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Trauma-Informed Care and Practice Organisational Toolkit

A Quality Improvement Organisational Change Resource

Stage 2
Supporting Organisational Change

Stage 3
Implementation

Information, Tools and Resources

New Edition

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Please cite this paper as follows:

Mental Health Coordinating Council (MHCC) 2018, *Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Resource, Stage 2 - Supporting Organisational Change and Stage 3 - Implementation* , Authors: Henderson, C (MHCC), Everett, M. Isobel S (Sydney LHD).

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Contents

Stage 2 - Organisational change planning

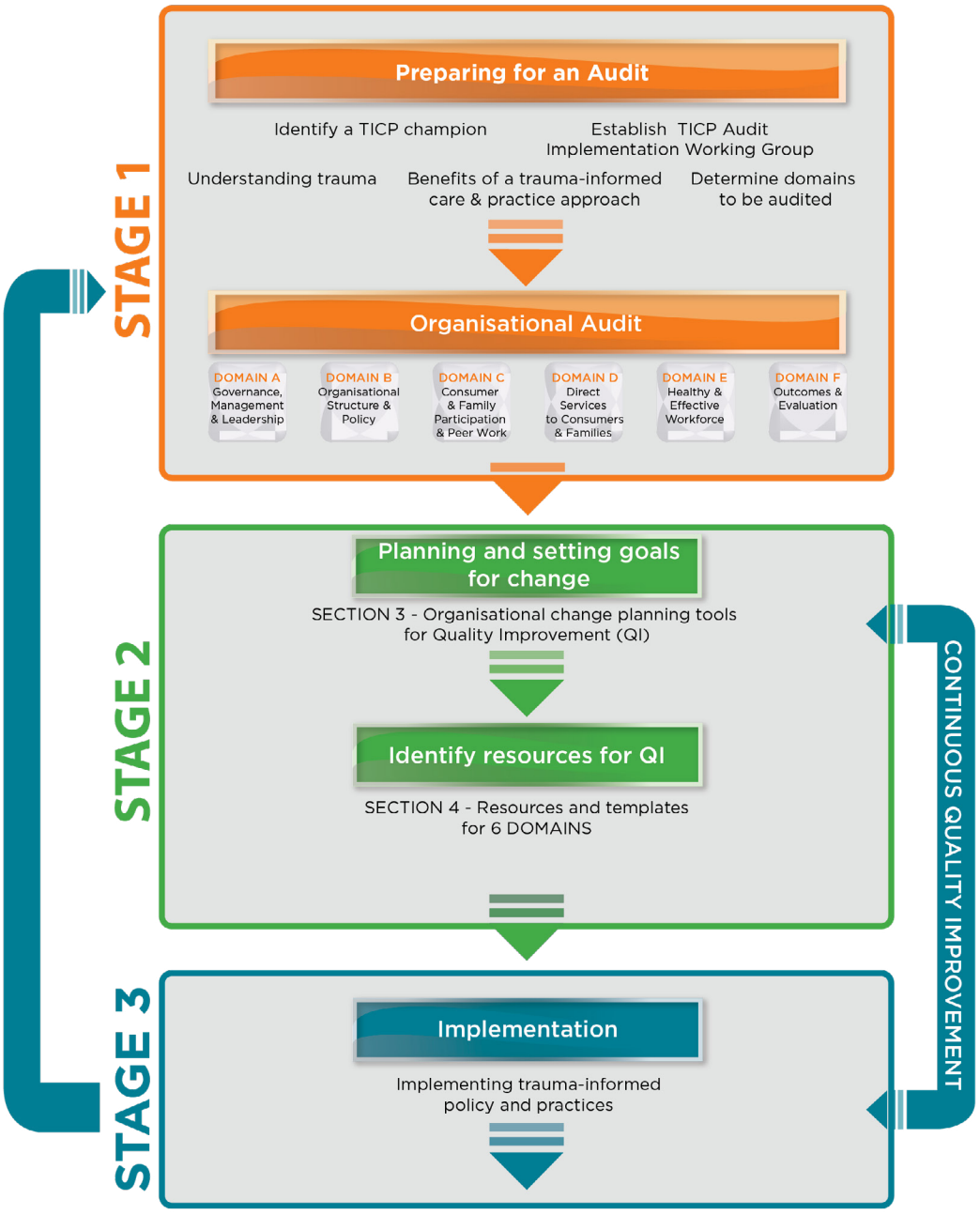

Figure: 1

Introduction

The process of becoming trauma-informed will be unique to each organisation and needs to be tailored. However, a universal aim is to establish a culture where the values and principles of TICP ultimately become second nature to all members of staff across the organisation. The process is intended to develop a service culture whereby staff remain receptive to the change and innovation needed to promote capacity building and sustainability.

Most organisations will not implement change in every aspect of their organisation, service and programs in one step. Through the audit process the TICPOT working group will identify a course of action that prioritises different areas for quality improvement over time according to their most pressing priorities.

An organisation may determine that their first priority is for example:

- trauma-informed education and training, AND/OR
- management needs to become skilled and knowledgeable enough to champion trauma-informed practices throughout the organisation, AND/OR
- policy, planning and structure must be in place first before changes can occur elsewhere in the organisation.

Planning and Implementation

Stage 2 & 3 of the TICPOT process builds on quality improvement processes for an organisation that has committed to:

- becoming trauma-informed
- undertaken the comprehensive organisational audit
- adopting a trauma-informed care and practice approach across organisational all/ or some domains

This document provides a number of tools, checklists and references to assist the organisation's AIWG to identify goals and develop a strategic plan for implementing organisational change.

I. Planning for Implementation checklist

Stages	Action
1. Identify a Leader in the organisation willing to champion TICP implementation and organisational change	**e.g. Appointed**
2. Implementation Working Group (including senior management and staff from across the organisation, and consumers and carers including current service users	**e.g. Established**
3. Prioritisation of areas to progress* following assessment stage – Goal statement Organisational domains for TICP assessment (essential) for action or quality improvement (to become trauma-informed):- A. Governance, Management and Leadership B. Organisational Policies and Structure C. Consumer and Carer/Family Participation D. Direct Services to Consumers E. Healthy and Effective Workforce F. Outcomes and Evaluation *Refer to the findings/recommendations arising from the organisational audit process	
4. Accountability has been clearly identified	
5. Timelines have been negotiated and agreed to	
6. Budget/Resources have been allocated	

II. Developing an implementation plan

Considerations for administrators: Implementation Plan [1]

The following are considerations as to how an organisation might start to design an implementation plan for quality improvement - having audited the organisation in one, several or all of the six domains.

You might start by undertaking the following:

1. Introduction and overview
    - Describe the organisation's history; the demographics that characterise its client base; the rationale for the implementation plan; and the rationale for incorporating of trauma-informed care and practice approach across some or all organisational domains
    - Identify strengths, weaknesses, opportunities, benefits and potential challenges
    - Provide an overview of goals and objectives (e.g. vision and purpose).

2. Specify specific goals and objectives

    Goals and objectives could address (for example):
    - Workforce development strategies for recruiting, hiring, retaining, training, upskilling supervising, and promoting wellness of mental health practitioners (clinical and nonclinical) to support a trauma-informed care and practice approach
    - Workforce development strategies to include the peer workforce
    - Consumer/carer participation and peer workforce support in implementation strategies for the review, development and co-design, delivery and evaluation of services and programs, policies and procedures
    - Policies, procedures, and practices to support a TICP approach that is culturally responsive, promotes safety both psychological and environmental , and prevents re-traumatisation
    - Identifying specific evidence-based best practice approaches to support a TICP approach in specific contexts
    - Strategies to amend facility design or environment to reinforce safety
    - Fiscal planning to ensure sustainability of the steps initiated in the organisation.

3. Establish guidelines for implementation

    - Guidelines should highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet TICP objectives
    - Specify how the service will be monitored, gather data, evaluate and measure outcomes and processes.
    - Consider whether to include 'a trauma-informed care and practice approach' in a Mission or Vision Statement) [2]
    - Consider workforce development training and professional development for different levels of practice need.

III. Ten Steps to support Quality Improvement

1. Identify new goals or challenges.
2. Gather input from each level of the organisation, partnering with consumers and other key stakeholders.
3. Analyse the feedback.
4. Explore improvement options and the potential barriers associated with each.
5. Select the overall approach and specific strategies to address barriers (anticipate potential barriers, and try to address them before they occur).
6. Develop an implementation plan, and present the plan to staff and other key stakeholders not directly involved in the quality improvement process.
7. Implement the plan, set a timeframe that everyone can agree to.
8. Reassess the new plan at predetermined stages.
9. Evaluate the results and determine if new goals or additional problems or issues need to be addressed.
10. Repeat the first nine steps after a set time period.

IV. Timeline Template

0	1	2	3	4
Date				
Person/s responsible:				
1-5 Audit conducted; Goals and challenges identified. No Data or plan	6 Plan has been developed but not implemented	7 Plan has been implemented	8 Plan has been implemented and data has been gathered regarding implementation	9 Plan has been implemented and revised based on feedback/ data regarding implementation
Reporting:				
Date:				

Overview

The following section offers some information, tools, templates and resources to support planning for organisational change based on the six organisational domains identified in *Stage 1 – Planning and Audit.*

The guide for users and the preamble to the audit tools in *Stage 1 – Planning and Assessment*, together with the sections following in this document, are provided to contextualise the six domains described and assist in the development of a quality improvement strategy. They will help identify organisational issues that may represent opportunities or barriers, and provide milestones to measure progress.

DOMAIN A - Governance, Management and Leadership

It is critical that an organisation's leadership and governance mechanisms invest in, and support, the implementation and sustainability of a trauma-informed care and practice approach. A person with the responsibility within the organisation to lead and oversight the process should be identified. TICPOT can provide a roadmap to help start the process of implementation by considering areas for quality improvement. While no checklist can cover every possible situation, and measurement metrics will vary across settings, general guidelines can be useful as a starting point (see listed resources following).

Trauma-informed organisations and systems recognise the impact of power. People who have experienced trauma often feel powerless, and can remain vulnerable to being further victimised in relationships and systems where they are powerless. Power can also be intentionally used by individuals and in organisations to facilitate change, and to influence and empower others. However, if the dynamics of power remain unrecognised they can obstruct growth, coerce and marginalise others, and leave anyone feeling powerless. This particularly applies to people who have experienced trauma in the past, and feel re-traumatised. Sharing power with all participants in the process of implementation is one way to ensure that power is not misused or abused.

A commitment to democratic leadership and participatory processes within organisations is a 'cultural antidote' to trauma (Bloom & Farragher 2013, p.113). [3] It provides checks and balances against the tendency to return to hierarchical or autocratic practices which make abuse of power more likely. Democratic leadership is defined (pp.98-116) [4] as "the everyday processes of hearing from everyone who will be involved in the decisions that affect their lives" (p.98). It does not refer to the political processes of equal representation and voting, but to a deep commitment of organisations to share power with individual accountability and responsibility (p.110).

To participate in democratic systems, people need to feel safe to speak up, certain that they will be heard and respected, and that others will be accountable for any decisions. Trauma-informed organisations provide safeguards for the participation of all those involved, including particular attention paid to the needs of those who have been marginalised and disempowered in the past.

DOMAIN A - Resources

Bloom, SL & Farragher, B 2013, Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care, Oxford University Press, New York, NY, pp. 108, 116.
Fallot, RD & Harris, MH 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self Assessment and Planning Protocol, Community Connections, Washington, DC. [5]

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, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA), MHCC, Sydney, NSW, pp.37-43. [6]

Substance Abuse and Mental Health Services Administration 2014, A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services, guide series 57, SAMHSA, Rockville, MD, HHS publication no. (SMA) 13-4801, Treatment Improvement Protocol (TIP), series 57. HHS publication no. (SMA) 13-4801. [7] Available from: https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

Urquhart, C, Jasiura, F & TIP Project Team 2013, Trauma-Informed Practice Guide, BC Provincial Mental Health and Substance Use Planning Council, Victoria, BC, p.45, 48, 55. [8] Note: This guide-book provides information implementing trauma-informed practice in three settings: inpatient, residential rehab and a community based service setting. Available: http://bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf

DOMAIN B - Organisational Policy and Structure

The following document is a policy template relating to integration of a trauma-informed care and practice approach. This resource is one template freely available from MHCC's Policy Resource Kit, the MHCC Organisational Builder (MOB). It can be downloaded from the MHCC website, modified and used as an overarching policy document as required.

This policy has been developed to broadly consider every part of an organisation, including administration, management and service-delivery systems, to incorporate trauma-informed principles into practice.

[1] Mental Health Coordinating Council 2012, MHCC Organisational Builder (MOB) - Policy Resource, Sydney, NSW. Note: Updated Version 17. Available from: http://mob.mhcc.org.au/media/748h9/ticp_policy_template_14.09.18__v.17_.pdf

Insert organisation name/logo

General
Integration of a Trauma-Informed Care and Practice Approach

Document Status: **Draft or Final**
Date Issued: **[date]**
Lead Author: **[name and position]**
Approved by: **[insert service name] Directors on [date]**
Scheduled Review Date: **[date]**

Record of Policy Review

Review Date		Other People Consulted

Triggers for Policy Review (tick all that apply)

- ☐ Standard review is timetabled
- ☐ A gap has been identified
- ☐ Additional knowledge or information has become available to supplement the policy
- ☐ External factors
  - ☐ Policy is no longer relevant/ current due to changes in external operating environment
  - ☐ Changes to laws, regulations, terminology and/or government policy
  - ☐ Other/s (please specify)
- ☐ Internal/organisational factors
  - ☐ A stakeholder has identified a need, e.g., by email, telephone etc.
  - ☐ A serious or critical incident has occurred, requiring an urgent review
  - ☐ A potential critical incident almost occurred, requiring a review to prevent a serious critical incident in the future
  - ☐ Need for consistency in service delivery across programs and organisations
  - ☐ Separate, stand-alone TI policy is now required (KPIs) or part of QI processes

Additional Comments *[for example, policy now covers details related to new legislation, regulations, standards and guidelines]*

Integration of a Trauma-Informed Care and Practice Approach

This service _____ **[insert name]** utilises policies and procedures to guide all its activities that are underpinned by recovery orientation and a trauma-informed practice approach. The service seeks to implement its core values at every level of engagement with clients, their carers and families, staff and the community utilising this practice approach.

Note: This template is designed to provide guidance as to possible inclusions as appropriate in a particular service/ setting; and is by no means comprehensive. It serves as an example for the development of specific policy document/s and related documents as required.

