

Trauma-informed care and practice in mental health services across NSW

Diagnostic report

September 2020

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Executive summary

Trauma-informed care and practice is an approach that represents a re-conceptualisation of traditional approaches to health and human service delivery, whereby all aspects of services are organised around an acknowledgement of the prevalence of trauma throughout society, including in the lives of people who access mental health 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 everyone accessing services.

Much of the literature internationally refers to trauma-informed care and practice as trauma-informed care or a trauma-informed approach. Therefore, for the purposes of this report, the authors use the acronym TIC or a trauma-informed approach, which builds on existing good mental healthcare that is person-centred, person-directed and recovery-oriented.

This project supports the premise that there is clear evidence of the benefits of TIC for consumers, carers, staff and services.

This report summarises experiential and observational data collected across mental health services in NSW in an effort to understand 'what needs to happen' to become trauma-informed. Experiential data collected in this report have been informed by the experiences of consumers, carers, mental health clinicians and other practitioners and managers. Observational data obtained in this report has been captured from a small number of declared mental health facilities in NSW. The findings in this report highlight that there are opportunities to implement a trauma-informed approach for mental health services across NSW, and that this can occur within existing practice and service structures. The report also identifies recommendations for future change. It demonstrates that there is a need for enhanced consumer, carer and clinician collaboration, a stronger emphasis on safety for both consumers and staff, a need and desire for TIC education, and for TIC to be seen as a lens through which new and improved models of mental health service delivery should be viewed.

The report highlights that there is a need for the experiences of Aboriginal consumers to be heard and for TIC to be culturally safe and sensitive to Aboriginal concepts of 'social and emotional wellbeing'. Aboriginal consumers have emphasised the importance of cultural connectedness to mental health and the urgent need for mental health services to recognise this.

Content warning

Some of the experiences reported in this document may be distressing. Distressing content includes examples of offensive or harmful language and reports of traumatic experiences in care. If you think you may become distressed by reading this content, we would encourage you to consider not reading any further or to seek support. Resources can be found at the end of this document.

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Introduction

Trauma-informed care (TIC) is an approach to care and service delivery that acknowledges the prevalence and impacts of trauma in the lives of people accessing care. It also seeks to minimise trauma and re-traumatisation and provide responsive care informed by evidence of best practice related to trauma (see Box 1).¹

A trauma-informed organisational approach is designed to improve experiences of services for those accessing them.¹ At the core of TIC is the acknowledgement that 'universal precautions' towards trauma are a best practice approach in service provision. These should be informed by the key principles of TIC which include trustworthiness, choice, collaboration, safety and empowerment.^{2,3} TIC is a strengths-based approach that reflects the principles of recovery-oriented and person-centred care. It is grounded in an understanding of the neurological, biological, psychological and social effects of trauma and recognises that services that are not trauma-informed can inadvertently mirror experiences of past trauma through dynamics of power and control.⁴ TIC includes acknowledgement of trauma in the lives of care providers as well as those receiving care, their families and support persons.

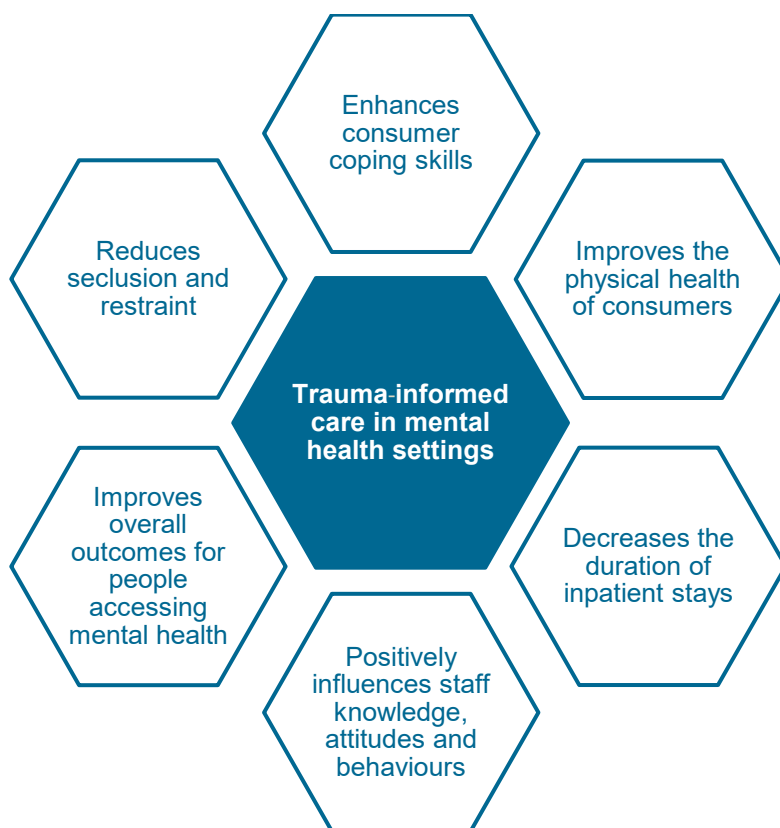
Box 1: SAMHSA model of a trauma-informed approach: the four Rs

- Realise the widespread impact of trauma and understands potential paths for recovery
- Recognise the signs and symptoms of trauma in clients, families, staff and others involved with the system
- Respond by fully integrating knowledge about trauma into policies, procedures and practices
- Resist re-traumatisation

The recent evidence review report, *Trauma-informed care and mental health in NSW*, published by the Agency for Clinical Innovation (ACI) found that TIC in mental health settings may:

- enhance consumer coping skills, improve physical health, decrease the duration of inpatient stays and improve overall outcomes for consumers
- influence staff knowledge, attitudes and behaviours
- reduce seclusion and restraint
- lead to a reduction in post-traumatic stress and general mental health symptoms
- positively influence experiences of care.⁵

Figure 1. Trauma-informed care and mental health in NSW summary



Purpose of this document

Although TIC is increasingly included within policies, guidelines and frameworks for mental health services in Australia and internationally, it is often unclear what is specifically required for services to become trauma-informed. While services across NSW have expressed that they recognise the need to become trauma-informed, there is a lack of consistency in an approach to implementation that can hamper genuine efforts to bring about change.

The recent evidence review highlighted emerging evidence that TIC can improve outcomes for consumers, staff and services.

Experiential evidence collected by the ACI indicates that consumers of mental health services in NSW feel that mental healthcare is generally not trauma-informed.

This aim of this report is to describe the experience of consumers, carers, clinicians and managers who generously agreed to share their experiences of mental health services in NSW. Nevertheless, it may not be representative of the experiences of all individuals or services across contexts.

The findings provide a valuable insight and evidence that TIC can improve outcomes for consumers and the experience of care for consumers, carers and staff.

Ethical approval

The information and data collected in this report have been approved by the Ethics Review Committee CRGH Zone of the Sydney Local Health District. The information and data collected at the Aboriginal Medical Service have been approved by the Aboriginal Health and Medical Research Council.

Methods (experiential evidence)

Data collection

The aim of this report is to describe the experiences of mental health services across NSW from the perspectives of consumers, carers and staff, with a focus on what is required to make services more trauma informed. A consumer and clinician co-design and co-production approach was undertaken to review the evidence review report survey results and identify what issues or problems required a more thorough understanding.⁵ These issues were then incorporated into interview and focus group questions that sought to explore ways for services to become more trauma informed. These questions were used in clinician focus groups, manager interviews, consumer focus groups and a carer focus group.

Clinician focus groups

A total of six clinician focus groups were facilitated across three local health districts (LHDs), including two rural and regional LHDs and one metropolitan LHD. Clinician focus groups included participants (n=64) from various public mental health settings: community mental health, inpatient mental health, consultation liaison psychiatry, education and training, eating disorders, child and adolescent psychiatry, early psychosis, rapid response teams, and other specialised mental health programs. All clinician focus groups were facilitated by a mental health clinician and consumer using a co-design approach.

- Three LHDs (two rural/regional, one metropolitan)
- Total of n=6 clinician focus groups
- Total of n=64 participants
- Community and inpatient mental health staff.

Focus groups were approximately 60 minutes in duration. There was a total of 24 open-ended questions that were based on the 2018 survey results and the principles of TIC and practice.

Environmental audit (snapshot)

The environmental observational audit was conducted at three sites across NSW to determine the characteristics of a trauma-informed approach in the physical environments of units and consider opportunities to align them more broadly to TIC principles. The *15 Steps Challenge Observational Audit* was used as the guiding framework.⁶ This was developed by the NHS Institute of Innovation and Improvement specifically for inpatient mental health settings to help understand service user and carer experiences of the environment. All environmental audits were undertaken using a co-design approach.

A total of three environmental observational audits were conducted across two LHDs. Two of the environmental observation audits were conducted in mental health units that were older than 10 years and one of the audits was conducted in a mental health unit that was less than five years old.

