EVIDENCE SERIES

Trauma-informed care and mental health in NSW

NOVEMBER 2019

Contents

NSW GOVERNMENT | AGENCY FOR CLINICAL INNOVATION

Mental Health Network

Trauma-informed care in NSW
At a glance

Trauma-informed care is 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.

Safety
Ensuring physical and emotional safety

Collaboration
Sharing decision making and power

Trauma-informed care incorporates...

Choice
Individuals have choice and control

Trustworthiness
Task clarity, consistency, interpersonal boundaries

Empowerment
Prioritising enablement and skill building
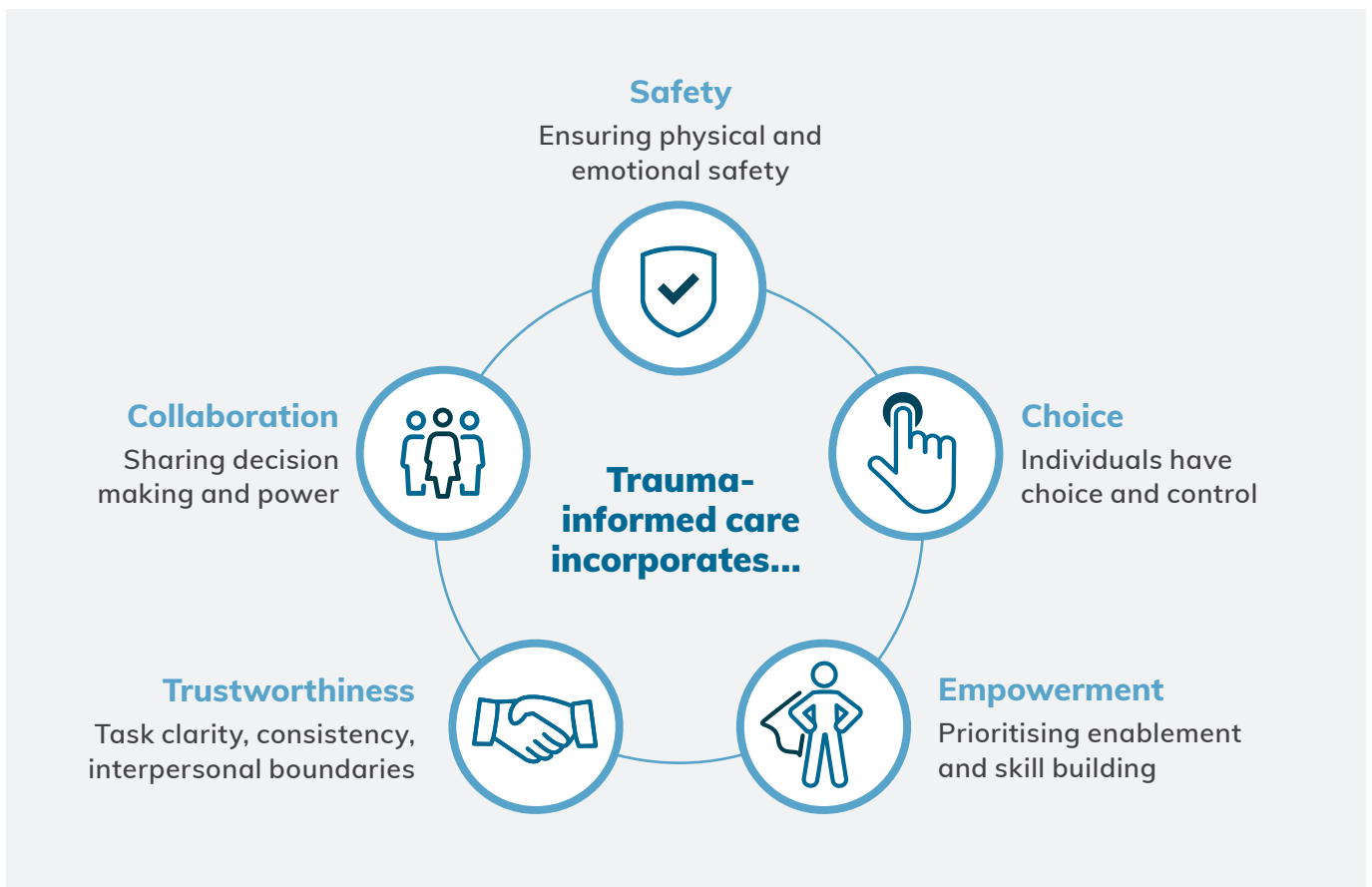
Research

There is evidence that trauma-informed care is associated with:

- Less seclusion and restraint
- Better outcome
- Fewer staff injuries
- Less over-utilisation of healthcare services

Consumer perspectives

From an online survey:

- Trust and therapeutic relationships are highly valued
- Fewer than half of respondents said:
  - they felt safe and comfortable
  - they were involved in decisions about their care and treatment

Clinician perspectives

From an online survey:

- Acceptance of the relevance of trauma in healthcare
- Almost one third respondents said care does not support people to recover from trauma
- The barriers to trauma informed care span organisational, professional, educational and structural factors

Summary

Trauma-informed care is an approach to healthcare service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.

Adopting a trauma-informed care approach has the potential to reduce the use of seclusion and restraint; enhance therapeutic relationships and their basis in trust, collaboration, respect and hope; and improve outcomes and value.

This report summarises research evidence on the impact of trauma-informed approaches on processes and outcomes of care; and considers the extent to which mental health services in NSW are trauma-informed, using empirical evidence drawn from survey data and experiential evidence from consumers and clinicians.

What do we mean by trauma?

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 or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being'.[1]

There is a substantial and growing body of evidence attesting to the pervasiveness and impact of trauma. It shows the following:

- Experiences of trauma are associated with the development of mental distress and there is evidence of a dose effect and association between the severity, frequency and range of adverse experiences, and the impact on overall mental, behavioural and physical health

- Many people accessing mental health services have experienced trauma

- Traumatic experiences are more common within Aboriginal, ethnic minority and socially disadvantaged groups

- Mental health services can cause iatrogenic harm to people who have experienced trauma and can inflict vicarious trauma on staff

- Trauma-informed care has widespread relevance that is broader than health extending into education, justice and other social services.[2]

Trauma-informed care represents a fundamental change but at the same time resonates with existing good practice

Many aspects of trauma-informed practice overlap with general principles of good care such as person-centredness, recovery-oriented care and compassionate care. Adoption of trauma-informed practice builds on the principles of good care, to emphasise the role that experiences of trauma play in healthcare encounters and outcomes.

Does trauma-informed care work?

Trauma-informed care has been associated with:

- decreased use of seclusion, restraint and other coercive practices

- symptom resolution – shorter length of stay, improved rates of discharge to lower level of care, fewer presenting problems

- better patient reported outcomes and coping skills

- fewer staff injuries

- cost benefits.

Policy on trauma-informed care

There is widespread policy support for trauma-informed care. For example, the *Fifth National Mental Health* and *Suicide Prevention Plan* states that all staff should be trained in delivery of recovery-oriented and trauma-informed care, and asserts that founding mental health services on trauma-informed principles is vital to ensure the greatest opportunity of recovery.[3] In NSW, multiple health policies mandate trauma-informed care, including *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*, Yarning Honestly About Aboriginal Mental Health in NSW 2013; and the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022.[4-6]

Are mental health services in NSW trauma-informed?

Multiple reports, investigations and inquiries conducted over the past decade have pointed to a need for more trauma-informed care in NSW.[7,8] A recent review of seclusion, restraint and observation in NSW health facilities described services that traumatise and show a lack of compassion and humanity.[9]

In 2018, ACI's Mental Health Network conducted two online surveys – one for consumers (105 respondents) and one for clinicians (506 respondents). Results show that services are not always trauma-informed.

Results from the consumer survey responses

- Over half of all respondents to the consumer survey said they either disagreed (30%) or strongly disagreed (22%) with the statement *I felt that staff understood how my life experiences may have impacted on my own mental health*.

- In response to the statement, *The care I received was sensitive to my individual needs*, 24% disagreed and 22% strongly disagreed.

- When asked whether they felt safe and comfortable in the mental health environment that was involved in their care and treatment, 21% said *occasionally* and 18% said *never*.

