Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia - a national strategic direction

Authors: Bateman, J and Henderson C 2013, Mental Health Coordinating Council (MHCC), NSW Australia, Authors: Kezelman, C, Adults Surviving Child Abuse (ASCA)

ABSTRACT

This paper describes the background to recommendations for a national strategic direction that promotes Trauma Informed Care and Practice (TICP) in Australia by championing a cultural shift in policy reform across mental health and human services. Informed by international and Australian evidence, it explains the rationale for embedding TICP Principles into broad-based policy reform and integration across service settings, systems and jurisdictions.

BACKGROUND

> *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)

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; and 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 (SAMHSA 2012).

EVOLUTION OF A STRATEGIC DIRECTION

> *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).

Recovery-orientation has been adopted as an overarching philosophy to guide mental health practice, and is embedded into policy and standards nationally. The Mental Health Coordinating Council (MHCC), Adults Surviving Child Abuse (ASCA) and collaborating partners propose that an understanding of trauma is integral to contemporary theory and best practice of the recovery-oriented approach. This requires a fundamental shift in philosophy, culture, and practice. This paper therefore highlights the necessity for a Trauma-Informed Recovery-Orientated approach to policy reform and service delivery for people accessing a diversity of mental health and human services (who often have lived experience of past and present trauma).

As we work to minimise systems' barriers to recovery so too must we work to reduce the possibilities for re-traumatisation and harm within service systems and practice. In order to do this the concepts of trauma- informed care and recovery must be integrated into one philosophy of practice and set of principles - to be embedded across systems and services. This involves recognition of lived experience of trauma and the particular 'triggers' that may lead to re-traumatisation and re-victimisation.

Professor Louise Newman (2012) Psychiatrist and Director, Centre for Developmental Psychiatry and Psychology, Monash University wrote:

> *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* (ASCA, 2012).

MHCC and ASCA have been instrumental in championing a national initiative to bring about the policy focus necessary to transform organisations, services and practitioner practice; embed TICP into service systems, and build the capacity of the mental health and human services workforce to recognise and respond appropriately to trauma. In 2010, MHCC and ASCA, together with collaborating partners NSW Health Education Against Violence (ECAV), and the Private Mental Health Consumer Carer Network (PMHCCN) formed a steering group to address clear deficits in the way in which service systems respond to people with mental health problems and underlying trauma history nationally. The partners convened a forum in 2010 which established the need to develop systems and service delivery cultures that embrace a TICP approach.

One of the outcomes of the forum was to host a national conference as part of an ongoing broader initiative advocating for a national TICP approach promoting a broad-based shift in organisational culture and practice. Following the landmark national conference held in 2011, *TICP: Meeting the Challenge Conference*, the partners established a National TICP advisory working group (NTICP AWG) that has collaborated to progress implementation of TICP principles and broad-based policy reform across public, private, community-based mental health and human service systems in Australia.

In October 2011, MHCC launched a microsite devoted to TICP matters which presents a diversity of regularly updated resources. In it stakeholders can share information, read about news and events; training opportunities; access research and view video presentations including some from some key speakers from the 2011 conference. The site also includes information as to how interested parties can join a trauma informed network to keep up to date with developments.

Following these events, interest in trauma and trauma-informed care and practice has grown in both policy reform and workforce development across service sectors. MHCC, ASCA and ECAV along with other training providers facilitate numerous courses and professional development opportunities targeted at different professional and practice groups. Over the last two years, MHCC has been inundated with enquires about the development of policy and organisational change resources and professional development across sectors and disciplines. We have been encouraged by the groundswell of interest, conversation and energy related to trauma, the need for organisational and policy reform and research into evidence based practice.

CURRENT SYSTEMS' RESPONSES TO TRAUMA AND ITS EFFECTS

Responding appropriately to trauma and its effects requires specialised knowledge, workforce development and collaboration across service systems.

Australia's mental health system has a poor record in recognising the relationship between trauma and the development of mental and physical health conditions and coexisting problems, and demonstrates a lack of understanding or policy focus on trauma-informed approaches within practice and service settings.

There are several reasons for this, including but not limited to:

- mental health system based on a 'diagnose and treat' approach which fails to identify or acknowledge the lived experience underlying presentations and their impacts;
- resistance by some health professionals to believe accounts of people disclosing abuse histories without substantiation from other parties/ sources. This therefore minimises and/or fails to validate lived experience;
- society which continues to ignore abuse and minimise its effects; which pathologises and blames the victim rather than providing informed support;
- use of coercive interventions (e.g., seclusion and restraint, forced involuntary medication practices), and philosophies of care based on control and containment rather than empowerment and choice. The result is often unintentional re-traumatisation in already vulnerable populations.