- Two LHDs (metropolitan and outer regional)
- Total of n=3 mental health units.
- Two acute adult mental health units older than 10 years old, one acute adult mental health unit less than five years old.

Carer focus group

One carer focus group was conducted that included 10 carers. One carer came from a rural area, one from a regional area and eight from a metropolitan area. Participants identified as being a

carer for one or more family members living with a mental health condition, who had either accessed public inpatient, community mental health services or both, or community managed mental health services. Each carer focus group was facilitated by a clinician, a consumer and an Aboriginal practitioner using a co-design approach. Additionally, the clinician disclosed having a lived experience as a mental health carer.

- One carer focus group
- Total of n=10 carers (two rural/regional and eight metropolitan participants).

The focus group was approximately 60 minutes in duration. A total of nine open-ended questions were asked based on the 2018 survey results and the principles of TIC and practice.

Consumer focus group

Of the two consumer focus groups totalling 10 consumers of mental health services, participants included two regional consumers and eight metropolitan consumers. All consumers identified as having accessed either acute public and community mental health services or both, and non-government community managed mental health services or private mental health services. The consumer focus group was facilitated by a clinician, a consumer and a clinician who is an Aboriginal practitioner in a co-design approach.

- Total of n=2 consumer focus groups
- Total of n=10 participants (two regional and eight metropolitan participants).

The focus group was approximately 60 minutes in duration. A total of 10 open-ended questions were asked based on the 2018 survey results and informed by the principles of TIC and practice.

Aboriginal Medical Service consumer focus group

One consumer focus group was located at a metropolitan Aboriginal Medical Service (AMS) with a total of five female participants. The participants identified as Aboriginal and had accessed acute public and/or community mental health services as well as non-government community managed mental health services or private mental health services. The consumer focus group was undertaken by two Aboriginal clinicians.

- Total of n=1 focus group
- Total of n=5 participants (all metropolitan participants).

The focus group was approximately 60 minutes in duration. A total of 10 open-ended questions were asked based on the 2018 survey results and informed by the principles of TIC and practice.

Manager interviews

A total of nine mental health managers were interviewed across NSW. Six managers were from a metropolitan LHD and three from a rural or regional LHD. The managers were from diverse operational and professional backgrounds and included: an operational nurse manager, district director, director of clinical services, district senior social worker, district director of psychology, senior occupational therapy manager, community partnership manager, operations manager, and a district medical director. The manager interviews were undertaken by a clinician.

- Total of n=9 manager interviews
- Total of three LHDs.

The manager interviews were approximately 60 minutes in duration. A total of 12 open-ended questions were asked based on the 2018 survey results and informed by the principles of TIC and practice.

Data analysis

Focus groups

All focus groups and interviews were audio recorded and transcribed verbatim. The transcripts were de-identified and coded manually or with NVivo software. All data analysis, including the transcripts, were carefully explored against the principles of TIC with a content analysis approach. Themes were identified by synthesising and analysing the codes and in consultation with a wider advisory group.

Environmental audit (snapshot)

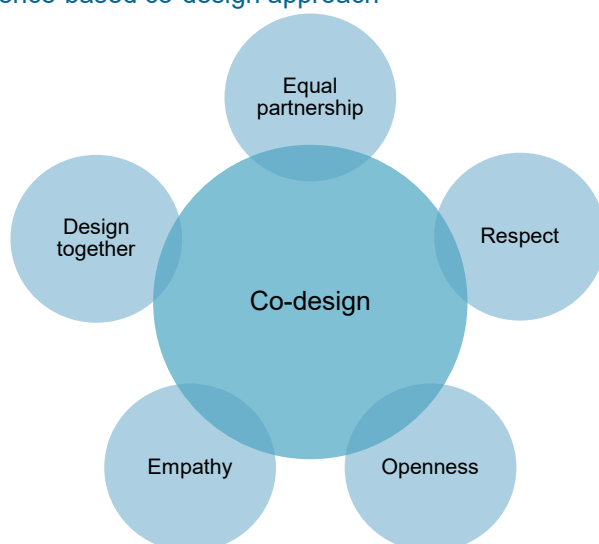
Observational field note data were documented and an in-depth analysis undertaken. A content analysis approach was used to consider opportunities for improvement.

Co-design method

The project used an experience-based co-design approach through all phases. Co-design acknowledges the strengths and importance of all stakeholders in understanding the problem. It is based on the five principles of experience-based co-design.⁷

- **Equal partnership** through the acknowledgement that all stakeholders are equally heard, with shared ownership and control. All stages of the project were owned and controlled by a group of individuals with a mix of clinical and lived experience.
- **Openness** through working together and learning together. Workshops were co-delivered and time was spent developing and examining all aspects of the project within collaborative relationships.
- **Respect** through uniquely valuing the views and experiences of each stakeholder. In this report, the voices and experiences of care recipients, family members and care providers are valued equally.
- **Empathy** is establishing and maintaining an environment that is safe and brings strength to all. All stages of the project were guided by the principles of TIC to ensure interpersonal and procedural safety.
- **Design together** is ensuring that all stakeholders work to design, implement and evaluate. All aspects of the project were developed iteratively in collaboration with stakeholders.

Figure 2. Experience-based co-design approach



Findings

This section will briefly summarise the findings from the data analysis, including the themes that were derived from the carer focus groups, consumer focus groups, Aboriginal consumer focus

groups, clinician focus groups, manager interviews and the environmental audits. The second part of this section will expand on these findings in more detail.

Focus group	Summary of findings (themes)
Carers	<ul style="list-style-type: none"> • Collaborating with carers • Engaging carers in care • Ensuring safety for consumers and carers • Creating a welcoming environment • Protecting human rights (see Figure 3. Carer focus group themes)
Consumers	<ul style="list-style-type: none"> • Delivering a diversity of models • Practising with consistency and continuity • Promoting collaboration and choice • Providing safe and therapeutic environments • Having awareness of trauma (see Figure 4. Consumer focus group themes)
Consumers: Aboriginal Medical Service	<ul style="list-style-type: none"> • Providing Aboriginal-led mental health services • Being heard and listened to without judgement • Fostering cultural connectedness • Supporting Aboriginal mental health workers • Prioritising cultural safety (see Figure 5. Consumer Aboriginal Medical Service focus group themes)
Clinicians	<ul style="list-style-type: none"> • Having awareness of staff wellbeing • Supporting different ways of working • Focusing on workplace culture • Increasing resources (see Figure 6. Clinician focus group themes)
Managers	<ul style="list-style-type: none"> • Clarity of TIC concept and actions • Leadership at all levels • Relevant and accessible training • Support for staff • Resolution of wider system issues (see Figure 7. Manager focus group themes)

Carer focus group (detailed findings)

Figure 3. Carer focus group themes



Collaborating with carers

'The use of seclusion and restraint – I have witnessed it in a way where I think that could have been de-escalated if they'd just – please let me come in and help resolve this, rather than surround my son with 15 large men to drag him to the ground and I'm watching from the window and they won't let me in.'

Many carers reported that experiences of care could be traumatic for them and their family members. Carers identified that enhanced collaboration between carers and mental health services could allow the delivery of services to be individually tailored to the consumer, resulting in more positive outcomes for their loved one.

Carers reported that, in service settings, they were often not well-oriented, their involvement was not valued, and they did not understand what was expected of them. This was further compounded by differences across facilities in policies and approaches to mental health service provision in general. Carers reported that their expertise as carers was often overlooked, meaning that care was delivered in ways that was not in the best interest of their loved ones. Carers identified that if they were included in a more meaningful way, there would be fewer traumatising practices and that they could provide guidance and support.

Engaging with carers

'We need to have more carer peer workers ... because carers can bridge the gap between the consumer and the clinician or the consumer and the police or whoever, because we've dealt with it on a 24-hour basis.'

Carers reported that they were not commonly asked to be involved in care and treatment planning decisions, and at times felt as though they were intentionally excluded from care processes. Carers described that improved engagement between carers and mental health services would support the development of safe and healing relationships between consumers and clinicians. Carers also spoke about a desire for improved and enhanced opportunities for consumers to connect with their

support networks during treatment, including their carers, but that this required communication and engagement. Carers discussed the need for more carer peer workers and observed a lack of carer representation in mental health legal bodies (that is, as members of the NSW Mental Health Review Tribunal).

Ensuring safety for consumers and carers

'He had a very bad response because five police break through the door, they throw him to the ground, they handcuff him and they inject him ... He's had a very bad response to the drugs ... I kept saying, "Please let me in because I'm his mother. I'm sure that's my son." They just kept saying, "It's an incident. You can't come in, you'll have to wait." I knew it was my son. They wouldn't even acknowledge that it was my son. They wouldn't discuss it with me or my son.'

