

# Trauma Informed Care in Mental Health Services

## Consultation on the development of a National Strategy for Trauma - Informed Care (NS-TIC)

The Mental Health Coordinating Council (MHCC), Adults Surviving Child Abuse (ASCA), the Private Mental Health Consumer Carer Network (PMHCCN) and Education Centre Against Violence (ECAV) are bringing together a group of consumers, mental health professionals, policy makers, educators, academics and interested organisations to discuss current thinking around Trauma Informed Care in the Mental Health Service Sector.

Our ultimate objective is the development of a **National Strategy for Trauma - Informed Care (NS-TIC)** funded by the Commonwealth to assist publicly-funded agencies, programs, and services both in the government and non-government sector in making the important cultural shift to more trauma informed practice in all health services — creating an environment that is more supportive, comprehensively integrated, empowering and therapeutic for a diversity of trauma survivors.

Our immediate objective is to clarify approaches to trauma informed care in Australia, and review this against existing international evidence. This will inform a position paper with which to lobby the Commonwealth to develop a National Strategy for Trauma Informed Care. Priorities may include for example: a) developing the standards and guidelines necessary to provide the appropriate trauma informed care in a diversity of public, private and community based settings and b) provision of funds for services specific to the needs of people impacted by trauma.

In this short paper we outline the research evidence as well as discuss the rationale for bringing this group together.

### What is Trauma-Informed Care?

Trauma-informed programs and services internationally represent the “new generation” of transformed mental health and allied human services organisations and programs which serve people with histories of violence and trauma.

Trauma survivors engaged in these services are likely to have histories of physical and/or sexual abuse as well as other types of trauma including chronic neglect and/or protracted emotional abuse, witnessing domestic violence, civilian involvement in wars and civil unrest, refugee and combatant trauma. Such trauma frequently leads to a diversity of mental health as well as other types of co-occurring problems such as poor physical health, substance abuse problems, eating disorders, relationship and self-esteem issues and contact with the criminal justice system.

When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services. Trauma-informed organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation.<sup>i</sup>

## Impact of Trauma

Currently people impacted by trauma present at a wide range of services. Many have not connected their current problems and behaviours with their prior trauma. Others have not disclosed or sought support previously. Some cannot recall their past trauma, while others only partially remember their traumatic pasts. The 'information-processing' deficits associated with unresolved trauma disrupt integrated neural processing. Such disruption is frequently predictive of later development of PTSD, and the disruption of interpersonal bonding and bodily regulation processes (Henry et al., 1984).<sup>ii</sup>

Symptoms of PTSD include intrusive re-experiencing of the trauma in nightmares or flashbacks, avoidance of situations associated with the trauma, inability to recall part of the trauma and emotional numbing as well as hyper-arousal. Perhaps the most dramatic trauma-related symptom is dissociation, which can involve phenomena ranging from altered awareness and out of body experiences to compartmentalisation involving a lack of integration of information within the cognitive system.

These consumers often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the inpatient, crisis, and residential services. They may carry a psychiatric diagnosis, and many carry more than one, with diagnoses varying over time. These include: Post-traumatic Stress Disorder (PTSD), borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychotic, dissociative disorder, addictive, somatoform, and sexual impairment—all diagnoses which may have been related to past trauma.<sup>iii</sup>

Many traumatised survivors and consumers have adopted extreme coping strategies in order to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships.<sup>iv</sup> Although their trauma may be core to their difficulties and awareness of it pivotal to their process of recovery, in public mental health settings their trauma per se is seldom identified or addressed, and yet it is central to their treatment.<sup>v</sup> Without addressing the core issues of their trauma, they will continue to struggle with daily functioning.