Recognition and integration of experienced trauma is fundamental to the recovery process. As the impacts of trauma are cumulative, current victimisation and trauma compounds the effects of prior trauma. 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.

Bloom and Farragher (2013) in their latest of a trilogy on trauma informed systems of care write:

> *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.*

TRAUMA-INFORMED CARE AND PRACTICE

So what is Trauma-Informed Care and Practice?

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

TICP exemplifies a 'new generation' of transformed mental health and human service organisations and programs which serve people with histories of past and current trauma. It is a practice that can be utilised to support service providers in moving from a 'caretaker to a collaborator role'.

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 a person seeking services.

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).

Systems failures occur when complex trauma and its effects are unrecognised or misdiagnosed, and mainstream services are unable to address trauma victims' needs. People impacted by trauma characteristically present to multiple services over a long period of time and care is often fragmented with inadequate coordination between services, and poor referral pathways and follow-up protocols which results in a `merry go round' of unintegrated care. This risks re-traumatisation and compounding problems as a result of unrecognised trauma. Such escalation and entrenchment of symptoms is psychologically, financially and systemically costly. Understanding that trauma underpins the way in which many people present who attend a diversity of service settings necessitates substantially new ways of operating.

Many trauma survivors have not connected their current problems and behaviours with past traumatic experiences - nor may health or mental health workers. The cost of inadequate service responses individually, to community in health, welfare and economic terms is immense.

Too often trauma survivors experience services as unsafe, disempowering and/or invalidating. Frequently, after failing to find a service which understands their behaviours and reactions in the context of their trauma history, they withdraw from seeking assistance. Unfortunately one of the pervasive impacts of trauma can include the way people approach potentially helpful relationships (Fallot et al., 2009). This includes seeking help from professionals. All too frequently failure to provide trauma-informed services, as well as poor access to trauma-specific services exacerbates mental and physical health issues and escalates the risk of suicide. Responsive and effective crisis management must be matched by affordable, accessible, ongoing care delivered in a manner maximising consumer self-determination.

ABSOLUTE MUSTS FOR IMPLEMENTATION

So what are absolute musts for implementation of TICP across service settings?

Trauma-Informed services regardless of contexts must be based on principles, policies, and procedures that provide safety, voice and choice. They must focus first and foremost on an individual's physical and psychological safety, including responding appropriately to suicidality. They must also be flexible, individualised, and culturally competent, promote respect and dignity, hope and optimism and reflect 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 (Meares, 2004: 2012).

Unfortunately the multiple symptoms and behaviours with which trauma survivors may present can cause confusion amongst clinicians and treating teams. Often consumer histories list several diagnoses and levels of need. Since current models of care in public and primary health care settings mostly focus on diagnosis many complex trauma survivors carry multiple diagnoses. Services that embed TICP principles not only move away from a sole focus on diagnosis but facilitate holistic care based on lived experience and individual need.

BENEFITS OF TICP

The international evidence clearly identifies benefits of introducing TICP. Outcome studies in the USA provide substantial evidence related to the benefits for consumers and workers, as well as the cost-effectiveness of introducing TI policies and practice (Hopper et al., 2010).

We know for example from studies (Cocozza et al., 2005) and pilot programs (Kammerer Project) utilising a trauma-informed model decreases psychiatric symptoms and substance use. Some of these programs have shown improvement in consumers' daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms. Early indications suggest that TIC may have a positive effect on housing stability, and decreases use of crisis-based services (Community Connections, 2002). Findings also suggest that integrating services for traumatic stress, substance use and mental health leads to better outcomes (Morrissey et al., 2005) and consumers were more satisfied when organisations are trauma-informed. Moreover, integrated TI programs do not cost more than standard programming (Domino et al., 2005).

Similarly, qualitative results find that providers also report positive outcomes in their organisations (Open Health Services and Policy Journal, 2010) and a sense of self-efficacy among consumers. Supervisors report improved staff morale, fewer negative events and more effective services (Community Connections, 2002).

One consumer wrote:

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

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 success story hundreds of thousands of people pass through service systems with unacknowledged and painful trauma histories every day. The good news is that people with trauma histories can and do recover.

A SYSTEMIC APPROACH

What we need is a systemic NO WRONG DOOR approach that recognises that core to accommodating the service needs of trauma survivors. Trauma must be seen as the expectation, not the exception. What we are advocating for a systemic approach which ensures that all people who come into contact with services of any nature, receive care that is sensitive and responsive to the impact/s of trauma. And that this must occur regardless of the 'door' through which they enter**.**

Roger Fallot (2009), US 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.*

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

ASCA's practice guidelines '*The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (2012) is one of the mechanisms for achieving a national strategic direction. Grounded in substantive research evidence they outline best practice principles for working with complex trauma specifically for trauma specific services as well as providing trauma- informed guidelines to set organisational standards across a range of services and systems in community, public, and private settings.

