



University of
South Australia

Trauma-Informed Approaches in Forensic Mental Health

A practical resource for health
professionals

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Introduction

A trauma-informed approach is one that works from the fundamental principles of trauma awareness. That is, working to avoid re-traumatisation by empowering consumers and staff in decision making, safety, trustworthiness, choice and collaboration as well as building of strengths and skills. Trauma-informed approaches are based on the understanding and belief that symptoms and experiences related to trauma are coping strategies developed to manage traumatic experiences. Consideration of behaviour through a trauma-informed lens means making revisions of (for example) aggressive or hostile consumer responses that might previously have been viewed as negative or 'deliberately difficult', or so called 'uncooperative' behaviours.

About this Resource

This resource is intended to provide evidence-based and best-practice information to practitioners working in mental health who want to work more effectively with people who have been exposed to traumas and/or are at risk of exhibiting traumatic stress reactions. Practitioners using this resource should also receive practice based education, clinical supervision surrounding specific interventions, including trauma specific strategies, building on resilience, developing safety and skills to negotiate the impact of trauma. Practitioners must also consider evidence on the neurobiological underpinnings of trauma, as well as the interrelationships between events, thoughts, emotions and behaviour.



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Key Objectives

The objective of this resource is to provide practitioners and service managers with knowledge to effectively work with people at the point of care who have been exposed to trauma and are at increased risk of exhibiting traumatic stress reactions. The key objectives of the resource are to:

- Share knowledge related to trauma-informed practice;
- Raise awareness and understanding of types of trauma and associated neurobiological and psychological effects;
- Increase awareness of specific trauma related events and experiences;
- Understand the importance of person-centred care in trauma-informed practice;
- Empower practitioners to engage with and contribute to trauma-informed services;
- Improve knowledge of chain of care associated with trauma-informed practice.

Key Dimensions

Inter-Professional Learning

To foster collegiality and a respectful health team environment learning across disciplines, this resource has been developed to encourage inter-professional discussion and information exchange.

Evidence-based Practice

This resource is informed by the principals and processes of evidence-based practice. This will ensure that practitioners have the skills to critique their practice and to identify the appropriate evidence to inform trauma-informed decision making.

Critical Thinking and Analysis

Critical thinking and analysis relates to self-appraisal through professional development and the value of critiquing evidence and research for practice. Practitioners using this resource are encouraged to reflect on practice, feelings and beliefs and the consequences for individuals and groups, seeing this as an important attribute in trauma-informed practice across a range of healthcare disciplines and clinical settings.

1. Understanding trauma

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotion, or spiritual well-being' (SAMHSA 2014a p. 7).

Multiple definitions of trauma exist. Trauma may include interpersonal violence (e.g. sexual, physical or emotional abuse), neglect, loss, terrorism, natural disasters, and/or witnessing others experience these same traumas (NETI 2005). For many, the experience of such events is usually repetitive, intentional, prolonged and severe, which means that the impact of trauma can be pervasive (NETI 2005). Instances where trauma is multiple or prolonged are described as complex trauma experiences. For many, trauma experiences occur early in life, and it has been suggested that 'Failure to acknowledge the reality of trauma and abuse in a child's life and the long term impact this can have in adolescence through to adulthood is one of the most significant clinical and moral deficits of current mental health approaches' (Newman 2012 as quoted in Kezelman, Stavropoulos & ASCA 2012).



Trauma in the healthcare system

It is acknowledged that individuals who have experienced trauma tend to represent the greatest proportion of people accessing mental health, forensic health and drug and alcohol services (Muskett 2014). Estimates suggest that up to 90% of public mental health consumers have been exposed to multiple trauma experiences (NETI 2005). This is supported by the Adverse Childhood Experiences (ACE) study, which reinforces the link between childhood trauma and long term negative health outcomes.

Therefore, there is now a growing movement that services and professionals move away from traditional methods in which we view, assess and treat such individuals into a more sensitive, trauma-informed manner in order to provide them with optimal service delivery to achieve optimal outcomes. Wall, Higgins and Hunter (2016) explain how 'Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage' (p. 2). Within the forensic system, consumers may have experienced amplified trauma, contributed to by factors such as their illness, social issues, legal complications and enforced incarceration through the judicial process (Cromar-Hayes & Chandley 2015; Muskett 2014). Minimising any additional trauma and simultaneously supporting our consumers through trauma-informed practice must be the foundation for holistic care planning (Muskett 2014).

Several people present to healthcare services with a complex range of behaviours related to past trauma. If practitioners do not recognise these behaviours as being related to the trauma, the service response may be uninformed and fragmented which could potentially re-traumatise the individual (Wall, Higgins & Hunter 2016). Within inpatient units, there are several factors, including the physical and social environment, which can be re-traumatising for individuals and not accurately responsive to their trauma history. Service providers can be inadvertently invalidating someone's experiences and therefore re-enforcing maladaptive behaviours and coping skills (Levenson 2014). For example, it has been common practise to utilise seclusion and restraint as interventions to manage people who display behaviours associated with trauma, including distress and aggression (Te Pou o et Whakaaro Nui 2011). The use of these strategies, as well as the environment within an inpatient setting, can be re-traumatising for the individual and the staff members involved, and are likely to impact the person's willingness to re-engage in such services. This will effectively destabilise the consumer's treatment and care and perhaps most significantly the therapeutic alliance between the consumer and the primary practitioners (Muskett 2014; Wigham & Emerson 2016). These strategies are in line with the past terminology as 'behaviour management' where behaviour is sought to be managed and contained rather than supported to change. It is a key national safety priority (NSW Health 2012; NMHC 2013) to reduce the use of seclusion and restraint as a

response to behaviours of concern. Without a clear understanding of the function behaviours serve, it is more likely for services to respond using involuntary restraint and restrictive practices including seclusion and which are potentially traumatising for the person, thus reinforcing the behaviours of concern. As such, a trauma-informed approach is required across all aspects of service delivery, rather than solely at the intervention level.

It is in this context that trauma-informed care has emerged as an important consideration in treatment and service delivery prioritisation and is an approach likely to lead to short- and long-term cost effectiveness (Quadara 2015).

2. Neurological, biological, psychological and social effects of trauma on the individual

Research indicates that a high population of mental health service users have a history of traumatic experiences or exposure (Champagne & Stromberg 2004). Trauma-informed care recognises that exposure to trauma can impart permanent physiological changes to the brain and in turn can have adverse physical and mental sequelae with lifelong negative consequences. The negative impact of trauma can affect the mind, body and ability to form attachments that are healthy and secure (LeBel et al. 2010). Survival strategies utilised by individuals during experiences of trauma might lead to the development of behaviours which were useful at the time of the trauma but are now viewed as maladaptive (Te Pou o et Whakaaro Nui 2011). Van Der Kolk (1994) describes how people with trauma backgrounds do not respond to stress in the same way as those without trauma backgrounds. When stressed or experiencing a heightened state of emotional stimulation, they can experience feelings likened to be being re-traumatised from 'retrieval of traumatic memories, sensory information, or behaviours associated with previous traumatic experiences' (Van der Kolk, 1994). The body's stress response system overstimulates arousal regulation which influences affect and behavioural regulation (Warner et al. 2013).

There is acknowledgement that children who experience traumatic events are affected adversely because they are unable to respond to the body's flight or fight response. Exposure to chronic stress has an effect on the body by releasing toxic levels of cortisol which has the devastating effect of killing off neurons in critical areas of the brain (Centre for

Non-violence and Social Justice 2014). According to the Centre for Non-violence and Social Justice in the United States there is, '...a wide body of research indicating that the brains of children who are exposed to trauma and stress are wired differently than children whose experiences have been more secure' (2014 p. 190). Studies have shown that traumatic stress suffered in childhood will affect brain performance and leave residual brain deficits. Baker and White-McMahon (2014) cite Goleman (2006 pp. 273-274), 'When the body endures ongoing stress, cortisol affects the rate at which neurons are either added or subtracted from the hippocampus. This can be a tremendous assault on learning. When the neurons are attacked by cortisol, the hippocampus loses neurons and is reduced in size. The reduced size in the hippocampal region results in learning, verbal and visual memory deficits.' Goleman further explains that while cortisol impairs the hippocampus the amygdala is stimulated. The amygdala's primary role is in processing memory and decision making and emotional responses. This stimulation causes a person to remember how they felt at the time of the trauma. It is this feeling and the emotional response we remember into adulthood (Baker & White-McMahon 2014).