## Trauma-Specific Interventions

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate recovery. Successful treatment programs generally recognise the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. The relationship between trauma and the related symptoms (e.g. substance abuse, eating disorders, depression, anxiety, etc.); and the need to work collaboratively way with survivors (and their carers, family and friends) and with other human services agencies to empower survivors as consumers, is key to positive outcomes.<sup>vi</sup>

Some trauma- specific interventions based upon psychosocial education empowerment principles have been extensively used in the USA including for example:

Addiction and Trauma Recovery Integration Model (ATRIUM)  
Essence of Being Real  
Risking Connection  
Sanctuary Model  
Seeking Safety  
Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model  
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)  
Trauma Recovery and Empowerment Model (TREM and M-TREM).<sup>vii</sup>

Many of the service delivery models in the USA are designed specifically to address the kinds of complex traumatic stress issues and problems common to the lives of individuals seen in mental health settings. It is unusual for services in Australia to utilise such interventions.

### **Trauma-Informed Care (A Recovery Orientated Approach): A Cultural Shift in mental health service delivery**

In providing mental health services, trauma informed care is an integral part of recovery orientated practice which clearly acknowledges and articulates 'that no one understands the challenges of the recovery journey from trauma better than the person living it'. Survivors of violence and trauma know their history, struggles, means of survival and coping, and what promotes healing, better than anyone else. Survivors frequently encounter services that mirror the power and control experienced in the abusive relationships that caused the past trauma. In the traditional program of services, healing and recovery is difficult and the risk of re-traumatisation is real.<sup>viii</sup>

### **Trauma-Informed – Recovery Partnerships for change**

A National Strategy would support providers in moving from a caretaker to a collaborator role by empowering the survivor in a model of recovery orientated practice. Trauma-informed care involves not only changing assumptions about how we organise and provide services, but creates organisational cultures that are personal, holistic, creative, open, and therapeutic. By facilitating recovery through trauma-informed care, re-victimisation can be minimised and self and community wellness and connectedness can be promoted.

Understanding that trauma underpins the presentation of many people to public, private and community based services, a National Strategy for Trauma – Informed Care must promote development and implementation of evidence based models and practice programs building capacity through supporting workforce education and training; data collection, research, outcome measurement and evaluation.

A model of Trauma-Informed Recovery Partnerships for change will bring about a revolutionary shift in the way mental health services are organised, delivered, and managed by improving outcomes for the consumers presenting with complex needs. An important part of this process is the development of a strategy for broadly based community awareness surrounding trauma and mental illness and the need to eradicate stigma and discrimination, and facilitate access and equity.

The National Centre for Trauma Informed Care (NCTIC) established in the USA in 2005 is based on the proposition that, with a better integration of trauma into all health services more trauma survivors will find their path to recovery and wellness. The NCTIC is funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. We can learn much from the American experience whilst formulating a uniquely Australian model to meet this diverse cultural context in which we live.



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**Private Mental Health  
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*engage, empower, enable choice in private mental health*

**Education Centre**  
**Against**  
**Violence**

<sup>i</sup> SAMHSA. National Mental Health Information Centre. Available:  
<http://mentalhealth.samhsa.gov/nctic/trauma.asp>

<sup>ii</sup> Henry et al, (1984). In Cozolino, L. J. (2002). The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain. New York: W.W. Norton & Company, p. 283.

<sup>iii</sup> Ford, J., Courtois, C., Steele, K., van der Hart, O., & Nijenhuis, E. (2004). Treatment of the complex sequelae of psychological trauma. Available: <http://www.annafoundation.org/MDT.pdf>

<sup>iv</sup> Saakvitne, K., Gamble, S., Pearlman, S., & Tabor Lev, B. (2000). Risking connection: A training curriculum for working with survivors of childhood abuse. Sidran Institute.

<sup>v</sup> Mueser, K., Rosenberg, S., Goodman, L., & Trumbetta, S. (2002). Trauma, PTSD, and the course of schizophrenia: An interactive model. Schizophrenia Research, 53, 123-143.  
<http://www.annafoundation.org/MDT.pdf>

<sup>vi</sup> SAMHSA. National Mental Health Information Centre. Available:  
<http://mentalhealth.samhsa.gov/nctic/trauma.asp>

<sup>vii</sup> Ibid.

<sup>viii</sup> NCTIC is funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services