MHCC has also developed resources to support implementation including an overarching policy template *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 system to be assessed and modified to incorporate Trauma-Informed principles into practice (MHCC, 2013).

MHCC is also in the process of developing a Trauma-Informed Care and Practice *TOOLKIT (TICPOT): a policy and practice implementation tool for community mental health and the human service sectors.* TICPOT is part of a broader initiative towards promoting integration of principles of TICP across service systems throughout Australia. The TOOLKIT is about organisational change, recommending practices to assist services and their workforce to embed TICP into every aspect of their organisation. It is designed to ensure that organisations are responding appropriately to the needs of people with lived experience of trauma prioritising safety for all. The resource will assist organisations to move from the 'What' to the 'How', transitioning research into practice. We hope to complete the TOOLKIT early in 2014.

CONCLUSION

Some US leaders in the field (Finkelstein & Hout, 2011) have made the following statements:

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

Our overall objective in championing the development of a TICP national strategic direction is to ensure that mental health policy reform acknowledges the need for all health and human services to become 'Trauma-Informed'. Governments must provide the necessary funding to enable publicly-funded agencies, programs, and services across sectors to facilitate an organisational and professional cultural shift (across disciplines).

Systems and services must support environments that are more comprehensively integrated, empowering and therapeutic for consumers impacted by past and current trauma. Governments must recognise the need to allocate funds for trauma-specific services and programs across service delivery settings, including e.g. inpatient; community based and self-referred trauma specific services and programs.

Important and central to our recommendations for a national strategic direction is capacity building, and workforce development is core to effective implementation. MHCC, ASCA and partner organisations have developed and deliver a variety of trauma-informed 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.

Central to our aims is that National and State-based Mental Health Commissions endorse and champion the changes needed to policy, service delivery and professional cultures by endorsing the recommendations of the NTICP AWG position paper *Trauma-Informed Care & Practice: towards a cultural shift in policy reform across mental health and human services in Australia –a national strategic direction* . Recommendations for the strategic direction are demonstrated in a position paper which will be disseminated in October (MHCC, ASCA, 2013).

January 2014

mhcc
mental health coordinating council

asca
adults surviving child abuse

REFERENCES

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

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

Cocozza J J, Jackson E W, Hennigan K 2005, 'Outcomes for women with co-occurring disorders and trauma: Program-level effects', *Journal Substance Abuse Treatment* 2005; 28: 109-19;

Community Connections 2002, *Trauma and abuse in the lives of homeless men and women, o*nline power point presentation, Washington: DC.

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

Norma Finkelstein, 2011, Executive Director & Laurie S. Markoff, Director of Trauma Integration Services Institute for Health and Recovery, Cambridge, Massachusetts

Herman, J 1992: 2001, *Trauma and Recovery: The Aftermath of Violence - from Domestic Abuse to Political Terror*. Pandora, UK.

Hopper, E., Bassuk, E & and Olivet, J 2010, Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, *The Open Health Services and Policy Journal*, 2010, 3, 80-100, available at: http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf

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

Kammerer N 2013, Project RISE evaluation report, unpublished program evaluation report. Boston, MA: *Health and Addictions Research Inc and Health Institute for Recovery*.

Meares, R 2004, The Conversational Model: An Outline, *American Journal Psychotherapy*, Vol.58.

Meares, R 2012, *A Dissociation Model of Borderline Personality Disorder*, Norton Series on Interpersonal Neurobiology, Hardback (USA), October 2012, and *Borderline Personality Disorder and the Conversational Model: a clinician's manual*; *Borderline Personality Disorder and the Conversational Model: A Clinician's Manual*, Paperback / softback (USA), October 2012.

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, Trauma -Informed Care and Practice - a national strategic direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA).

Mental Health Coordinating Council 2013, template available at: http://mob.mhcc.org.au/media/5956/diversity-trauma-informed-care-practice-policy-2013-06-03.pdf

Mental Health Coordinating Council 2013, TICP website, available at: http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx

Morrissey J P, Ellis A R, Gatz M 2005, Outcomes for women with co-occurring disorders and trauma: Program and person-level effects, *Journal Substance Abuse Treatment* 2005; 28: 121-33.

Morrissey J P, Jackson E W, Ellis A R 2005, Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders, *Psychiatric Services* 2005; 56: 1213-22.

Substance Abuse Mental Health Administration (SAMHSA) 2012, *National Center for Trauma-Informed Care* (NCTIC), Website available: http://www.samhsa.gov/nctic/

Victorian Department of Health 2011, *Recovery-oriented practice Literature review*.