1. Purpose and Scope

The purpose of this policy is to enable the following:
Every part of the service, including administration, management and service delivery is assessed and modified to incorporate trauma-informed principles into its practice approach

- Provision of safe environments is paramount. Re-traumatisation of consumers is minimised, carers' needs are understood and acknowledged, and staff health and wellbeing is fostered

- Staff understand the need to recognise and be informed about trauma and its dynamics, so as to minimise triggers which may interfere with effective executive functioning in both consumers and staff members with a lived experience of trauma

- Staff are informed about pathways to other services which can provide appropriate integrated support and/or referrals for consumers presenting with complex trauma related needs or co-occurring mental health and psychosocial difficulties

- To provide assistance to **[insert service name]** to establish clear policies and procedures to minimise risks to work health and safety, e.g. re-traumatisation of staff and/or clients/ consumers with lived experience of trauma; vicarious traumatisation (staff); and self-harming and challenging behaviours (clients)

- That this policy applies to all consumer services and programs of **[insert service name]** and all staff of **[insert service name]**. It does not prescribe specific treatments, philosophies or counselling/therapeutic techniques. It is based on a trauma-informed recovery-oriented practice approach and the collaborative model of engagement across service systems
- That this policy may be appropriate across a diversity of mental health and human service sectors and systems, and contexts.

This policy is implemented in conjunction with a number of other policies, all of which reflect a recovery oriented trauma-informed practice approach, e.g.,: 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. Key Terms

Complex need [2] is a term often used to define suitability for supports or services. Within a recovery oriented approach, we consider that a person and their needs are not complex, rather their circumstances and/or the environment they experience is complex. The term 'complex needs' is commonly used to refer to individuals who present with an inter-related mix of coexisting mental health and physical health issues, who often also live with developmental and psychosocial difficulties. People may also have lived experience of trauma.

Complex trauma occurs as a result of cumulative traumatic stressors that are most often intentionally perpetrated by one human being on another, usually commencing in childhood. These actions can be both violating and exploitative of another person and include ongoing abuse which occurs in the context of the family and intimate relationships. Complex trauma typically involves a fundamental betrayal of trust in primary care relationships. The cumulative impacts of repetitive and interpersonal traumatic stress, particularly during developmental periods, can result in compounded and persistent effects of a complex nature. Complex trauma is associated with increased risk of mental illness and complex post-traumatic stress disorder and may impact physical health and psychobiological development across multiple domains. [3] [4]

Cultural safety has been described as providing "an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening." [5] It reminds us that people who do not belong to the dominant culture may have been subject to oppression, abuse or discrimination.

Cultural competence [6] refers to an ability to interact effectively with people from different cultures and socio-economic backgrounds, particularly in the context of human resources; and providing services in any community, public or private context where employees work with persons from different cultural/ethnic backgrounds. Cultural competence comprises four components: awareness of one's own cultural worldview, attitude towards cultural differences, knowledge of different cultural practices and worldviews, and cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. To be trauma-informed is to acknowledge the inherent privilege of race, education, status, gender etc. that a provider may hold or be perceived to have and reflect on the barriers that privilege may evoke in engaging with people who experience marginalisation and disadvantage in our society.

Diversity , is refers to the inclusion and acceptance of difference and variation among people inclusive of but not limited to their culture, religion, spirituality, ability, power, status, gender and sexual identity and socioeconomic status (State of Victoria, Department of Health 2013, p. 13). [7]

Direct Services in most instances refers to services provided that are active services to a client and include work with clients, as distinguished from staff functions or organisational functions. However, in the context of some organisations, a direct service may also be considered training provided to students; services to members of an organisation such as a telephone information service, online or telephone counselling etc.

Trauma-informed is the re-conceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised around acknowledgment of the prevalence of trauma throughout society, including in the lives of people who access services. `Trauma-informed'

services are aware of and sensitive to the dynamics of trauma, including its effects on people's lives, health and engagement with services. A trauma-informed approach is strengths-based and responsive to the impacts of trauma; emphasising physical, psychological, and emotional safety for both service providers and survivors.

Trauma-informed services are alert to the possibility of the existence of trauma in the lives of all clients/ patients/consumers/service users, irrespective of whether it is explicitly known. Trauma-informed services are distinct from trauma specific or trauma treatment services.
Trauma-specific refers to treatment approaches and services which directly address the impacts of trauma using therapeutic means (counselling, psychotherapy etc).

Secondary Traumatic Stress is often used interchangeably with the term Vicarious Trauma. However, the term specifically refers to the emotional distress that occurs when an individual hears about or is exposed to the impacts of the first hand trauma experiences of another. Its symptoms are similar to those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary traumatic stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. [8]

Vicarious Trauma is the debilitating emotional and psychological impact of connecting with the traumatic and disturbing life events of other people. It is an insidious form of stress and is pervasive among people working with those who have experienced trauma. It often occurs without awareness, accumulates over time, and can change a worker's overall view of the world and the people around them. It can affect cognitive functioning and values and can be as debilitating as primary trauma. [9]

3. Principles

[Insert service name] adheres to **eight foundational principles** that represent the core values of trauma-informed care and practice approach. 10 These principles are outlined below:

1. **Understanding trauma and its impact** - A trauma-informed approach recognises the prevalence of trauma and understands the impact of trauma on the emotional, psychological and social wellbeing of individuals and communities.

2. **Promoting safety** - A trauma-informed approach promotes safety - Establishing a safe physical, psychological and emotional environment where basic needs are met, which recognises the social, interpersonal, personal and environmental dimensions of safety and where safety measures are in place and provider responses are consistent, predictable, and respectful.

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[2] Rosengard, A, Laing, I, Ridley, J & Hunter, S 2007, A Literature Review on Multiple and Complex Needs, Scottish Executive Social Research, Edinburgh. Available from: http://www.scotland.gov.uk/Resource/Doc/163153/0044343.pdf
[3] Kezelman, C & Stavropoulos. P 2012, 'The Last Frontier': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW.
[4] Courtois, CA. & Ford, JD (eds) 2009, Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide, The Guildford Press, New York, NY.
[5] McGough, S Wynaden, D & Wright, M 2018, Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. International Journal of Mental Health Nursing. 27(1): pp. 204-213.
[6] Martin, M & Vaughn, B 2007, 'Cultural Competence: The Nuts and Bolts of Diversity and Inclusion', Strategic Diversity and Inclusion Management, vol. 1, no. 1, pp. 31-36, DTUI Publications Division, San Francisco, CA.
[7] State of Victoria, Department of Health 2013, National Practice Standards for the Mental Health Workforce 2013, Victorian Government Department of Health, Melbourne, VIC.

3. **Supporting consumer control, choice and autonomy** - A trauma-informed approach values and respects the individual, their choices and autonomy, their culture and their values.

4. **Ensuring cultural competence** - A trauma-informed approach understands how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity; and uses interventions respectful of and specific to cultural backgrounds.

5. **Safe and healing relationships** - A trauma-informed approach fosters healing relationships where disclosures of trauma are possible and are responded to appropriately. It also promotes collaborative, strengths-based practice that values the person's expertise and judgement.

6. **Sharing power and governance** - A trauma-informed approach recognises the impact of power and ensures that power is shared.

7. **Recovery is possible** - A trauma-informed approach understands 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.

8. **Integrating care** - A trauma-informed approach maintains a holistic view of consumers and their recovery process; and facilitating communication within and among service providers and systems.

To undertake trauma-informed care and practice, **[insert service name]** will promote the principles (detailed above) as core values of a trauma-informed practice approach.

4. Strategies

A. Recognise the prevalence of trauma in the community, among mental health consumers as well as people using a diversity of mental health and human services

B. Recognise the evidence behind high rates of poor mental and/or physical health and complex psychosocial difficulties related to exposure to trauma in children and adults

C. Recognise that mental health treatment and environments are often traumatising, in and of themselves, both overtly and covertly

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[8] Stamm, BH (ed) 1999, Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators, 2nd edn, Sidran Institute Press, Baltimore, MD.

[9] Department of Communities, Child Safety and Disability Services 2014, 5. Implement Strategies to Manage Stress, Vicarious Trauma and Critical Incident Stress, The State of Queensland, Brisbane, QLD. Available from: http://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-11-staff-safety-and-well-being/key-steps/5-implement-strategies-to-manage-stress-vicarious-trauma-and-critical-incident-stress

[10] These principles were identified and adapted on the basis of knowledge about trauma, its prevalence and its impact. Findings of the Co-Occurring Disorders and Violence Project (Moses, DJ, Reed, BG, 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, Policy Research Associates, Delmar, NY, literature on therapeutic communities); Campling, P 2001, Therapeutic Communities, Advances in Psychiatric Treatment, vol.7, pp.365–372; Fallot, RD & Harris, M 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol, Community Connections, Washington, DC. Available from: https://www.theannainstitute.org/CCTICSELFASSPP.pdf and 'The Sanctuary Model' as developed by Sandra Bloom and colleagues, Bloom, SL & Sreedhar, SY 2008, 'The Sanctuary Model of Trauma-Informed Organizational Change', Reclaiming Children and Youth: From Trauma to Trust, vol. 17, no. 3, pp. 48-53; Bloom, SL & Farragher, B 2013, 'Restoring Sanctuary: A New Operating System for Trauma-Informed Systems of Care', Oxford University Press, New York, NY.

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 education and training to incorporate the principles of a trauma-informed care and practice approach

G. Provide staff education and training on reducing re-traumatising practices

H. Inform staff about the appropriate inclusion of trauma screening and assessment processes and necessary prerequisites (i.e. establishing safety first)

I. Review policies, procedures and practices to incorporate trauma-informed principles (see item 3)

J. Understand the impacts of trauma, complex needs and the importance working with people utilising a trauma-informed approach that is coordinated across all services providing integrated care, treatment and support

K. Articulate and uphold a trauma-informed human rights perspective to access and equity and service provision.

5. Outcomes

[Insert service name] works with (and assesses, where required) all service users informed by a trauma-informed understanding of mental health and psychosocial difficulties; including that these difficulties commonly co-exist as a consequence of exposure to all forms of trauma. Experience and consequences of trauma do not constitute criteria for service exclusion or denial.

[Insert service name] provides staff with trauma-informed information, education, and have access to training and workplace supports required to develop their skills and undertake their specific role/s, which may include: assessment and screening where appropriate; and support/care planning, development and coordination and direct service delivery.

[Insert service name] develops and maintains partnerships with trauma-specific services, and mental health and related services that are capable of providing trauma-informed coordinated/integrated support to clients.

[Insert service name] creates a safe and healthy work environment for consumers, carers, employees, contractors, volunteers and visitors.Support is provided for staff members who may have difficulty addressing trauma-related issues. This may include workers living with their own experiences of trauma. The high prevalence of lived experience of trauma in community and helping professions is recognised and acknowledged.

[Insert service name] fosters a person-led, holistic, creative, open and therapeutic culture that supports workers adopt a collaborative approach informed by a recovery-oriented trauma-informed practice approach.

[Insert service name] ensures all policies and procedures are trauma-informed and that disciplinary processes are consistently managed in accordance with the Staff Performance and Conduct Procedures that are likewise informed.

6. Functions and Delegations

Position	Delegation / Task
Directors	Endorse policy which integrates a trauma-informed culture
Management	Develop, maintain and formalise (where appropriate) collaborative partnerships and interagency relationships with relevant government and community managed services that are trauma-informed. Ensure workers are supported by leadership culture that is trauma-informed.
Staff	Identify support needs directed by consumers that maximise autonomy. Maintain trauma-informed knowledge and skills required to ensure best practice in service provision related to complex trauma and co-existing mental health and psychosocial issues. Develop, foster and maintain partnerships and collaborative arrangements with local mental health and related services.

7. 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 intake and assessment, are identified and appropriately trained and/or qualified to conduct trauma screening/ assessment (only when appropriate and taking into account willingness/capacity of consumer to share lived experience), and to support access or referral to trauma-specific services, avoid re-traumatisation and engage in ongoing support. Refer to e.g., Supervision Policy.

Assessment of 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 e.g., Dignity of Risk Policy.

The service has a suite of policy documents that are trauma-informed. This may include (as relevant) practice guidelines, policies, procedures, rules, regulations and standards which all must be trauma-informed. All employees including administrative staff (who interact with service users) receive orientation about the prevalence and impact of trauma; the impacts of culture and other demographics on experience and perception and the ways people cope and have survived trauma; recovery and healing. Direct service staff members undertake more extensive training and are provided with ongoing professional development. Refer to e.g., Professional and Personal Development Policy.

8. Policy Implementation

This policy is developed and co-designed in consultation with staff, consumers and carers, and is approved by 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 service name]**'s continuous quality improvement program and/or relevant legislative changes.

9. Policy Detail

9.1 Supporting Consumers

[Insert service name] provides collaborative/integrated support for consumers which is trauma-informed i.e. collaborating organisations 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 service name], with collaborative support planning and frequent communication processes across collaborating organisations/agencies.
- Where a consumer gives consent, trauma-related support is provided by **[insert service**
- **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 within collaborative support planning and frequent communication.
- In circumstances where consumers are receiving services from two or more support services/

agencies and/or other practitioner/s, it is recommended that regular case conferences are convened. This involves a meeting between all support providers and support workers, carers, and, unless it is not in the consumer's best interests or the consumer does not wish to attend, 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 e.g., Individual Supports Policy and Integration Policy.

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

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

For more information refer to e.g., Individual Supports Policy.

9.2 Supporting Employees of [Insert service name]

9.2.1 Establishing a supportive workplace culture

[Insert service 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 relate/ vicarious trauma issues (e.g. access to an employee assistance program)
- providing opportunities to access practice supervision that is independent of line management
- providing opportunities for 'communities of practice', enabling staff to share information and learnings with colleagues (and across disciplines)
- 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

9.2.2 Procedure

It is the goal of [Insert service name] to:

- Promote a supportive culture that encourages a co-operative approach between management and employees which builds on their shared interest in trauma-informed work health and safety.

10. References + Resources

10.1 Internal

List the policy documents that may relate to this document e.g.
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

10.2 External Resources

Air American Institute for Research, Available: http://www.familyhomelessness.org/

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.

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. Available: https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf and www.familyhomelessness.org

Fallot, R & Harris, M 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Washington, DC: Community Connections. Available: https://www.theannainstitute.org/CCTICSELFASSPP.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. http://www.theannainstitute.org/Models%20for%20Developing%20Traums-Report%201-09-09%20_FINAL_.pdf

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, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA).

Substance Abuse and Mental Health Services Administration (SAMHSA) U.S. Department Of Health and Human Services, Center for Substance Abuse Treatment 2014, 'A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services', Part 2, Chap 1 – Trauma-informed Organizations, pp. 151- 171. Available: https://www.integration.samhsa.gov/clinical-practice/SAMSA_TIP_Trauma.pdf

Guide', British Columbia Provincial Mental Health and Substance Use Planning Council. Available: http://bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf

McGough, S Wynaden, D & Wright, M 2018, Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. International Journal of Mental Health Nursing. 27(1): pp. 204-213.