A shared view among carers was that mental health services must prioritise minimisation of trauma and re-traumatisation that is often experienced in mental health services. Carers spoke about the need for services to be safer for carers as well as for consumers. Many practices and processes were identified as traumatising, such as the physical environment of mental health services and admission process to an inpatient mental health facility. Carers reported high levels of distress and trauma for consumers associated with involuntary admission, police intervention and emergency department (ED) processes. They suggested that enhanced education and collaboration with emergency personnel could minimise trauma and re-traumatisation and support improved satisfaction with services.

'The hospital ... It's very traumatic for him. It's very traumatic for anybody. It also impedes his own help-seeking behaviour and what he thinks he can disclose when he needs help. It has a negative impact all the way down the line, on the system and on his own health.'

The blanket policies and the lack of activities negatively affected people's engagement in treatment, and they found the program to have a counterproductive effect on their recovery and wellbeing. Carers felt torn between identifying that harm occurred in care, but being not always able to manage their loved ones without support.

Creating a welcoming environment

Many carers discussed the importance of the physical environment and how this can be traumatising for consumers. Carers stressed that inconsistent and inequitable access to therapeutic programs, technological devices, music, entertainment and social activities, gyms and outdoor spaces in mental health units can significantly contribute to dissatisfaction with services. Carers were highly aware that technical devices (such as mobile phones or computers) could be seen as a potential safety issues when determining clinical decisions made in an acute mental health environment. However, there was a common view that this could be addressed with enhanced carer involvement and alignment to person-centred care. Carers spoke about how providing additional therapeutic items could drastically improve the physical environment.

'It's not just cutting out traumatic things. It's adding things in to assist, so adding plants and natural things, and dogs, trying to imagine an environment that workers may be used to, from the point of view of the consumer and their family.'

Protecting human rights

The *Universal Declaration of Human Rights* outlines that all people have the right to basic necessities, dignity and equal treatment.⁸ Carers described that, at times, basic needs of the consumer were not met within inpatient mental health units. While rare, these events were highly distressing to carers and drastically affected their perception of safety in services for their loved ones.

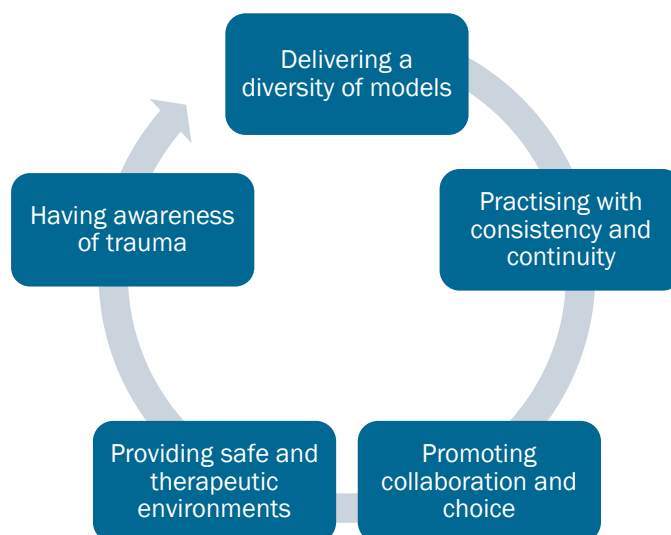
'I've certainly experienced that in one of the hospitals where there was no water available in the ward ... No water. Thankfully we weren't in there for very long. I had to knock on the window and say, can we please have water, repeatedly.'

Carers also noted that the conditions for patients on public mental health wards were not the same as patients in other general health wards or private mental health facilities.

'Actually this patient has a right the same as any other patient. So if patients in that ward have their phones, why doesn't this? If patients in that ward are allowed visitors and flowers then, it's not equity. Isn't it maybe time we just go, yeah, this is a human rights disgrace?'

Consumer focus groups (detailed findings)

Figure 4. Consumer focus group themes



Delivering a diversity of models

Consumers talked about the limitations of treatment and how this affected their experiences of care. They identified that there was a heavy focus on diagnosis, often with no discussion or reflection on the acceptability of a diagnosis for the person and limited chances to review decisions. Consumers felt that some diagnoses lacked validity, but they could be 'stuck' with one or many labels. Consumers described a scepticism about the science behind some of their diagnoses, but felt that their diagnoses directly impacted the kind of care they received. Consumers were aware that judgements were made about certain diagnoses, such as personality disorders, leading to discrimination and impacting on access to services. Other aspects of the consumer's life could also be affected as a result of their diagnosis, subsequently impacting on their care.

'People see trans(gender) stuff as a result of borderline ... I don't know any trans person including myself that has ever felt safe in any service because of that.'

Consumers felt disempowered by the language used by clinicians, also reflected in documentation such as discharge summaries. There was a shared frustration around the utility of labels applied to them. The language used to describe the person, their diagnosis and their care was described as risk management-based rather than strengths-based or helpful, and often consumers felt like it did not match their experiences.

'The language is so alien and clinical and distant.'

Consumers reported a lack of diversity of available treatment options. They felt there was an excessive focus on pharmacological therapies, with minimal access to psychological therapies, even though consumers reported that medication had little benefit for trauma-related symptoms or experiences. Consumers wanted skills and strategies to cope when they were at home, but felt that all they received from services were diagnoses and medication management, often leading them to develop a sense of hopelessness or finality.

'When I was first diagnosed with schizophrenia ... there was nothing except "this is the antipsychotic medication you've got to take that for the rest of your life". When I was subsequently re-diagnosed with bipolar "this is the lithium you've got to take for the rest of your life".'

Generally, consumers described a profound sense of having no control or input into their own treatment and felt that their unique experiences, preferences and expertise were barely heard.

'You just feel like you're screaming and no one can hear you.'

Practising with consistency and continuity

Consumers identified a lack of consistency and poor continuity in care that detrimentally affected their experiences and impeded engagement building. They described their interactions with services as confusing and at times scary, with transitions between service settings often dealt with poorly and communicated badly. At the times, they had experienced consistent engagement with individuals, either through in-reach by community staff into hospitals or by medical continuity, which drastically improved how they felt about their experiences.

'[One admission] had continuity of care. So it went from outside a hospital to in hospital still treated by the same doctor and then discharged to the same psychiatrist ... it had that follow through. I think that made a huge difference.'

Even when consumers had a primary clinician in the community, such as a private psychiatrist, this person was often not consulted about the best way to provide treatment, and decisions were made without discussion or awareness of what might help. Consumers identified that this disconnect made them frequently feel unsafe when they had to come into public services.

'Getting the response that, "Well you're at this hospital now, you're our patient, we do as we like" type of thing.'

During times of crisis, consumers' ability to contact a staff member or service with which they were familiar helped them to feel safe and helped to resolve the crisis.

'It's like they get the language I use and they know how to bring me down, make me feel listened to, heard but also reassuring calming ... other calls I'll end up hanging up in frustration.'

Consumers recognised the limitations of the structures of care and the difficulties when engaging with individual professionals over time, but nevertheless identified that individual clinicians could make a profound difference to consumers' experience of these challenges through their approach and interpersonal manner.

'Sometimes there's one nurse or one person you come into contact with that really can support you.'

Relationships with community clinicians who spent time building trust and worked from strengths-based approaches were recognised as giving consumers strength and hope beyond what they sometimes felt for themselves.

'She can see something in me that I can't see in myself.'

Promoting collaboration and choice

Consumers spoke about the benefits of collaboration and having opportunities for their voices to be heard on the planning of treatment and care they receive. They were more likely to trust services if decisions were explained and there was transparency around how and why they were made. This could be through mechanisms such as advanced care planning or inclusion of consumers in discussions about what was documented about them.

Consumers were very conscious of stigma and discrimination and reported that words written about them by health professionals held significant weight across services. This could impact how they were treated and their ability to receive care or request treatment.

'People that already know about me ... that's one thing, [but the] ones that don't, sorry, who are they going to believe, the doctor or the crazy person?'

Formal or informal care plans that incorporated consumer preferences about care, and that were then used by services and teams, were seen as demonstrations of respect. Being given choice, control and the ability to provide input into decisions made about them, even when they were very unwell, made a huge difference to their recovery. Often consumers identified that they did not feel they had any ownership or control about what was written about them in medical records, and that they felt that these records were often inaccurate but held significant power over them and their future care.

'Instead of writing a note about someone where you type up the mental state assessment or talk about ... "Bob was making good eye contact and wearing a blue sweater but he seemed a bit stinky and I wonder if he's off his meds" ... [ask me] what feels important to say, "What would you like in the notes?" ... so people have control about what's being said about them in their absence.'

Consumers described that they often had an understanding of what medications worked for them or not, but that these experiences were not taken seriously or listened to.

'I'm allergic to penicillin. That's written everywhere ... But if I try and say, "Hey I've had a really bad reaction on these [psychiatric] meds ... They make me really zonked out ... I end up dribbling myself. It's not the dignified life that I want for myself," that's not reflected in my care.'

When describing reactions to medications and side effects, consumers described that their concerns were often not taken seriously or were actively dismissed.

