mhcc
mental health coordinating council

ticpot

Trauma-Informed Care and Practice Organisational Toolkit

A Quality Improvement Organisational Change Resource

Stage 1
Planning and Audit
Overview and Guide

Organisational Domains

New Edition

Mental Health Coordinating Council Inc.
Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

Corinne Henderson
Principal Advisor/Policy & Legislative Reform

Carmel Tebbutt
Chief Executive Officer

Please cite this paper as follows:

Mental Health Coordinating Council (MHCC) 2018, *Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Process Resource, Stage 1 - Planning and Audit*, Authors: Henderson, C (MHCC), Everett, M. Isobel S (Sydney LHD).

For any further information please contact:
Corinne Henderson, Principal Advisor / Policy & Legislative Reform
Tel: (02) 9555 8388 #101
E: corinne@mhcc.org.au

Contents

Acknowledgements

The new edition of the Trauma-informed Care and Practice Organisational Toolkit (TICPOT) sits on the shoulders of the first edition published in September 2015. The Mental Health Coordinating Council (MHCC) acknowledges and thanks the TICPOT Advisory Reference Group, who at that time contributed their extensive experience and expertise concerning trauma, and the provision of trauma-informed services to this endeavour.

The Toolkit was originally developed in response to a recommendation proposed in the National Strategic Direction position paper: Mental Health Coordinating Council, 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. The TICPOT Advisory Reference Group responded with enthusiasm and energy and we acknowledge that this support was vital to the design of this important resource, unique in Australia at the time.

Mental health and human services working to improve culture and incorporate a trauma-informed care and practice approach can use TICPOT. The use of TICPOT can support these changes in both service delivery programs and within the broader organisation. This new edition includes many elements from the original version but has sought to improve on the resource though incorporating the experience and feedback of those who utilised the Toolkit over the last three years, as well the increasing literature available on the subject both internationally and nationally.

MHCC also wish to acknowledge and thank the National Trauma-Informed Care and Practice Reference Group, whose participation in the development of the National Strategic Direction informed this work so thoroughly. The details of this work and those that contributed to it are available from these two links below. [1]

MHCC particularly thanks Sophie Isobel, A/Nurse Manager/Research and Ethics, Sydney Mental Health Services and Michelle Everett, Program Manager Official Visitors Program for their unflagging and enthusiastic participation as friends and advisors to the ongoing TICPOT project, and their assistance with the update and rewrite of this new edition.

The project has been designed and managed by Corinne Henderson, Principal Advisor/ Policy & Legislative Reform, Mental Health Coordinating Council and co-authored with Sophie Isobel and original co-author and consultant to the project, Michelle Everett.

MHCC also acknowledge the many researchers and contributors both internationally and in Australia whose work informs and underpins this resource and the position paper from which TICPOT emanates.

[1] Mental Health Coordinating Council 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. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf
MHCC Website: Trauma-informed Care & Practice, General Information and Resources: Available from: General Information: http://www.mhccorg.au/policy-advocacy-reform/influence-and-reform/trauma-informed-care-and-practice-a-national-strategic-direction.aspx

Background

The Trauma-Informed Care and Practice Organisational Toolkit (TICPOT) is part of a broad strategic direction promoting trauma-informed care and practice (TICP) across service systems throughout Australia. The development of this toolkit began in 2011 when MHCC established the National Trauma-Informed Care and Practice Advisory Reference Group. A Position Paper published in November 2013 proposed a National Strategic Direction (MHCC, 2013) [2] and made a number of recommendations including the development of a mechanism for organisations to measure their organisational practices against the values and principles of trauma-informed care and practice and plan for change. This led to the development of TICPOT: A Trauma-Informed Care and Practice Organisational Toolkit.

TICPOT is a resource designed to assist services and their workforce in quality improvement initiatives and organisational change processes. TICPOT can be used to embed TICP principles into every aspect of an organisation. TICPOT is targeted at a broad range of services both in the public and community based contexts across the mental health and human service systems and sectors. TICPOT provides an overview of trauma, the principles of trauma-informed care and practice and guidelines for planning and conducting an organisational audit. TICPOT also provides information and links to resources and tools to support organisational change planning and implementation. TICPOT has been developed to assist organisations build on their existing trauma-informed policies and practices or to begin their journey to become trauma-informed. The audit tool is divided into six organisational domains that help to identify and inform possible quality improvement activities. TICPOT is designed to support staff and services to continue to develop their practices so that they can become more aware of and responsive to the needs of people engaging with their service who may be impacted by past and current trauma.

Language

Language is important. Our objective is to be as inclusive as possible whilst acknowledging the differences in terminology used across disciplines, systems and services.
This toolkit seeks to be trauma-informed in every aspect it addresses. Whilst acknowledging that many people seeking or engaging in services across mental health and human service sectors have lived experience of trauma, we do not suggest or identify everyone as a 'survivor' or 'victim' of trauma. Where possible we use the term person living with a mental health condition, elsewhere we use consumer or service user throughout these resources because these best identify a person as a user/ recipient of services across the service spectrum. For a full list of the key terms used throughout and their intended meaning, please see Appendix A.

---

[2] Mental Health Coordinating Council 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. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf
MHCC Website: Trauma-informed Care & Practice, General Information and Resources: Available from: General Information: http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/trauma-informed-care-and-practice-a-national-strategic-direction.aspx

Stage 1 - Planning and Audit: a Guide for TICPOT users

An important component of a quality improvement cycle or organisational change process is to audit and reflect on current policies and practices.

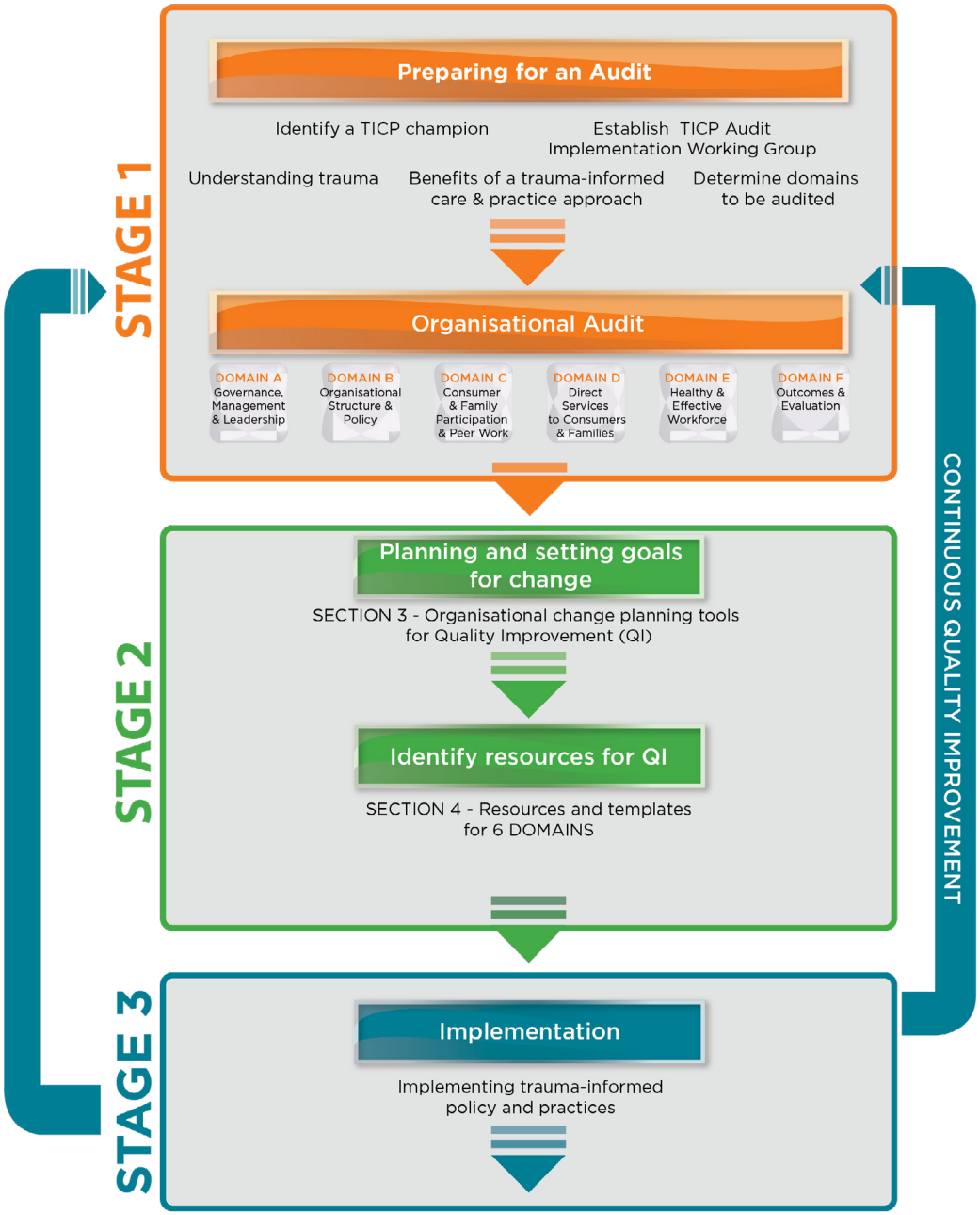

Figure: 1

Preparing for your audit

TICPOT has been developed to be used as an offline DIY audit tool.

Depending on the size and complexity of your organisation, the audit process may vary. It is important to prepare thoroughly to ensure a meaningful result and a strong foundation for change management and quality improvement in the future.

We recommend the following preparatory steps:

1. With the support of leadership in the organisation, service or program, identify a champion within the organisation to lead the TICPOT process.(Consider: Organisations with numerous locations may need more than one champion)

2. Establish a Trauma-Informed Care and Practice Audit and Implementation Working Group (TICP AIWG) prior to commencing planning and conducting the audit.

   (Following cvompletion of the audit process, the AIWG will conduct the analytics and thereafter design and drive strategic planning for organisational change. The AIWG may oversight future planning of quality improvement initiatives and evaluation processes beyond the initial activities).

3. Ideally the AIWG will include members from across the organisation, e.g.:

   - consumer and carer representatives/service users
   - executive and senior management
   - middle management/ supervisors/team leaders
   - front-line support workers
   - clinical practitioners across disciplines
   - support staff (e.g. security, administration)
   - peer workers
   - training and education staff
   - volunteers

4. The AIWG should familiarise themselves with the pre-audit information and resources provided, including the six Domains prior to planning and undertaking the audit.

   Group members should be thoroughly briefed on:
   - the organisation's goals and vision in becoming more trauma-informed
   - the planning and audit process
   - the timeframes expected to undertake initial planning, complete the audit, analysis and implementation process
   - the ongoing quality improvement process
   - the safety issues for staff and service users (e.g. disclosure, triggers)

5. The AIWG will need to determine:
   - how best to recruit staff willing to be part of the process (this should be a voluntary involvement of people interested and willing to champion organisational change). This must be a trauma-informed process not a 'must do' directive
   - how best to complete the audit (individual or group/ single site, multiple or across multiple locations) the domains relevant to each staff member or sub-group (Note: consider also where staff may be representing more than one role)
   - what supporting information may be required for the planning and audit activities (e.g.: policy and procedure manual, feedback from service users)

After the audit:

- how to analyse and identify the appropriate actions arising from the data
- and how to prioritise those actions

(Templates and resources to support planning and implementation are provided in a second document: ***Stage 2 – Supporting Organisational Change and Stage 3 - Implementation***

Notes regarding the organisational change process

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

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.

