves recognition of lived experience of trauma and the particular 'triggers' that may lead to re-traumatisation and re-victimisation. In trauma-informed recovery-oriented services, care of people experiencing mental health conditions and associated difficulties must consider the possibility of trauma and its impact in relation to recovery. While not advocating that workers should elicit disclosure (unless appropriately conducted in the context of a safe therapeutic space by a practitioner trained to work with complex trauma, its effects and be able to offer containment), practitioners should integrate trauma-informed care and practice in supporting people on their recovery journeys in any environment.²

Due to the prevalence of trauma among people with mental illness and its broad applicability trauma-informed care can be considered appropriate in all service delivery contexts, not just in treatment of consumers with known experiences of previous trauma. ¹²⁰

² There are many therapeutic models commonly used in government and community services as well as in private practice nationally and internationally. They may be used integratively or as specific therapeutic models such as Dialectical Behaviour Therapy (DBT) or psychodynamic models, e.g. Conversational Model. For more information on some models, see MHCC, 2010, *Reframing Responses Stage 11 Supporting Women Survivors of Child Abuse: An Information Resource Guide and Workbook for Community Managed Organisations*, <http://www.mhcc.org.au/documents/Projects/Reframing-Responses-Resource-Guide-and-Workbook.pdf>

However, it should be noted that not everyone with a diagnosed mental illness/disorder has experienced trauma and not all traumatised people have a mental health problem or diagnosis.

8. Why we need to change cultures and systems:

- Lack of awareness around trauma

The evidence highlights the need for greater awareness by mental health and human services about the complex sequelae of childhood, adolescent and adult trauma, and the need to implement effective systems of care. These include the provision of a 'no wrong door' approach, to ensure that no one is denied access to services because of a particular diagnosis or condition perceived to be untreatable or because of a lack of capacity to meet some of the needs of a person with a trauma history and attendant complex mental health and psychosocial difficulties.

- Failures to identify and respond appropriately to complex and intergenerational trauma

There is now a wealth of research related to the effects of complex trauma on the developing brain not just in infancy but right through the life cycle. Research has also identified the capacity for the brain to repair and so for those affected to recover and these research findings have substantial implications for mental health responses. Research shows that resolution of trauma equates with neural integration.¹²¹ Neural integration is actively impeded by unintegrated human services which are not only compartmentalised, but which lack basic trauma awareness and may re-victimise and re-traumatise clients.¹²²

Research also demonstrates that longstanding trauma can be resolved, and its negative intergenerational effects intercepted.¹²³ Positive relational experiences have great healing potential while negative relational experiences compound emotional and psychological problems. Since healing is relational, positive experiences need to take place within services and organisational settings accessed by those with trauma histories. For this to occur, mental health, human and specialised services need to reflect the current research insights.

- Poor consumer outcomes

Hubble, Duncan and Miller (1999) reviewed a large number of studies about factors which influence therapeutic outcomes, primarily in mental health settings. They found that 60% of positive outcomes are dependent on elements of service delivery and the nature of relationships between practitioners and consumers.¹²⁴ Given that interpersonal trauma is experienced in the context of relationships, those undertaking care and practice relationships in services need to be trauma-informed.

- Recognition of re-traumatisation

Currently the majority of trauma survivors cannot access and/or afford to sustain the holistic support they need to make sense of their histories and work towards recovery. Trauma-informed care recognises that receiving mental health care can be traumatic (Mueser, Rosenberg & Wolfe, 2010). Some events that occur in the process of accessing and receiving mental health services constitute a primary trauma, while some aspects of care

reflect the dynamics of prior trauma, and are re-traumatising. These include but are not limited to being scheduled and experiencing involuntary admissions, seclusion and restraint practices, mistreatment/abuse of power by staff including the overuse or misuse of some psychotropic medications as well as treatments such as ECT.¹²⁵

Some routine processes in mental health services are distressing for some consumers. Frueh et al. (2005)¹²⁶ interviewed 142 patients receiving mental health care in a public mental health unit. They collected information on their lifetime experience of a range of potentially traumatic events, aspects of the mental health service environment and the degree of distress, trauma symptoms and perception of safety within the service. They note the distress associated with a loss of control for consumers in this environment, and make strong recommendations for increased attention to safety within inpatient settings in particular. Frueh et al. (2005) also found evidence that those who have survived previous trauma (sexual and physical abuse as children and sexual assault as adults) are more likely to experience coercion and restraint by mental health staff.

- Siloed services versus holistic response

The co-occurrence of past and/or current trauma, mental health, co-existing psychosocial and substance-abuse issues presents complex clinical challenges. Existing service systems are often siloed, taking a compartmentalised approach to people with complex trauma, determined by a single diagnosis or presentation. Significant barriers to recovery related to fragmented service responses are further exacerbated by limited trauma screening, as well as a lack of specific trauma services and cross-services training (Domino et al., 2005).¹²⁷ All services need to be trauma-informed whether they provide specialised trauma services or are providing a range of psychosocial care and support programs.

- Respect for lived experience of trauma – consumer involvement in policy development

Consumer participation in mental health services has been acknowledged nationally and internationally as the cornerstone of mental health policy (Steward et al., 2008).¹²⁸ Consumer participation across service systems provides opportunities to improve mental health services, tackle negative community attitudes, promote a better quality of life for consumers and assist in the recovery process. Consumer participation and leadership is crucial to transforming mental health services into trauma-informed recovery-oriented services. A focus on wellness rather than illness drives this response. The need for this approach has been recognised in some services including within Aboriginal and refugee populations, although it needs to be integrated more broadly.

Section 5

Trauma-Informed Care and Practice in Australia – A National Strategic Direction

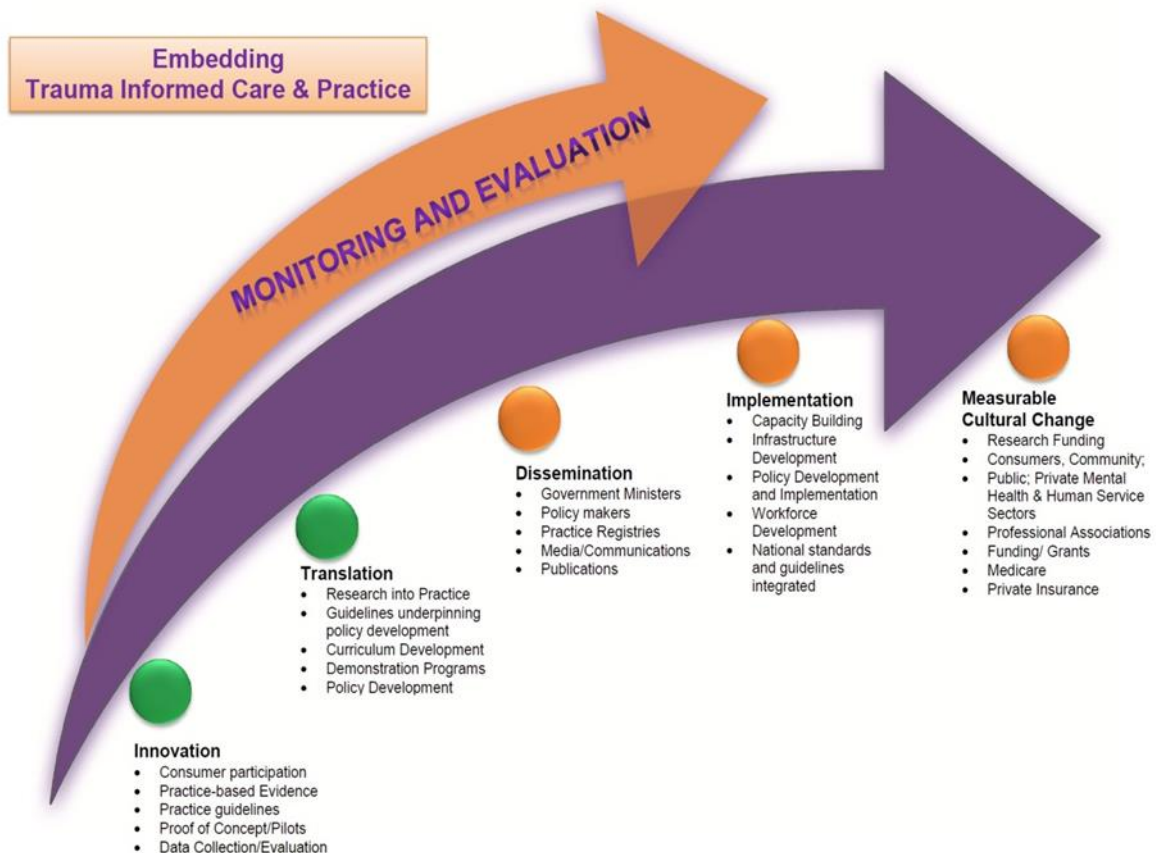
The major challenge to implementing trauma-informed services is the comprehensive nature of the change required.

Norma Finkelstein, Executive Director &
Laurie S Markoff, Director of Trauma Integration Services
Institute for Health and Recovery, Cambridge, Massachusetts

The diagram below describes:

- the journey undertaken by the NTICP AWG and others to date to progress the TICP agenda; *and*
- the future journey required for policy reform and cultural change.

Substantial progress has been achieved in the areas of **Innovation** and **Translation**. The focus must now be on **Dissemination** and **Implementation** in order to achieve **Measurable Cultural Change**.



Scope of reform

a) Mental health in Australia: current policy and workforce challenges

The Australian Institute of Health and Welfare (AIHW) publication *Mental health services in Australia – in brief* (2012)¹²⁹ stated that over \$6.3 billion or \$287 per Australian was spent on mental health-related services during 2009/10. This was funded by a combination of State and Territory Governments, the Australian Government and private health insurance funds. Expenditure on services increased by an average annual rate of 4.5% per Australian between years 2005/06 and 2009/10.

Over \$3.9 billion was spent on state and territory specialised mental health services (running costs only) in 2009/10. The largest proportion was spent on public hospital services for admitted mental health care (\$1.7 billion). Community mental health care spending accounted for \$1.5 billion in 2009/10. A further \$220 million was spent on residential mental health services, with the majority spent on 24-hour staffed services. Expenditure on state and territory specialised mental health services increased on average annually by 3.4%.

*The Fourth National Mental Health Policy: An agenda for collaborative government action in mental health 2009–2014*¹³⁰ provides an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community. This vision was promoted in the context of the social inclusion agenda, which focuses on engagement of the whole community, especially in areas of social and economic disadvantage.

Despite considerable expenditure and vision, we have largely failed to *address weaknesses and gaps in services* to people with mental illness as a consequence of complex trauma. We now have ample evidence, knowledge and will to progress this agenda through policy development, standards and guidelines and practice frameworks.

- National Recovery-Oriented Mental Health Practice Framework and Recovery-Oriented Service Self-Assessment Tool (ROSSAT)¹³¹
- ASCA Practice Guidelines

The Commonwealth Government's report: *A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission* (June 2009)¹³² recommended a particular focus on improving care for people with (or at risk of) serious mental illness. The authors stated that, *Getting the right support and care services for people with severe mental illness involves some fundamental changes to how we organise care. We set out ways to ensure there is a range of treatment and support services connected across the spectrum of care.*

The system has not only failed to provide prevention and early intervention initiatives for people who have experienced interpersonal trauma and better management of mental health disorders as a consequence of complex trauma, but has failed to offer the right types of specialist services when people experience a crisis, and/or need ongoing care. A first step in the process to correct these deficiencies is to build workforce capacity across service systems through training and education.

The Community Services and Health Industry Skills Council Environmental Scan 2012 has identified that *workforce changes are occurring in parallel to, and as part of, industry reform, with major change themes including a shift towards interdisciplinary practice and person-centred models of service, an increasing focus on service delivery within the community setting, an emphasis on client functional independence and increasing recognition of complex and multiple needs* (p.15).¹³³

A key recommendation for continuous improvement of the mental health workforce training packages included: examination of potential for higher-level competency standards, qualifications or skill sets reflecting advanced practice and practice leadership, and examination of expansion of care-coordination roles and skills/practices to support increasingly complex needs, including trauma-informed care and talking therapies.

*Optimal mental health [service delivery] is an individualised process where providers collaborate with service users to tailor the best possible services and supports for that individual, based on the person's needs, strengths, preferences, and recovery goals.*¹³⁴

Mental Health Coordinating Council 2012,
Service Coordination Workforce Competencies: an investigation into service user and provider perspective

People with mental health and trauma-related problems may interact with a range of mental health and human service sectors across the lifespan. The quality of care, treatment and support a person receives often depends on the health professional/s they encounter, and the discipline in which those professionals were trained. The multiplicities of clinical and psycho-social perspectives are as varied as individuals' lived experiences. Responses exist along a divided philosophical and theoretical continuum between 'medicate and manage' and 'trauma-informed recovery-oriented practice'. Certain treatment models and interventions criticised in one domain can be widely endorsed elsewhere.

In a National Inquiry into the Human Rights of People with Mental Illness, a report tabled in Parliament in 1993, Commissioner Brian Burdekin wrote: *some professionals place an over reliance on symptomatology and purely medical models to the exclusion of psycho-social and environmental factors in diagnosing psychiatric disorders* (Chapter 5).¹³⁵ While all modalities have their critics, the medical model has been highlighted here because it is the dominant model utilised by clinicians working in mental health settings. The emphasis has changed little since Burdekin's comments.

We need greater collaboration and improved communication within and between service systems and professional disciplines to deliver effective holistic service/care coordination. This includes trauma-specific services.

b) Costs of retaining the status quo: health utilisation, burden of cost – to individuals and communities

Women adult survivors represent the greatest percentage of women requiring services from women's and community health centres and mental health services (NSW Health, 1998).

In 1997/98, child victims accounted for 34% of all presentations; there is little recent data unfortunately. While adults who experienced recent sexual assault accounted for 42% of presentations, adult survivors comprised 24% of victims seen by Australian sexual assault

services. Comparative studies in the USA have shown similar rates of mental health service utilisation. Unfortunately there is scant data that relates to male trauma/mental health service utilisation.

