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Trauma-informed care in mental health services across NSW

A framework for change

Trauma-informed care changes the question from 'what is wrong with you?' to 'what has happened to you?'.

Trauma is defined as: "an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful and has lasting adverse effects on a person's mental, physical, social, emotional or spiritual well-being".[1] There is a high prevalence of trauma in the lives of people accessing mental health services.

Trauma-informed care is based on the principles of safety, choice, collaboration, trust and empowerment.[2] It emphasises safety and minimises re-traumatisation for both service providers and people accessing services.

Trauma-informed care is associated with:

- improved patient-reported outcomes and coping skills
- improved safety and fewer injures for staff
- increased rates of discharge to lower level of care
- decreased use of seclusion and restraint
- decrease in presenting problems
- improved symptoms with shorter length of stay.

Trauma-informed care

Trauma-informed care or trauma-informed care and practice is a strengths-based approach that is responsive to the impact of trauma. It emphasises physical, psychological and emotional safety for both survivors of trauma and service providers. Trauma-informed care creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in an understanding of the neurological, biological, psychological and social effects of trauma, and recognises the high prevalence of these experiences for people who access mental health services.

Some experts in NSW prefer the term 'trauma-informed care and practice'. This framework uses the term 'trauma-informed care' as it is the predominant terminology used in the literature.

How can this framework be used?

The intention of this document is to support the implementation of trauma-informed care in mental health services across NSW. The framework identifies what good practice looks like for mental health systems, services and staff, and includes related actions.

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What does trauma-informed care look like?

Trauma-informed care looks like:

- treating consumers with empathy and compassion
- taking the time to engage with clients in order to build safety
- asking questions to understand a consumer's experience
- providing consumers with access to space, resources or supports when dysregulated
- providing choice and collaboration wherever possible
- assuming consumers are doing the best they can with the resources they have, at all times.

How was this framework developed?

The following provided the basis of the framework:

- *Trauma-informed care and mental health in NSW: Evidence report*[2]
- *Trauma-informed care and practice in mental health services across NSW: Diagnostic report*[3]
- Statewide solution design workshops

This framework was developed by clinicians, managers, people with a lived experience, carers, families, kinship groups and other experts in the field.

Who is the framework for?

This framework is for everybody working in mental health services, people accessing support and those who support them. While this framework has been developed for mental health services, the priority areas and actions identified can be applied across other health settings. Trauma-informed care is everyone's business. Action areas are targeted across the system and will involve a multi-level approach for implementation.

System – NSW- Ministry of Health (the Ministry), NSW Health pillar organisations, and tertiary training institutions to develop resources and provide support to local health districts (LHDs) and specialty health networks (SHNs).

Service – LHD and SHN mental health services to implement trauma-informed care and support staff in adapting practice.

Individual – All staff working in mental health services across the lifespan, including administration, clinical, non-clinical and management, to incorporate trauma-informed care into their practice.

Priority areas for improvement

The six identified priority areas for action are:

1. Cultural safety*
2. Collaboration
3. Safety for all
4. New and improved models of mental health care
5. Education and training
6. Leadership and governance

** The cultural safety icon designed by Phillip Orcher.*

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Their voices have made this framework possible.

Priority area 1. **Provide culturally safe and competent services for focus populations**