A trauma-informed organisational change process is expected to improve the quality of life, psychosocial and health outcomes for all people engaging across public and community services including the workforce. However, a service system is likely to experience limited capacity to assess the transformation's impact on individuals, families, and communities unless it has an understanding of health needs, and measures outcomes (from all perspectives). It must also have the ability to identify and address disparities resulting from the lack of specificity, uniformity, and quality in data collection and reporting procedures.

An initial audit process aiming to identify priorities for quality improvement to be addressed in stages will determine a course of action that prioritises specific areas over-time. The concept is to support best-practice in a way that a particular organisation can comfortably accommodate. This may include training or other internal and external development strategies.

For example an organisation may determine that their first priority is:

- trauma-informed education and training, AND/OR that
- management needs to become skilled and knowledgeable enough to champion trauma-informed practices throughout the organisation or in one or a number of contexts, AND that
- policies and structures must be in place first before any changes can occur elsewhere in the organisation.

The process of becoming trauma-informed is an evolutionary journey. The principal objective should be to establish a culture that will foster best practice, 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 as well as longitudinal change.

(*See Stage 2 & Stage 3 – Supporting Organisational Change & Implementation* for more information about prioritising and planning for implementation).

Essential reading: pre-audit and planning

The impact of trauma

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

The Transformation Center, 2012 [3]

The experience of trauma and its impacts on individuals, communities and society as a whole are substantial. Trauma-informed services and systems recognise the prevalence of trauma, particularly interpersonal trauma in our society. Trauma-informed services are aware of and acknowledge that a large percentage of individuals seeking care, treatment and support across a range of health and human service settings have lived experience of trauma that may seriously affect their mental and physical health and wellbeing. [1]

The impacts of trauma persist long after the trauma has ended. Although estimates of prevalence vary, there is broad consensus that many people who engage with public, private and community managed mental health and human services are trauma survivors and that their trauma experiences shape their responses to service providers. [2]

Trauma can be experienced as a result of single or multiple traumatic events. However, complex trauma [3] is characteristically the product of overwhelming stress that is interpersonally generated. Its multiple impacts include those affecting a person's 'sense of self'. As interpersonal violence and abuse often occur in secrecy and are steeped in shame, survivors often struggle to have their experience recognised and validated by others. Trauma occurring in the context of interpersonal violence, either covert or overt, often brings about complex and chronic psychological and physiological injuries. [4]

There is now a wealth of research related to the effects of complex trauma on the brain not just in infancy and childhood but throughout the life cycle. Research has also clearly identified the capacity for the brain to repair; enabling those affected to recover. These research findings have substantial implications for mental health and human service responses. [5] Research has shown that with appropriate supports and interventions, people can overcome traumatic experiences. [6] However, when trauma goes unaddressed, the risk of mental, physical and co-existing conditions characteristically escalates. [7]

Complex trauma survivors are likely to have histories that include experiences of physical and/or sexual abuse; as well as unrelenting neglect and/or protracted emotional abuse; witnessing domestic violence; and/or have been victims of interpersonal violence as a consequence of wars, genocide, civil unrest, refugee and combatant trauma. Such experiences frequently lead to a complex mix of mental health, co-occurring conditions and psychosocial disability. These problems can include: poor physical health, substance misuse, eating disorders, relationship and self-esteem difficulties, suicidality, self-harming behaviours and contact with the criminal justice system. People impacted by trauma may also experience poor education and negative employment outcomes and therefore are more likely to be affected by poverty, chronic social problems, and early death.

These difficulties may affect individuals and their families and communities over generations. Trauma has no boundaries with regards to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. [8]

---

[3] The Transformation Center n.d., Trauma-Sensitive Care, Roxbury, MA. Available from: http://www.transformation-center.org

Trauma-Informed Care and Practice (TICP) [9]

Integral to contemporary thinking about what constitutes an evidence-based 'trauma-informed recovery-oriented approach' is a paradigm shift in service delivery culture, in which practitioners are attuned to, respect and validate a person's experience. (Bloom 2013, 1997, p. 71). [10]

When an organisation is **trauma-informed** it exemplifies a 'new generation' of transformed mental health and human service organisations. These organisations serve people with experience of past and present trauma. They are structured around recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. However, a distinction does need to be made between a trauma-informed approach (which is indicated in all service settings) and the approach needed to work directly with trauma material (trauma specific) in a clinical context (although this should likewise be underpinned by trauma-informed principles and a practice approach).

TICP is a strengths-based framework emphasising physical, psychological, and emotional safety for both service providers and survivors. This framework creates opportunities for survivors to rebuild a sense of control and empowerment. The framework is informed by a blending of the research, practice and survivor knowledge which has enabled the generation of a framework for improving the capacity of services and systems to better address the trauma-related difficulties experienced by those they seek to support. [11] Trauma survivors (that is people with lived experience of trauma) have powerfully and systematically documented their pathways to recovery. [12] The merging of survivor experience, clinical practice and research highlights the central role traumatic experiences play in the lives of people with mental health and coexisting conditions. This connection offers a potential explanation as to what has happened to individuals, who come to the attention of mental health and human services. [13]

Responding appropriately to trauma and its effects requires knowledge and understanding of the nature and impacts of trauma, and broad-based workforce education and training to build capacity. Collaboration between people with lived experience and carers, policy makers and service providers is also required and an appropriate response applied across service systems. It involves not only changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic. Whilst many people using mental health and human services have lived experience of trauma, a TICP culture is relevant and beneficial for all people engaging in service provision whatever their life experiences.

TICP can be utilised to support service providers in moving from a 'caretaker to a collaborator role'. [14] When a human service 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. [15]

By facilitating recovery through trauma-informed care, re-victimisation can be minimised and self and community wellbeing and connectedness can be promoted. Trauma-Informed services understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible (Herman 2001). [16]

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). Services and programs can then be more supportive, effective and avoid re-traumatisation.

Principles of Trauma-Informed Care and Practice [17]

Broadly speaking a trauma-informed care and practice approach is:

- informed by a philosophy of practice approach underpinned by values and principles
- based on the most contemporary literature
- informed by research and evidence of effective practices
- led by people with lived experience and survivors of interpersonal trauma
- culturally safe and inclusive of diversity

The **eight foundational principles** that represent the core values of trauma-informed care and practice approach are: [18]

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.

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.

Intergrated Trauma-Informed System [19]

A trauma-informed system will:

- Provide a system of care that is comprehensive, sustainable and integrated (taking into account whole of person needs)
- Establish and maintain open dialogue between service providers, consumers and carers across service systems
- Be aware of current knowledge, theory and treatment models across a range of knowledge bases and disciplines, and remain open to development of clinical practice and empirical knowledge including respect for the experience and knowledge held by service users, the peer workforce and carers
- Identify the components needed for a comprehensive, continuous and integrated and sustainable system and increase capacity by cross training, modification of services and the addition of new service components that are co-designed by people with lived experience
- Identify ways to facilitate integration and ensure that this is articulated, monitored and measured.

Key features of trauma-informed organisations

- Trauma-informed organisations will:
- Recognise that the high rates of complex mental health conditions and psychosocial disability amongst service users may be related to interpersonal trauma including exposure to trauma as a child
- Be Inclusive of the survivor's perspective, invite and value their contribution in all aspects of care and treatment
- Respond empathically, be objective and use supportive language
- Offer individually flexible plans or approaches
- Recognise that coercive and involuntary interventions cause traumatisation/re-traumatisation – and are to be avoided
- Recognise that mental health treatment environments are often traumatising, both overtly and covertly
- Provide early and thoughtful diagnostic evaluations with focused consideration of trauma in people presenting with complicated illnesses, and deemed 'treatment-resistant' [4]
- Mental health professionals across all service settings (public, primary health and community-based) will be provided with the education and support necessary to recognise and respond to the impacts of trauma
- Provide awareness/training on re-traumatising practices, as well as training and supervision in assessment, care and treatment of people who have experienced trauma
- Focus on what happened to the person rather than what is 'wrong with them' (i.e. a diagnosis). Note: this is not about knowing the details of their experiences, but considering their presentation in the context of trauma
- Ask questions about a person's current safety, address the current risk and develop a safety plan for discharge and ongoing support
- Assume trauma as the expectation, not the exception, and that every person in a treatment setting may have been exposed to abuse, violence, neglect or other traumatic experiences.

[4] 'Treatment resistant' is a controversial term that refers to mental health conditions that do not respond to standard (primarily pharmacological) treatments. The term is sometimes used in a pejorative way to indicate that an individual is somehow to blame for this.

Trauma and the workforce

Trauma affects workers as well as the people accessing services and programs. Workers may be survivors of interpersonal trauma themselves and may be subject to many of the same 'triggers' that affect the service users they support.

Working in organisations and services with people who have experienced trauma and continue to live with ongoing trauma inevitably creates stressors that can deeply affect administrators, practitioners, and support staff. Not only is 'secondary trauma' or 'vicarious traumatisation' common, but direct threats to physical and emotional safety are a frequent concern. Being asked to do 'more and more with less and less' becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities (Fallot & Harris 2009). [20]

Vicarious trauma (VT) has been described as: *the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them* (Pearlman & Caringi 2009). [21] It does not in any way suggest weakness or fault on the part of the worker, but is often inherent in work undertaken (Ross & Halpern 2009). [22]

An individual worker's personal history (including prior traumatic experiences), coping strategies, and support network, and other factors can interact with his/her work environment and give rise to vicarious trauma. This factor underlies the individual nature of responses or adaptations to VT, as well as individual ways of coping with and transforming it.

Often the demands of the work itself or the environment or circumstances in an organisation, can interfere with a worker's ability to fulfil his/her responsibility and can contribute to VT (Pryce, Shackelford & Price 2007). [23] A lack of training, managerial support and leadership as well as the absence of practice supervision for the individual worker can all exacerbate and contribute to VT.

The symptoms and signs of VT may parallel those of a directly experienced trauma and are likely to be more intense for workers who have lived experience who may be more vulnerable to VT. However, the research findings on this point are mixed (Bride 2004). [24]

Prior and existing trauma

The re-traumatisation of people with past experiences of trauma, by and within diverse services of the health sector, is highly prevalent. Research establishes that service practices which lead to re-traumatisation are common. Recognition that trauma has often occurred in the service context itself is a major driver for the introduction of `trauma-informed' practice. [25] When trauma occurs within a service, this impacts on both the worker and the person engaging with the service.

Secondary traumatic stress (STS) is the emotional distress that results when an individual hears about the trauma experiences of another. STS is a condition, and those with symptoms severe enough may be diagnosed with Post-traumatic Stress Disorder (PTSD). Accordingly, individuals affected by STS 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, mood, and perception; alterations in their sense of selfefficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence (National Child Traumatic Stress Network, 2013, Secondary Traumatic Stress, (http://www.nctsn.org) [26]

Several other terms capture elements of this definition but are not strictly interchangeable:

Vicarious Trauma is different to secondary traumatic stress in that STS can happen suddenly, while vicarious trauma is a response to an accumulation of exposure to the pain of others (Figley, 1995). The symptoms of secondary trauma are nearly identical to those of vicarious trauma. [27]

Compassion Fatigue is something that can affect anyone as a result of serving in a helping capacity.

