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Trauma Informed Care & Practice – Using a wide angle lens

Dr Cathy Kezelman trained as a medical practitioner and practiced as a GP for 20 years. She has been both CEO and Executive Director of Adults Surviving Child Abuse (ASCA) and is now of ASCA, a national organisation advocating at a state and national level and working to meet the needs of the than 2 million Australian adults abused as children. She is a board member of the MHCC (Mental Health Coordinating Council).

In 2010 Cathy published her own memoir, *Innocence Revisited* - a tale in parts, chronicling her own battle with depression and suicidal ideation, at the core of which was unresolved childhood trauma.

Corinne Henderson is Senior Policy Officer, MHCC. Her role is primarily to advocate for legislative and systemic reform in mental health. She is a trained psychotherapist and sits on the NSW Mental Health Review Tribunal. Publications include *Reframing Responses 1 & 11* (2010) and the NSW Mental Health Rights Manual (2011).

Cathy Kezelman

Mental health in Australia

I am a medical practitioner, a director of ASCA (Adults Surviving Child Abuse) and a director of the Mental Health Coordinating Council (MHCC). I am also a mental health consumer. My co-presenter is Corinne Henderson, Senior Policy Officer at MHCC, member of the MHRT, and a psychotherapist in private practice.

The MHCC and ASCA have collaborated over a number of years lobbying for the needs of adult survivors of childhood trauma with complex needs. We have also been working together with our other partners for 18 months developing and advocating for a national agenda around trauma informed care and practice.

We are encouraged that the political environment now has a much greater focus on mental health. Minister Mark Butler the first federal minister for health recently announced a number of new initiatives and funding opportunities.

However planning and funding for consumers impacted by trauma histories falls perilously short of what's needed. Whilst trauma is core to the difficulties of many consumers and awareness of it pivotal to their sustained recovery, in services, trauma per se is seldom identified or addressed, leaving many consumers struggling with their daily functioning.

Trauma

It is rare to travel through life without experiencing trauma and the spectrum is vast.

Any traumatic experience has the potential to invoke fear, helplessness, and horror, and overwhelm a person's resources for coping. However today I would like to talk about trauma which can be characterised as complex trauma.

Defining Complex trauma

Complex trauma refers to traumatic stressors that are *interpersonal* - premeditated, planned, and perpetrated by one human being on another. These actions can be both violating and exploitative of another person.¹

Childhood trauma

Individuals' and society's responses to trauma vary enormously but reactions to complex trauma tend to be more severe with diverse impacts which persist long after the trauma has ended.

Experiences of interpersonal trauma are appallingly prevalent in our society. They can be a once off event such as a physical or sexual assault, perpetrated by a stranger (rarely) occurring without warning. However the trauma of child abuse – physical, sexual, and emotional abuse in all its forms including chronic neglect as well as witnessing and experiencing domestic violence, perpetrated by someone the child knows and trusts, (often those charged with the child's care), are generally repeated, prolonged and extreme.

Most commonly child abuse is perpetrated within the family or by other adults in positions of trust and in regular contact through school, church, sports or other community activities.

Childhood trauma generally characterizes a series of traumatic events starting at a young age which disrupt the earliest of attachments. Its effects are all the more pervasive because children are young, vulnerable and developmentally immature.

As it is usually intentional, these experiences differ from the trauma of natural disasters and separation, death and loss. Because the acts are often repeated the child victim is often becomes hyper-vigilant, anxiously anticipating further harm - in fight, flight or freeze mode.

Trauma in childhood can and does affect the rapid growth, structure, and functioning of the brain.

Impacts of childhood trauma

Without a safe, stable attachment, abused children focus on simply surviving, shifting resources normally earmarked for learning and development. This combination of ongoing trauma exposure and the developmental impact of such exposure typifies *complex trauma*, which features a multitude of traumatic stress challenges.

Such abuse involves a fundamental betrayal of key relationships establishing lifetime patterns of fear and mistrust, impacting an individual's sense of self, self-worth, and relationships with others and with the world in general, emotional regulation, self-soothing and stress management. Consequences are commonly more global than those caused by abuse perpetrated in adulthood.

Coping strategies

Many adults who have suffered childhood trauma have adopted extreme coping strategies which can persist into adult life (as an attempt to manage overwhelming traumatic stress). They include suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships. Whilst challenging, in the context of trauma these behaviours make perfect sense.