- In a related statement regarding the way staff responded: *When I did not feel safe, staff listened to my concerns and supported me* 30% of respondents said *occasionally* and 19% said *never*.

Results from the clinician survey

- In response to the statement *I believe the service I work in supports people to recover from trauma*, 21% of clinicians disagreed and 8% strongly disagreed.

- A quarter of respondents said they either disagreed (20%) or strongly disagreed (5%) with the statement *I feel supported to deliver care that incorporates trauma-informed approache*s.

- The overwhelming majority of respondents said they disagreed (42%) or strongly disagreed (51%) with the statement *The impact of trauma is not relevant when a person is seeking general/ physical health services.*

Towards a new organisational model?

The adoption of trauma-informed care can involve widespread change to practices, policies, the physical environment and organisational culture in healthcare settings.

Shifting to new models of practice will require an understanding of barriers and enablers of trauma-informed care delivery at individual, organisational and system levels.

Introduction

Trauma-informed care is an approach to service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage.[10,12]

It recognises the importance of patient-centredness; universal precautions focused on careful and sensitively performed screening for trauma; safe and welcoming environments; and choice and shared decision making.[13,14]

Trauma-informed practice acknowledges the prevalence and potential impact of trauma, and seeks to avoid the potential for people to exclude themselves from services as a result of trauma related distress triggered by contact with staff and services. Trauma-informed services change the question from 'What is wrong with you?' to 'What has happened to you?'.[10,15] The trauma-informed approach acknowledges that those in most need of services may also be the hardest to reach and most unlikely to engage effectively with services.

What is trauma?

Trauma is a multifaceted and complex concept that encompasses a broad range of harmful, abusive or neglectful experiences (Figure 1).

A widely cited definition of trauma is: 'an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being'.[1]

Trauma can be a single incident or sustained, cumulative or unresolved experiences, sometimes known as complex trauma.[16] People experience trauma in many different ways and it can have a profound and enduring influence on people's lives.

How prevalent is trauma?

An estimated 75% of Australians have experienced a potentially traumatic event in their lifetime; a rate similar to the 70% reported internationally.[17,18] Incidence varies across Australia, with higher rates in Aboriginal, prison populations and socially disadvantaged groups.[12] Not everyone who has been exposed to trauma suffers from significant psychological or emotional effects.

The link between experiences of trauma and mental health is well established. There is evidence of a dose dependent relationship, with a clear correlation between the severity, frequency, and duration of adverse experiences and outcomes.[19-21]

Many people who access mental health services have a lived experienced of trauma and are more likely to have a history of complex trauma.[22-24]

Mental health services and treatment can unintentionally cause harm. They can traumatise through the use of coercive practices, such as seclusion, physical and chemical restraint, and involuntary admissions. Re-traumatisation can occur when a past traumatic event is evoked or recounted.[15,25]

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*   This report uses the term 'trauma-informed care' which is the predominant terminology in the literature. Some experts in NSW prefer the term 'trauma-informed care and practice'. Trauma-informed care and practice is a strengths-based practice approach that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for people with lived experience to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services.

Staff are also at risk of trauma. Mental health nurses experience significant rates of physical and verbal abuse.[26] Staff are also at risk of developing compassion fatigue, and suffering burnout and vicarious trauma.

The Mental Health Coordinating Council, the peak body for community managed mental health organisations in NSW, has identified eight foundational principles of trauma-informed care and practice.[27] These reflect elements of safety, choice, collaboration, trust and empowerment.

Box 1. The Mental Health Coordinating Council's eight foundational principles for trauma-informed care and practice

1. Understanding trauma and its impact
2. Promoting safety
3. Ensuring cultural competence
4. Supporting consumer control, choice and autonomy
5. Sharing power and governance
6. Integrating care
7. Healing happens in relationships
8. Recovery is possible

Figure 2. Schematic of types of trauma

Trauma

Lifetime experiences
Domestic violence
Sustained mental illness
Coercive practices in care settings
Racism
Asylum seeking
Intergenerational trauma
Vicarious trauma
War

Adverse childhood experiences
Emotional, physical or sexual abuse
Neglect
Parental mental illness/ substance use/incarceration
Exposure to domestic violence
Cultural trauma

Complex trauma
(Sustained, cumulative or unresolved)

Single incident
Assault
Hospitalisation or other acute illness
Accident
Rape

(Adapted from NHS Education for Scotland, Transforming Psychological Trauma)

Data and methods

The production of this report has drawn on three main types of evidence (Figure 2).

1. Research evidence

PubMed was searched using a two stage approach. First, a review of reviews was conducted to identify existing syntheses and meta-analyses. Second, search strategies used in the existing reviews were updated to find any more recent studies (Figure 3).

Snowball searches were conducted from the reference lists of key articles.
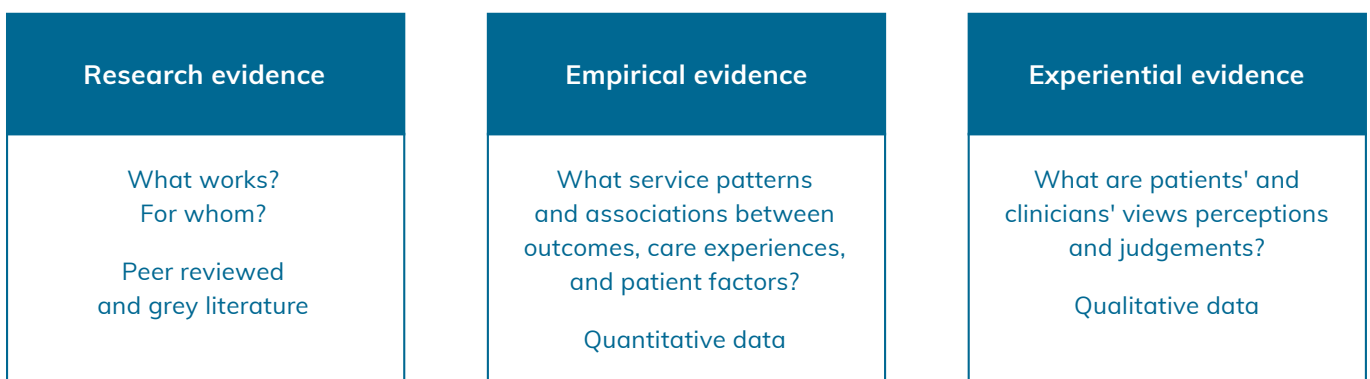
2. Grey literature review

Internet searches, using key terms ['trauma-informed care'; 'mental health' AND trauma] were undertaken alongside focused searches on key websites, including the National Institute for Health and Care Excellence (NICE); the National Health Service (NHS) (in England and Scotland); Department of Health and Human Services, Victoria; Queensland Health, and MIND. A brief description of trauma-informed care in other jurisdictions is shown in Appendix 1.

3. Empirical evidence

Consumer and staff surveys

In July 2018, two online surveys were distributed to Mental Health Network members: one for consumers (10 multiple choice and two free text questions) and the other for clinicians (14 multiple choice and three free text questions). Responses were received from 105 consumers and 506 clinicians. Multiple choice questions focused on views and experiences of care and the extent to which care was trauma-informed. Answers to multiple choice questions were analysed using SAS PROC-FREQ function; free text questions were analysed using N-VIVO.

Figure 2. ACI evidence series reports: three types of evidence

Research evidence	Empirical evidence	Experiential evidence
What works? For whom? Peer reviewed and grey literature	What service patterns and associations between outcomes, care experiences, and patient factors? Quantitative data	What are patients' and clinicians' views perceptions and judgements? Qualitative data

* Full annotated table of retained articles is available on request.

4. Policy context

Alongside collection and collation of relevant evidence, key policy documents were reviewed, including the following:

National Health Policies

- Fifth National Mental Health and Suicide Prevention Plan

- Trauma-informed Services and Trauma-Specific Care for Indigenous Australian Children

- Roadmap for National Mental Health Reform 2012-2022

- National Mental Health Commission 2015, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services, Volume 1 Strategic Directions, Practical Solutions 1–2 years.[3,28-30]

NSW Health Policy

- NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022

- Aboriginal Mental Health and Well Being Policy 2006-2010

- Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused Upon Older People

- Aggression, Seclusion & Restraint in Mental Health Facilities

- Building Strong Foundations (BSF) Program Service Standards

- Clinical Care of People Who May Be Suicidal

- Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines

- Sexual Safety – Responsibilities and Minimum Requirements for Mental Health Services

- Sexual Safety of Mental Health Consumers Guidelines

- Living Well – A Strategic Plan for Mental Health in NSW 2014-2024

- Yarning Honestly About Aboriginal Mental Health in NSW 2013.[4,6,31-38]

Figure 3. Search strategy for PubMed

Research evidence
Does trauma-informed care work?