Burnout describes the experience of anyone whose health is suffering or whose outlook on life has turned negative because of the impact of the overload of their work. It is usually characteristed by exhaustion, depersonalisation, and a reduced feeling of individual accomplishment.

In the literature as well as in practice, secondary traumatic stress and vicarious trauma are terms often used interchangeably. In our view they are different because secondary trauma refers to the presence of post-traumatic stress disorder (PTSD) symptoms whereas vicarious trauma refers to the more general cognitive changes a person experiences.

Service providers often find working with people with experiences of trauma stressful because of the way that trauma may shape the way that a person may conduct interpersonal relationships (Palmer et al. 2001). [28] The nature of the work is particularly stressful when it involves listening to detailed descriptions of very painful, often horrific events (Palmer et al., 2001). There is no doubt that hearing and thinking about the experiences some people have endured can stay with us well after the client has left. [29]

Vicarious trauma and secondary traumatic stress (see key terms Appendix A) both involve a cumulative effect, which can affect many aspects of a person's life. It may consist of short-term reactions, or longer-term effects that continue long after the work has finished. Some argue that its effects are potentially permanent (Mouldern & Firestone 2007, p. 68). [30]

Some effects of vicarious traumatisation may parallel those experienced by a survivor, and secondary traumatisation can lead to a person experiencing the symptoms of PTSD. While the symptoms of trauma should be recognised as culturally diverse and specific (Wasco 2003), trauma reactions are generally divided into three categories: [31]

- *intrusive reactions:* dreams/nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event;
- *avoidant reactions:* general numbing in responsiveness and avoidance (particularly of things related to the traumatic material); and
- *hyper-arousal reactions:* hyper-vigilance and difficulty concentrating.

Connected to these experiences vicarious traumatisation may also involve a change in a person's beliefs about themselves, the world, and other people within it. This is known in the psychological field as changes in their 'cognitive schema'. This may have may have significant impacts on the worker's feelings, relationships and life (NADA & MHCC 2007). [32]

Common belief systems affected by vicarious traumatisation include:

- Dependency/trust
- Safety
- Sense of power
- self-esteem
- Intimacy
- Shift in world view.

Vicarious trauma is just one way of conceptualising people's reactions to working with people who have experienced trauma. It can be a useful way, because it can offer legitimacy to the prevalence and nature of people's experiences. However, it is important not to 'pathologise' these reactions. In fact, much research on this subject points out that these reactions are "normal human reactions to repeated exposure to distressing events" (Morrison 2007). [33]

Benefit of continuous, sustainable trauma-informed care and practice

Trauma-informed services are designed specifically to avoid re-traumatisation of those who are seeking support as well as staff working in service settings. These services seek "safety first" and commit themselves to "do no harm" (SAMSHA 2003).

Outcome studies internationally provide substantial evidence related to the benefits for consumers and workers, as well as the cost-effectiveness of introducing trauma-informed policies and practice guidelines. [35] Some examples identified are listed as follows:

- Trauma-informed service settings, with trauma-specific services available, have better outcomes than 'treatment as usual' for people experiencing numerous symptoms. We know from a variety of studies [36] and pilot programs [37] that environments utilising a trauma-informed approach report a decrease in psychiatric symptoms and substance use.

- Some of programs have shown an improvement in a person's daily functioning and a decrease in trauma responses, substance use, and symptoms of mental illness. These findings suggest that integrating services that address traumatic stress, substance use and mental health leads to better outcomes. [38]

- Early indications suggest that a trauma-informed approach may have a positive effect on housing stability. A multi-site study of trauma-informed care for homeless families found that, at 18 months, 88% of participants had either remained in existing temporary housing or moved to permanent housing. [39] Likewise an outreach and care coordination program that provided family-focused, integrated, trauma-informed care to homeless mothers found that the program led to increased residential stability. [40]

- A trauma-informed approach may lead to a decrease in the need for crisis support services. Some studies have found decreases in the use of intensive services such as hospitalisation and crisis intervention following the implementation of a trauma-informed care and practice approach. [41]

- Trauma-informed, integrated services are cost-effective. They have shown improved outcomes but do not cost more than standard programming. [42]

- Qualitative results found that trauma-informed service providers report positive outcomes in their organisations. [43]

- In implementing a trauma-informed care and practice approach, providers report greater collaboration with consumers, who feel that they receive more support from their agencies and have the opportunity to develop enhanced skills and a greater sense of self-efficacy. Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events and more effective services. [44]

- Qualitative results indicate that consumers respond well to trauma-informed care. Within Jennings Trauma Collaboration study (2004), consumers reported an increased sense of safety, better collaboration with staff, and a more significant "voice" in their care and treatment planning. Eighty-four per cent of consumers rated their overall experience with these trauma-informed services using the highest rating available. [45] Survey results suggest that consumers were very satisfied with trauma-informed changes in service delivery. [46]

A key objective of TICPOT is to assist organisations embed trauma-informed principles and integrate a trauma-informed practice approach throughout organisational structures and contexts and direct service delivery programs. [47]

Other organisational development and planning resources

The following publications provide samples of organisational guidelines for implementing TICP:

Biomed Central, 2016, *Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: a pilot study, BMG Nurs, 2016,15:21,* Hall, A McKenna, B Dearie, V Charleston, R & Furness, T, Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4806472/

Centre for Health Care Strategies, Inc (CHCS), 2016, *Issues Brief: Key Ingredients for Successful Trauma-Informed Care Implementation*, Menschner C & Maul A, Center for Health Care Strategies, Available from: http://www.chcs.org/media/ATC_whitepaper_040616.pdf

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

Guarino, K, Soares, P, Konnath, K, Clervil, R & Bassuk, E 2009, *Trauma-Informed Organizational Toolkit,* 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, Rockville, MD.

Huckshorn, K 2009, *Transforming Cultures of Care toward Recovery Oriented Services: Guidelines toward Creating a Trauma Informed System of Care,* in National Association of State Mental Health Program Directors (ed.), Trauma Informed Care (TIC) Planning Guidelines for Use in Developing an Organizational Action Plan, NASMHPD, Alexandria, VA.

Jennings, A 2009, *Criteria for Building a Trauma-Informed Mental Health Service System*, Available from: http://www.theannainstitute.org/CBTINHMHS.pdf

Prescott, L, Soares, P, Konnath, K, & Bassuk, E 2008, *A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness*, draft resource guide, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Daniels Fund, The National Child Traumatic Stress Network & W.K. Kellogg Foundation, Rockville, MD. The following resource is a system-wide set of guidelines for implementing TIC.

Substance Abuse and Mental Health Services Administration 2014, *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*, HHS Publication No. (SMA) 14-4884. Rockville, MD.

The Thrive Initiative 2010, Guide to Trauma-informed Organizational Development, Portland ME.

U.S. Department of Health and Human Services, Health Resources and Services Administration 2006, *Model Trauma System: Planning and Evaluation*, HRSA, Rockville, MD.

USER TIP - gathering your evidence

In preparation for an audit assessment, the AIWG should review existing information which would support the organisation's current trauma-informed policy and practice.

This may include but is not limited to:

- Policy and procedure manual
- Reporting mechanisms
- Risk analyses
- Training records
- Accreditation and assessment information
- Opportunities for participation
- Feedback from service users

Support for TICPOT users

Stage 2 - Supporting Organisational Change & **Stage 3** – Implementation (in one document) resources and templates

NOTE: TICPOT neither provides an exhaustive literature review on trauma and its impacts nor access to the extensive material on which the assessment tool is based. Nevertheless, the references and bibliographies included identify many resources to which the reader can refer if more in-depth material is required.

ticpot

Trauma-Informed Care and Practice Organisational Toolkit

A Quality Improvement Organisational Change Resource

ORGANISATIONAL DOMAINS AND AUDIT TOOL

The Six Organisational Domains

Areas for quality improvement and organisational change

A. Governance, Management and Leadership

A culture of shared governance involves consumers in every aspect of the organisation, provides for greater accountability and transparency. Facilitating power sharing power with people who have experienced trauma, requires active leadership engagement which demonstrates a deep commitment to a transformational process of change. It requires managers and leaders to be aware of the impacts of trauma and to implement leadership and organisational change practices which are consistent with the principles of a trauma-informed care and practice approach.

B. Organisational Policies and Structure

Policies and procedures must reflect TICP values and principles and incorporate them in all aspects of policy, administration, practice, and service delivery. This will ensure that organisations value and adapt to diversity and the cultural contexts of the communities they serve.

Policy will reflect service design that is reviewed for their processes of access, referral and discharge to minimise trauma occurring in the context of transfers of care. Policy will also demonstrate that service environments are reviewed for their provision of emotionally and physically safe spaces and the provision of accessible and transparent information.

C. Consumer and Carer/Family Participation

Administrators make collaboration and supported decision-making a key part of organisational structures and change processes. Consumers, carers and family play an active role in co-designing all aspects of service planning, implementation, and evaluation.

D. Direct services to Consumers

In relation to direct services and the environment in which they are provided, a systemic approach must ensure that all services are sensitive to and responsive to trauma whatever the service context. This ensures that safety is maximised and the risk of re-traumatisation is minimised.

E. Healthy and Effective Workforce

Organisations that are trauma-informed foster healthy and effective workforces. They provide education and training particularly in: assessment and screening; understanding symptoms and behaviours that may arise from interpersonal trauma; and the relationship between trauma, vicarious and secondary traumatic stress. They support supervision and workforce wellbeing programs.

F. Outcomes and Evaluation

It is critical that organisations collect data concerning outcomes for service users. This must include evaluation of service provision, including practice that shows evidence of efficacy from the perspective of consumers with regards to outcomes, through their evaluation concerning their experience of services and their recovery.

IMPORTANT

Guidance for users about providing responses and evidence when completing the survey

When completing the survey there are 6 categories for rating a response:

Strongly Agree = SA
Agree = A
Disagree = D
Strongly Disagree = SD
Not Applicable = NA
Don't Know = DK

Some people may feel ambivalent when answering a question because, in some circumstances, they agree with the question but there are caveats to that rating. In such circumstances an answer should be rated as **Disagree** and the rating explained in the evidence provided (e.g. the organisation provides trauma training to front-line workers but not to all staff). This **Disagree** rating might later be assessed by a reviewer as Somewhat Trauma-Informed (see below).

For the purposes of analysing the data gathered, the person/s who will be reviewing the data must consider the evidence from the following perspectives:

Strongly Agree = Extensively Trauma-Informed (ETI)
Agree = Markedly Trauma-Informed (MTI)
Disagree = Somewhat Trauma-Informed (STI)
Strongly Disagree = Least Trauma-Informed (LTI)

If a question does not apply to the organisation or the person completing a particular Domain please note as **NA**, if they have no idea what the question means or really don't know, answer **DK**. It would also be good to provide a reason or comment for this response in the evidence (e.g. Not familiar with the terminology used).

Organisational audit of trauma-informed practice - quality improvement overview

The trauma-informed organisational audit provides a mechanism for quality improvement that facilitates data collection and analysis of the organisation and its services at every level. The process fosters a cultural shift across the numerous domains. It also supports the development and dissemination of effective, best-practice interventions and services.