Symptoms of trauma can be described as physical, cognitive, behavioural and emotional. Physical symptoms can be exhibiting excessive alertness, on the lookout for signs of danger, fatigue/exhaustion, disturbed sleep and failure to cope in certain circumstances. Cognitive (thinking) symptoms involve intrusive thoughts, memories and visual images of the event, nightmares, poor concentration and memory, disorientation and confusion. Additionally, behavioural symptoms can be described as avoidance of places or activities that are reminders of the event, social withdrawal, isolation and loss of interest in normal activities. Emotional symptoms can include grief, detachment, depression, guilt, anger, anxiety and panic. The combinations of physical, cognitive, behavioural and emotional symptoms are all normal reactions to trauma. They can be distressing to the individual. However these symptoms will settle in time for most people after they have adjusted to the event and processed their experience.

There are some people, however, who develop more serious conditions such as depression, anxiety disorders, post-traumatic stress disorder (PTSD) and/or alcohol and drug issues. Many mental illnesses are considered to be the result of unresolved trauma that occurred in childhood

(Klinik Community Health Centre 2013). Exposure to complex traumas have been linked to socio-emotional developmental issues and manifests in children as impairment in attachment, biology, affect regulation, disassociation, behaviour regulation, cognition and self-concept (Holmes et al. 2014). This biological impairment manifests behaviourally as depression, anxiety and aggression (Holmes et al. 2014). Muskett found that, 'exposure to childhood trauma, especially if an isolated adverse event, is able to be counteracted by the presence of other resilience-enhancing factors in the child's immediate environment' (2014 p. 2). Muskett clarifies this statement by adding that low levels of family discord, nurturing relationships with parents and the absence of mental illness and/or drug misuse are some of the key areas that provide resilience for children. These are known as protective factors. Trauma in childhood results in risky health behaviours, chronic health conditions, reduced life fulfilment and death. Trauma is a serious public health issue (CDCP 2016).

3. Principles of trauma-informed practice

A program, organization, or system that is trauma-informed **realises** the widespread impact of trauma and understands potential paths for recovery; **recognises** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatisation**. (SAMHSA 2014a p. 9).

Clearly the symptoms of trauma have potential to be expressed across a range of physical, cognitive, behavioural and emotional domains. SAMHSA (2014 p. 10) describe the following as core principles of trauma-informed practice:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support;
4. Collaboration and mutuality;
5. Empowerment, voice, and choice;
6. Cultural, historical, and gender issues.

The above principles will now be discussed in more detail.

Safety

Within an organisation it is important that staff and consumers alike feel physically and psychologically safe. This includes a sense of safety in a physical

setting and with interpersonal interactions. For staff, safety 'generally means maximising control over the service environment and minimising risk' (Almazar & Sims 2016). It is important for leadership to acknowledge that all change involves loss, and that practices are likely to have developed in order for staff to feel safe and secure. When facilitating a cultural and practice change it is important for leadership to ask 'What will make you feel safe?' Cromar-Hayes and Chandley state that 'staff need to feel secure – professionally and personally – before they could fully engage in recovery with patients (2015 p. 36)'. A workplace with a psychologically safe environment is one that has a shared belief held by staff that their psychological safety and well-being is protected and supported by senior management. Often it is the small actions that staff will judge management and leaders by, and whether they care about staff. Examples could include listening with empathy to staff following a difficult interaction with a consumer, or being aware of a staff member's triggers and supporting them at these times.

Trustworthiness and transparency

This refers to organisational operations and decisions being developed and implemented with transparency with the purpose of building and maintaining trust. This principle is equally important for consumers as well as staff across all levels from the most junior to those working in senior management positions. When an organisation is undergoing a philosophical change or transformation, leadership is key. Those in leadership positions at all levels of the organisation must define and articulate a vision, values and philosophy that express the principals of trauma-informed practice (NETI 2005). This transparent communication will help to nurture the connections leadership teams have with staff and develop trust with regards to the change. When undergoing an organisational change to be a trauma-informed service, it is important that all policies and procedures are based on knowledge and principles of recovery and trauma-informed care (NETI 2005). Transparency from senior management and leadership teams can be done in simple ways in order for staff to feel connected to the leadership and service they are providing. For example, by providing a regular newsletter written by senior management to communicate any organisational changes and reasoning behind these to all staff. If senior management demonstrates trustworthiness and transparency to staff, then staff are more likely to demonstrate the same towards consumers and carers.

Peer support and mentoring

Peer support and mentoring mechanisms are important means for establishing safety and hope, building trust, and enhancing collaboration' (SAMHSA 2014a p. 11). At a deeper level peer support and mentoring is about the development of collegial support structures and culture. There must also be demonstrable commitment to staff support structures and processes. Clinical supervision is widely recognised as being essential, and reflective practice groups are also highly beneficial. On a day to day level, service leaders can ask staff 'Who is available to you to seek support from?' There must be an enabling culture for staff to seek and provide that support at times of need. Peer support and mentoring mechanisms promote the building of workplace resilience, through building a sense of community and acknowledgement. There are endless ways this can be facilitated; however, generally speaking, building a peer support community occurs through activities (e.g. staff lunches) and acknowledgement of individual for job well done and for caring acts, or commitment to the workplace. If staff are to nourish consumers, they themselves need to feel themselves nourished as well.

Collaboration and mutuality

This principle is concerned with partnerships and levelling of the power difference between staff and consumers, and among organisational staff of all levels, demonstrating that *healing happens in relationships and in the meaningful sharing of power and decision-making* (SAMHSA 2014a). This is key when looking at a cultural change within a workplace or organisation. It is important for leadership to understand the culture they are trying to change. For staff to get 'on board' with the change, they need to know that senior working within the organisation are addressing the narrative of the workplace and its associated culture. In trauma-informed care, it is widely recognised that 'all behaviour has meaning'. This can be applied to staff and for leadership teams to understand what purpose current practices are serving. Staff also need to be acknowledged for current practices that are already trauma-informed and have these honoured, before being asked to change. The Mental Health Coordinating Council (MHCC et al. 2013) identified eight foundational principles that represent the core values of trauma-informed care; these include the sharing of power and governance. Referring to 'promoting democracy and equalisation of power differentials; sharing power and decision-making across all levels of an organisation, whether related to daily decisions or

in the review and creation of policies and procedures' (MHCC et al. 2013 p. 10). This could be undertaken through involvement of direct-care staff in committees, consulting staff in the review of procedures and in decision-making. This principle highlights that healing happens in relationships and that collaboration gives everyone a voice to start healing the organisation.



Empowerment, voice and choice

'Throughout the organisation and among the consumers served, individuals' strengths and experiences are recognised and built upon' (SAMHSA 2014a p. 11). Within the organisation the workforce development and services need to foster empowerment for staff and consumers. 'Staff are empowered to do their work as well as possible by adequate organisational support' (SAMHSA 2014a p. 11). It is particularly through empowerment that an organisation will foster a belief in resilience. Kezelman, Stavropoulos & ASCA 2012 identify that for a shift towards trauma-informed care to occur, empowerment and skill building of staff must be prioritised. Leadership teams could empower staff by highlighting the small acts they do which are already trauma-informed. For example, engaging in meaningful activity, or asking consumers their preferences. Miller and Najavits (2012) identify that staff and consumer relationships are the day to day fabric of trauma recovery and re-traumatisation. It is the responsibility of leadership teams to empower staff to facilitate trauma recovery through trauma-informed care.

Workforce development and education is widely recognised as being critical to facilitate a shift to trauma-informed care. Muskett reports that 'trauma-informed care was found to only be possible when staff were confident and competent in the knowledge of the prevalence and impact of trauma on consumers, and the understanding of their responsibilities in mitigating re-traumatisation' (2014 p. 7). Workforce development is a core strategy for the

implementation of trauma-informed services (NETI 2005). Staff provided with training and education to equip them with knowledge of the impact of trauma, as well as skill development to implement trauma-informed practices to provide alternatives to current interventions (e.g. use of assessment tools, positive risk taking or calming sensory interventions).

Cultural, historical and gender issues

SAMHSA articulates this principle as ‘the organisation actively moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value of traditional cultural connections and recognises and addresses historical trauma’ (2014 p. 11). This could be in reference to identifying the need for a cultural shift within an organisation. To assist with the cultural shift it is important to identify the core values of the organisation, as defined by staff and not by senior management. One key vehicle to facilitate this cultural shift towards trauma-informed care is the conscious use of language. The British Columbia Trauma Informed Practice Guide (Urquhart & Jasiura 2013) identifies that the behaviours and responses of those with trauma experiences are often misunderstood or labelled in a stigmatising and deficit-based way. At these times, a shift in language from ‘what is wrong with this person?’ to ‘what has happened to this person?’ facilitates a viewpoint on the situation from a trauma-informed and strengths-based perspectives. Leadership should role model this language and facilitate these style discussions as a means to facilitate a cultural shift.