Trauma frequently leads to a diversity of mental health as well as other types of co-existing problems such as poor physical health, substance abuse, eating disorders, relationship and self-esteem issues and contact with the criminal justice system.

By way of illustration I would like to share a bit of my personal story. I am a survivor of child sexual and emotional abuse, the impact of which I have grappled with for 13 years. My story of recovery and beyond has been chronicled in a memoir entitled *Innocence Revisited* – a tale in parts.

As a medical practitioner, one would assume that I was informed about trauma, its effects on mental health and how to address the impact. Nothing was further from the truth!

I was a GP in Sydney for twenty years. I worked hard juggling the demands of practice with being married with 4 children and a foster child. Back then I could, do most things relatively easily.

In April 1998 when I was in my mid 40's my niece was killed in a car accident. I grieved for her, as one would expect and grieving takes as long as it takes. As other members of my family started to come to terms with their loss I was becoming more distressed. I started to feel anxious and then had my first panic attack. I thought I was going to die! The panic attacks became more frequent, the anxiety generalized and I grew depressed. Then came the nightmares and flashbacks as the trauma stored in my subconscious unlocked.

Soon I could barely function. I was forced to leave work setting myself a 4 month sabbatical - that was 13 years ago. After that my world collapsed.

I spent most of the next 2 years in bed, completely immobilized, battling a relentless blackness of mood. I struggled with suicidal thoughts and then gestures. The antidepressants the psychiatrist prescribed helped take the edge off my mood at times, but it was a lengthy psychotherapeutic process which helped me come to terms with my history and its impact which finally got me functioning again.

Therapy guided my process of integration and I am now well and no longer subsumed in my trauma. For the first time, I can not only live in the present but embrace my future. Acknowledging and appropriately addressing my complex trauma caused by childhood abuse was core to my recovery. Anything less would have, at worst, seen me lost to suicide, or at best barely functioning in my daily life.

Prevalence

I am one of more than 2 million Australian adults who suffered some form of childhood trauma and I am lucky. I had the resources and the support to recover. Research tells us that 1 in 5 women and 1 in 7 men are affected. On this basis in every room of 25 people at least 4 will have experienced childhood abuse in some form or other.

Challenges of supporting consumers with history of childhood trauma

Consumers with a history of childhood trauma are a vulnerable group. Many are disadvantaged, not only by their trauma but also by the accompanying socio-economic disadvantage. Survivors often experience deep feelings of insecurity, low self-esteem, poor frustration tolerance, difficulties with trust and interpersonal relationships, and sensitivity to criticism, and well as all risk-taking and life threatening behaviours which compound the challenges.

Complex trauma -aetiology

Complex trauma is compounded and cumulative and not limited to that of child abuse. When it occurs later in life it can compound that from childhood. It can include all forms of violence experienced within the community – civil unrest, war trauma, genocide, cultural dislocation, sexual exploitation, incarceration as well as the impacts homelessness, poverty and chronic disadvantage and mental, physical health issues and disability, grief and loss.

Service responses

The criteria of a diagnosis of PTSD were developed to capture the impacts of war trauma. It features a triad - of intrusive re-experiencing of traumatic memories, emotional numbing and avoidance of

reminders of the trauma, including memory loss, and hyper-arousal. The characterization of the impacts of childhood trauma in terms of PTSD fail to capture the often pervasive impacts of childhood trauma and service responses based solely on the diagnosis most generally fall short.

Working through the compounded impacts of complex trauma can be slow process involving a number of phases including establishing safety, stability, building a therapeutic relationship, education and skill building, processing and integration. The failure of practitioners, systems and governments to appreciate these complexities means that many survivors of complex trauma do not find the care and support they need to reclaim their health and wellbeing.

Corinne Henderson

Many of us working in the mental health sector have long advocated the necessity of a new approach to service delivery for people with mental illness and co-existing problems who frequently have a history of trauma. This approach must move away from prioritising the search for diagnoses to recognising the person's traumatic life experience within a holistic framework.

For over 100 years, clinicians often at odds with societal values have acknowledged the link between trauma, mental illness and psychosocial disadvantage. However, it was not until the feminist movement in the 1970s which exposed the consequences of interpersonal violence, and the work of clinicians such as Bessel van de Kolk,ⁱⁱ Babette Rothchild,ⁱⁱⁱ Judith Herman^{iv} and others in the 80s & 90s that research findings provided strong evidence about the prevalence and impact of trauma.