The toolkit emphasises 'culture' because it represents an agency, organisation or program's fundamental approach to its work. Organisational culture reflects what is considered important and unimportant, what warrants attention, how it understands the people it serves and the people who support them, and how it puts this understanding into daily practice. In short, culture expresses core values. Culture extends well beyond the introduction of new services or the training of a particular group of staff members; it is pervasive, and includes all aspects of an agency's functioning. [48]

In the initial planning the organisation must consider the importance of, and commitment to, a trauma-informed change process.

The following elements are key to the successful planning of organisational trauma-informed change:

a) Administrative commitment to and support of the initiative

b) Formation of a TICP audit and implementation working group to lead and oversee the change process

c) Full representation of each significant stakeholder group on the working group—consumers, carers, administrators, supervisors, direct service staff, and support staff

d) Identification of TICP 'champions' to keep the initiative alive, and

e) Programmatic awareness of the scope (the entire agency and its culture) and timeline (e.g., two - three years) to establish the process and embed ongoing quality improvement.

Audit Tool

DOMAIN	A	B	C	D	E	F
	Governance, Management and Leadership	Organisational Policies and Structure	Consumer and Carer/Family Participation	Direct Services to Consumers	Healthy and Effective Workforce	Outcomes and Evaluation
Audit lead name(s)						
Role						
Date						

A. Governance, Management and Leadership

All levels of governance, management and leadership need to be trauma-informed. A point of responsibility needs to be clearly identified within the organisation, charged with fostering the changes required to implement trauma-informed principles and practice. This could be a manager with high-visibility leadership skills supported by the board, with a clear framework and time-frame for quality improvement and implementation processes across the organisation. Under this leadership a Working Group should be established from across various roles and responsibilities in the organisation, and including participation of service users past or current including consumer/s and carer/s.

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. **Identified roles for consumers and carers in governance bodies (and management)** [5]
No organisation can be trauma-informed without direct consumer/carer participation in all aspects of policy and program development.

The organisation can demonstrate that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. There are identified leadership and governance roles at all levels for consumers and carers (e.g. Director or CEO of the service is a person with lived experience; the Board of the organisation includes lived experience) 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							

[5]Primary References: Bloom, S, 1997, Creating Sanctuary: Toward the evolution of sane societies. New York, Routledge; Fallot, RD & Harris, MH 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol, Community Connections, Washington, DC.

2. Leadership style and skills
Leadership in trauma-informed organisations needs to model the values of respect, compassion and transparency.[49] Effective leaders can reflect and adjust their style in response to the needs of the organisation. [50]

In this organisation, managers and leaders:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Managers and leaders provide clear direction regarding organisational change required to implement trauma-informed practice							
ii. Managers and leaders provide clear leadership in how to reduce the use of coercive and restrictive practices with the organisation							
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 consumers and 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							

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.

This organisation can demonstrate that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. All managers and leaders have participated in training and education about the incidence, prevalence and impact of trauma across the lifespan							
ii. All managers and leaders have participated in training and education regarding trauma-informed care and practice, policy and procedures							
iii. Managers and leaders have an understanding of trauma-informed principles and practice and support staff at all levels to participate in training and education about the incidence, prevalence and impact of trauma							
iv. Managers and leaders support staff at all levels to participate in training, education or information about trauma-informed care and practice							

4. Organisational Mission
The organisation and staff understand and support trauma-informed principles. TICP is part of the organisation's mission which provides a focus and vision that directs every aspect of an organisation's practice.

The organisation can demonstrate that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. The organisation has a documented commitment to a trauma-informed care and practice approach and communicates this to consumers, carers/families and staff							
ii. Staff are informed of the organisation's mission and actively engage in supporting and delivering on its purpose							
iii. The organisation's mission statement is publicly accessible							
iv. The organisation has clear value statements regarding consumer rights and the promotion of self-determination							

5. Organisational Change *Managers and leaders need to be highly visible in the process of guiding change, and collaborate and communicate with staff, consumers and carers/families.*							
The organisation can demonstrate that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. The organisation documents and reports on change-management processes							
ii. Staff in the organisation are informed of change before it occurs and as it progresses							
iii. Staff in the organisation are actively involved in the process of organisational change							
iv. Staff provide to other partner organisations and services information about trauma-informed care and practice							
v. It models a trauma-informed approach in all its interactions with the community							

B. Organisational Policies and Structure

Policies, reporting structures, communication and the physical environment

Policies and procedures that guide organisational practices are central to ensuring that trauma-informed and trauma-specific assessment and services are adopted consistently. Licensing, regulations, certification, quality improvement tools and contracting mechanisms should all focus on being trauma–informed. Policies and regulations addressing confidentiality, involuntary hospitalisation and coercive practices, consumer preferences and choice, privacy, human resources, and rights and grievances for employees also need to be trauma-informed. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services. Safety is the first priority in a trauma-informed organisation, for consumers, carers, families and the workforce. Workers, consumers, carers and families all have the right to provide and receive care in an environment that minimises the risk of re-traumatisation and vicarious trauma and that maximises self-determination and avoids coercive practices. [51 52]

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. Communication of information about the organisation
Trauma-informed organisations promote open dialogue among service providers and recipients of services, e.g., enhancing protocols for support and treatment services, referrals and access.

The organisation ensures:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Information that explains the purpose of the organisation is easily accessible							
ii. Information that describes the organisation's values is easily accessible							
iii. Information that explains how the organisation accepts referral/s, and why they may not be able to accept a referral is easily understood and accessible							
iv. information that explains how a service may assist or support a person if unable to accept a direct referral is easily understood and accessible							
v. Information that explains how the organisation terminates contact with a person/family/other service which is easily understood and accessible							

2. *Safety of the work environment (for paid staff and volunteers, referred to inclusively as staff)
Trauma-informed organisations recognise that trauma profoundly affects a) a person's sense of safety with others and in the environment, and b) that negotiating and maintaining safety is critical to being able to work effectively.

The organisation has policies that ensure that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. The work environment provides quiet space/s, away from direct service delivery, reception/office space							
ii. There is the possibility to modify the environment to an individual worker's needs							
iii. Staff receive a prompt response to expressed concerns about safety							
iv. Staff are routinely asked if they feel safe when undertaking off-site work							
v. Staff are required to document safety assessments of off-site work (such as home visits)							

In a trauma-informed organisation, all staff need to be made aware that they have a right to be free from the misuse of power, and how to identify and respond to interpersonal bullying and harassment.

The organisation has policies that:	SA	A	Evidence	D	SD	Action/Plan	NA
vi. Describe an internal complaints process for staff and guide staff in the actions to take in response to alleged bullying, harassment or other forms of interpersonal abuse in the workplace							
vii. Clearly state a right to be free from bullying, harassment and other forms of interpersonal abuse in the workplace							
viii. Protect staff who make complaints from reprisals or disadvantage							

3. Safety of the service environment (for consumers, carers and families) * *Trauma-informed organisations recognise that trauma profoundly affects a person's sense of safety with others and in the environment, and that negotiating and maintaining safety is critical to be able to participate in a service.*							
The organisation has policies that ensure that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. People who access the service can make choices (where possible) can modify the environment in which they are seen, to enhance personal safety							
ii. Consumers are routinely asked if they feel safe in the service environment (not limited to an absence of identifiable threat, but incorporates a subjective assessment of resources required by consumers to feel safe)							
iii. Carers/family members are routinely asked if they feel safe in the service environment (not limited to an absence of identifiable threat, but incorporates a subjective assessment of resources required by consumers to feel safe)							
iv. Discussion regarding safety clearly incorporates the dimensions of psychological, emotional and cultural safety (i.e., is not limited to physical safety)							
v. Consumers, carers and family receive prompt responses to expressed concerns about safety							
vi. In residential services, people have access to a private bedroom and bathroom							
vii. In residential services, people have access to single gender spaces							

	SA	A	Evidence	D	SD	Action/Plan	NA
viii. When consumers are changing accommodation/ returning to live with a family member or carer the safety of both/all are systematically assessed							
ix. For residential settings, if a 'no sex' policy # applies all staff are aware of this policy							
x. Consumers, carers and family members receive a prompt response and support from the organisation/staff after an incident of threat or harm							

*All items repeated in Domain D – Direct Services to Consumers

A 'no sex' policy applies to all public mental health services in NSW, and similar policies may apply in other States and Territories.

4. Rights:
Trauma-informed organisations recognise that knowledge and understanding of rights is critical for empowerment.

The organisation ensures that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. A statement of Rights and Responsibilities is publicly displayed and easily accessible							
ii. Rights and Responsibilities statements are provided to all consumers, carers/family and staff							
iii. Ensures as far as possible that Rights and Responsibilities statements are understood by consumers, carers and families							
iv. Supports consumers, carers/families to access and understand rights frameworks under state and national law *							

5. Policies
Trauma–informed organisations recognise that specific policy guidance is required for ensuring that responses to vulnerable groups are appropriate, empowering and value diversity.

If providing direct services to consumers, the organisation has policies that:-	SA	A	Evidence	D	SD	Action/Plan	NA
i. The organisation invites feedback from consumers, carers/family and staff in a variety of ways (i.e. in writing, verbally, anonymously, in focus groups etc.)							
ii. When policies are reviewed the organisation seeks and responds to input from consumers, carers/family and staff							
iii. Consumers, carers/family and staff are formally notified of the outcomes or changes as a result of their feedback							
iv. Relate to responses to disclosure of current or recent harm from self or others							
v. Emphasise consumer choice and self-determination when responding to disclosure							
vi. Emphasise consumer choice and self-determination regarding service provision and decision-making							
vii. Clearly state organisational values regarding diversity							
viii. Provide clear guidance regarding responding to risk of harm to children and young people							

ix. Provide clear guidance regarding responding to risk of harm to older or vulnerable adults	SA	A	Evidence	D	SD	Action/Plan	NA
x. Are related to minimising trauma and distress during contact with the service (including coercive and restrictive practices)							
xi. Acknowledge the likelihood of Aboriginal and Torres Strait Islander Peoples having prior traumatic experience and consequent mistrust of systems and services							

6. Processes for the organisation to seek and respond to feedback from consumers, carers/family and staff *Trauma-informed organisations elicit and value feedback from consumers, families/carers and staff.*							
The organisation ensures that:	SA	A	Evidence	D	SD	Action/Plan	NA
i. The organisation invites feedback from consumers, carers/family and staff in a variety of ways (i.e. in writing, verbally, anonymously, in focus groups etc.)							
ii. When policies are reviewed the organisation seeks and responds to input from consumers, carers/family and staff							
iii. Consumers, carers/family and staff are formally notified of the outcomes or changes as a result of their feedback							

C. Consumer and Carer/Family Participation

Consumer participation in mental health services has been acknowledged nationally and internationally as a cornerstone of mental health policy (Steward et al., 2008). [53] Consumer participation across service systems provides opportunities to improve all human services, tackle negative community attitudes, promote a better quality of life for consumers and assist in the recovery process. Consumer participation and leadership is crucial to transforming mental health services into trauma-informed recovery-oriented services. A focus on wellness rather than illness drives this response. The need for this approach has been recognised in some services including within Aboriginal and Torres Islander peoples and refugee populations, although it needs to be integrated more broadly.

