Trauma-informed care
and practice
Forum report and evaluation

*Mental Health Coordinating Council,*
*Adults Surviving Child Abuse*

*This paper was prepared for the Mental Health Commission of NSW to support the development of the Strategic Plan for Mental Health in NSW 2014 – 2024*

October 2014
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Event Report

Trauma Informed Care & Practice Forum

18 November 2013

Background

The principles and approach embodied in Trauma-Informed Care and Practice (TICP) are integral to the reform process occurring nationally across mental health and human service systems and sectors. The Mental Health Coordinating Council (MHCC) and Adults Surviving Child Abuse (ASCA) in collaboration with members of the National TICP Advisory Working Group advocate the need for a national trauma-informed care and practice strategic direction to be incorporated into policy reform. We are pleased to be collaborating with the NSW Mental Health Commission (MHC) in the context of the Commission developing its Strategic Plan for Mental Health in NSW.

The MHC is working closely with the sector and the community to develop and implement a strategy which is recovery-oriented, and which puts the individual at its centre. The trauma-informed agenda aligns to and enhances that of recovery orientation, building on contemporary thinking, about what constitutes the principles and best practice for improved service user and worker outcomes. This matter is particularly important in relation to the dynamic environmental developments and challenges for the sector, including the National Disability Insurance Scheme, Partners in Recovery and funding reforms at a state level such as Partnerships for Health.

Introduction

To further discussion and consultation on these matters, the MHC partnered with MHCC and ASCA to host a Trauma-Informed Care and Practice (TICP) Forum on 18 November 2013 in Sydney, held at Ariel Convention Centre in Ultimo. The aim of the forum was to bring together senior managers and practitioners from agencies across services sectors in NSW.

Sixty-five participants attended including MHCC and MHC staff members and invited presenters. Participants came from government departments, health agencies and community managed bodies representing mental health and human services. The purpose was to share knowledge and information around the evidence, principles, policy and practice needed for the broad uptake of trauma-informed care and practice across mental health and human service systems and sectors and discuss its integration into the Draft Strategic Plan for Mental Health in NSW.
It was our objective that, by the end of the forum, participants would walk away with a greater understanding of trauma-informed care and practice and its importance for client and worker health and wellbeing, and with new ideas about the role that everyone can play in the reform process.

**Presentations**

Forum participants appreciated and actively engaged with the presentations that put TICP squarely on the table as a policy and practice issue appropriate for inclusion in the reform agenda. The Commissioner, John Feneley, in his opening address, stressed the Commission’s commitment to embracing the evidence-base that supports contemporary thinking around embedding trauma-informed care into a recovery approach. He acknowledged the substantial need, given the prevalence and impacts of trauma amongst people accessing a diversity of services who have mental health conditions and/or experience psychosocial difficulties.

Dr Cathy Kezelman reflected on her own journey as a survivor of childhood trauma, outlining her recovery from the trauma underpinning her mental health difficulties. She highlighted the prevalence, impacts and costs of trauma for individuals and societally. She also outlined ASCA’s Practice Guidelines, a world first to provide a framework for practice, grounded in evidence, at both an organisational and practice level.

Corinne Henderson, Senior Policy Advisor MHCC presented the imperative and timeliness for a national strategic direction, informed by international evidence, and advocated by ASCA, MHCC and the work of the national TICP advisory working group. This presentation gave an overview of the recommendations for policy and practice reform across mental health and human service sectors and systems. The forum was also an opportunity to present the Strategic Directions Position Paper containing the evidence and recommendations to the audience.

Jeff Lucas, Operations Manager, Wesley Counselling and Iggy Kim, Clinical Nurse Consultant, Royal Prince Alfred Hospital, Missenden Unit presented TICP in action in disparate contexts, each pioneering in its implementation. Jeff alluded to his own journey, and Wesley’s commitment towards embedding TI policy and practice into every aspect of the organisation. This included training of staff at all levels, and the need for trauma-informed induction processes and sustainability over time. Iggy presented the complex challenges of implementation within an acute setting. He was inspirational in clarifying the transformational outcomes for patients a cultural shift could enable including, minimising re-traumatisation, promoting recovery, and improved outcomes for staff at all levels of practice.

Bradley Foxlewin, Deputy NSW Mental Health Commissioner, reflected on his personal experience as a survivor of trauma, the mental health system and how he had found his road to recovery. He stressed the importance of creating trauma-informed environments, as well as services, offering flexible and holistic approaches, to which to refer survivors needing support as they work through their trauma.
Cathy Kezelman outlined the Life Journeys in the MHC draft strategic plan, identifying how being trauma-informed could dramatically improve outcomes for consumers, and how services and practitioners in viewing presentations and symptomology through a different lens, could better engage consumers, minimising re-traumatisation. She stressed the importance of a strengths-based trauma-informed approach whether in a treatment specific context or the wide range of service settings, the principle being ‘no wrong door’.