The knowledge base has grown steadily confirming that a very large percentage of those seeking help at a diversity of health and welfare settings have trauma histories which are severely affecting their health and wellbeing.

Australia's mental health system has, generally speaking, a poor record in recognising the relationship between trauma and the development of mental health problems. There is a lack of policy focus as to how this knowledge can be incorporated into service delivery.

There may be several reasons for this including:

- a mental health system based on a 'diagnose and treat' approach to mental health care that fails to acknowledge the possible underlying causes of the presenting problems;
- differing perspectives on the scientific validation of the lived experience of people presenting with trauma related symptoms;
- clinical assessment focused on what constitutes a diagnosis in terms of a set of characteristics or symptoms – resulting in a medicalised response for people impacted by trauma, that is often less than therapeutic;

The substantive core issue of what happened to that person to impact them so profoundly is often relegated to 'interest value' only. This characterisation makes little sense given that recognition and integration of experienced trauma is fundamental to the recovery process.

The work of the MHCC, the organisation I represent, in the area of trauma started in 2006. We examined the evidence surrounding the impacts of interpersonal trauma on women with mental health problems internationally and conducted a study into access and equity for women survivors of childhood abuse with complex needs in NSW.

The *Reframing Responses* project as it was called also looked at the capacity of the public and community managed sectors to provide services and understand safety issues, identify gaps and models of care, inequalities and barriers to access and make recommendations to government regarding service delivery models. Government responses both state-based and nationally were disappointing.

The project demonstrated a desperate need for improved access for these consumers marginalised and vulnerable as a consequence of mental illness, substance dependency, co-morbidity, ethnicity, socio-economic status, disability or sexual preference.

Subsequently, we embarked on stage two of the *Reframing Responses* project and late in 2010 MHCC launched an *Information Resource Guide and Workbook for Community Managed Organisations*. This guide aims to assist workers in a broad range of mental health and allied health services to understand the dynamics of childhood abuse, and make sense of the context of the trauma in which problems affecting consumers develop.

During this period the Senate Standing Committee on Community Affairs, *Inquiry into Mental Health in Australia* tabled a report in September 2008: *Towards recovery: Mental health services in Australia* of. In its recommendations, the government focussed on people with a diagnosis of BPD who characteristically have a history of childhood abuse was started.

BPD is but one of the possible impacts of childhood abuse, and represents a most pathologising diagnosis which carries enormous stigma implying hopelessness, manipulation and resistance to treatment.

ASCA & MHCC emphasise a broader focus on the spectrum of complex mental health and psychosocial problems resulting from unaddressed and often unacknowledged trauma histories and services responding to the diversity of complex need.

People can be impacted by trauma through a diversity of experiences which know no boundaries with regards to age, race, ethnicity, social or economic status, gender, disability; geography or sexual orientation. Trauma affects us all, directly or indirectly and can be devastating and debilitating.

We propose that to context a particular diagnosis as a means to access services is stigmatising and discriminatory. Only a wide range of flexible services holistically delivered with an understanding of the behaviours which characterise presentations in terms of traumatic stress, disrupted attachment, personal invalidation and adaptive coping strategies can meet the needs of these consumers.

We strenuously advocate a **trauma informed approach to care and practice** which moves away from prioritising the search for a diagnosis to recognition of the person's traumatic life experience and that it is the consumer's lived experience which may have resulted in an individual's contact with mental health services through adoption of extreme coping strategies. We propose that a shift to a trauma informed care and practice approach are not limited to mental health but apply to multiple systems requiring an integrated approach which has survivors at the centre of a model of recovery.

A trauma informed approach to care must also be supported by trauma specific services, providing specific interventions designed to address the consequences of trauma in the individual and facilitate recovery.

ASCA and the MHCC have worked closely together over many years. Since 1995 ASCA has delivered trauma specific services to mental health consumers with a history of childhood trauma, who have no other place to turn. Amongst their other services they have developed and deliver evidence-based workshops to adult survivors nationally as well as providing education and training to health professionals and community workers, to support them in providing services to their members. We collaborated with ASCA in the development of a 2 day workshop for community mental health workforce: *Long term impacts of Childhood Abuse: An Introduction*, which we co-facilitate through MHCC's Learning and Development Unit.