There has been a number of systematic reviews and evidence syntheses published in the past five years (Table 1)[†].

The available evidence shows that trauma-informed care is associated with:

- decreased use of seclusion and restraint [39-44,58]

- improved symptoms – shorter length of stay, increase in rates of discharge to lower level of care, decrease in presenting problems[45-47]

- better patient reported outcomes and coping skills[48-50]

- fewer staff injuries[41]

- cost benefits.[51,52]

Trauma-informed care was not found to affect emergency room, prison and shelter use.[53]

While several studies are large, multi-site and quasi-experimental in design, the evidence-base is limited by the relatively small number of projects, with most undertaken in the USA.

There is a separate body of literature that considers different approaches to specific aims of trauma-informed care, for example, interventions to reduce seclusion and restraint (e.g. NICE, 2015; Ashcraft and Anthony, 2008; Barton et al, 2009).[39,54,55] That literature has not been synthesised in this document.

Table 1: Review articles focused on the effectiveness of trauma-informed care

Article	Method	Main findings
Purtle et al, 2018[56] Systematic Review of Evaluations of Trauma-Informed Organisational Interventions That Include Staff Trainings	A systematic review of peer-reviewed studies that evaluated the effects of trauma-informed organisational interventions that included a staff training component. Searched PubMed, PsycINFO, and the Published International Literature on Traumatic Stress database to July 2017 23 articles met inclusion criteria.	Staff knowledge, attitudes, and behaviours related to trauma-informed practice improved significantly pre-post training in 12 studies and seven studies found that these improvements were retained at one month follow-up. Eight studies assessed the effects of a trauma-informed organisational intervention on client outcomes, five of which found statistically significant improvements. The strength of evidence about trauma-informed organisation intervention effects is limited by preponderance of single group, pre-post test designs with short follow up periods, unsophisticated analytic approaches, and inconsistent use of assessment instruments.
Sweeney et al, 2016[42] Trauma-informed mental healthcare in the UK: what is it and how can we further its development?	Searched nine electronic databases (Medline, Embase, PsycInfo, CINAHL, Cochrane Library, Sociologicial Abstracts, Social Policy and Practice, Global Health and Maternity and Infant Care) using the title-word search "trauma and informed". Searches were from the earliest date of each database to August 2014 Eight studies met the inclusion criteria.	All studies were conducted in the USA. Four were controlled pre-and post-studies, two were pre-post-studies and one was a qualitative study. Beneficial effects noted included reduction in seclusion, reduced post-traumatic stress and general mental health symptoms, increased coping skills, improved physical health, greater treatment retention and shorter inpatient stays. There was no change in substance misuse, emergency room use, imprisonment and shelter use.

Article	Method	Main findings
Reeves et al 2015[57] A Synthesis of the Literature on Trauma-Informed Care	Examined existing research on trauma-informed care for survivors of physical and sexual abuse. Searched CINAHL and PubMed to September 2013.	Theme: trauma screening and patient disclosure, provider patient relationships, minimising distress and maximising autonomy, multidisciplinary collaboration and referrals, and trauma-informed care in diverse settings.
Muskett, 2013[44] Trauma-informed care in inpatient mental health settings: A review of the literature	Search of the Psychology and Behavioural Sciences, Nursing and Allied Health Comprehensive and Biomedical Collections electronic databases was performed, linking the primary subject terms of 'trauma-informed' plus 'adult' or 'youth inpatient mental health/ psychiatric care'. Specific search parameters were also applied to identify articles published from January 2000 to June 2011. 13 articles met inclusion criteria.	The use of multiple strategies was found to be more effective in the implementation of trauma-informed care across a range of mental health settings, including inpatient units. Critical ingredients in successful implementation of trauma-informed care in the USA were: active leadership support, role modelling, and engagement in trauma-informed principles; data collection (e.g. seclusion and restraint incidents); rigorous debriefing and prevention-focused analysis of events that do occur; trauma-informed education and skill development of staff; use of a range of assessments (e.g. trauma, risk, and strengths identification) and tools to teach self-management of illness and emotional regulation; and involvement and inclusion of consumers at all levels of care.
Wilson et al 2017[58] Literature review of trauma-informed care: implications for mental health nurses working in acute inpatient settings in Australia. International Journal	Integrative literature review. Total of n= 10 studies met the inclusion criteria. • Examined trauma-informed care in an acute adult mental health unit • Written in English • Met the overarching aim of the review Content analysis approach guided by trauma-informed care and practice principles.	Five themes were identified for trauma-informed care: 1. Therapeutic relationship 2. Recovery 3. Choice and control 4. Seclusion and restraint 5. The environment Positive outcomes from trauma-informed care education and training most apparent around seclusion and restraint. Trauma-informed care highlighted challenges regarding therapeutic relationships and embedding recovery principles within mental health.

Consumer survey – multiple choice questions
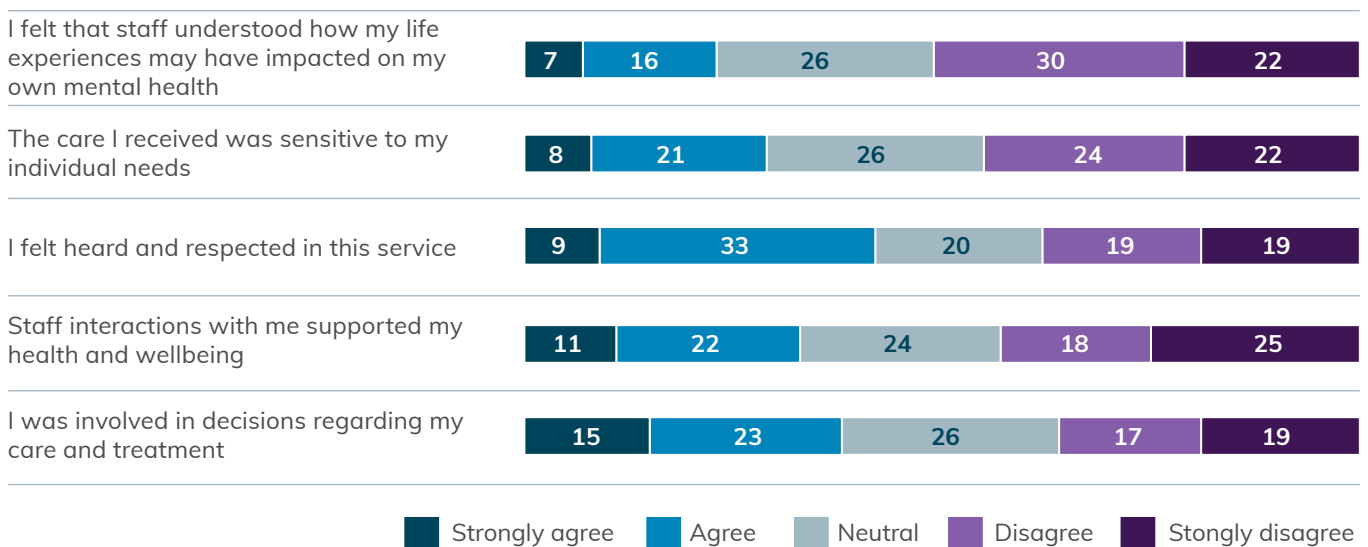## Is mental health care in NSW trauma-informed?

Currently, many mental health services provide care for people who have experienced trauma but without directly addressing trauma. In many cases, service providers are unaware that trauma has occurred.[16]

Individuals with experiences of past and current trauma can present to a diverse range of services over extended periods, during which they may receive multiple and fragmented interventions that fail to address their underlying needs.[10] This pattern of care comes at a significant cost to the individual, the community and the health services that seek to support them.