A study by Walker et al. (1999)¹³⁶ in the USA examined health care utilisation, and found that women who reported a history of child sexual assault (CSA) were more likely to visit hospital emergency facilities and had annual total health care costs significantly higher than those without abuse histories. These differences were observed even after excluding the costs of mental health care. Survivors of CSA also appear to utilise high levels of health care (more physician visits and higher outpatient costs) than women who have been victims of other types of crime (e.g. theft) (Koss et al., 1991).¹³⁷

In terms of burden of cost of mental health in Australia, the comprehensive assessment of the health status of Australians published in 2007 states the following.

*Child sexual abuse was responsible for 0.9% of the total burden of disease and injury in Australia in 2003. Ninety-four per cent of this burden was due to anxiety and depression, suicide and self-inflicted injuries and alcohol abuse. Of the 14 risk factors examined, child sexual abuse was the second leading cause of burden in females under the age of 45. Just over four-fifths of the burden from child sexual abuse was experienced by females and 14% was due to mortality. The burden from child sexual abuse both in terms of rate per head of population, and in absolute terms, peaked at around 40 years old and then declined with age. The contribution from anxiety and depression dominated at this age after which contributions from suicide and self-inflicted injuries and alcohol abuse became increasingly important.*¹³⁸

Australian Bureau of Statistics 2007,
The burden of disease and injury in Australia 2003

These figures are undoubtedly low as a result of lack of screening and identification of underlying trauma.

According to the ABS (2007) the prevalence of mental disorders is the proportion of people in a given population who meet the criteria for diagnosis of a mental disorder at a point in time. There were 3.2 million people who had a 12-month mental disorder. In total, 14.4% (2.3 million) of Australians aged 16–85 years had a 12-month Anxiety disorder, 6.2% (995,900) had a 12-month Affective disorder and 5.1% (819,800) had a 12-month Substance Use disorder.¹³⁹

Women experienced higher rates of 12-month mental disorders than men (22% compared with 18%). Women experienced higher rates than men of Anxiety (18% and 11% respectively) and Affective disorders (7.1% and 5.3% respectively). However, men had twice the rate of Substance Use disorders (7.0% compared with 3.3% for women).

According to the AIHW (2009)¹⁴⁰ the national recurrent expenditure on mental health services in 2006–07 was estimated to be \$4.7 billion. Of this total, 62% (\$2.9 billion) came from state and territory governments, 34% (\$1.6 billion) from the Australian Government and the remaining 4% (\$177 million) from private health insurance funds.

An estimated 12 million GP-patient encounters in 2007–08 involved management of a mental health issue, with the number of encounters growing by an annual average of 4.4% since 2003–04. The majority of these encounters were not claimed as Medicare mental health-specific items, and therefore are not included in the estimated national expenditure on mental health-related services. Community mental health and hospital outpatient services provided close to 6 million mental health-related service contacts to mental health consumers in 2006–07, an increase of more than 5% from 2005–06.

According to the report *Mental Health Services in Australia 2009*,¹⁴¹ there were 20 million mental health-related prescriptions subsidised through the Pharmaceutical Benefits Scheme in 2007–08, accounting for just over one in ten of all prescription claims. While the number of prescriptions decreased by 0.4% per year on average from 2003–04, spending on these mental health-related prescriptions was over \$700 million, with prescriptions for antipsychotics and antidepressants accounting for just over 90% of the total.

From 2002–03 to 2006–07, the number of beds in specialised psychiatric wards of public hospitals increased on average by just over 3% to around 4,200 beds, while over the same period, stand-alone public psychiatric hospitals beds decreased by 1.6% to just over 2,200 beds.

Collins and Lapsley (2008b)¹⁴² calculated the tangible social costs which are borne by the community as a result of alcohol and illicit drugs being consumed together amounted to \$1,057.8 million. The total social costs of alcohol abuse (both tangible and intangible) in 2004/05 are estimated to be, at a minimum, \$15.3 billion, with a further \$1.1 billion attributable to the joint consumption of alcohol and illicit drugs.

The introduction of ‘trauma and its impacts’ screening in the USA, in the form of a well-designed questionnaire with some staff training, on evaluation elicited a 35% reduction in doctor visits, an 11% reduction in emergency visits and a 3% reduction in hospitalisations the following year.¹⁴³

The well-established links between complex trauma, mental illness and co-existing health and psychosocial difficulties and these compelling statistics cannot be ignored.

Creating a trauma-informed system of care requires cross-system collaboration around information collection and sharing, training, a common vision across public and private systems, and the ability to blend funding in a way that creates a seamless system. It also requires leadership.

Laura Huot, 2011, Director of Children’s Community Mental Health and Deborah Willis, Director of Research and Evaluation, The Guidance Center, Wayne County, Michigan¹⁴⁴

c) Systems for change – broader implementation

Criteria for Building a Trauma-Informed Mental Health & Human Services System

The following elements should be in place across all service systems committed to meeting the needs of people who have histories of trauma.

Administrative Policies/Guidelines regarding systems

1. *Trauma function and focus in Australian state mental health departments.* A single, high-level, clearly identified point of responsibility should exist within each state administrative structure charged with implementing trauma-informed service systems. This could be a unit or office within the health and human services department, with high-visibility leadership and a clear framework for implementation across the service system.
2. *National Government trauma policy or position paper.* A written policy or position statement should be adopted and endorsed with bi-partisan support and sign off from State and Commonwealth Governments, and disseminated to all parts of the service system, stakeholder groups and other collaborating systems. This document should include a definition of interpersonal violence and trauma, make a clear statement about the relationship between complex trauma, mental health and recovery, and publicly declare trauma to be a priority health and mental health issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed service system.³
3. *Workforce Recruitment, Hiring and Retention.* The system should prioritise recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. This priority should be clearly described in job descriptions and postings. These staff and/or ‘trauma-champions’ provide much-needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They will advocate for consideration of trauma in all aspects of the system. There should be outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organisations, peer-led and peer-support programs, consumer advocacy groups and other training sites).
4. *Workforce orientation, training, support, job competencies and standards related to trauma.* All human resource development activities should: reflect understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address the prevalence and impact of traumatic events. Administrative policy should support accomplishment of the following goals.

All employees, including administration, should receive orientation and basic education about the prevalence and traumatic impacts of interpersonal abuse and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduction of harm, curriculums used for orientation and basic training should

³ The NASMHPD Position Statement on Services and Supports to Trauma Survivors (www.nasmhpd.org) is a useful reference and was utilised to inform this position paper.

cover dynamics of re-traumatisation and how insensitive practice can mimic original abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability and socio-economic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing.

Direct-service staff and professionals providing clinical care should be educated in a trauma-informed understanding of unusual or difficult behaviours; in the maintenance of personal and professional boundaries; in trauma dynamics and avoidance of iatrogenic re-traumatisation; in the relationships between trauma and mental health symptoms and other problems and life difficulties, and in vicarious traumatisation and self-care. They should learn application of trauma-informed approaches in their specific content areas (including crisis response), and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients. Curriculums and training programs for direct service and clinical staff should cover these issues.

Input from and involvement of persons (consumers and staff) with lived experience of trauma should be a part of all employee and staff trauma trainings.

Staff whose work includes assessment and treatment should be required and supported to implement evidence-based and promising practices for the treatment of trauma. Whenever possible, training and training programs should be multi-service system, inclusive of staff in mental health and substance abuse, suicide prevention and critical incident, health care, education, criminal justice, social services systems and agencies, and promoting systems collaboration, coordination and integration.

5. *Undergraduate education in universities and accredited colleges.* Professional organisations and universities should be approached to offer curriculums preparing students to work with trauma survivors. Support and training should be provided for direct-care staff to address impacts on staff of trauma work. There should be a written policy and regularly monitored plan for building and supporting workforce trauma-competency in all aspects of the service system.
6. *Consumer/Trauma Survivor/Recovering person involvement in trauma-informed practice implementation.* The voice and participation of consumers with lived experience of trauma should be actively encouraged and consumers involved in all aspects of systems planning, oversight, and evaluation.

Consumers with trauma histories should be significantly involved in staff orientation, training and curriculum development and play a lead role in the creation of state mental health plans, the improvement of access and accountability for people with mental health conditions and in orienting the mental health system towards trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g. right to trauma treatment, freedom from re-traumatisation, and rights to maximise choice, self-determination, collaboration and empowerment) and to the ways in which these rights may be systematically violated. Administration-level policy or position statements should support these goals.

Administrative Policies/Guidelines regarding Services

7. *Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising practice trauma treatment models and services.* Funding strategies should be linked to promising practices. This would help to eliminate disparities in mental health services by improving access to evidence-based and promising practices in trauma care.

Financing criteria and mechanisms to support the establishment of trauma-specific services. Many survivors require long-term treatment and care, generally unavailable in the public and community-based sectors, and often unaffordable in the private sector. Promising practices in trauma treatment must be utilised to meet the care and treatment needs of the high percentage of clients with unaddressed complex trauma histories. This will require commitment to new funding strategies, key to a successful change strategy.

8. *Practice guidelines for working with children and adults with trauma histories.* Findings from studies, including the Substance Abuse and Mental Health Administration's (SAMHSA) *Women, Co-occurring Disorders, and Violence* study¹⁴⁵ increasingly provide evidence that trauma treatment is effective. Numerous practice approaches have been manualised and guidelines have been developed. Practice approaches to trauma treatment should clearly identify trauma as the issue being treated, promote recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, address secondary trauma and self-care for the caregiver, respect cultural diversity, and be experienced as empowering by consumer/survivors. (It should be noted that this may involve protracted care.)
9. *Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid re-traumatisation.* Policies and regulations that guide system-wide practices are central to ensuring that trauma-informed and trauma-specific assessment and services are adopted consistently. Trauma-informed policies and procedures are crucial to reducing or eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. Such practices must be carefully reviewed, revised, monitored and required to take into account the needs of trauma survivors. Licensing, regulations, certification, quality improvement tools and contracting mechanisms should all reflect a consistent focus on trauma. Policies and regulations addressing confidentiality, involuntary hospitalisation and coercive practices, consumer preferences and choice, privacy, human resources, rights and grievances for employees are also key issues. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services.
10. *Needs assessment, evaluation, and research to explore prevalence and impacts of trauma, assess trauma survivor satisfaction, service utilisation and needs, and to monitor and make adjustments in trauma-informed and trauma-specific service approaches.* Data on trauma prevalence, trauma impacts, effectiveness of trauma services and consumer satisfaction can provide rationale for support/funding of such services and the training necessary for their implementation. Such data should be regularly collected and used as part of ongoing quality improvement and planning processes. Evaluation and research

activities should be carried out through internal staffing or through liaison with external evaluators and researchers, to determine the effectiveness of systems change to a trauma-informed system, and to identify outcomes of trauma-related services. These findings are incorporated into ongoing service modifications and planning.

Trauma Services

11. Trauma screening and assessment. Trauma screening and assessment should be undertaken on adults and children seeking clinical care when they have been identified as individuals with a past history of abuse and trauma or are at current risk. Trauma screening should be undertaken for all those who enter any system of care, regardless of which ‘door’ they enter. They should be screened at or close to admission by staff members who have undertaken trauma and assessment training (as detailed in the ASCA Practice Guidelines).¹⁴⁶ It should be clearly understood that these people may require ongoing support, particularly since referral options may be limited. At a minimum, questions should be appropriate to seek histories of physical, emotional and sexual abuse, domestic violence and having witnessed violence to others. Individuals with a positive response to the screen should have a trauma assessment as an integral part of the clinical picture, to be revisited periodically and used as a part of all care and support, treatment, psycho-social recovery and discharge planning. Clients with trauma histories should be informed about and where possible referred to quality, trauma-informed and trauma-specific services and supports.

12. Trauma-informed services and service systems. A ‘trauma-informed’ service system and/or organisation is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health, drug and alcohol and psychosocial services. A ‘trauma-informed’ organisational environment may be capable of supporting and sustaining ‘trauma-specific’ services as they develop (see definitions, p 9).

A trauma-informed system recognises that trauma results in multiple vulnerabilities and affects many aspects of a survivor’s life over the lifespan. Such a system will coordinate and integrate trauma-informed activities and training together with recovery-oriented services together with other elements of care that they may be delivering to trauma survivors. A good understanding of trauma and trauma dynamics shown to be prevalent in the histories of mental health consumers should be held by all staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid re-traumatisation.

People within a trauma-informed service system are knowledgeable and competent to recognise and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, whether interpersonal in nature or caused by natural events and disasters. There should be written plans and procedures to develop methods to identify and evaluate improvements and outcomes. Training programs for this purpose should be implemented.

13. Trauma-specific services, including evidence-based and promising-practice treatment models. Services designed to address the sequelae of interpersonal abuse and other psychological trauma should be available in adequate numbers to serve the population and should be accessible to all consumers, including adults, adolescents, and children and their

families. As part of national research initiatives (including the SAMHSA *Women, Co-Occurring Disorders, and Violence* study and SAMHSA's National Child Traumatic Stress Network) numerous evidence-based and promising-practice trauma-treatment models appropriate for adults or children and applicable in public sector service systems, have been manualised and in many cases proven to be effective in reducing symptoms.⁴

Although program models may vary widely, all should be recovery-oriented, emphasise consumer voice and consumer choice, and be trauma-informed. In addition, because of the numbers of adult and adolescent trauma survivors with co-occurring difficulties and conditions, and given significant positive findings from numerous studies, trauma-treatment programs should provide integrated trauma, mental health and substance abuse services which address all three issues simultaneously.

Adapted in this paper from original and subsequent sources:
Jennings, A, 2004, 'Models for Developing Trauma-Informed Behavioural Health Services: Strategies emerging from the States', *Psychosocial Rehabilitation Journal*, Spring pp 1–15; then adapted by Blanch, A, 2003, 'Developing Trauma-Informed Behavioral Health Systems: Report from NTAC National Experts Meeting on Trauma and Violence'

d) Current developments in Australian TICP reform

Guidelines and accountability

1. Guidelines

The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery (ASCA, 2012, Authors: Kezelman, C & Stavropoulos, P) is a concrete reference for becoming trauma-informed and measuring improved outcomes. The Guidelines are a mechanism for achieving the first strategic recommendation identified by the NTICP AWG (p 7).