10.3 Quality and Accreditation Standards

EQuIP4 - Provided by the Australian Council on Healthcare Standards (ACHS)
Select appropriate criteria to identify

Health and Community Service Standards (6th edition) - Provided by the Quality Improvement Council (QIC)

DOMAIN B - Resources

Air American Institute for Research. Trauma-informed resources various. Available from: http://www.familyhomelessness.org/tic_curriculum.php?p=ss

Fallot, RD & Harris, MH 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Community Connections, Washington, DC. [9]

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. Available from: https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf and http://www.familyhomelessness.org/media/90.pdf

Jennings, A 2004, *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*, report, National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC), Alexandria, VA. Available from: http://theannainstitute.org/MDT.pdf

Substance Abuse and Mental Health Services Administration 2014, *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services*, guide series 57, SAMHSA, Rockville, MD, HHS publication no. (SMA) 13-4801, Treatment Improvement Protocol (TIP), series 57. HHS publication no. (SMA) 13-4801, pp. 157-171. Available from: https://www.theannainstitute.org/CCTICSELFASSPP.pdf

Urquhart, C, Jasiura, F & TIP Project Team 2013, *Trauma-Informed Practice Guide, BC Provincial Mental Health and Substance Use Planning Council*, Victoria, BC, p. 55. [10]Available from: http://bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf

DOMAIN C - Consumer and Family/Carer Participation

Consumer and carer participation and co-design is integral to the process of becoming trauma-informed. Consumers and carers must be encouraged and supported to engage through active participation strategies. Consumer and carer participation must inform and influence all decision-making processes regarding individual support, care and treatment. Equally, organisations must actively promote co-design by encouraging and supporting consumers and carers to participate in the development, planning and implementation of policy and evaluation of services, and to be part of all quality improvement processes and activities. By listening to and utilising lived experience wisdom, perspectives and feedback and incorporating this expertise in upskilling staff, an organisation can go some way to meeting the principle of sharing power and governance, Principle 6.

It is necessary to inform consumers and their carers about the organisation's structure, processes, functions, roles and responsibilities in such a way that will facilitate consumer/s and carers' active participation. A process for consumer/carer participation will incorporate and recognise the individual for their abilities to influence, collaborate, and apply any other appropriate skills that will enable their perspectives to be articulated. This process will also provide a diversity of ways for consumers and carers to be significantly involved. This includes recognising the potential for power dynamics to hinder or inhibit effective participation.

Consumer participation is a right and a critical aspect of citizenship. The National Mental Health Service Standards, promotes the social inclusion of consumers and advocates for their rights of citizenship and freedom from discrimination. TICPOT incorporates this concept into its Audit questions in Domain C.

DOMAIN C - Resources

Australian Health Ministers' Advisory Council 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*, Commonwealth of Australia, Canberra, ACT, p.22. [11]

Australian Health Ministers' Advisory Council 2013, *A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory*, Commonwealth of Australia, Canberra, ACT. [12]

National Mental Health Commission 2013, *Paid Participation Policy for people with a Lived Experience of Mental Health Difficulties, Their Families and Support People*, NMHC, Sydney, NSW. [13]

Department of Health and Ageing 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra, ACT. [14]

Stewart, S, Watson, S, Montague, R & Stevenson, C 2008, 'Set up To Fail? Consumer Participation in the Mental Health Service System', *Australasian Psychiatry*, vol. 16, no. 5, pp. 348-353.

Tait, L & Lester, H 2005, 'Encouraging User Involvement in Mental Health Services', *Advances in Psychiatric Treatment*, vol. 11, no. 3, pp. 168–175.

The Transformation Center. Specialists in information, USA, [15]training and resources for Peer Workforce. Available from: http://transformation-center.org/home/training/certified-peer-specialists/

DOMAIN D - Direct Services to Consumers

Trauma-informed screening and assessment

During initial contact with a service, some form of assessment (of needs, difficulties or suitability for the service) is typically required. A trauma-informed assessment process acknowledges the high prevalence, and profound impacts of trauma, and sets out to create a safe and supported environment in which the person can disclose their lived experience both of past and/or current trauma - if they choose to do so.

Knowing that the person is presently unsafe in their personal life or feels unsafe in the context of support is critical when providing any service, whether mental health or in relation to other psychosocial supports or human services. If a person is experiencing present abuse, or has experienced trauma that continues to affect their wellbeing, workers cannot be at their most effective without this knowledge.

Many people who have had prior contact with mental health and other support services will not have been asked if they have experienced abuse or trauma. Even when past trauma has been acknowledged, the impact of trauma may not be included in a formulation or service/care plan. Services need to have planned and pay systematic attention to screening and assessment that takes the impact of trauma into account. [18]

Screening and assessment practices in mental health and human service contexts must ensure that service users are not coerced into disclosing information at a time when they may not have adequate supports and coping skills to manage such disclosures, or may not wish to disclose.

Trauma-informed screening and assessment is critical to prevent misdiagnosis, to minimise re-traumatisation and to ensure service provision is as effective as possible. However, it needs to be guided by the safety needs of both the person seeking the service and the worker. If trauma impacts are overlooked there is a much greater likelihood of ineffective service provision.

Timing and pacing questions that ask about trauma, and worker responses to disclosure, are critical factors in minimising the risk of traumatisation or re-traumatisation. Inappropriate service responses can lead to further distress, distrust and disengagement. Also, opportunities to work more therapeutically with service users may be lost as some workers are reluctant to ask about experiences of trauma due to fears of causing distress, or due to the perception that more pressing concerns preclude asking about trauma. [19]

Guidance to enable services to ask about trauma safely and effectively are available (see Appendices 4 & 5) and existing screening and assessment practices can be modified in order to be ‘trauma-informed’.

Trauma screening refers to a brief but focused inquiry into whether the person has experienced any traumatic events in their lives. Where a service does provide trauma screening this should occur close to initial contact with the service, by someone with whom the consumer feels safe. [20]

Screening for exposure to and impact of trauma should not be a ‘one off’ event but represent part of ongoing opportunities for a person to disclose. Questions should be prefaced with some context, and include a statement that recognises that people have a choice when responding.

To ensure that service users have choice and control over what they disclose during the screening process, it is recommended that a preamble is used, for example:

> *"We are going to ask some questions that may feel uncomfortable to you; if you don't want to answer, please say 'I don't want to answer'. You do not have to give a false answer, you just don't have to answer, you have a choice"*
> (Brown Bachrach & Melchoir 2008). [21]

Screening for trauma (and assessing current risk) can be considered as a standard practice, but should not become a mechanistic process. The practice should still be open to variation based on individual needs, personality features, culture and gender, and practitioners will always bring their personal style to interpersonal engagement. However, they do need to be reflective of the inherent power differential and what that may represent to a person with lived experience of trauma.

During initial contact between a person and a support service, trauma-informed screening should incorporate an awareness of the high prevalence of trauma amongst people with mental health conditions, and its relevance to mental health and wellbeing, This is not dissimilar to how screening for other common and relevant factors (such as substance use) operates. Screening for trauma relies upon a sound understanding and recognition of the characteristic impacts of trauma, and can progress to a more comprehensive assessment if required and if safe to do so.

At a systems-level, information about the prevalence of trauma amongst those using the service can support the development of more comprehensive and responsive services.

Trauma assessment refers to a much more in-depth inquiry about the nature and extent of the trauma after the initial screening has taken place. The **processing** of prior trauma (and its impacts) through the re-examination of memories and their consequences should only occur when the person can tolerate the degree of distress associated with doing so (the 'window of tolerance') and they have agreed to go down this road. [22]

In specialist services it would not be unusual to use standardised screening and assessment of trauma; including gathering information about the nature of the trauma, when the experience/s occurred, the people involved and how this is impacting on the person's current functioning. Assessment can support some aspects of treatment such as service matching, ensuring current safety and promoting the safety of other program participants. Additionally, for some trauma survivors, acknowledging and validating the connections between traumatic life experiences, coping, and for example substance use at an early point of engagement, can be helpful.

Note: See Appendices 4 & 5 Screening Tools

However, the process of assessment can increase the potential for re-traumatisation and may result in riskier patterns of, for example: substance use or self-harm, and may lead to disengagement with the service. Ensuring that people have access to appropriate supports, are currently safe and have plans and strategies to manage distress is essential before embarking on a detailed assessment of trauma.

Workers can support and prepare a person for the process of a more in-depth trauma assessment or trauma specific therapeutic interventions. This can be achieved through supporting the person to

recognise responses such as hyper-arousal (anxious, fearful or angry) or hypo-arousal (shut down or dissociated) and restoring safety and equilibrium whenever possible.

Keep in mind that when a person is **disclosing, re-experiencing or talking about trauma** and experience either hyper-aroused or hypo-aroused physical states, appropriate responses of others can help a person restore some equilibrium and safety.

Safety planning

One mechanism of preventing harm occurring in the course of care and delivering care (that is sensitive to the individualised effects of trauma) is through collaborative, trauma-sensitive safety planning between the service user and service deliverer. Safety planning is a targeted activity focused on identifying ways that the service can maximise safety; prevent re-traumatising individuals and restore safety after any potential incident. A number of structured tools are available to support this conversation.

Safety planning needs to occur within the course of care in a manner that is supported and respected. Safety planning also requires communication and ways of embedding mechanisms to enhance safety and minimise triggers into consistent everyday responses. Safety planning must also be embedded within a system that offers support resources and processes to ensure that plans are adhered to by services and that efforts are made to enhance safety.

A NSW Health Patient Safety Plan (SMR-025090) template (Appendix 6) provides a template to assist workers collaborate with consumers to develop a safety plan. This is particularly useful in inpatient settings, but can also be applied in multiple contexts.

Collaborative care planning

Safety planning is one component of a wider commitment to collaborative care planning. Care plans are currently used in mental health settings to summarise goals and clinical intents of care. They are also used for monitoring progress and facilitating recovery. Traditional approaches to care planning in mental health have been based on illness models where professional expertise is used to determine the priorities of care. However there is little evidence that demonstrates the impact of care plans on consumer care and clinical outcomes (Tunmore & Thomas 2000). [23] When completed collaboratively with consumers, care plans provide an important opportunity to engage in choice and shared power but they also provides an opportunity for engagement and collaboration towards overall goals of care and treatment. A collaborative care plan is a document, but also a process (Reid, Escott, Isobel 2018) [24] that involves workers and service users working together to identify individual goals and strategies for recovery, and then using these to direct the foci of care.

Efforts towards collaborative care require consideration of how to integrate the identified goals into the primary focus of care rather than seeing them as an adjunct to treatment. Implementation of collaborative care planning may require consideration of how and when this occurs, where it is documented and how it is communicated amongst service providers. Service users should always also have a copy of their care plan and opportunities to discuss progress and seek support.

Responding to disclosure of trauma

Many people who have experienced trauma have disclosed previously (or attempted to disclose) and received unsupportive responses. [25] Previous attempts to speak to about trauma or its impacts to others may be associated with shame, denial, disbelief, anger, distress or disgust (by the person or others). They may also have experienced negative consequences of disclosure, for example on the quality of existing relationships, loss of relationships, violent and abuse reactions and unexpected legal consequences (e.g. reporting to child protection authorities). A disclosure of trauma and abuse that is met with a supportive response has the potential to strengthen interpersonal and broader social relationships. [26]

For examples of supporting trauma-informed practice and principles in action, i.e., Decision- making and a guide to managing disclosure please refer to Cash et al., 2014. [27]

A Trauma-informed practice approach allows for the possibility that a person receiving support will disclose experiences of trauma, interpersonal violence or other form of harm to a worker.
The quality of a relationship between the person and the worker is likely to affect the prospect of disclosure. [28] The features of a relationship with a worker that assist people to feel safe to disclose are highlighted by Henderson and Bateman (Reframing Responses Stage II, MHCC 2010). [29]

In such a relationship the helper:

- is approachable and understanding
- has an open, honest and transparent professional agenda
- is an interested and engaged professional
- provides a supportive safe environment
- is willing to listen non-judgementally to disclosures of trauma and abuse
- receives a client's story calmly and does not dramatize or treat the story as unspeakable
- maintains confidentiality

Earlier disclosure/s may have been met with minimisation of the experience, disbelief, a lack of understanding and no follow up. [30] When somebody discloses that they have experienced trauma or other forms of harm, they are likely to be in a position of vulnerability and therefore the way in which workers respond is important. The evidence is clear that supportive responses to disclosure are associated with better outcomes, and non-supportive responses can do further harm (Ullman 2003). [31]

Disclosure that trauma has occurred is not the same as sharing (or collecting) all of the details of the traumatic event. A common misconception is that in order to recover people need to share all the details of their experience. Some people may feel an internal pressure to 'share the details' prior to having sufficient trust in the worker, safety established or strategies in place to manage the inevitable distress likely to occur when recalling and sharing traumatic experiences. For many people, even acknowledging trauma will be an intense experience. If they do not have adequate strategies to manage the distress they may disengage from services. [32]

Timing and pacing disclosure and follow up discussion about trauma and its impacts are important. Workers need to know enough about the physiological arousal associated with trauma and trauma recollection to keep any interaction as safe as possible. Without this knowledge informing practice both the consumer and the worker may become overwhelmed during disclosure.

Principles to use when a person discloses a trauma or abuse:	Examples of responses
Affirm that it was a good thing to tell someone	"Thank you for telling me – that's important to know" "I'm so sorry that happened to you – I'm glad you were able to tell us"
Do not try to gather all the details, you are not an investigator	"It's important to know that – but before we talk further I'd like to establish a few things first – is it ok if we talk for a while about what is happening now?" "Many people feel like they need to talk about the details of what happened – that is possible, but should happen in safe ways and usually in stages – can we talk about the process first?"
Ask if the person has told anyone before—and what was their response	"What happened after you told her/him? How did they take it? How did you feel afterwards?" "Many people wait for a long time to tell anyone – or have tried many times but felt unable to – has that happened for you?"
Offer support (make sure you know what is available)	"Many people find talking about these things difficult for a while afterwards – if you feel distressed later on, can I give you a number to call?"
Ask whether the client relates the past or current abuse to their current difficulties	"Do you think that what has happened to you has any connection with what is happening for you right now?" "Do you see any ways that what has happened in the past is affecting the difficulties you are having at the moment?"
Check for safety from ongoing abuse that they may be experiencing at the moment	"When people have experienced prior trauma it is not uncommon that this affects their current relationships – can I ask you some questions about how safe you feel right now with people in your life?"
Check emotional state at end of session	"What has this process been like for you? Now that we are almost finished talking for the moment, how are you feeling right now?" "Do you feel safe to leave here now?" "What are your immediate plans when you leave here?"
Offer follow-up/'check-in'.	"When would it be best for me (or the service) to check-in with you about this?" "Next time we meet, is it OK with you if I check-in with you about what we talked about today?"
Adapted from: Read, J, Hammersley, P & Rudegeair, T 2007, 'Why, When and How to Ask about Childhood Abuse', *Advances in Psychiatric Treatment*, vol. 13, 101–110.	

