Principles of Trauma-informed approaches to child sexual abuse: A discussion paper

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The Royal Commission into Institutional Responses to Child Sexual Abuse commissioned and funded this research project. It was carried out by the following researchers: Dr Antonia Quadara and Cathryn Hunter.

Disclaimer

The views and findings expressed in this report are those of the authors and do not necessarily reflect those of the Royal Commission.

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Preface

On Friday 11 January 2013, the Governor-General appointed a six-member Royal Commission to inquire into how institutions with a responsibility for children have managed and responded to allegations and instances of child sexual abuse.

The Royal Commission is tasked with investigating where systems have failed to protect children, and making recommendations on how to improve laws, policies and practices to prevent and better respond to child sexual abuse in institutions.

The Royal Commission has developed a comprehensive research program to support its work and to inform its findings and recommendations. The program focuses on eight themes:
1.   Why does child sexual abuse occur in institutions?
2.   How can child sexual abuse in institutions be prevented?
3.   How can child sexual abuse be better identified?
4.   How should institutions respond where child sexual abuse has occurred?
5.   How should government and statutory authorities respond?
6.   What are the treatment and support needs of victim/survivors and their families?
7.   What is the history of particular institutions of interest?
8.   How do we ensure the Royal Commission has a positive impact?

This research report falls within theme 6.

The research program means the Royal Commission can:
- obtain relevant background information
- fill key evidence gaps
- explore what is known and what works
- develop recommendations that are informed by evidence, can be implemented and respond to contemporary issues.

For more on this program, please visit www.childabuseroyalcommission.gov.au/research

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Executive summary

From the outset, trauma-informed care has been explicitly envisaged as a *systemic change* approach that is reflected at all levels of the service system:

> To provide trauma-informed services, all staff of an organization, from the receptionist to the direct care worker to the board of directors, must understand how violence impacts on the lives of the people being served so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization. (Elliot et al., 2005, p 462)

The origins of trauma-informed care sprang from the observation that:

> human service systems such as the mental health and alcohol and drug sectors often served survivors of trauma without treating them for the consequences of that trauma, and, more significantly, without even being aware of the trauma that occurred. (Harris & Fallot, 2001b, p 3)

As a result of this lack of awareness, a system's usual operating procedures, practice standards and treatment response can inadvertently re-traumatise consumers[1] of these services.

A trauma-informed service system thus has two key dimensions:

- awareness of a consumer's history of past and current abuse; and

- system-wide understanding of the role of violence and victimisation in the lives of consumers of mental health services and 'to use that understanding to design service systems;

The research and commentary in this area draw a distinction between trauma-informed care and trauma-specific services (which are designed to treat the symptoms and impacts of trauma such as grounding techniques, dialectical behaviour therapy, eye movement desensitisation and reprocessing, exposure therapy, trauma-focused cognitive behavioural therapy, and narrative or behavioural therapies).

Organisational principles and toolkits have been developed to guide the transformation of services and settings in becoming trauma informed.

Although there are some differences in how these are articulated, at a basic level, the principles of a trauma-informed system of care include:

- having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and people's functioning

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[1] The term 'consumer' is used throughout this paper, particularly in relation to research on the development of trauma-informed care in mental health contexts. During the 1980s, consumer or "mental health consumer" started to be used by people experiencing mental health issues or mental illness as a way challenging attitudes, practices and paradigms that pathologised people with mental health issues and justified intrusive, involuntary treatments. The resulting 'consumer movement' emphasised the involvement of mental health consumers in all aspects of mental health service design and delivery. Consumer is now a common term Australian mental health policy and guidance literature. See the national Mental Health Professional Online Development (MHPOD) portal's module on Consumer Identity and Advocacy for more information.

- ensuring that organisational, operational and direct service–provision practices and procedures promote, not undermine, the physical, psychological and emotional safety of consumers and survivors

- adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches

- recognising and being responsive to the lived, social and cultural contexts of consumers (for example, recognising gender, race, culture and ethnicity), which shape their needs as well as recovery and healing pathways

- recognising the relational nature of both trauma and healing.

Appendix 2 provides examples of how these principles have been expressed in different sources and guidance literature.

Implementing these principles within specific settings and systems (for example, custodial environments, residential care and school settings) is a central piece of strategic, organisational and procedural work for agencies.

To what extent is there a shared understanding of trauma-informed care?

In the last several years, there has been a growing interest in Australia in trauma-informed approaches to service provision in health, community and human services across a range of settings, such as education and corrections. Services are seeking to implement trauma-informed practices and there are a number of agencies providing resources, guidance and training to support these efforts.

A review of the foundational literature that first conceptualised trauma-informed care, as well as the subsequent developments to this body of knowledge, suggests that the meaning of trauma-informed care is quite clear. Further, there is consistency in how the underlying principles of trauma-informed care are framed across different service systems. That is to say, trauma-informed care (or a trauma-informed approach) is clearly envisaged as an organisation- and system-level initiative, and this is reflected in many statements and working definitions in use. It is seen as an organisational orientation to understanding trauma, such that all staff – clinical and non-clinical, direct care, support staff and executive leadership – undertake their tasks and interaction with clients, residents and students with an understanding of the impacts of trauma and strategies to minimise the possibility of re-traumatising clients.

While there are variations in the key principles that underpin trauma-informed care, both in number and wording, the meanings are fairly consistent, drawing on what the evidence tells us about the needs of trauma survivors – including recognition of the impacts of trauma, safety, transparency, empowerment, choice, pathways to recovery, collaboration and cultural safety.

How is trauma-informed care being implemented?

While there is a shared understanding of what trauma-informed care means, there are variations in the way trauma-informed care is being implemented. Despite this variation, trauma-informed care is implemented at three key levels:

Systems and organisational settings

Systems and organisational efforts work *across* the range of services, departments and sectors that may be involved in supporting a particular population (for example, children or people with mental health problems) or in responding to a particular social issue (for example, family violence) and may often work *down* through the levels of these various agencies.

Individual organisations and settings

Trauma-informed initiatives aimed at individual organisations and service settings, such as acute mental health settings, residential care and schools, are often part of the broader systems-change efforts described above, and many of the findings and issues at the broader systems' change efforts also apply to organisational change efforts. In addition to key organisational models such as the Sanctuary Model, there are many toolkits and guidance materials available for different service sectors. Foster care and residential settings have been the major focus of research on trauma-informed care with children and adolescents. School settings represent an emerging area of interest in implementing trauma-informed care; however, research and grey literature regarding this area are very limited.

Trauma-integrated interventions with clients

Findings suggest that integrated, trauma-informed service provision does improve mental health outcomes for service users (which includes individuals with sexual abuse histories) when compared to standard care (see Appendix 3 for summary of research evidence). Relative to the available research on trauma-integrated interventions with adult survivors, there is comparatively less research on such interventions with children and adolescents. There also appears to be less clarity or distinction made between trauma-specific interventions (that is, interventions that explicitly target the impacts of trauma) and interventions that target other presenting issues (such as self-esteem, body image and depression) but still integrate trauma awareness into the therapy.

What does the evidence suggest about the utility of trauma-informed care?

Research exploring the outcomes of trauma-integrated interventions with clients and service users suggests that these programs and treatments have a positive impact on the biopsychosocial symptoms of trauma and on other issues such as mental health disorders or substance abuse. Evaluation of organisation- and systems-level interventions following the implementation of trauma-informed care, training or organisational change has demonstrated increases in participants' knowledge in two areas: the impacts of trauma on individuals and how this might present within the

service setting. It also showed that this increase in knowledge can be sustained three months after the training was provided. However, behavioural change as a result of that training has been more difficult to achieve. Further, trauma-informed care as a systems-level change has been more difficult to both implement and evaluate. In terms of implementation, the available research finds that systems-level change takes time. Moreover, research and evaluation methodologies have not been appropriately matched to demonstrating system-level outcomes or theorising the connections between interventions and outcomes.

What is the status of trauma-informed care in Australia?

In the authors' opinion, the status of the application of trauma-informed care in Australia could be described as:

- *Emergent*: practice wisdom and evaluation knowledge have not yet coalesced sufficiently to guide how the principles are put into practice in different settings.

- *Enthusiastic*: there is significant interest across a range of sectors in becoming trauma-informed.

- *Opaque*: there is a lack of publicly available, coordinated material on the trauma-informed care programs and models being developed and the format they take.

- *Piecemeal*: without strong, collaborative national leadership, the development of trauma-informed care models is driven by individual services.

While there does appear to be a shared philosophy underpinning trauma-informed care, the first challenge lies in determining how the principles should be translated into practice. That is, how do a receptionist, child protection worker, nurse, supervisor, cleaner, support worker and educator 'do' trauma-informed care? There are likely to be differences depending on an individual's role, which is to be expected and appropriate. Analysis suggests that workers may need concrete strategies and tools to embed trauma-informed care in their roles. The second challenge is based on the fact that the systems-level architecture to support trauma-informed care as a systems-level intervention is not sufficiently emphasised. This means that individual programs and service models may achieve positive outcomes but be undermined by the contradictions and conditions inherent in complex human-services systems (for example, how funding is allocated, a lack of support or buy-in from leadership and different service philosophies).

The emergent and enthusiastic take-up of the idea of trauma-informed care would be significantly strengthened through national leadership and collaborative initiatives to design, implement and evaluate organisational and systemic approaches. Alongside the continued development of organisational and program-level efforts to implement trauma-informed care, a complementary tranche of activity – related to creating a funding, dissemination and resource-sharing infrastructure to support collaborative work and research that is accessible – would be helpful, so that information on how trauma-informed care is being implemented in different settings can be shared and fed back into the overall philosophy and principles.

1. Overview

This paper describes the emergence of trauma-informed care in both the international and Australian service contexts. Since the early 2000s, human services, criminal justice and community welfare services have endeavored to incorporate an understanding of trauma into their organisational structures, treatment services and day-to-day practices – that is, to become *trauma-informed*. This was the case even if the service itself did not work directly with trauma, and a considerable body of scholarship, as well as practice and guidance literature, has developed around the notion of being trauma-informed.

While there are some common principles of trauma-informed care, a number of questions remain unresolved. For example, there appears to be a lack of consensus about:

- the extent to which trauma-informed care signals *systems and organisational* reform, compared to changes to specific practices and interventions

- whether being trauma-informed means providing trauma counselling to clients and service users

- whether practitioners need to have clinical or counselling backgrounds

- which settings trauma-informed approaches are most appropriately applied to

- what constitutes effective or successful trauma-informed care and practice

- how trauma-informed care intersects with mental health policy more generally (Atkinson, 2002; Denham, 2008; Muskett, 2014).