The Practice Guidelines focus on two areas, Complex Trauma (clinical) and Trauma-Informed Care and Service Delivery (organisational) which are proposed as standards in both areas: 1) to serve the needs of a range of services across service systems in community, public and private settings who wish to become Trauma-Informed and 2) specifically for trauma-specific services.

For the purposes of this position paper specific reference is made to the *Trauma-Informed Care and Service Delivery Guidelines: **Organisational***. These guidelines were developed in recognition of the need for health and other human service systems to be aware of the possibility of trauma in their diverse client groups (distinct from and in addition to trauma-specific services which directly cater to this need).

The format in which the section of the Guidelines **Organisational** are presented reflects both the diversity of material relevant to trauma-informed practice and the diversity of organisational and service settings to which it would be applied.

⁴ NOTE: Many of these evidence-based and promising practice models have been identified in the SAMHSA publication 'Models for Developing Trauma-Informed Behavioural Health Systems and Trauma-Specific Services'

Section I, 'Philosophy and Vision' outlines the core principles which underlie and infuse care and trauma-informed practice.

Section II, 'Mapping to Practice', is divided into two parts:

- (a) System level and
- (b) Service level

To aid clarity, Guidelines in both these sections are initially presented in summary form, and then reiterated and expanded with additional commentary to aid their practical translation.

In this second more detailed iteration, a number of key points are presented to assist application of trauma-informed principles at (a) Systems level. In light of the diversity of services to which TIC principles are applicable, Part (b) Service level lists recommended steps with reference to the concept of domains.¹⁴⁷ It also lists the corresponding steps that may need to be undertaken in relation to these.

Additional sections are presented in relation to service policies and screening for trauma. Within each of these sections, questions are posed to aid application to individual service environments.

While these Guidelines provide the principles for practice implementation formal training is recommended.

2. Accountability

a) The National Center on Family Homelessness (NCFH) developed the *Trauma-Informed Organizational Self-Assessment* to translate the principles of trauma-informed care into concrete practices that can be incorporated into daily programming (in shelter and housing programs). This tool is designed to be used by programs to: 1) evaluate programming based on how well they incorporate self-assessment practices; 2) identify areas for organisational growth; and 3) make practical changes using the self-assessment as a guide.¹⁴⁸

b) MHCC has developed an overarching policy document *Integration of a Trauma-Informed Care and Practice Approach*. The purpose and scope of this policy is to enable every part of an organisation, including administration, management and service-delivery systems, to be assessed and modified to incorporate Trauma-Informed principles into practice. The template is available in Appendix 2.⁵

c) MHCC is developing a *Trauma-Informed Care & Practice Organisational Toolkit* (TICPOT).⁶ This policy and practice implementation tool for community mental health and the human service sectors will assist services and their workforce to develop policies and practice that both embed TICP principles into every aspect of their organisation *and* evaluate outcomes. The toolkit will provide the necessary resources to transition from research into practice (Appendix 5).

⁵ Also available online at: <http://mob.mhcc.org.au/media/5956/diversity-trauma-informed-care-practice-policy-2013-06-03.pdf>

⁶ Note: more details on the MHCC TICPOT Toolkit (Appendix 5)

Innovation

The national TICP agenda has been significantly progressed by the development of specific resources which assist mental health services and their staff to become trauma-informed.

a) Policy: *Integration of a Trauma-Informed Care and Practice Approach Policy.*

This is included in the ***MHCC Organisation Builder (MOB) – Policy Resource*** (Appendix 2). This policy has been developed to enable every part of an organisation, including administration, management and service-delivery systems to be assessed and modified to incorporate trauma-informed principles into practice.

The innovation process has been informed by the international evidence base and outcome evaluation of programs underpinned by the principles. Integral to the process has been consumer participation at all level of policy and program development.¹⁴⁹

b) Policy and Practice: Trauma-Informed Care and Practice Organisational Toolkit (TICPOT)

The development of *TICPOT* is targeted at the community managed mental health and human services sectors in Australia. It fills a gap in resources in the Australian context by assisting organisations and their workforce to progress from the ‘What’ to the ‘How’, transitioning from research into practice. It sets out to recommend practices to support organisations to develop TICP policies and practice into every aspect of their organisation. This requires an organisational culture shift and commitment to facilitating re-orientation towards trauma-informed recovery by incorporating these values into organisational change processes.

TICPOT will provide a package that supports training and professional development, identifying the processes managers and the workforce can utilise to implement organisational change.

Specifically *TICPOT* will be designed to assist organisations and staff:

- at an operational level
- in service planning and evaluation
- in the delivery of services and programs
- In the provision of workforce development and training to support best practice

TICPOT will provide organisations with information about trauma and overview of TICP principles and practice together with a set of guidelines, templates, checklists and assessment tools on how to modify their practices and policies to ensure that they are responding appropriately to the needs of people who have experienced traumatic stress.

Whilst the exact contents are in draft, *TICPOT* is likely to include certain basic elements such as:

1. TICP User Guide

- Introduction to TICP and brief overview of evidence base

- Information about what it means to be trauma-informed and provide trauma-informed services, and why this is important to consumers and services

2. Organisational TICP Tools, Templates and Checklists

- A tool designed to assess and evaluate organisations
- A tool that assists managers to assess and evaluate services and programs
- A tool designed to self-assess workers and evaluate understanding of TICP workplace culture
- A tool to measure consumer outcomes and experience of service

3. How-To Manual for creating Organisational Change

- Identify concrete steps for organisations to become trauma-informed – creating TI environments and approaches
- Identify ways to implement organisational change including policy development
- Sustaining trauma-informed Change: supporting organisational culture and commitment – continuous review; practice supervision; training and professional development; and other frameworks to guide practice
- Recommended practices for awareness of trauma and assessment of risk that ensure safety and minimise re-traumatisation

c) Practice/Practice Guidelines

The research presented in the ASCA Practice Guidelines¹⁵⁰ mentioned in the earlier section (Scope of Reform: current developments in Australia, p 34) is grounded in two decades of national and international evidence. It establishes the need for core principles of practice to be adopted by two sets of stakeholders: clinicians working with people with a lived experience of complex trauma and workers in a broad spectrum of service settings to which people with unresolved trauma present.

The Guidelines establish a framework that responds to the national health challenge of trauma and set standards in each of the following domains.

- ‘Practice Guidelines for treatment of Complex Trauma’ are for the clinical context, and reflect growing insights into the role of trauma in the aetiology of mental illness and new possibilities for clinical treatment.
- ‘Practice Guidelines for Trauma-Informed Care and Service Delivery’ are directed to all services with which people with trauma histories come into contact.

Prior to their release the Guidelines were endorsed by the NTICP AWG as well as by a large number of experts in the complex trauma field both in Australia and overseas (Appendix 3).

Professor Louise Newman, Psychiatrist and Director, Centre for Developmental Psychiatry and Psychology, Monash University wrote in her endorsement of the Guidelines that *with these important guidelines comes an opportunity to develop Trauma-Informed systems of care and to progress approaches to prevention and early intervention.*

Translation

a) Workforce development and training

Understanding that trauma may underpin the complex presentation of many people to public, private and community-based services, this paper proposes a national approach that develops and implements evidence-based practice models and programs, building capacity through supporting workforce education and training, data collection, research, outcome measurement and evaluation and ongoing research.

Several NTICP AWG partner organisations have developed and deliver a variety of trauma-based training and professional development opportunities to a range of workers, services and practitioners across Australia. Many other service providers and health practitioners from a range of disciplines also offer training across Australia.

b) Workforce capacity building

MHCC in collaboration with ASCA ran its first workforce development training orientation in trauma-informed care and practice in November 2012 – *Understanding and Responding to Trauma: Trauma-Informed Care in mental health and community-based services*. This course was designed for workers within the mental health and community-service sectors who support people who may have experienced trauma in the context of interpersonal relationships. The course provides an understanding of the principles of trauma-informed care and applying them in the workplace, as well as understanding the relationship between recovery-oriented practice and trauma-informed care. Learnings include understanding trauma and the impact on the individual, the family and communities and individual responses that may result in complex mental and physical health and psychosocial difficulties. The demand for this training was substantial and the MHCC is currently developing a TICP orientation unit under the range of VET qualifications that comprise the Certificate IV in Mental Health while recommending that a TICP unit be compulsory for both the Cert IV and Diploma in Mental Health qualifications.

Implementing Trauma-Informed Practice is an intensive one-day workshop directed at leaders and managers in organisations who are in a position to embed and implement trauma-informed policies and practices at an organisational and service/program level. This workshop cements earlier learnings from *Understanding and Responding to Trauma* and provides the resources to support staff and determine priorities for organisational change, including self-assessment of current practices.

MHCC also offer a workshop, *Trauma-Informed Approaches to Aboriginal Wellbeing*, designed, developed and delivered by Aboriginal people for workers in the mental health or community-service sectors who support Aboriginal people impacted by trauma. This includes generational trauma, family violence, sexual assault, alcohol or drug problems and mental distress. Created by We Al-li, this workshop is a celebration of life – a process of healing, sharing and regeneration – which is equally relevant to Indigenous and non-Indigenous workers. Aboriginal people have already embraced a Trauma-Informed approach in

response to the healing needs of Indigenous families and communities. While the impact of trauma is still under-recognised in provision of mental health services, Aboriginal people already use a trauma-informed approach in response to the healing needs of Indigenous families and communities.

ASCA also provides a number of training and professional development opportunities. All such ASCA programs are grounded in the evidence presented in ASCA's *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery*.

Trauma-Informed Training for the Community Services Sector is a two-day trauma-informed training package developed specifically for the community sector. It features flexible modules for workers, volunteers and managers which can be varied depending on the particular service's structure and culture. The workshop introduces the concept of TICP, emphasising the need for awareness of the possibility of unresolved trauma in those contacting a service and how to minimise the risk of re-traumatisation in services, as well as vicarious traumatisation in workers. The training establishes why TICP is necessary, what it involves and the changes needed to integrate it into existing ways of operating. The training also addresses how the foundational trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment can be applied. The workshop involves experiential work with particular reference to individual practice and roles in different services, including those of managers in implementing TICP into their service.

Trauma-Informed Training for Mental Health Sector is a one-day trauma-informed training package has been developed specifically for the mental health sector. It is designed for mental health workers across a diversity of mental health settings. The training establishes why TICP is necessary, what it involves and the changes needed to integrate it into existing ways of operating. It also addresses how foundational trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment can be applied.

A half-day trauma-informed training for managers is also available. The half-day training for managers is tailored to the needs of managerial staff who seek to implement trauma-informed principles across and within the service culture/s of their organisation/s. The training also presents in a condensed form some of the key themes addressed in the one-day training workshop for workers.

In addition ASCA delivers professional development training for health professionals, a one-day workshop for practitioners working therapeutically with adult survivors of complex trauma, at a basic and advanced level.

NSW Health Education Against Violence (ECAV) has been influential in supporting NSW Health Mental Health services to embrace a Trauma-Informed Practice Framework; over the past 16 years it has built workforce capacity in assessment and clinical practice of current sexual safety and past childhood trauma for consumers.

In 1997 ECAV along with Women and Mental Health Inc was instrumental in authoring and publishing the research report *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions* (Davidson, 1997).¹⁵¹ Since 1998, ECAV has delivered trauma-informed practice training.

ECAV worked closely with Mental Health Drug and Alcohol Office (MHDAO) to develop and implement the Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services (1999) as well as the comprehensive revision of the Guidelines in 2004 and 2012. ECAV have played an integral role in assisting NSW Mental Health services to implement these Guidelines through three specific state-wide training programs. They include: utilising a trauma-informed framework in responding to child and adult sexual assault for mental health professionals; implementing sexual safety from sexual assault and harassment in adult mental health inpatient units; and implementing sexual safety from sexual assault and harassment in child and adolescent mental health inpatient units.

ECAV has established a partnership with the University of Sydney, NSW Official Visitors' Program and the NSW Institute of Psychiatry (NSW IOP). ECAV co-delivers a Graduate Certificate in Human and Community Services (Interpersonal Trauma) with the Faculty of Social Work, Sydney University. This is a one-year postgraduate certificate course that will provide a professional pathway, for Aboriginal students in particular, to a Masters of Social Work.

ECAV has developed two trauma-informed audit tools for use in mental health facilities by the Official Visitors' Program to provide practical mechanisms for staff to check service responses to sexual harassment or sexual assault trauma. These have been incorporated into larger auditing exercises. Since 1993 ECAV has worked with the NSW IOP to assist with building trauma-informed practice into the Institute's curriculum. In 2010 ECAV in partnership with the Institute co-wrote and delivered a Trauma-Informed Care (Interventions and Systems) module at the post-graduate level, assisting mental health practitioners to understand the dynamics of trauma from an individual and whole-of-system response.

c) Research into practice

The concept of research into practice is reflected in the recommendations of this paper in both process and outcomes, and emphasises the need for engagement across all service sectors. This initiative includes engagement with the public and private sectors in acute and community mental health contexts. A number of organisations in Australia have begun to implement TICP policy into their service organisations. These initiatives are based on extensive research evidence and practice guidelines both international and from Australia.¹⁵²

As part of the national approach towards a cultural shift in policy reform in mental health and human services in Australia, the NTICP AWG partners aim to convene a national forum in 2014 showcasing research into practice in Australia, and report outcomes for services which have embraced the implementation of TICP.

The NTCIP AWG are pleased to report in this paper of a diversity of Australian organisations that are actively progressing the TICP agenda, embedding TIC policy and implementing practice in their organisations, services and programs. In numerous instances MHCC and ASCA have been sharing ideas and providing input and resources at a number of different levels. We congratulate these organisations for taking the initiative, leading the way, and providing a role model for other mental health and human services.

We have identified a number of organisations that have embarked on the TICP journey at an organisational and/or service delivery/programmatic level, and anticipate their involvement in presenting their work and outcomes in a forum planned for 2014.