However, whilst conversations and program delivery around TIC are occurring in small service pockets, (and Women's health services have pioneered this work for decades) this does not amount to a broad based systemic change across the mental health service system. Such TIC programs and services that do exist clearly acknowledge *'that no one understands the challenges of the recovery journey from trauma better than the person living it'*. The underpinning philosophy is informed by an understanding of the particular vulnerabilities and 'triggers' that trauma survivors experience, with services delivering better outcomes; minimising re-victimisation and ensuring self and community wellness and connectedness can be promoted. It is a paradigm shift in service delivery culture.

Our desire to promote this cultural shift motivated an initiative which began in September 2010 when MHCC together with ASCA; Education Centre Against Violence (ECAV) and Private Mental Health Consumer Carer Network Australia (PMHCCN) held an inaugural forum to discuss a national strategy and agenda for promoting Trauma Informed Care across all human service systems. The aim of the forum was to inform and progress our thinking, as well as to draw together interested stakeholders and identify possible champions.

A committee was formed to clarify thinking around approaches to TIC in Australia, and review these against existing international evidence. The aim being that this has the potential to create an environment that is more supportive, comprehensively integrated, empowering and therapeutic for a diversity of trauma survivors.

One of our stated objectives as a result of a National forum was to organise a ground-breaking conference devoted entirely to Trauma Informed Care & Practice which we held late in June this year. The conference forms part of a broader ongoing initiative towards a national agenda which MHCC and its collaborating partners will drive.

We are encouraged by the broad-based interest in the integration of TICP into service systems. We are inspired by the work in the USA of the US Department of Health and Human Services; Substance Abuse and Mental Health Services Administration SAMHSA, and the National Centre for TIC, a centre of excellence promoting an organisation shift from a traditional 'top-down' to collaboratively consumer focused service delivery model. We can learn much from SAMSHA's example whilst developing a strategy appropriate to our particular social and cultural context in Australia.

Because of the prevalence of histories of trauma among those with alcohol and other drug problems, it is vital that services be designed to work effectively with trauma survivors. SAMHSA's *Women, Co-Occurring Disorders and Violence study* demonstrated that trauma-informed, integrated services that included skill-building trauma recovery groups produced better outcomes for women with co-occurring substance abuse and mental health disorders and histories of physical and sexual abuse than did services as usual.

We are pleased to note that corrective services in NSW have acknowledged the impact of trauma for the greatest percentage of women in the criminal justice systems and have initiated strategies towards addressing the complex needs of these women. This is encouraging and important to a more generalised systemic movement for change.

So what is TIC?

- It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence and the prevalence of these experiences in persons who receive mental health services.

Trauma-Informed Care and Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

What is a Trauma-Based Approach?

It primarily views the individual as having been harmed by something or someone: thus connecting the personal and the socio-political environments, (Bloom, 1997, p. 71).

This framework expects individuals to learn about the nature of their injuries and to take responsibility in their own recovery (Bloom, 2000).^v

What are the Key Principles?

- Integrate philosophies of quality care that guide assessment and all clinical interventions
- Is based on current literature
- Is informed by research and evidence of effective practices and philosophies

Trauma Informed Care & Practice

Involves not only changing assumptions about how we organise and provide services, but creates organisational cultures that are personal, holistic, creative, open, and therapeutic

It is a practice that can be utilised to support service providers in moving from a caretaker to a collaborator role using a model of recovery-orientated approach

A Cultural Shift

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.^{vi}

Systemic Transformation occurs

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.

Transformational Outcomes can happen when

Organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation.^{vii}

So how different might service systems look if the Trauma Informed

Key Features of Trauma Informed Care & Practice Systems

Examples

Systems without Trauma Sensitivity	Trauma Informed Care Systems
Consumers are labelled & 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 traumatization / re-traumatization – and are to be avoided
Culture of secrecy - no advocates, poor monitoring of staff	Recognise high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults
Staff believe key role are as rule enforcers	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 traumatizing, both overtly and covertly
Institutions that emphasize “compliance” rather than collaboration	Recognise that the majority of mental health staff are uninformed about trauma, do not recognize 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	Use neutral, objective and supportive language
Lower treatment adherence	Offer individually flexible plans approaches
High rates of adult, child/family complaints	Avoid all shaming / humiliation
Higher rates of staff turnover and low morale	Provide awareness/training on re-traumatizing practices
Longer lengths of stay/increase in recidivism	Are institutions that are open to outside parties: advocacy and clinical consultants
	Provide training and supervision in assessment and treatment of people with trauma histories
	Focusing on what happened to the client rather than what is ‘wrong with you’ (i.e. your diagnosis)
	Ask questions about current abuse
	Address the current risk and develop a safety plan for discharge
	Presume that every person in a treatment setting may have been exposed to abuse, violence, neglect or other traumatic experiences