This lack of consensus can lead to multiple interpretations of *trauma-informed care*, leaving practitioners and professionals uncertain about what the term means for them in their day-to-day practice.

The overall purpose of this paper is to provide conceptual clarity based on the available research literature and a critical analysis of the ways in which the concept is being implemented in practice.

Methodology

Appendix 1 describes the search strategy used to identify relevant literature. Given the purpose of this paper, searches initially focused on literature in which 'trauma-informed' was included as a subject term or keyword term, or contained within the abstract (if available). This may have excluded approaches and interventions that reflect the principles of trauma-informed care, even if they are not explicit. Subsequent literature searches resulted in some other approaches or interventions being included (for example, therapeutic residential care). Where appropriate, these have been included in discussion about trauma-informed approaches. At the same time, it is not clear, for example, that all forms of therapeutic residential care are the same as trauma-informed approaches. As a result, I have been cautious in automatically naming a range of approaches as trauma-informed care simply because there are shared principles.

Terminology

Some researchers have noted a difference in terminology between *trauma-informed care* and *trauma-informed approaches*, suggesting there may be some slight distinctions between them (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013). The most recent guidance from the Substance Abuse Mental Health Services Association (SAMHSA) in the United States (US) indicates that these terms can be – and are – used interchangeably, and doing so does not suggest different meanings. This paper also uses *trauma-informed care* and *trauma-informed approach* interchangeably, referring to:

> frameworks and strategies to ensure that the practices, policies and culture of an organisation, and its staff, understand, recognise and respond to the effects of trauma on client wellbeing and behaviour.

Other key terms used in this paper are:

- *trauma-integrated interventions*: refers to therapeutic and clinical interventions with clients that integrate an awareness of violence and trauma impacts into the program, even though the intervention itself is not designed to treat the trauma symptoms, and which also integrate program modules addressing the role of trauma into the treatment of presenting needs (for example, substance abuse)

- *trauma-specific interventions*: refers to interventions designed specifically to 'treat trauma-related symptoms, trauma-related disorders, and specific disorders of traumatic stress' (SAMHSA, 2014). These can be focused on the present, past or future, depending on the psycho-social needs of the client. Interventions of this nature include psychological first aid (for acute incidents), trauma-focused cognitive behaviour therapy, skills for intrapersonal and interpersonal regulation, Dialectical Behaviour Therapy, Prolonged Exposure, Narrative Therapy and Art Therapy. These specific interventions are not considered in this paper.

Structure of paper

The first section provides a brief contextual backdrop for the interest in trauma-informed care in human service systems.

The second section describes the emergence of the concept of a trauma-informed approach to service provision and provides a summary of the key principles underpinning a trauma-informed approach. In section three, the available evidence on current approaches to trauma-informed models and programs in different settings is described and assessed. Considered here is what the research suggests about the success or effectiveness of trauma-informed approaches and what this suggests about the overall utility of the concept. This section also considers how trauma-informed care is being applied in the Australian context.

The final section provides an overall assessment of how trauma-informed approaches are applied in practice, including a critical analysis of the strengths and limits of these practices, and the empirical evidence and practice-based understandings that underpin trauma-informed approaches and treatments.

2. Context

In Australia, approximately one in three girls and one in seven boys have experienced some form of contact sexual abuse by an adult perpetrator in their lifetimes (Child Family Community Australia, 2013). Young people also engage in sexually abusive behaviours against children (Boyd & Bromfield, 2006; O'Brien, 2008; Stathopoulos, 2012). The extent of sexual abuse and the wide-ranging adverse impacts – both in the short and long term – on victim/survivors' physical health, mental and emotional wellbeing, and psycho-social development have made the prevention of child sexual abuse a priority public health issue.[2] In addition to the importance of prevention and early intervention, many human- and community-service sectors are becoming increasingly aware that a significant proportion of service users have histories of interpersonal victimisation and that the traumatic impacts of these experiences are often an integral part of a client's presenting needs. Recent reviews of the research evidence highlight that individuals with victimisation histories – including child sexual abuse – are engaged in a range of human service systems, notably mental health services, alcohol and other drug treatment services, homelessness and housing services, child welfare services, child protection systems, and juvenile justice and correctional systems.

A recent review highlighted the significant body of literature demonstrating a strong, though complex, relationship between women's experiences of sexual victimisation and poor mental health outcomes, which suggests that child sexual abuse is a risk factor for the development of later mental health problems such as anxiety disorders, depression, substance use and suicidality, as well as less prevalent disorders such as psychotic disorders (Quadara, 2015). Research also shows that individuals with severe mental illness, or those seeking mental health treatment, have high rates of sexual victimisation in both childhood and adulthood (Maniglio, 2010; Mueser et al., 2002).

In relation to substance misuse, Australian research found that child sexual abuse victims had an increased risk for a number of disorders including substance abuse. Compared to a control group, sexual abuse victims were on average almost six times more likely to have either a known alcohol or drug dependency. This risk was particularly pronounced for female victims; they were almost nine times more likely to have a known alcohol or drug dependency, compared to the female control group (Bloom, 2004). These findings are similar to international studies (Quadara, Stathopoulos & Jenkinson, 2015).

In correctional systems, available Australian research indicates that between 57 per cent and 90 per cent of female offenders have experienced sexual victimisation, with a high number of those women also experiencing re-victimisation over their lives (Stathopoulos & Quadara, 2014). Other research has also highlighted the high rate of service users in homelessness services with sexual abuse histories (Morrison, 2009). These issues can subsequently have impacts on educational attainment, employment outcomes and parenting capacity (Tarczon, 2012; Whiteford & McKeon, 2012).

While the available evidence clearly indicates an association between child sexual abuse and these varied issues, service sectors have historically been relatively unaware of the extent of trauma histories among their client populations, and uncertain about the significance of a history of trauma

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[2] In the Australian context, this is currently demonstrated through the Australian Government's National Framework for Protecting Australia's Children 2009–2020.

in the constellation of needs and presenting issues that service users bring with them (Harris & Fallot, 2001b).

Screening for a history of abuse has not traditionally occurred within services such as mental health (Huntington, Moses & Veysey, 2005). Often, the underlying trauma history is treated as a separate service need and is rarely integrated into treatment, and/or the complexity of symptoms results in multiple and changing diagnoses (Harris & Fallot, 2001). Furthermore, populations with complex needs are at high risk of falling through the gaps of service delivery systems due to a lack of service coordination and the related barriers to service integration (Whiteford & McKeon, 2012). Services that do not specialise in trauma sometimes fear that trauma treatment means opening up a 'Pandora's box' with the client, including taking on the role of trauma counsellor, having to talk about the abuse, and dealing with complications related to privacy and information sharing (McLindon & Harms, 2011; Wright et al., 2003). As van der Kolk and colleagues (2005) noted:

> Despite the ubiquitous occurrence of numerous posttraumatic problems other than PTSD [post-traumatic stress disorder], the relationship between PTSD and the multiple other symptoms associated with early and prolonged trauma has received surprisingly little attention. In the PTSD literature, psychiatric problems that do not fall within its framework are generally referred to as "comorbid conditions", *as if they occurred independently from the PTSD symptoms* (p 390, emphasis added).

For victims seeking access to multiple services, this can mean being deemed ineligible for services (for example, where individuals cannot engage in mental health treatment until they have 'dealt with' their substance abuse issues or vice versa) or being expected to separate their trauma experiences from their service or treatment needs. It can also mean that challenging or disruptive behaviours, comprehension difficulties, treatment relapses or forgotten appointments are viewed as belligerence, aggression or manipulation; personality or other disorders; treatment resistance; cognitive impairment; or disrespect, rather than as behaviours and coping strategies associated with traumatic stress. Increased scrutiny and compliance conditions; expulsion from treatment programs; voluntary and involuntary commitment, seclusion and restraint; and continued cycling through multiple service systems can be the result. This segmenting of the meaning, impact and role of trauma history has resulted in:

- fragmented service responses and referral pathways

- inaccurate diagnostic assessments of presenting issues

- ineffective treatment interventions

- misunderstanding of the barriers to treatment and program retention.

In contexts such as these, victim/survivors can experience the business-as-usual practices of a given service or setting as profoundly re-traumatising.

3. The origins of the concept of trauma-informed care

The concept of trauma-informed care was developed in an effort to 'short-circuit' the re-traumatising potential in many human and community services. In 2001 Maxine Harris and Roger Fallot published several papers on the idea of reorienting and redesigning human service systems based on what we knew about the impacts of trauma (Harris & Fallot, 2001a, 2001b). They observed that:

> human service systems such as the mental health and alcohol and drug sectors often served survivors of trauma without treating them for the consequences of that trauma, and, more significantly, without even being aware of the trauma that occurred (Harris & Fallot, 2001b, p 3).

At the same time, the US federal government's Substance Abuse and Mental Health Services Administration set up a collaborative project from 1998 to 2003 to develop integrated services for women who were the victims of violence and also diagnosed with both a psychiatric illness and a substance abuse problem. Known as the Women with Co-occurring Disorders and Violence Study (WCDVS), this five-year, multisite study aimed to generate knowledge about the effectiveness of comprehensive integrated service models for women with co-occurring disorders and histories of trauma.[3]

The WCDVS remains the largest study to implement and evaluate the effectiveness of trauma-informed care and service models in addressing the needs of trauma survivors and consumers of mental health services. The final sample comprised nine intervention sites, with more than 2,000 women interviewed, both at baseline and at four follow-up points (three, six, nine and twelve months).[4] This initiative subsequently generated a significant body of literature about the theoretical underpinnings of trauma-informed care and its implementation (Amaro, Chernoff, et al., 2007; Amaro, Dai, et al., 2007; Clark & Power, 2005; Cocozza et al., 2005; Domino et al., 2007; Gatz et al., 2007; Huntington, Jahn Moses & Veysey, 2005; Markoff et al., 2005; Morrissey et al., 2005; Noether et al., 2005). Research, guidance and practice resources have since been developed on how to design trauma-informed service and care models in settings such as:

- homelessness services (Hopper, Bassuk & Olivet, 2007)

- mental and behavioural health systems (Jennings, 2004)

- correctional services (Atkinson, Hamblin & Wright, 1981; Covington, 2008; McLindon & Harms, 2011)

- justice systems (Whittemore & Knafl, 2005).

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[3] Information about the study can be found at www.wcdvs.com.

[4] The interview tool assessed multiple domains of personal history (including trauma history), behavioural health (namely, alcohol use, drug use, mental health status and PTSD), service use and consumer satisfaction. The original baseline sample was 2,729. The six-month sample size (that is, women who completed interviews at baseline and at the six-month mark) was 2,006.