A range of data can help assess the extent of gaps in trauma-informed care and practice in NSW – including consumer and clinician surveys, and administrative data sources. The survey found that over half of respondents said they either disagreed (30%) or strongly disagreed (22%) with the statement I felt that staff understood how my life experiences may have impacted on my own mental health.

More than 4 in 10 respondents said that the care they received was not sensitive to their individual needs (46%); and that staff interactions did not support their health and well-being (43%).

Figure 4: Consumer survey on trauma-informed care, NSW, 2018
[agreement statements, % selecting each response category]

Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I felt that staff understood how my life experiences may have impacted on my own mental health	7	16	26	30	22
The care I received was sensitive to my individual needs	8	21	26	24	22
I felt heard and respected in this service	9	33	20	19	19
Staff interactions with me supported my health and wellbeing	11	22	24	18	25
I was involved in decisions regarding my care and treatment	15	23	26	17	19

Legend: ■ Strongly agree ■ Agree ■ Neutral ■ Disagree ■ Stongly disagree

Source: Trauma-informed care and practice survey, 2018

When asked whether they felt safe and comfortable in the mental health environment involved in their care and treatment, 21% of consumers said occasionally and 18% said never.

In response to a related statement regarding the way staff reacted: *When I did not feel safe, staff listened to my concerns and supported me*, 30% of consumers said *occasionally* and 19% said *never*.

Interestingly, when staff were asked to react to a similar statement: *The environment I work in is physically safe for consumers* and *staff* – 8% of clinicians said *occasionally* and 4% said *never*.
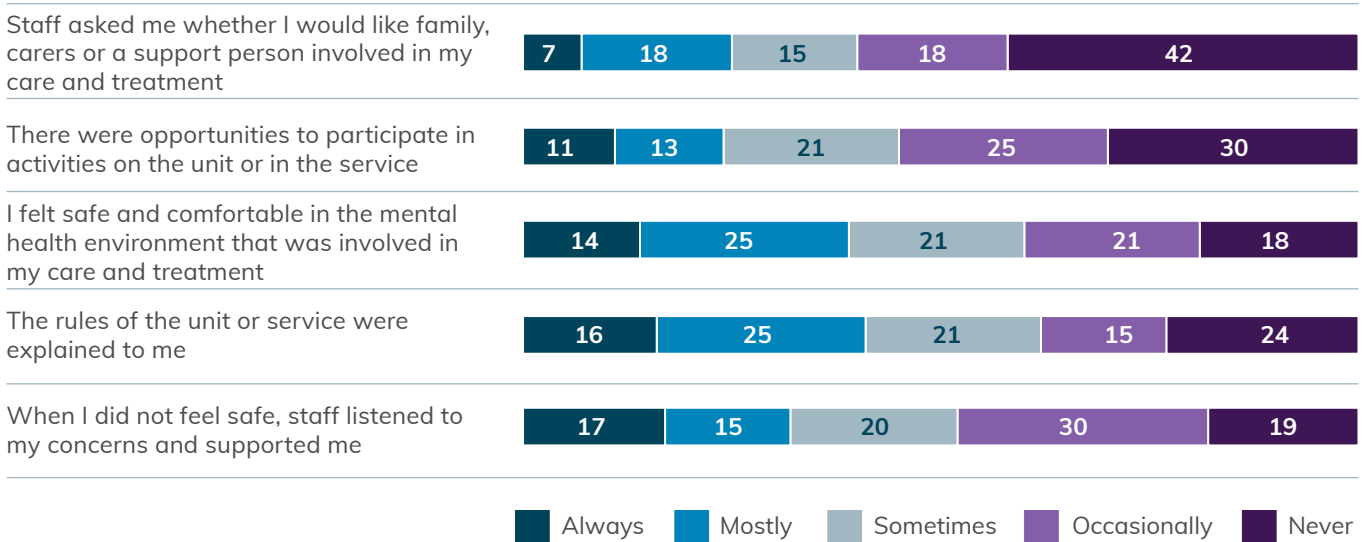
In response to a related statement regarding the way staff reacted: *When I did not feel safe, staff listened to my concerns and supported me*, 30% of consumers said *occasionally* and 19% said *never*.

Interestingly, when staff were asked to react to a similar statement: *The environment I work in is physically safe for consumers and staff* – 8% of clinicians said *occasionally* and 4% said *never*.

Figure 5: Consumer survey on trauma-informed care, NSW, 2018
[quantity statements, % selecting each response category]

Statement	Always	Mostly	Sometimes	Occasionally	Never
Staff asked me whether I would like family, carers or a support person involved in my care and treatment	7	18	15	18	42
There were opportunities to participate in activities on the unit or in the service	11	13	21	25	30
I felt safe and comfortable in the mental health environment that was involved in my care and treatment	14	25	21	21	18
The rules of the unit or service were explained to me	16	25	21	15	24
When I did not feel safe, staff listened to my concerns and supported me	17	15	20	30	19

Legend: ■ Always ■ Mostly ■ Sometimes ■ Occasionally ■ Never

Source: Trauma-informed care and practice survey, 2018

Consumer survey – free text comments
Is mental health care in NSW trauma-informed?

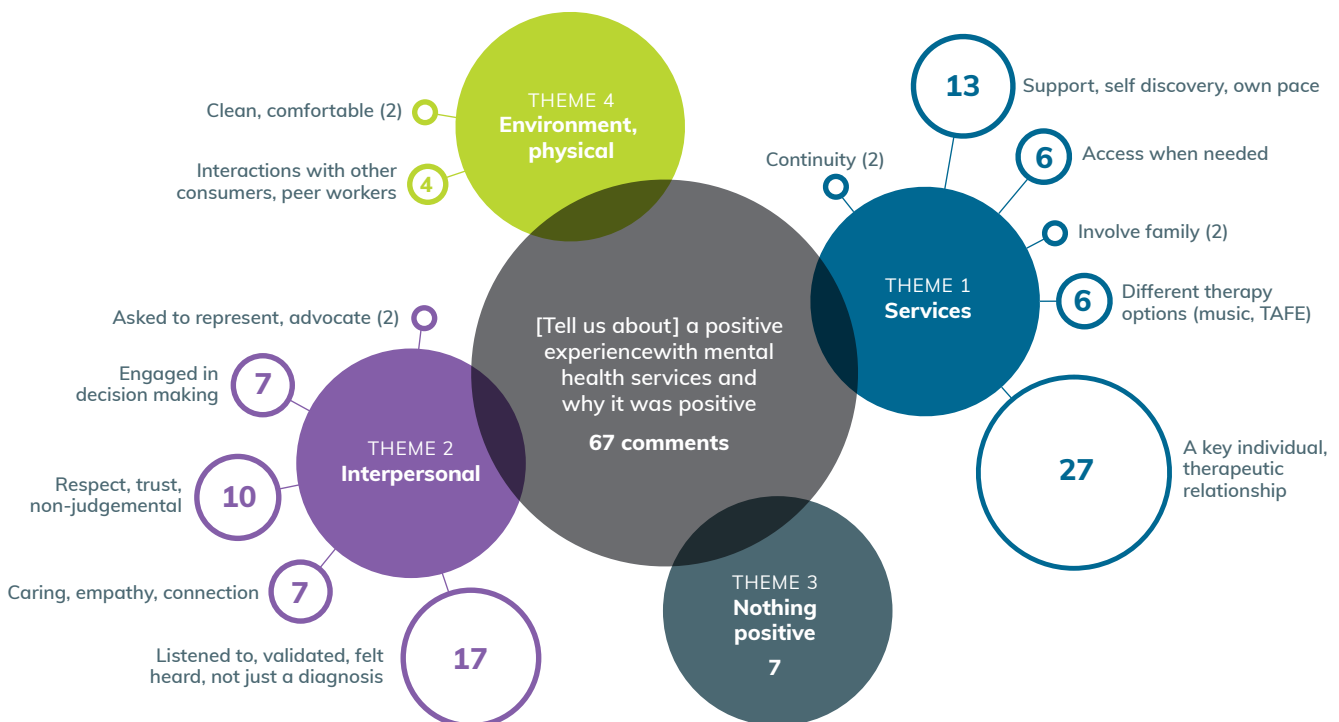The online consumer survey included two free-text questions:

- *Can you tell us about a time where you had a positive experience with mental health services and why was this experience positive for you?*

- *What can mental health services do to improve your experiences of care and support?*

Responses were explored using qualitative data analysis approaches. All responses were parsed and clustered into thematic tables (see for example, Table 2) and concept maps (Figures 6 and 7).