4. Trauma-informed practices with different populations

Regardless of the population, some general trauma-informed principles apply. At its heart, the approach suggests that the validation of an individual’s personal story is important in understanding their behaviour. The key question to be asked is, *What happened to you?* This type of questioning acknowledges that the person has some form of traumatic event inflicted on them. An individual’s trauma must be recognised by the treating practitioners to inform care and to assist with painting the whole picture in order to better understand where a person has been in their life

and what traumatic experiences may have occurred. With this in mind it is also important to not re-traumatise an individual with the line of questioning in history taking i.e. try to make your questions personable but not too probing as it may feel as if you are interrogating the consumer. Providing a safe place where people who have experienced trauma can discuss their stories in a supported environment is an important start in the recovery process. Also of importance is that a person is not forced or coerced into discussing their story. Recovery processes are best supported in a positive, comforting environment and complementing this is safety in the therapeutic relationship (MHPOD 2016). The key components of trauma-informed practice include: collaboration, trust, safety, choice and empowerment. The use of appropriate sensitive language is most important in forming trusting relationships (MHPOD 2016). This framework is not unlike the recovery framework where the person is at the centre of their care, making their own choices in collaboration with practitioners. It is recognising the good work that we are already doing and pulling all the care principles together that will make a difference and improve outcomes for consumers on this difficult trauma recovery journey.

This next section describes some specific trauma-informed responses when working with diverse populations.

4.1 Trauma-informed care and working with Aboriginal people¹

One community member’s experience of trauma can affect a whole community, and the potential exposure to cumulative stressors across the lifespan can be passed from one generation to another through experiencing and remembering traumatic events in the mind of an individual or life of the community (Atkinson, Nelson & Atkinson 2010). This can impact the social and emotional wellbeing of Aboriginal people which encompasses the mental health, social, cultural and spiritual health of individuals, their families and community.

Aboriginal Australians are twice as likely as non-Aboriginal Australians to report high/very high levels of psychological distress (Pink & Allbon & AIHW 2008); they are hospitalised for mental and behavioural disorders at 1.8 times the rate of non-

¹ The authors would like to acknowledge the valuable contribution made by Damian Coulthard, Aboriginal Inpatient Liaison Worker, Rural and Remote Mental Health Service, for this section 4.1 of the resource.

Aboriginal people (AIHW 2015). The leading causes of mental health related hospitalisations for Aboriginal people include schizophrenia, alcohol misuse and reactions to severe stress (AIHW 2015).

Almost one in 10 Aboriginal and Torres Strait Islander people aged 15 years and over have been incarcerated in their lifetime, and are 13 times more likely than other Australians to be in prison (Pink, Allbon & AIHW 2008). There is limited data on the rates of Aboriginal people in an inpatient forensic setting in South Australia; however, studies facilitated in Western Australia show that Aboriginal people represent approximately 30% of admissions to the State Forensic Mental Health Service (ABS 2012, Durey et al. 2013). When combining the incidence of trauma, incarceration, mental illness and admission to forensic inpatient settings it is important to reflect on how practitioners and services consider trauma-informed practice when providing services to Aboriginal people. Although this information is targeted toward an inpatient forensic mental health setting it is anticipated that this material may also be transferrable to other secure settings such as correctional facilities and inpatient psychiatric units.

When working with Aboriginal people it is important to reflect on the connection with country and kin, and how strong kinship systems and connection to cultural traditions, country and community can serve as a protective factor in the face of trauma experiences (Atkinson 2013). It is therefore important to also reflect on the potential impact that disconnection from family, community and country has on an Aboriginal person's social and emotional wellbeing as a result of incarceration, or admission to an inpatient psychiatric or forensic service. While acknowledging the incidence and impact of trauma it is also important to recognise the level of resilience of Aboriginal people and culture in the face of great adversity (Atkinson 2013).

Rather than utilising a standardised approach, this section provides some key considerations for working with Aboriginal people in a secure setting, applying the principles of consumer centred practice and recognising and respecting the diversity of Aboriginal people and the economic, social and geographic circumstances of the person. In particular, focusing on the role of the clinician in gathering information regarding a person's daily functioning, providing a narrative example of what a traditional interview-based assessment may look

like and what a more trauma-informed and culturally safe interaction may look like.

The initial interaction and assessment facilitated within an inpatient forensic setting seeks to gain information about a person's sense of roles, habits and responsibilities, physical and cognitive abilities, motivation, and environmental factors (social, cultural, physical, spiritual). This would typically occur in an interview room and would start with a brief introduction of the therapist and consumer, a description of the practitioner's role within the setting, and the purpose of the assessment.

Introducing the role of Occupational Therapy (for example) typically includes supporting the person to do the things they need and want to do in order to live a meaningful and purposeful life, exploring their strengths and skills associated with activities of daily living and areas of support that the person may benefit from. Following this introduction the first lines of enquiry may include questions such as:

- Can you please describe your living arrangements prior to your admission?
- Can you please describe some of the roles or responsibilities that you have? Can you say how you are going with meeting these?
- Can you describe a typical weekday before your admission?
- Can you describe your daily routine? What does it look like now?
- What do you think is important for me to know about your personal values and/or things that are most important to you in your life?
- What do you think is important for me to know about activities are you interested in?
- Do you ever find that you have difficulty with remembering things, concentrating or solving problems that come up?
- Do you have any physical problems that prevent you from doing the things that you need to do?
- Can you please tell me a bit about what was happening for you leading up to your admission?
- Can you please describe your thoughts and feelings when things in your life were going most well for you?
- Can you please describe your thoughts and feelings when things in your life were at their worst?
- How do you think your past experiences have impacted on your current situation?

While the above questions are useful to build a trusting therapeutic engagement and interaction, there are some further considerations for applying a culturally competent trauma-informed approach:

- Firstly, it is important that practitioners seek out the guidance and support of an Aboriginal Liaison Officer (ALO) and inviting the option of the ALO being present during the discussion. It is also important to explore whether or not the person would like to have an interpreter present, not only to translate from one language to another, but also to assist with ensuring a mutual understanding of words and meanings.
- Acknowledge the importance of the location and time of the conversation. Even if the options for location and time are limited within an inpatient forensic setting, where possible offer the option of meeting either in an interview room or a courtyard to provide a sense of control and choice. Although timeframes for meeting may also be limited within a secure setting, where possible offer the options of meeting earlier or later in the day and allocate sufficient time for the conversation so that it does not feel 'hurried'.
- Consider the importance of facilitating a clear and unhurried introduction of self and building familiarity with the person. Initially focus on who you are not what you are, and within the professional boundaries of your role, take the time to find common ground such as sharing knowledge of the person's country and/or community, previous work with ALOs (particularly if the person has had contact with the ALO in the past) and interest in working with Aboriginal people and communities.
- Show a genuine interest in the person's wellbeing through consistency of interactions, honesty, openness and dependability. Let the person know what to expect – what is the purpose of the conversation and how will it support the person with moving forward?
- Consider the person's previous experience of service providers, either through personal experience or secondary exposure, and how this might impact on your relationship.
- Consider the environment, your posture, gestures and eye contact; take the persons lead on what is most comfortable to them.
- Where possible, try to facilitate the initial assessment as a more informal conversation rather than a list of questions.
- Reflect on your own cultural values and benchmarks for practice and be open to exploring and understanding behaviours and functioning through a different cultural lens.
- Acknowledge sensitive topics and the potential discomfort when asking about certain areas of daily living (e.g. self-care); however, also highlight the benefits of gathering this information to assist the person with moving forward.
- Listen to the language that the person is using and how they are telling their story, and use similar language and communication styles in your own interactions. Create an environment that allows the person to tell their story.

Taking into account the above considerations, the following questions are examples of how the initial interaction and assessment could be adapted to demonstrate a trauma-informed approach when working with Aboriginal people:

- Where do you normally live? Can you go back there?
- Do you have any family responsibilities? Is there anything with family that you are worried about?
- What are the main things that you do for the house?
- What was happening before you came here?
- What was different when your life was good?
- Can you tell me what it was like when life was bad?
- Where do you think your past fits into your life now?
- Do you ever find it difficult to stay focused or pay attention?
- Is there anything wrong with your body which is making it hard to do things during the day? Can you find a way around this?
- What do you like to do for fun? Is there anything that is getting in your way of doing this?
- Do you have any worries that make it hard to do things during the day?
- What's it like for you here? How could it be better?

4.2 Trauma-informed care and Intellectual Disability

People with an intellectual disability (ID) are at greater risk of being exposed to trauma (Jackson & Waters 2015) including violence, neglect and abuse (Robinson 2015). Janessen et al. (2002) propose that a person's cognition can impact on their ability to cope with stress and develop attachment relationships. It is indicated that an early diagnosis of ID is linked to insecure attachment (Esterhuyzen & Hollins 1997). Secure attachment acts as a moderator for a person's thinking manner and can contribute towards a greater level of resilience in the longer term (Janssen, Schuengel & Stolk 2002). In contrast, poor attachment is considered a potentially traumatic event (Almazar & Sims 2016) and may interfere with the typical development of the right brain's stress coping system (Bradley 2000; Schore 2001). As a result, people with poor attachment are less able to regulate their behaviour (Esterhuyzen & Hollins 1997; Janssen, Schuengel & Stolk 2002).