Other countries have more recently started exploring the concept of trauma-informed care and service systems, including Australia (Atkinson, 2013; Bath, 2008; Kezelman & Stavropoulos, 2012; Mental Health Coordinating Council [MHCC], 2013), Canada (British Columbia Centre of Excellence for Women's Health, 2013; CSAAP, 2012), New Zealand (Ministry of Health, 2007) and the United Kingdom (Power, 2014). However, research and practice in these countries are not as developed as in the US.

Principles of trauma-informed care

Underlying ethos

From the outset, trauma-informed care was explicitly envisaged as a *systemic change* approach that is reflected at all levels of the service system:

> to provide trauma-informed services, all staff of an organization, from the receptionist to the direct care worker to the board of directors, must understand how violence impacts on the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization (Elliot et al., 2005, p 462).

A trauma-informed service system had two key dimensions. First, it meant being aware of a consumer's history of past and current abuse. Of note, this was not the same as trauma-specific services or interventions, which are designed to treat the actual consequences of sexual or physical abuse trauma (such as grounding techniques, dialectical behaviour therapy, eye movement desensitisation and reprocessing, exposure therapy, trauma-focused cognitive behavior therapy, and narrative or behavioural therapies).

The second, and more crucial element in Harris and Fallot's (2001b) view, was to understand the role violence and victimisation play in the lives of consumers of mental health services *and* 'to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that facilitates consumer participation in treatment' (Harris & Fallot, 2001b, p 4). Table 1 (below) summarises how Harris and Fallot defined the difference between 'traditional' human service systems and those that are trauma-informed.

Table 1: Comparison of traditional and trauma-informed service models (adapted from Harris & Fallot, 2001)

Traditional services and systems	Trauma-informed services and systems
Traumatic stress is not viewed as a primary event in defining people's lives.	Traumatic and violent events are central, primary events that impact everything else in the lives of victims or survivors. Assumes the impact of trauma is all-encompassing.
Problems or symptoms are discrete or separate, and require a separate source of support and/or intervention.	Problems or symptoms are interrelated responses or coping mechanisms to deal with trauma.

Hierarchical approach: clinical staff and administrators are trained to respond to trauma survivors in a specific way. Clinical personnel are seen as the experts who assign diagnoses to treat a condition. The focus is on being objective and distant. This approach is based on power imbalances.	Shared power/decreased hierarchy: everyone is trained to respond to individuals in distress, and understand the impact of trauma in the lives of clients. This approach emphasises the importance of viewing clients' responses through the lens of trauma and attempts to equalise power imbalances in relationships.
Primary goals are defined by service providers, and focus on symptom reduction.	Primary goals are defined by the person or family presenting at services, and focus on recovery, self-efficacy and healing.
Reactive: services and systems are crisis-driven and focused on maintaining security.	Proactive: services and systems focus on preventing further crises and avoiding re-traumatisation. At the systemic level, policies and practices are adjusted to avoid re-traumatising.
Views clients as broken, vulnerable, damaged and needing protection from themselves. Agencies and providers are responsible for fixing the problem.	Understand that providing clients with the maximum level of choice, autonomy, self-determination, dignity and respect is central to healing – based on a philosophy of holistic healing and resilience. Agencies are responsible for creating an environment conducive to healing and becoming partners in a process defined by the individual.

This system/organisational-level perspective is reflected in many of the current definitions of trauma-informed care. For example, SAMHSA describes 'trauma-informed' in the following terms:

> When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization (SAMHSA, 2015).

The US-based National Child Traumatic Stress Network (NCTSN) defines a trauma-informed child- and family-service system as:

> …one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family (NCTSN, no date).

In the last decade, this work has been further developed in the US through:

- ongoing leadership from SAMHSA in the form of funding, resources and guidance material

- the establishment of the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint

- the development of resources such as guidelines, organisational toolkits, websites and training material for implementing trauma-informed care in different systems, including homelessness services, behavioural health, child welfare systems, courts, corrections, juvenile justice and schools.

Trauma-informed care has been expressed in the Australian context in similar terms. For example, the MHCC states that trauma-informed care:

> exemplifies a 'new generation' of transformed mental health and human service organisations and programs that serve people with histories of trauma. Responding appropriately to trauma and its effects requires knowledge and understanding of trauma, workforce education and training, and collaboration between consumers and carers, policy makers, and service providers and crosses service systems. It involves not only changing assumptions about how we organise and provide services, build workforce capacity and supervise workers, but creates organisational cultures that are personal, holistic, creative, open, safe and therapeutic (MHCC, 2013, p 5).

The Blue Knot Foundation's Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care and Service Delivery also clearly frame trauma-informed care as an organisation-level endeavour, with guidelines for the development of service charters; policy and procedure assessment and revision; service assessment and revision; and education and training (Kezelman & Stavropoulos, 2012).

To provide clarity about the term 'trauma-informed care', it is instructive to consider the initial principles of trauma-informed care.

Principles

In addition to the overall ethos of trauma-informed care, organisational principles have been developed to guide the transformation of services and settings in becoming trauma-informed. Jennings (2004) initially developed seven principles that services needed to emphasise:

- safety from physical harm and re-traumatisation

- an understanding of clients and their symptoms in the context of their life experiences, history, cultures and society

- open and genuine collaboration between provider and consumer at all phases of the service delivery

- an emphasis on skill building and acquisition rather than symptom management

- an understanding of symptoms as coping adaptations and strategies

- a view of trauma as a defining and organising experience that forms the core of an individual's identity rather than a single discrete event

- a focus on what has happened to a person rather than what is wrong with a person (Jennings, 2004, in Morrison, 2009, p 7).

Following implementation, evaluation and enquiry with researchers and consumers as part of the WCDVS, Elliot and colleagues (2005) refined the initial seven principles, developing 10 principles of trauma-informed care that services needed to embrace. These were to:

- recognise the impact of violence and victimisation on development and coping strategies

- identify recovery from trauma as a primary goal

- employ an empowerment model

- strive to maximise a woman's choices and control over her recovery

- base services in relational collaboration

- create an atmosphere that is respectful of survivors' need for safety, respect and acceptance

- emphasise women's strengths, highlighting adaptations over symptoms and resilience over pathology

- aim to minimise the possibilities of re-traumatisation

- strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background

- solicit consumer input and involve consumers in designing and evaluating services (Elliot et al., 2005, pp 465–469).

Although these have been further refined and articulated differently, at a basic level, the principles of a trauma-informed system of care include:

- having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and functioning

- ensuring that organisational, operational and direct service provision practices and procedures don't undermine and indeed promote the physical, psychological and emotional safety of consumers and survivors

- adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches

- recognising and being responsive to the lived, social and cultural contexts of consumers (for example, recognising gender, race, culture and ethnicity), which shape both their needs as well as recovery and healing pathways

- recognising the relational nature of both trauma and healing.

Appendix 2 provides a summary of the principles of trauma-informed care that have been articulated by five key sources. At the conceptual and philosophical levels, the following propositions seem clear:

- Trauma-informed care or a trauma-informed approach is, in the first instance, an organisational and/or systems-wide endeavour to (re)orient all aspects of the organisation/system through the lens of trauma.

- Trauma-informed care does not require the organisation or the people within it to provide treatment or interventions that work on the symptoms of trauma.

- The principles of trauma-informed care articulated across the guidance literature are relatively consistent.

A consistent point made in this body of literature is that trauma-informed care is not about treating symptoms related to sexual or physical abuse, or other trauma. A clear distinction is often made between *trauma-specific interventions,* which are expressly designed to ameliorate trauma symptoms (such as grounding techniques, dialectical behaviour therapy, eye movement desensitisation and reprocessing, exposure therapy, narrative or behavioural therapies, trauma-focused cognitive behaviour therapy, and acceptance and commitment therapy), and *trauma-informed care*, which, as described, is about building an understanding of the traumatic impacts of victimisation into all levels of an organisation or system. It also involves implementing the attendant changes to culture and practice to ensure that, at a minimum, the service does not re-traumatise users, and hopefully facilitates their recovery. Therefore, it is not necessary for a trauma-informed organisation to provide trauma-specific counselling or therapies, or for practitioners to have expertise in such therapies. However, a trauma-informed organisation should be linked to, or integrated with, trauma-specific services, and practitioners should incorporate their knowledge of trauma and its impacts into their ways of working.

4. The implementation of trauma-informed systems, services and programs: Findings from the research base

The following section draws on the available research and grey literature to consider how trauma-informed care – as described in the previous section – has been implemented, and where possible, what the impacts have been. It is examined at several key levels, including:

- a systems level (that is, targeting whole-of-system change or multiple organisations or services that serve a particular population)

- the organisational or settings level (that is, targeting an individual organisation or discrete setting)

- the trauma-integrated interventions level (that is, targeting service users).

Trauma-informed systems

There are several examples of developing service systems that are trauma-informed. These efforts work *across* the range of services, departments and sectors that may be involved in supporting a particular population (for example, children or people with mental health problems) or in responding to a particular social issue (for example, family violence), and may often work *down* through the levels of these various agencies. A recent review examining the implementation of trauma-informed care in mental health care described three such models, developed as part of the WCDVS (Quadara, 2015).

'Allies: An Integrated System of Care' was implemented in a small county provider of healthcare services for people with substance abuse and mental health issues in California, and was delivered through five substance-abuse treatment programs. The target populations were women and their children accessing the services. Its primary goals were to reduce women's alcohol and drug abuse and their mental health and trauma-related symptoms, as well as increase parenting abilities (Heckman et al., 2004). Trauma-integrated programs that dealt with trauma, co-occurring disorders (including Seeking Safety and the Trauma Recovery and Empowerment Model) and parenting difficulties were provided to clients. Care coordination was provided through a case manager. At the systems level, Allies aimed to integrate trauma-informed practice across mental health, alcohol and other drug treatment providers, and focused on including trauma/violence services in broader mental health and other social services networks. The goal of the systems integration was to increase providers' awareness of the benefits of effectively collaborating across disciplines for the wellbeing of their mutual clients. Community-wide strategies for accomplishing this included presentations, newsletters, pamphlets and posters on the importance of integrated, trauma-informed and trauma-specific services for the target population; training events; and ongoing inter-agency coordinating body meetings. A key observation from this study site was that 'significantly altering service delivery philosophies and approaches across large numbers of providers require[d] time', reflecting that the two-year period allocated to accomplish awareness, buy-in and changed practices may not have been sufficient (Heckman et al., 2004, p 175).

Risking Connection (RC) was designed as a training curriculum for professionals working with survivors of child abuse in mental health, substance abuse, domestic violence and child welfare services, and correctional settings (Brown, Baker & Wilcox, 2012; Giller, Vermilyea & Steele, 2006; Saakvitne et al., 2000; Saakvitne & Gamble, 2002). A recent study examined the impact of the curriculum-based RC trauma training on the knowledge, beliefs and behaviours of 261 staff trainees in 12 trainee groups at five congregate care agencies for children. The results showed an increase in knowledge about the core concepts of the RC training consistently across each group, an increase in beliefs favourable to trauma-informed care over time, and an increase in self-reported staff behaviour favourable to trauma-informed care. 'Train-the-trainer' was an effective model for the dissemination of the program.