Relationships and boundaries

In a trauma-informed environment, boundaries must be negotiated in a flexible, equitable and collaborative way that ensures a person maintains a sense of control and predictability in the relationship. Most importantly healthy boundaries ensure the safety of both staff and consumers, and should be aligned to organisational policies.

People who have experienced trauma, especially interpersonal trauma, have endured a violation of their own physical, emotional or sexual boundaries. They may continue to struggle to establish and manage healthy boundaries in interpersonal relationships, including those with service providers and workers.

'Boundaries' means far more than the rules and guidelines that define and delineate the context of a relationship between worker and consumer. Rules and guidelines are likely to be written and formalised, and may include ethical guidelines, codes of conduct, rules of the service, and delineation of a work role. Some violations of these types of boundaries could result in disciplinary action within a service or professional group, or criminal proceedings (including sexual comments or touch, verbal abuse or vilification and threats of violence).

However, what is referred to in this context are **less tangible features of a relationship** that may not be formally specified but are in constant negotiation between two people or between a person and a service. Service providers are in a position of greater power, and it is always the responsibility of the service and service provider to attend to and maintain boundaries. In establishing relationships in a trauma-informed environment, as in any relationship, some boundaries are negotiable, others are non-negotiable, and the central reference point should be the safety and wellbeing of the consumer.

Some signs that boundaries are at risk of being confused or violated are:

- the worker is reluctant or embarrassed to discuss their specific interactions with a consumer, or details of the service provision to the consumer, in supervision or team meetings
- the worker acts in a controlling or possessive way regarding contact with the consumer
- the worker advocates with unusual and excessive vehemence for the consumer
- the worker is over-responsible for the client
- the worker becomes defensive and closed to hearing ideas from the supervisor or the team, or exploring their own emotional reactions to the consumer
- the worker increases self-disclosure without being able to identify the reasons for the disclosure

(Adapted from: SAMHSA 2014, p.188) [11]

[11]Substance Abuse and Mental Health Services Administration 2014, A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services, guide series 57, SAMHSA, Rockville, MD, HHS publication no. (SMA) 13-4801, Treatment Improvement Protocol (TIP), series 57. HHS publication no. (SMA) 13-4801. Available from: http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health Services/SMA14-4816

Choice and self-determination

A trauma-informed practice approach maximises consumer choice and self-determination (ASCA 2012, p.25). [33] When circumstances have overwhelmed the person in the past, further experience of others having 'power over' them, and where choice is limited or absent, has the potential to trigger traumatic memories or induce distress. Conversely, important contributions to recovery and healing can be achieved by gaining or re-establishing control through exercising choice and self-determination.

Sometimes services implement rules and 'ways of doing things' through an organisational culture that reduces or deprives people of choice without offering a rationale that is meaningful to consumers. When consumers are offered many choices, even in everyday interactions; like where to sit, how they prefer to be addressed, which refreshments are available, etc., their experience of service is entirely different. Consumers should also be offered real choices about the services available, how they are delivered and who by. When plans for access to a service can be made, and can be changed, consumers can experience significant personal power by having their preferences noted and responded to.

Supporting self-determination and control is especially important to Aboriginal and Torres Strait Islander peoples, as they have experienced an historical (and ongoing) violation of self-determination and governmental control. [34] [35]Services available to Aboriginal and Torres Strait Islander people need to recognise the impacts of recent and historical loss and trauma, ongoing racism and discrimination and the intergenerational impact of trauma. [36] Culturally safe and appropriate care is not possible without genuine collaboration with Aboriginal and Torres Strait Islander communities and individuals as to how services are designed and delivered.

Genuine collaboration does not mean abandoning professional knowledge or skill, but rather offering these in ways that can be adjusted according to the needs and preferences of the person concerned. Collaboration in the context of a trauma-informed care and practice approach includes working with the person about what they want from a service, and with other services and workers to maximise continuity of care (ASCA 2012, p.8). [37] Collaborating with families and carers where possible is also vital; recognising that those with close relationships to a consumer have unique and important perspectives to share; including that they may also have experienced trauma and lack of safety in the context of their own lives and in the context of service provision.

Strengths-based practice

Strengths-based practice is important for trauma survivors as it assumes the presence of strengths, abilities and resources and recognises that people have survived and often flourished. Workers need to acknowledge those abilities and work in ways that build on the strengths that enabled a person to survive.

The underlying assumptions of strengths-based practice are that:

- people must set their **own goals**, reflecting what they want for their own lives
- strengths are **always present** and are recognised through systematic assessment (i.e. rather than only assessing 'the problem')
- the environment is rich in **resources**, including people

- support relationships need to be **hope inducing**
- meaningful choices are offered and people have the authority to make choices

(Rapp, Saleebey & Sullivan 2005) [12]

Strengths-based practice does not mean that the worker or service determines the person's particular strengths and abilities. Moreover, receiving praise and compliments may feel good for some people in some contexts, but may be unsettling or difficult for people who have experienced interpersonal abuse and trauma. Praise, compliments and comments about appearance can also be triggering of prior experiences of 'grooming' by an abuser. Always seek feedback about how people receive compliments, and do not mistake this for strengths-based practice.

Trauma impacts

Strengths-based practice does not mean that the worker or service determines the person's particular strengths and abilities. Moreover, receiving praise and compliments may feel good for some people in some contexts, but may be unsettling or difficult for people who have experienced interpersonal abuse and trauma. Praise, compliments and comments about appearance can also be triggering of prior experiences of 'grooming' by an abuser. Always seek feedback about how people receive compliments, and do not mistake this for strengths-based practice.

The effects of complex (cumulative, underlying) trauma are pervasive, and if unresolved, negatively impact mental and physical health across the lifespan.

Fallot & Harris 2009 [13]

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.

Filson, Robinson & Jensen 2012 [14]

The multiple impacts of interpersonal trauma and violence, including those on a person's psyche and 'sense of self', can be defined as complex trauma (see key terms) - the product of overwhelming stress that is interpersonally generated. Trauma occurring in this context, whether covert or overt, often gives rise to complex and chronic psychological and physiological injuries.

There is evidence of a wealth of research related to the effects of complex trauma on the developing brain not just in infancy but throughout the life cycle. Research has also identified the capacity for the brain to repair and for those affected to recover. These research findings present substantial implications for mental health and human service responses. [38]

No single diagnostic term has been agreed upon internationally which captures the complexity of presentations related to complex trauma. However, studies have shown that 76% 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. [39]

Survivors of abuse often have a number of concurrent mental health diagnoses, including: post-traumatic stress disorder (PTSD), borderline personality disorder, schizophrenia, [40] 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 to services with multiple coexisting conditions and difficulties including: substance misuse,[41] eating disorders, [42 43] self-harming behaviours, [44 45] and suicidality, [46 47] and frequently have interactions with the criminal justice system, [48] and experience homelessness.[49]

Extensive research has shown that child sexual abuse is associated with two and a half times the rates of mental disorder, [50] 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. [51]

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

Further information concerning the wide ranging impacts of trauma on mental and physical health and psychosocial disability can be found in the Trauma-Informed Care and Practice Strategic Direction position paper (MHCC 2013) [52] and the Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery (ASCA 2012). [53]

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[12] Rapp, C, Saleebey, D & Sullivan, W 2005, 'The Future of Strengths-based Social Work', Advances in Social Work, vol. 6, no. 1, pp. 79–90.
[13] Fallot, RD & Harris, MH 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol, Community Connections, Washington, DC, p.1. Available from: https://www.theannainstitute.org/CCTICSELFASSPP.pdf
[14] Filson, B, Robinson, P & Jensen, S 2012, Trauma Informed Care and Peer Support, PowerPoint presentation, Wichita, Kansas, viewed Feb, 2015. Available from: http://webs.wichita.edu/?u=ccsr&p=/trauma_informed_care/
The Transformation Center 2012. Available from: http://www.transformation-center.org

Recognition of the impacts of trauma

The first tenet of a trauma-informed practice approach is that the prevalence of trauma is acknowledged and understood, and all staff recognise the diversity and complexity of the impacts of trauma on individuals and communities. [54]

These impacts include: [55]

- loss of trust in others
- changes to physiological arousal (either chronic hyper-arousal or hypo-arousal or both)
- difficulty with self-regulation
- sensitivity to trauma reminders and triggers
- development of identity that is shaped by trauma and survival
- difficulty using language to talk about or describe trauma
- difficulties with attention, learning and memory [56] [57]
- difficulty establishing context when experiencing fear, [58] therefore experiencing distress when there is no danger
- increased attention and sensitivity to cues for threat, for example angry faces, [59] [60] therefore responding with extreme fearfulness when exposed to small signals of threat - like a person being annoyed or frustrated
- difficulty with 'sensory integration' leading to heightened anxiety [61] if the brain cannot co-ordinatE all of the information available to it
- difficulty interpreting and regulating emotion [62] therefore annoyance can become rage, and disappointment despair quite quickly
- greater awareness and notice taken of non-verbal 'negative' information [63] like body language and facial expressions
- less reward may be anticipated from an activity, which can appear as low motivation [64] because less pleasure is expected

Minimising trauma in a service context

In order to minimise trauma occurring in a service context, it is critical that a program's activities and settings maximise collaboration and sharing of power between staff and consumers. Services must look at ways they can modify practices to ensure that collaboration and power-sharing are maximised. [65]

The literature clearly shows that seclusion and restraint practices have been found to be re-traumatising. These practices add to emotional turmoil: sense of abandonment, loss of control, fear or terror, humiliation and disorientation that are re-traumatising for many consumers and staff.[66] Many consumers report how coercive interventions result in trauma that frequently resonates with the experience of being coerced in the past. [67] The recent Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2017) [68] conducted by the Chief Psychiatrist and the Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2018) [69] encouragingly points towards a trauma-informed care and practice approach which requires that staff recognise the ways in which services or organisations can harm or re-traumatise people and act in ways to minimise the risk. This includes the use of language that is culturally appropriate, respectful, does not stigmatise and recognises the person's preference for identity (i.e. consumer, survivor, etc.)

Re-traumatising practices include:

- discounting or minimising accounts of a person's experience, including reports of abuse
- labelling behaviour using language such as 'manipulative' or otherwise pathological terminology
- conducting physical or mental health assessments in the presence of others or without sufficient thought to issues of consent or privacy
- sexualised comments and discriminatory use of 'humour' by workers
- being ignored, dismissed or spoken to abruptly
- the use of coercive practices such as seclusion and restraint, including chemical restraint, but also psychological coercion such as withholding of basic needs or punitive responses and denial of basic requests
- being talked about within hearing
- anger, resistance and avoidance being pathologised (these are all understandable responses to trauma and abuse)

Re-traumatising circumstances in a service can include:

- frequent and unexpected changes in staff, including loss of valued connections
- poor acknowledgement of these losses in support and connectedness
- meetings and service plans conducted in the absence of the person
- promoting dependence on services or staff for basic needs
- being 'assigned' a worker without opportunity to make a meaningful choice
- inconsistent or arbitrary rules
- introducing and imposing rules without prior explanation

Workers need to recognise the importance safety plays in a person's sense of wellbeing and be able to discuss a multidimensional understanding of safety with consumers and their families and carers. In this context safety is far more than the 'freedom from hazard' (National Practice Standards for the Mental Health Workforce 2013, p 24), but includes the recognition of emotional, psychological, interpersonal and intrapersonal safety and recognition of the different perspectives that individuals may experience.

Debrief after incidents

At times distressing events occur during the course of care. These may be events experienced directly by the service user or witnessed occurring in the service context. While trauma-informed approaches including safety planning and environmental adjustments can minimise the likelihood of these occurring, there is also a need for services to respond transparently after incidents and provide opportunities for meaningful reflection, repair and further safety planning. The use of structured debriefs may be beneficial for staff, for consumers and for family members or carers.

Debriefs should be offered as soon as possible after the end of a distressing event and re-offered at a later time if initially refused. Choice of who is involved in debriefing may be important to ensure that service users have an opportunity to talk to a worker they feel safe with. Debriefs should occur in a private space and at a time when the worker is not rushed or distracted. Care should be taken not to defend events, attribute blame or defend the service. False assurance or dismissive statements should also be avoided. The conversation may include, what the person experienced, their understanding of why the incident occurred, what explanation they were given at the time and what else may have helped them. Conversation may also include how the service can best avoid

any further incidents and incorporate further safety planning to identify early warning signs or best responses. Opportunities for ongoing support should be offered.

Safety of the service environment

People who have experienced trauma are more likely to feel unsafe in service environments. [70] Safety from the perspective of a consumer often looks and feels very different to safety from the perspective of service providers. [71]

The table below outlines the meaning of safety from the perspective of consumers and services.

SAFETY FOR CONSUMERS MEANS: minimising loss of control over their lives	**SAFETY FOR PROVIDERS MEANS:** minimising loss of control over the environment and risk
• Maximising choice • Authentic relationships • Exploring limits • Defining self • Defining experiences without judgement • Receiving consistent information • ahead of time • Freedom from force, coercion, threats and punishment • Owning and expressing feelings without fear	• Maximising routine and predictability • Assigning staff based on availability • Setting limits and rules • Designating diagnoses • Judging experiences to determine competence • Rotating staff and providing information as time allows • Use of control such as medication, restraint or seclusion to prevent dangerous behaviour • Reducing expressions of strong emotion (Blanch & Prescott 2002)[15]

An environment that feels safe for consumers is also best for staff.

In your service environment, consider the following questions regarding the perception of safety:

- Are there separate spaces for male and female consumers to meet with staff or receive services if wanted?
- Are there comfortable and safe time-out spaces for consumers?
- Is there a high level of respect for personal modesty?
- Are same-gender staff always available?
- Is there a high level of respect for personal space and boundaries?
- Do staff know the people with whom the consumer does not feel safe, either in the service or their life more broadly, and have they addressed strategies for managing them with the consumer?
- Do staff know the elements of the service's physical space and routines the consumer may find difficult?
- Are staff aware that their perception of safety may be very different to that of the consumer?
- Have staff checked whether a consumer is comfortable to be in a room with them when the door is closed/or open?
- Are consumers asked about the least intrusive way by which staff can check on them and their spaces?
- Are all staff trained in strategies for safe non-physical de-escalation?
- Are there private spaces for staff and consumers to discuss personal issues?
- Do consumers have access to private locked spaces for their belongings?