As Kath Thorburn and Michelle Everett said in their recent presentation at the TICP conference, TICP is in mutual relationship with Recovery Orientated Practice, enhancing outcomes for a large number of consumers. It requires fundamental shifts in thinking and practice.

Cathy Kezelman

Medical model

The medical model is the basis of our primary care system. It works on the principle that something is wrong with a person rather than highlighting that something wrong was done to or happened to a person. Trauma survivors are frequently pathologised with a range of diagnoses over a long period of time. Anyone interacting with trauma survivors must understand the impact traumatic life events have on the development of individuals.

I am a medical practitioner by training. The Hippocratic Oath states: "First do no harm". However harm is done to trauma survivors when their experience goes unacknowledged and when their particular vulnerabilities and sensitivities are disregarded, disrespected and misunderstood. Harm is done when survivors are labelled; when they are negated as human beings; and when the traumatic experience at the very core of their being is disaffirmed.

Trauma informed care involves the provision of services that do no harm – e.g., that do not re-traumatise or blame victims for their efforts to manage their traumatic reactions. Trauma-informed care facilitates recovery, minimises re-victimisation and promotes self and community wellness and connectedness.

Services often mirror the power and control experienced in past abusive relationships. The composite failures in service provision and expertise, as well as in access and equity exacerbate mental health issues for consumers and escalate the risk of suicide. Responsive and effective crisis management must be matched by affordable, accessible, ongoing care

Trauma survivors often experience services as unsafe, disempowering and/or invalidating and frequently after searching for a service which understands them, their behaviours and reactions in the context of their trauma history they often give up in despair.

Current services

Trauma survivors characteristically seek help from a diversity of public, private and community services over a long period of time. Mainstream services cannot adequately address their needs - being crisis-driven, or meeting short term needs only. Care is often fragmented with little to no co-ordination between services and poor referral and follow-up pathways.

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

Every day ASCA receives calls from child abuse survivors who cannot find or afford the care and support they need. They have experienced a health care professional who has been disempowering, re-victimising or otherwise unhelpful; a GP who was uninformed, who didn't inquire about trauma despite highly suggestive symptoms. A worker who didn't know how to respond to a disclosure, a counsellor, psychologist or psychiatrist they felt had minimized or dismissed their feelings and experiences rather than listening empathically and validating them.

They have been told "It happened such a long-time ago; there's no value in talking about it. What does it matter? Stop whingeing about it." Some workers believe that talking about past traumas is irrelevant and self-pitying or imply that the trauma was the person's fault, that he/she is carrying on about nothing, making things up, exaggerating, or has a personality disorder.

Co-morbidity

Trauma survivors with complex needs often experience a range of co-existing mental health, substance abuse problems and other life burdens. However they are not co-morbid at all, but rather a range of 'normal' human responses to horrendous experiences. Most clients presenting to mental health AOD services have trauma histories yet care is often fragmented and fails to respond to their multiple needs which can include unemployment, welfare dependency, homelessness and social exclusion.

Embracing model of trauma informed care and practice

We propose the integration of a model of Trauma-Informed Care and Practice across all health, mental health and human services. This necessitates the development of evidence based models and practice programs building capacity through supporting workforce education and training; data collection, research, outcome measurement and evaluation.

This must include strategies to increase community awareness around the relationship between trauma and mental health while working to eradicate stigma and discrimination, and facilitate access and equity.

Successful model

Successful treatment programs need to recognise a survivor's need to be respected, informed, connected, and hopeful regarding recovery. Providers must move from a caretaker to a collaborator role, empowering survivors in recovery orientated model. Trauma-informed care changes assumptions about service design and provision, creating organisational cultures that are personal, holistic, creative, open, and therapeutic. There must be an emphasis on collaboration, partnership and cooperation, promoting linkages between services.