The Women Embracing Life and Living (WELL) Project (Finkelstein & Markoff, 2005) was implemented in Massachusetts, US.[5] It was expected to eventually impact the whole service system; therefore, it had a statewide focus. To achieve this, the initiative aimed to foster integration at the agency, community and state levels:

- Integration at the agency level involved the introduction of an Integrated Care Facilitator, who worked within an agency and across agencies, attending meetings, participating in case conferences and hosting training to embed an integrated view into day-to-day practice, and was the central contact for women for service coordination and advocacy.

- Integration at the community or sector level was facilitated through the Integrated Care Facilitator, who convened a local leadership council. The council had a broad membership of consumers and providers across violence, mental health, and alcohol and other drugs services; aimed to foster dialogue and relationship building among the members; and provided the basis for cross-curriculum training.

- Integration at the state level built on these structures. A high-level state leadership council was instigated with representation from the core state departments that serve women with co-occurring disorders and trauma histories. The leadership council produced the Principles for the Trauma-Informed Care of Women with Co-occurring Mental Health and Substance Abuse Disorders for a range of service providers to sign up to.

In reviewing the impact of the WELL Project, the researchers noted that the cross-disciplinary training initially highlighted the diverse perspectives different agencies brought to understanding the role of trauma in clients' lives and what their role was in engaging with it. This meant that before cross-disciplinary training could be effective, services needed to engage in a 'values clarification' exercise, conducted by an outside facilitator, to arrive at a consensus statement of principles, which was then used to inform service delivery. The next step was to determine what *core* knowledge all agencies needed to know about the issues so that there was a basic, shared knowledge base. This then formed the basis of the cross-training modules.

Using Trauma Theory to Design Service Systems (Harris & Fallot, 2001) is another systems-level initiative. This is a step-by-step model for mental health, substance abuse and other public human service systems and service agencies to become 'trauma-informed'. The model identifies the essential elements necessary for a system to integrate a basic understanding of trauma into its core service programs, and provides training and support for systems and services from the initial planning stage to training and to the development of long-term, sustainable change (Jennings, 2004). The evaluation findings from a pilot project found positive responses from administrators, clinicians and consumers. Each of these groups valued the increased collaboration, and emphasis on recovery, as well as on physical and emotional safety, as a result of the initiative (Jennings, 2004).

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[5] In this state, funding for mental health, and alcohol and other drugs services was largely provided directly by the state (rather than through counties). Funding streams for mental health, alcohol and other drugs, and violence services were separate, which resulted in treatment being provided in a parallel, non-integrated fashion.

Child- and youth-focused systems

More recently, initiatives have been implemented in the child welfare system, including:

- the Arkansas Building Effective Services for Trauma (AR BEST) training (Kramer et al., 2013)

- the Chadwick Trauma-Informed Systems Dissemination and Implementation Project and the Chadwick Trauma-Informed Systems Project (Hendricks, Conradi & Wilson, 2011)

- the Massachusetts Child Trauma Project (Bartlett et al., 2015).

The format and impact of these initiatives are briefly described below.

AR BEST was implemented with 102 area directors and supervisors working in Arkansas' child welfare system. The training was based on the NCTSN's trauma-informed training for child welfare workers and involved two-day workshops with services. The purpose of this training was to support general skills transfer by first securing supervisor-level support. Following this stage, all front-line staff members were to be trained. Evaluation of the director- and supervisor-level training involved pre- and post-tests (at a three-month follow-up). Prior to the training, between one-third and two-thirds of participants regularly used trauma-informed practices. The follow-up test results showed a statistically significant increase in the number of supervisors regularly using trauma-informed practices (Kramer et al., 2013). Evaluation of the impact of the training on knowledge and the use of trauma-informed care practices across three groups of child welfare staff (caseworkers, program assistants and other front-line staff) showed positive results: the training process was highly successful in improving participants' knowledge of trauma-informed care practices, especially among staff members with the lowest levels of formal education and training. A significant increase in the use of trauma-informed care practices by staff members at the three-month follow-up was also noted, with little difference observed across staff groups (Conners-Burrow et al., 2013).

However, the impact of the project in promoting trauma-informed practices in direct support for children was small. The project had a larger impact on indirect support services designed to build a more trauma-informed system around children, including those that provide support and education to foster parents or make appropriate referrals. Conners-Burrow and colleagues (2013) identified a number of possible barriers to explain the modest impact on direct service provision, including large caseloads that made addressing even basic care requirements difficult and the difficulty of applying trauma-informed practices in stressful, hostile and crisis-driven situations, such as when removing a child from parental care. Kramer and colleagues (2013) identified other barriers to implementing trauma-informed training across a large service system, including the logistics and cost of a statewide implementation; having to obtain 'buy-in' from the child welfare system; and the difficulty of achieving high participation rates.

The Chadwick Trauma-Informed Systems Project was a community assessment process designed to evaluate a specific child welfare jurisdiction based on the current definition of trauma-informed child welfare and its essential elements. The assessment process was further developed and pilot-tested within three diverse child welfare systems in the US, with the aim of identifying strengths and barriers related to trauma and child welfare in each site, and developing specialised service delivery models for the public child welfare system (Hendricks et al., 2011). The Chadwick Trauma-Informed

Systems Dissemination and Implementation Project builds on the toolkits developed in the first project. With funding secured from SAMHSA in 2012, project staff worked with five 'supercommunities' across the US[6] to test, refine and disseminate a service system-level intervention (Chadwick Center for Children and Families, no date). At this stage, no research findings are available.

The Massachusetts Child Trauma Project is a five-year, statewide systems-improvement initiative, funded in 2011. Its objectives include:

- improving the identification and assessment of children exposed to complex trauma

- building service-provider capacity for the delivery of trauma-specific, evidence-based treatments (EBT) in agencies serving child welfare-involved children

- increasing links with, and referrals of children to, EBTs

- increasing caregivers' understanding of and sensitivity to child trauma (Bartlett et al., 2015).

Three central activities underpin the project: training and workforce development of child welfare practitioners; statewide dissemination, through training and collaborative learning, of three trauma treatments with empirical support (namely, attachment, self-regulation and competency; trauma-focused CBT; and child–parent psychotherapy); and systems integration through the implementation of Trauma-Informed Leadership Teams, to provide a supporting structure for systems integration at the community level. Currently, the findings from the first year of the project's implementation are available. The key findings were that Trauma-Informed Leadership Teams based in child welfare offices emerged as key structures for trauma-informed care systems integration, and that participation in EBT Learning Collaboratives was linked to improvements in individual and agency trauma-informed practices. Bartlett and colleagues (2015) concluded that the study supported the notion that a trauma-informed approach in child welfare required coordination and changes at multiples levels of child- and family-serving systems that align across implementation domains. However, they also cautioned that the results were modest, which may partly relate to requiring a longer period to effect systems-level change (Bartlett et al. 2015)

It is apparent from the published literature that there are additional systems approaches to trauma-informed care occurring in a number of US states; however, a search for initiatives in other countries such as Canada, New Zealand and Australia did not turn up any results.

Trauma-informed organisations and service settings

Trauma-informed initiatives aimed at individual organisations and service settings (such as acute mental health settings, residential care and schools) are more numerous. They are also often part of the broader systems-change efforts described above, and many of the findings and issues at this level also apply to organisational-change efforts. For this reason, they are not all individually dealt

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[6] These are: Custer County, Oklahoma; Orange County, California; State of Rhode Island; Southeastern Minnesota; and Volusia County, Florida.

with here. The following section provides a synthesis of the available research and grey literature relating to such initiatives, the majority of which, again, are based on trauma-informed care efforts in the US.

One of the most well-known and comprehensive models is the Sanctuary Model. Developed (and trademarked) by Sandra Bloom in the mid-1990s, the Sanctuary Model has been implemented in acute care inpatient services for adults and children; child residential care; community-based programs; juvenile justice; and substance abuse programs for women, children and adolescents (Bloom & Farragher, 2010, 2013; Bloom & Yanosy Sreedhar, 2008; Esaki et al., 2013).

The Sanctuary Model is a theory-based (trauma and therapeutic communities), trauma-informed, evidence-supported, whole-culture approach for organisational change. The change model is based on seven organisational 'commitments': nonviolence, emotional intelligence, social learning, open communication, democracy, social responsibility, and growth and change. It also focuses on four key domains of recovery: safety, emotions, loss and future. Overall, the organisational change process is phased over a two-year period, involving organisational assessment, setting up organisational infrastructure and leadership, and relationship building and values clarification to develop and implement an action plan, which includes training and workforce development to refine and revise the organisational action plan.

In a review of treatment models for residential and group care, James (2011) observed that the evaluative research of the Sanctuary Model was limited. However, the model is evidence-informed and, based on the evaluations published to date, can be considered a promising template for practice (James 2011). While the evaluation evidence is limited, there is a significant body of work by Bloom and associated researchers that describes the model's theoretical underpinnings and its implementation approach (Bloom, 2000; Bloom & Yanosy Sreedhar, 2008; Esaki et al., 2013; Mortell et al., 2014).

In Australia, there has been significant interest in the Sanctuary Model, particularly in its application in youth residential care settings. A number of service providers, both government and non-government organisations, have used the Sanctuary Model to redesign youth residential care settings, including in Victoria, Western Australia and New South Wales.

While this model is particularly well known and has been adapted to a variety of settings, there are also a number of organisational toolkits that have been developed for use in a variety of settings, including:

- the Trauma-Informed Organizational Toolkit for Homeless Services, developed by the National Center on Family Homelessness (Guarino et al., 2009)

- the Treatment Improvement Protocol No 57 – Trauma-Informed Care in Behavioral Health Services, developed by SAMHSA

- the Child Welfare Trauma Training Toolkit, developed by the NCTSN.

As these are toolkits, it is not known how trauma-informed care is being implemented within specific organisations. However, given a key aim of the WCDVS was to create trauma-informed organisations

and settings for women with histories of abuse who were also experiencing co-occurring disorders (such as mental illness and substance abuse), the findings generated from this study provide important lessons about implementing organisational models of trauma-informed care. These lessons are considered in some detail by Quadara (2015). For the purposes of this review, the key lessons in implementing trauma-informed organisational models were:

- Services need to develop, or link with, trauma-specific services (that is, services designed to address the specific consequences of exposure to traumatic events), establish peer-run services, and employ resource coordination and advocacy approaches (for example, wrap-around, case management and care coordination).