System actions	**Service** actions	**Individual** actions
1.1 An accountability framework for racism and discrimination is developed to ensure cultural safety and competency. This should be guided by *National Cultural Competency Standards*.[4]	**1.7** Mental health services address the social and emotional wellbeing of focus population staff, consumers and social support networks.	**1.18** All staff are aware of the potential additional trauma experienced by many Aboriginal people and common triggers (e.g. racism) when accessing government services.
1.2 Cultural safety training is embedded in all NSW mental health facilities.	**1.8** A cultural assessment tool is used by mental health staff to determine the aspects of safety.	**1.19** All staff are aware of the unique experiences of trauma experienced by those from culturally and linguistically diverse backgrounds.
1.3 A co-designed cultural assessment tool is developed to determine aspects of safety for focus populations.	**1.9** Physical spaces provide consumers and kinship groups with cultural, emotional, social and physical safety.	**1.20** Staff know how to use identified cultural assessment tools to determine all aspects of safety.
1.4 Mental health care plans designed for Aboriginal people are developed and included in electronic medical records (eMR).	**1.10** Ongoing cultural safety training is provided to all staff.	**1.21** Staff understand the importance of creating physical spaces that provide consumers and kinship groups with cultural, emotional, social and physical safety.
1.5 *NSW Health Services Aboriginal Cultural Engagement Self Assessment Tool* is used in facilities.[5]	**1.11** Culturally-accredited supervisors are available for all staff.	**1.22** All staff understand the cultural significance of Aboriginal artwork displayed in their mental health facility.
1.6 Dedicated Aboriginal workforce positions are funded in each LHD and SHN.	**1.12** Regular support is provided to staff to assist them to provide culturally appropriate care to Aboriginal people, people from diverse backgrounds and their families.	**1.23** All staff are aware of and acknowledge the Traditional Custodians of the land on which the organisation is located.
	1.13 There is compliance and accountability for completion of Aboriginal Impact Statements for all projects, policies and procedure development.[6]	**1.24** Staff ask Aboriginal consumers if they would like to be linked to an Aboriginal mental health worker.
	1.14 Use of mental health care plans designed for Aboriginal people in eMR.	**1.25** Yarning is used in clinical assessments and care planning with Aboriginal people.
	1.15 Use of *NSW Health Services Aboriginal Cultural Engagement Self Assessment Tool*.[5]	**1.26** Staff use mental health care plans designed for Aboriginal people in eMR.
	1.16 Aboriginal workforce positions are recruited to.	**1.27** Staff work alongside social and emotional wellbeing teams in Aboriginal community controlled organisations.
	1.17 Services engage local community stakeholders, including Aboriginal community controlled health services, and support referral pathways, communication and options for shared care.	**1.28** Staff use clear and plain English language, without clinical jargon, that incorporates trauma-sensitive language and non-verbal communication.

Priority area 2. **Enhance collaboration between consumer, clinician and social support networks**

System actions

2.1 Clear, consistent guidance about the appropriate recognition and engagement of carers and consumers is developed.

2.2 People with lived experience of mental health issues are employed in governance committees at all levels.

2.3 A framework for peer workforce development is co-developed and provided to LHDs and SHNs and aligned with the NSW Mental Health Commission's *Lived Experience Framework* [7] and the *National Lived Experience Workforce Development Guidelines* [8].

2.4 Clear accountability is established for embedding the NSW Mental Health Commission's *Lived Experience Framework* [7] and the *National Lived Experience Workforce Development Guidelines* [8].

2.5 An advance care directive policy and framework for all mental health services is developed and embedded in the eMR.

2.6 A framework is developed to identify organisational structures which enable co-designed approaches. Co-design in service planning and delivery is a key performance indicator (KPI).

2.7 Partnerships with tertiary training institutions are established to ensure curriculum for healthcare professionals includes training on the value of lived experience perspectives and roles.

2.8 Resources are committed to enable consumers to have access to peer-led services.

Service actions

2.9 Integrated pathways of care are developed between public services, health services, non-government and community managed organisations and other services.

2.10 Trauma-informed orientation to mental health services is developed for consumers and social support networks.

2.11 Training and support is provided to consumers and social support networks to participate in governance groups, steering committees and working parties.

2.12 There are lived experience co-chairs on all committees.

Consumers and social support networks

2.13 Are active and valued members of mental health governance groups, steering committees and relevant working parties. Membership is evaluated and reported.

2.14 Have access to co-design processes for service development and quality improvement.

2.15 Have access to co-developed care plans which are interactive, easy to read and accessible.

2.16 Have access to regular forums to discuss challenges and opportunities for service improvement.

Peer workforce

2.17 Are active and valued members of mental health governance groups, steering committees and working parties.

2.18 Service structures enable the peer workforce to work alongside clinical lead positions and participate in dialogues between consumers and clinicians.

2.19 Service structures and processes enable the peer workforce to be involved in initial engagement, throughout support and follow up with consumers.

2.20 Services provide access to supervision, training, career advancement and leadership opportunities to peer workforce.

Individual actions

All staff consider the following actions:

Consumers and social support networks

2.21 Are valued, recognised and supported as central to the recovery journey.*

2.22 Are actively involved in all phases of care planning and receive a copy of care plans.*

2.23 Participate in shared decision-making.*

2.24 Receive a trauma-informed orientation to public mental health services.

2.25 Receive clear transparent, consistent information about their care in trauma-sensitive language.

2.26 Have access to Your Experience of Service (YES) and Carer Experience of Service (CES) surveys, to provide feedback to services.