'Sometimes with medications I'm just lied to ... like I'll say, "Look this medication, I feel it's doing this to me or that." I feel that sometimes it's just easier for people to just give me a "Oh no that doesn't sound like it's from the medication." But it's like they make me question myself because I can feel differences in my own thinking, my own body that aren't – they don't tell people about and I'm not – I am listened to but it's just, no one knows how it isn't right.'

Often, consumers felt that they were not given a chance to speak, let alone collaborate in care. They perceived treatment to be dictated by the treating team and that they were expected to be passive recipients of that care. At times, they felt they had no capacity to influence what happened to them and that conversations about care and treatment were one sided, with no opportunity for input.

'You can't feel listened to if you're not influencing the outcome. You feel like the outcome would have been the same if you'd brought a cardboard cut-out of yourself.'

Consumers specifically identified they wanted input into the gender of people providing direct care; the settings in which they received care; where they met with their community clinicians; and what hospitals they felt safe in. They felt they could contribute to these processes by being actively asked for their feedback and for this to be taken seriously and listened to, even when changes could not be made.

Consumers described that they felt the lack of input into care was replicated at a larger systems level and that being able to access consumer-run and peer-led organisations, as well as organisations that employ people with lived experience at all levels, could drastically help to balance trust issues with clinical services. Consumers described a shared lack of power and privilege and a subsequent distrust in clinician-led services.

'I think I have more trust in an organisation staffed with people with lived experience...you know how terrible it is to feel powerless...it's really difficult. People with sane privilege don't know what it's like to not have that.'

Access to peer workers was identified as very beneficial in supporting feelings of safety and trustworthiness in services. Peer workers were able to meet consumers as equals, and also balance power within clinical interactions, advocate for consumers within the systems and change the culture of teams.

'I think peer workers are the key to trauma-informed care ... I've seen peer workers just being in [multidisciplinary teams] and meetings and stuff ... it's really hard to be an asshole if you've got a peer in there.'

Providing safe and therapeutic environments

Consumers described the numerous ways that environments, service structures and people made them feel unsafe in care. Frequently, this involved a lack of information about what was happening or what decisions were being made. Issues in hospital settings also included restrictive rules enforced without apparent justification or communication, for example, taking away phones without explanation. A lack of basic privacy when showering or toileting was also identified as a trigger for many people who have experienced trauma. Privacy issues were identified more broadly as people felt they were seen as 'isolating' if they went to their room for some space, when shared spaces in units were often experienced as unsafe or unpredictable spaces for consumers.

'You can't move freely, you can't get solitude or quiet but you can't also move away from danger as well very well, except to your bedroom and often that's discouraged isn't it?'

Consumers felt they encountered staff who made them feel disrespected or who lacked basic knowledge about how to make them feel safe. This was noted when clinicians made no eye contact or took notes while people talked, or in their response to consumers through their demeanour, tone of voice or the words they used.

'I think the biggest one is they speak to you like you're a person. So many times when you're in situations you get talked to like you're a toddler. That's probably the best tone of voice I can think of for it – rather than you're being spoken to like you're just a person, like they would speak to – do you see some doctors, the way that they speak to you is so different to the way they're speaking to the nurses. It's just sort of like, why don't I get that same level of conversation?'

Within inpatient settings, consumers felt that there was a divide between staff and consumers. This was reinforced by situations such as seeing the nurses in the office spaces drinking coffee or using their phones when they (consumers) were restricted from doing so.

Consumers felt isolated and disconnected from the things that were important to them, with limited opportunities to contact their family and friends or listen to their own music. The environment itself often impeded their sense of recovery and hope.

'Why is it so sterile and different to what we normally have? Why does it have to be that?'

Within the hospital environment, consumers also experienced intense boredom and described that nothing was offered to do and there was no way to engage in usual activities.

'There's literally nothing to do. How can you make someone get better when you're sitting them in a box all day long? Especially when they're in seclusion, you're going to send them crazy. That sends anyone crazy.'

Having awareness of trauma

Consumers reported their experience of a lack of access to trauma-specific information across service settings. Consumers described the fact that the staff they had encountered in public mental health services appeared to have inconsistent knowledge of trauma and a reluctance to talk about it. Consumers clearly described that they did not need staff to actively explore their trauma, but they expected staff to be able to link behaviours in the present to feelings from the past and to receive care that considered them in the context of their lives.

'I don't want to sit and rehash trauma, but I want them to discuss it and help me pick out links.'

Reluctance to talk about trauma was seen by consumers as reflecting an excessive focus on behaviours and medication: what was wrong with them, rather than what had happened to them. They described that it would be difficult to identify if a service or clinician was 'trauma-informed', but they thought that being trauma-informed would be reflected in the way the services made them feel.

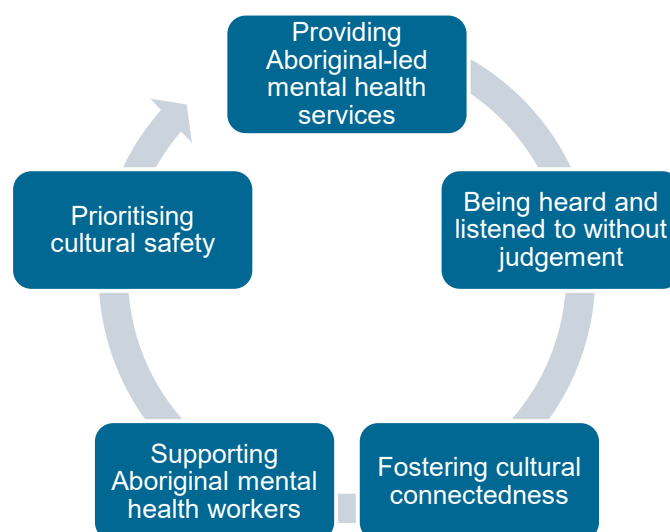
'It's something that's hard to quantify when people do it well...it's hard to make a framework for someone to act like they give a shit about your life.'

Consumers expressed concern that services did not prioritise the context of people's lives, including trauma, and that clinicians hid behind facades of being too busy to think about or talk to people about things that made them feel uncomfortable. Consumers were aware that staff feared upsetting them and often did not ask about their lives. However, they wanted staff to have an understanding of trauma, to have the skills to address trauma, and to be consistent in doing so. Consumers identified that care received through a trauma lens could be much more meaningful to them in the long term.

'I didn't know what had happened to me was trauma until someone had explained it to me ... it was completely pivotal when people explained that the things I was doing, how I was feeling were adaptations to what had happened.'

Consumer focus group: Aboriginal Medical Service (detailed findings)

Figure 5. Consumer Aboriginal Medical Service focus group themes



Providing Aboriginal-led mental health services

Participants identified that an AMS provides culturally tailored, holistic mental healthcare and support to consumers and they want to see more such services. Many consumers reported that the AMS provided ongoing and unconditional support through their mental health recovery.

*'They'll stick by you're a*** no matter what. If you're doing wrong, they'll kick you're a***. They don't care. Do you know what I mean? That's what you need. You need someone who cares. If you f*** up, they're going to be there and tell you you've f***** up.'*

Consumers identified that the AMS staff, irrespective of professional background, were collaborative in their approach to mental healthcare. Collaborative teamwork among AMS employees helped to integrate care and was identified by consumers as one of the strengths of AMS service delivery.

'I don't think it's about [the AMS]. I think it's about the people they've got working there now. The people that they've got, they communicate together, do you know what I mean, but not just that, you're comfortable ... I can go and talk to Jenny [sic] at the reception desk. Like a reception worker, you can't do that at a normal place.'

Consumers felt that they were unconditionally cared for and that the AMS prioritised their needs.

*'You don't just have three chances and we're going to f*** you off. No way. How many times have I f***** up with, like 50,000 times. They've always been there for me.'*

Being heard and listened to without judgement

Many consumers reported that being heard was a very important component of their recovery journey. They appreciated support that was non-judgemental, as many consumers reported often feeling stigmatised and marginalised. Judgement, not feeling heard, and being marginalised were recognised as traumatising for consumers.

*'They genuinely care and they show that they genuinely care. It's good because if you f*** up, I know I can go say look ... I [had a shot today] or I did this. I know she'll kick my a*** but I know she's not going to judge me on it or put me down for it. It's good to be able to do that.'*

Aboriginal workers who listened and supported consumers were often referred to as family, moving beyond traditional constructs of the clinician and consumer relationship. Once trust was established, the relationship was highly valued.

'It takes ages. It took me 10 years just to find someone willing to sit down and be able to talk and not to be judged on it. Like you get judged so easy. It's so hard just to find the right person to talk to.'

Stigma was a common concern among Aboriginal consumers regarding substance use, with a fear of clinicians' judgement a commonly reported concern. Consumers suggested that there should be an emphasis on a strengths-based approach.

'We don't have strengths. We need people to have strengths. That's how we feel. When we go there. They look at us as if we have no willpower, we have no ... you need to see an Aboriginal person to say that we have strength because they don't think we do. They just look down at us. They don't give you any positive feeling at all.'