Disability itself can be perceived as a trauma, both for the parents when receiving the diagnosis, but also for the person when they become cognitively aware of the diagnosis (Hollins & Sinason 2000). Hollins and Sinason (2000) propose people with ID use behaviour as a medium to express distress. With reduced ability to cope with stress, people with ID may perceive stress in a more frequent, sustained and intense manner than members of the general population (Janssen, Schuengel & Stolk 2002), likely resulting in a higher prevalence of these behaviours. If behaviour patterns are developed in the context of responding to stress or trauma, they can become deeply embedded (Levenson 2014). These behaviours of concern may include verbal and physical aggression, unwanted sexual advances, property damage and self-injury (Oliver-Africano, Murphy & Tyrer 2009). Such behaviours are common among people with ID across their lifespan (Brylewski & Duggan 2004).

Engaging in trauma-informed care when working with people experiencing ID requires an understanding of contemporary treatment approaches. Research into psychotherapeutic strategies and the benefits for the consumer with an ID continues to grow. Two examples are discussed here.

Modified Cognitive-Behavioural Therapy (CBT) has proven successful. Inclusion of communication aides such as pictures, photographs and props may be incorporated depending on the individual's

needs. Active support engages the consumer in meaningful and enjoyable activities. Learning and developing new skills signifies improved confidence and self-worth, thereby promoting empowerment. A consumer who feels empowered and who feels they have the right to make decisions will have less need to express loss of control and or challenging behaviours (Budiselik et al. 2011; Cromar-Hayes & Chandley 2015).



Specifically adapted mindfulness training for clinical staff offers an approach which allows practitioners to evaluate the person as a whole and is a useful de-escalation technique. Encouraging consumer awareness of their internal emotional state and external factors allows the practitioner to help the consumer focus on the present and re-introduce the concept of the consumer taking control of their own behavioural responses. Environmental strategies are useful in minimising potential risk to the consumer and those around them. The peace or perhaps distraction of a comfort room with visual aids, television, music, games or just alone time may be the key to de-escalating potential aggressive behaviour. Counter-intuitive intervention strategies allow the practitioner to help diffuse and de-escalate a consumer with potentially dangerous and or aggressive behaviour. Being able to negotiate plan objectives and modify activities to offer the consumer a reward for negative behaviour may be the only means available to de-escalate the crisis and minimise risk of harm to others. At a later stage or more appropriate time specific CBT intervention may be utilised to address the issue of aggression (Budiselik et al. 2011).

The benefits of trauma-informed practice for consumers with an ID are numerous. The themes

that frequent the literature include trauma history assessment for every consumer and a focus on care plans developed by the treating team that incorporate trauma-informed practice strategies. The use of this model and strategies will likely reduce the need for restraint, seclusion and isolation strategies which are still utilised in some forensic mental health inpatient services. Unfortunately, historical research has indicated that for a long period of time, consumers with an ID were not offered or receiving the benefits of trauma-informed counselling, CBT, environmental alternatives or mindfulness training. Ongoing research demonstrates the value of these interventions for consumers with an ID and the benefits of inclusion in the care plan formulation. To do this effectively adequate clinical staff training is fundamental to orientate staff to new methods of supporting consumers through traumatic experiences and ultimately strengthening the consumer-practitioner bond.

4.3. Trauma-informed care for inpatient mental health: Using sensory approaches

The utilisation of sensory approaches is emerging to fit well with services which are recovery-orientated and encompass a trauma-informed model of practice (Scanlan & Novak 2015; Te Pou o et Whakaaro Nui 2011). Sensory approaches in inpatient mental health settings can include individual interventions, group programs, and/or adaption of environment.

Sensory modulation is the ability for a person to regulate and adapt their own response to sensory input 'in a graded and adaptive manner' (Miller et al. 2001, p. 57). The ability to be able to do this helps individuals to function and perform within the optimal range throughout the day. The expression the 'sensory diet' was created by Wilbarger (1984) as individuals seek out sensory stimuli and experiences which offer them the preferred stimuli to allow them to meet these needs to optimise functioning (Champagne & Stromberg 2004). Each person's sensory diet is individual. Various activities and experiences can help to foster feelings of calming, grounding, centring and/or altering which fit the concept of self-organisation (Champagne & Stromberg 2004). Recognising and identifying what would be within an individual's sensory diet is useful for a range of therapeutic approaches around support, maintaining optimal arousal levels in order to function and knowing what is required to wind down and relax.

Awareness and caution must also be used. People with a history of trauma can be overwhelmed by multi-sensory experiences. 'Unwanted sounds, smells, bodily discomforts, nausea, intrusive memories and feelings of frozenness' (LeBel et al. 2010, p. 2) can impact on an individual's ability to regulate their arousal levels and behaviour (LeBel et al. 2010). Hence, focusing on one's physical state and addressing the 'disorganised sensations' being experienced supports the use of integrating sensory approaches into practice (LeBel & Champagne 2010). Sensory approaches designed to directly support individuals to identify sensory preferences to address the physical sensations which can be felt during times of distress can help restore the sense of safety and calm. It is important to address such physical feelings and states prior to utilising other interventions which rely on cognitive appraisal or are language dominant (LeBel et al. 2010).



There is a growing body of evidence and literature to support the use of sensory approaches within inpatient mental health settings, suggesting that the use of such approaches can support reducing distress and problematic behaviours (Scanlan & Novak 2015). Guided by the recognition that 'individuals with trauma histories, mental illness, or addictions, or who've developed problematic behaviour patterns, are sometimes unaware of

their sensory or stress needs' (Champagne & Stromberg 2004, p. 38). This approach supports working with individuals within mental health settings with trauma experiences to explore their sensory preferences and needs as a therapeutic intervention. A guiding foundation to trauma-informed care is to minimise feelings of distress through restoring feelings of safety, a sense of control and stability and increasing feeling of calm (Te Pou o et Whakaaro Nui 2011). Utilising sensory approaches to support individuals to identify more adaptive responses and to develop their own self-management skill set, rather than placing reliance on others or environmental measures such as seclusion or restraint, in order to meet a level of control.

Humans are sensory beings, seeking information from the world around them through sensory stimuli including sight, sound, smell, touch and taste. Working with individuals to identify their sensory preferences is essential as each person has their own unique sensory profile. Certain sensory stimuli that may be calming for one person may be alerting or aggravating for another person. The use of exploratory opportunities trialling various sensory modalities and a person's response to these are the foundations of developing a person's 'sensory diet' (Champagne & Stromberg 2004). Taking account of the sensory diet means identifying strategies that are useful as (for example) calming responses and using them within individual mental healthcare plans, personal safety plans or individual crisis plans (Champagne & Stromberg 2004). Additionally, trauma-informed care principles, particularly recognition and assessment of trauma history, and identifying risk factors and triggers for individuals, are all important to consider and can support in identifying a crisis response or individual service plan. Such plans are useful to incorporate calming or grounding strategies which can be used by the individual in the clinical setting. These tools are useful for both service users and staff alike to clearly document triggers and strategies for de-escalation before crisis point is reached (Champagne & Stromberg 2004). Such an approach can also be empowering (Te Pou o et Whakaaro Nui 2011), as it supports individuals to have a voice to inform others what their own sensory preferences are and what strategies are useful for them.

5. Screening and assessment

Universal principles of trauma-informed care should be incorporated into the screening and assessment process. Let us use a fictional case study

to explore how we would assess and screen for trauma in an individual from a traditional non-trauma-informed perspective versus a contemporary trauma-informed perspective.

CONSUMER NARRATIVE

Jacob's current situation:

Jacob is 25 years of age, single and unemployed. His current presentation to mental health services has been in the context of a psychotic episode that resulted in him committing an index offence and being found not guilty by reason of mental impairment. Prior to this admission, Jacob had never been a consumer of the service; however, over the years had sporadically attended GPs when feeling 'depressed' or 'suicidal' as a result of an argument with someone in his life, or when feeling 'paranoid' about his physical health due to the large quantities of illicit drugs consumed over the years. At these times, he would be prescribed medication, referred to a psychologist and drug/alcohol rehabilitation services and would attend only once or twice before no longer attending.