Peer workforce

2.27 Work alongside clinical lead positions and liaise between consumers and clinicians.

2.28 Are involved in initial engagement, throughout support and follow-up with consumers.

2.29 Have access to peer supervision, training, career advancement and leadership opportunities.

* Information exchange with social support networks should occur in consideration of clients' expressed support network and consent for information exchange.

Priority area 3. **Have a stronger emphasis on safety for all**

System actions	**Service** actions	**Individual** actions
3.1 A trauma-informed care organisational self-assessment tool is developed for all mental health care settings.	**3.9** Trauma-informed care organisational self-assessments are conducted across all mental health care settings.	**3.20** Staff and consumers provide feedback to management about any concerns or quality improvement recommendations arising from assessments and care delivery processes.
3.2 Accreditation with White Ribbon[9] and RainbowTick[10] is embedded and supported in all services.	**3.10** All services are White Ribbon[9] and Rainbow Tick [10] accredited.	**3.21** Staff understand principles of White Ribbon[9] and Rainbow Tick[10] accreditation.
3.3 Co-designed supervision is embedded for all professional streams working in mental health services, including peer workforce, and follows evidence-based models of safety for all.	**3.11** Reports from YES and CES are incorporated into trauma-informed care quality improvements.	**3.22** Consumer-led safety plans are routinely used by staff.
3.4 Workforce strategies include provisions for reflective practice, debriefing, monitoring and mitigating compassion fatigue, burnout and vicarious trauma.	**3.12** Process for staff, consumers and social support networks to provide feedback and quality improvement recommendations arising from care delivery are implemented and clearly communicated.	**3.23** Staff are aware of wellbeing services available to them.
3.5 Communities of practice for trauma-informed care are established for both clinicians and peer workers, and include diverse and culturally safe representation.	**3.13** Frequent reviews of admission processes, physical environments, clinical interactions (person-centred and directed care) against the principles of trauma-informed care, are conducted using an audit tool or self-assessment tool.	**3.24** Staff provide opportunities for debriefing processes to consumers and social support networks.
3.6 Trauma-informed care principles are part of accreditation and are embedded in the *National Safety and Quality Health Service Standards*.[11]	**3.14** Formal debriefing and reflective practice processes are developed.	**3.25** Staff consider opportunities to choose a physical place for assessment that promotes sense of safety and minimises re-traumatisation for consumers.
3.7 Staff injuries, consumer injuries and incidents are reported and publicly available.	**3.15** Trauma-informed supervision programs and reflective practice are encouraged for all mental health staff as part of performance. Supervisors should be culturally accredited.	
3.8 Staff health programs are embedded in all LHDs and SHNs and are part of models of care and service delivery.	**3.16** A workforce wellbeing strategy is developed, including self-care, team-based and organisational strategies for cultural change.	
	3.17 Staff are encouraged to identify their self-care and burnout prevention plans as part of their orientation and ongoing performance reviews.	
	3.18 Peer-led trauma-informed diversional program activities are available in all service settings for consumers.	
	3.19 Consumers and social support networks are offered debriefing opportunities following inpatient incidents.	