(Harris & Fallot 2001 [16]; Guarino et al. 2009) [17]

Within mental health services even routine medical processes can be distressing for consumers. Frueh et al., (2005) [72] interviewed 142 patients receiving mental health care in a public mental health unit. Their study collected information on patients' 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 noted the distress associated with a loss of control for consumers in this environment, and made strong recommendations for increased attention to safety within inpatient settings in particular. [73]

This study also found some evidence for an increased likelihood that those who have survived previous trauma (sexual and physical abuse as children and sexual assault as an adult) are more likely to experience coercion and restraint. Additionally, survivors of previous trauma were more likely to report they had experienced unwanted sexual advances, a lack of privacy for bathing and dressing, and feeling bullied or labelled as 'crazy' by staff when in mental health services. [74] Survivors of sexual assault and those who reported symptoms of PTSD also reported significantly higher scores on measures for feeling unsafe, helpless, and experiencing fear and distress.

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[15] Blanch, A & Prescott, LA 2002, 'Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health Treatment Settings', report from the National Experts Meeting on Conflict Management and Alternative Dispute Resolution April 25–26, 2002, viewed 25 September 2012. Available from: https://www.nasmhpd.org/sites/default/files/ManagingConflictCooperativelyADR(1).pdf
[16] Harris, M & Fallot, R (eds) 2001, Using Trauma Theory to Design Service Systems, Jossey-Bass, San Francisco.
[17] Cited in: Harris, M & Fallot, R 2001, Using trauma theory to design service systems, Jossey-Bass, San Francisco.
Even if you are working in a trauma-informed service setting, keep in mind that the people you support may have experienced some traumatising experiences in a prior contact with services. Likewise, keep this in mind when considering referrals to health professionals who may not be trauma-informed.

Invasive procedures are often the most dramatic examples of trigger events occurring in a medical setting. [75] Even in a typically non-threatening environment, such as a visit with a GP or other health practitioners, a number of triggers may evoke traumatic responses. These include being touched, the removal or absence of clothing, the focus on bodily pain or function, and as mentioned earlier, the power differential between a consumer and practitioner which can mirror the power differential experienced in the original trauma.

Even if you are working in a trauma-informed service setting, keep in mind that the people you support may have experienced some traumatising experiences in a prior contact with services. Likewise, keep this in mind when considering referrals to health professionals who may not be trauma-informed.

Since safety is a pre-requisite for recovery post- trauma, services will be unable to contribute meaningfully to this recovery without addressing the **experience of safety** in service provision.

Responding to distress

In a trauma-informed system the feelings and behaviour that accompany heightened distress can be viewed as:

- the direct impact of trauma
- the person's means of coping with that trauma over time
- a reaction to current triggers that have aroused feelings, thoughts or behaviours associated with past trauma

Being trauma-informed includes an understanding that events in the present can 'trigger' intense feelings, thoughts or behaviours directly (or indirectly) related to past trauma. Our understanding of the impact of trauma means we can acknowledge the person's experience of intense emotion, physiological arousal and responsiveness and their ability to regulate this arousal. We should also consider the possibility that the person is experiencing a 'stress response' that presents as either hyper-arousal or hypo-arousal.

In both cases enhancing the person's sense of safety and present-moment awareness can be helpful. However, exercises that relax and 'ground' the person may not be helpful if they are already feeling flat, numbed or are in a state of hypo-arousal. In such cases, encouraging gentle movement such as slow walking, or sensory awareness of the present environment (if safe) and cues for current safety might be more helpful. [76]

People will express heightened distress in a number of ways including sudden escalation of risky coping strategies such as substance misuse and deliberate self-harm, or express despair or suicidality, and demonstrate heightened anger or suddenly withdraw from contact with others. Supporting consumers will allow them to gain or regain a sense of control over their daily lives and build competencies to strengthen their sense of autonomy.

DOMAIN D - Resources

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Fallot, RD & Harris, MH 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol*, Community Connections, Washington, DC.
Available from: https://www.theannainstitute.org/CCTICSELFASSPP.pdf

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Prins, A Ouimette, P & Kimerling, R 2003, 'Primary Care PTSD Screen (PC-PTSD)', U.S. Department of Veterans Affairs, Washington, DC. This is a 4 item screen for use primarily in a primary health care setting. This is a good model for non-intrusive questions suitable in community managed mental health and human service settings. (See Appendix 5/6 Screening Tools, TICPOT). Available from: http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

Rapp, CA & Goscha RJ 2011, *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services*, 3rd edn, Oxford University Press, New York, NY.

Rapp, C, Saleebey, D & Sullivan, W 2005, 'The Future of Strengths-based Social Work', *Advances in Social Work*, vol. 6, no. 1, pp. 79–90.

Substance Abuse and Mental Health Services Administration 2014, *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services,* guide series 57, SAMHSA, Rockville, MD, HHS publication no. (SMA) 13-4801, Treatment Improvement Protocol (TIP), series 57. HHS publication no. (SMA) 13-4801. Available from: http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

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Coalescing on Women and Substance, British Columbia Centre of Excellence, Vancouver, BC. Available from: http://www.coalescing-vc.org

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Urquhart, C, Jasiura, F & TIP Project Team 2013, *Trauma-Informed Practice Guide*, BC Provincial Mental Health and Substance Use Planning Council, Victoria, BC, p.52, 54. Available from: http://bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf

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DOMAIN E - A Healthy and Effective Workforce

Workers and services adopting a trauma-informed care and practice approach will respond appropriately to trauma and its impacts informed by specific knowledge and understanding. Education and training is an important component to informing and embedding a best practice approach in any service context. Collaboration between consumers and carers, policy makers and service providers across-service systems not only involves changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but helps to create organisational cultures that are personal, holistic, creative, open, safe and therapeutic.

A trauma-informed organisation will endeavour to facilitate joint initiatives for knowledge and information sharing on an ongoing basis. This is with a view to strengthening organisational capacity in all relevant sectors, as well as promoting education, training and workforce development across disciplines. A healthy and effective mental health workforce is one provided with no only the education, skills and competencies, but is supported to provide trauma-informed assessments and screening where appropriate; is able to enhance care coordination and maximise worker self-care.

Important to creating and sustaining a healthy and effective workforce are two key elements: supervision and awareness and responsiveness to vicarious trauma (VT). Both these elements are addressed in detail in this document.

TICPOT provides detail particularly about supervision because until recently, what actually constituted trauma-informed supervision has been absent from the literature.

1. Trauma-Informed Supervision – an overview

Trauma-informed workforce capacity building is vital, but training alone rarely brings about change in practice. Thus an important part of a trauma-informed practice approach also relies on establishing supervision that supports, develops and sustains practice. Supervision can serve as a model and parallel process for trauma-informed practice, and help to embed principles across an organisation by identifying the competencies required that support its practice. With this in mind, TICPOT includes some guidelines to providing trauma-informed supervision that fosters these competencies.

The tools provided in this section are based on resources in: 'Developing Trauma-Informed Organizations: Second Edition', 2012, *Institute for Health and Recovery*. [77] The information provided is presented as reinforcing training in this context.

Supervision Guide

Process
Trauma-informed supervision is safe for everyone involved. The manner in which supervision is conducted and how staff members treat each other is reflective of the overarching principles that guide service delivery to consumers and carers. The principles are mirrored in supervision as a parallel process, through which the relationships in both contexts can be fostered in a non-hierarchical way. Relationships are fundamental to the healing process for people with lived experience of trauma and attending to relationships in supervision reflects this understanding.

Culture
As with supervision in all contexts, the supervisory relationship is influenced by a person's culture and belief system. This includes attitudes, values, assumptions and behaviours acquired from their family of origin, social group and history. A trauma-informed supervisor maintains awareness of his/her own and the supervisee's culture and how this may impact their relationship. Importantly, these factors should be openly acknowledged and worked with in supervision, as in worker relationships with consumers and carers.

For further information on Trauma–Informed Supervision please see the following:

Appendix 1:	Supervisor Self-Check
Appendix 2:	Trauma-Informed Guide – Competencies Building Supervisee Competency Building Supervisee Competency Guide
Appendix 3:	Trauma-Informed Guide – Learning Reflection

Power differential
Since the supervisory relationship has an inbuilt power differential (unless it is peer supervision as understood in a clinical context), it is important to acknowledge that a supervisee may feel unsafe for a number of reasons including age, experience, gender, professional qualifications/discipline as well as potentially, their own trauma history. It is important that a supervisee is able to share their vulnerabilities, struggles and doubts without feeling further disempowered. It is also important that different disciplines, experiences and perspectives, roles and responsibilities are respected so that safety and trust can build the relationship over time. Honesty must be respectfully communicated in a kindly manner so that supervisees can feel supported and encouraged to improve their practice over time. Supervisors must practice fairly with all supervisees irrespective of 'likeability' and differences.

Strengths-based
Trauma-informed supervision is underpinned by strengths-based principles. The learning process is enhanced by acknowledging good practice and developmental milestones as well as addressing areas for growth and improvement as necessary.

Holding the space
Whilst supervision is not counselling, supervisors must respond empathically when supervisees are upset or have experienced a crisis. When crises occur mistakes are often made, and it is important to give a supervisee the time to gather themselves so that the circumstances can be evaluated and discussed calmly. It can be an opportunity to model best practice for working with consumers in a trauma-informed way.

Reflective practice
An important goal of supervision is to encourage emotional intelligence and self-reflection. Supervisees need to know what they are doing and why. Appropriate questioning, and active listening fostering self-reflection, avoids assumptions and clarifies what might otherwise be misunderstood.

Empower
Since the primary purpose of supervision is to enhance skills, a supervisor should encourage and elicit solutions rather than direct and advise a supervisee. When stuck, a supervisor should facilitate brainstorming alternatives so that the supervisee can experience a process of evaluating the possible alternatives, whilst maintaining as much choice and autonomy as possible.

Self-care
Work undertaken in human services frequently exposes staff to painful and difficult circumstances. Stories can be very triggering or traumatising, especially if staff have their own trauma experiences. Even without a personal trauma history the accumulating effect of working in the field can impact attitudes, behaviours and well-being. A trauma-informed supervisor models good self-care, and supports supervisees to implement self-care strategies that work for them. This includes healthy life choices, work/life balance, setting appropriate boundaries with co-workers and clients and utilising peer and other professional supports.

2. Trauma-informed measures and vicarious trauma

An overview of the impacts of trauma on the workforce in relation to past and existing trauma, vicarious trauma and trauma in service provision is broadly covered in *Stage 1 – Planning and Audit* (pp. 10-11). This section provides additional evidence-based material for organisations to consider when seeking Quality Improvement in Domain E (A Healthy & Effective Workforce) in the TICPOT Audit Tool.

Over the years, people have measured vicarious trauma (VT) in a variety of ways. Vicarious trauma is a multifaceted construct requiring a multifaceted assessment. More specifically, the aspects of VT that would need to be measured for a complete assessment include self-capacity, ego resources, frame of reference (identity, world view, and spirituality), psychological needs, and trauma symptoms (McCann & Pearlman 1990; Pearlman 2001, & Saakvitne et al. 2000).

Measures of some of these elements of VT exist, including the following:

- Psychological needs: Trauma and Attachment Belief Scale (Pearlman 2003). Western Psychological Services. Inc. Available from: https://www.wpspublish.com/store/p/3011/tabs-trauma-and-attachment-belief-scale
- Inventory of Altered Self-Capacities (IASC, Briere 2002). Available from: http://www4.parinc.com/Products/Product.aspx?ProductID=IASC

Trauma symptoms:

- PTSD Checklist for DSM-5 (PCL-5), Weathers, FW Litz, BT Keane, TM Palmieri, PA Marx, BP & Schnurr, PP 2013, The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov
- Impact of Events Scale (IES, Horowitz 1979: IES-R; Weiss & Marmar 1996). Revised. Available from: http://consultgerirn.org/uploads/File/trythis/try_this_19.pdf
- Briere, J. (2001). DAPS—Detailed Assessment of Posttraumatic Stress Professional Manual. Odessa, FL: Psychological Assessment Resources. Available: https://www.parinc.com/Products/Pkey/80

Key Features of Trauma-Informed Care and Practice Systems

Systems without Trauma Sensitivity	Trauma-Informed Care Systems
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
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

Systems without Trauma Sensitivity	Trauma-Informed Care Systems
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)
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

DOMAIN E - Resources

Air American Institute for Research. Available from: http://www.familyhomelessness.org

Kezelman, C & Stavropoulos. P 2012, '*The Last Frontier*': Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery, Adults Surviving Child Abuse (ASCA), Kirribilli, NSW. [78]

Professional quality of life (ProQOL) incorporates two aspects, the positive (Compassion Satisfaction) and the negative (Compassion Fatigue).The ProQOL is frequently used in research and has been psychometrically tested. Section 8 (p.26 – 30), provides test handouts and scoring scale. Stamm, BH 2010, The Concise ProQOL Manual, 2nd edn, ProQOL.org, Pocatello, ID; ProQOL.org 2009, Professional Quality of Life Scale (ProQOL): *Professional Quality of Life: Compassion Satisfaction and Compassion Fatigue* (ProQOL) Version 5, ProQOL.org, Pocatello, ID. [79]

Detailed background information, checklists and activities that offer strategies for implementing organisational change around self-care; workplace training and education curriculums, and self-reflective practice on VT and Self-Care, in addition to providing links to other resources. Volk, KT Guarino, K, Grandin, ME & Clervil R 2008, *What about You?: A workbook for Those who Work with Others. National Center on Family Homelessness*, Waltham, MA. [80]

Bell, H, Kulkami, S & Dalton, L 2003, 'Organizational Prevention of Vicarious Trauma', *Families in Society*, vol. 84, no. 4, pp. 463-470. Available from: https://journals.sagepub.com/doi/10.1606/1044-3894.131

Strategies for developing trauma-informed services by tracing the experience of a homeless service. Guarino, K & Chervil, R 2008, *Trauma-Aware to Trauma-Informed*, report, Homelessness Resource Center (HRC), Newton Centre, MA. Available: http://www.homelesshub.ca/Library/Trauma-Aware-to-Trauma-Informed-33349.aspx

McCann, IL & Pearlman, LA 1990, 'Psychological Trauma and the Adult survivor: Theory, Therapy, and Transformation', Brunner/Mazel, New York, NY.

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Pearlman, LA 2003, *Trauma and Attachment Belief Scale Manual*, Western Psychological Services, Los Angeles, CA.

Saakvitne, KW, Gamble, S, Pearlman, LA & Lev, B 2000, *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*, Sidran Press, Lutherville, MD.