Fostering cultural connectedness

Cultural connectedness was an important component of mental healthcare for Aboriginal consumers. Displaying Aboriginal artwork in the service environment was one way of displaying cultural connectedness. However, such artwork needed to be displayed meaningfully to reflect a wider understanding of Aboriginal culture, rather than in a way that was tokenistic.

'I've been in places where they have had Aboriginal paintings and you walk in and then you think. "Oh, yeah, that's mad, look at that, unreal," but then you'll get the service and it's just the same as the normal service. Because they've got Aboriginal paintings there it doesn't mean they respect us.'

Some government services were reported to have Aboriginal artwork without knowing its cultural significance, which consumers viewed as offensive and defeated the purpose.

'... even in DoCS when you walk into DoCS and they've got them all and you'll go, "Oh do you know what that is?" and they'll go "No". Why have you got them up there then if you don't understand what the – even the handprints – they've got this big thing of the handprint and I'm trying to explain to them that it's their community thing.'

One consumer highlighted the importance of an Aboriginal liaison worker in mental health settings. It was acknowledged that when there is limited access to Aboriginal liaison workers, sound cultural competence and a non-judgemental attitude was important to consumers accessing mental healthcare.

'... Whether it's an Aboriginal worker or not, you need someone there who knows about Aboriginal culture and who isn't going to be judgemental. Yeah, it would be ideally perfect to have an Aboriginal worker there, but if you can't, it would be perfect to have a white person who knows a lot about Aboriginal culture and who can connect with Aboriginal people.'

Supporting Aboriginal mental health workers

The focus groups highlighted the cultural significance and importance of access to Aboriginal mental health workers for mental health and overall wellbeing. Many consumers reported they felt uncomfortable accessing public mental health hospitals, often due to fear of stigma. The presence of Aboriginal staff members minimised experiences of stigma and improved overall experiences of care.

'If you go to a public hospital you're so uncomfortable until you find an Aboriginal worker there, until she comes and talks to you, which could be a day or two later, but you still – I find I can't even talk to the doctors, do you know what I mean.'

All consumers agreed that mental health services required more Aboriginal workers and that this was a clear limitation within the existing public mental health model of care. This led to some very negative interactions.

'...an Aboriginal worker, they tend to sit there and listen and not – you can sit there and tell them the worst things possible and they won't judge you on it. They'll work out with you, not on their own, they'll work out with you...'

Prioritising cultural safety

Aboriginal consumers reported negative experiences across multiple government sectors. Trauma and re-traumatisation was experienced by many, and one consumer reported that she felt police were not well trained in responding to the complexity of mental health difficulties experienced in many Aboriginal communities. Another consumer reported that fear of police made it more challenging to seek support.

*'You know the thing that scares me the most when you go to places is the coppers. Seeing the coppers just makes you automatically, do you know what I mean, because you think, "What the f*** are they doing here, I'm not going," you know what I mean? I'm not a danger. That's what revs you up more, I think.'*

One consumer reported her experience of re-traumatisation that had occurred when she received her own file from another service.

'I wasn't traumatised until you brought my file to me and asked me to read my file from my childhood.'

Past government policies have allowed forced removal of Aboriginal and Torres Strait Islander children from their kinship groups, communities and land. The impact of child displacement has resulted in extreme experiences of trauma, grief and loss of culture for Aboriginal and Torres Strait Islander people, families and communities. This pain and grief is still visible today through intergenerational trauma, impacting on their social and emotional health and wellbeing. Removal of Aboriginal children from their immediate and extended families was a common theme related to trauma. The experience of generational displacement has led to an overall lack of trust in government agencies that has impacted negatively on Aboriginal people's experiences of service delivery. Mental health services were seen as one component of the government. The legacy of past wrongs is seen to impact on present interactions with services, compounded by ongoing stigma. These issues were experienced across sectors and lead to widespread mistrust and re-traumatisation.

'My mum and dad really wanted my son to be in care with them. So they could show my son the culture. My son was in an Aboriginal preschool. He was getting picked on because his mum was black. That's what the report was to DoCS. So the carers took my son out of the Aboriginal preschool, put him into another school and I don't know any information from there.'

Clinician focus groups (detailed findings)

Figure 6. Clinician focus group themes



Having awareness of staff wellbeing

Clinicians identified that, for services to be trauma-informed, they must pay attention to staff needs and wellbeing. Clinicians felt under-supported as their organisations lacked structures to facilitate professional self-care. This affected their ability to deliver care to consumers in ways that they would like. Valuing staff wellbeing required ensuring access to and time for external clinical supervision, debriefing after incidents, and access to programs to reduce burnout and vicarious trauma.

Many clinicians, particularly nurses, reported that they lacked access to clinical supervision. Despite the acuity and stress associated with their roles, they were *'expected to get on with it'*. When clinical supervision was available, there was limited access to appropriate supervisors, supervision had to be self-initiated, and it lacked clarity of purpose.

'We need a model of clinical supervision which aligns itself to trauma-informed care practice that's consistent with those values and principles.'

While some clinicians have access to formal debriefing processes after incidents, many reported they had had to develop their own processes of informal peer support or coping. Many clinicians described a strong camaraderie within their teams, supporting one another through incidents at work and in their personal lives.

Commonly, services arranged access to group employee assistance programs following serious incidents, but many staff felt limited in what they could say at these sessions as managers were also present. Clinicians were clear that there was a need for staff wellbeing activities and programs to be integrated into workplaces and supported by managers.

'Support comes in many ways but it's about advertising, supporting, letting it be known that it's actually a very important model and that it's something that should be business as usual, not something that we do as a project, but it should be sustained and maintained over time.'

Clinicians often felt the impact of work stressors in their personal lives, with some identifying symptoms of compassion fatigue, burnout or vicarious trauma.

'... you go home and you sort of start dwelling on it and you know, all things later I could have done this better and self-blaming starts kicking in ...'

Clinicians spoke about often feeling fatigued and emotionally drained, with some explicitly describing how hearing about a consumer's trauma could trigger their own traumatic memories, which they needed to suppress in order to get on with the job. The roles required of them could also be directly traumatising.

'... being a nurse in our system can mean that you're experiencing significant trauma just in the conduct of your work, whether it's vicarious through the stories you hear and the relationships and things you witness or the actual participation in practices ...'

At times there was a 'disconnect' between the system and their own ways of working, which could adversely affect their wellbeing.

'I think in terms of working inside a system that was not trauma-informed, and wanting to be a trauma-informed clinician who is promoting really good care for a consumer.'

Supporting different ways of working

To be trauma-informed in practice, clinicians identified that they needed to be supported to work differently. This meant workplaces must actively support efforts to promote consumer rights, autonomy, self-determination and choice, as well as fostering person-centred care. Clinicians also said that they required clarity around TIC as a model.

Clinicians recognised the importance of demonstrating to consumers that they practised transparently, but felt limited by current systems, including documentation, records, forms and workloads.

'I think the caseload is so big that you want to do your best by everybody, but there's just not enough time. The way our systems are with all our documentation, unfortunately we spend a lot of time documenting, sometimes more so than we actually do with the client.'

Clinicians gave examples of ways that they tried to adapt their practice to be oriented around the needs of consumers, rather than expecting consumers to fit into services.

'You've got to meet people in the places that they go ... I would meet them. I knew where they went. I knew their routines, their schedules. They didn't have to come to see me. I would meet them at the park or at the corner or at the pharmacy or at mum's place ... It was about meeting people in the places that they go...'

Clinicians identified examples of how current ways of working could promote stigma and limit benefits for consumers, for example through siloing physical healthcare from mental healthcare. Clinicians described that consumers frequently felt uncomfortable accessing physical health services in settings such as EDs, because they often had complex care needs.

'I've had a lady who did not want to go to an ED at all, ever, and she didn't want to see cardiologists when she needed to see one, she didn't want to go'

and see anyone because she had had such bad experiences with her physical health.'

Clinicians recognised that peer workers were essential to TIC, but were underrepresented in services. Some participants did not know the role of a peer worker, while others were aware that peer workers were employed in some settings but not in others. Clinicians stated that there were not enough peer workers to be involved on committees where important decisions were made and consumer input required. Clinicians recognised the value of peer workers in improving service delivery but recognised that care was required in how such roles were introduced and supported.

'I think sometimes the lived experience view isn't something that's acknowledged or given the same value as the nursing voice or the social work voice. I think that that comes with the fact that the Ministry doesn't see them as a professional body of people that we employ in our workforce. They are not paid properly. I think that that's a travesty in a way, because they bring so much that can really meet this need. But we don't give it as much credence as we should.'

TIC is recognised as a significant change in the way that clinicians work but that what it means exactly is unclear, and ways to measure this are lacking.

'There is an assumption by people that they work in a trauma-informed way by just the very nature of the work that they do. There is no measurement for trauma-informed practices. So there's concepts but no way of saying whether it's happening or not.'