On the ward, he was treated for the psychotic symptoms and appeared to respond to the treatment provided and was eventually approved to reside in a community residential rehabilitation program. He often preferred to spend time in his own company, generally pacing the outdoor area or sitting in his unit. When developing his weekly routines he would put minimal activities down and when encouraged to explore his interests and incorporate these into how he spends his time on site as well as off-site he would appear reluctant to do so. On the occasions he did come and participate in group activities, he would avoid eye contact with others, look down when speaking in response to be spoken to by staff and appear a mixture of disinterested and hypervigilant. During 1:1 sessions with staff, he would deny any concerns, advising staff that there would be no further such events in his life that would lead to future relapse of illness or recidivism. He reported that he had no challenges or barriers that would impede his long-term recovery journey. Initially this made working with and engaging Jacob in his rehabilitation slow progress.

Responding to Jacob from a traditional perspective:

At this point, a traditional perspective used the following terms to describe Jacob: 'Difficult to engage'; 'Uncooperative'; 'Agitated'; 'Guarded';

‘Dismissive’; ‘Non-compliant’; and ‘Lacking motivation’.

Staff attempted to encourage Jacob to participate more in his rehabilitation by suggesting possible hobbies or activities he may like to occupy his time with or by outlining expectations and responsibilities. Furthermore, they highlighted that should he fulfil these aspects, he would achieve his goals of additional flexibility in leave program e.g. small periods of unaccompanied leave in addition to accompanied leave. Staff also explored his mental state further, asking him ‘is everything ok with you?’, ‘are you feeling ok?’ However, Jacob’s reluctance continued and staff concluded that he may in fact be ‘rigid’ in his routines and/or not functioning as well as initially thought.



Responding to Jacob from a trauma-informed perspective:

By taking into consideration more of Jacob’s history, we learn that he had struggled growing up to fit in at school, was bullied by the older kids because he ‘dressed funny’ and felt alone at home being an only child to parents who continuously fought. He witnessed his father physically and emotionally abusing his mother, and his parents always told him to go to his room when he sought them out for company and affection. He felt like a ‘loner’ so decided to use drugs when offered to him at age 13 as a way to make friends. This made him feel more confident to express himself and he found he was quite funny and people were drawn to his sense of humour. However, he would also be known from this point on to be getting into fights with male peers at parties if they made any comments about his mother or put him down. He became possessive of girlfriends, and was suspended by the principal for, among other things, being in possession of illicit drugs and vandalising the school office when sent there by his class teacher for ‘not respecting class rules’. As an adult, he was able to find entry-level jobs easily but did not keep them for long as he would become ‘fed up’

or ‘bored’ with the workplace, colleagues or supervisors who did not ‘understand him’ and/or ‘bossed him around’. This would be the same for romantic relationships in his life.

If we then take this information into consideration from a trauma-informed perspective to help us understand Jacob’s current presentation and engagement style with staff and the program, we can begin to understand that his behaviours were in fact coping mechanisms to keep him safe and in control. Growing up feeling invalidated and out of control in the home environment meant that he did not develop the skills to be able to regulate his emotions or to express himself in an adaptive manner when he felt powerless. Instead he would withdraw when things became overwhelming; this contributed to an inability to make lasting meaningful connections with others. Furthermore, when he behaved this way at school, instead of being supported to work through his behaviours and learn alternative methods, he was ‘punished’ and ‘excluded’, which contributed to his feeling that he could not trust others. This then translated into the mental health service, where staff were coordinating his treatment plans and encouraging him to get involved in his rehabilitation. He was confusing this approach and associating it with other experiences where power imbalances occurred in his life, thus feelings such as powerlessness and vulnerability occurred. Additionally he would then feel embarrassed, shameful and guilty that he could enter this cycle of emotion and not have any control over this. Furthermore, he felt confused by the approach of staff who were saying that they wanted him to feel comfortable, engage with his rehabilitation and be directed by his own goals, but would then not give him the time to come up with the language or actions to follow through with this. Hence, he struggled to build a rapport with staff in order to then be able to disclose his wishes, which further impacted upon his non-engagement with his rehabilitation (NETI 2005).

Therefore, as practitioner a trauma-informed approach to begin working with Jacob may include:

- Assuming that trauma is the central problem and that the presenting illness is a symptom or complicating factor of the trauma. Furthermore, view past occupational and social challenges in functioning as part of the trauma history (NETI 2005; Van der Kolk 2001).
- Acknowledging that violence teaches withdrawal, anxiety, distrust, overreaction, hypervigilance and

aggression coping behaviours (NETI 2005) and that by role modelling and consistency in a supported environment these behaviours can begin to change.

- Using statements such as ‘what has happened to you?’ This is a more positive approach than ‘is everything ok with you?’, ‘are you feeling ok?’ which assumes something is ‘wrong’ with the person (SAMHSA 2014a).
- Asking ‘What makes you feel comfortable?’; ‘What do you find challenges you outside your comfort zone?’ (Almazar & Sims 2016).
- Asking ‘What is important to you?’; ‘What do I or should I know about you?’ (Almazar & Sims 2016).
- Considering working collaboratively with him on a plan to manage challenges should Jacob disclose something which he perceives may get in the way of him fully participating in his rehabilitation. If the environment is conducive to open and honest interactions with joint expectations, there will be a better outcome for Jacob rather than leaving him to feel fearful that disclosure will lead to ‘setbacks’ or that ‘greater control measures’ will be put in place (NETI 2005).
- Being mindful of suicide and self-harm risk as trauma memories and re-traumatisation can trigger cycles to be repeated (SAMHSA 2014b).
- Using person first language (NETI 2005).
- Focusing on strengths and resilience factors (SAMHSA 2014a). For example, enquiring about someone’s values and how they may see these as playing a part in their rehabilitation. Ask them how they coped previously managing a difficult situation (SAMHSA 2014a).
- Providing consistent responses to set up an ordered environment. Research indicates disordered environments can produce disordered skills (NETI 2005).
- Being mindful of the power imbalance and demeanour used by practitioners e.g. tone of voice, body language, mirroring and eye contact.
- Considering the setting for interviews. Use a garden or comfortable room rather than an office or interview room for interactions. This can enhance comfort and defuse distress (Muskett 2014).
- Allow time for the consumer to respond. Do not assume or pre-empt what the

consumer may say (NETI 2005). This dismissal or conditioning of a response ahead of time can lead to lack of connection and rapport affecting service user trajectory and engagement (Almazar & Sims 2016).

- Beginning with general questions, gradually becoming more specific. This acknowledges the sensitivity and personal nature of someone’s situation rather than reinforcing a person’s avoidance of engagement and connection (SAMHSA 2014a).
- Should a person be withdrawing from substances, screening should still occur and should not be delayed (SAMHSA 2014a).

This approach will enable the following:

- Put into context a presentation of trauma history and how this can impact on current functioning from a neurological, biological, psychological, social and occupational perspective (Turecki & Brent 2016; SAMHSA 2014a).
- Assist with managing the potential for re-traumatisation (NETI 2005).
- Get the person on board with their recovery journey (Almazar & Sims 2016).
- Consider the impact of the environment e.g. similarities and differences of the pre-admission environment to the current environment and when and where is appropriate to finalise a discharge plan (Almazar & Sims 2016).
- Believe in voice, choice and time and not view something that is ‘lacking’ as non-compliance. Some people take their time to find their voice, especially if traumatised or conditioned to behave in a certain way in a certain environment (Almazar & Sims 2016).
- Allow individuals to feel hopeful about being successful (Almazar & Sims 2016).
- Support individuals to learn adaptive behaviours and coping skills to replace maladaptive ones without referencing punitive measures. Rather than having a privilege system that people have to ‘earn’, offer them the tools to be able to learn with support (Almazar & Sims 2016).
- Normalise needs, behaviours and emotions which will remove shame and humiliation (Almazar & Sims 2016).
- Allow staff to be mindful of barriers that develop as a result of trauma such as

avoidance, reluctance to discuss anything uncomfortable, difficulty articulating or recognising experiences, denial, tired of being asked same the questions, belief that it doesn't matter, tendency to reject support, holding onto grievances for a long time, not taking responsibility for behaviour, repeating the same mistakes, somatic symptoms e.g. gastrointestinal upsets, headaches etc. (SAMSHA 2014; NETI 2005; Muskett 2014).

- Encourage collaboration and choice. This will enable the consumer to feel validated and in turn minimise shame, guilt, and humiliation and reduce the risk of violence being used as a form of control (NETI 2005).
- Allow individuals to rebuild connections to heal from 'the feeling of disconnect' associated with trauma (Almazar & Sims 2016).
- Provide a platform for ongoing discussions. This is important, not just at point of entry for 'assessment' or 'rapport building', but may lead to further disclosure and collaboration (SAMHSA 2014a).