- The most effective ways of establishing service integration and coordination involved creating coordinating bodies of interested organisations to participate in the project; formalising arrangements with participating organisations using written memoranda of understanding, which outlined agency roles and responsibilities; and cross-training mental health and substance abuse providers, including training on trauma.

- In working with adults with co-occurring problems, trauma awareness needed to be integrated into mental health and substance abuse treatment programs rather than provided separately, which meant that non-specialist service providers needed to receive training on trauma and resolve their anxieties that addressing trauma would 'open a Pandora's Box' in treatment.

Child- and adolescent-focused organisations and settings

Foster care and residential settings have been the major focus of research on trauma-informed care with children and adolescents (Ford & Blaustein, 2013; Greenwald et al., 2012; Gudiño et al., 2014; Hodgdon et al., 2013). The development of therapeutic residential care (TRC) has been a key approach to organisational trauma-informed care. TRC is defined as 'intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs' (cited in McLean, Price-Robertson & Robinson, 2011, p 2). The American Association of Children's Residential Centers (2014) suggested that trauma-informed programming in residential centres involves the following strategies:

- proactively attending to elements of milieu routine that are generally known as 'triggers' (for example, bedtime, room checks, yelling, close physical proximity and time spent at home or in the community)

- training staff in brief interventions that help children identify and learn how to manage potential triggers

- identifying early warning signs and physical precursors of distress that can signal upset or an impending crisis

- implementing sensory-integration and sensory-modulation opportunities

- incorporating expressive therapies, focusing on art and music, to enhance thinking skills in general and to foster the potential to process traumatic memories

- focusing on activities and interventions that promote thinking skills by asking children and youth to think through situations and make choices

- developing and sustaining a rich variety of opportunities for children and youth to be active and to learn by doing

- making activities an explicit cornerstone of treatment rather than simply a recreational privilege

- ensuring that programming creates opportunities for relationship development, and teaching staff members to use programming to develop appropriate therapeutic relationships while still supporting and encouraging healthy relationships with family and community peers

- involving parents and family members in activities to the greatest extent possible to expand family skill building opportunities

- responding to family trauma associated with extended separation by programming opportunities for connectivity

- implementing wrap-around principles and planning processes within residential services, and linking those services with community-based services and supports

- focusing explicitly on skill building throughout all programming, helping children identify the skills they are developing

- adopting initiatives to reduce, and ultimately eliminate, seclusion and restraint

- promoting trauma-informed practices with system partners.

As this shows, trauma-informed care largely involves the creation of physical and psychological safety, self-regulation skills and strengths-based development across all activities. The conceptual frameworks used to guide organisational and staff practices are primarily those of Sandra Bloom, James Anglin and Bruce Perry (McLean et al., 2011). In addition to the Sanctuary Model, Children and Residential Experiences (CARE) is another organisational approach to improving outcomes for children in care by altering organisational practices and culture. The CARE intervention involves:

- personnel training

- organisational technical assistance

- exposure to concepts and principles

- practice (Holden, 2014).

Outcomes for staff relate to knowledge, skills, motivation and confidence, and the translation of principles into practice. Outcomes for children relate to improvements in children's experiences and

perceptions of themselves and others, and improvements in their wellbeing and behaviour. At the organisational level, the outcomes focus on changes that ensure congruence between the needs and experiences of children and the organisation's culture and staff practices – including policies and practices that support innovations and data-based decision-making.

Evaluation studies on the effectiveness of TRC as an organisational model are limited, with most research focused on treatment outcomes for children. However, a synthesis of research conducted by McLean et al. (2011) suggests that the following are key components for an effective TRC model:

- clearly articulating a philosophy of care, which involves ensuring that:

  o the organisation has a clearly documented statement of its values and culture that is consistent with the provision of a therapeutic care environment

  o staff members have initial and ongoing training on the rationale and theoretical underpinning of the practice

  o all care staff members understand the agreed philosophy and practice

  o staff members are able to provide a clear rationale for interventions

  o staff members have structured opportunities to reflect on practice

- prioritising children and young people with complex needs who are able to benefit from the trauma-informed therapeutic approach, by conducting comprehensive assessments of young people's needs

- providing a therapeutic milieu that:

  o prioritises the safety of staff members and young people

  o ensures staff members have relevant qualifications and experience

  o ensures the program and staff members provide a sense of safety, structure, acceptance and security at all times

  o enables the program design to accommodate psycho-education about trauma, and address grief and loss issues regarding family of origin

  o provides a stable and consistent environment

  o encourages staff members to model prosocial behaviour

  o places value on strong, positive relationships between staff members and young people, and emphasises these relationships as being integral to therapeutic healing

- adopting a trauma-based orientation to program design by ensuring that:

  o staff members are given specialist training in the trauma theory model

- staff members are able to identify specific behaviours and triggers as possible outcomes of trauma

- psycho-education on trauma is included in program design

- staff members create a safe, predictable environment in which young people are protected from re-traumatising experiences

- young people are provided with access to trauma and loss counselling

- creating individualised therapeutic plans based on the best available evidence

- encouraging young people to participate in shaping their care by:

  - ensuring that staff members listen to young people and allow them to participate in decision-making processes regarding their therapeutic program and placement

  - clearly communicating with young people about the rationale of their care plan and giving them opportunities to provide feedback

  - ensuring young people have access to advocacy

- engaging with young people's families, communities and cultures by:

  - engaging with young people's families of origin (including siblings) where possible, and at whatever level possible (for example, phone meetings, visits or family therapy)

  - engaging with relevant stakeholders in young people's lives (for example, school, sporting or community)

  - ensuring that young people have opportunities to remain engaged with cultural practices (especially important for those from Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities)

  - providing an approach to care that is sensitive and respectful, and actively explores and seeks to understand each child's unique circumstances and experiences arising from the impact of their culture. This is especially important for those from Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities (adapted from McLean et al. 2011).

It is important to note that TRC is seen as a highly intensive form of care, to be used 'judiciously' with children and young people with complex and high needs (Anglin, 2013).

School settings represent an emerging area of interest in the implementation of trauma-informed care (Chafouleas et al., 2015); however, research and grey literature in this area are extremely limited.

Trauma-integrated interventions

Trauma-integrated interventions refer to therapeutic and clinical interventions with service users in which knowledge of the impacts of victimisation, together with strategies to manage these impacts, is integrated into the program, even though the intervention or program is not itself trauma-specific. Substance abuse treatment programs that integrate a psycho-educational component on trauma are an example of such interventions. These include:

- A Woman's Path to Recovery

- Seeking Safety (Morrissey et al., 2005)

- Helping Women Recover (HWR): A Program for Treating Addiction.

These treatment models have been implemented in a range of US settings and are designed for stabilisation, containment and the establishment of safety.

The WCDVS developed a cross-site methodology to evaluate the effectiveness of trauma-integrated interventions across nine study sites, to see what differences, if any, integrated programs and service models had on the levels of PTSD, substance abuse and mental health problems, and on service use compared to standard care. A common interview tool was developed for use in all sites, and was administered at baseline and four follow-up points (three, six, nine and twelve months). The interview tool assessed multiple domains, including personal history (including trauma history), behavioural health (namely, alcohol use, drug use, mental health status and PTSD), service use and consumer satisfaction. Details and evaluation findings for the specific trauma-integrated interventions can be found at Appendix 3.

Overall, the findings suggest that integrated, trauma-informed service provision does improve outcomes across the key domains as compared to standard care sites. In addition to single-site evaluations, meta-evaluations were also conducted across the nine sites (Cocozza et al., 2005; Morrissey et al., 2005). Cocozza and colleagues determined that, similar to the findings above, women in both groups – intervention and comparison – reported improved outcomes across all four behavioural health measures at the six-month data collection point. However, women in the intervention group reported better outcomes on drug addiction severity and PTSD severity, which were statistically significant. There were also greater improvements to mental health status in the intervention group, though the findings were not statistically significant. While the improvements in the outcomes of the intervention group as compared to the control were small, they were still sufficient to suggest that comprehensive, integrated service provision generated the improvements (Cocozza et al., 2005).

Relative to the available research on trauma-integrated interventions with adult survivors, there is comparatively less research on such interventions being used with children and adolescents. There also appears to be less clarity or distinction made between trauma-specific interventions (that is, interventions that explicitly target the impacts of trauma) and interventions that target other presenting issues (such as self-esteem, body image and depression) but still integrate trauma awareness into the therapy. For example, one recent review included what could be considered trauma-specific therapies and trauma-integrated therapies as both comprising 'trauma-informed'

interventions (Black et al., 2012). Using the definition of trauma-integrated interventions above, the review identified the following models as examples of trauma-informed interventions:

- Partnering to Achieve School Success (PASS): a multimodal intervention for children with attention deficit hyperactivity disorder. PASS components include family engagement strategies, family behaviour therapy, family–school consultation, collaborative care with the paediatric primary care provider and trauma-informed care (Power et al., 2014).

- Trauma Adapted Family Connections: a conceptual model for working with families experiencing complex developmental trauma that identifies the core components for such work. The model integrates:

  o trauma-focused family assessment and engagement

  o psycho-education to teach family members about trauma symptomatology

  o a focus on building safety capacity within the community and immediate environment

  o trauma-informed parenting practices and communication

  o trauma-informed approaches to working with families (Collins et al., 2011).

- Ecosystemic Structural Family Therapy: a systemic, strengths-based and trauma-informed family therapy model designed to assist families with children who are experiencing behavioural health problems and are at the risk of out-of-home placement (Lindblad-Goldberg & Northey Jr, 2013).

- Head Start Trauma Smart (HSTS): an early education/mental health cross-systems partnership – provided in Head Start preschool programs in 26 counties in Kansas City – that is designed to work within a child's natural setting. The goal of HSTS is to decrease the stress of chronic trauma, foster age-appropriate social and cognitive development, and create an integrated, trauma-informed culture for young children, parents and staff (Holmes et al., 2015).

- Training in the Fairy Tale: a trauma-informed treatment model provided to clinical and direct care staff to treat problem behaviours using a trauma lens. The program is strengths-based, and focuses on stabilisation, coping and tolerance skills, resolution of trauma and loss, and moving to the future. Other trauma treatments such as eye movement desensitisation and reprocessing can be used alongside this program.[7]

5. Application of trauma-informed care in the Australian context

As noted earlier, there has been growing interest in the concept of trauma-informed care in Australia, as demonstrated through:

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[7] See www.childtrauma.com/training/fairy-tale-model.