Clinicians report that the term 'trauma-informed care' needs to be operationalised and clear guidance is required to successfully establish practice. However, they recognised a need for entire organisations to be clear on its definition and implications, not just its impact on the individual work and practice of clinicians.

'I think the service as a whole doesn't actually know what it is. I think that's coming from the executive. I think they love the word and I think they love the ability to tick a box saying that they are, but I don't actually believe that they know what it is. I think for our service to be trauma-informed, it needs to come from the top down.'

Focusing on workplace culture

Clinicians described that successful implementation of TIC is strongly linked to workplace culture. Culture was seen to be inclusive of how staff supported each other, the language used by staff, and the capacity to challenge each other's practice. Also linked to culture was the need for TIC orientation, induction and appropriate support for new staff members. Participants referred to a need to incorporate TIC principles into recruitment processes, so that services recruited staff with the relevant values and experience to implement TIC.

Many clinicians referred to the use of negative and stigmatising language in services and identified that, at times, they had to challenge the language used by their colleagues. Language was noted to have an impact on the delivery of services, but some clinicians also felt they were unable to challenge the language of management.

'Changing your language influences how you see people and how you actually deliver that service.'

TIC was clearly identified as beneficial for drawing attention to language, but also for thinking differently about experiences and labels.

'One of the really good points of the movement of trauma-informed care is changing how we label consumers with diagnoses and I think it's really important to start moving away from, "Oh, they're a borderline" or "They're a personality [disorder]". They're not, they're a person that suffered some significant trauma in their life.'

Clinicians mainly reported that they were all supportive of one another in their workplaces and that they worked within teams that had developed locally supportive cultures.

'You've got to have each other's back because we are a team and we function like a team.'

However, clinicians also expressed frustration with organisations' wider culture and felt that characteristically staff were not consulted or included in decisions that affected their teams. Clinicians recognised that TIC extended beyond the relationship between the clinician and consumer, and that they also needed to observe the principles being enacted by senior management within organisations. Managing a wider workplace culture was also seen as a challenge.

'So if you speak up to the union, if you speak up when managers are present, you can basically forego that potential promotion or getting up into a higher graded position. You just won't, basically, be looked at for those, so it's pretty demoralising to staff that do want to speak up because they're here for the good of the consumers.'

Increasing resources

Clinicians reflected on many ways that they observed a lack of resources impeding the establishment of TIC. This included issues related to workloads, staffing, recruitment, work environments and access to education and training.

Clinicians reported that units and teams were suffering from being under-resourced. They reported that working overtime was leading to staff burnout and turnover. A generalised lack of staff impacted on their ability to take leave, with staff reporting they felt guilty if they took leave due to the pressure this placed on colleagues. Clinicians reported a key factor in under-resourcing was the failure to fill vacant positions. Clinicians reported excessive workloads and overtime when several staff members were absent, causing stress.

Clinicians referred to the need for experienced staff to upskill graduates who were recruited to roles, which further drained resources and time available for the consumers.

'We took on about four times as many new grads as we normally do in the last 12 months ... We have new staff that weren't necessarily from mental health backgrounds. There was a lot of demand on experienced staff to like a big step up and impart their knowledge and make sure the culture and that is instilled from the outset as well.'

Clinicians felt overworked but were also aware that the issues went beyond mental health settings. For example, a lack of mental health staff in ED settings impacted consumer experiences, and this in turn affected outcomes. Workload was also reported a widespread problem.

'It's pretty hard to provide trauma-informed care when you've got just the sheer number of people that you try to care for.'

To become trauma-informed, clinicians require access to education and training in TIC and to be supported to attend. Clinicians thought that TIC training should be prioritised over some other mandatory training. Many clinicians were not aware of any training they could access locally. Some clinicians said they felt fatigued with the training and education requirements of their roles and thought that it was managers who should be required to undertake training to become trauma-informed. But, overall, clinicians wanted accessible TIC education that linked theory to practice, for example, how to undertake trauma-informed multidisciplinary team meetings and handovers. Clinicians recognised that it was necessary for all staff to attend TIC training, not just those who were interested. This required clear messaging about TIC and the integration of its underpinning principles into all training.

'It's about embedding it into everything that we're doing, rather than teaching it as being something separate or different or additional, which I think has been a barrier in the past, where people have said we don't have time. It's – in doing what you're already doing, you can be trauma-informed.'

Consumer involvement in education and training for TIC was reported as having a positive impact on clinicians' experiences of training. This, in turn, improved their understanding of recovery and consumer experiences of care.

The need for increased resources also extended to recommendations for upgrading facilities to ensure safe and welcoming environments as part of delivering TIC. Staff reported feeling constrained by their physical environments in implementing TIC as they lacked access to spaces for de-escalation or sensory modulation. Clinicians identified some tension among staff as to how to provide trauma-informed physically safe environments.

Clinicians identified there were many competing demands on their time, which impacted upon their ability to deliver TIC. Documentation requirements were frequently mentioned as occupying large amounts of their time.

'...most frustrating is just the amount of documentation that we have to do. That is what gets in the way, so much of the really trauma-informed care of being able to sit down with a client and really delving into what's going on.'

However, others believed that time was an excuse used by staff to avoid therapeutic engagement with consumers.

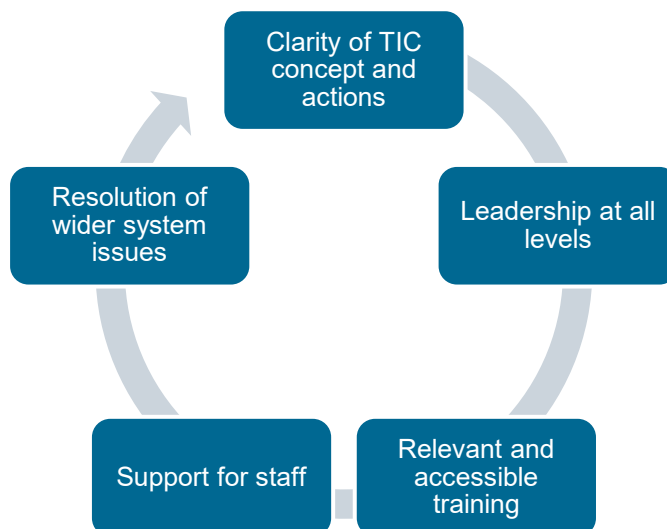
'If people are saying that they don't have time to implement it, maybe that's because ... what is the task that is most valued that's then prioritised at the expense of better trauma-informed care practice?'

Regardless, all clinicians identified that lack of staffing and high workloads meant they did not have as much time as they would like to engage with consumers.

'You're just putting out spot fires really. I'm just here, I'm there, I'm there and then I'll grab the phone and then I'll do this, then you're not actually doing anything properly.'

Manager interviews (detailed findings)

Figure 7. Manager focus group themes



Clarity of TIC concept and actions

Managers described the need for consistent and clear definitions and guidance around TIC. While having formed their own understandings, they viewed TIC as poorly understood. TIC was seen as not a new idea, and was in many ways business as usual, though it had not been prioritised until recently. This may be a result of TIC not being an active priority until recently.

Some managers reported they already worked in a trauma-informed way as it aligned with the existing values of the organisation. However, nearly all recognised that significant work was required to make an entire organisation trauma-informed. A whole-of-service approach was seen as necessary to ensure best care for consumers, but this required significant investment and commitment, and should be guided by a clearer framework for implementation and translation into practice. Without this clarity, there was potential for TIC to be *'...just another one of these adjectives describing what a service is meant to be without it actually changing the service'*. Many described TIC as being an evolution of existing models such as the recovery-oriented approach and person-centered care, reflecting the core values of the organisation. Embedding the principles of TIC was seen as a challenge, with no points of measure.

'I think it's a poorly defined concept ... when it is discussed, it gets diluted into many different sorts of tangents and people don't really end up with a concrete action and ... there is an assumption by people that they work in a trauma-informed way by just the very nature of the work that they do. There is [also] no measurement for trauma-informed practices. So there's concepts but no way of saying whether it's happening or not.'

Managers wanted information about best practice in TIC, clear tools to guide screening and intervention, information about how to adapt TIC across settings, and guides for fidelity and clarity regarding sustainability and integration into existing models.

While TIC was seen to have 'face validity', as people knew that many of their clients had and continue to experience trauma, managers generally reported that how it looked in practice lacked clarity.

'One of the tricky issues that I've noticed in trauma-informed discussions is that the same discussion point can go round in circles and that there can be sometimes dominant voices that means that it sort of swamps an issue that is clearly important but not able to be challenged. I think we do work in an environment that's very much influenced by evidence-based practice and randomised control trials and clear evidence that something works. It's not clear that that's as well articulated to me in trauma-informed practices.'

Leadership at all levels

Managers spoke about the multiple layers of leadership required to drive TIC, both at an organisational and systems level. Leadership was viewed as requiring clear expectations and consistent messages around TIC.