Some examples of this engagement in TICP are listed below:

Centre for Developmental Psychiatry and Psychology, Monash University, Melbourne

The Monash University Centre for Developmental Psychiatry and Psychology (CDPP) was established in December 1989. The CDPP has a mandate to provide research and teaching in the field of developmental psychiatry and psychology with a particular focus on child, adolescent and family mental health.

MHCC highlight the significant work in the trauma field conducted by Louise Newman, Professor of Developmental Psychiatry and Director at the Monash University Centre. She is a practising infant psychiatrist with expertise in the area of disorders of early parenting and attachment difficulties in infants and has been influential in highlighting the impact of trauma on the developing child. Louise has been a strong supporter of MHCC and ASCA in championing the TICP strategic direction and endorsing the Practice Guidelines. She was also a keynote speaker at the Meeting the Challenge Conference 2011.

Prior to this appointment she was the Chair of Perinatal and Infant Psychiatry at the University of Newcastle and the previous Director of the New South Wales Institute of Psychiatry. In January 2011 she was appointed as a Member in the General Division of the Order of Australia. Her current research focuses on the evaluation of infant-parent interventions in high-risk populations, the concept of parental reflective functioning in mothers with borderline personality disorder and the neurobiology of parenting disturbance.

She is the Convenor of the Alliance of Health Professions for Asylum Seekers and an advocate for the rights of asylum seekers and refugees. She is the Chair of the Detention Expert Health Advisory Group an independent body providing advice to the Department of Immigration and Citizenship on the health needs of asylum seekers. She has been involved in research into the traumatic impact of immigration detention on child asylum seekers.

Defence Abuse Response Taskforce

Following the Piper Review of allegations of sexual and physical abuse in the Australian Defence Force (ADF), MHCC and ASCA assisted the Psychological Support Services, Defence Abuse Response Taskforce (Attorney General Taskforce) in accessing trauma-informed services and resources to support people independently from the ADF. The Second Interim Report to the Attorney-General and Minister for Defence (June 2013) included details about the Counselling Program, which aims to provide an equitable service nationally and to ensure quality assurance of that service. Through the Program, principles of trauma-informed practice will ensure flexibility and responsiveness to the individual's needs. Counselling staff have received training regarding trauma-informed care. The Taskforce's Case Coordinators work closely with complainants as their matters are dealt with by the Taskforce. If psychological support is required, Case Coordinators will refer complainants to registered external counselling providers who work from a trauma-informed care perspective.

Department for Child Protection and Family Services, Western Australia

Traumatised children cannot heal within traumatising (or traumatised) organisations.

Sandra L Bloom, 2005

The Department for Child Protection and Family Services in WA use the Sanctuary Model for residential care across the state. The Residential Care Conceptual and Operational Framework describe the major expansion and reform of residential care incorporating the overarching model and core elements informing how the Department for Child Protection residential facilities operate transforming larger hostels into smaller houses and establishing additional facilities in partnership with the community sector.

The Framework is based on the principles of the Sanctuary Model developed by Sandra Bloom and a study into residential care conducted by James Anglin in 2004. It introduces a coherent therapeutic approach to care and more importantly is a model for organisational change within the facilities. As this change is achieved it supports the gains already made.

Journey to Social Inclusion, Melbourne

Journey to Social Inclusion (J2SI) is a Sacred Heart Mission initiated service model which was piloted over three years between November 2009 and October 2012. The project, first of its kind in Australia, aimed to demonstrate that it is possible to end a person's long-term homelessness and doing so, given the right investment, makes economic sense.

J2SI draws on research and best practice in Australia and overseas. It shows that a permanent transition out of homelessness through intensive, individually tailored, long-term support is possible by addressing the underlying causes of the person's homeless as well as trauma experienced while homeless. The program delivers intensive and individually tailored support, rapid access to permanent housing and therapeutic services to address the trauma that is both a cause and a consequence of long-term homelessness and a skills-building program that equips participants with life skills so that they can reconnect with the mainstream community and build social networks outside of the homeless subculture. The total cost of the pilot over the three years was almost \$4 million – around \$30,000 per supported participant per year. A partnership with the Royal Melbourne Institute of Technology (RMIT) was established to evaluate the social impact of J2SI on participants and the Melbourne Institute of Applied Economic and Social Research to undertake the economic evaluation. J2SI won a National Homelessness Services Achievement Award for a pioneering pilot designed to end long-term homelessness – trauma-informed care was a key principle in its framework.¹⁵³

Lighthouse Foundation, Melbourne

The Lighthouse Foundation is an attachment and trauma informed not-for-profit organisation. Through its Therapeutic Family Model of Care™, the Foundation is dedicated to providing long-term therapeutic residential care and specialist mental health support for children and young people have experienced complex trauma as a result of childhood abuse and neglect. Over the last 21 years, the organisation has developed a psychodynamic, attachment and trauma-informed approach to its work, which has recently been published in a book (Barton et al., 2012).¹⁵⁴

The Lighthouse Therapeutic Family Model of Care draws upon a mounting body of empirical evidence which demonstrates that if traumatised children and young people are offered a safe and consistent physical living environment, with positive parental role models, as well as clinical and support services they can (re)build their sense of self, learn new ways of trusting and relating to others, and sustain positive and reciprocal relationships with others

across their lives – a hallmark of healthy and autonomous adulthood – and develop pro-social connections within their broader communities.

The success and integrity of the Therapeutic Family Model of Care also depends on the ability to deliver positive, measurable outcomes for young people. The need for outcomes-based practice has culminated in the development of the Therapeutic Outcomes Assessment™ tool, which measures the recovery of children and young people across eight key developmental areas.

The Institute also focuses on the promotion and development of attachment and trauma-informed practice in work with children and young people, and ending youth homelessness through community debate, education, training, consultancy and research. The Lighthouse Institute is a 'Knowledge Centre' that draws on its 21 years of practice as well as applied research in the fields of child and adolescent psychology/psychiatry, community psychology, trauma neurobiology studies and clinical practice from around the world.

Mental Health Commissions in Australia

On 11 and 12 March 2013 a meeting hosted by the National Mental Health Commission of Australia in partnership with the New South Wales Mental Health Commission and the Mental Health Commission of Canada was held in Sydney for Australian State and National Mental Health and International Mental Health Leaders. In the Meeting Communiqué, The Sydney Declaration, signed by Mental Health Commissioners within and outside Australia, included a commitment to 'Advocate for and promote trauma-informed care approaches to strengthen mental health practice across all our communities.'¹⁵⁵

Missenden Unit and Community Mental Health Services, SLHD

The Missenden Psychiatric Unit is an acute 38-bed inpatient Mental Health Unit within Royal Prince Alfred Hospital in Inner Sydney. The Missenden Psychiatric Unit is implementing a Trauma-Informed Model of Care and Practice across the unit to commence during second half 2013. Translating Trauma-Informed Care into a psychiatric inpatient setting, which experiences constant and high levels of acuity and complexity among consumers, involves a multidisciplinary and staged approach focusing on reduction of overtly traumatising practices such as seclusion and restraint, increased consumer collaboration in care planning, comprehensive trauma assessments, targeted staff education, training and supervision and a review of all the unit's policies, rules and practices. The unit is committed to implementing both an overarching philosophy of care and an operational model of care that recognises the experiences of trauma present in its service users' lives and actively minimises further traumatisation in the care setting.

Victoria Family Institute, Bouverie Centre, La Trobe University

The Bouverie Centre has developed a small resource brochure: *Guidelines for Trauma-Informed Family Sensitive Practice in Adult Health Services*. The resource provides some useful information about trauma and its impacts and describes how a trauma-informed approach can assist workers engage with families and their children. The resource also describes opportunities to contribute to healing for adults and children by adopting appropriate language, informed by helpful tips.

Sexual Assault Resource Centre SARC WA

The Sexual Assault Resource Centre (SARC) is the state-wide service for responding to individuals 13 years and over who have experienced any form of sexual violence. SARC provides medical and forensic, psychological first aide and therapy services. SARC has made an ongoing commitment to provide trauma-informed services to clients. An understanding of all forms of psychological trauma is central to the work at SARC and all counsellors undertake ongoing professional development in this area. Regular supervision is provided to all counselling staff and the impact of vicarious trauma is incorporated in staff development. SARC conducts regular telephone follow-up to gather feedback from clients on their experience of using the services. The feedback guides further changes to organisational procedures and service provision in an effort to make the service more trauma informed. Aspects of service delivery that are important to clients include having no signage on the building, being offered an appointment soon after making contact, being greeted in a friendly and caring manner on arrival, not being rushed at appointments and having a say in counselling. Clients also identified specific features of counsellors in assisting in their recovery process. These included a non-judgemental attitude, ability to listen and have an understanding, empathetic and caring approach.

SARC recognises that achievements in providing a quality trauma-informed service must be an ongoing commitment; they require a collaborative approach with clients, consumers and other key stakeholders. SARC provides state-wide education and training to other professionals who work with sexual violence and are committed to supporting services becoming trauma-informed.

Take Two and other trauma-informed initiatives at Berry Street Melbourne [156](#)

Berry Street is a non-government organisation that has been supporting Victorian children and families since 1877. They work with children, young people and families with the most challenging and complex needs. These children and young people have often suffered great distress and significant harm growing up in families where violence, neglect, abuse, trauma and poverty have prevented them from having a good childhood.

A major development in 2008 was the partnership between the Child Trauma Academy and Dr Bruce Perry. This partnership works towards Take Two staff being certified in the Neuro-sequential Model of Therapeutics (NMT), which is a neuro-biologically, developmentally and trauma-informed approach to therapeutic approaches for children who have experienced chronic abuse and neglect (Perry, 2006). Take Two's practice framework is trauma-informed and the Aboriginal team is building further understanding about trauma and attachment around historical consequences for Aboriginal communities. NMT provides a valuable foundation for assessment of and intervention for children who have experienced chronic trauma and deprivation. This approach emphasises the impact on different parts of the brain of early in life trauma and neglect. NMT does not dictate specific interventions but rather provides guidance regarding the choices and sequencing of interventions. Take Two program agency for the evaluation of Take Two is the School of Social Work and Social Policy, La Trobe University.

The Just Care model was developed as an outcome of a project undertaken by Take Two with Dr Jenny Dwyer, Associate Professor Margarita Frederico and Sue Jones to develop a

model for youth justice custodial staff and management. This model was to provide an integrated trauma-informed response to the difficult behaviours presented by many young women in custody, especially those involving violence towards self or others. The Just Care model was developed as a result of the analysis from the literature, interviews and the project team's experience. The young women in custody had complex individual issues such as mental health or intellectual disability issues and in addition traumatic backgrounds, all of which meant they had extreme difficulty in self-regulation. Findings from the literature review and interviews included that young women were seen to respond differently from young men in custody, yet programs applied in custodial institutions had frequently been designed for young men.

Wesley Mission Counselling Support Services (WMCSS) and Gambling Services (WMGS)

WMCSS offers problem gambling counselling, financial counselling, financial literacy programs, psychological services and other supporting services to low-income consumers and people affected by addictions and mental health issues. It is a sizeable organisation with 49 staff including counsellors, community educators, lawyers, managers and administration staff. It operates at six sites throughout NSW including outreach services. A significant proportion of the client base is trauma affected and the organisation has never before addressed this important issue in a systematic way. After attending the Mental Health Coordinating Council (MHCC) TICP conference in 2011, Wesley's Operations Manager immediately established a working committee to give impetus to the development of a Trauma-Informed Care and Practice building on the *Integration of a Trauma-Informed Care and Practice Approach Policy included in the MHCC Organisation Builder (MOB) – Policy Resource* and the Trauma-Informed Organisational Toolkit as developed by the National Centre on Family Homelessness in the USA.

Dissemination

TICP in Australia – a national strategic direction

The NTICP AWG recommends a number of points of engagement in order to promote a national strategic direction. Importantly, this will require commitment from governments to develop a strategy for broad-based community awareness around the association between trauma, particularly complex trauma and mental illness, to eradicate stigma and discrimination, and facilitate access and equity across the lifespan.

TICP in Australia – a national strategic direction will bring about a revolutionary shift in the way mental health services are organised, delivered and managed to improve outcomes for the consumers with complex needs.

MHCC as representative of Community Mental Health Australia (CMHA)⁷, a coalition of community managed mental health peak bodies in all eight states and territories has raised the importance of TICP with the Safety and Quality Partnerships Subcommittee (SQPS), a

⁷ CMHA was established in 2007 in recognition of the shared activities, challenges and potential to effect change of the State and Territory community-sector mental health peak bodies and their respective memberships of more than 800 non-government community-managed organisations (NGOs/CMOs) nationally. The primary goals of CMHA are to build a viable and sustainable community-managed mental health sector and to promote the value and outcomes delivered by community-managed mental health services based on a philosophy of recovery and social inclusion.

sub-group of the Mental Health Principle Committee (MHPC) tasked to progress the mental health safety and quality agenda.

The SQPS has a watching brief in relation to safety and quality in mental health and may respond, on emerging issues of concern and related quality and safety initiatives, through the provision of advice to the MHPC. SPQS also provides advice to the national Mental Health Commission and works in partnership with the Australian Commission for Safety and Quality in Health Care (ACSQHC), which leads national efforts to improve safety and quality in health care provision in Australia.

A key role of the SQPS is the provision of expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health. The direction is informed by the National Mental Health Strategy, the current Fourth National Mental Health Plan, and mainstream health initiatives. The SQPS also provides advice and direction in relation to monitoring and implementation of the National Standards for Mental Health Services.

The SQPS has had carriage of the National Recovery Framework (launched in August 2013).¹⁵⁷ As a member of SQPS, MHCC was instrumental in ensuring that trauma-informed care and practice was embedded in the Framework and that the document is informed by and makes reference to the Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery (ASCA).¹⁵⁸

The recommendations for a TICP national strategic direction also identifies the broader human service sector as playing an important role in embedding trauma-informed policy and its implementation across service systems. This cannot be emphasised too strongly in the light of the roll-out of NDIS nationally. This will necessitate buy-in from national and state departments including (in the light of the NDIS) the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and its state counterparts such as Ageing, Disability and Home Care (ADHC), part of the Department of Family and Community Services (FACS) in NSW.