Priority area 4. **Design new and improved models of mental health care**

System actions	**Service** actions	**Individual** actions
4.1 Trauma-informed care is innovatively embedded in all system level agreements.	**4.12** Strategies that promote innovation, research and interdisciplinary collaboration relevant to service delivery are implemented.	**4.24** Clinicians use appreciative and respectful enquiry and ensure that consumer's strengths are incorporated into assessments.
4.2 Strategies that promote innovation, research and interdisciplinary collaboration relevant to service delivery are supported.	**4.13** Feedback from consumers, social support networks and mental health workers is consistently integrated into mental health service improvement.	**4.25** Clinicians ensure continuity of care and collaborative transitions of care occur.
4.3 Health infrastructure and redesign incorporates trauma-informed care best practice.	**4.14** Models of care are localised by LHDs and SHNs and training programs are implemented to reinforce and ensure system KPIs can be met.	**4.26** Care plans are developed in partnership with consumers and social support networks, and are clearly communicated by staff.
4.4 Trauma-informed care is measured in all models of care through KPIs.	**4.15** Peer-led services are available across mental health services.	**4.27** Mental health staff deliver trauma-informed care orientation to mental health services to consumers and social support networks.
4.5 Consistent trauma-informed care messaging, definitions and practice approaches are used across the state.	**4.16** Services promote appreciative and respectful enquiry and ensure that consumers' strengths are incorporated into assessments.	**4.28** Staff are aware of wellbeing services available to them.
4.6 All NSW mental health policies and practices embed principles of trauma-informed care.	**4.17** Paid consumer and carer worker roles are recruited to throughout mental health services.	**4.29** Staff provide psychological therapies to consumers.
4.7 Resources are committed for paid consumer and carer roles to be available in mental health services.	**4.18** Vicarious trauma is monitored and there is compassionate management of burnout and compassion-fatigue of staff.	**4.30** Staff are aware of complimentary therapies available to consumers (e.g. yoga, meditation and sensory modulation).
4.8 Strengths-based care assessments are promoted for all mental health care settings.	**4.19** Staff are supported to access health initiatives and wellbeing services during work hours (e.g. yoga and meditation).	**4.31** All staff approach consumers and social support networks with principles of good customer service.
4.9 Inclusion of validated and recognised screening tools in new and emerging models of care should be considered (e.g. adverse childhood experiences).	**4.20** Staff are trained in, and there is increased access to, evidence-based psychological therapies for consumers (e.g. cognitive behavioral therapy).	
4.10 Guidelines for optimal staffing models are developed in line with trauma-informed care principles and practice and are supported in LHDs and SHNs.	**4.21** Access to complimentary therapies for consumers is increased (e.g. yoga, meditation, sensory modulation).	
4.11 Support to increase consumer access to complimentary and psychological therapies is provided to LHDs and SHNs.	**4.22** Trauma-informed orientation to public mental health services is developed for consumers and social support networks.	
	4.23 Inclusion of validated and recognised screening tools in existing and emerging models of care and workflows is considered (e.g. adverse childhood experiences).	

Priority area 5. **Enhance education and training for staff**

System actions	**Service** actions	**Individual** actions
5.1 Statewide trauma-informed care core principles training is developed for all NSW Health staff. Training should include a focus on: • Aboriginal and culturally and linguistically diverse people • lesbian, gay, bisexual, trans and gender diverse, intersex and queer people (LGBTIQ+) • historical, cultural and contemporary experiences of trauma • good customer service skills applied in a healthcare context • mitigation strategies around vicarious trauma, compassion fatigue, burnout and fostering wellbeing for staff. **5.2** Specialist trauma-informed care training is developed for all NSW Health mental health staff at all levels, including management, executive, clinical and non-clinical. **5.3** Accredited cultural safety training is developed for all NSW Health mental health staff. **5.4** Trauma-informed care training is co-designed, co-developed and co-delivered with consumers, carers and peer workers. **5.5** Explore options for trauma-informed care core training to be developed and made available for all mental health first responders and emergency service providers. **5.6** Partnerships with tertiary training institutions and accreditation bodies are established to minimise disconnect between workplace expectations and professional development.	**5.7** All NSW Health staff complete trauma-informed care training that includes a focus on: • Aboriginal and culturally and linguistically diverse people • LGBTIQ+ people • historical, cultural and contemporary experiences of trauma • good customer service skills applied in a healthcare context • mitigation strategies around vicarious trauma, compassion fatigue and burnout, and fostering wellbeing for staff. **5.8** Ongoing trauma-informed care training is prioritised for frontline workers, managers and executive. Compliance is monitored by the senior executive teams of each service. **5.9** Trauma-informed care training is co-designed and co-facilitated by consumers, carers and peer workers. **5.10** All mental health staff, including management, executive, clinical and non-clinical, are provided with ongoing specialist trauma-informed care training. **5.11** All clinical staff receive training in strengths-based care assessments. **5.12** Mental health staff received culturally safe and comprehensive training in screening tools and interventions included in existing and emerging models of care. **5.13** All mental health workers receive accredited cultural safety training and are confident using cultural assessment tools and yarning principles.	**5.14** All NSW Health staff undertake trauma-informed care training that includes a focus on: • Aboriginal and culturally and linguistically diverse people • LGBTIQ+ people • historical, cultural and contemporary experiences of trauma • good customer service skills applied in a healthcare context • mitigation strategies around vicarious trauma, compassion fatigue, burnout and fostering wellbeing for staff. **5.15** Continuing professional development includes trauma-informed care training and education. **5.16** Clinicians are actively engaged in clinical supervision. **5.17** Mental health workers complete accredited cultural safety training and are confident using cultural assessment tools and yarning principles. **5.18** All mental health staff, including management, executive, clinical and non-clinical, complete ongoing specialist trauma-informed care training. **5.19** Mental health staff complete culturally safe and comprehensive training in screening tools and interventions included in existing and emerging models of care. **5.20** Clinical staff complete training in strengths-based care assessments.