The most frequently cited element in positive experiences concerned a key individual with whom the consumer made a connection.

In terms of suggestions for improvement, staff training and education was most frequently mentioned and there was strong support for peer workers, consumer consultants, and transitional care.

Figure 6: Concept map of consumer responses to the survey question: *Can you tell us about a time where you had a positive experience with mental health services and why was this experience positive for you?*

Clean, comfortable (2)

THEME 4
Environment, physical

Interactions with other consumers, peer workers — 4

13 Support, self discovery, own pace

Continuity (2)

6 Access when needed

Involve family (2)

THEME 1
Services

6 Different therapy options (music, TAFE)

Asked to represent, advocate (2)

Engaged in decision making — 7

[Tell us about] a positive experience with mental health services and why it was positive
67 comments

THEME 2
Interpersonal

Respect, trust, non-judgemental — 10

27 A key individual, therapeutic relationship

Caring, empathy, connection — 7

THEME 3
Nothing positive
7

Listened to, validated, felt heard, not just a diagnosis — 17

Source: Trauma-informed care and practice survey, 2018

Table 2: Example of response nodes to the online survey question: *Can you tell us about a time where you had a positive experience with mental health services and why was this experience positive for you?*

Major theme	Sub themes (n)	Examples
Interpersonal interactions	Listened to, validated, felt heard, not just a diagnosis (17 comments)	*I had a positive experience with the service when I felt heard by my psychiatrist.* *My private psychologist treats me as a human being rather than a diagnosis to be dealt with.*
	Respect, trust, non-judgemental (10 comments)	*Case worker at the time was a good match to support my recovery process. Mainly due to the relationship being based on trust and dignity.* *Being encouraged by a mental health worker to do the thing that I enjoyed and had a great understanding of what it could be like to have a mental health issue and being non-judgemental of the person.*
	Engaged in decision making (7 comments)	*I had a positive experience with my last acute admission to xxx hospital adult psychiatric unit. I was involved in all my care decisions, including length of stay, what medication I was given and given sufficient leave.*
	Caring, empathy, connection (7 comments)	*When accessing ongoing support from a community mental health service, I was linked with the most supportive and understanding psychologist who was instrumental in helping me overcome what had happened to me …* *Knowing that my support had lived experience and understood my journey.*

There were 67 responses to the question, some responses were parsed into multiple themes.

Figure 7: Concept map of consumer responses to the survey question:
What can mental health services do to improve your experiences of care and support?
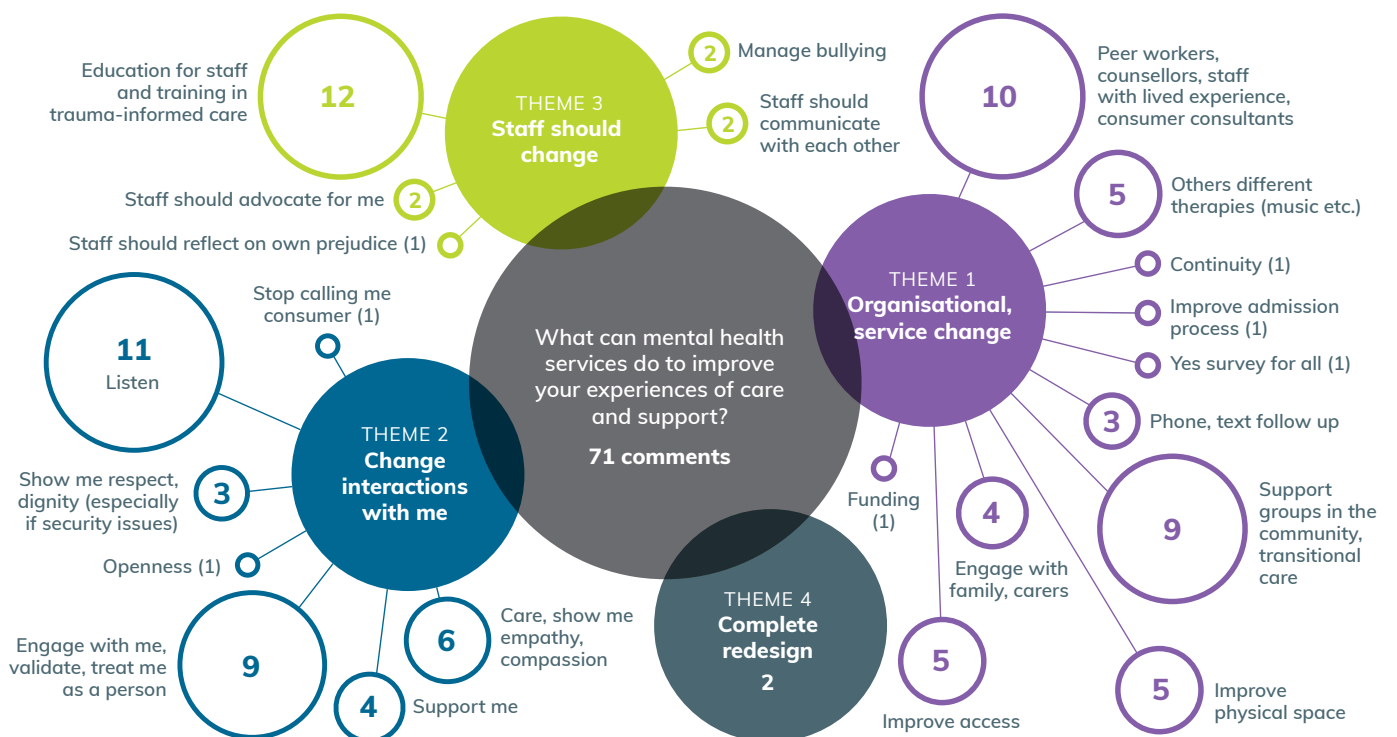
Clinician survey – multiple choice questions
## Is mental health care in NSW trauma-informed?

There were 506 clinicians who responded to the online survey about trauma-informed care. The results show that there are opportunities to improve in the delivery of trauma-informed care in NSW (Figures 8, 9 and 10).

Most clinicians acknowledged the important role that trauma plays in health. The overwhelming majority said they disagreed (42%) or strongly disagreed (51%) with the statement *The impact of trauma is not relevant when a person is seeking general/physical health services.*

However many clinicians recognise that the care provided to consumers is not always trauma-informed. In response to the statement *I believe the service I work in supports people to recover from trauma*, 21% of clinicians disagreed and 8% strongly disagreed.

A quarter of respondents said they either disagreed (20%) or strongly disagreed (5%) with the statement *I feel supported to deliver care that incorporates trauma-informed approaches.*

Figure 8: Clinician survey on trauma-informed care, NSW, 2018

[agreement statements, % selecting each response category]
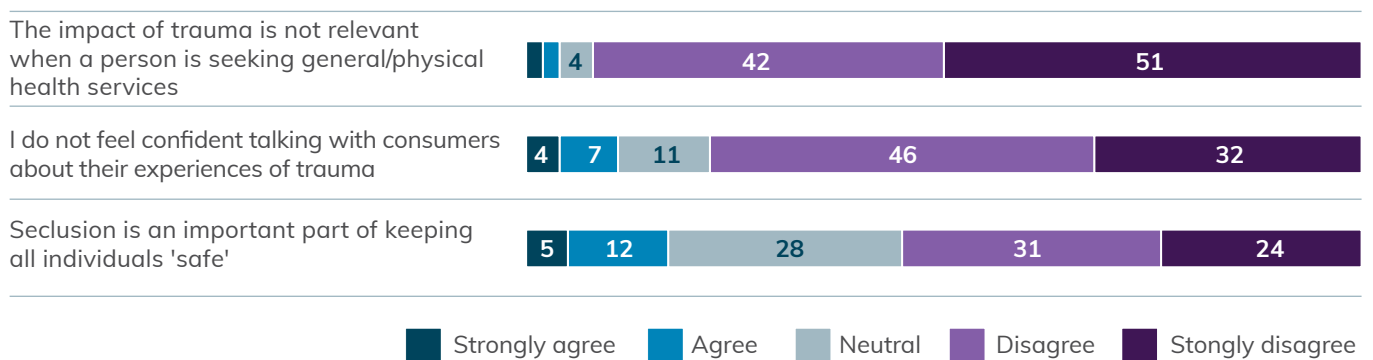
Note: Detailed result tables are available in supplementary Excel files