ASCA's Practice Guidelines will continue to inform policy makers and the sector, and will have an ongoing and critical role in the dissemination process. The Guidelines were originally launched in Parliament House Canberra by Hon Mark Butler, then Minister for Mental Health and Ageing, Minister for Social Inclusion. They have now been launched in each state including: in WA by the WA Mental Health Commissioner, Eddie Bartnik, in NSW by the NSW Mental Health Commissioner, John Feneley and Queensland by the Queensland Health Minister, Hon Lawrence Springborg MP, and in Victoria at the THEMHS Conference. To date there have been close to 6,000 downloads from the ASCA Guidelines for ASCA's website and 1,200 hard copies distributed. The publication of the Guidelines has meant that ASCA has been consulted extensively in relation to the establishment of the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia, and trauma-informed training to personnel.

The extensive workforce development and training as described earlier in this paper (Translation p 43) are important factors in the dissemination process, providing the material necessary to meet capacity-building needs at all levels of the system including at an

organisational or program/service delivery level, in public, private or community mental health and human services.

The NTCIP AWG note that the National Centre for Trauma-Informed Care (NCTIC) was established in the USA in 2005 on the basis that better integration of trauma across all health and human services would enable more trauma survivors to find their path to recovery and wellness. The NCTIC is funded by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). This national centre has developed a guide based on the American experience from which we can formulate a uniquely Australian model.

Implementation

a. Role of the National Trauma-Informed Care and Practice Advisory Working Group

The original NTICP AWG Terms of Reference stated that they sought to improve the mental health and wellbeing of people with trauma histories by advocating for a National Agenda for TICP (Appendix 1). A National Agenda is a call for *systemic reform and the development of a strategy that embodies a shift in service delivery culture across mental health and human service sectors, and the workforce training and professional development to support the approach*. The terms of reference have subsequently been updated to reflect the objectives stated in the revised terms.

Under revised Terms of Reference⁸ the NTICP AWG has determined to:

1. advise MHCC and ASCA as to how best to progress the National Strategic Directions as detailed in the Position Paper Recommendations
2. support dissemination of the Position Paper and help design a communication strategy for the Position Paper to engage a broader network to promote the strategic direction
3. assist MHCC and ASCA in understanding the wide range of interest groups and stakeholders including consumers and carers as well as the TICP Network, and people with expertise outside of the AWG
4. identify relevant points of engagement with politicians and policy makers in each state across mental health and human service sectors
5. contribute knowledge and understanding of national standards, guidelines and frameworks/strategies in which TICP should be integrated
6. support and contribute to joint initiatives, knowledge and information sharing on an ongoing basis
7. advise on research initiatives and help promote the translation of TICP research into practice

Objectives of the NTICP AWG are to ensure that:

⁸ The NTICP AWG reviewed and amended the Terms of Reference on 29 August 2013. This is to reflect the ongoing role and future work of the AWG moving into the next stage of progressing a TICP national strategic direction.

1. National and State-based Mental Health Commissions endorse and champion the changes needed to policy, service delivery and practice cultures
2. mental health policy reform acknowledges the need for all health and human services to become Trauma-Informed and to embed those principles into mental health, health and human services and systems, policy and practice, and sector development
3. Governments provide the necessary funding to enable agencies, programs and services across sectors to facilitate organisational and inter-disciplinary re-orientation towards trauma-informed care and practice
4. systems and services support environments that are comprehensively integrated, empowering and therapeutic for trauma survivors engaging with a range of services
5. Governments recognise the need to allocate resources for trauma-specific services and programs across service-delivery settings, including e.g. inpatient, all community-based services and private trauma-specific services and programs

b. MHCC and ASCA activities supporting and promoting TICP nationally

Activities leading to and subsequent to the establishment of the partnership committee are detailed in Appendix 4.

c. NTICP AWG ongoing activities

As the NTICP AWG continues to progress its call for a national TICP strategic as identified in its revised Terms of Reference the NTICP AWG and its collaborating partners will continue to meet and promote this position paper and its broader agenda to State and Commonwealth Governments, Mental Health Commissions and senior policy makers across mental health and human service sectors.

d. Priority activities for the NTICP AWG will include:

1. supporting the information sharing/clearinghouse function MHCC has established through the TICP website
2. supporting the integration of TICP into policies and procedures in community-managed sectors, public and private services
3. promoting TICP resources and engagement in forums, workshops and seminars
4. recommending and advocating resource development projects
5. assisting with engaging and influencing cross-sectoral peaks in each state
6. investigating potential areas and opportunities for research e.g. The National Health and Medical Research Council (NHMRC)

Section 6

Measurable Cultural Change

The National Trauma-Informed Care and Practice Advisory Working Group propose that the recommendations that underpin the national strategic direction identified in this paper will lead to 'Measurable Cultural Change' across service systems and practice.

Recommendations

Coordinated Government response

Process

- whole-of-government policy reform – take-up/cross-portfolio
- cross-government collaboration between Federal, State and Territory Governments as well as the CMO sector

Outcome

- implementation of TICP across the broad range of human service sectors
- incorporation of these recommendations for change to be accepted broadly across national mental health reform processes

Mental Health and Human Services

Aims

- to implement TICP principles into practice across and within mental health and human services and systems
- to embed TICP principles into the National Recovery Framework
- to integrate TICP principles into National Standards
- inclusion of TICP in the national agenda in the next National Mental Health Commission Report Card

Process

- engagement with State and Federal Mental Health and Human Service Ministers and senior policy makers
- engagement with National and State Mental Health Commissions (prioritisation for policy, planning, research and sector funding)
- integration of TICP principles into practice within the Royal Commission into Institutional Responses to Child Sexual Abuse
- networking and collaboration with the international trauma-informed community

- education and engagement of sector (Tools, Showcase Forum, Training)
- implementation of research into practice – policy reform and practice standards, embedding Practice Guidelines

Outcomes

- uptake and accepted practice for community-managed organisations (CMOs), public and private agencies to integrate TICP into systems and services
- Workforce Development and capacity building in TICP
- broad-based National Communications Strategy surrounding trauma

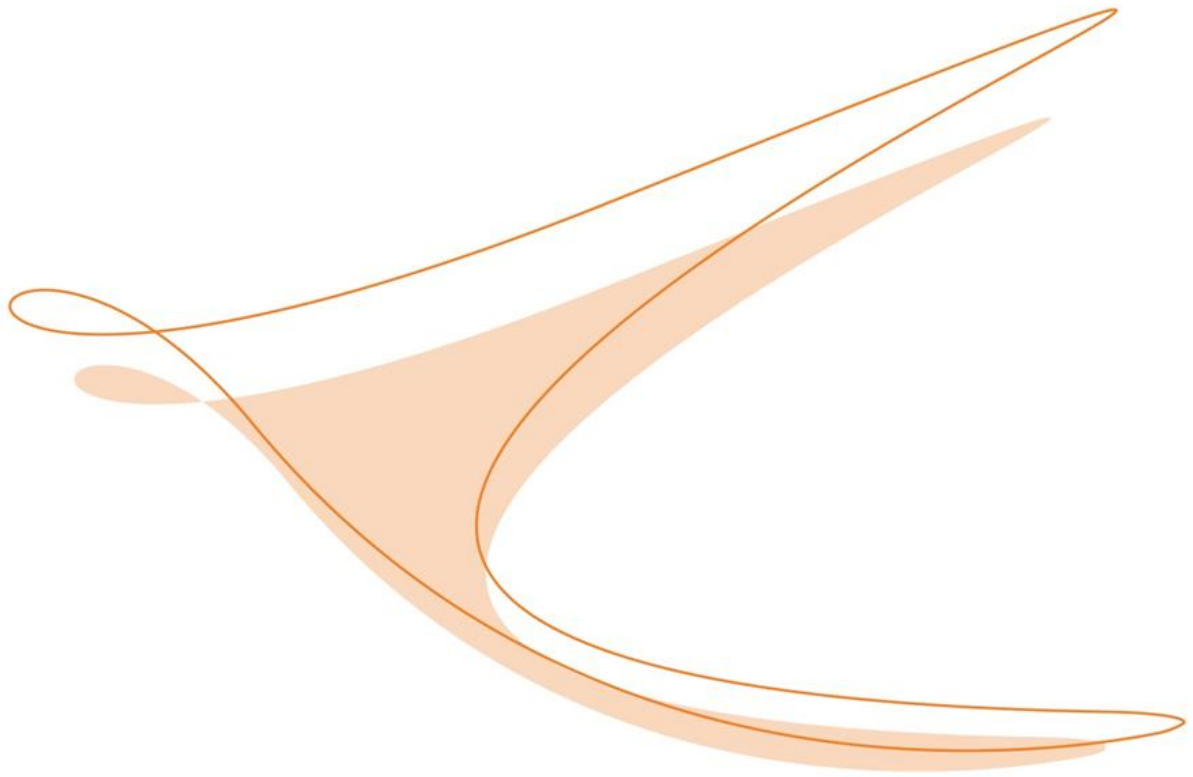
Consultation

This position paper and recommendations: *Trauma-Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia – A National Strategic Direction* has established the substantive evidence around the need, process and benefits for broad-based policy reform for a national approach to trauma-informed care and practice. All recommendations made in this paper are informed by national and international experience, evidence and research. This approach necessitates a national integrated approach supported by Governments, State and Federal, with bipartisan support, and by a diversity of health and human systems, sectors and jurisdictions. It is a broad-based agenda and one which we must embrace as key to ensuring the improved health and wellbeing of large numbers of Australians whom the system has failed to date.

The National Trauma-Informed Care and Practice Advisory Working Group are keen to hear from stakeholders and welcome comments on this paper and its recommendations for a national strategic direction.

Please address your comments to Corinne Henderson, Senior Policy Advisor at corinne@mhcc.org.au

Appendices



Appendix 1

National Trauma-Informed Care & Practice

Advisory Working Group

Terms of Reference 1

Definition: Trauma

To understand the concept of 'trauma' a distinction needs to be made between the event/s and the person's reaction to the event/s.

Trauma may arise from single or repeated adverse events that can interfere with a person's ability to cope or to integrate the experience. It is an experience of real or perceived threat to life, bodily integrity and / or sense of self. Trauma, particularly that which arises from interpersonal abuse in childhood, can lead to serious long-term consequences: many survivors adopt strategies and responses that can persist into adult life. Some of these may include suicidality, substance abuse and addictions, self-harming behaviours, dissociation, and vulnerability to re-traumatisation and a wide range of mental health impacts. Traumatic experiences can be cumulative across the lifespan. Trauma can be trans-generational for individuals and affect whole communities.

Under this **Terms of Reference** the work of the **National Trauma-Informed Advisory Working Group** (NTICP AWG) particularly focuses on trauma occurring in the context of interpersonal violence, either covert or overt, and on the psychological, social, physical, cultural and spiritual reactions to the event/s. All papers emanating from the AWG should be understood in terms of this definition.

Terms of Reference

Purpose

The National Trauma-Informed Care & Practice Advisory Working Group (NTICP AWG) seeks to improve the mental health and wellbeing of people with trauma histories by advocating for a National Agenda for TICP. A National Agenda for TICP is a call for systemic reform and the development of a strategy that embodies a paradigm shift in philosophy, culture and service delivery across health, mental health and all human service sectors. To support this approach education, training and workforce development are critical.

Objectives of the NTICP AWG are to ensure that:

1. Mental health policy reform acknowledges the need for all health and human services to become Trauma-Informed and to embed its principles into mental health, health and human services policy

2. Governments provide the necessary funding to enable publicly-funded agencies, programs and services in the Government- and community-managed sectors to facilitate the organisational and professional cultural shift (across disciplines) towards Trauma-Informed Care and Practice in all health and human services
3. Systems and services support environments that are more supportive, comprehensively integrated, empowering and therapeutic for a diversity of trauma survivors
4. Governments recognise the need to allocate funds for trauma-specific services and programs across service-delivery settings, including e.g. inpatient, community-based services and self-referred trauma-specific services and programs
5. National and State-based Mental Health Commissions endorse and champion the changes needed to policy, service delivery and professional cultures
6. The recommendations of this report be widely adopted

The NTICP AWG has determined to:

- act as a coordinating and review body to champion the implementation of TICP, providing a centralised reference point for coordination of initiatives of MHCC and collaborating partners
- ensure active consultation with a wide range of interest groups including consumers and carers as well as the TICP Network, individuals and groups, and people with expertise outside of the AWG
- influence politicians and policy makers to adopt the TICP approach across mental health and human service sectors and provide expert advice to government, members and key stakeholders in relation to research, policy and programs
- advocate for the development and implementation of TICP national standards, guidelines and implementation of frameworks/strategies and advise on workforce/sector development requirements in relation to TICP
- facilitate joint initiatives, knowledge and information sharing on an ongoing basis with a view to strengthen organisational capacity in all relevant sectors, as well as promote education, training and workforce development
- advise on research requirements and promote the translation of TICP research into practice

Projected activities are likely to include:

- expanding and developing information sharing/clearinghouse function MHCC has established through the TICP website
- advocate grant funding for community-managed organisations to integrate TICP into their policies and procedures, implement tools and conduct forums and seminars on TICP, and initiate research projects

- supporting and engaging a wider group of consumers, carers and human service stakeholders through the TICP Network, and developing processes to consult with this group
- investigating potential areas and opportunities for research e.g. The National Health and Medical Research Council (NHMRC)

Membership of the group

Membership is to be limited to 12 including MHCC Secretariat. Membership is by invitation of the AWG. Members will include persons who have lived experience of trauma and representatives from across the public, private and community-managed mental health sectors with expertise and experience in the area of trauma and Trauma-Informed Care and Practice.

There is an expectation that members will have the time and capacity to contribute to the group agenda.

MHCC will chair the meetings and provide secretariat.

Acknowledgement of cooperating partners

Cooperating partners will be acknowledged in all business of the group.

Term of the group

The group will initially run for three years. The group will review the ToR annually.