Substance Abuse and Mental Health Services Administration 2014, *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services*, guide series 57, SAMHSA, Rockville, MD, HHS publication no. (SMA) 13-4801, Treatment Improvement Protocol (TIP), series 57. HHS publication no. (SMA) 13-4801, Part 2, Chap 2 – Building a Trauma-informed Workforce, pp. 173 – 205. Available from: http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Urquhart, C, Jasiura, F & TIP Project Team 2013, *Trauma-Informed Practice Guide*, BC Provincial Mental Health and Substance Use Planning Council, Victoria, BC, Appendix 6, p.50, 52, 76. [81]

Klinic Community Health Centre 2008, *The Trauma-Informed Toolkit*, KCHC, Winnipeg, MB, p.75. [82]

The Headington Institute was established in 2001 in order to provide support for humanitarian relief and development personnel worldwide. It provides a range of free on-line training tools and resources particularly useful in the area of trauma and VT. [83] Available from: http://www.mhcc.org.au/home/

van Veen, S 2012, *Vicarious Trauma Assessment Toolkit for the Violence Against Women Sector*, Social Innovation Research Group, Waterloo, ON. [84] Available from: http://voicesinitiativeblog.files.wordpress.com/2013/01/vicarious-trauma-toolkit.pdf

DOMAIN F - Outcomes and Evaluation

Many Australian funders of mental health and human services promote use of outcome measures by community based organisations. A Key Performance Indicator (KPI) assessment process generally sets KPIs as a condition of operating a program, and/or with KPIs agreed by the organisation and funder.
According to Gregory and Howard (2009), [85] funders need to refocus their attention on outcomes by asking "What are we trying to achieve?" and "What would define success?" In so doing, they will signal to their grantees that the impact of their service matters more than anything else. "Even focusing on approximate or crude indicators is better than looking at cost efficiencies, as focusing on the latter may lead to narrow decisions that undermine program results." (Gregory & Howard, 2009, p.52). [86]

In Australia, community based organisations use a broad range of tools, including many formal outcome measurement instruments (AMHOCN and CMHA 2013). [87] The eight most common tools used by community based organisations in the mental health space in Australia are:

- Kessler-10 Plus (K-10+)
- Behaviour and Symptom Identification Scale 32 (BASIS-32®)
- Camberwell Assessment of Need - Short Appraisal Schedule (CANSAS)
- Depression Anxiety Stress Scales (DASS)
- The Health of the Nation Outcome Scales (HoNOS)
- Life Skills Profile 16 (LSP-16)
- World Health Organisation – Quality of Life scale (WHO-QOL)
- The Recovery STAR

NSW Health utilise a number of tools in public services including:

- Mental Health Outcomes & Assessment Tools

Required Data Items for the MH-OAT Data Collection include a rating response and summary score data items as specified in age specific standardised measures

Adults

- HoNOS (Health of the Nation Outcome Scales)
- LSP–16 (an abbreviated version of the Life Skills Profile)
- K10+–LM or K10–L3D (two versions of the Kessler–10)

Older people

- HoNOS 65+ (an alternative version of the HoNOS)
- RUG–ADL (Resource Utilisation Groups – Activities of Daily Scale)
- LSP–16 (an abbreviated version of the Life Skills Profile)
- K10+–LM or K10–L3D (two versions of the Kessler–10)

The Health of the Nation Outcome Scales (HoNOS) is also a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning for those in the 18 - 64 years old age group.

TICPOT highlight the following for consideration. Our understanding is that all the tools are consumer completed tools with the exception of the last item listed, CANSAS, which is consumer/ carer and worker completed.

Recovery	Recovery Assessment Scale (RAS) or Stages of Recovery Instrument (STORI)
Thoughts and Feelings	Kessler-10 (K-10) or CarerQoL (CarerQoL-7D+VAS)
Daily Living and Maintaining Relationships	Work and Social Adjustment Scale (WSAS)
Social Inclusion	Living in the Community Questionnaire (LCQ)
Quality of Life	World Health Organisation Quality of Life –Brief, Australian Version (WHOQoL- BREF)
Experience of Service	Consumers Experience of Care or Carers Experience of Service Provision
Multidimensional	Camberwell Assessment of Need – Short Appraisal Scale (CANSAS)

Increasingly organisations are moving toward targeted measurement of recovery-orientation ('recovery tools'). These are further detailed in the AMHOCN and CMHA National CMO Outcome Measurement Project Final Report (2013). [88]

Little research has specifically focused on the measurement of trauma in mainstream mental health services. While some tools have items that assess some trauma information – e.g. tools designed for use with people experiencing PTSD – they do not represent the standard in an all-of-service routine outcome measurement collection.

However, it is important to mention the ACE Study [89] which is an ongoing collaborative research between the Center for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, California. This research links childhood trauma to long-term health and social consequences.[90]

This study collated evidence from over 17,000 clients who participated in routine health screening who volunteered to be part of the study. Data resulting from their participation continues to be analysed; it reveals staggering proof of the health, social, and economic risks that result from childhood trauma. The Center for Disease Control and Prevention provides access to the peer-reviewed publications resulting from The ACE Study. [91]

DOMAIN F - Resources

More detailed scientific information about the ACE study design can be found in: Felitti, VJ, Anda, RF, Nordenberg, Williamson, DF, Spitz, AM, Edwards, V, Koss, MP, Marks, JS 1998, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults', *American Journal of Preventive Medicine*, vol. 14, no. 4, pp. 245-258. Available from: http://acestudy.org/ ; http://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract

Center for Disease Control (CDC) & Kaiser Permanente, 'Adverse Childhood Experiences Study', www.ACEstudy.org

Urquhart, C, Jasiura, F & TIP Project Team 2013, *Trauma-Informed Practice Guide*, BC Provincial Mental Health and Substance Use Planning Council, Victoria, BC, Appendix 2, p.57, Available: http://bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf

Stage 3 - Implementation

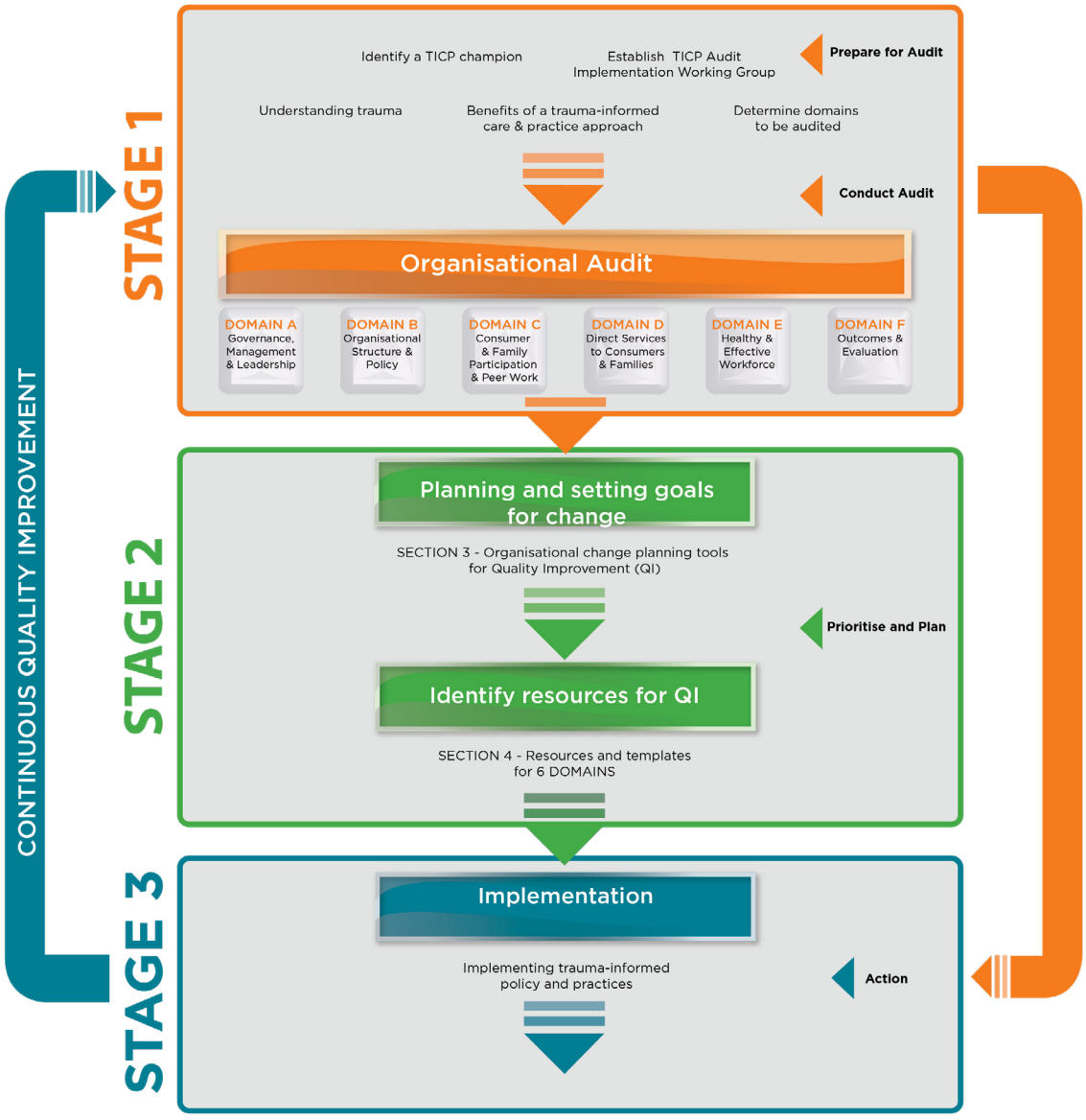

Figure: 2

Stage 3: Implementing Change

As mentioned in the introduction to this document, most organisations will not implement change in every aspect of their organisation, services and programs in one step. Having completed an audit and an analysis process it will be necessary to move towards prioritising next steps/actions.

Following the audit process, the organisation will identify a course of action that prioritises different areas for quality improvement over time according to their identified most pressing priorities. For example, an organisation may determine from the audit analysis that their first priority is:

- trauma-informed education and training, AND/OR
- that management needs to become skilled and knowledgeable enough to champion a trauma-informed practice approach throughout the organisation, AND/OR
- that policies and structures which need to be developed and in place before changes can occur elsewhere in the organisation.

REMEMBER: The process of becoming trauma-informed should be both intentional and organic. The principle objective is to establish a culture that will foster best practice, and nurture flexibility and innovation in order to promote sustainability. Subsequent audit processes can be rescheduled as part of the action plan to measure short-term and longitudinal change.

Stage 2 – SUPPORTING ORGANISATIONAL CHANGE provides a number of planning tools, checklists and references to assist the Audit & Implementation Working Group (AIWG) to develop a strategic plan and identify goals for implementing organisational change.

Stage 3 – IMPLEMENTING CHANGE builds on quality improvement processes for an organisation/ service/ program/unit that has committed to:

- becoming trauma-informed
- to providing services that adopt a trauma-informed care and practice approach, and have
- undertaken the comprehensive or part audit

The Trauma-Informed Care and Practice Implementation Working Group (TICP AIWG) established prior to the assessment process, drives strategic planning for organisational change. The AIWG can continue as a group to provide oversight of future planning of quality improvement initiatives and evaluation processes. Ideally, the AIWG should include members from across the organisation, as outlined in Stage 1.

1. Implementation sample checklist

1. Identify a leader and/or leaders in the organisation/ site/team willing to champion TICP implementation and organisational change	Appointed
2. Implementation Working Group (ideally to include senior management and staff from across the organisation, and consumers and carers including current service users identified from an EOI process)	Established
3. Prioritisation of areas to progress* following audit Stage – 1 Goal statement Organisational domains for TICP post audit action/ quality improvement: A. Governance, Management and Leadership B. Organisational Policies and Structure C. Consumer and Carer/Family Participation D. Direct Services to Consumers E. Healthy and Effective Workforce F. Outcomes and Evaluation *Refer to the findings/recommendations arising from your organisational audit	Priority areas: A; B; D
5. Accountability has been clearly identified	Staff responsibilities reporting
6. Timelines have been negotiated and agreed to	Dates
7. Budget/Resources have been allocated	Attach budget

2. Develop an implementation plan

Matters for administrators: [92]

The following are post-audit considerations as to how an organisation might begin to construct an implementation plan for quality improvement in one or more of the six domains.

Introduction and overview

- Describe the organisation's history; the demographics that characterise its client base; the rationale for the implementation plan; and the rationale for incorporating a trauma-informed care and practice approach across some/all organisational domains
- Identify strengths, weaknesses, opportunities, and barriers
- Provide an overview of goals and objectives.

3. Set specific goals and objectives

Goals and objectives to address (for example):

- Workforce development strategies for recruiting, hiring, retaining, training, supervising, and promoting readiness of clinical and non-clinical staff to support TICP
- Workforce development strategies to foster a peer workforce as essential team members
- Consumer/carer participation and co-design of all implementation strategies
- Policies, procedures, and practices to support culturally responsive services, that promote safety, and to prevent re-traumatisation
- Identifying specific best practice approaches to TICP relevant to service context
- Strategies to review and modify facility design/ environment to reinforce safety
- Fiscal planning to ensure sustainability of the steps initiated in the organisation.

Establish guidelines for implementation

- Highlight the specific steps, roles, responsibilities, and timeframes for each activity to meet implementation objectives
- Specify methods/ tools for monitoring and review of outcomes and evaluation processes
- Consider inclusion/ provision of trauma-informed care and practice statement in Mission or Vision Statement/ Communications that promote the service (for example: our service adopts acknowledges the prevalence and impact of trauma on the lives of individuals and families, and embraces a trauma-informed care and practice approach to all its activities) [93]
- Consider workforce capacity building (information, training and professional development) for different roles and responsibilities.

4. Ten Steps Supporting Quality Improvement

1. Identify new goals or challenge
2. Consultation with every level of the organisation, consumers and other key stakeholders
3. Analyse the feedback
4. Explore improvement options and the potential barriers associated with each
5. Develop and co-design an overall approach with identified strategies to address barriers (anticipate obstacles, and try to address them before they occur)
6. Develop and co-design the implementation plan, and present to staff and other key stakeholders not directly involved in the quality improvement/ implementation process
7. Implement the plan
8. Reassess the new plan
9. Evaluate the outcomes and determine if new goals and objectives or additional problems or issues need to be address.
10. Repeat the first nine steps after a designated time period.

5. Timeline Template

This template can be utilised to plan and identify the timelines for different elements and goals for implementation.