Outcomes for Jacob's situation following a trauma-informed approach:

Jacob slowly began to trust staff by opening up about his past and talking about his current hopes. This was evidenced by Jacob giving more eye contact during interactions and smiling. It was revealed that Jacob felt like he was ignored, not heard by his parents or other adults growing up and therefore he did not know how to express his needs during his formative years. When he used substances, he became disinhibited and his emotions spilled over. He felt overwhelmed and overpowered by them, but did not feel that he could seek help to learn how to control them. What he also found was that when he was angry or agitated people took notice of him and listened, which he craved. However, what this also meant was that his expression of agitation and aggression was also viewed as something that needed to be 'controlled' and 'managed' which led to further disempowerment. As such, his 'lack of engagement' with his rehabilitation was his attempt of 'maintaining control of himself' and by staff encouraging 'compliance', this re-traumatised him and reinforced his previous patterns of behaviour. Therefore, staff would instead discuss requests with Jacob; they would collaborate over what aspects he could control while acknowledging his feelings of what he couldn't. This validated his

efforts when learning new skills being taught. Feeling valued, informed and hopeful about his recovery Jacob was able to change his cycle of presentation (Muskett 2014; NETI 2005).

6. Trauma-informed service design and delivery

To date, there is a limited body of literature addressing trauma-informed service delivery in adult mental health settings. Trauma-informed organisational and systems change is not nearly as developed in Australia, the UK or Canada compared to the United States (Muskett 2014). Muskett (2014) highlights how mental health practitioners can find it difficult to employ trauma-informed strategies in day-to-day care, and the main trauma-informed care initiative to date has been the reduction or ceasing of restraint and seclusion. As such organisational-level change is required if trauma-informed care is to become successfully widely adopted, and to prevent re-traumatisation occurring within the mental health system. Some insights from the available literature are described here.

The primary goals of trauma-informed service delivery are accurate identification of trauma and related symptoms, training all staff to be aware of the impact of trauma, minimising re-traumatisation, and a fundamental 'do no harm' approach that is sensitive to how institutions may inadvertently re-enact traumatic dynamics (Fallot & Harris 2001; Hodes, 2006).

There have been numerous interpretations over time of the fundamental principles that underpin trauma-informed care. Quadara (2015) suggests the following considerations form the basics of what service providers should be embracing:

- Understanding 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 clinical practice ensure the physical and emotional safety of consumers/survivors;
- Creating 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 (e.g. recognising gender, race, culture, ethnicity) of consumers, which shape both

- their needs as well as recovery and healing pathways; and
- Recognising the relational nature of both trauma and healing.

Quadara (2015) continues to assert that even with the variety of organisational and systems models of trauma-informed care, there is limited evaluation material publically available about their effectiveness at the organisational or system level. Substance Abuse and Mental Health Services Administration (SAMHSA 2014a) is the driving force behind trauma-informed practice change in the USA and has highlighted ten Domains to achieve for system change, stating that ‘these are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care. What makes it unique to establishing a trauma-informed organizational approach is the cross-walk with the key principles and trauma-specific content’ (SAMHSA 2014a):

- Governance and leadership
- Policy
- Physical environment
- Engagement and involvement
- Cross-sector collaboration
- Screening, assessment and treatment
- Training and workforce development
- Progress monitoring and quality assurance
- Financing
- Evaluation

Quadara (2015) in response to the lack of a strategic direction in Australia, states that a National Trauma Informed Care and Practice Advisory Working Group was established and released a paper with recommendations for a national strategic direction. In conjunction with the national specialist organisation for adult survivors of child abuse practice guidelines were developed for the treatment of complex trauma and guidelines for trauma-informed service agencies (Kezelman Stavropoulos & ASCA 2012).

The National Strategic Direction reasoned 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. A key area of future focus was on implementation of trauma-informed practice at a scale enough to create measurable cultural change (MHCC et al. 2013). This involves:

- Capacity building;

- Infrastructure development;
- Policy development and implementation;
- Workforce development; and
- National standards and guidelines.

In order to achieve a shift to a trauma-informed mental health and human services system, a number of supportive elements are needed (Jennings 2004; MHCC et al. 2013). These involve administrative policies and initiatives at the systems level to:

- Address governmental policy and responsibility for systems change;
- Foster recruitment, hiring and retention of staff with educational backgrounds, training in and/or lived experience of trauma;
- Support funding models for the development of a trauma-informed service system and implementation of evidence-based and promising trauma treatment models and services;
- Support service models that integrate trauma awareness into core business and that support integrated, co-ordinated cross system care;
- Incorporate trauma awareness in workforce development, standards, competencies and operational practice;
- Encourage undergraduate education in universities and accredited colleges to offer curriculums preparing students to work with trauma survivors; and
- Encourage and support cultural advisor involvement in trauma-informed practice implementation.

Notwithstanding the level of research and work put into creating change within mental health settings, Quadara (2015) asserts that ‘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. Lessons learnt from change initiatives in other complex service settings such as child and youth mental health provide innovative ways for thinking about and implementing sustainable whole-of-system change.’

Adults Surviving Child Abuse developed and released Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery in 2012, based on the work of Fallot and Harris (2002). Quadara (2015) summarised this work:

The guideline document outlines six organisational objectives to realise an organisational 'philosophy and vision' for trauma-informed care. It then provides concrete strategies for translating this vision into system and service level change such as how to construct a trauma-informed service charter, consideration of how trauma-informed care can be addressed in compliance, training and work hiring policies and specific questions to ask at the service level about how practitioners can realise the key principles of trauma-informed care in their practice.

7. Trauma-informed leadership

Given the nature and potential scope of trauma-informed practice there are significant considerations regarding how best to develop and deploy leadership within this context. Compassion, the ability to provide genuine understanding, kindness and care are key attributes in trauma-informed leadership. The emerging idea of *compassion leadership* in mental health service delivery means that staff at all levels demonstrate active empathy as a therapeutic means of making an emotional connection with people in mental distress (Procter, Kenny & Grech 2016).

Such activity is also central to building trust in mental healthcare. In *trust leadership*, carers and practitioners are poised to create a guiding partnership towards consumer recovery processes that have value and meaning primarily for the consumer. This means that consumer understanding is central to meaningful engagement. At a practical and applied level, *trust leadership* is concerned with using and respecting the language, experience and priorities of the consumer. The resulting trust helps enormously in creating and fulfilling a shared objective of advancing recovery processes.

Trust is what brings people together in mental healthcare; it has the potential to do much more than help people achieve the same health outcomes or objectives. In a clinical leadership context, trust is embedded in the everyday professionalism of practitioners: the way they seek to provide interventions marked by quality and safety across care episodes, in what they say, do, think and feel, in documentation, in telephone conversations or during face-to-face contact at the point of care. In *trust leadership* therapeutic processes are not limited by professional discipline boundaries.

Trust leadership is interdisciplinary, achieved when consumers feel as if they are in receipt of respected, supported, evidence-based clinical care, facilitated with dignity. For practitioners at all levels, this means knowing how and when to move in new ways to encourage practitioners to look beyond taken for granted assumptions that transcend short-term interests. Only then does teamwork for *trust leadership* become real to those who need it most.

Lived Experience Leadership

It is difficult to overestimate the importance of lived experience leadership in trauma-informed practice. Lived experience leadership entails the privileging and valuing of consumer and carer knowledge and the contribution of this knowledge and perspective to care partnerships and also to broader service design processes. In trauma-informed practice this means recognising that consumers and family or key friends have travelled through experiences of mental health crisis, service use, treatment, and wellbeing practices. Over time, many consumers and carers develop a deep knowledge of experience. This can inform how services should be designed and delivered. Beyond that consumers can inform practitioners of the signs of oncoming relapse, the signs of wellness, what is supportive during crisis and recovery, preferred use of medicines, and what therapeutic practices practitioners can provide to assist.

Practitioners providing leadership recognise this range of expertise and ask about how it can contribute to mental healthcare at present and into the future. *Lived experience leadership* also values and includes social, cultural and historical aspects of the person's life which support personal identity and signify strengths and capacities. In terms of the workforce, *lived experience leadership* operates to support the development and outcomes of peer specialists working in mental healthcare. This includes understanding the role that peer workers and specialists play in recovery based practice and ensuring that clear expectations and rationales are available to teams, services and the community. On the service design level, *lived experience leadership* understands that mental health services are learning organisations. Programs and services are evaluated, planned and delivered within a framework of co-design or co-production, where the lived experience of consumers and carers and the practical experiences of staff are valued alongside evidence-based practice.