Frequency of meetings

The group shall meet approximately once every two months unless the need to meet more frequently on occasion is determined by the group. The group will aim to meet face to face twice a year and hold four teleconference meetings.

Signed off 4 June 2012

NOTE: These Terms of Reference (ToR) were reviewed and have been superseded by a second ToR signed off on 29 August 2013. The new ToR reflect the ongoing role and work of the Advisory Working Group moving into the next stage of promoting a strategic direction.

Appendix 2

[insert organisation name/logo]

General

Integration of a Trauma-Informed Care and Practice Approach

Document Status: Draft or Final

Date Issued: 3.06.13 [date] latest version

Lead Author: [name and position]

Approved by: [insert organisation name] Board of Directors on [date]

Scheduled Review Date: [date]

Record of Policy Review

Review Date	Person Initiating/Leading Review	Other People Consulted

Triggers for Policy Review (tick all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Standard review is timetabled | <input type="checkbox"/> Internal / organisational factors |
| <input type="checkbox"/> A gap has been identified | <input type="checkbox"/> A stakeholder has identified a need, e.g. by email, telephone etc. |
| <input type="checkbox"/> Additional knowledge or information has become available to supplement the policy | <input type="checkbox"/> A serious or critical incident has occurred, requiring an urgent review |
| <input type="checkbox"/> External factors | <input type="checkbox"/> Need for consistency in service delivery across programs and organisations |
| <input type="checkbox"/> Policy is no longer relevant/ current due to changes in external operating environment. | <input type="checkbox"/> Separate, stand-alone policy is now warranted |
| <input type="checkbox"/> There are changes to laws, regulations, terminology and/or government policy | <input type="checkbox"/> A near miss has occurred, requiring a review to prevent a serious/critical incident in the future |
| <input type="checkbox"/> Changes to funding environment, including requirements of funding bod(y)ies | |
| <input type="checkbox"/> Other (please specify) | |

Additional Comments

[for example, policy now covers details related to new legislation]

Trauma-Informed Care & Practice Policy

1. Purpose and Scope

The purpose of this policy is to enable:

- every part of the organisation, including administration, management and service-delivery systems is assessed and modified to incorporate trauma-informed principles into practice
- the provision of safe environments in which re-traumatisation of consumers is minimised and staff health and wellbeing are fostered
- staff to understand that they must be informed about trauma and its dynamics so as to minimise triggers which may interfere with effective executive functioning in both consumers and other staff members with a lived experience of trauma
- the workforce to be informed about pathways to services which can provide appropriate integrated support and/or referrals for consumers presenting with complex trauma, co-occurring mental health and psycho-social difficulties
- assistance to **[insert organisation name]** to establish clear policies and procedures to minimise risks to work health and safety e.g. re-traumatisation of staff and/or clients with past trauma histories, vicarious traumatisation (staff) and self-harming behaviours (clients)
- this policy applies to all consumer services and programs of **[insert organisation name]** and all staff of **[insert organisation name]**. It does not prescribe specific treatments, philosophies or counselling techniques. It is based on trauma-informed recovery-oriented practice and the collaborative recovery model for community managed organisations.

This policy is implemented in conjunction with the Abuse and Neglect Policy, Advocacy Policy, Dignity of Risk Policy, Diversity Policy, Emergency and Critical Incidents Policy, Individual Supports Policy, Professional and Personal Development Policy and Supervision Policy.

2. Definitions

Complex trauma – is cumulative, repetitive and interpersonally generated, and includes ongoing abuse which occurs in the context of the family and intimate relationships. Complex trauma usually involves a fundamental betrayal of trust in primary-care relationships, because it is often perpetrated by someone in close contact with the victim. Unlike a one-off event, the cumulative impact of premeditated and multiple episodes of abuse involves compounded impacts and persistent effects. Complex trauma places the person at risk of mental illness and complex post-traumatic stress disorder and may impact physical health and psychobiological development.

Complex post-traumatic stress disorder – may lead to stress reactions associated with histories of multiple traumatic stressor exposures and experiences, along with severe disturbances in primary caregiving relationships (Courtois & Ford, 2009).

Safety – The foundational principle in treatment of complex trauma may require active facilitation not previously experienced by consumers with complex trauma histories. A sense of safety is prerequisite to the ability to regulate affect, which is itself critical to the capacity to process and integrate trauma. Safety is also a key concept of trauma-informed care and practice.

Trauma-informed – The re-conceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised acknowledging the prevalence of trauma throughout society. ‘Trauma-informed’ services are aware of and sensitive to the dynamics of trauma as distinct from directly treating trauma per se. The appropriate term in the latter case is ‘trauma specific’ (note the overlap between the two).

Trauma-informed services are alert to the possibility of the existence of trauma in the lives of all clients/patients/consumers, irrespective of whether it is known to exist in individual cases. They are not the same as:

Trauma-specific treatment approaches and trauma-informed services, which directly address trauma in its various forms.

Vicarious trauma (VT) – 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 affect 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 survivor, and can lead to a person experiencing the symptoms of post-traumatic stress disorder (PTSD).

3. Principles

[Insert organisation name] adheres to five principles of trauma-informed best practice outlined below.

- SAFETY: Ensure physical and emotional safety
- TRUSTWORTHINESS: Maximise trustworthiness through task clarity, consistency, and interpersonal boundaries
- CHOICE: Maximise consumer choice and control
- COLLABORATION: Maximise collaboration and sharing of power
- EMPOWERMENT: Prioritise empowerment and skill-building

Reference: *Adults Surviving Child Abuse*, 2012, ‘Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery’, Authors Kezelman C A & Stavropoulos P A

Strategies

- (A) recognise the prevalence of trauma in mental health consumers
- (B) recognise high rates of mental health, physical health and psycho-social disorders related to trauma exposure in children and adults
- (C) recognise that mental health treatment environments are often traumatising, both overtly and covertly
- (D) recognise that coercive interventions cause traumatisation/re-traumatisation and avoid such practices
- (E) recognise that the majority of mental health staff are uninformed about trauma, do not recognise it and do not know how to manage it
- (F) review policies and procedures to incorporate trauma-informed principles – ‘What happened to the consumer?’ rather than focus on a diagnosis
- (G) review education and training to incorporate trauma-informed practice
- (H) provide training on reducing re-traumatising practices
- (I) inform regarding where trauma screening is appropriate
- (J) understand the impacts of trauma, complex need and the importance of coordinated care
- (K) articulate and uphold trauma-informed human rights

To undertake trauma-informed care and practice, **[insert organisation]** will promote the following as core values of trauma-informed care including the following:

- understanding trauma and its impact
- promoting safety
- ensuring cultural competence
- supporting consumer control, choice and autonomy
- sharing power and governance
- integrating care
- healing happens in relationships
- recovery is possible

4. Outcomes

[Insert organisation name] assess all consumers with the understanding of mental health presentations from a trauma-informed perspective. Co-existing mental health and complex need occur commonly as a consequence of trauma and need to be understood as such. They do not constitute criteria for service exclusion or denial.

Workers are provided with education, skills and support in trauma-informed mental health assessment, screening where appropriate; support plan development and support coordination.

[Insert organisation name] develops and maintains partnerships with trauma specific services, mental health and related services to provide integrated support for consumers.

[Insert organisation name] creates a safe and healthy work environment for all employees, contractors, consumers and visitors.

Support is provided for personnel who may have difficulty addressing trauma-related issues. This may include those with their own trauma history. The high prevalence of pre-existing trauma in workers needs to be recognised and acknowledged.

[Insert organisation name] fosters a personal, holistic, creative, open and therapeutic culture that supports service providers in moving from a caretaker to a collaborator role using a recovery-oriented approach.

[Insert organisation name] ensures all disciplinary processes are consistently managed in accordance with the Staff Performance and Conduct Procedure.

5. Functions and Delegations

Position	Delegation/Task
Board of Directors	Endorse a Policy which integrates a Trauma-Informed Culture
Management	Develop, maintain and formalise (where appropriate) collaborative partnerships and interagency relationships with relevant government and non-government services
Staff	<p>Identify consumers' support and support needs</p> <p>Maintain knowledge of current good practice related to complex trauma and co-existing mental health and psycho-social issues</p> <p>Develop and maintain partnerships with local mental health and related services</p>

6. Risk Management

As far as possible, traumatic events and re-traumatisation are prevented, and the impacts of trauma are minimised following traumatic events.

Workers with responsibility for consumer intake and assessment are identified and appropriately trained and skilled to conduct trauma screening (only when appropriate, taking into account willingness/capacity of consumer to share lived experience) and support access to trauma-specific services, avoid re-traumatisation and engage in ongoing support. Refer to Supervision Policy.

Assessment and responses to suicide and self-harm risk is undertaken by appropriately trained and qualified staff, using evidence-based assessment and response practices within trauma-informed service systems. Refer to Dignity of Risk Policy.

Service/organisation policy developed and implemented is trauma-informed. This includes practice guidelines, policies, procedures, rules, regulations and standards which all must be trauma-informed. All employees including administration receive orientation regarding the prevalence and impact of trauma, and the impacts of culture and other demographics on experience and perception and ways of coping or healing. Direct-service staff members undertake more extensive training and are provided with ongoing professional development. Refer to Professional and Personal Development Policy.

7. Policy Implementation

This policy is developed in consultation with staff, consumers and carers, and is approved by the Board of Directors. This policy is part of staff orientation/induction processes and all staff members are responsible for understanding and adhering to it. This policy is reviewed in line with **[insert organisation name]**'s continuous quality improvement program and/or relevant legislative changes.

8. Policy Detail

8.1 Supporting Consumers

[Insert organisation name] provides integrated support for consumers that is trauma-informed i.e. providers are aware of past trauma, its mental and physical health impacts and possibilities for recovery.

The most appropriate options should be available for the consumer. These include:

- trauma-informed and trauma-specific mental health support are facilitated by a staff member and/or between staff and/or teams at **[insert organisation name]**, with collaborative support planning and frequent communication processes
- where consumer consent allows, trauma-related support is provided by **[insert organisation name]** at the same time as trauma-specific mental health service provision by a specialist trauma/mental health service, private psychiatrist, GP or private psychologist within a 'shared care' model, or collaborative support planning and frequent communication.

In circumstances where consumers are receiving services from two or more support agencies and or support agency/practitioner, it is recommended that regular case conferences are organised and convened. This involves coordinating a meeting between all support providers and support workers, carers, and, unless it is not in the consumer's best interests, the consumer.

In a case conference, the roles of each support provider/practitioner and support worker are clarified, and the needs and goals of the consumer are discussed in order to formulate a coordinated approach to the support plan, reduce the gaps between services and provide better outcomes for consumers.

For more information refer to the [Individual Supports Policy](#) and [Integration Policy](#).

Workers assist consumers with referrals and linkages to other specialist and generalist services that the consumer may require during their support at **[insert organisation name]**.

Where appropriate, staff advocate for consumers to receive informed mental health support, and, where possible, facilitate access to this support.

For more information refer to the [Individual Supports Policy](#).

8.2 Supporting Employees of [Insert organisation name]

8.2.1 Establishing a supportive culture

[Insert organisation name] promotes a supportive culture in which employees are able to seek the assistance of their employer in a non-threatening environment, through:

- providing non-threatening assistance to employees who recognise that they have trauma related/vicarious trauma issues (e.g. access to an employee assistance program)
- ensuring that clear and consistent processes are in place for addressing risks to health and safety in the workplace
- respecting the privacy of employees by ensuring that appropriate systems are in place to maintain confidentiality

8.2.2 Procedure

It is the goal of **[Insert organisation name]** to:

- promote a supportive culture that encourages a co-operative approach between management and employees and builds on the shared interest in trauma-informed work health and safety

9. References + Resources

9.1 Internal

Abuse and Neglect Policy

Advocacy Policy

Diversity Policy

Emergency and Critical Incidents Policy

Professional and Personal Development Policy

Service Entry Policy

Individual Supports Policy

Dignity of Risk Policy

Supervision Policy

9.2 External

Adults Surviving Child Abuse, 2012, *Practice Guidelines for Treatment of Complex*

Kezelman C A & Stavropoulos P A, *Trauma and Trauma-Informed Care and Service Delivery*, Adults Surviving Child Abuse

Briere, J, 1992, *Child Abuse Trauma: Theory and Treatment of the Lasting Effects* Newbury Park, CA, Sage

Courtois, C A, 1988, *Healing the Incest Wound: Adult Survivors in Therapy*, 2nd ed, New York, Norton

Courtois, C A & Ford, J D (eds), 2009, *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*, New York, The Guilford Press

Guarino, K, Soares, P, Konnath, K, Clervil, R & Bassuk, E, 2009, *Trauma-Informed Organizational Toolkit*, Rockville, MD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. www.homeless.samhsa.gov and www.familyhomelessness.org

Henderson, C, & Bateman, J, 2010, *Reframing Responses Stage II: Supporting Women Survivors of Child Abuse, An Information Resource Guide and Workbook for Community Managed Organisations*, Mental Health Coordinating Council, NSW

Fallot, R, & Harris, M, 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Washington, DC, Community Connections, <http://www.annafoundation.org/CCTICSELFASSPP.pdf><http://www.healthcare.uiowa.edu/icm/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf>

Jennings, A, 2004, *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*, National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Centre for State Mental Health Planning (NTAC), United States

9.3 Quality and Accreditation Standards

EQUIP4

Provided by the Australian Council on Healthcare Standards (ACHS)

Standard 1.1: Consumers/patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.1: The assessment system ensures current and ongoing needs of the consumer/ patient are identified.

Criterion 1.1.2: Care is planned and delivered in partnership with the consumer/patient and when relevant, the carer, to achieve the best possible outcomes.

Criterion 1.1.3: Consumers/patients are informed of the consent process, understand and provide consent for their health care.

Criterion 1.1.5: Processes for discharge/transfer address the needs of the consumer/patient for ongoing care.

Criterion 1.1.6: Systems for ongoing care of the consumer/patient are coordinated and effective.

Standard 1.2: Consumers/patients/communities have access to health services and care appropriate to their needs.

Standard 1.3: Appropriate care and services are provided to consumers/patients.