The voice and participation of lived experience should be actively encouraged and consumers should be involved in all aspects of co-designing systems planning, oversight, and evaluation. Consumers should be significantly involved in staff orientation, training and curriculum development. They should also play a lead role in the creation of state mental health plans, the improvement of access and accountability for people with mental health conditions and in orienting the mental health system towards trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g. the right to trauma treatment, freedom from re-traumatisation, the right to maximise choice, self-determination, collaboration and empowerment) and to the ways in which these rights are sometimes systematically violated. Administration-level policy or position statements should support these goals.

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. Consumer participation (organisation response) *The voice of people with lived experience is essential to the co-design and development of services and programs, and to maximise self-determination and meet recovery goals* [54]							
In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Consumers are provided with information about trauma and its impacts							
ii. Consumers are actively involved in leadership of the organisation							
iii. Consumers are actively involved in policy development and review							
iv. Consumers are actively involved in service design and delivery							
v. Consumers are readily available as advocates*							

	SA	A	Evidence	D	SD	Action/Plan	NA
vi. Consumer advocates* and representatives embody diverse backgrounds and perspectives							
vii. Consumers are actively involved in consultative processes, e.g., projects, research etc.							
viii. Consumers are actively involved as educators within the organisation							
ix. Peer workers are actively involved as mentors for other consumers within the organisation							

*Note that Consumer Advocates may also be considered as part of the Peer Workforce

2. Carer/family participation (organisational response)
The voice of carers/and families' is essential to the development of services and programs.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Carers are provided with information about trauma and its impacts							
ii. Carers/families are actively involved in leadership of the organisation							
iii. Carers/families are actively involved in policy development, co-design and review of programs and services							
iv. Carers/families are readily available as advocates and representatives represent diverse backgrounds and perspectives							
v. Carers are actively involved in consultative processes, e.g., projects, research etc.							
vi. Carers are actively involved as educators within the organisation							
vii. Carers are actively involved as mentors for other consumers participating within the organisation							

D. Direct Services

Practices regarding assessment and intake of consumers

Organisational processes and procedures regarding contact with consumers, including responding to distress and disclosure

Recognition of trauma and its prevalence are key to accommodating the service needs of trauma survivors. Trauma must be seen as the expectation, not the exception. A trauma-informed approach advocates a systemic focus that ensures that all people in Australia who come into contact with services of any nature, receive care that is sensitive and responsive to the impact/s of trauma. This must occur regardless of the 'door' through which they enter and whether they access a trauma-specific treatment program or not.

Additionally, a trauma-informed practice approach involves recognition of lived experience and the particular 'triggers' that may lead to re-traumatisation and re-victimisation. Trauma-informed recovery-oriented services that care for people experiencing mental health and associated difficulties must consider the possibility of trauma and its impact/s in relation to recovery. While not advocating that workers should elicit disclosure (unless conducted in the context of a safe therapeutic space by a practitioner trained to work with complex trauma and its effects, and appropriately contained), practitioners should support people on their recovery journeys by integrating trauma-informed practice in any environment. Due to the prevalence of trauma among people across multiple service systems, and its broad applicability, trauma-informed care and practice can be considered appropriate in all service delivery contexts; and not just in the delivery of direct services to people known to have experienced trauma.

Trauma-informed practice also involves a consistent attentiveness to maximising choice, control and autonomy for consumers; including during times of increased risk of self-directed harm. While ensuring care is not negligent, and within the parameters of a safe service, trauma-informed practice will always and actively support, seek out and work to create opportunities for appropriate and positive risk-taking by consumers, which can promote recovery and, thereby, address over the longer term the underlying contributing factors to self-destructive behaviours.

Trauma-informed policies and procedures are crucial to reducing or eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. Such practices must be carefully reviewed, revised, monitored and consider the needs of trauma survivors.

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. Trauma-informed assessment
All direct services must be person and family-centred, safe and reflect the principles for trauma-informed care and practice (p.9).

A trauma-informed assessment provides an opportunity for disclosure of past or current trauma and acknowledges the impact of traumatic experiences.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. During assessment processes, consumers are offered privacy, choices, and provided with clear explanations regarding intake and assessment processes							
ii. Consumers are advised that their safety before, during and after the assessment is a priority							
iii. Consumers are asked sensitively about prior trauma at intake/initial assessment *							
iv.Intake/Assessment is not the only opportunity for consumers to disclose prior trauma *							
v. A screening tool or available documentation is utilised to indicate likely impacts/effects of trauma*							
vi. Consumers are asked about current potential harm/safety in relationships (including domestic violence)							
vii. Where domestic or family violence is disclosed (or suspected), safety implications of communication with family members are considered							

	SA	A	Evidence	D	SD	Action/Plan	NA
viii. Consumers who disclose recent or ongoing domestic violence or sexual assault are offered referrals to appropriate specialist services and or/ authorities							
ix. Responses to acute distress are collaborative and strengths-based							
x. The perspectives and needs of carers/family perspectives (including safety) are sought and responded to							
xi. At initial contact with the service consumers' diverse social and cultural needs (including spiritual/religious, gender, sexuality and language needs) are assessed							
xii. This service respects consumers' perspectives concerning their lived experience.							

2. Trauma-informed relationships
Trauma- informed services acknowledge the role relationships play in establishing safety. Trauma-informed services also acknowledge that reminders of trauma can occur within relationships and take care to establish and support safe boundaries.

The organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Recognises the role of relationships as central to trauma-informed practice (e.g. acknowledges in training provided or acknowledges in widely distributed documentation)							
ii. Supports staff in the development of safe therapeutic relationships with consumers							
iii. Promotes direct relationships between consumers and all staff that are characterised by mutual respect, compassion and healthy boundaries **							
iv. Promotes the role and significance of relationships in the lives of consumers and assesses its presence							
v. Enables staff to make adjustments to service provision (e.g. preference for gender of staff member) in response to consumer feedback and provide clear explanations for when adjustments are not possible							
vi. All staff ** who have direct contact with consumers and families/carers are supported to value a strengths-based view of others							
vii. All staff ** who have direct contact with consumers and families/carers are required to understand the importance of the development of trust							

*Includes documentation, sharing with others, formal reporting

**Includes administrative and ancillary staff

3. Service delivery supports collaboration, choice and self determination
Trauma- informed services acknowledge that choice and self-determination are critical for recovery, and act to minimise re-traumatisation within service and interpersonal context.

The organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Where possible, consumers are offered choices regarding what services are provided							
ii. Where possible, Consumers are given choices regarding who provides the service							
iii. Plans for service or care are flexible, reviewed regularly and modified if they are not meeting the consumer's needs or preferences							
iv. Plans for service provision or care are made collaboratively, and clearly reflect consumer choice and preferences							
v. Plans for service are individually negotiated, with reference to any specific needs, developmental level and capabilities of the consumer and their carer/ family							
vi. Staff collaborate with consumers to develop written individual safety plans (this may include triggers, i.e., situations that are stressful and overwhelming and remind the consumer of past traumatic experiences and list ways that a consumer may show they are stressed or overwhelmed, i.e., behaviours and ways of responding)							
vii. Written safety plans including goals and advance directives are incorporated into consumer plans							

	SA	A	Evidence	D	SD	Action/Plan	NA
vii. Written safety plans including goals and advance directives are incorporated into consumer plans							
viii. When consumers disclose prior trauma they are offered meaningful choices about any action to be taken as a result of this disclosure *							
ix. Services and staff consult with Aboriginal and Torres Strait Islander peoples regarding culturally appropriate protocols for engagement and care							
x. Staff collaborate with consumers and families/carers regarding an assessment of risk(s)paying consideration of dignity of risk							

4. Recognition of the impacts of trauma
Trauma-informed services recognise that trauma can affect an individual in multiple, profound ways that can continue for many years.

The organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Staff can access information regarding the incidence and prevalence of trauma amongst consumers interacting with the organisation							
ii. Staff are able to recognise common impacts of trauma and trauma related forms of distress							
iii. Staff use language that fosters hope and does not discriminate or cause distress							
iv. Staff provide information to consumers, carers and family about the impacts of trauma							
v. Staff regularly engage in discussion with consumers regarding personal safety, including psychological safety							
vi. Staff provide care that recognises that people who have experienced trauma may have ongoing difficulties managing distress states							
vii. Staff are trained to support people affected by trauma efforts to self-regulate psychological & emotional arousal							
viii. Staff provide care that is sensitive to the potential for the service environment to contain triggers that can elicit memory of prior trauma							
ix. Staff provide care that recognises the cultural context of trauma and healing							

	SA	A	Evidence	D	SD	Action/Plan	NA
x. Staff provide care that is sensitive to the complexity of trauma and loss for Aboriginal and Torres Strait Islander peoples							
xi. Staff provide care that acknowledges that Aboriginal and Torres Strait Islander peoples may have lost trust in other services as a result of past trauma							
xii. Staff provide care that recognises that the impacts of trauma may be intergenerational							

5. Safety of the service environment (for consumers, carers and families) **
Trauma-informed organisations recognise that trauma profoundly affects sense of safety with others and in the environment, and that negotiating and maintaining safety is critical to be able to participate in a service.

The organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. People who access the service can make choices about the environment in which they are seen							
ii. Consumers are routinely asked if they feel safe in the service environment (not limited to an absence of an identified threat, but incorporates a subjective assessment of resources required by consumers to feel safe)							
iii. Carers/family members are routinely asked if they feel safe in the service environment (not limited to an absence of an identified threat, but incorporates a subjective assessment of resources required by carers to feel safe)							

	SA	A	Evidence	D	SD	Action/Plan	NA
iv. Discussion regarding safety clearly incorporates the dimensions of psychological, emotional and cultural safety (i.e., is not limited to physical safety)							
v. Consumers, carers and family receive prompt responses to expressed concerns about safety							
vi. In residential or inpatient services, people have access to a private bedroom and bathroom							
vii. In residential services, people have access to single gender spaces							
viii. When consumers are changing accommodation/ returning to live with a family member or carer the safety of both/all are systematically assessed							
ix. The importance of sexual safety is recognised especially in residential settings							
x. Consumers, carers and family members receive prompt response and support after an incident of threat or harm							

* Includes documentation, sharing with others, formal reporting

** # Repeated in Domain B #. This policy applies in all NSW Health acute mental health facilities

6. Reduction of coercive practices
Trauma-informed organisations recognise that coercive practices may profoundly affect a person's sense of safety; trigger experiences of past trauma, and affect future participation in a service.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Care is individualised based on individual needs, including the response to incidents							
ii. Processes of reviewing incidents are systematically implemented and independently facilitated							
iii. Structured Debriefs for consumers are conducted							
iv. Consumers are involved in review of incidents							
v. Debriefs are documented in clinical notes							
vi. Debriefs for families are conducted where appropriate							
vii. Debriefs for staff are conducted by experienced facilitators							
viii. Outcomes of reviews are implemented into practice							
ix. A plan is in place to reduce or eliminate seclusion and restraint as part of quality improvement, over a specified timeframe							
x. Accurate records are kept and reviewed regarding all forms of restraint utilised							
xi. Staff are provided with training and skills regarding de-escalation techniques							

	SA	A	Evidence	D	SD	Action/Plan	NA
xii. Safe spaces are available for staff to undertake assessments xiii. Sensory or comfort rooms are readily available							
xiv. Systematic attention is paid to (identify, minimise or eliminate) service practices that could re-traumatise consumers							

E. Healthy and Effective Workforce*

Staff selection and retention, orientation, workforce development and training, wellbeing and supervision

All human resource development activities should: reflect an understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address the prevalence and impact of traumatic events.