A trauma informed system

The new system we envisage will be characterized by safety from physical harm and re-traumatization; an understanding of survivors and their symptoms in the context of their history, culture, sexual orientation, ethnicity and gender and community; open and genuine collaboration between workers and those seeking help at all phases of service delivery; an emphasis on building on strengths and acquiring skills rather than on managing symptoms; an understanding that symptoms represent attempts to cope, regardless of how extreme they may seem; a perception that childhood trauma was a defining experience/s that an individual's core identity.

Improved outcomes

Studies have shown that programs that utilize a trauma-informed model, report a decrease in psychiatric symptoms, substance use and trauma symptoms, an improvement in consumers' daily functioning, decreases in the use of intensive services such as hospitalization and crisis intervention.

Trauma-informed services do not cost more than standard services and report more successful collaboration with all stakeholders, enhanced skills, and a greater sense of self-efficacy among consumers, improved staff morale, fewer negative events, and more effective services and positive outcomes. A trauma-informed care and practice approach provides renewed hope of recovery to consumers with complex trauma histories who experience severe, and persistent mental health AOD problems.

Corinne Henderson

We need to address the systemic failure of the existing mental health system to provide appropriate trauma-informed services to the majority of Australians needing them.

While recent budget announcements with increased funding for mental health are welcomed the changes fail to acknowledge the prevalence of trauma, its dynamics and/or the needs of trauma clients. However we are truly encouraged by the groundswell of interest in moving this agenda forward, with conversations clearing starting to occur in government circles as well.

Our recent conference highlighted how an international movement to change the way service systems respond to trauma can substantially improve the lives of those affected by complex trauma.

Our combined vision is to increase awareness and knowledge about TICP and drive an important policy and systemic change – promoting a cultural shift that embraces the concept across both the government and non-government sectors in all health and community services.

This has the potential to create an environment that is more supportive, comprehensively integrated, empowering and therapeutic for a diversity of trauma survivors.

Following from the conference we have identified a number of starting point for discussion to move the National TICP agenda forward further which include the need to:

- Investigate current trauma informed care and practice evident in Australia and New Zealand – a mini audit of service delivery and evaluation processes
- Investigate existing gaps (such as in inpatient services)
- provide an overview of evidence-based literature from international and Australian sources
- define TIC in practice and determine what is transferable across sectors, and
- develop principles, standards and guidelines that will assist us in developing an assessment tool for organisations working in the community, public and private sectors

In all of our discussions we emphasise the importance of community services that enable people to remain connected to their communities and families, remain in work, and recover and reintegrate with the community, such as: adult education programs, psycho-social rehabilitation, home-based outreach, peer support, supported accommodation and job placement and support services. Such services enable trauma survivors to stay living in the community, in their own homes, limiting hospitalizations and crisis presentations. With the right care and support, trauma survivors can ultimately live well.

So to conclude - MHCC has now developed a microsite devoted to TICP

- Key conference presentations are available in full plus a range of research papers and news and information on TICP
- MHCC, ASCA and collaborating partners have established a TICP Network currently comprising over 200 people which will enable us to keep those interested up to date and in communication with interested others.

We encourage you to visit the website, join our network and make use of the resources.

Moreover we ask you to share your knowledge and expertise with us by sending us your comments and feedback.

Thank you

ⁱ Christine A. Courtois .Understanding Complex Trauma, Complex Reactions, and Treatment Approaches Available: <http://www.giftfromwithin.org/pdf/Understanding-CPTSD.pdf>

ⁱⁱ Bessel van der Kolk, Alexander McFarlane & Lars Weisaeth. 2007. *Traumatic Stress: The Effects of Overwhelming Experience on the Mind, Body and Society*.

ⁱⁱⁱ Babette Rothchild. 2000. *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*

^{iv} Judith Herman. 1992. *Trauma & Recovery: From Domestic Abuse to Political Terror*.

^v Bloom, S. 1997: 2000. *Creating Sanctuary: Toward the evolution of sane societies*. New York: Routledge

^{vi} Corinne Henderson & Jenna Bateman. 2010. *A National Strategy for Trauma Informed Care*. Mental Health Coordinating Council.

^{vii} Corinne Henderson & Jenna Bateman. 2010. *A National Strategy for Trauma Informed Care*. Mental Health Coordinating Council.