Workshop

An afternoon workshop was facilitated by Jenna Bateman, MHCC CEO, and was designed around six vignettes based on life journeys reflective of those included in the reform planning process, identified in the MHC’s draft strategic plan. These were presented as themes based on life stages/journeys, reflecting some difficulties that may arise at those stages and across the life-span.

Some vignettes were adapted from stories in the draft plan and some were developed from experience and practice across service contexts. The stories were specially designed for participants to identify the possible ‘hidden’ trauma-related issues, past and present. Without too much detail, workshop groups could speculate as to what might constitute improved service/practitioner trauma-informed responses, leading to better outcomes for consumers and their families. Feedback and evaluation from the workshops would inform the strategic plan.

The vignettes show that life issues rarely fit into defined categories. There is considerable overlap, since the course of mental illness and recovery is rarely linear. Consumers’ needs often fluctuate as they are impacted by many events that occur during a lifetime, which can present both opportunities and challenges. Important to these considerations is the matter of resilience and the strengths clients demonstrate throughout their life from childhood.

Over a two-hour period six groups considered how systems and services across a diversity of service settings could better respond to people with lived experience of trauma, past and current, across the lifespan.

Vignettes informing the strategic reform process

See Appendix 1

Each vignette is described followed by the responses articulated by a group representative to the entire group of forum participants.

Summary

The forum was highly successful as evidenced by the evaluations and active engagement of participants throughout the proceedings as well as the robust discussions during the workshop.
MHCC and ASCA propose that the forum outcomes were achieved in that participants not only acquired knowledge and information around trauma, but increased awareness to the possibility of trauma, past and present, and how it affects the way people engage with systems and services, at different stages of the life cycle. In this way the input from participants provided useful material that can be utilised in developing the Commission’s Strategic Plan.

MHCC and ASCA did however reflect that presentation of the vignettes assumed a prior understanding and engagement with the strategic planning process by participants that may not have been the case for all those present. Therefore a simple overview of the life journeys in a diagrammatic form might have been helpful.

However, most encouraging was that participant responses to presentations and workshop discussions clearly established the importance of incorporating a trauma-informed approach into policy and practice and investing in its broad-based implementation within NSW as a requisite for the NSW mental health plan.

Key messages and findings included that:

- The prevalence of trauma, past and present, at all stages of the life cycle and its potential compounded impacts in people engaging with and working within a diversity of human and mental health services makes many people prone to re-traumatisation and must always be kept in mind.

- An awareness and understanding that the lived experience of trauma, past and present, at all stages of the life cycle is critical to the way all human and mental health services should interact with those seeking help and for the potential for recovery.

- Trauma-informed principles need to inform all aspects of service delivery, involving all staff, employees and volunteers.

- There is `cross over’ between different roles, positions and activities within services, trauma-informed philosophy, principles and practice which needs `buy in from everyone.

- A cultural shift is needed to embed a trauma-informed approach into systems and the design of services; and includes capacity building (workforce training, practice supervision and supports), evaluation and review processes as well as access to information, resources and mechanisms for sustainability.

- Regardless of the service or sector, foundational principles of trauma-informed practice are consistent across all service areas to which people present.

- Trauma-informed practice benefits not only individuals, families, carers and communities, but as attested by the research, workers and agencies.
• Need for an integrated system in which a trauma-informed approach to care is coordinated across and between services and sectors.

**Implications for change**

Trauma-informed care and practice is an evidence-based approach, the principles of which are closely aligned but additional to that of recovery-orientation. Its principles need to be embedded into policy and practice to facilitate recovery for the large number of people engaging with the mental health and human services systems including the criminal justice system.

The prevalence and costs of unidentified and unaddressed trauma, past and present, are substantial. Failure to appropriately address trauma coupled with the frequent re-traumatisation and re-victimisation of people in a diversity of public, private and community services which are not trauma-informed has profound impacts on the health and wellbeing of people, their families, carers and communities in NSW.

Recovery from trauma is possible; re-traumatisation can be minimised. To optimise outcomes we need broad-based change which is ‘top down’ as well as ‘bottom up’. International experience coupled with that of the growing pockets of Australian innovation have established the benefits of trauma-informed systems and services. To do so, requires collaboration between consumers, carers, service providers, managers and policy makers, with consumers at the centre of decision-making, leading and being supported to achieve their identified recovery journeys. Doing so is cost-effective with established outcomes both for those receiving services as well as those providing it.

The reform process has begun and is readily achievable with political will and informed collaboration. The plan for mental health in NSW offers a unique opportunity to reflect the reality of cycles of trauma and complex need of a large number of people engaging with service systems at all stages of the life cycle. The incorporation of trauma-informed principles, policy and practice, research and evaluation methodology into the NSW Mental Health Plan is not only achievable but crucial for a healthier NSW.