Source: Trauma-informed care and practice survey, 2018

Figure 9: Clinician survey on trauma-informed care, NSW, 2018
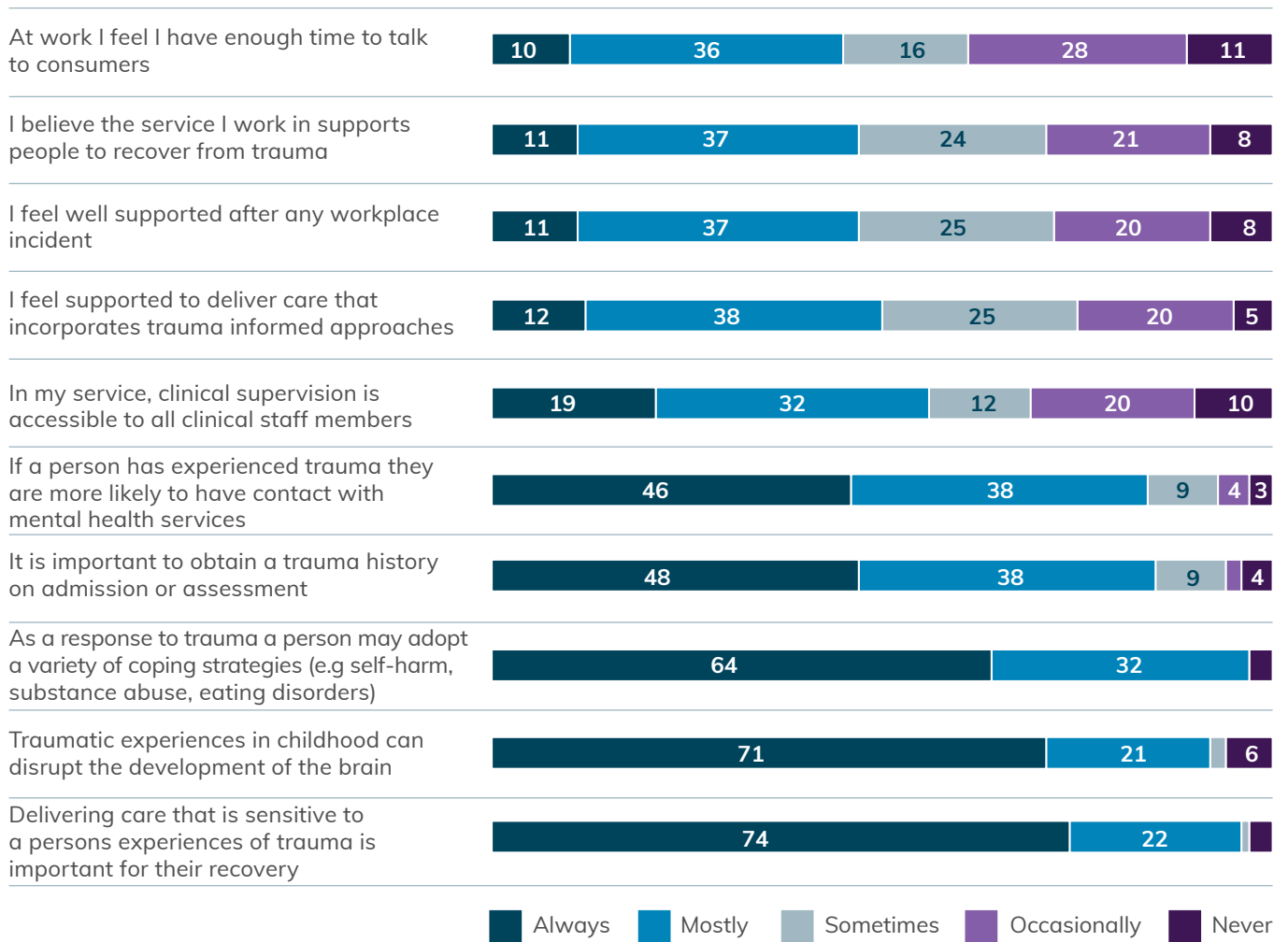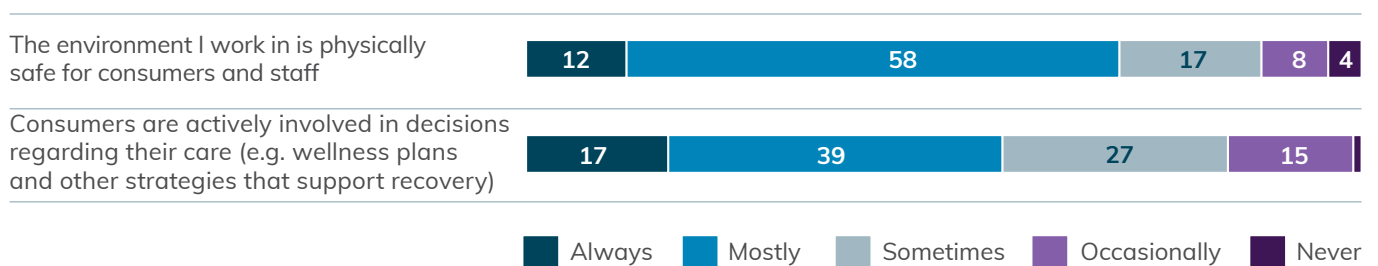[agreement statements, % selecting each response category]

Statement	Always	Mostly	Sometimes	Occasionally	Never
At work I feel I have enough time to talk to consumers	10	36	16	28	11
I believe the service I work in supports people to recover from trauma	11	37	24	21	8
I feel well supported after any workplace incident	11	37	25	20	8
I feel supported to deliver care that incorporates trauma informed approaches	12	38	25	20	5
In my service, clinical supervision is accessible to all clinical staff members	19	32	12	20	10
If a person has experienced trauma they are more likely to have contact with mental health services	46	38	9	4	3
It is important to obtain a trauma history on admission or assessment	48	38	9		4
As a response to trauma a person may adopt a variety of coping strategies (e.g self-harm, substance abuse, eating disorders)	64	32			
Traumatic experiences in childhood can disrupt the development of the brain	71	21			6
Delivering care that is sensitive to a persons experiences of trauma is important for their recovery	74	22			

Legend: ■ Always ■ Mostly ■ Sometimes ■ Occasionally ■ Never

Figure 10: Clinician survey on trauma-informed care, NSW, 2018 [quantity statements, % selecting each response category]

Statement	Always	Mostly	Sometimes	Occasionally	Never
The environment I work in is physically safe for consumers and staff	12	58	17	8	4
Consumers are actively involved in decisions regarding their care (e.g. wellness plans and other strategies that support recovery)	17	39	27	15	

Legend: ■ Always ■ Mostly ■ Sometimes ■ Occasionally ■ Never

Source: Trauma-informed care and practice survey, 2018

Clinician survey – free text comments
## Is mental health care in NSW trauma-informed?

The online consumer survey included three free text questions.

- *Can you describe, in your own words, what trauma-informed care looks like in your day to day practice?*

- *What do you see as the biggest barriers to delivering trauma-informed care in your service?*

- *What do you think you need to support you in your services setting to deliver trauma-informed care?*

Responses were explored using qualitative data analysis approaches. All responses were parsed and clustered into thematic tables (Table 3) and concept maps (Figures 11 and 12).

The most frequently mentioned feature of trauma-informed care was an awareness of and sensitivity to trauma. There was an interesting dichotomy that emerged in terms of how to interact with consumers – for many clinicians, taking a full history was seen as essential in embarking on care, while for others, it was important to let consumers' history emerge over time.