Administrative policy should support accomplishment of the following goals:

- All employees, including administration, should receive orientation and basic education about the prevalence and impacts of interpersonal trauma and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduce harm, curriculums used for orientation and basic training should cover the dynamics of re-traumatisation and how insensitive practice can mimic original abuse, trigger trauma responses and cause further harm. All employees must also be educated about the impacts culture, race, ethnicity, gender, age, sexual orientation, disability and socio-economic status have on an individual's experience and perceptions of trauma and their unique ways of coping or healing.
- Direct-service staff and professionals providing 'clinical' care should be educated in a trauma-informed understanding of unusual or difficult presentations/behaviours; in the maintenance of personal and professional boundaries; in trauma dynamics and avoidance of iatrogenic [6] re-traumatisation; in the relationships between trauma and mental health symptoms, other life difficulties; and in vicarious traumatisation and self-care. They should apply trauma-informed approaches in their specific content areas (including crisis response), and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients. Curriculums and training programs for direct service and clinical staff should cover these matters.
- Input from and involvement of persons (consumers, carers and staff) with lived experience of trauma should be a part of all employee and staff trauma trainings. Staff whose work includes assessment and treatment should be required and supported to implement, or refer to services that can implement evidence-based and promising practices for the treatment of trauma. Whenever possible, training programs should be multi-service systems, inclusive of staff in mental health and substance abuse, suicide prevention and critical incident, health care, education, criminal justice, social services systems and agencies, and promoting systems collaboration, coordination and integration.

*All paid and voluntary roles in the operation of the organisation's mission

[6]Iatrogenic – Refers to a physical or mental condition caused by a physician or healthcare provider (e.g., iatrogenic disease) due to exposure to pathogens, toxins or injurious treatment or procedures. In this context the term refers to the re-traumatisation that may occur because an intervention mirrors an aspect or aspects of the original trauma experienced.

The Peer Workforce is an emerging workforce across mental health and human services. Whilst we draw a distinction between consumer/carer participation and peer workers, both roles in terms of participation are valued and encouraged in trauma-informed organisations.

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. Staff selection and orientation
Trauma-informed organisations select and prepare staff members who are able to a) implement the core values of the organisation and b) promote trauma-informed practice.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Questions reflecting the principles and values of a trauma-informed approach are asked at interview for all direct service provision staff							
ii. The staff selection process is transparent and accountable							
iii. During the staff selection process staff are made aware that they will be working with people who may have experienced trauma							
iv. Initial staff induction/ orientation includes principles of trauma-informed care and practice							
v. The staff selection and orientation process emphasises teamwork and respect for diversity amongst colleagues							
vi. All staff are provided with induction training or orientation to the organisation's values and practice approach, including familiarity with the principles of trauma-informed care and practice, prior to direct contact with consumers							

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:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Training and information about the prevalence and impacts of trauma							
ii. Training about the impacts of intergenerational trauma							
iii. Information and education regarding vicarious trauma and self-care							
iv. Information on healing and recovery from trauma							
v. Training in communication skills							
vi. Training in cultural competence and cultural safety							
vii. Training in valuing diversity and strengths, recognising discrimination and privilege							
viii. Training in relationship building and negotiating boundaries							
ix. Training in conflict resolution skills							
x. Training about responding to disclosures of trauma							
xi. Training about responding sensitively to stress							

	SA	A	Evidence	D	SD	Action/Plan	NA
xii. Training and policy guidance about responding to risk of harm to children and young people							
xiii. Training and policy guidance about responding to risk of harm to older or vulnerable adults							
xiv.Training about collaborative and strengths-based practice							
xv. Training about collaborative safety assessment and planning							
xvi. Information about consumer & carer support needs and referral processes							
xvii. Administrative and ancillary staff members are given trauma- informed training suitable to their roles							
xviii. Staff who have initial contact with consumers or families are all aware of the ways in which trauma can affect behaviour							
xix. All Staff who have direct contact with consumers and families/carers understand the concept of re-traumatisation and how to minimise the risk							

3. Workforce supervision and professional development
Trauma-informed organisations recognise that supervision and ongoing professional development are critical for safe and effective practice.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Staff at all levels can readily access reflective supervision that meets their needs and goals							
ii. All staff providing direct service receive clinical supervision that supports trauma-informed practice							
iii. There is a well-documented schedule of professional development activities for all staff							
iv. All staff can access professional development that recognises their individual learning needs and organisational goals							
v. Supervision includes awareness of the potential impact of a worker's prior trauma on direct service provision*							
vi. The purpose of supervision is clearly stated (and includes wellness and accountability)							
vii. Additional supervision or support is available to all staff after incidents							

4. Workforce wellbeing
Trauma- informed organisations recognise that the emotional and psychological wellbeing of the workforce benefits consumers, families and carers.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Self-care is discussed and encouraged in the workplace (workplace culture supports self-care and wellbeing)							
ii. The organisation has effective policies about the recognition and response to psychological harm that may occur in the context of employment including bullying and harassment							
iii. The organisation has a clear process for minimisation of risk, response to and management of vicarious trauma							
iv. Where possible flexible work practices and choices are accommodated							
v. Written material regarding work related stress and wellbeing are readily available							
vi. Staff have access to debriefing /support that suits their needs following a crisis/ incident							
vii. Staff who experience work related stress are supported appropriately/have choices regarding the support they can access							
viii. The organisation recognises that staff may have lived experience of trauma							
ix. Managers / supervisors demonstrate the importance of self-care							

5. Peer workers
Peer workers may have experienced trauma within the context of services or organisations that are similar to (or in fact the same as) the services they are now working with. Trauma reminders may be present and undermine their experience of safety in that environment or service.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. When participating in service delivery, the potential for distress related to prior experience (of contact with services) is acknowledged							
ii. Steps are taken to reduce the potential for re-experiencing trauma or distress when peer workers are involved in service delivery							
iii. Peer workers from diverse perspectives and groups are sought and valued							
iv. Peer workers are asked if they feel safe and supported in conducting their work							
v. Peer workers are asked if they feel safe to attend and participate in mandatory training							
vi. Peer workers have access to peer-specific supervision and supports							

F. Outcomes and Evaluation

Seeking and utilising consumer and carer/family feedback (outcomes/evaluation) for quality improvement

A trauma-informed organisation must conduct needs assessments, and evaluate service user satisfaction to monitor and make adjustments to trauma-informed and trauma-specific service approaches. Data on trauma prevalence, impacts, effectiveness of trauma services and consumer satisfaction can provide the rationale for funding for such services and the training necessary for their implementation. Such data should be collected regularly and used as part of ongoing quality improvement and planning processes. Evaluation and research activities should be carried out through internal staffing or liaison with external evaluators and researchers. This will determine the effectiveness of a systems change and identify outcomes of trauma-related services. Findings can be utilised and incorporated into ongoing service modifications and planning.

In the community managed sector, organisations are so diverse that they do not necessarily share a common indicator of program effectiveness. In the absence of an indicator, many funders try to understand an organisation's efficiency by monitoring overheads and other easily obtained (but often faulty) indicators. A trauma-informed organisation should be focused on demonstrating that their services are 'doing what they say they do'. Commonly, this is achieved through the use of outcome measurement tools or instruments which can be implemented in three steps:

1. Identification of outcome measurement tool(s) appropriate to the program
2. Training staff in the use of the selected tool(s) so that the collected data is valid
3. Routine implementation, collection, evaluation and reporting on outcome measurement.

In LHDs, trauma informed outcome measure quality improvement may involve using existing documentation and standardised measures in different ways that are more sensitive and/or specific to trauma, or include consumer co-design.

Response Key	SA	Strongly Agree	A	Agree	D	Disagree	SD	Strongly Disagree

1. Evaluation and quality improvement
Trauma- informed quality improvement processes systems must include service user evaluation from the consumer and carer perspective as well as from staff.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. Processes are in place to encourage and respond to feedback from consumers / carers and their families							
ii. Consumer feedback processes have identified service gaps, which are acknowledged by the organisation in visible ways							
iii. Evaluation about consumer/ carer service experience is sought and accepted in a range of ways (verbally, written, anonymously, focus groups etc.)							
iv. Consumer/carer evaluations are systematically collected, assessed and reported on							
v. Processes are in place to encourage evaluation feedback from staff members (which includes acknowledgement and response to comments about the services provided and any related matters, e.g. suggestions regarding any quality improvements in relation to recovery-oriented trauma-informed practice							

2. Outcomes of service
Trauma-informed services acknowledge that recovery is highly individually determined, and that consumers have a right to define a successful outcome of service.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. A range of outcomes for consumers are systematically collected and assessed at regular intervals							
ii. Consumers have an opportunity to define the outcomes that are important to them as individuals							
iii. Outcomes for carers are routinely assessed							
iv. Consumer representative/s and peak bodies are consulted in regards to defining and measuring outcomes							

3. Complaints
Trauma- informed systems recognise power differences between consumers, carers/families and services and how those differences can make making a complaint, difficult. Trauma-informed services ensure that feedback/complaints can be delivered in a variety of ways and that it is received effectively and respectfully.

In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. There is a documented complaints process accessible to consumers and carers/ family							
ii. Complaints can be made and accepted in a range of ways							
iii. All consumers are made aware of the complaints processes							
iv. All staff are made aware of the complaints processes							
v. The outcomes (action/ resolution) of complaints are clearly documented							
vi. The complaints process is easy for staff to access							
vii. The complaints process is easy for carers/family to access							
viii. Complaints are documented and responded to in a timely way							

4. Processes for feedback from consumers, carers/family and staff. *Trauma- informed systems recognise that people may have difficulty providing feedback or making a complaint and that feedback can be routinely elicited and responded to effectively and respectfully.*							
In the organisation:	SA	A	Evidence	D	SD	Action/Plan	NA
i. The organisation values and utilises consumer feedback about service practices							
ii. The organisation values and utilises carer/family feedback about service practices							
iii. The organisation invites feedback from consumers, staff and carers/family in a variety of ways (i.e. in writing, verbally, in focus groups etc.)							
iv. Feedback about service provision is sought at regular intervals							
v. When policies are reviewed the organisation seeks and responds to input from consumers, staff and carers/ family *							
vi. When policies and programs are reviewed and revised, consumers and carers are sought to engage in co-design and development activities							
vii. Consumers, staff and carers/family are formally notified of the outcomes or changes as a result of their feedback *							

* Includes documentation, sharing with others, formal reporting

Make multiple copies as required

Trauma-informed quality improvement change required - Recording Form

Item (e.g. A.2.iii)		Personal / team responsible	Date commenced
Change required	Action(s) planned:		
	Barriers identified:		
	Resources required:		
Change required	Action(s) planned:		
	Barriers identified:		
	Resources required:		
Change required	Action(s) planned:		
	Barriers identified:		
	Resources required:		

Bibliography

Australian Health Ministers 2003, *National Mental Health Plan 2003–2008*, Commonwealth of Australia, Canberra, ACT.