	0	1	2	3	4
Date					
Person responsible					
Example			All staff have received training in valuing diversity, recognising discrimination and privilege	Evaluation survey from participants to be completed	
Status	No data, no plan (prior to TICPOT Assessment)	No data, no plan (prior to TICPOT Assessment)	Plan has been implemented	Plan has been implemented and data has been gathered regarding implementation	Initial plan has been implemented and new plan developed based on feedback/data regarding implementation
Reporting to:				TICP WG	
Date:			Completed	By Date	

6. Principles of Trauma-Informed Care and Practice

Remember that the Principles of a Trauma-Informed Care and Practice approach must guide all your endeavours throughout the process of Implementation (see page 48)

Implementation Guidelines for Consultant/Analyst

- Your organisation has conducted your own analysis of the TICPOT audit tool; or you have engaged an independent consultant that has analysed the data and provided a Survey and Evaluation Report and Recommendations.
- The Implementation Working Group/ Broader Group/ as required – have determined next steps.
- In each Domain the questions which have been answered by the service are identified and reviewed by the in-house Analyst or Consultant under one of four categories:

Service		Analyst / Consultant	
Strongly Agree	**SA**	Extensively Trauma - Informed	**ETI**
Agree	**A**	Markedly TI	**MTI**
Disagree	**D**	Somewhat TI	**STI**
Strongly Disagree	**SD**	Least TI	**LTI**
Not Applicable	**N/A**		
Don't know	**D/K**		

- We now propose a **STRENGTHS-BASED ENQUIRY (SBE)** for establishing priorities, to be conducted for each Domain to determine the Roadmap to Implementation.
- Don't forget to look at the TICPOT Resources part of this document in Stage 2.
- The kinds of questions you might ask **against each response item** determined by the Consultant/Analyst as either **STI** or **LTI** may look something like the following:

STRENGTH-BASED ENQUIRY – Possible Questions **For each item that is STI or LTI (see above) ask the following:**	**Response**
Does **THIS** already happen in the organisation, at least some of the time? When and where does THIS happen?	
Is there anywhere in the organisation where **THIS** happens very well?	
What are the essential elements of **THIS**? Do any of these elements occur in the organisation?	
What is needed for **THIS** (practice) to occur elsewhere within the organisation?	
Where in the organisation is **THIS** most likely to be accepted?	
Are there opportunities for people involved in **THIS** practice to support others?	
What are the resources and supports needed for **THIS** practice to develop? – e.g.: time; expertise; training; resources; funds.	

How can the knowledge, skills, competences and confidence required be supported?	**Response**
Are there fears about change in this area?	

STRENGTH-BASED ENQUIRY – Possible Questions For each item that is STI or LTI (see above) ask the following:	**Response**
What might people need to feel safer and be able to embrace change in this area?	
What might/do people who are not satisfied with the practice in this area suggest/ want/ need?	
BRAINSTORMING ideas e.g.:	**Response**
► Which ideas might be adopted?	
► Who is responsible for championing and implementation?	
If this idea is **ADOPTED** – Who by? When? How?	
If this idea is adopted by someone, to whom are they **ACCOUNTABLE?** –Working Group; Management of the Organisation; Service User; the Staff etc.?	
What might be the **EVALUATIVE** processes for any action?	

Prioritising implementation actions

When you have completed the TICPOT audit process, and the data has been gathered, the AIWG will need to work to identify areas that demonstrate that the organisation, service or programs should consider a quality improvement action, because that area/ or areas denote that it/they is /are **only somewhat** or **least trauma-informed**.

From the process you may have undertaken the **Strength-Based Enquiry** and can now consider how you might proceed. You need to ask yourselves: Is the issue Urgent? If it is not urgent, but easy to address now and therefore represents "a quick win" this could serve as a motivating action. If it is a priority, must it be done now, in the near future or later? Ask yourselves where it might comfortably sit within your time frame for quality improvement actions?

The following template example aims to assist you in this process.

A Prioritising Process – DOMAIN A	Are any of the following items:		Timing				
Identified action required	**Urgent**	**Easy**	**Now**	**Next**	**Later**	**N/A**	**Comments How / Date**
1. Identified roles for consumers and carers in governance bodies (and management) No organisation can be trauma-informed without direct carer participation in all aspects of policy and program development. The organisation can demonstrate that:							
i. There are identified leadership and governance roles at all levels for consumers to ensure representation and contribution							
ii. There are identified leadership and governance roles at all levels for carers/family members (e.g. Board member/Director) to ensure representation and contribution for carers/ families							
iii. This organisation can provide evidence that consumers and carers/family members have been involved in decision-making and/ or governance of the organisation							

A Prioritising Process – DOMAIN A	Are any of the following items:		Timing				
Identified action required	**Urgent**	**Easy**	**Now**	**Next**	**Later**	**N/A**	**Comments How / Date**
2. Leadership style and skills Leadership in trauma-informed organisations needs to model the values of respect, compassion and transparency. Effective leaders can reflect and adjust their style in response to the needs of the organisation. In this organisation, managers and leaders:-							
iii. Utilise and support engagement with reflective practice							
iv. Actively facilitate and support collaborative / shared decision-making with frontline staff							
v. Support frontline staff to engage in collaborative/shared decision-making with carers/ family							
vi. Are responsive to formal feedback regarding their management and leadership skills							
vii. Are transparent about how decisions are made and communicated within the organisation							

A Prioritising Process – DOMAIN A	Are any of the following items:		Timing				
Identified action required	**Urgent**	**Easy**	**Now**	**Next**	**Later**	**N/A**	**Comments How / Date**
3. Knowledge of trauma and trauma-informed practice amongst leaders and managers All people in the organisation need knowledge concerning the impact of trauma and understand a trauma-informed care and practice approach, including managers and leaders providing direction for organisational change.							
ii. All managers and leaders have participated in training and education regarding trauma-informed care and practice, policy and procedures							

Year 1 - Organisation XYZ – Quarter 1 – Action Working Plan - Template EXAMPLE 2

Having identified priorities the organisation may want to develop an Actions Working Plan for each quarter contributing towards an overarching QI Plan for the entire period set for implementation.

Date Submitted:	**Organisation XYZ Lead:**
Goal: Domain	**Applicable Performance Areas:** HR; **Orientation;** KPIs**; Policy; Standards** etc

Initiative DOMAIN A-F	Initiative Lead	Evidence of Completion	Target Date	Documentation of Needs - Examples				Quarterly Update
				Tech Asst.	Consumer/ Carer	Data Research Evaluation	Workgroup	
Describe	Person	Description	00/00/00	QI				
		Training module developed	5/03/16	e.g. Map to	e.g. Focus Groups	e.g. Uni partner	Who	e.g. Line manager confirm completed
Report to CEO		CEO Inc Board Report entry	9/04/16 Next BM				Who	e.g. Report to Board

TICP Quality Improvement Implementation – Plan/Period – Template Example 3

Domain E	The organisation aims to address as a priority the issue that arose from the question: 2. Workforce development and training. Trauma-informed organisations prepare and support staff to deliver services safely and effectively, and recognise that additional training may be required. In the organisation staff can readily access : 1. Training and information about the prevalence and impacts of trauma 2. Training about the impacts of intergenerational trauma 3. Information and education regarding vicarious trauma and self-care 4. Information on healing and recovery from trauma 5. Training in communication skills 6. Training in cultural competence and cultural safety 7. Training in valuing diversity and strengths, recognising discrimination and privilege 8. Training in relationship building and negotiating boundaries 9. Training in conflict resolution skills 10. Training about responding to disclosures of trauma 11. Training about responding sensitively to stress 12. Training and policy guidance about responding to risk of harm to children and young people 13. Training and policy guidance about responding to risk of harm to older or vulnerable adults 14. Training about collaborative and strengths-based practice 15. Training about collaborative safety assessment and planning 16. Information about consumer & carer support needs and referral processes 17. etc

Implementation Action	Status	Proposed Outcome	Achievement	Implementation Action	Evidence/ Date
1. Workforce development and training	Date - Example Currently only clinicians in this service have access to limited training and professional development in trauma and TICP. Only 14% have attended such training in 2015. Staff say they don't have time to attend training except at weekends.	That the entire workforce have access to different levels and modes of training including e-learning models. The org ensures that staff have back up to attend training.	Over 2 years, 5 staff teams have had access to e-learning Also 2 day FTF - Introduction to trauma and TICP.	Investigate learning options and budget to include at least 2/ 2 day courses and e-learning options for non-clinical staff across the organisation. EOI circulated amongst staff and survey to gauge existing knowledge and experience, interest and willingness to attend.	To Date – 50% staff uptake across programs and services area, administration etc. - Scheduled date - Conduct consumer/ carer survey of experience of service, environment, staff culture etc. - Scheduled/ Conducted date - Conduct staff survey re impact of training to practice.

Setting Priorities: Helping you undertake prioritisation - a process

The Process should be:

- Reasonable – the process must mirror TICP Principles in that it is
  - o Transparent – the process must be clear and accessible
  - o Responsive – the process must respond to feedback
  - o Accountable – it must be clear who is responsible for ensuring the process is followed

Develop a list of priorities that have been identified from the TICPOT audit survey (see Template Example (1)

From this priority list identify within a stated timeframe a final list, and determine a maximum number of actions e.g., 10 max over 12 months that can be addressed.

As mentioned earlier under Prioritising implementation actions (p.50) some priorities may be determined as urgent and needing to be actioned straight away, or may be considered now because they are easy to initiate and provide a motivational easy win (e.g. the organisation can easily fund training for staff within the timeframe; get a pot of paint or buy some furniture). Others may be urgent, but not feasible now but possible soon or next (when a staff member has the time to complete this task). Another priority may be important but can wait until later, or a priority may be urgent but cannot wait because current practice may do harm.

Considering priorities:

- Develop a prepared list
- Having decided on a maximum number (if an initiative goes on the list something else must come off)

Considering Priorities – common pitfalls

- Proxy for policy
- Too ambitious without a clear mandate
- Can't be implemented
- Solution doesn't match the problem

Consider what will change if a priority is selected – from a number of perspectives, e.g. practice based factors, values based factors, and contextual factors.

Consider value-based factors

- What outcomes do you want to achieve from this priority? Policy, practice, procedures?
- Who is likely to benefit? Improved practice – better outcomes for consumer; carers; families; workforce
- Might this priority offer systemic benefits?
- What does it cost to achieve this outcome? People, capacity, resources etc?
- Do you have the resources to make this change, now, next, later, or not at all?
- Which priority is more urgent because of potential harm?

Consider practice factors

- Does this priority represent best practice from a trauma-informed recovery oriented perspective?
- What is the evidence supporting this practice, policy, procedure, etc?
- What is the evidence supporting change?
- What is likely impact of this initiative?\
- Have others conducted this practice that can assist implementation?
- Where are the sources of information?
- Have consumers, carers and the workforce been consulted about this priority?
- Does your organisation have the skills and competencies to progress this priority?

Consider contextual factors

- Is this a common priority across the sector/ services?
- Who else can we learn from in this context?
- Do we have the capacity and capability within the organisation?
- Can savings be made whilst improving quality outcomes?
- Do we have the leadership to progress this priority?

Having undertaking this process

- Do we have a list of shared implementation priorities that the WG have agreed to and that management support?
- Do we understand the rational for these priorities and can advocate for their initiation?
- Do we agree on where we start and time-lines for action? [18]

[18] Developed from the ACI NSW Agency for Clinical Innovation - Model of Prioritisation

Appendix 1 - Supervisor Self-Check

The following template can be used as a template for self-assessment after provision of supervision.

Date: Name of Supervisor:

Name of Supervisee:

During supervision

	Yes	No	N/A
1. Did I remember to point out what the supervisee did well? Example:			
2. Was I respectful, honest and fair?			
3. Did I consider the impact of what I said on our relationship?			
4. Did I ask questions and listen closely rather than make assumptions?			
5. Did I remember to compose myself before I addressed difficult issues?			
6. Did I consider the impact of differences in our culture on the relationship and on how the supervisee practices?			
7. Did I maintain awareness of my own feelings, attitudes, beliefs and assumptions?			
8. Did I encourage the supervisee to come up with solutions rather than tell them what to do?			
9. Did I give the supervisee as much choice and control as possible?			
10. Did I support and encourage good self-care?			
11. Did I acknowledge the impact the work has on us?			
12. Did I communicate my belief that the supervisee can learn and grow on the job?			
13. Did I acknowledge the supervisee's professional goals and aspirations?			
Any other comments?			

Appendix 2 - Trauma-Informed Competencies [19]

a) Building Supervisee Competency

The process of supervision mirrors trauma-informed principles and practice. A trauma-informed supervisor encourages supervisees to pay particular regard to the relationships they develop with those they serve. They also encourage supervisees to be emotionally aware of the impact of what they say and do on the relationship with consumers.

As well as understanding how one's behaviour impacts on how one is seen as a worker, how this affects people's view of the agency and indeed care and support in general is important. A bad experience with service providers and systems often leads to avoidance of further opportunities for support, care and assistance. Sometimes it can take years to re-engage with a consumer, and regain their trust and respect in services and providers. A poor relationship with a service can lead to exacerbated risk of harm and very poor long-term health outcomes.

Supervisors can model best practice by asking supervisees questions that build awareness and competency. While by no means exhaustive, the following list provides some guidance for trauma-informed supervision:

1. Goal setting
People are motivated by working towards their own professional and personal goals rather than have others identify, 'what is best for them'. There is a tendency in us all to think we know what others need and forget to ask what is important to them. This leads to misunderstandings and disappointments.

2. Avoid making assumptions
Assumptions characteristically are a barrier to understand another person's point of view. Approaching others with openness and curiosity promotes empathy and understanding.

3. Demonstrate respect, honesty and fairness
As a general rule most people working in the caring professions try to be respectful, honest and fair in all their interactions and relationships. When we fail to achieve this it is usually because we are holding some feelings that we may not be aware of. The feelings may be due to some aspect/s of the situation or interaction we are responding to, or feelings that we brought to the workplace. Supervisors can assist supervisees by helping them reflect on why they reacted as they did.

4. Acknowledging culture
Many of our attitudes, beliefs and assumptions come from our culture. Other people have different perspectives because their background and experience is different. Supervisors can help supervisees improve their awareness and sensitivities to culture and cultural differences.

5. Build on strengths, abilities, interests and creativity
People seeking services are often aware of their deficits and difficulties. In trying to support them we often focus on what is 'wrong' with them, what is not working for them and what they have been unable to do. This often exacerbates their poor sense of 'self' and their feelings of inadequacy. Frequently we miss asking what happened to them, what has worked and sustained them and encourage a strengths-based interaction. Supervisors should encourage supervisees to adopt a strengths-based approach and support creativity and innovation in practice.

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[19] This entire resource is adapted from the work of: Elliott, DE, Bjelajac, P, Fallot, RD, Markoff, LS & Reed, BG 2005, 'Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women', Journal of Community Psychology, Special Issue: Serving the Needs of Women with Co-Occurring Disorders and a History of Trauma, vol. 33, no. 4, pp. 461–477.