Figure 11: Concept map of clinician responses to the survey question:
Can you describe, in your own words, what trauma-informed care looks like in your day to day practice?
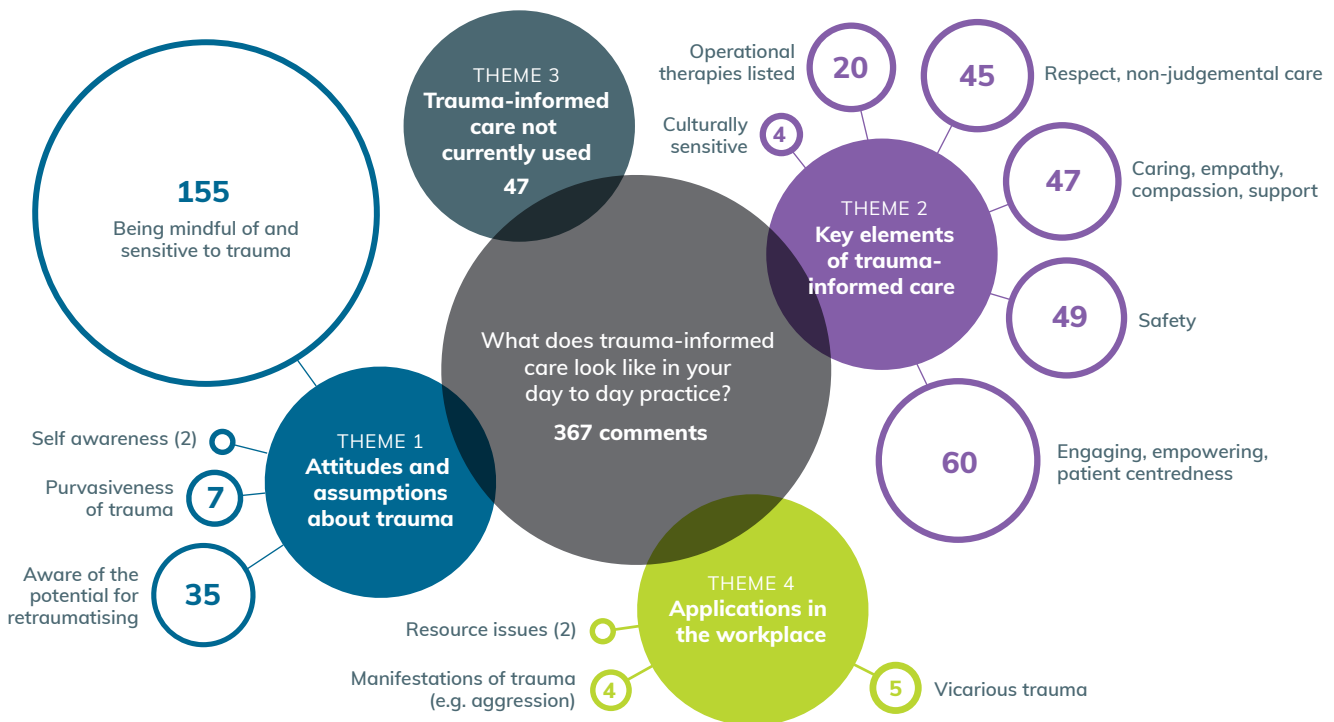

Note: Question 2 focused on the barriers to delivering trauma-informed care and practice and Question 3 focused on what was required to support trauma-informed care and practice which elicited similar responses the map of Question 3 is not shown, full data files are available.

Table 2: : Example of response nodes to the mental health clinician online survey question:

Can you describe, in your own words, what trauma-informed care looks like in your day to day practice?

Major theme	Sub themes (n)	Example
Attitudes and assumptions about trauma	Being mindful of or sensitive to trauma (155 comments)	*I am aware that trauma is a reality for a significant proportion of the people I care for. I am acutely aware that such trauma has had a significant impact on those people and continues to do so.* *Being aware that the people that I am engaging with have often experienced trauma in their past.*
	Awareness of the potential for re-traumatising (35 comments)	*Conscious awareness not to traumatise them further during inpatient stay.* *Also being mindful of the pace that the client wishes to go in this regard and being aware of not re-traumatising them.*
	Pervasiveness of trauma (7 comments)	*Being aware of the pervasive nature of trauma in the community.*
	Self-awareness (2 comments)	*Having a high level of self-awareness as a clinician, being aware of what I am bringing to work each day emotionally, physically, how I am communicating directly and indirectly, having an awareness of how I may be perceived by others.*

There were 367 responses to the question, some responses were parsed into multiple themes

Figure 12: Concept map of clinician responses to the survey questions:

What do you see as the biggest barriers to delivering trauma-informed care in your service?
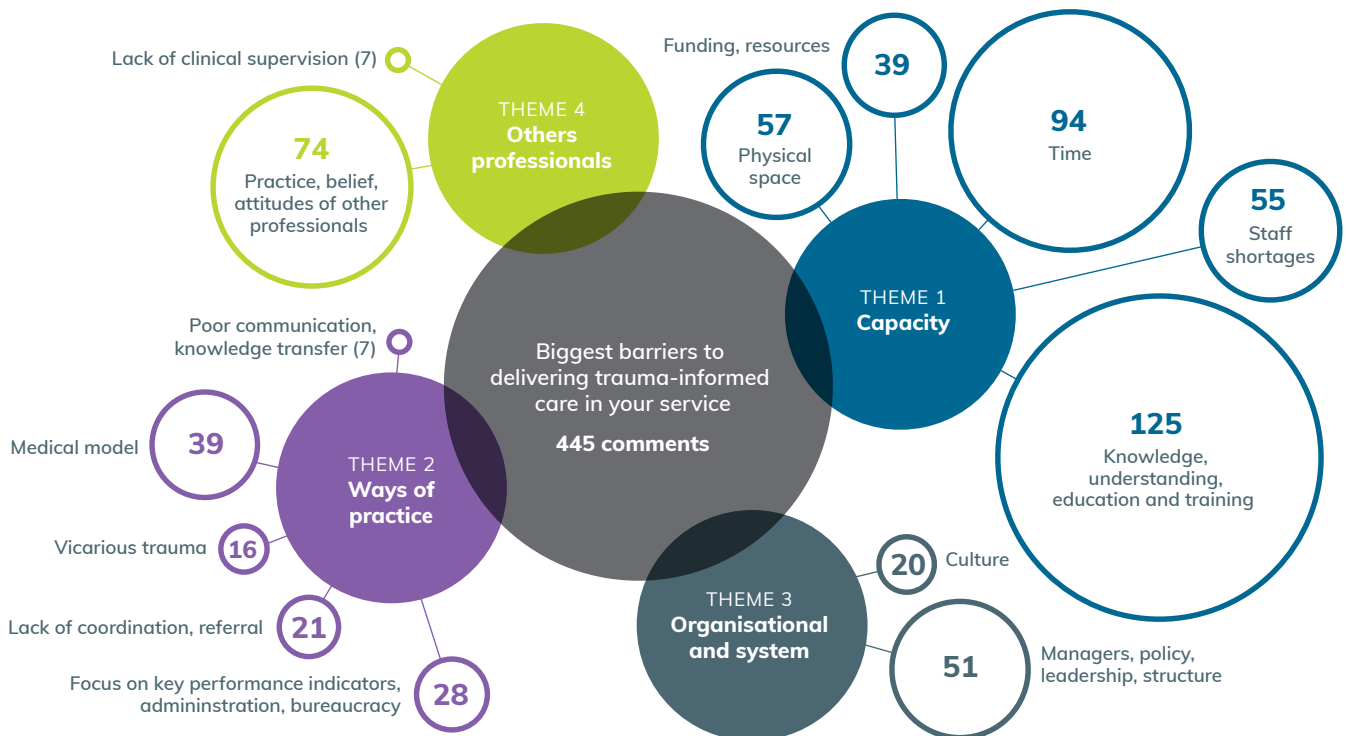
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Appendix 1: Trauma-informed care in select jurisdictions

Trauma-informed care is a topic of particular interest in a number of healthcare systems both within Australia and internationally.