Equally, they saw their roles in providing local leadership of TIC as demonstrating fidelity to the behaviours they were promoting, responding to poor practice among staff and communicating organisational visions embracing TIC. Modelling trauma-informed practice and behaviour demonstrated to staff that they were not tokenistic.

'You can say many things, you can say beautiful words, but what really for me makes sense is whether the behaviour and the language are congruent ... If there's that congruence, people see that, where it's incongruent, you say it but you don't actually live it, people see that too.'

When they were under pressure with numerous initiatives, maintaining strong messaging about TIC as a priority was seen as a challenge. These messages are required to be led by the Ministry of Health and then driven by service leaders on the ground.

'What I'd really like to see is a very strong, you know, "We are behind this, this is important" message. So, the message behind it has to be very strong, it has to be supported at all levels. Having said that too, there needs to also be buy-in from people too, they need to accept that it is an important thing.'

Importantly, managers saw part of their role as leaders as looking after staff wellbeing, which inevitably flowed on to improved consumer care. This included encouraging staff to take breaks and leave on time, supporting supervision and empowering the workforce to look after themselves. They also identified a need to foster 'ground-up' initiatives developing TIC practice and supporting local champions.

Managers identified that TIC fitted into their existing practice and staff expectations, but they required more strategic guidance, resources and tools at a state and national level in order to be clear on what changes are required.

'At the moment, we've got pockets of people that are doing some trauma-informed framework. Whether it's for adolescent services or for other places but I think an overall, either a national framework that says, for trauma-

informed care and practice, these are the elements that we think we need to focus on.'

Resources to support change

All managers identified a major lack of resources as a significant challenge for driving TIC within their organisations. Implementing TIC effectively was seen as requiring staff time, access to training and education opportunities, co-development, peer engagement and the establishment of dedicated champion positions.

Managers were aware of the wider system pressures on resourcing. They said it was difficult to put a 'cost' against TIC as standard budgetary costings were based on the activity-based funding model and diagnosis-based measures. A need to report on key performance indicators was seen to be driving service delivery and interfering with a focus on TIC. These issues led them to consider how they could build TIC into existing practices without key drivers.

'We constantly are asking staff to focus on more stuff without giving them any extra resources. So the message is not necessarily about, well, look, this is a new form that you need to fill in or this is a new half hour you need to spend with the patients. It's more about but, well, look, you should be meeting with the patients anyway, we've got to complete these forms, these are the dialogue that we want you to have with consumers, the things we want you to consider.'

Pockets of money were at times sourced or used for TIC, usually to attend training. One district had previously created a specific TIC position that was seen to be very effective in promoting and supporting TIC.

'Bridge the divide between a lot of the working parties and committees that help implement a lot of the practices on the ground level.'

Backfilling staff was raised as problematic because frequently staff could not be released to attend training or supervision, and it was difficult to get away from immediate clinical demands to reflect on practice. Many districts experience large numbers of vacancies, or find they are unable to recruit to existing vacancies because they are required to reduce costs or save budget. This also means that staff frequently work without leave and have increased workloads. Managers identified that many teams struggled to provide even adequate care. The requirement for relational engagement to be trauma-informed was noted as a challenge due to staff being under significant pressure.

Technology and systems used for documentation were seen as confounding this issue, since a lack of documentation concerning safety plans, collaboration and care plans was either impossible or not easy. However, the lack of time was also recognised by some managers to be a diversion or perhaps even an excuse used by staff reluctant to embrace change, rather than a considered stance related to TIC. In essence, TIC was viewed not as an additional component of care but a values-led way of delivering existing care that should not require substantial additional resources. However, the structures required to support this way of working did have significant implications for managers and services, and resources are required to allow access to sufficient education, supervision and cultural change processes.

'[TIC is] really seen as something that's additional to the way that we work, and therefore the obstacles would be we don't have the time, we don't think in that particular way ... It does, in some ways compete with a very dominant

medical model ... it's almost like a competition and it doesn't need to be. But I think it's being able to convince people that the two can work together.'

Relevant and accessible training

To become trauma-informed, all managers identified a need for ongoing and practical training for staff. Ideally, this training would be locally developed and co-designed with service users, but based on agreed statewide content. In their view, training needs to be practical rather than too theoretical, using clinical examples, and learning needs to break the practice of TIC down into smaller sections.

'I don't find it terribly useful to talk about trauma-informed care but I do find it useful to talk about, you know, when do you ask sensitive questions about a person's wellbeing, or what do you do if you see someone feeling unsafe in the course of an interview, or how do you reduce people staying on community treatment orders in community? So if you break it down into chunks or actions and I see it as something that's achievable.'

Training was identified as important to raise awareness, reduce trauma and re-traumatising practice and shape interventions to meet the needs of different clinical environments. However, managers identified that they lacked the capacity and resources to develop this training and consequently were reliant on existing training options that often did not meet their particular needs. Efforts had been made to build TIC principles into existing internal training opportunities, but a gap still existed in trauma-specific packages. Managers described that, at times, issues were called to be resolved without focus or collaboration with those who already had some understanding of the solutions.

While some managers identified projects or initiatives that had developed and delivered education, the sustainability of these were problematic in that they did not embed practice change long term or support an ever-changing workforce. Managers identified a need for time for individual teams to reflect on how to apply theory within their context, as, even when external training was available, skills could be lost without a focus on local culture.

'[Staff have] gone to a training which says don't do this, and they come back and the team culture overwhelms the training. So I think if you're going to affect the operations of teams, you have to provide training in a team-based setting.'

While training was seen as necessary, it needs to be linked to other structures in order to implement or sustain learnings. For example, any training initiatives also need a focus on how consumer care reviews are run, how handovers occur between services, access to supervision, how practice champions are sought, and time to develop local protocols.

Support for staff

Managers spoke in detail about their perception of the need to support staff as an important component of establishing TIC culture, and their roles and challenges in doing so. They identified that divisions may exist between executives and staff that often mean staff do not understand the reasons for decisions or the focus perpetuated by organisations. Managers recognised the vicarious trauma that can occur from working in mental health settings and asking staff to be more trauma-informed. This acknowledges the potential for transference, countertransference, compassion fatigue and burnout which can compromise meaningful responsiveness to trauma.

'We get more value out of keeping our staff member within the service and helping them overcome a problem, whether it be compassion fatigue, whether it be complications of both. Yes, this is my job and then I've got my personal life, because people are human beings after they leave here, after their 38 hours a week, but we need them to be emotionally available for consumers.'

Suggested strategies to address these issues included meditation sessions, access to employee assistance programs, varying debriefing processes after incidents, supervision and awareness initiatives. Structural approaches such as rotating staff were also identified as strategies for reducing burnout.

'When our staff are more burnt-out themselves, and overburdened and over-pressured, that's when they all seem to be more vulnerable to then slipping into behaviours that are not helpful in terms of clients who are traumatised, where we can end up re-traumatising people purely by mistake.'

Managers identified that they felt tension about their responsibilities and how to respond to staff who are not demonstrating trauma-informed practice. This involves intervening when they hear language that reflects pejorative attitudes about clients and addressing complaints and incidents appropriately. Supporting peer workers to integrate into teams was also seen as one strategy to enhance trauma-informed practice and reduce re-traumatising practice. Managers spoke about the need to foster cultures where talking about staff wellbeing was supported and encouraged as key to embedding TIC. However, this had largely not been achieved to date.

'I think probably creating an environment or a culture where it's okay to say that you're not coping as well. We still don't do that very well.'

Managers felt a responsibility towards their staff and described supporting their staff directly as one of their key roles in driving TIC, as clearly staff who do not feel supported themselves will be less likely to provide care that is trauma-informed.

'In my role ... actually the most clinical care that I provide now is to our staff. In a way, they are the most important clients to me at this point in time, because their wellbeing we know is directly linked to the quality of the service that they provide. It is directly linked to their ability to provide trauma-informed care.'

While managers were largely supportive of broad approaches to staff wellness within the workplace, there remains some scepticism that this would reduce burnout if little was done to address resourcing and workload issues.

'Access to stuff like the meditation groups that are happening and gym membership and stuff, which is all very important to ensure staff feel valued and that there's recognition that the work comes with pressures that need other ways of dealing with it. However, I think, fundamentally, if we get clinical processes working effectively and there's enough staff to an adequate degree, I think that's the key ... people don't mind being busy. I think they just mind being super-busy and doing stuff that they wouldn't have to do if things were working more effectively.'

Resolution of wider systems issues

Managers identified factors out of their control that influence their capacity to drive or support TIC in their organisation and teams. Issues included those already mentioned related to structures and focus of care, as well as: the treatment of mental health staff by other services; existing models of care; expectations of the Ministry in relation to reporting; and widespread bed pressures and clinical acuity. All managers identified that wider systems stress such as bed pressures and insufficient community resources meant that teams were functioning in a state of reactivity and acuity, which hampered innovation. TIC was widely seen to be the responsibility of all health services and not purely that of mental health service systems. Challenges were particularly noted in relation to EDs, community partner organisations and security personnel. Efforts to drive TIC at a state level were perceived as needing to be broad and inclusive of such settings.