8. Vicarious trauma and self-care strategies

Care and understanding towards those who work in trauma settings is an integral aspect of trauma-informed care. Nurses, psychiatrists, occupational therapists and other mental health professionals who work with trauma victims are at risk of secondary traumatisation, known as 'vicarious trauma' or 'burn out'. This is a normal response to repeated exposure and empathetic engagement with distressing traumatic material and environments, and should be recognised as an occupational hazard when working in trauma settings (Klinik Community Health Centre 2013). The symptoms experienced are usually less severe than PTSD symptoms, but they can affect the livelihoods and careers of those with considerable training and experience, such as those working with trauma survivors. Compassion fatigue may also be experienced.

Self-care for such staff includes cognitive, physical, social, recreational and/or verbal strategies. This may include staff taking regular breaks at work and from work, therapeutic support when needed, as well as taking up opportunities for de-briefing such as their Employee Assistance Program. This is an opportunity in a neutral environment for employees to discuss any issues of trauma encountered in their personal and professional lives. Another self-care strategy is to be accepting of support and positive feedback when it is offered, and also reciprocate by providing support and positive feedback to others. Finally, treating oneself well with the use of physical activity, spiritual engagement, humour and identifying one's own successes are important strategies.

9. Clinical practice reflections

This section provides three clinical practice reflections. The reflections describe the application of trauma-informed practice in various forensic mental health settings, and draw on case studies where appropriate.

Clinical Practice Reflection 1:

James Nash House is a state-wide forensic mental health service in its third decade of operations. It was the first health-based, purpose built secure Forensic Psychiatric Unit in Australia when it opened in 1987. Other states have since followed suit, including Forensic buildings in Tasmania (The Wilfred Lopes Centre) and the Thomas Embling Hospital in Victoria. Forensic mental health is

concerned with the mental health assessment and treatment of a person with a mental illness who has interfaced with the criminal justice system. Some of the most disadvantaged members of our community are cared for within forensic mental health settings. Political and community attitudes operative at the time dictate and limit the nature and extent of security and the opportunities for therapeutic innovations.

Being confined in a prison/secure forensic setting is neither normal nor natural, and constitutes one of the more challenging experiences an individual might endure. Schill and Marcus (1998) suggest that people in these settings are at increased risk of mental deterioration and apathy, endure personality changes and become uncertain about their identities. Many have a diagnosis of post-traumatic stress disorder, as well as other mental health conditions such as panic attack, depression and paranoia. Prolonged confinements can promote a sense of helplessness, greater dependency and introversion and undermine quality of decision making.

The knowledge and witnessing of violence is commonly reported during individual incarceration. Globally it has been reported that emotional punishment and physical restraint when required and psychological punishment are inflicted on the individual. These experiences can result from deprivations caused by a loss of freedom to come and go, material impoverishment, personal inadequacy, loss of heterosexual relationships and loss of autonomy and personal security (Sykes 1958).

In the last few years South Australia has experienced a large increase in the number of intellectually disabled (ID) forensic mental health consumers admitted in to the Forensic Mental Health Services, due to changes in the Criminal Law Consolidation Act Part 8A Mental Impairment (1935). These changes have allowed the Mental Impairment Defence to be adopted by ID forensic mental health consumers.

FORENSIC MENTAL HEALTH FACILITY has admitted chronically behaviourally ID consumers into the Forensic facility as a result of the decentralisation of psychiatric and disability services within South Australia. These consumers have ended up in the Criminal Justice System after coming into conflict in the community and have been admitted for treatment and rehabilitation.

The work at a Forensic Mental Health Facility can be challenging, but rewarding. The combination of high acuity of the consumers and the increase in ID consumers has led to a high risk of aggression to staff and consumers, including inappropriate sexualised behaviour, self-harming behaviour and destruction of property. Previous literature on forensic care involving ID consumers according to Sondenaa et al. (2008) has reflected that a higher rate of violent offences are committed by males with an ID rather than people without ID (Sondenaa et al. 2008). Staff injuries have increased and clinical practice has had to be reviewed along with policies, organisational costs increased due to property damage and staff loss of time. The fall out of this means that the consumer ends up with more criminal charges laid and a delay in freedom and release in to the community.

Forensic mental health units are restrictive environments for the individual governed by Laws, Acts, Policies, Guidelines and Rules. These rules are unique to the area. An example of this is *The Restraint and Seclusion in Mental Health Services Policy Guideline* (2015) developed by The Office of the Chief Psychiatrist, System Performance and Service Delivery. These Guidelines are to assist the nursing staff with information to meet the relevant legislative requirements, guide the development of restraint and seclusion reduction programmes and to make sure that the consumer's rights and dignity are maintained when a restraint or seclusion is used.

The last few years in Forensic Mental Health Services in South Australia have been challenging due to a significant increase in the number of consumers who have experienced different types of trauma in their lives. A specific group of these consumers are ID forensic mental health consumers; they represent an extremely challenging group. According to literature a majority of these consumers have experienced or have been exposed to some kind of trauma in the past such as domestic violence and physical, psychological or sexual abuse. These traumatic experiences have caused significant damage to these people resulting with them being more prone to re-occurring traumatic experiences during their hospitalisation. These consumers have high exceptional and complex needs and are identified as a presenting risk to themselves and the community. Many of these consumers share common characteristics which make them extremely vulnerable as they travel through the Criminal Justice System and especially while incarcerated.

Practical Example

Antony is a 19 year old Caucasian male with an intellectual disability (ID), Jacob's Syndrome (a strong and persistent adult sexual interest in [pubescent](#) [early [adolescent](#)] individuals typically aged 9–12) and an interest in ultra-violence videos.

Antony was admitted to a forensic mental health facility in 2016 following a charge of deviant sexual offending involving children under the age of 18 years in the community. His sentence is nine years as this was the first time he had been charged for an offence. To protect the public from this consumer the presiding judge believed that Antony would be best managed in the Forensic Secure Unit, where staff would have sufficient skills and knowledge to engage with his explosive behavioural issues. In order to understand Antony's behaviours and offences, it is necessary to explore his developmental history and possible traumas experienced in his childhood and adulthood, as these may have contributed to his individual development and potentially his sexual offending.

Developmental History

Antony was born as the elder of two children, having a younger sister. He was born with a chromosomal abnormality, Jacob's Syndrome or 47 XYY, where there is an extra Y chromosome in his genetic profile. This is commonly associated with higher than average height and amplified male characteristics such as aggression and impulsivity. Researchers have identified that people with this abnormality have a higher risk of ID and a propensity to commit sexual offences. Antony's younger sibling has an ID and has presented with challenging behaviours at times. Offences reported include minor larceny and property damage.

Milestones

Antony has been seen and managed by Disability SA since his adulthood through different settings such as community housing and in-patient facilities, where he continued to express aggression and violent behaviour towards other residents, carers, nursing staff and his own family members. When at his parental home Antony's anger would be channelled towards property damage at home rather than towards his parents or his siblings. In centres where he was cared for, there was involvement in forceful homosexual behaviour with other vulnerable residents, as well as sexual propositioning of female staff. Lindsay et al. (2007) states that there is a significantly high rate of sexual abuse of ID consumers due to being vulnerable; 42% of abuse of ID consumers has actually been perpetrated by someone who also has an ID.

Antony's strong physical build intimidated his victims to achieve his sexual goals.

Admission to a forensic facility

Since his admission to the forensic mental health facility, Antony has displayed multiple aggressive behaviours which have been described as 'quite deliberate and pre-meditated'. These have been directed towards both staff members and other consumers. There have been multiple assaults on staff members, some of which have been quite severe, resulting in significant trauma to the staff involved. In the face of having to cope with Antony's aggressive behaviour on a daily basis, the staff resolved to deliver trauma-informed practice and continue to strive to provide the best clinical care.

In the early days following his admission, Antony had several aggressive outbursts, both verbal and physical, which resulted in staff having to intercede to try to defuse the situation. These included offering Antony the opportunity to spend time in his room or in the courtyard and also the offer of medication, in order to calm Antony and reduce the risk of harm to all concerned. These attempts were met with varying levels of success. Unfortunately these incidents became more frequent and more aggressive and on one of these occasions staff resorted to physical restraint to ensure that no harm came to Antony or any other consumers and staff. Physical restraint has and always will be used as a last resort. During this incident Antony was physically restrained and taken to his room, PRN medication in the form of an injection was given and he was placed in seclusion for a time to allow him to settle before returning to the open ward area.

Following a period of unpredictable behaviour and after all strategies employed were unsuccessful in diffusing Antony's violent and aggressive outbursts, it was decided to attempt a new approach to the situation. Discussions involving Antony and clinical staff resulted in a trauma-informed intervention where a plan was put in place to transfer control from staff to the consumer. With the majority of public mental health consumers having been exposed to trauma, creating a trauma-informed program is essential to help the consumer feel less vulnerable and more in control (Mueser et al. 2003).