Australian Health Ministers' Advisory Council 2013, *A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory*, Commonwealth of Australia, Canberra, ACT, pp. 17-24.

Bloom, SL 1997, *Creating Sanctuary: Toward the Evolution of Sane Societies*, New York, Routledge.

Bloom, SL 2006, *Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation, white paper for the National Technical Assistance Center for State Mental Health Planning* (NTAC), National Association of State Mental Health Program Directors, p.81. Available from: http://www.sanctuaryweb.com

Bloom, SL, Bennington-Davis, M, Farragher, B, McCorkle, D, Nice-Martini, K & Wellbank, K 2003, 'Multiple Opportunities for Creating Sanctuary', *Psychiatric Quarterly*, vol. 74, no. 2, pp. 173-190.

Bloom, SL & Farragher, B 2013, Restoring Sanctuary: *A New Operating System for Trauma-Informed Systems of Care*, Oxford University Press, New York, NY.

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.

Bride, B 2004, 'The Impact of Providing Psychosocial Services to Traumatized Populations', *Trauma and Crisis*: An International Journal, vol. 7, no. 1, pp. 29-46.

Campling, P 2001,'Therapeutic Communities', *Advances in Psychiatric Treatment*, vol.7, pp.365–372.

Celever, SL, Ford, DE, Rubenstein, LV, Rost, KM, Meredith, LS, Sherbourne, CD, Wang, NY, Arbalaez, JJ & Cooper, LA 2006, 'Primary Care Patients' Involvement in Decision-Making is Associated with Improvement in Depression', *Med Care*, vol. 44, no. 5, pp.398–403.

Coates, D & MHCC 2009, 'Working with Adult Survivors of Child Abuse', *ASCA Workshop,* manual, MHCC, Lilyfield, NSW.

Cocozza, JJ, Jackson, EW & Hennigan, K, Morrissey, JP, Reed, BG, Fallot, R & Banks, S 2005, 'Outcomes for Women with Co Occurring Disorders and Trauma: Program-Level Effects', *Journal of Substance Abuse Treatment*, vol. 28, no. 2, pp 109–119.

Community Connections 2002, 'Trauma and Abuse in the Lives of Homeless Men and Women', PowerPoint presentation, Washington, DC.

Community Connections 2003, 'Final Report: Trauma-Informed Pilot Project at the Rumford (Maine) Unit of Tri-County Mental Health Services', report, *Community Connections*, Parramatta, NSW.

Cozolino, L 2002, *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*, W.W. Norton & Co., New York, NY.

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

Department of Health and Ageing 2010, *National Standards for Mental Health Services 2010*, Commonwealth of Australia, Canberra, ACT. Available: http://www.health.gov.au/internet/main/publishing.nsf/content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

Department of Social Services 2013, *National Standards for Disability Services*, DSS, Greenway, ACT. Available from: http://www.dss.gov.au/sites/default/files/documents/12_2013/nsds_web.pdf

Doidge, N 2007, *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Neuroscience*, Viking, New York, NY.

Domino, ME, Morrissey, JP, Chung, S, Huntington, N, Larson, MJ & Russell, LA 2005, 'Service Use and Costs for Women with Co Occurring Mental and Substance Use Disorders and a History of Violence', Psychiatric Services, vol. 56, no. 10, p. 1223–1232.

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 and http://www.academia.edu/19422672/Creating_Cultures_of_Trauma-Informed_Care_CCTIC_A_Fidelity_Scale

Figley, C 1995, 'Compassion Fatigue', New York: Brunner/Mazel.

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

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

Institute for Health and Recovery 2012, *Developing Trauma-Informed Organizations: A Tool Kit*, 2nd edn, Institute for Health and Recovery, Inc., Cambridge, MA, p.3.

Interrelate 2013, 'Peer Workforce in Mental Health: Part 1: Proposal to Develop an International Consensus to the International Initiative for Mental Health Leadership (IIMHL)', National Empowerment Center (NEC), Lawrence, MA.

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://www.theannainstitute.org/MDT. pdf, p.6.

Kammerer, N (n.d.) 'Project RISE Evaluation Report', unpublished program evaluation report, Health and Addictions Research Inc and Health Institute for Recovery, Boston, MA.

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.

Krug, EG, Dahlberg, LL Mercy, JA, Zwi, AB & Lozano, R (eds) 2002, *World Report on Violence and Health*, World Health Organisation, Geneva.

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.

Mental Health Coordinating Council 2012, *Recovery Oriented Service Self-Assessment Toolkit*, MHCC, Rozelle, NSW.

Mental Health Coordinating Council 2013, T*rauma-Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia – A National Strategic Direction*. Available from: http://www.mhcc.org. au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.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), MHCC, Sydney, NSW. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

MHCC Website: Trauma-informed Care & Practice, General Information and Resources: Available from: General Information: http://www.mhcc.org.au/policy-advocacy-reform/influence-and-reform/trauma-informed-care-and-practice-a-national-strategic-direction.aspx.

Morrison, Z 2007, ''Feeling Heavy': Vicarious Trauma and Other Issues Facing Those Who Work in the Sexual Assault Field', ACSSA Wrap no. 4, Australian Centre for the Study of Sexual Assault, Melbourne, VIC. Available from: http://www.aifs. gov.au/acssa/pubs/wrap/w4.html#what

Morrissey, JP, Ellis, AR, Gatz, M, Amaro, H, Reed, BG, Savage, A, Finkelstein, N, Mazelis, R, Brown, V, Jackson, EW & Banks S 2005, 'Outcomes for Women with Co-Occurring Disorders and Trauma: Program and Person-Level Effects', *Journal of Substance Abuse Treatment*, 2005, vol. 28, no. 2, p. 121–133.

Morrissey, JP, Jackson, EW, Ellis, AR, Amaro, H, Brown, VB & Najavits, LM 2005, 'Twelve-Month Outcomes of Trauma-Informed Interventions for Women with Co-Occurring Disorders', *Psychiatric Services*, vol. 56, no. 10, p. 1213–1222.

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.

Mouldern, HM & Firestone, P 2007, 'Vicarious Traumatization: The Impact on Therapists Who Work with Sexual Offenders', *Trauma, Violence & Abuse*, vol. 8, no. 1, pp. 67-83.

NADA & MHCC 2009, 'Module 5: Self-Care and Review', *No Wrong Door: Mental Health Drug & Alcohol Change Management Project*, Lilyfield, NSW.

Palmer, SE, Brown, RA, Rae-Grant, NI & Loughin, MJ 2001, 'Survivors of Childhood Abuse: Their Reported Experiences with Professional Help', *Social Work*, vol. 46, no. 2, pp. 136-145.

Pryce, JG, Shackelford, KK & Price, DH 2007, *Secondary Traumatic Stress and the Child Welfare Professional*, Lyceum Books, Inc., Chicago, IL.

Rog, DJ, Holupka, CS & McCombs-Thornton, KL 1995, 'Implementation of the Homeless Families Program 1: Service Models and Preliminary Outcomes', *American Journal of Orthopsychiatry*, vol. 65, no. 4, p. 502–513.

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

Ross, CA & Halpern, N 2009, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity*, Manitou Communications, Inc., Richardson, TX.

SAMHSA National Center for Trauma-Informed Care (NCTIC), Rockville, MD. Available from: http://www.samhsa.gov/nctic/

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

State of Victoria, Department of Health 2013, *National Practice Standards for the Mental Health Workforce 2013*, Victorian Government Department of Health, Melbourne, VIC. Available: https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13

Steward, 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.

Substance Abuse and Mental Health Services Administration 2003, *The Women, Co-Occurring Disorders and Violence Study and Children's Subset Study*, SAMHSA, Rockville, MD.

Tait, L & Lester, H 2005, 'Encouraging User Involvement in Mental Health Services', *Advances in Psychiatric Treatment*, vol. 11, pp. 168–175.

TAFE Courses Online, Archived, *What is Cultural Safety*, TAFE. Available from: http://www.culturalsafetytraining.com.au/home8/what-is-cultural-safety

The National Child Traumatic Stress Network 2013, *Secondary Traumatic Stress*, NCTSN, Rockville, MD. Available from: http://www.nctsn.org

The Transformation Center n.d., *Trauma-Sensitive Care*, Roxbury, MA. Available from: http://www.transformation-center.org

Wasco, SM, Campbell, R & Clark, M 2002, 'A Multiple Case Study of Rape Victim Advocates' Self-Care Routines: The Influence of Organizational Context', *American Journal of Community Psychology*, vol. 30, no. 5, pp. 731-60.

Appendix A

Key Terms

A Carer is a person who provides ongoing care or assistance to another person who requires assistance with everyday tasks because of age, disability, chronic illness, frailty, or pain. Carers include, for example, parents, partners, children, family members and/or friends of the consumer. [55]

A Consumer is a person with lived experience of mental health condition who is accessing or has previously accessed a mental health service.. [56] Within a child and youth mental health context, both the parents and the child or young person may also be described as consumers. However the term means far more than being a user of a service, it also recognises the freedom of choice that people who use services have over their health and wellbeing (Watson, 2009).

A 'consumer' is a person with personal lived experience of mental illness or distress who exercises freedom of choice over their mental health and wellbeing. (Watson, 2009)

Complex need [7] 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 (emotional, physical and/or sexual abuse), as well as other types of interpersonal trauma experienced in childhood, including but not limited to chronic neglect and the effects of family violence. These individuals are often described as having complex needs.

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 includes 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. [57] [58]

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." [59] It reminds us that people who do not belong to the dominant culture may have been subject to oppression, abuse or discrimination.

---

[7] 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

Cultural competence [8] 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 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). [60]

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.

Interpersonal violence has been defined by the World Health Organisation (WHO) *as the intentional use of physical force, or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has a likelihood of resulting in, injury, death, psychological harm, mal-development or deprivation* (WHO, Krug et al., 2002 p 5). This definition includes victimisation perpetrated against intimate partners, parents, siblings, children, other relatives, friends, acquaintances, colleagues and strangers. [61] It should be noted that interpersonal violence is often gendered and primarily experienced by women, with marginalised groups also being at greater risk, including but not limited to LGBTQI people and Aboriginal and Torres Strait Islander people and people with disabilities.

Peer work, peer workers and peer workforce includes all workers in public or community based mental health services or initiatives who are employed to openly identify and use their lived experience of mental health conditions as part of their work. Peer support workers provide support for personal and social recovery to people with mental health problems, including in acute mental health services, housing, supported employment, community support and so on. [62] Peer work is the fastest growing occupational group in the mental health workforce. Peer services are a core component of a genuinely recovery oriented service.

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.

---

[8] 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.