- a national conference in 2011 titled Trauma Informed Care and Practice: Meeting the Challenge Conference (convened by the MHCC in collaboration with Adults Surviving Child Abuse [now the Blue Knot Foundation], the NSW Health Education Centre Against Violence and the Private Mental Health Consumer Carer Network, and funded by the NSW Health Mental Health Drug & Alcohol Office)

- the development and publication of Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery (Blue Knot Foundation)

- the development and publication of a national strategic direction discussion paper to further develop trauma-informed care (MHCC)

- the development and publication of a resource for the education sector and schools to implement trauma-informed approaches in schools (Australian Childhood Foundation)

- the delivery of training on trauma-informed care and practices by a range of service providers (for example, the MHCC, Education Centre against Violence, Blue Knot Foundation and Phoenix House).

While there is growing activity in exploring the value of trauma-informed care, the research literature describing Australian initiatives explicitly identified as 'trauma-informed' is extremely limited. This makes it difficult to understand how trauma-informed care is generally being applied. The available information is primarily published online by individual organisations and services that are implementing a trauma-informed care approach themselves and/or providing training to other organisations. There may be a number of organisations and agencies that are implementing trauma-informed care initiatives but for a variety of reasons have not published this information. Furthermore, training curricula are not generally made available. As such, there is no central repository of information about current practice in trauma-informed care, making the picture of the current situation in Australia opaque and fragmented.

Based on the information we have been able to locate, trauma-informed care is being, or has been, implemented in settings such as:

- mental health

- corrections

- youth residential care

- schools.

In terms of adult-focused organisations, settings and systems, a number of agencies deliver trauma-informed training to range of services within the community services, family violence, corrections and mental health sectors. The MHCC recently developed the Trauma-Informed Care and Practice Organisational Toolkit (TICPOT), which can be applied across mental health and human services in

public, community and private contexts.[8] TICPOT is a two-stage process involving (1) preparing for and undertaking organisational assessment, and (2) goal setting for organisational change and implementing that change. This is designed to be an ongoing quality improvement process. The toolkit can be applied in one of two ways:

- a self-assessment tool

- a comprehensive online assessment package with orientation, post-assessment report and supporting resources for completion (facilitated by an MHCC consultant).

The toolkit has been mapped against national Australian standards and the Recovery Oriented Service Self-Assessment Toolkit.

In the mental health sector, a project is underway to implement a trauma-informed systems model of care, which will take a whole-of-organisation approach for services, including environment, management, direct contact with clients, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages.[9] The model will then be implemented in three settings – a tertiary women's hospital with a sexual violence service, area mental health services and a community mental health service. As this project is in the early stages of implementation, no research is available about the model.

In correctional settings, we are aware that Corrective Services NSW has investigated the application of trauma-informed care in custodial environments and has trained Corrective Services staff through MHCC.[10]

Schools and educational settings are another key area for the implementation of trauma-informed care. The Australian Childhood Foundation has developed Making SPACE for Learning, a resource guide for school leaders and staff to respond to traumatised children in the school setting (Australian Childhood Foundation, 2010). The guide provides a summary of the empirical and clinical research on children and trauma, includes case studies to stimulate discussion and sets out the principles underpinning trauma-informed practice in schools. The guide's principles are based on the acronym SPACE:

- *Staged*: this principle is based on the neurobiology of trauma and the ways in which trauma interferes with the developmental processes of neurological formation. It indicates that strategies aimed at resourcing traumatised children and young people need to follow this staged pattern of conceptualisation and implementation to succeed.

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[8] Information about this toolkit is available at mhcc.org.au/sector-development/recovery-and-practice-approaches/ticpot.aspx.

[9] This project has been funded through a research grant provided by the Australia's National Research Organisation for Women's Safety (ANROWS). Antonia Quadara is a chief investigator on this project, with responsibility for the literature review to inform the project.

[10] Corrective Services' investigation was informed by a project they commissioned the Australian Institute of Family Studies to undertake in 2010–12. See Stathopoulos and Quadara (2014).

- *Predictable*: this principle relates to the biopsychological stress (through hyperarousal) trauma generates. It indicates that strategies which promote stability and familiarity reduce the need for the stress system to be as actively engaged.

- *Adaptive*: this principle is based on the concept that traumatised children and young people rely on a limited set of behavioural routines to respond to challenges and changes in their context. In practice, this principle involves strategies that promote adaptability in children and young people, ensuring they are able to maintain multiple meanings for behaviour and remain open to different options for intervention.

- *Connected*: traumatic stress can result from insecure and unstable templates for forming, maintaining and being in relationships. Effective strategies to support traumatised children and young people emphasise relationships with safe and consistent adults and peers as the foundation for change.

- *Enabled*: self-perception can be negatively affected by traumatic experiences, and children and young people may not experience themselves as a coherent identity with a coherent narrative. Effective strategies for responding to traumatised children and young people in the school context will enable them to make links between, and give meaning to, their past and present experiences, their feelings and behaviour, and their thoughts and actions.

Making SPACE also provides a range of strategies for teachers to integrate these principles into their teaching practice and activities.

The above approaches are examples of initiatives that explicitly describe themselves as implementing models of trauma-informed care. It is important to note, however, that the principles of trauma-informed care are also being integrated into other service, care and program frameworks. Two key examples are TRC and Aboriginal and Torres Strait Islander healing programs. These are discussed below.

There have been significant efforts to apply the principles of trauma-informed care to youth residential care settings. Several jurisdictions have developed models of care that integrate trauma-informed frameworks for organisational change, such as the Sanctuary Model, into therapeutic residential care. An evaluation of the impact of trauma-informed TRC was undertaken with Victorian service providers in 2011 (Verso, 2011). It found that the TRC model implemented led to better outcomes for children and young people, when compared to children and young people in residential care settings that had not implemented the model. The improved outcomes covered a number of key areas, including:

- placement stability, with those in TRC settings experiencing a significantly longer placement period

- the quality of relationships and contact with family, and the quality of contact with residential carers over time

- mental and emotional health, with those in TRC settings reporting significant reductions in the severity of mental health symptoms

- physical health

- relationships with school.

At the program level, the evaluation found improved outcomes such as lower staff turnover and the adoption of a range of practices that supported positive outcomes for clients. The evaluators concluded that the contrast in outcomes between the TRC group and the comparison group was significant, and that the pilot status of the TRC programs be removed, rendering them 'legitimate and on-going models of residential care' (Verso, 2011, p 10).

Aboriginal and Torres Strait Islander healing programs and initiatives emerged in the wake of a broader acknowledgement of the impact that colonisation, dispossession, disenfranchisement and child removal has had on Aboriginal and Torres Strait Islander communities. Four primary principles have been identified to support the healing journey:

- addressing the causes of community dysfunction, not its symptoms

- recognising the fundamental importance of Aboriginal and Torres Strait Islander people's ownership, definition, design and evaluation of healing initiatives

- designing initiatives based on Aboriginal and Torres Strait Islander worldviews, not western health understandings alone

- strengthening and supporting initiatives that use positive, strengths-based approaches (Muru Marri, 2014).

The term 'healing' refers to:

> recovery from the psychological and physical impacts of trauma. For Aboriginal and Torres Strait Islander people this trauma is predominantly the result of colonisation and past government policies. Healing is not an outcome or a cure but a process; a process that is unique to each individual. It enables individuals, families and communities to gain control over the direction of their lives and reach their full potential. Healing continues throughout a person's lifetime and across generations. It can take many forms and is underpinned by a strong cultural and spiritual base (Healing Foundation, Glossary of Terms).

Within this context, the acknowledgment of trauma and the importance of being trauma-informed have been central. Trauma-informed practice is seen a key ingredient of good practice (Muru Marri, 2014), and is defined in the following way:

> Trauma-informed practice is a strengths-based approach to healing that:

- is based on an understanding of, and responsiveness to, the impact of trauma

- emphasises physical, psychological, and emotional safety for people seeking help and for the helpers

- creates opportunities for people affected by trauma to rebuild a sense of control and empowerment.

It recognises the prevalence of trauma and is sensitive to and informed by the impacts of trauma on the wellbeing of individuals and communities (Healing Foundation, Glossary of Terms; Atkinson, 2013).

A review of healing-informed organisations noted that trauma within a community, and among staff and board members, can undermine the healthy functioning of an organization. The concept of healing:

enables a fresh approach to addressing dysfunction and rebuilding sustainability. It takes the focus away from an individual or a specific conflict, and places it in the context of the effects of trauma (Healing Foundation, 2015).

A report by the Healing Foundation noted that there was a limited body of evidence on culturally specific organisational management and governance responses to trauma. However, it did acknowledge there were 'emerging organisational frameworks for responding to trauma', specifically naming the Sanctuary Model as one framework, and noted that the principles of the Sanctuary Model could be used to help culturally specific organisational management and governance responses to trauma (Healing Foundation, 2015).

The status of trauma-informed care in Australia

In the authors' opinion, the status of the application of trauma-informed care in Australia could be described as:

- *Emergent*: practice wisdom and evaluation knowledge have not yet coalesced sufficiently to guide how the principles are put into practice in different settings.

- *Enthusiastic*: there is significant interest across a range of sectors in becoming trauma-informed.

- *Opaque*: there is a lack of publicly available, coordinated material on the trauma-informed care programs and models being developed and the format they take.

- *Piecemeal*: without strong, collaborative national leadership, the development of trauma-informed care models is driven by individual services.

In this context, it is not surprising that there is a sense of confusion about the meaning of trauma-informed care. In a recent review of the trauma-informed literature and its application to the Australian mental health nursing context, Muskett (2014) noted that although trauma-informed care was emerging as fundamental to 'effective and contemporary mental health nursing practice', mental health nurses were in fact struggling to translate these values into day-to-day practice and were confused about what individual actions they could take to support these values (p 1).

However, to reiterate, the academic, practice and guidance literature consistently point out that the provision and practice of trauma-informed care is a *systems-level* endeavour. This means that trauma-informed practice goes beyond providing skills and training to practitioners, or implementing treatment interventions that integrate an awareness of trauma into the program. As noted earlier, it extends to evaluating and modifying all aspects of a system – workforce development, policies and

protocols, funding structures and standard practices – in light of what is known about the effects of violence on mental health. As Kezleman and Stavropoulos (2012) note: 'The prevalence of unrecognised and untreated underlying trauma raises disturbing questions not only about health systems. It has disturbing implications for the full spectrum of service delivery and raises critical questions about societal organisation per se.' (p 43)

As such, the desired change is not limited to improved measures for service users, or changes across particular types of practices, but necessarily includes changes to operational, organisational and structural features that shape the delivery of care across all systems. Thus, an emerging issue for discussion in the Australian context is whether incorporating trauma-informed care as a 'key ingredient' in other service philosophies or models is sufficient to achieve systemic change, even if it makes sense at the organisational or settings level.