'We have a significant portion of people come through via our EDs and medical units and a whole range of bits and pieces and we have capacity to enforce but not own the practices obviously in there.'

The overarching frameworks of care were seen as not being conducive to TIC and, at times, in direct conflict, with a focus on risk aversion or rapid discharge. Expectations of mental health services to ensure the safety of all consumers and the community means that services are dealing with rates of presentations beyond their capacity to respond, and that services are also being allocated reactively with little room for flexibility. Thinking about clients through a trauma lens was characteristically not seen as important by the wider systems that monitor and direct mental health services.

'Look at it from a systems perspective, look at it from a truly biopsychosocial model really. I mean I think we pay lip service to that. We say that's what we do but in reality that's not at all what we do. What we do is provide very basic minimal care in terms of we look after people physically as well as we can I suppose, and even that's questionable sometimes in terms of some of the things we could be doing. I think we have a very hands-on approach, very quick turnover, and we don't pay enough attention to the root causes of why people keep coming back to us.'

Decisions about allocation of care and how that care is delivered were seen to be driven by policy and financial decisions at a state and federal level. Managers identified that wider systems of health needed to be more trauma-informed in their structures, with an ability to reflect on how money was spent and reported on, so that local organisations could better provide services that are trauma-informed.

'I know that public resources are tight, but, in fact, I think there's a lot of false economy going on because if you're keeping people in expensive inpatient units who don't really need to be there, but still need a level of support of care, it would enable us to make better use of our acute inpatient units, stop people sitting in EDs for a long time which again is pretty traumatic. I know there are multiple competing demands, but we are not using our resources particularly smartly at the moment.'

Environmental audit (snapshot)

An environmental audit was conducted in three subacute mental health inpatient facilities in NSW. Two metropolitan Sydney sites and one regional site was visited. The ACI trauma-informed care and practice project members appreciated the friendliness of the staff at the units who afforded them the time and opportunity to undertake the audit. The *15 Steps Challenge Observational Audit* was used as the guiding framework.⁶ The audits provided a view of three overarching themes: the atmosphere, the physical aspects and amenities the facilities provided, and the interactions and communications observed and catered for.

First impressions of all three facilities indicated that they were well organised and clean, and a resident or carer visitor would likely have the confidence that they are safe, secure, well-run units. Two of the facilities acknowledged Aboriginal culture, one displaying numerous substantial pieces of Aboriginal art. However, one facility had very limited visible Aboriginal artwork, with only a map of Aboriginal lands across Australia noted. There was some variability as to how welcoming the environments were in terms of design, décor and space, both internal and external. This largely reflected the age and architecture of the facility. The use of colour to create a warm and homely atmosphere was particularly evident in two settings. All of the units were well-lit with pleasant, well-cared for external areas such as a garden or balcony that offered peace and recreation. Consumer art was visible throughout all facilities, and all units had feature scenic wall panels to create individualised spaces and character.

Positive interactions between consumers and staff were observed in two facilities, with all staff out and about on the ward. However, in the third facility, consumers appeared to be somewhat isolated, with no interactions observed between staff and consumers, with all staff remaining during the visit in the office area on the computers. Two of the facilities offered some opportunities to access information about staff, care and weekly activities, and provided ways for consumers to comment to the team. A reasonable selection of arranged activities were available such as games and televisions in common areas; however, they were not available in bedrooms. The third facility had minimal visible information available for consumers, with no visible communication or activity boards. Family spaces were available in all three facilities but offered variable levels of family-centric amenities. The 'YES Consumer Experience Survey' forms and Official Visitors boxes were observed in all three facilities. Two facilities displayed service vision and policy information very clearly. One had limited accessible information on the service values and general information. All three facilities provided excellent sensory spaces accessible to consumers; however, there was variability between the units in the types of sensory equipment available. Some of the sensory items included relaxation and massage armchairs, soft lighting, a sophisticated music selection system, as well as nature mobile visuals on screen and attractive scenic wall panels. Exercise equipment, musical instruments and other recreational activities were openly available in all units. One facility had a designated music room.

One facility offered bedrooms that appeared homely and included en-suite bathroom facilities. However, another facility had starkly decorated bedrooms with shared bathrooms, which were cold and clinical in nature. All of the units were mixed gender environments, with gender-specific bedroom corridors available in all settings. Two of the facilities had designated female and male-only areas. The dining areas were reasonably appropriate but there was limited ability to access fresh food snacks and fluids. One facility had very limited access to free-flowing water. Numerous planned upgrades were reported and noted at two sites.

Discussion

This report has used experiential and observational data to describe experiences of staff (clinicians and managers), consumers and carers. It highlights numerous areas for improvement in service provision across NSW mental health services.

Five key areas have been identified for immediate priority for services. These are: the need for enhanced collaboration between consumers, clinicians and carers; a stronger emphasis on safety for all; new and improved models for mental health service delivery; enhanced education and training in TIC; and a focus on culturally safe and competent services.

Enhanced collaboration between consumers, clinicians and carers



There is a need to improve engagement with carers particularly in discussions and decisions about mental health care. There are opportunities for collaboration to support better overall outcomes for consumers. Consumers report a strong desire to enhance communication and collaboration in order to ensure experiences of care are therapeutic and less confusing. Increased transparency would aid consumers and carers to understand why and how decisions are made. While clinicians also desire services to reflect person-centred care and collaboration to enhance TIC, they require support to navigate obstacles related to documentation, time and workloads. These principles conflict with their capacity to provide therapeutic care. Managers may perceive such issues are used as an excuse to not undertake TIC and, as such, collaborative approaches are required to reach mutual understanding of the issues and co-develop workable solutions.

A stronger emphasis on safety for all



All participant groups highlighted a need for an increased focus on safety within services. This includes minimising trauma and re-traumatisation for consumers, carers and staff. Provision of staff wellbeing activities and professional support in a safe workplace culture are required to ensure staff are able to adequately address the needs of consumers and carers. Safety for consumers and carers includes the physical environment of services, interactions with staff and the provision of individually tailored care. Asking about trauma and providing interventions to address experiences of trauma and minimise further harm are essential to TIC.

New and improved models for mental health service delivery (TIC as a lens)



To be trauma-informed, services must consider new and flexible models of care. Current approaches to service provision in mental health are limited in their capacity to deliver effective and trauma-informed care for consumers and staff alike. Existing approaches to care were described as inconsistent, not strengths-based and often failing to meet the therapeutic needs of consumers. Inconsistencies in care were described as leading to negative experiences of care. Consumers have expressed interest in opportunities to access alternative approaches to care, rather than purely pharmaceutically driven treatment.

Enhanced education, training and governance in trauma-informed care



Delivering TIC to consumers and carers, clinicians and managers requires widespread access to locally developed training to ensure relevant and practically oriented understandings of TIC. Staff also need to be able to provide consumers with information about trauma and trauma-specific interventions. Any implementation of TIC or associated activities will require attention to change management and implementation to ensure staff feel supported through the processes of change and to transparently address issues of under-resourcing and change fatigue.

Managers reported feeling fatigued by the numerous initiatives occurring in health. Similarly, carers and consumers shared experiences of fatigue and confusion with various policies and approaches across mental health services. Clinicians also felt fatigued; however, their experiences of fatigue centred around frequent reports of poorly or under-resourced services and high rates of staff turnover. While clinical supervision was viewed positively by clinicians, there were barriers to accessing this.

Focus on culturally safe and competent services



Many Aboriginal consumers reported experiences of stigma, marginalisation, trauma and re-traumatisation when accessing mental health services. The data presented in this report highlight issues specific to the Aboriginal community that was engaged, that require attention for implementation of TIC. TIC is an integral element of any service working with Aboriginal people and diverse communities. There is an urgent need for services to review and ensure mental health services deliver culturally safe and competent services that address social and emotional wellbeing as understood by Aboriginal consumers and their families.

Conclusion

This report has highlighted many things that 'need to be done' for NSW mental health services to move towards TIC. While five key priority areas have been identified, there are many pathways to change. Focus groups and interviews highlighted numerous individuals and teams working innovatively to deliver trauma-informed services and programs. There is a need for ongoing support, vigilance and resources to support individuals and teams sustain a momentum of TIC, and for services to deliver best practice to consumers and carers in ways that are sensitive to trauma and reduce harm occurring in care.

Limitations

Authors acknowledge that there are some limitations in this report. While efforts were made to recruit widely, the experiences of consumers, carers, clinicians and managers reported cannot be assumed to encompass those of all services, contexts or individuals. We recommend further exploration to expand our knowledge, particularly about the experiences of people living in rural and remote areas, Aboriginal consumers and individuals who access the services of community managed organisations.

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