Priority area 6. **Ensure clear leadership and governance**

System actions	**Service** actions	**Individual** actions
6.1 A NSW Health-wide definition and approach to trauma-informed care is identified and communicated with all LHDs and SHNs. **6.2** Trauma-informed care education and training is promoted and monitored by the executive as a KPI. **6.3** Trauma-informed care quality improvement processes are created. **6.4** Trauma-informed policy is applied in all mental health service settings. **6.5** Trauma-informed care KPIs are developed and monitored in LHDs and SHNs. **6.6** Human resource and work health and safety policies are informed by, and include, principles of trauma-informed care. **6.7** Leave matters policies are updated to acknowledge that it is appropriate for staff to take sick leave for mental health matters as well as physical health.	**6.8** There are appointed trauma-informed care champions and leads in each service. **6.9** Each service has a clear governance structure and reporting lines for trauma-informed care. **6.10** Trauma-informed care training for staff is monitored and reported on by leadership. **6.11** Trauma-informed care organisational self-assessments (e.g. *Trauma-informed care and practice organisational toolkit* (TICPOT)[12]) are used across mental health settings to guide service reform. **6.12** Localisation of human resources and work health and safety policies are informed by, and include, principles of trauma-informed care.	**6.13** Staff know who are the appointed trauma-informed care champions and leads in each service. **6.14** Staff have a clear understanding of service governance structure and reporting lines for trauma-informed care.

Glossary

Aboriginal community controlled health organisation	A primary healthcare service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate healthcare to the community which controls it (through a locally elected board of management).
Co-developed	A process that enables consumers and carers to become equal partners in the development and improvement process for health services.
Consumer	A person with lived experience of a mental health condition who is accessing, or has previously accessed, a mental health service.
Cultural safety	Cultural safety in healthcare means designing and providing services that meet the needs of patients through a process of self-reflection, awareness of cultural biases and processes to actively respond in a way that will benefit the patient's health and wellbeing.
Diversional programs	Diversional programs recognise that leisure and recreational experiences are the right of all individuals. Activities are designed to support, challenge and enhance the psychological, spiritual, social, emotional and physical wellbeing of individuals.
eMR	electronic medical record
Focus populations	In the context of cultural safety, focus populations are those who experience inequalities. This includes people who are Aboriginal, culturally and linguistically diverse, LGBTIQ+, refugees, experiencing homelessness and other marginalised populations.
Good customer service skills	Good customer service means consumers and families, carers and kinship groups receive clear and thorough communication, timely and quality assistance, and interactions with staff are pleasant in nature to ensure a positive experience.
Kinship group	Generally refers to relatives, friends or local community members.
KPI	Key performance indicator
LGBTIQ+	Lesbian, gay, bisexual, trans and gender diverse, intersex and queer people.[13]
LHD	Local health district
NSW Health pillars	Includes the Clinical Excellence Commission, Agency for Clinical Innovation, Bureau of Health Information, Cancer Institute NSW and Health Education and Training Institute.
Peer worker	A mental health peer worker is someone employed on the basis of their personal lived experience of mental illness and recovery (a consumer peer worker), or their experience of supporting family or friends with mental illness (carer peer worker). This lived experience is an essential qualification for their job, in addition to other skills and experience required for the particular role they undertake.

Safety for all	A concept in healthcare where clinical and non-clinical staff work in partnership with consumers, families and carers to improve the safety of mental health services for all who work in and access them.
SHN	Specialty health network
Social support network	Inclusive of people with lived experience of caring, supporting and being part of family, kinship group or friends of people with lived experience of mental illness.
Strengths-based	Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.
Trauma-informed care	An approach to service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage. It incorporates principles of safety, choice, collaboration, trust and empowerment.
Yarning	An informal conversation that is culturally friendly and recognised by Aboriginal people as meaning to talk about something, someone, or provide and receive information.
YES and CES	The Your Experience of Service (YES) and Carer Experience of Service (CES) surveys are designed to gather information from consumers and carers about their experiences of care. They aim to help mental health services, consumers and carers to work together to build better services.

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