Mental health and human service agencies in Australia are increasingly considering how their service systems can become trauma-informed, not only to strengthen inter-agency collaboration, but also to minimise the risk of clients being re-traumatised through standard operational practices. Despite this activity and the relatively clear origins of trauma-informed care, there is little guidance on the extent to which services can embed trauma-informed care in their organisations, how this should occur and what systems-level infrastructure is required to support trauma-informed practice throughout and between service organisations (Quadara & Hegarty, 2015; MHCC, 2013; Rose, Freeman & Proudlock, 2012). Wall and colleagues (2016) also noted this gap between theory and implementation in Australia.

Clearly, trauma-informed organisational and systems change is not nearly as developed in Australia, the UK or Canada, as compared to the US (Muskett, 2014; van Veen & Lafreniere, 2012). This is understandable given its more recent history in Australia (and indeed elsewhere). At this stage, a national, coordinated approach to reform, practice and policy development, such as that driven through the SAMHSA mechanisms, is absent. In recognition of this, a National Trauma-Informed Care and Practice Advisory Working Group, convened by the MHCC, released a position paper and recommendations for a national strategic direction (MHCC, 2013). Similarly, the Blue Knot Foundation, the national organisation for adult survivors of child abuse, developed practice guidelines for treating complex trauma, and guidelines for trauma-informed service agencies (Kezelman & Stavropoulos, 2012).

Given the emergent and enthusiastic take-up of the idea of trauma-informed care, national leadership on framing trauma-informed care and collaborative initiatives to design, implement and evaluate organisational and systemic approaches are essential. The MHCC's national strategic direction paper argued that substantial progress had been made in developing a research and practice base for undertaking trauma-informed care and practice, and in translating that research into practice guidelines. It recognised that the 'implementation of trauma-informed practice at scale enough to create measurable cultural change' was a key area to focus on in the future (MHCC, 2013). This involves:

- capacity building

- infrastructure development

- policy development and implementation

- workforce development

- national standards and guidelines.

Alongside the continued development of organisational and program-level efforts to implement trauma-informed care, a complementary tranche of activity – related to creating a funding, dissemination and resource-sharing infrastructure to support collaborative work and research that is accessible – is required, so that information on how trauma-informed care is being implemented in different settings can be shared and fed back into the overall philosophy and principles.

There is also work to be done in exploring how the principles of trauma-informed care are integrated into broader frameworks, such as therapeutic residential care and healing programs, and with what effects. Although these are two key domains in which the principles of trauma-informed care have been deliberately incorporated, it is not clear whether this means we can, or should, refer to them interchangeably – as, for example, 'therapeutic residential care' or 'trauma-informed residential care'.

6. Assessing the promise of trauma-informed care

What are the strengths and limitations of trauma-informed care?

Before considering its strengths and limitations, it is important to note that trauma-informed care, by definition, aims to address multiple levels of a service setting, organisation or system. SAMHSA, in its recent guidance, identified 10 'implementation domains':

- governance and leadership

- policy

- the physical environment

- engagement and involvement

- cross-sector collaboration

- screening, assessment and treatment services

- training and workforce development

- progress monitoring and quality assurance

- financing

- evaluation (SAMHSA, 2014).

The research and evaluation evidence on how well trauma-informed care is being implemented, and with what outcomes, has not been conducted equally across all of these domains. Research exploring the outcomes of trauma-integrated interventions with clients and service users suggests that these programs and treatments do have a positive impact on the biopsychosocial symptoms of trauma and on other issues such as mental health disorders or substance abuse (See appendix 3). Evaluation of organisation- and systems-level outcomes following the implementation of trauma-informed care training or organisational change has demonstrated increases in participants' knowledge in two areas: the impacts of trauma on individuals, and how such impacts might present within the service setting. It also showed that this increase in knowledge can be sustained three months after the training was provided. Behavioural change as a result of that training has been more difficult to assess. The research does, however, tend to suggest that staff members from supporting services were better able to implement the principles of trauma-informed care into practice than front-line statutory childcare workers or others working in a crisis-driven context. The research also suggests that practitioners working in different settings find value in collaborative practice and networking.

The effect of trauma-informed care as a systems-level change effort has been more difficult to implement and evaluate. In terms of implementation, the available research finds that systems change takes time. In particular, working through different organisational philosophies, customs and imperatives can prevent buy-in from all agencies involved and, if not addressed and worked through at the outset, can derail cross-sector training. Implementation is also challenging at the systems level due to the complex, dynamic nature of service systems. Foster-Fishman and colleagues (2007) argue that many systems-change efforts in human service environments have not attended to the dynamics and characteristics of the systems they are trying to change:

> Simply put, systems change efforts are intended to change systems; yet, many systems change efforts ignore the systemic nature of the contexts they target and the complexity of the change process (Foster-Fishman et al., 2007, p 198, cited in Quadara, 2015).

This challenge also extends to evaluating effectiveness at the systems level. Research and evaluation methodologies have not been appropriately matched to demonstrating systems-level outcomes or theorising the connections between interventions and outcomes (Foster-Fishman & Behrens, 2007).

On balance, however, trauma-informed care, or a trauma-informed approach, is a promising way of altering how the many service systems respond to people who have trauma histories.

Are there differences in how trauma-informed care is envisaged?

Recently, some researchers suggested that there is a lack of consensus and clarity about the definition and principles of trauma-informed care (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Price et al., 2014). These observations drew from an article published in 2010 that reviewed the various practice definitions of trauma-informed care in use at the time, as well as the wider research literature (Hopper, Bassuk & Olivet, 2010). It argued that the meaning of trauma-informed care 'remains murky and the mechanisms for systems change using this framework are poorly defined' (Hopper et al., 2010, p 80).

My review of the original paper suggests that the meaning of the authors' argument has become 'lost in translation'. Although Hopper and colleagues argued that there was 'no consensus on a definition clearly explaining the nature of trauma-informed care', they also noted that there was 'agreement that "trauma-informed" refer[red] generally to a philosophical/cultural stance' that integrated an understanding of trauma and provided an 'overarching framework that emphasize[d] the impact of trauma and that guide[d] the general organization and behavior of an entire system' (2010, p 81). In other words, there was a shared understanding about the overall philosophy and purpose of trauma-informed care.

This does not mean, however, that there is consistency in how trauma-informed care is translated into *practice* or operationalised in different settings (Bartlett et al., 2015). To a degree, this is to be expected. As a 'paradigm shift' for organisations or systems that have not traditionally applied a trauma lens – and in some cases whose very purpose works against the principles of trauma-informed care (for example, custodial settings) – the principles and practices of trauma-informed care need to be translated in such a way as to be meaningful and feasible in that setting. An organisation, system or setting that is built on statutory authority and legislated coercive powers, for example, will by necessity practice trauma-informed care in a very different way to a community health centre. This does not signal an inherent problem with the concept of trauma-informed care itself, and indeed reflects the challenges of operationalising an overall principle or ethos across multiple service systems. Wall and colleagues (2015) noted that being trauma informed involved a shift for services from being "trauma-blind" to trauma sensitive and on to trauma-informed. It is important not to see this continuum or process as a "typology" of level of being trauma-informed, but as a way of acknowledging that being aware of trauma in client populations is not sufficient to change systems and organisational cultures[11].

Other examples include implementing 'victim-centred' crisis responses to sexual assault across sexual assault services, police and medical services (Kelly & Regan, 2003; Lovett, Regan & Kelly, 2004; Robinson, Hudson & Brookman, 2008), or operationalising 'best interests' principles across the family law and child protection systems (Wall et al., 2016). The first question for organisations and service settings to ask is:

> Given what we know about the impacts of trauma on the people we serve, what can we change in our policies, protocols, hiring practices, training, physical environment and general practice to ensure that, in performing our core business, we do not, at a minimum, re-traumatise our service users (or clients, patients or students), and hopefully work with them in a strengths-based and future-oriented way?

Other inconsistencies potentially present more of an issue, including the interchangeable use of terminology such as 'trauma-specific', 'trauma-informed' and 'trauma-focused' to describe similar practices. This can create confusion among practitioners about how they should undertake direct service provision and client engagement (Wall, Higgins & Hunter, 2016). In the context of child welfare, the principles of 'trauma-informed child welfare practice' differ somewhat. The NCTSN identified the following key principles:

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[11] See Wall et al (2016: 5) for further detail on this continuum and a useful resource outlining some practical steps to progress through four stages from being – trauma aware, trauma sensitive and trauma responsive to trauma informed.

- maximise the child's sense of safety

- assist children in reducing overwhelming emotion

- help children make new meaning of their trauma history and current experiences

- address the impact of trauma and subsequent changes in the child's behaviour, development and relationships

- coordinate services with other agencies

- utilise comprehensive assessment of the child's trauma experiences and their impact on the child's development and behaviour to guide services

- support and promote positive and stable relationships in the life of the child

- provide support and guidance to the child's family and caregivers

- manage professional and personal stress.

Compared to the principles developed for adult services, these trauma-informed principles for child welfare more explicitly target the symptoms of trauma. For example:

- help children make new meaning of their trauma history and current experiences

- address the impact of trauma and subsequent changes in the child's behaviour, development and relationships

- utilise comprehensive assessment of the child's trauma experiences and their impact on the child's development and behaviour to guide services.

These principles suggest that trauma-informed care involves a degree of clinical work with children. However, understandings of trauma-informed care as articulated by SAMSHA, for example, make clear distinctions between trauma-informed and trauma-specific interventions, and also make plain that it is not necessary for service providers or individual practitioners to be clinicians, or do trauma-specific work. This is an important issue to clarify: if a key driver of trauma-informed care is the recognition that non-specialist service systems and settings need to acknowledge trauma, it seems problematic to suggest that specialist or clinical expertise is required. It can cause non-trauma specialists – that is, those working in alcohol and drug services, teachers and Centrelink officers – to be concerned that they should have specialist knowledge and will be expected to work specifically with the symptoms of trauma. In addition, there are risks that those without specialist trauma expertise will undertake trauma counselling with clients, raising the possibility of causing further harm.

Implications

The development of, and increasing desire for, trauma-informed care is seen by many as a paradigm shift in (a) acknowledging the complex relationships between trauma, mental illness, substance

abuse and other complex needs, and (b) developing ways of working organisationally and systemically that can attend to the interconnected nature of trauma, including the range of other needs that survivors experience. In Australia, there is a demonstrated growing desire for, and provision of, training for trauma-informed care and practice among mental health professionals, child welfare services and other human service practitioners. These are positive developments. However, to ensure that the diverse service systems and practitioners are appropriately supported to realise this paradigm shift, the following two key areas should guide future directions:

- *Maintain and drive a national or coordinated leadership to encourage reform, and practice and policy development.* The adoption of trauma-informed care in Australia is at an early stage of development. A key priority at this stage is to foster national leadership, coordination and communities of practice that share information on how trauma-informed care is being implemented and the lessons that can be learnt from this. Furthermore, unlike in the US, there is limited shared, authoritative guidance literature and resource material to guide services and practitioners. This means a lack of visibility about how trauma-informed care is being implemented, increasing the likelihood of services and providers 'doing their own thing'.