Criterion 1.3.1: Health care and services are appropriate and delivered in the most appropriate setting.

Health and Community Service Standards (6th edition)

Provided by the Quality Improvement Council (QIC)

Standard 2.2: Service and programs are provided in an effective, safe and responsive way to ensure positive outcomes for consumers and communities.

Evidence Questions: What is the evidence that:

- a) interventions and action are based on assessment and planning?
- b) services and programs are managed to ensure positive outcomes for consumers and communities?
- c) information about the rationale, risks and effects of services and programs is routinely provided to consumers and communities?

- d) consumers and communities participate in decision-making about services and programs they receive?
- e) services and programs are safe and risks are identified and addressed?
- i) services and programs are evidenced based?
- j) services and programs follow case/care plans developed with consumers?

9.4 National Mental Health Standards (Revised 2010)

Criterion 2.1: The organisation promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.

Criterion 2.2: The organisation reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.

Criterion 2.10: Staff are regularly trained to, wherever possible, prevent, minimise and safely respond to aggressive and other difficult behaviours.

Criterion 6.2: Consumers have the right to receive service free from abuse, exploitation, discrimination, coercion, harassment and neglect.

9.5 Recovery-Oriented Service Self-Assessment Tool (ROSSAT)

Item 2.28a: Policy and procedures are in place that acknowledge the human rights that inform service provision.

Item 2.28b: Policy and procedures are in place that safeguard all people against abuse and discrimination.

Item 2.28c: Policy and procedures are in place that outline processes for reporting abuse of workers and consumers.

9.6 NSW Disability Services Standards (DSS)

10.1: The service provider develops and implements policies and procedures relating to the prevention of sexual, physical and emotional abuse.

10.2: The service provider develops and implements procedures for reporting and responding to abuse.

Appendix 3 – Endorsement Listing

Kezelman, C, & Stavropoulos, P, Adults Surviving Child Abuse, 2012, *'The Last Frontier' Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery*

Register, download and/or purchase available at:

www.asca.org.au/guidelines

The Guidelines (funded by Department of Health & Ageing DoHA) were launched in October 2012 by the Hon Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, Minister Assisting the Prime Minister on Mental Health Reform, and present the evidence base needed to translate research into practice. They highlight the urgent need for all service and practitioner cultures and practice to be sensitive to the prevalence, impacts and stakes of complex trauma and the needs of complex trauma consumers. Their primary purpose is to inform a diverse audience about new ways of conceptualising and responding to trauma in clinical practice and health and human service settings. Their broad-based implementation will enable new possibilities for recovery for survivors of trauma and their children.

The following national and international endorsements for the Guidelines were provided prior to publication:

Trauma-Informed Care & Practice Advisory Working Group:

Jenna Bateman	MHCC	NSW
Corinne Henderson	MHCC	NSW
Dr Cathy Kezelman	ASCA	National
Dr Richard Benjamin	Eastern Mental Health Services, Rosny	TAS
Dr Sabin Fernbacher	Northern Area Mental Health Service	VIC
Jo Campbell	ECAV	NSW
Dragan Wright	Creating Differently Private Practitioner	NSW
Janne McMahon	Private Mental Health Consumer Carer Network Australia	SA/National
Jan Roberts	NSW Principal Official Visitor	NSW
Alan Woodward	Lifeline Foundation for Suicide Prevention	ACT/National

Endorsement statements (International)

It is my pleasure to inform you that the Board of Directors of the International Society for the Study of Trauma and Dissociation, upon recommendation of the Scientific Committee of the International Society for the Study of Trauma and Dissociation, has passed the following resolutions unanimously.

The International Society for the Study of Trauma and Dissociation endorses the final draft of the Australian ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery.

The Board of Directors of the International Society for the Study of Trauma and Dissociation commends ASCA, Dr Cathy Kezelman, Dr Pam Stavropoulos, and the Department of Health and Ageing of the Federal Government of Australia for making these guidelines possible.

Thomas G Carlton, MD

President, International Society for the Study of Trauma and Dissociation (ISSTD), USA

The world map on countries that provide understanding and treatment for the most traumatised people with dissociative disorders has now expanded as Australia rigorously, compassionately and robustly provides us with clinical guidelines.

Dr Valerie Sinason, PhD

MACP, M Institute of Psychoanalysis FIPD, Director, Clinic for Dissociative Studies, London

Individual endorsements

Emeritus Professor Judy Atkinson, Patron We-Ali, NSW
Dr Richard Benjamin, Psychiatrist, Clarence & Eastern District Adult Community Health Service, Tasmania
Robyn Bradey, Mental Health Accredited Social Worker in Private Practice, NSW
Thomas G. Carlton, MD, President, International Society for the Study of Trauma and Dissociation; Emeritus Professor Russell Meares MD, Emeritus Professor of Psychiatry at Sydney University, Foundation chair of Psychiatry of Sydney University at Westmead Hospital, Foundation President of the Australian and New Zealand Association of Psychotherapy
Adjunct Professor Warwick Middleton MB BS, FRANZCP, MD, Chair, The Cannan Institute, Director, Trauma & Dissociation Unit, Belmont Hospital, Fellow, International Society for the Study of Trauma and Dissociation, Adjunct Professor, School of Public Health, La Trobe University, Melbourne
Associate Professor, School of Medicine, University of Queensland, Brisbane, Adjunct Professor, School of Behavioural, Cognitive & Social Sciences, University of New England
Dr Brendan Nelson MBBS, Ambassador to European Union, Belgium, Luxembourg, NATO, Former leader Federal opposition (Liberal Party), former President AMA

Associate Professor Carolyn Quadrio, Associate Professor of Psychiatry UNSW, private practice in Forensic and Child and Family Psychiatry, former Chairperson of the Bi-National Committee for Advanced Training in Psychotherapy for the Royal Australian and New Zealand College of Psychiatrists, former Director of Mental Health Services with Corrections Health Service in New South Wales
Dr Jan Resnick, Senior Psychotherapist, (Past) Founding President Psychotherapists & Counsellors Association WA (Inc.), Founding Director of Training of The Churchill Clinic (Inc), Editorial Advisory Board member Psychotherapy in Australia, Clinical Member PACFA, Accredited Supervisor (of Psychotherapy) RANZCP
Lenaire Seager, Clinical Co-ordinator, Trauma and Dissociation Unit Belmont Private Hospital, Brisbane, Queensland
Emeritus Professor Freda Briggs AO, Professor Emeritus, Child Development, University of South Australia, foundation Dean of the de Lissa Institute of Early Childhood and Family Studies, recipient the Inaugural Australian Humanitarian Award, ANZAC Fellowship Award, Jean Denton Memorial Fellowship, Creswick Fellowship Award, Inaugural Senior Australian of the Year 2000 award
Associate Professor Martin Dorahy, PhD, DClinPsych, Associate Professor Department of Psychology University of Canterbury; member Research Advisor Panel of the Cannan Institute.
Chair International Society for Study of Trauma and Dissociation's David Caul Graduate Research Award, Co-editor European Society for Trauma and Dissociation Newsletter
Dr Jan Ewing PhD, MCP, Clinical Neuropsychologist, Clinical Psychologist, founding member of the College of Clinical Neuropsychologists, founding member and Fellow of the Australian Society for the Study of Brain Impairment
Dr William Glaser MB, BS, BA, DipCrim, FRANZCP, Consultant Psychiatrist State-wide Forensic Services, Disability Services, Victoria
Corinne Henderson, MA, M Couns Clinical Member CAPA, Clinical Member PACFA, Senior Policy Advisor Mental Health Coordinating Council NSW, Counsellor, Psychotherapist, Member, NSW Mental Health Review Tribunal
Dr Anthony James Korner, MBBS (Hons), M Med (Psychotherapy), FRANZCP, Coordinator Westmead Psychotherapy Program, Senior Clinical Lecturer University of Sydney
Dr David Leonard MB, BS, DPM, FRANZCP, AM, Consultant Psychiatrist, University of Melbourne, Member of the Order of Australia for services to psychiatry 2010

International – 1. Organisations | Bodies

Organisation | Body State | Country

- Clinic for Dissociative Studies, London
- International Society for Study of Trauma and Dissociation, USA
- The National Center on Family Homelessness Needham Heights, MA USA
- Trauma and Dissociation, Israel

International – 2. Individuals

Name Role State | Country

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Appendix 4

MHCC and ASCA National Trauma-Informed Care and Practice activities 2010–13

<p>Pre-NTICP</p> <p>2006</p> <p>2010</p>	<ul style="list-style-type: none"> • Funded by the Victims of Violent Crime Grants Project • Reframing Responses Stage 1 – MHCC project examining the international evidence surrounding the long-term impacts of interpersonal trauma on the mental health of women survivors of childhood trauma. Also a study into access and equity for women survivors of childhood abuse with complex needs in NSW. ASCA was a reference group member. • Reframing Responses Stage 11 – MHCC project that provided an Information Resource Guide and Workbook for Community Managed Organisations
<p>May 2010</p>	<p>Borderline Personality Disorder Reconsidered :considerations regarding current diagnosis, treatment and service delivery: a position paper</p>
<p>June 2010</p>	<p>Partnership Committee formed between MHCC, ASCA, ECAV and PMHCCN to further discussion surrounding trauma, mental health issues and access and equity to trauma specific services</p>
<p>NTICP</p> <p>May, 2010</p>	<p>Consultation paper on the development of a National Strategy for Trauma-Informed Care</p>
<p>September 2010 Highlight</p>	<p>Inaugural Trauma-Informed Care & Practice Forum</p>
<p>November 2010</p>	<p>Report and Outcomes Paper from the Inaugural Trauma-Informed Care & Practice Forum</p>
<p>January 2011</p>	<p>Trauma-Informed Care and Practice Conference committee established</p>
<p>June 2011 Highlight</p>	<ul style="list-style-type: none"> • Trauma-Informed Care & Practice: Meeting the Challenge, two-day National Conference • Conference evaluation and outcome/ actions report provided to the sector
<p>July 2011 Highlight</p>	<p>ASCA awarded grant from DoHA for the development of Best Practice Guidelines around Complex Trauma and Trauma-Informed Care and Service Delivery</p>
<p>August 2011 Highlight</p>	<ul style="list-style-type: none"> • MHCC, ASCA and ECAV Collaboration on Community Services and Health Industry Skills Council Certificate IV in Mental Health Peer Work qualification framework • Unit of Competence – Orientation to Trauma-Informed Care – knowledge and skills required by individuals to understand and practice Trauma-Informed Care

Sept – Nov 2011 Highlight	<ul style="list-style-type: none"> • Invitations to ‘targeted experts’ to join the NTICP AWG as well as second-tier reference group • Establish NTICP AWG • Establish TICP Network database
September 2011	ASCA and MHCC Presentation – The MHS 21st Annual Conference Adelaide – RESILIENCE IN CHANGE : <i>Trauma-Informed Care & Practice: using a wide angle lens</i>
October 2011 Highlight	<p>Launch TICP microsite hosted on MHCC website</p> <p>This includes: TICP specific news and events, conference material, videos, audios, presentations, research material, network updates etc.</p>
November 2011	<ul style="list-style-type: none"> • ASCA Forget Me Knot Day • Parliamentary Briefing NSW: ASCA & MHCC • <i>Complex trauma and Trauma-Informed Care and Practice: a national agenda</i>
December 2011	<ul style="list-style-type: none"> • First meeting of the NTICP AWG • NADA TICP Forum Presentation • MHCC – Panel discussion participant • Completion of first draft Practice Guidelines around Complex Trauma and Trauma-Informed Care and Service Delivery (ASCA) • Review by project internal stakeholders
February 2012	<ul style="list-style-type: none"> • MHCC Learning and Development • Form reference group for the development of Professional Development and accredited courses surrounding Trauma-Informed Care and Practice
March 2012	<ul style="list-style-type: none"> • Completion second draft Best Practice Guidelines (ASCA) • Review by external stakeholders • Second Meeting of the NTICP AWG • Terms of Reference finalised
May 2012	<ul style="list-style-type: none"> • Third Meeting of the AWG • Completion of final draft Practice Guidelines (ASCA) • Presentation to DoHA for sign off • Endorsements Australia and International experts
May 2012 Highlight	MHCC pilot workshop: <i>Trauma-Informed Approaches to Aboriginal Wellbeing</i>
June 2012	MHCC Presentation at Altering States: Working for Wellbeing Conference 2012, in Brisbane. <i>Building Workforce Capacity in Trauma-Informed Care</i>
June 2012	<ul style="list-style-type: none"> • ASCA Presentation: <i>Recognising and responding appropriately to Trauma</i>. APSAC Conference • ASCA Presentation: <i>Informed Responsiveness to Complex</i>

	<i>Trauma. Australasian Conference of Childhood Trauma</i>
August 2012	<ul style="list-style-type: none"> • 15 NSW Rural Mental Health Conference Joint Presentation MHCC and ASCA. <i>Trauma-Informed Care & Practice: towards a shift in service delivery culture in mental health and human service sectors in Australia</i>
September 2012	<ul style="list-style-type: none"> • MHCC application to the NSW Law and Justice Foundation • Project: <i>A Trauma-Informed approach to working with people with mental health and complex psychosocial issues interacting with the criminal justice system</i>
October 2012	<ul style="list-style-type: none"> • ASCA presentation, Keynote PACFA conference: <i>Trauma-Informed Care</i> • ASCA presentation workshop, annual Conference International Society for Study and Trauma and Dissociation, Los Angeles LA: <i>Connecting the Dots Integrating Complex Trauma Policy, Principles & Practice</i>
October 2012 Highlight	ASCA Launch <i>The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery</i> (Kezelman, C, & Stavropoulos, P, 2012). Launched by Hon Mark Butler, Minister for Mental Health and Ageing, Minister for Social Inclusion, Parliament House Canberra
November 2012	ASCA presentation: <i>Minimising Trauma in Service Settings; Care without Coercion: Inside Out</i>
November 2012 Highlight	MHCC pilot training professional development 2 day workshop held. <i>Understanding and Responding to Trauma: Trauma-informed care in mental health and community –based services</i>
December 2012	MHCC and ASCA presentation and panel participation at the Sydney Institute of Criminology Conference 2012: <i>Tackling Complex Needs: An Inter-disciplinary Exploration</i> . Presented on the relationship between complex need, a history of trauma and interactions with the criminal justice system (CJS). The paper proposed a trauma-informed approach across human service sectors and new models of care for people with complex needs in order to prevent them interacting with the CJS and assist them transition back into the community. A panel discussion expanded on the subject. MHCC promoted LD workforce development and described the TICP agenda and work of the TICP Advisory WG.
February 2013	MHCC Submission to the Premier's Council on Homelessness: <i>Pathways into homelessness and child protection</i> . There is little robust evidence in Australia highlighting children's pathways between homelessness and child protection and vice versa. Existing evidence points to families at risk with complex needs are both homeless and in contact with the child protection system. The issues highlighted included: 1. Data collection and research evidence to provide an understanding of children in contact with child protection systems and