Australia

Blue Knot Foundation: Trauma-informed care

The Blue Knot Foundation is the National Centre for Excellence for complex trauma. The organisation aims to empower recovery and build resilience for people who experience trauma. It provides education, training and evidence based resources to embed trauma-informed care in policy and practice across the community and relevant organisations.

www.blueknot.org.au/resources/Publications/ Practice-Guidelines

NSW

Mental Health Coordinating Council (MHCC)

The Mental Health Coordinating Council (MHCC) is the peak body for community mental health organisations in New South Wales. The purpose of the MHCC is to support a strong and sustainable community-managed mental health sector that provides effective health, psychosocial and wellbeing programs and services to the people of NSW. MHCC provides policy leadership and promotes legislative reform and systemic change and example of this is the Trauma-informed Care and Practice Organisational Toolkit (TICPOT). The TICPOT is a systematic approach to guiding organisational change, suitable for any human services organisation.

http://www.mhcc.org.au/resource/ticpot-stage-1-2-3/

Victoria

A 10-year mental health plan technical paper (2016)

A 10-year mental health plan technical paper (2016) highlighted the role of the workforce in creating services that are recovery-oriented, trauma-informed, evidence-based, outcomes focused, culturally safe, inclusive and accessible, and that adapt to the diverse needs of services users and their carers and families.

www.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

USA

The Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) has been instrumental in highlighting the impact of trauma experiences; the potential benefits of trauma-informed care and in supporting research implementation and research.

www.store.samhsa.gov/system/files/sma14-4884.pdf

The Adverse Childhood Experiences (ACE) Study

The Adverse Childhood Experiences (ACE) Study is a research study conducted by Kaiser Permanente and the Centers for Disease Control and Prevention. Participants were recruited to the ACE study between 1995 and 1997 and have been in long-term follow up. ACE examined traumatic and adverse experiences reported in childhood and demonstrated the links between trauma and longer-term health, mental health and social impacts. The ACE study was one of the first to show the 'dose effect', – that is, the more trauma and adversity someone experiences, the more likely they are to suffer consequences. The Center for Disease Control CDC continues ongoing surveillance of ACEs by assessing the medical status of the study participants via periodic updates of morbidity and mortality data. ACE studies, major findings and statistics, ACE questionnaires and resources for presentations are available at:

www.cdc.gov/violenceprevention/acestudy/about_ace.html

Scotland

The Transforming Psychological Trauma framework

The Scottish government commissioned a framework that considers the impact on people of living through any trauma, at any stage in life. The Transforming Psychological Trauma framework is broadly focused and addresses how to equip the Scottish workforce in trauma-informed care, including mental health but also extending into wider areas of society. The framework considers safety, choice, collaboration, trustworthiness and empowerment.

www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf

Appendix 2: Empirically based studies of the effectiveness of trauma-informed care

Table 6. Empirically based studies of the effectiveness of trauma-informed care

Study	Method	Main findings
Suarez et al, 2014 An evaluation of Project Kealahou: - Hawai'i's trauma-informed system of care for at-risk girls and young women	At enrolment and six months post enrolment patient reported measures.	Preliminary outcome data demonstrates that Project Kealahou youth and their caregivers reported significant improvements in measures of youth strengths (P = .024), competence (P = .027), depression (P = .009), impairment (P = .007), behavioural problems (P = .017), emotional problems (P = .007), as well as caregiver strain (P = .001),
Messina et al, 2014	Controlled pre-post study. 277 women offenders, USA Intervention was gender-responsive treatment.	Using generalised estimation equations, detected significant group × time interactions in post traumatic stress disorder (odds ratio [OR] = 0.17) and some related symptomatology (-: OR = 0.42; and avoidance: OR = 0.24).
Greenwald et al, 2012	Pre-post study 53 adolescents in a residential treatment facility, USA Intervention was training in the 'Fairy Tale' model of trauma-informed treatment.	In the intervention year (compared to the previous year), there was a 34% improvement in presenting problems; 39% decrease in time to discharge, and 100% increase in the rate of discharge to lower level of care.
Goetz and Taylor-Trujillo, 2012	Intervention was two-day trauma-informed training on aggression management provided by SAMHSA staff, USA.	**Staff outcomes:** Number of staff injuries reduced by 48% in first year after implementation. Staff perceptions of safety improved in five of the 10 areas in first year after implementation. **Patient outcomes:** Hours of seclusion, hours of restraint, and number of aggressive patient incidents were reduced by approximately 50% in first year after implementation (exact figures not presented).
Azeem et al, 2011	Pre-post study 458 patients admitted to a child and adolescent psychiatric hospital, USA Intervention was training staff in six core strategies based on trauma-informed care.	A decrease in the number of seclusion or /restraint episodes from 93 (73 seclusions, /20 restraints), involving 22 children and adolescents to 31 episodes (six seclusions, /25 restraints) involving 11 children and adolescents.
Borckadt et al, 2011	Randomised, controlled study, with each of five inpatient units randomly assigned to implement an intervention component at different stages. PROC Mixed (version 9.2 in SAS) was used to determine impact of intervention on seclusion and restraint rates over a 3.5 year period.	Trauma-informed care interventions included staff training, policy and language change, environmental changes, and client involvement in treatment planning. At completion of study, seclusion and restraints had reduced by 82.3% (P = 0.008). Unlike other interventions, changes to the physical environment were associated with reductions in seclusion and restraint rates, independent of when introduced.

Study	Method	Main findings
Barton et al, 2009	Retrospective audit of client-related data on both rates of restraint and administration of sedative hypnotic medications across 3 year periods audited pre-and post-training.	Unit incidence of restraint reduced from 19 in 2001/2002 (pre-training) to 9 in 2004/2005, and to 0 for 2007/2008 audits (post-training). The use of sedative hypnotic medications also showed a decline across same three audit periods for all clients. (Muskett summary)
Weissbecker and Clark, 2007	Controlled pre-post study 2,189 women with co-occurring disorders and histories of violence. Intervention was a comprehensive, integrated, trauma-informed and consumer-involved approach.	Improved physical health outcomes in the intervention group. Significant reductions in the number of physical illnesses, the number of injuries, the severity of somatic symptoms, medical services use, and cigarette smoking.
Gatz et al, 2007	Controlled pre-post study 313 women with mental health and substance use disorders and histories of trauma, USA Interventions was 'Seeking safety', a trauma-specific group treatment focusing on safety and coping skills.	Intervention group had significantly better treatment retention over three months and greater improvement on post-traumatic stress symptoms and coping skills.
Domino et al, 2006	Controlled pre-post study 1,023 women with co-occurring mental health and substance abuse problems with histories of interpersonal violence, USA Intervention was trauma-informed outpatient group counselling.	Intervention group women used the internal services provided. The intervention did not have strong effects on patterns of service use external to the intervention, such as emergency room, jail and shelter use.
Champagne and Stromburg, 2006	Single site Patient reported measure before and after sensory room session Intervention was trauma-informed sensory interventions in an acute care setting.	Client perceptions of levels of distress were measured routinely before and after a sensory room session, with 89% patients reporting a significant decrease, 10% reporting no change, and 1% reporting an increase in the level of distress following the session.
Elliot et al, 2006	Survey restaff practices that align with trauma-informed care across nine comprehensive mental health and substance abuse services for women with co-existing conditions (USA). Delphi process.	Practices found to be valuable in inpatient settings: creating respectful, safe, and welcoming service settings; specific staff training in interventions to assist patients establish supportive connections with others; effectively manage strong emotions and enhance personal safety; and staff clinical supervision.
Cocozza et al, 2005	Controlled before and after study. Nine USA sites. Intervention was comprehensive, integrated, trauma-informed, and consumer-involved services for women who have mental health problems, substance use disorders, and who have experienced interpersonal violence.	Improved post-traumatic symptoms ($p < 0.02$), drug use problem severity ($p < 0.02$), and nearly significant for mental health symptoms ($p < 0.06$). There was significant heterogeneity in effect sizes across sites.
Morrissey et al, 2005	Controlled pre-post study 3,034 women with co-occurring mental health and substance use disorders in nine outpatient sites, USA Intervention was a comprehensive, integrated, trauma-informed and consumer-involved approach to treatment.	There was a small but statistically significant overall improvement in women's trauma and mental health symptoms in the intervention relative to the usual-care comparison condition. No effect was found for substance use outcomes.

Acknowledgements

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

Our innovations are:

- person-centred
- clinically-led
- evidence-based
- value-driven.

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Our vision is to create the future of healthcare, and healthier futures for the people of NSW.