It was decided to follow the S.M.A.R.T. formula. This was laid out in a paper by Doran (1981), with the goals being:

Specific

Measurable

Appropriate to the consumer's abilities and needs

Realistic

Timely (there is a deadline to work towards). The short term goals should be a response to the special needs of the consumer with required support strategies and a process for evaluating progress.

Time was spent with Antony explaining the various stages of the plan and encouraging him to participate and put forward any ideas he had to help ensure success. We all started by finding an area where Antony felt at ease and without feelings of risk to his safety. The area chosen by Antony was the courtyard. Weather permitting we would meet there; when not possible he agreed to meet in Occupational Therapy area.

We held several meetings and spent a great deal of time collaborating in attempts to formulate a workable program. This involved working within the policies and procedures of the unit and attempting to include Antony's desires, although this was not always possible. This occasionally, although not often, resulted in Antony leaving the meeting. Once he had settled and staff had explained reasons why his request could not be met he reluctantly accepted and moved on.

The greatest hurdle faced was gaining Antony's trust. This distrust had originated from people making him false promises. When these promises were not met aggressive episodes resulted. In order for this program to succeed it was imperative that all staff followed the agreed plan precisely.

After several meetings between staff and Antony a consumer centred individualised plan agreed by all was set in place. Antony was encouraged to approach staff any time he was experiencing issues when it was difficult to control his behaviour, even with the use of strategies which were put into place. He was encouraged to follow the plan as agreed. Regular weekly meetings were scheduled to discuss the ongoing workings of the plan and allow mutually agreed changes as required.

The use of a trauma-informed approach

Examples of the use of trauma-informed care when working with Antony:

Situation: Following visits Antony becomes quite distressed when saying goodbye to relatives. In the past he had wanted to leave with them, resulting in staff being injured and him being restrained and secluded.

Trauma-informed response: Distraction techniques are put in place following visits, such as extra staff escorting Antony back to the ward or to the gym or out to the 'big yard' to help alleviate anxiety and disappointment.

Situation: When consumers are being transferred to another ward or being discharged from the forensic mental health facility Antony can become quite sullen and angry.

Trauma-informed response: Reassurance is given to Antony that his turn will come and distraction techniques are adopted and put in place prior to the transfer or discharge taking place. Measures such as going to the Occupational Therapy Department with nursing staff are taken. Occupational Therapy staff will include him in cooking for the ward and/or spend time with Antony in a quiet area listening to his preferred music and keeping him occupied.

Situation: Antony does not like being told 'No' to his requests. It happens when regular staff are rostered on the ward who know Antony and his challenging behaviours.

Trauma-informed response: Staff allow Antony to ventilate his feelings. He responds well to one-to-one conversations with nursing staff, with extra staff standing in close vicinity. Responses such as 'We will look into this for you' as opposed to 'NO' work well and short verbal responses are required. Antony needs to be occupied throughout the day, and functions very well with daily routines.

Situation: Antony has become angry and frustrated when his peers talk about him regarding his ID and his offences.

Trauma-informed response: De-escalation techniques need to be adopted by nursing staff, e.g. speaking with him on a one-to-one basis and removing him from the environment. Group therapy can be conducted by the nursing staff, whereby Antony is given the opportunity to speak and ventilate his feelings to his peers. This then gives him confidence and they are then made accountable in the group setting utilising group rules.

It is necessary that the above mentioned approaches/care are regularly reviewed in order to make adjustments. There is also a need for all staff caring for Antony to be working together and following the agreed trauma-informed practice guidelines.

Conclusion

There is a clear need to undertake strategic actions in order to improve services for people who have

experienced trauma in their past. Upon admission to a forensic mental health facility, Antony required on a number of occasions to be physically restrained after all negotiating measures had been tried and proven unsuccessful. From the point that Antony had become more actively involved with his care management, thus empowering him and allowing him to strive for and work toward future goals, the use of physical restraint has lessened. This has been due to the use of the principles of trauma-informed practice and care. However, there have still been occasions where physical restraint has been required. These incidences are much less frequent and remain absolutely the last resort of managing Antony's behaviour. Further education in this vast and expanding area, along with staff annual competencies relating to this topic, would be beneficial, as significant gaps in clinical practice appear to exist due to lack of staff education about trauma-informed practices and how to successfully implement them. Chaplin (2011) states that negative beliefs and attitudes or insufficient knowledge can have a detrimental impact on the quality of the care that is provided to individuals with subsequent diminishing of therapeutic outcomes.

Clinical Practice Reflection 2: Birdwood Unit

I have worked in Forensic Mental Health Inpatient Services as a mental health registered nurse for nearly 16 years. I began as a novice during a student placement, and I was exceptionally pleased when a full-time permanent position was offered to me at the completion of my graduate diploma studies. Currently, I work as a clinical nurse in the sub-acute/rehabilitation unit known as Birdwood. Birdwood is in the process of transition and separation into a specialised ID and acquired brain injury unit, effectively separating it from the more traditional mental health units. This promises to be an exciting time of change and remodelling, not only structurally but also, I hope, in the way we as practitioners view our consumers and their ever changing needs. I foresee the philosophy and inclusion of trauma-informed practice as essential to ensuring the holistic treatment, care and positive journey for our consumers with an ID, within the complex domain of a forensic mental health inpatient unit.

Our consumers with an ID face additional challenges. Adversities such as learning difficulties, communication difficulties and social isolation are prevalent within this consumer group. It is expected that this specific population within our inpatient

setting will require the therapeutic benefits of trauma-informed practice and support more so than the general consumer group. History suggests consumers with an ID were openly excluded from counselling and trauma-informed practice in many hospital and community settings (AIPC 2016).

Here I will draw upon a clinical experience to focus on the traumatic experience of grief and loss. This affected a male consumer 'Matthew', with an ID and a complex personality disorder. He had been an inpatient of Forensic Mental Health Service for approximately one year. With respect to this consumer and the team of practitioners involved with his treatment and care I will give a broad outline of events that occurred. Matthew found out through a visit from his mother and close family members that his father had passed away in hospital after a short illness. Matthew expressed his feelings of grief and loss as most of us would, with tears and questions of his family. When the visit was required to end Matthew became increasingly upset and distressed as he wished to return to the family home with his mother and offer support and help with funeral preparations. He had no legal right to leave the facility or freedom to do so. Matthew became increasingly violent towards staff, and restraint and seclusion practices were initiated. Staff were injured and emotionally traumatised at this time and Matthew was moved to a more secure and restrictive unit. AIPC literature (2016) suggests grief, loss and bereavement counselling and support strategies are incredibly relevant to consumers with an ID. They may require modification to aide communication and increased involvement of close family members to reinforce supportive and comforting techniques. It is also important to note that emotions expressed and behaviours demonstrated are fundamentally a result of the trauma experience and not because the individual has an ID (AIPC 2016). As practitioners we need to understand the level of therapeutic intervention that is appropriate and of value to our individual consumer. The trauma of grief and loss is unquestionably a shared human experience, and our consumer group, regardless of diagnostic label, have the right to feel supported and comforted by those closest to them (Brickell & Munir 2008).

Clinical Practice Reflection 3: Practitioner reflection on the application of trauma-informed care

As a senior nurse working in a the forensic mental health facility I am invested in ensuring that the

best possible evidence-based care is provided for some of the most marginalised people in our society. I witness trauma-informed practice every day; however, after attending the two-day workshop on trauma-informed practice it made me realise that we need to improve the way we articulate our challenging work. Values are at the core of how we care for others, but it becomes more difficult translating these values into practice (Muskett 2014). I am also acutely aware of the environmental obstacles that provide staff with extra challenges. Keeping a focus on our values is the key. To understand trauma-informed practice is to have an appreciation that no-one understands the challenges of the recovery journey from trauma better than the person living with it.

The introduction of non-violent crisis intervention training, sensory modulation, the change in attitude towards canvas clothing and seclusion/restraint has been a positive direction in care. These modalities all feed nicely into trauma-informed practice. I do see some deficits which are mainly in the trauma history taken on admission and how this together with 'every behaviour has meaning' is a better framework for informing our care and identifying triggers. This would provide a shift in the past philosophy with understanding at its core (Wolfaardt 2013).

Everyone has the right to have a future not dictated by the past (Saakvitne 2013). This statement is powerful in the Forensic Mental Health System. Each person admitted is in conflict within themselves and with others whether that is family, police, the court system or mental health services. In the general mental health system they are seen as dangerous before any of their stories get a chance to be told. Certainly consumers within the forensic system are not always afforded the same empathetic approach. There are also barriers to discharge which come in the form of stereotyping. To transfer a consumer to a general mental health ward or to a supported housing in the community is difficult because of the forensic history.

Trauma-informed practice education will break down a lot of these myths. In fact, the application of this practice would be useful in all areas of health and in the wider community as psychological trauma is a public health issue.

10. Additional resources

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