	2. Care and treatment for people under mental health legislation – i.e. a trauma-informed (TICP) recovery-oriented approach.
Feb – March 2013	ASCA pilot workshops – two-day. Trauma-informed care to community service sector 4 pilot sites. MHCC Professional Development – two-day. <i>Understanding and responding to trauma</i>
March 2013 Highlight	Presentation to Mental Health Council Australia and USA Guests USA guests attending were Susan Coleman, Recovery Innovations and Gary Parker, Kansas Consumer Advisory Council. The presentation outlined the work of MHCC, ASCA and the National TICP Advisory Working Group. The presentation described the background and events facilitated, e.g. the TICP Conference, the TICP microsite and described the resources/training opportunities that have been developed to inform and build sector capacity. MHCC Professional Development – 2 day. <i>Trauma Informed Response to Aboriginal Healing Needs</i>
May – June 2013	MHCC engagement with various organisation implementing TICP into service systems: <ul style="list-style-type: none"> - Wesley Mission Counselling Services - Missenden Unit & Community Mental Health Services, SLHD - NSW Department of Family & Community Services – Special Homelessness Services, Learning & Development Branch - Mental Health Policy Unit, Policy & Government Relations, ACT Government, Health Directorate - Stepping Out Housing Program, NSW
April 2013	<ul style="list-style-type: none"> • WA launch of ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery by Eddie Bartnik, WA Mental Health Commissioner, hosted by Sexual Assault Resource Centre WA. • MHCC Professional Development – two-day. <i>Understanding and responding to trauma</i>
April 2013	<ul style="list-style-type: none"> • Child Aware Approaches Conference – ASCA presentation of outcome of pilot program two-day trauma-informed training to community services sector. • NSW Launch ASCA Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery by John Feneley NSW Mental Health Commissioner at MHCC graduation ceremony • PHAA Complex Needs Conference – ASCA presentation Complex trauma and its impacts – a substantial public health issue • MHPN webinar on complex trauma – ASCA presentation around Trauma-Informed Care and Practice

May 2013	<ul style="list-style-type: none"> • Launch of ASCA Practice Guidelines in Queensland by Qld Minister of Health, the Hon Lawrence Springborg MP • Sydney Law School – multidisciplinary forum historical child sexual assault ASCA presentation survivor support needs • Australian Women’s Health Conference: <i>Improving outcomes for women impacted by childhood trauma</i>
May – June 2013	ASCA pilots 3 different workshops for survivors, carers, health professionals grounded in research from ASCA Practice Guidelines nationally.
April –June 2013	<ul style="list-style-type: none"> • ASCA in-house training to number of organisations re including TICP <ul style="list-style-type: none"> - Victims and witnesses of Crime Court Support - MICAH Projects Qld - Goldfields Midwest Medicare Local - St. John of God Richmond • MHCC Professional Development – 2 day. <i>Understanding and responding to trauma</i>
June 2013	MHCC & ASCA Finalist THEMHS Award Special Achievement to be announced at Conference August 2013
July 2013	<ul style="list-style-type: none"> • ASCA – Annual National Suicide Prevention Australia Conference Melbourne – <i>Complex trauma and the lived experience of suicidality</i> • MHCC Professional Development – two-day. <i>Understanding and responding to trauma</i> – 2 courses
August 2013	<ul style="list-style-type: none"> • ASCA – ACSSA Forum <i>Trauma, Trauma Frameworks and Being Trauma-Informed</i> – Panel participant • MHCC – panel participant • MHCC Professional Development – two-day. <i>Understanding and responding to trauma</i> • ASCA – Keynote, Lighthouse Institute Journey to Recovery International Conference for Attachment and Trauma-Informed Practice: <i>Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery</i> • ASCA – Presentation TICP and Recovery Orientation, Professional Development NSW Mental Health Review Tribunal • MHCC – Lighthouse Conference: <i>TICP towards a cultural shift in mental health and human services in Australia</i>

<p>August 2013</p> <p style="text-align: center;">Highlight</p>	<ul style="list-style-type: none"> • MHCC – TheMHS Forging the Future Conference Melbourne: <i>TICP towards a cultural shift in mental health and human services in Australia</i> • MHCC and ASCA receive Special Achievement Award at TheMHS 2013 for their work on their leadership role in championing the development of a national TICP strategic direction • ASCA – TheMHS conference: <i>Forging the future for people and communities affected by unresolved trauma</i> • ASCA – Professional Development MHRT: <i>Embedding TIC into ROP</i> • NTICP AWG – Review and sign off second Terms of Reference heralding the next stage of the project
<p>September 2013</p>	<p>MHCC Professional Development – two-day. <i>Understanding and responding to trauma</i>. 7 courses.</p>

Appendix 5

Project Plan (Brief version)

Trauma-Informed Care and practice Organisational Toolkit (TICPOT): a policy and practice implementation tool for community mental health and the human service sectors

Project Purpose

The *Trauma-Informed Care & Practice Organisational Toolkit (TICPOT): a policy and practice implementation tool for community mental health and the human service sectors* project evolved as a consequence of a broader national initiative championed by MHCC, ASCA and collaborating partners and a network of stakeholders across mental health and human service sectors recommending the principles of trauma-informed care and practice be integrated across mental health and human service sectors and systems throughout Australia.

The toolkit aims to recommend practices to assist community-managed organisations to develop policies and practice that embed TICP principles into every aspect of their organisation. This requires an organisational culture committed to facilitating re-orientation towards trauma-informed recovery by incorporating trauma-informed values into organisational change processes. This includes becoming trauma-informed at an operational level, in service planning and evaluation, delivery of services and programs, as well as in the workforce development and training provided to support best practice. One of the aims of the project is to assist organisational change processes.

This project aims to support the aims and objectives identified in the strategic direction recommendations proposed by the National Trauma-Informed Care & Practice Advisory Working Group (NTCIP AWG) in their Position Paper to be released in October 2013. This document: Mental Health Coordinating Council (MHCC), 2013, *Trauma-Informed Care and Practice: towards a cultural shift in policy reform across mental health and human services in Australia – A National Strategic Direction*, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, is underpinned by international evidence referenced in the position paper literature review.

The toolkit will fill an identified gap in resources available to the community-managed mental health and human services sectors in Australia and will support organisations and their workforce to progress from the 'What' to the 'How', transitioning from research into practice.

Project aims

- In undertaking this project MHCC aim to develop a mechanism by which community-managed organisations can be supported to embed TICP principles.
- The *TICPOT* project is a necessary next step in developing a package of resources to support training and professional development across the mental health and human service sectors, identifying the processes that can be utilised to implement organisational change.

The vision is that:

- health and human service communities come to embody these values;
- these communities are equitably engaged as partners to address health disparities and have agency and resources to facilitate healing; and
- implementation of trauma-informed services and supports is a broad-based prevention strategy.¹⁵⁹

Eight foundational principles will underpin all the contents included in TICPOT. They represent the core values of trauma-informed care.¹⁶⁰

Following from the completion of *TICPOT*, MHCC will consider the benefits of offering an Organisational Change Consultancy service to the mental health and human services sectors, involving the services of a consultant/s to assist with in-house organisational change processes to enable implementation of trauma-informed recovery principles and practice across operational, administrative and service delivery contexts.

Other related projects and activities

Recovery-Oriented Service Self-Assessment Toolkit, ROSSAT: Following from the work in progress to an understanding of the psychometric properties of the ROSSAT, which aims to establish the 'face validity', or the content and response process validity, of the two key ROSSAT tools: Tool for Organisations (T4O) and a Tool for Workers (T4W), it will be necessary for the assessment aspects of TICPOT to interface with the ROSSAT tools.

Implementing Practice Supervision in Mental Health CMOs in NSW

The Project studied the evidence surrounding supervision and mentoring practices internationally and in Australia, and provided an analysis of consultations conducted with a diversity of the MHCC member organisations into supervision practices in their organisations. The Project explored ways in which CMOs are using supervision, examined potential benefits and costs relating to different types of supervision, and sets out to understand some of the factors that may promote or hinder effective implementation and practice of supervision in the community sector. The project provides some resources and offers some guidelines as to how CMOs might develop and implement policy in the context of their specific service. In the context of development of TICPOT resources, practice supervision will be an important aspect of organisational change to be considered.

Project description

While the exact contents are yet to be finalised, *TICPOT* it is likely to include certain basic elements such as the following:

1. TICP User Guide

- Introduction to TICP and brief overview of evidence base
- Information about what it means to be trauma-informed and provide trauma-informed services, and why this is important to consumers and services

2. Organisational TICP Tools, Templates and Checklists

- A tool designed to assess and evaluate organisations
- A tool that assists managers to assess and evaluate services and programs
- A tool designed to self-assess workers and evaluate understanding of TICP workplace culture
- A tool to measure consumer outcomes and experience of service

3. How-To Manual for creating Organisational Change

- Identify concrete steps for organisations to become trauma-informed – creating TI environments and approaches
- Identify ways to implement organisational change including policy development
- Sustaining trauma-informed Change: supporting organisational culture and commitment – continuous review; practice supervision; training and professional development; and other frameworks to guide practice
- Recommended practices for awareness of trauma and assessment of risk that ensure safety and minimise re-traumatisation

Appendix 6 – Bibliography

Please note that all links are current as at 18 October 2013. Most will open the hyperlink directly, but some require reader to copy/paste into the Browser.

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Appendix 7 – Endnotes

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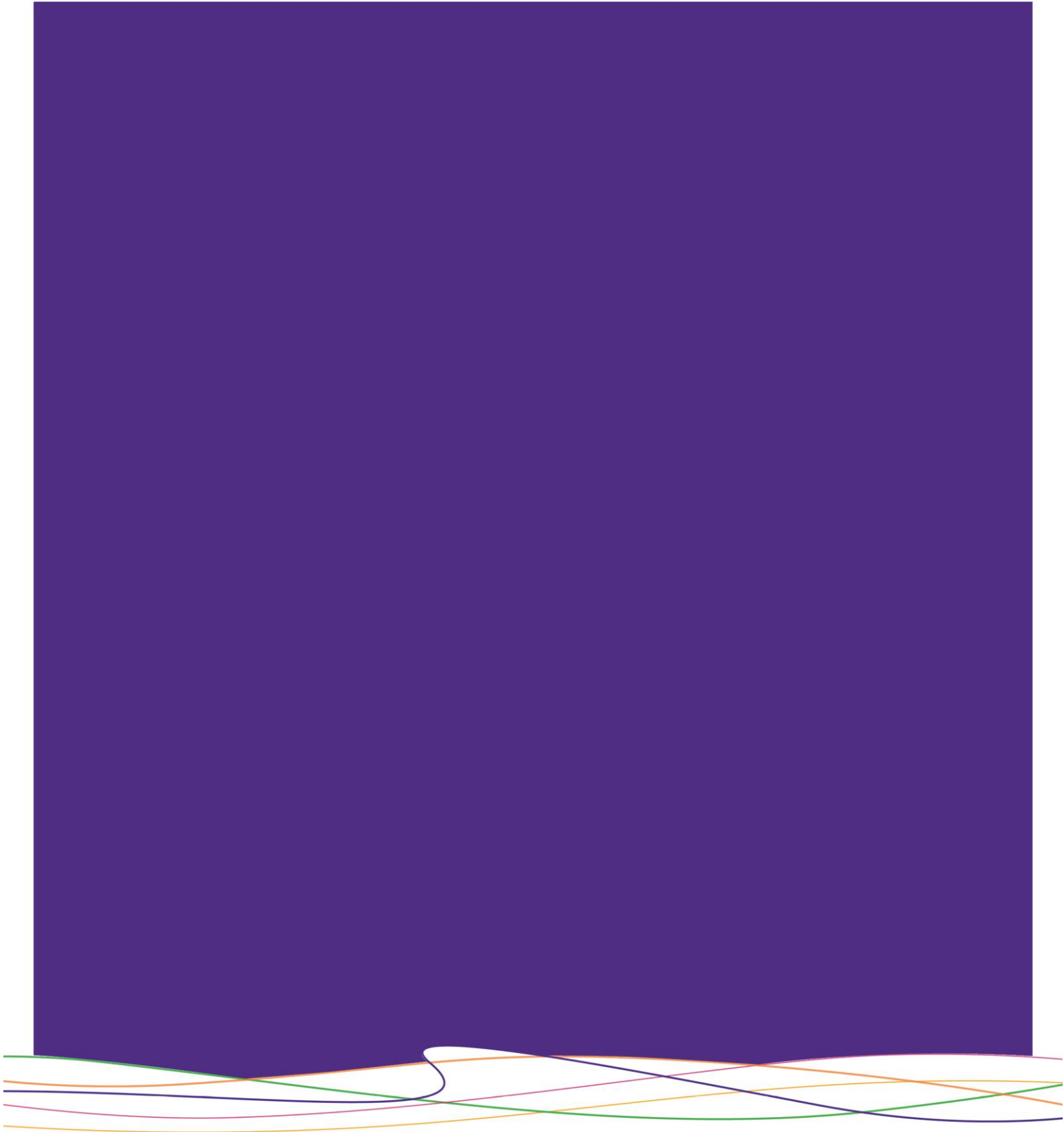
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