- *Support the systems focus of trauma-informed care*. While it is essential that individual practitioners receive training and professional development in providing trauma-informed care in their day-to-day practice, this on its own is not sufficient to support change within an organisation or service setting. There is very little research that specifically examines the implementation of trauma-informed care at the organisational and systemic level, and how this implementation should be assessed. This is despite the research generated by the WCDVS; the development of models, toolkits and service guides for trauma-informed care; and the articulation of organisational, administrative and policy strategies to embed trauma-informed care into human service settings. Systems change and models of care have emerged as key areas of service, policy and research interest, in recognition of the fragmented, siloed and uncoordinated systems of care individuals experience when accessing mental health, substance use, income support, housing and legal services (Foster-Fishman et al., 2007). Such initiatives are based on the assumption that significant improvements in the outcomes of a targeted population will not occur 'unless the surrounding system (e.g. service delivery system) adjusts to accommodate the desired goals' (Foster-Fishman et al., 2007, p 197). This involves adjusting the underlying structures and supporting mechanisms that operate within a system, such as the policies, routines, relationships, resources, power structures and values (Allen, Foster-Fishman & Salem, 2002). To shift to a trauma-informed mental health and human services system, a number of elements need to be in place (Jennings 2008; MHCC 2013). These involve administrative policies and initiatives at the systems level, to:

  o address government policy and responsibility for systems change

  o support funding models for the development of a trauma-informed service system and implementation of evidence-based and promising trauma treatment models and services

  o foster the recruitment, hiring and retention of staff members with an understanding of trauma, whether through educational background, training or lived experience.

Conclusion

Both the academic and grey literature demonstrate consistent themes in regard to the principles of trauma-informed care; however, there is little evaluative evidence to inform organisational and systemic change. To support the considerable effort and commitment to improving service responses to people with trauma histories, the next stages involve developing the service infrastructure to make trauma-informed care sustainable practice.

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Appendix 1: Search strategy

The search strategy involved the following:

1. Searching for academic research literature using the following databases:

    - EBSCO (PsycInfo; SocIndex)

    - Informit (Australian Criminology Database [CINCH]; Australian Family and Society Abstracts [AFSA]; Health Collection; Humanities & Social Sciences Collection; Indigenous Collection)

    - ProQuest Social Science Journals

    - PubMed.

    a. For literature on the concept of 'trauma' and 'trauma-focused interventions', the following search terms and search strings were used:[12]

        o   SU: trauma AND KW: history
        o   SU: trauma AND KW: intergenerational trauma OR collective trauma
        o   SU: trauma AND KW: Aboriginal OR Indigenous
        o   SU: trauma AND KW: Aboriginal OR Indigenous
        o   KW: Aboriginal OR Indigenous AND KW or Abstract: intergenerational trauma OR collective trauma
        o   SU: trauma AND KW: refugee OR humanitarian migrant
        o   KW: refugee OR humanitarian migrant AND KW or Abstract: intergenerational trauma OR collective trauma
        o   KW: PTSD AND KW: history
        o   KW: PTSD AND KW: cross-cultural or transcultural psychiatry
        o   KW: PTSD AND KW: cross-cultural or transcultural psychiatry
        o   SU: sexual abuse OR child sexual abuse AND SU: emotional trauma AND SU: treatment OR intervention AND ANY: effectiveness OR KW: outcomes
        o   SU: sexual abuse OR child sexual abuse AND SU: child OR children AND SU: treatment OR intervention AND ANY: effectiveness OR KW: outcome.

        The search parameters were as follows: peer-reviewed and published in English.

    b. For literature relating to trauma-informed care or trauma-informed approaches, the following search strings were used:

        o   KW trauma-informed AND KW child
        o   KW trauma-informed AND KW Aboriginal or Indigenous

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[12] In the search strings, 'SU' = subject; 'KW' = keyword and 'ANY' = any search field.

- KW trauma-informed AND KW Refugee OR humanitarian migrant
- KW trauma-informed AND KW child welfare system
- KW trauma-informed AND KW children
- KW trauma-informed AND KW interventions AND KW children
- ANY trauma-informed AND (interventions or strategies)
- ANY trauma-informed AND (intervention)
- SU: emotional trauma AND SU: mental health
- SU: mental health services AND SU: trauma
- SU: emotional trauma AND Abstract: mental health services
- KW: trauma-informed care AND Abstract: mental health
- KW: mental health AND keyword: trauma AND Abstract: model of care
- KW: mental health services AND KW: trauma.

The search parameters were as follows: peer-reviewed, published in English and published after 2000.

2. Searching for grey literature on trauma-informed care. The following key mechanisms were used:

- the Australian Institute of Family Studies library catalogue, where 'trauma-informed' was used in 'subject' or 'title' search

- Google Search, where 'trauma-informed care' was used for material published within any domain and within Australian domains

- known organisations that publish information on trauma-informed care, namely:

  - Substance Abuse and Mental Health Services Association
  - National Child Traumatic Stress Network
  - Mental Health Co-ordinating Council.

3. As expected, this was an iterative search process with additional search terms used, specifically:

- 'healing', in order to locate material relevant to Aboriginal approaches to trauma-informed care

- 'therapeutic residential care', as a recent model of trauma-informed care in residential care settings for children.

4. This material was collated into an EndNote library and grouped into key thematic areas. Annotated bibliographies were produced and reviewed. Key resources were identified and reviewed in depth.

5. The material was reviewed using a traditional narrative method (that is, identification of key findings, themes and knowledge gaps/limitations), which is appropriate to the stated aims of the paper.

Appendix 2: Principles of trauma-informed care

Jennings (2004)	Elliot et al. (2005)	SAMSHA (2014)	NCTSN	MHCC (2012)
• offer safety from physical harm and re-traumatisation • develop an understanding of clients and their symptoms in the context of their life experiences, history, cultures and society • facilitate open and genuine collaboration between provider and consumer at all phases of the service delivery • emphasise skill building and acquisition rather than symptom management • understand symptoms as attempts to cope • adopt a view of trauma as a defining and organising experience that forms the core of an individual's identity, rather than a single discrete event • focus on what has happened to a person rather than what is wrong with a person	• recognise the impact of violence and victimisation on development and coping strategies • identify recovery from trauma as a primary goal • employ an empowerment model • strive to maximise a woman's choices and control over her recovery • base services in relational collaboration • create an atmosphere that is respectful of survivors' need for safety, respect and acceptance • emphasise women's strengths, highlighting adaptations over symptoms and resilience over pathology • aim to minimise the possibilities of re-traumatisation • strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background	• encourage safety, including the physical and psychological safety of staff members and the people they serve • create trustworthiness and transparency, meaning that organisational operations and decisions are conducted with transparency and aim to build and maintain trust • foster peer support and mutual self-help – key vehicles for establishing trust, safety and empowerment • facilitate collaboration and mutuality so there is true partnering and levelling of power differences • encourage empowerment, voice and choice – recognise, build on and validate individuals' strengths, and develop new skills as necessary • address cultural, historical and gender issues – organisations actively move past cultural stereotypes and biases, and offer gender-responsive services, leverage the healing value of traditional cultural	• routinely screen for trauma exposure and related symptoms • use culturally appropriate, evidence-based assessment and treatment for traumatic stress and associated mental health symptoms • make resources available to children, families and providers on trauma exposure, its impact and treatment • engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma • address parent and caregiver trauma and its impact on the family system • emphasise continuity of care and collaboration across child-service systems • maintain an environment of care for staff that addresses, minimises and treats secondary traumatic stress, and that increases staff resilience	• understand trauma and its impact • promote safety • ensure cultural competence • support consumer control, choice and autonomy • share power and governance, and integrate care • recognise that healing happens in relationships, and that recovery is possible

- solicit consumer input and involve them in designing and evaluating services	connections, and recognise and address historical trauma

Appendix 3: Summary of evaluation findings of trauma-integrated interventions

Model	Key information	Intended audience	Settings	Measures	Outcomes
A Woman's Path to Recovery		Adult women	Inpatient; residential; outpatient	Alcohol; drugs; mental health; quality of life; social functioning	Evaluated one pre- (intake) and post-treatment study (two months after intake). Participants showed significant decreases in self-reported substance use; significant global clinical improvement from mid-treatment to post-treatment; significant decreases in self-reported impulsive and addictive behaviour.
Seeking Safety (Morrissey et al., 2005)	A quasi-experimental treatment outcome study conducted from 2001 to 2003 at nine sites of multiple programs	Adult women with co-occurring disorders		Substance use problem severity, mental health symptoms and trauma symptoms were measured at baseline; follow-up data was analysed with prospective meta-analysis and hierarchical linear modelling	A total of 2,026 women had data at the 12-month follow-up: 1,018 in the intervention group and 1,008 in the usual-care group. For substance use outcomes, no effect was found. The meta-analysis demonstrated small but statistically significant overall improvement in women's trauma and mental health symptoms in the intervention, relative to the usual-care comparison condition. Analysis of key program elements demonstrated that integrating substance abuse, mental health and trauma-related issues into counselling yielded greater improvement, whereas the delivery of numerous core services yielded less improvement relative to the comparison group. A few person-level characteristics were associated with increases or decreases in the intervention effect. These neither moderated nor supplanted the effects of integrated counselling.

| Women's Integrated Treatment Helping Women Recover (HWR): A Program for Treating Addiction | Three fundamental theories underlie the model: relational-cultural theory, addiction theory and trauma theory

Counsellors use a strengths-based approach with a focus on personal safety to help clients develop effective coping skills, build healthy relationships that foster growth and develop a strong, positive interpersonal support network | Adult women with co-occurring disorders | Criminal justice or correctional settings | Substance use; after-care retention and completion; re-incarceration | Evaluated one experimental study.

From baseline to the 12-month post-parole follow-up, women in the intervention group had a larger decrease in drug use than their counterparts in the comparison group, after controlling for ethnicity, marital status and employment.

Retention in the first episode of residential after-care treatment following parole was longer for women in the intervention group than it was for women in the comparison group. Women in the intervention group were more than four times as likely to successfully complete this after-care treatment episode following parole than women in the comparison group.

A smaller percentage of women in the intervention-group than comparison-group were re-incarcerated during the twelve months following parole. During this time, women in the intervention group were 67 per cent less likely than women in the comparison group to be re-incarcerated, after controlling for ethnicity, marital status and living situation. |