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. [63]

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. [64]

Endnotes

[1] SAMHSA National Center for Trauma-Informed Care (NCTIC), Rockville, MD. Available from: http://www.samhsa.gov/nctic/
[2] Ibid.
[3] SEE Key terms - Complex Trauma, Appendix A (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; Courtois, CA & Ford, JD (eds) 2009, 'Treating Complex Trauma: An Evidence-Based Guide', New York, The Guildford Press.)
[4] Op cit., Kezelman, C & Stavropoulos. P 2012; Courtois, C A & Ford, J D (eds) 2009.
[5] Doidge, N 2007, 'The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Neuroscience', Viking, New York, NY; Cozolino, L 2002, 'The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain', W.W. Norton & Co., New York, NY.
[6] Covington S 2008, Women and Addiction: A Trauma-Informed Approach, Journal of Psychoactive Drugs, SARC Supplement 5, November 2008, 377-385.
[7] Anda, R.F., Brown, D.W., Dube, S.R., Bremner, J.D., Felitti, V.J, and Giles, W.H 2008, Adverse childhood experiences and chronic obstructive pulmonary disease in adults, American Journal of Preventive Medicine, 34(5), 396-403.11; Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., and Anda, R.F 2003, Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study, Pediatrics, 111(3), 564-572.12.
[8] SAMJSA 2014, Concept of Trauma and guidance for a Trauma-Informed Approach, U.S. Department of Health and Human Services, p.2.
[9] 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. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf
[10] Bloom, S, 1997, 'Creating Sanctuary: Toward the Evolution of Sane Societies', New York, Routledge, Available: http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/trauma-informed-care-and-practice.aspx
[11] SAMJSA 2014, Concept of Trauma and guidance for a Trauma-Informed Approach, U.S. Department of Health and Human

Services, p.4.

[12] Bloom, S. L., and Farragher, B 2011, 'Destroying sanctuary: the crisis in human services delivery systems', New York: Oxford University Press; Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bassuk, E 2009, Trauma-In-formed Organizational Toolkit, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network and the W.K. Kellogg Foundation.

[13] Op cit, Bloom, S. L., and Farragher, B 2011; Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bassuk, E 2009; Dekel, S., Ein-Dor, T., and Zahava, S 2012, Posttraumatic growth and posttraumatic distress: A longitudinal study, Psychological Trauma: Theory, Research, Practice, and Policy, 4(1), 94-101.28.

[14] 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 http://www.academia.edu/19422672/Creating_Cultures_of_Trauma-Informed_Care_CCTIC_A_Fidelity_Scale

[15] Ibid.

[16] Herman, J 2001, 'Trauma and Recovery: The Aftermath of Violence – from Domestic Abuse to Political Terror', Pandora, UK.

[17] Op cit, Fallot, RD & Harris, M 2009.

[18] Principles identified and adapted based on knowledge about trauma, its prevalence and 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); Fallot, RD & Harris, M 2009, Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol, Community Connections, Washington, DC. Available from: http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf
and 'The Sanctuary Model' developed by 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.

[19] Institute for Health and Recovery 2012, Developing Trauma-Informed Organizations: A Tool Kit, 2nd edn, Institute for Health and Recovery, Inc., Cambridge, MA, p.3.

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

[21] Pearlman, LA & Caringi, J 2009, 'Living and Working Self-Reflectively to Address Vicarious Trauma', in CA Courtois & JD Ford (eds), Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide, (pp. 202–224). Guildford Press, New York, NY.

[22] Ross, CA & Halpern, N 2009, Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity, Manitou Communications, Inc., Richardson, TX.

[23] Pryce, JG, Shackelford, KK & Price, DH 2007, 'Secondary Traumatic Stress and the Child Welfare Professional', Lyceum Books, Inc., Chicago, IL.

[24] Bride, B 2004, The Impact of Providing Psychosocial Services to Traumatized Populations, Trauma and Crisis: An International Journal, vol. 7, no. 1, pp. 29-46.

[25] 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://www.theannainstitute.org/MDT.pdf, p.6.

[26] The National Child Traumatic Stress Network 2013, Secondary Traumatic Stress, NCTSN, Rockville, MD. Available from: http://www.nctsn.org

[27] Figley, C 1995, 'Compassion Fatigue', New York: Brunner/Mazel.

[28] Palmer, SE, Brown, RA, Rae-Grant, NI & Loughin, MJ 2001, Survivors of Childhood Abuse: Their Reported Experiences with Professional Help, Social Work, vol. 46, no. 2, pp. 136-145; Coates, D & MHCC 2009, Working with Adult Survivors of Child

Abuse, ASCA Workshop, manual, MHCC, Lilyfield, NSW; Palmer, SE, Brown, RA, Rae-Grant, NI & Loughin, MJ 2001, Survivors of Childhood Abuse: Their Reported Experiences with Professional Help, Social Work, vol. 46, no. 2, pp. 136-145.

[29] Ibid, Palmer, SE, Brown, RA, Rae-Grant, NI & Loughin, MJ 2001; Coates, D & MHCC 2009, 'Working with Adult Survivors of Child Abuse', ASCA Workshop, manual, MHCC, Lilyfield, NSW.

[30] Mouldern, HM & Firestone, P 2007, 'Vicarious Traumatization: The Impact on Therapists Who Work with Sexual Offenders', Trauma, Violence & Abuse, vol. 8, no. 1, pp. 67-83.

[31] Wasco, SM, Campbell, R & Clark, M 2002, A Multiple Case Study of Rape Victim Advocates' Self-Care Routines: The Influence of Organizational Context, American Journal of Community Psychology, vol. 30, no. 5, pp. 731-60.

32 NADA & MHCC 2009, Module 5: Self-Care and Review, No Wrong Door: Mental Health Drug & Alcohol Change Management Project, Lilyfield, NSW.

[33] Morrison, Z 2007, 'Feeling Heavy': Vicarious Trauma and Other Issues Facing Those Who Work in the Sexual Assault Field, ACSSA Wrap no. 4, Australian Centre for the Study of Sexual Assault, Melbourne, VIC. Available from: http://www.aifs.gov.au/acssa/pubs/wrap/w4.html#what

[34] Substance Abuse and Mental Health Services Administration 2003, The Women, Co-Occurring Disorders and Violence Study and Children's Subset Study, SAMHSA, Rockville, MD.

[35] Hopper, EK, Bassuk, EL & Olivet, J 2010, Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, The Open Health Services and Policy Journal, vol. 3, pp. 80–100. Available from: http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf

[36] Cocozza, JJ, Jackson, EW & Hennigan, K, Morrissey, JP, Reed, BG, Fallot, R & Banks, S 2005, Outcomes for Women with Co-Occurring Disorders and Trauma: Program-Level Effects, Journal of Substance Abuse Treatment, vol. 28, no. 2, pp 109–119; Morrissey, JP, Ellis, AR, Gatz, M, Amaro, H, Reed, BG, Savage, A, Finkelstein, N, Mazelis, R, Brown, V, Jackson, EW & Banks S 2005, Outcomes for Women with Co-Occurring Disorders and Trauma: Program and Person-Level Effects, Journal of Substance Abuse Treatment, 2005, vol. 28, no. 2, p. 121–133.

[37] Kammerer, N (n.d.)2015, Project RISE Evaluation Report, unpublished program evaluation report, Health and Addictions Research Inc and Health Institute for Recovery, Boston, MA.

[38] Morrissey, JP, Jackson, EW, Ellis, AR, Amaro, H, Brown, VB & Najavits, LM 2005, Twelve-Month Outcomes of Trauma-Informed Interventions for Women with Co-Occurring Disorders, Psychiatric Services, vol. 56, no. 10, p. 1213–1222.

[39] Rog, DJ, Holupka, CS & McCombs-Thornton, KL 1995, Implementation of the Homeless Families Program 1: Service Models and Preliminary Outcomes, American Journal of Orthopsychiatry, vol. 65, no. 4, p. 502–513.

[40] Ibid, Kammerer, N (n.d.) 2015

[41] Community Connections 2002, Trauma and Abuse in the Lives of Homeless Men and Women, PowerPoint presentation, Washington, DC.

[42] Domino, ME, Morrissey, JP, Chung, S, Huntington, N, Larson, MJ & Russell, LA 2005, Service Use and Costs for Women with Co-Occurring Mental and Substance Use Disorders and a History of Violence, Psychiatric Services, vol. 56, no. 10, p. 1223–1232.

[43] Hopper, EK, Bassuk, EL & Olivet, J 2010, Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings, The Open Health Services and Policy Journal, vol. 3, pp. 80-100. Available from: http://homeless.samhsa.gov/ResourceFiles/cenfdthy.pdf

[44] Op cit., Community Connections 2002.

[45] Jennings, A (ed.) 2004, The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System, National Association of State Mental Health Program Directors (NASMHPD) and National Technical Assistance Center for State Mental Health Planning (NTAC), Alexandria, VA.

[46] Community Connections 2003, Final Report: Trauma-Informed Pilot Project at the Rumford (Maine) Unit of Tri-County Mental Health Services, Report, Community Connections, Parramatta, NSW.

[47] 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. Available from: http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf

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

[49] Bloom, SL, Bennington-Davis, M, Farragher, B, McCorkle, D, Nice-Martini, K & Wellbank, K 2003, 'Multiple Opportunities for Creating Sanctuary', Psychiatric Quarterly, vol. 74, no. 2, pp. 173-190.

[50] Bloom, SL 2006, Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation, white paper for the National Technical Assistance Center for State Mental Health Planning (NTAC), National Association of State Mental Health Program Directors, p.81. Available from: http://www.sanctuaryweb.com

[51] NSDS 1 – Rights: The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.

[52] NSMHS 2.1 - The organisation promotes the optimal safety and wellbeing of the consumer in all mental health settings and ensures that the consumer is protected from abuse and exploitation.

[53] Steward, 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, pp. 168–175.

[54] Australian Health Ministers' Advisory Council 2013, A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory, Commonwealth of Australia, Canberra, ACT, pp. 17-24; and NSMHS 10.1.4.

[55] Celever, SL, Ford, DE, Rubenstein, LV, Rost, KM, Meredith, LS, Sherbourne, CD, Wang, NY, Arbalaez, JJ & Cooper, LA 2006, 'Primary Care Patients' Involvement in Decision-Making is Associated with Improvement in Depression', Med Care, vol. 44, no. 5, pp.398–403.

[56] Australian Health Ministers 2003, National Mental Health Plan 2003–2008, Commonwealth of Australia, Canberra, ACT.

[57] 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.

[58] Courtois, CA. & Ford, JD (eds) 2009, Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide, The Guildford Press, New York, NY.

[59] TAFE Courses Online n.d., What is Cultural Safety, archived, TAFE. Available from: http://www.culturalsafetytraining.com.au/home8/what-is-cultural-safety

[60] State of Victoria, Department of Health 2013, National Practice Standards for the Mental Health Workforce 2013, Victorian Government Department of Health, Melbourne, VIC.

[61] Krug, EG, Dahlberg, LL Mercy, JA, Zwi, AB & Lozano, R (eds) 2002, World Report on Violence and Health, World Health Organisation, Geneva.

[62] Interrelate 2013, 'Peer Workforce in Mental Health: Part 1: Proposal to Develop an International Consensus to the International Initiative for Mental Health Leadership (IIMHL)', National Empowerment Center (NEC), Lawrence, MA.

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

[64] 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

Ross, CA & Halpern, N 2009, Trauma Model Therapy: A Treatment Approach For Trauma, Dissociation And Complex Comorbidity, Manitou Communications, Inc., Richardson, TX.

Mental Health Coordinating Council
Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

For further information please contact:

Corinne Henderson
Principal Advisor / Policy & Legislative Reform
Tel: (02) 9555 8388 #101
E: corinne@mhcc.org.au