6. Encourage and support as much choice and control as possible
People feel respected and valued when they are able to make their own decisions. Making choices and experiencing the outcomes of those choices is the way we all learn and grow. 'Dignity of risk' is an important concept to promote in the caring professions. It is important for supervisors to encourage supervisees to consider the balance between 'duty of care' and 'dignity of risk' in relation to those they serve and the context of their particular role and work. Many people we work with have had their capacity to make decisions questioned or taken away from them, leaving them feeling powerless and hopeless. We want the people we serve to have the opportunity to use and learn from their own power. Supervisors can assist supervisees to reflect on where they may have imposed unnecessary rules, limits and restrictions, and even been punitive rather than supporting others to make choices and learning from their mistakes. Supervisors can support supervisees to adopt a supported decision-making approach to maximise their clients' ability to make significant decisions, exercise their legal capacity, make choices about their life and exercise control over the things that are important to them.

7. Exploring situations with others and supporting people to develop their own solutions
A central principle of trauma-informed care and practice is to support people to establish or re-establish their sense of choice and control. This is particularly difficult for people who may have been chronically abused, traumatised and robbed of any self-power especially during childhood. One way we can assist is to support them to make their own decisions and find solutions to their problems rather than telling them 'what's best' for them.

8. Communicate hope
Sadly, many of the people we work with do not believe their situation can improve. Often this becomes a self-fulfilling prophecy. They have lost their will to fight, dream of a future and ability to stand their ground. Our role is to hold hope for everyone; genuinely believe that everyone can grow, learn and improve their circumstances; and that possibilities exist if we maintain a hopeful attitude. Supervisors should be aware of supervisees expressing negative statements and believing that there is no potential for change and growth. They should also question what is happening in the consumer/worker relationship as well as in a parallel process in supervision.

9. Coping skills developed as a consequence of trauma
Characteristically, survivors of childhood abuse exhibit early onset of mental health difficulties with a tendency towards chronicity, lowered self-esteem and a sense of hopelessness (Henderson & Brown, 1988; Harris, 1988; Romans et al., 1992). [94] 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 people we work with have been labelled as having 'challenging behaviours'.

In trauma-informed environments, supervisors can assist supervisees to remember and be particularly aware that those we serve may be victims of abuse. They deserve our patience and empathy and should not be re-victimised by reactive responses.

10. Managing one's own and others' distress
When a person is distressed, being approached by a worker who is also upset only exacerbates the situation. When people are distressed, they rarely think clearly, and are less likely to come up with effective solutions. Supervisors can model calming and grounding techniques and strategies when supervisees are upset, and guide them reflect on how a situation might have been better managed.

11. Identify 'triggers' and grounding strategies
Everyone has things that 'push their buttons'. These are 'triggers' that can present as sights, sounds, or a feeling or situation that reminds us of something that happened to us, an experience held in our conscious or unconscious memory that was bad, unpleasant, frightening or threatening for example. When triggered, feelings from the past are re-enacted in the present, and generally are experienced more intensely that the current situation requires. It is important that we are aware of

what our particular triggers are, and have strategies at our fingertips to manage them. A trauma-informed supervisor can assist a supervisee to identify what their triggers are and what strategies might help them. There is no 'one-size fits all' and we all need to be sensitive to the possibility that what works for one person may intensify the situation for another. It is important that in the context of supervision the original trauma or past experience does not become the central focus. Rather, centre on what the supervisee might have done differently, and what strategies they might utilise in the future. Obviously if the supervisee is re-traumatised, they should be supported and directed to appropriate interventions and supports, such as counselling, de-briefing, EAP etc.

12. Creating a safe environment for workers and service users
The safer people feel in our facilities and programs, the more they will be able to grow and learn. The environment needs to be visually and aesthetically pleasing, comfortable, calm and predictable. Communications should make clear what the expectations are, and when mistakes and difficulties occur, they need to be dealt with in a collaborative, supportive way. In this kind of environment people feel able to raise their concerns and offer input. To create a safe environment, workers must be able to do what they have said they will do. They should clearly answer questions and provide information in advance about changes or unexpected events. When difficulties occur it should be acknowledged and discussed so that ways of preventing a recurrence can be developed with all those involved. Supervisees should be supported to communicate directly and clearly to colleagues as well as their clients.

13. Facilitate consumer/carer participation in program planning, decision making and implementation
An important principle of being trauma-informed is about empowering the people we work with. The more we ask people 'what helps them', the more they feel respected and valued. Apart from this they have valuable information from having been recipients of our service. They can make us aware of factors that we are unaware of, or have not fully understood make a difference to them. Asking service users to help us has enormous benefits, and is something we frequently fail to do. Our training does not necessarily give us insight into how people will respond to the way we design programs and conduct our practice/s. Supervisors should keep this in mind and encourage supervisees to consult consumers and carers, and work with them to co-design, develop and evaluate all aspects of service delivery and programs. [95]

b) Building Supervisee Competency Guide
Supervisors can model best practice by asking questions such as:-

1. Goal Setting
- What is important to this person?
- What achievement would make this person feel better or positive about themselves?
- What is this person trying to achieve?
- What does this person want?

2. Avoid making assumptions
- Why do you believe that is what was intended?
- Have you asked them what is happening?
- Are there other possible explanations for what happened?

3. Demonstrate respect, honesty and fairness
- How do you feel about how you handled that interaction?
- What was it about this situation that made it difficult to handle?
- How were you feeling before the interaction?
- How did you feel afterwards?
- What might have helped make things go more smoothly?

4. Acknowledging culture

- What in your background led to this value/belief?
- Do you think there are people who may see this differently?
- Can you imagine a reason why this person might see this differently than you do?

5. Build on strengths, abilities, interests and creativity

- What does this person do well?
- What does this person like to do?
- Was there a time in their life that this person was doing better? What was happening then? What were they like at that time?

6. Encourage and support as much choice and control as possible

- How might you have supported that person to make choices and learn from the experience?
- How might your own fears have played into your decision to take control?

7. Exploring situations with others and supporting people to develop their own solutions

- Have you asked this person what they think might improve the situation?
- Have you asked this person if they would like you to assist them in some way?

8. Communicate hope

- Do you really believe that there is no possibility that this situation (or person) will improve?
- What leads you to believe that?
- Can you imagine any circumstances under which this person might behave differently?

9. Coping skills developed as a consequence of trauma

- How might this person's behaviour or symptom have developed as a consequence of trauma?
- How does this behaviour make this person feel safer?

10. Managing one's own and others' distress

- How were you feeling when you spoke to this person?
- Might things have gone better if you had taken a moment to ground yourself before you spoke to this person?
- Do you have some strategies to help you if a similar situation arises?

11. Identify triggers and grounding strategies

- How did you feel when that happened?
- What was it about the situation that was so upsetting?
- Is this the kind of situation that usually 'pushes your buttons'?
- Is this something that is happening more often to you at the moment?
- What do you think would have happened if you had been able to use a grounding/calming strategy in this situation?

12. Creating a safe environment for workers and service users

- Did you ask this person whether they felt safe and comfortable?
- What might you have done to acknowledge their discomfort?
- How might you deal with a multitude of differing needs?
- What boundaries and strategies might be used in a similar situation to minimise safety concerns?
- How might you collaborate with colleagues to create a safer environment?

13. Facilitate consumer/carer participation in program planning, decision making and implementation?

- Have you asked this person how the environment/service/program might better meet their needs and expectations?
- Have you asked this person whether they would like to participate in consultations about the service?
- Have you asked this person what the barriers are to participation and how the service could support their participation?

Appendix 3 - Trauma-Informed Learning Reflection

The following template can be used by both the supervisee and supervisor to reflect upon the development of competency in trauma-informed care and practice.

Date Name of Supervisor Name of Supervisee	1 = Outstanding 2 = Good 3 = Encourage 4 = Don't Know
Considers the impact of what they do on others	
Attends to strengths, abilities and interests of others	
Asks questions rather than makes assumptions	
Works with people on the goals they set for themselves	
Is respectful, honest and fair	
Asks people being served for input	
Is aware of own feelings, beliefs and assumptions	
Considers the impact of culture on self and others	
Encourages others to come up with solutions	
Considers the impact of trauma on presentation, behaviour and symptoms	
Remembers to calm/ground before approaching someone in distress	
Is aware of own triggers and uses strategies to manage	
Assists others with triggers and can utilise a range of strategies	
Pays attention to creating a safe environment	
Supports others in making choices and having as much control as possible	
Communicates hope and belief that others can learn and grow	

Appendix 4 – Examples of Screening Tools

Primary Care PTSD Screen (PC-PTSD).
Prins, Ouimette & Kimerling, 2003.
This is a 4 item screen for use chiefly in a primary health care setting. This is a good model for non-intrusive questions suitable in community managed mental health and human service settings (See D2- TICPOT Appendix 6, p.76). Available: http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

Posttraumatic Stress Disorder Checklist – PCL-5
Weathers, F W Litz, B T Keane, T M Palmieri, P A Marx, B P &. Schnurr P P1993, *PTSD Checklist for DSM-5 (PCL-5)*, US Department of Veterans Affairs.
Available: http://www.ptsd.va.gov/
The PCL-5 is a 17-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. The PCL-5 has a variety of purposes, including:

- Monitoring symptom change during and after treatment
- Screening individuals for PTSD
- Making a provisional PTSD diagnosis

The Trauma History Screen (Self-report for a wide range of traumatic events)
Carlson, E Palmieri, P Smith, S Kimerling, R Ruzek, J & Burling, T 2009, *A brief self-report measure of traumatic events: The Trauma History Screen*. Veterans Affairs National Center for PTSD (US). Available: http://www.ptsd.va.gov/professional/assessment/te-measures/ths.asp

The Impact of events scale – Revised (IES-R) (A 21 item self-report scale that can be used to measure change across time)
Weiss, D S & Marmar, CR, The impact of event scale-revised, in Wilson, JP & Kean, TM (eds.) Assessing psychological trauma and PTSD: a practitioner's handbook (Ch 15). N.Y: Guildford, 1995. Available: https://www.aerztenetz-grafschaft.de/download/IES-R-englisch-5-stufig.pdf

The Cojac Screener
Brown, VB Bachrach, K & Melchoir, L 2008, Introducing the COJAC Screener: A short screening instrument for COD and trauma. Available: http://www.uclaisap.org/slides/psattc/cod/2008/K_The_Cojac_Screener

Trauma Screening Questionnaire (TSQ) (A 10 item scale, 5 reflecting arousal and 5 reflecting re-experiencing).
Brewin, CR Rose, S Andrews, B Green, J Tata, P McEvedy, C Turner, S & Foa, EB, 2002, Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry*, 181, 158-162. Available: http://www.nus.edu.sg/uhc/cps/resources/selfhelp/TSQ.pdf

Appendix 5- Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES / NO

3. Were constantly on guard, watchful, or easily startled?
   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?
   YES / NO

Reference entire resource - SAMHSA, Prins, A Ouimette, P & Kimerling, R 2003,
Available from: http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

Code: SMR025090

NSW GOVERNMENT Health

Facility:

MENTAL HEALTH PATIENT SAFETY PLAN

Family Name	MRN
Given Name	☐ Male ☐ Female
D.O.B. ___ / ___ / ___	M.O.
Address	
Location / Ward	
Complete all details or affix patient label here	

This Safety Plan can help you identify calming strategies that you have used before of think may help while you are in hospital, particularly when you feel you are becoming upset or angry. This information can also help you and your treating team to identify things that can help your treatment and care while while in hospital. You can add to your Safety Plan at anytime.

Staff may not always be able to accomodate your preferences but will strive to support your wellbeing and recovery and this information will be valued.

A staff member or consumer advocate can assist you in completing this form.

What are some of the things that you can do to calm yourself down or keep you safe?
Please place a tick next to your preferred strategies:

- ☐ Talking with staff
- ☐ Talking to a consumer worker
- ☐ Talking to other patients
- ☐ Ringing family or friends
- ☐ Having medication
- ☐ Having a drink / food
- ☐ Time in your room or a quiet area
- ☐ Relaxing in the courtyard
- ☐ Exercise
- ☐ Going for a walk
- ☐ Having a bath / shower
- ☐ Joining a group activity
- ☐ Reading
- ☐ Listening to music
- ☐ Writing or doing artwork
- ☐ Watching TV
- ☐ Playing cards / board games etc.

Other calming strategies?_____

In your experience, what things especially 'trigger''your upset feelings

- ☐ Not being listened to
- ☐ Feeling lonely
- ☐ Feeling bored
- ☐ Feeling depressed
- ☐ Contact with family / friends
- ☐ Hearing voices
- ☐ Having Distressed thoughts
- ☐ Feeling intimidated or bullied
- ☐ Name calling / being made fun of
- ☐ Being touched
- ☐ Being threatened / feeling unsafe
- ☐ Arguments
- ☐ An anniversary of an event
- ☐ Particluar time of day / night / year
- ☐ Hanging out (for cigarettes / drugs / alcohol)
- ☐ Being asked to do things you don't want to do

Other things that particularly upset you: _____

_____

_____

_____

_____

Code: SMR025090

NSW GOVERNMENT Health

Facility:

MENTAL HEALTH PATIENT SAFETY PLAN

Family Name	MRN
Given Name	☐ Male ☐ Female
D.O.B. ___ / ___ / ___	M.O.
Address	
Location / Ward	
Complete all details or affix patient label here	

Staff would like to help you manage your distress early. What are some of your WARNING SIGNS that you are becoming upset? This may help you and others notice early that you are beginning to lose control.

- ☐ Sleeping a lot
- ☐ Sleeping less
- ☐ Shouting
- ☐ Wanting to hurt yourself
- ☐ Pacing
- ☐ Throwing objects
- ☐ Clenching fists
- ☐ Unable to sit still
- ☐ Talking too much or too little
- ☐ Swearing
- ☐ Avoiding people
- ☐ Not taking care of self
- ☐ Not eating
- ☐ Over-eating
- ☐ Worrying a lot / thinking too much
- ☐ Being abrupt or snappy with others
- ☐ Other: _____

Do you have a preferred way you can work with and communicate with staff about your distress?

_____

_____

While doing everything they can to avoid this, if you become unable to manage your behaviour, the staff may need to protect you and others by using Seclusion (making you stay alone in a room or aread from which free exit is prevented until you have regained your self control), or by physically restraining you.

Is there anything you would like to tell staff that would impact on this decision?

_____

_____

_____

Is there anything else that staff can do or should know about you to help make your stay in hospital more comfortable?

_____

_____

_____

Patient Name:

_____

Signature:

Staff Name:
Signature:
Date

Updated on:

Signature:

Staff Name:
Signature:

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