**Participant Evaluation Forum**

See Appendix 2
Appendix 1

TABLE 1: Danny J3 - Troubled Kids

Danny is a 10 year old Aboriginal boy, who lives with his mother Lela and 5 year old sister Amy in an Inner Sydney public housing unit. They are poorly connected to extended family and the community. Danny’s father has been in gaol for 3 years, and has had no contact with the family since Amy’s birth. Lela is well known to mental health services, has a history of lengthy admissions (during which the children were cared for in separate foster homes). She has a diagnosis of Bipolar Affective Disorder, poor physical health. Abused as a child, Lela has had a number of abusive relationships as an adult and has been known to access Women’s Health support services. Danny is a bright and articulate child whose attendance at school has recently become patchy. His form teacher thinks he is under-performing and developing oppositional behaviour. There is some suggestion that he may have learning difficulties. Danny suffers from asthma which limits his participation in physical activities, but likes playing computer games. Described as a ‘loner’ Danny has limited peer relationships but is very protective towards Amy and his mother.

What issues of concern is this vignette focused on:

1. Aboriginal boy (stigma associated with culture)
2. Lack of adult relationships (mother often unwell, father absent)/ lack of peer relationships
3. Poverty, isolated & resource issues
4. Schooling, bright but not performing – not identifying the contributing issues
5. Mum’s mental health/ physical health & abuse issues – possible witnessing of DV (Danny & Amy)

Looking at Danny and his family through a TICP lens

1. Identify the possible traumas past and present for Danny and his family
   • Domestic violence
   • Separation Mum & Dad
   • Foster homes – possible trauma/separated from sibling
   • Mum’s mental health issues, frequent admissions
   • Housing, environment
   • What is happening at school because of Danny’s situation and health issues

2. How might the issues identified in this vignette be viewed if the service response was trauma-informed as opposed to not trauma-informed
   • Importance of a strength based approach for Danny
   • Work with family as well
   • Not labelling/ working with/ listening to
   • Teachers need to be TIC savvy
   • Give Danny choice and voice on what needs to happen to support him
   • Is Danny safe, if not how to make it safe
   • Is the family safe
   • Understand trauma from a family/ generational/ individual perspective
3. How might those different responses affect outcomes for them as individuals and as a family?

- Developing improved relationships with each other, the community, the school
- Children understand what is happening – not just Danny’s issue/ social/ family
- Keep family together and connected especially when Mum in hospital

**TABLE 2 : Anna J4 – Healthy Transitions**

Anna is 15, living in Western Sydney and is part of a large Filipino family network. Anna’s parents speak English poorly and she is expected to communicate on their behalf for almost all day to day transactions. Despite this, her parents are strict and have very set expectations for her future. Anna’s only permitted activity is to be part of the church youth group. Anna’s school counsellor is concerned that her school results are slipping and it is suspected that she may have an eating disorder. She has lost a lot of weight and become quite secretive. However, she uses Facebook a lot to keep in touch with friends and has been uploading some disturbing material recently, related to the church group activities. Anna’s parents appear shamed when the school counsellor tries to engage them about the possible eating disorder and when trying to encourage her parents to be more supportive. Recently Anna had a panic attack in school and would only speak to her mentor at the church.

**What issues of concern is this vignette focused on:**

1. Isolation and lacking broader connections
2. CALD issues / Anna parentalised
3. School performance
4. Cultural issues/ parental shame re mental illness and privacy issues
5. Eating disorder/ panic attacks/ weight loss – Anna doing a good job flagging her issues
6. Potential abuse issues church group
7. Possible questions - is this teenage outrage, disappearing away from a life over which Anna has little control over (except for what she eats) how is moving into adulthood affecting her and the family

**Looking at Anna and her family through a TICP lens**

1. Identify possible traumas past and present for Anna and her family
   - Migration
   - Parentalisation (having to be very responsible and adult, but also being strictly limited and treated as a child)
   - Shame, cultural issues, secrecy re trauma past and present for Anna and her parents

2. How might the issues identified in this vignette be viewed if the service response was trauma- informed as opposed to not trauma-informed?
   - Responses must be trauma-informed, risk assessment delicately handled, culturally appropriate and safe
   - Importance of building a safe and supportive relationship independent of family and school
Open door to parents and their issues / support family and understanding Anna’s issues
Strength-based approach, Anna as having decision making abilities
Psychosocial education, holistic view of eating disorder

3. How might those different responses affect outcomes for them as individuals and as a family?
- Not make any assumptions, but seek meaning from all involved
- Partnership and connection across services and connected to school
- Check parent/ family needs – empower Anna and her parents
- Not want to replicate a system of control that Anna is struggling with
- Options: Headspace, school counsellor and check church connections safe
- How best to manage eating disorder and not ‘treat’ as illness

TABLE 3: Ralph J5 Towards a Better Life

Ralph is a homeless, unemployed person who has persistent mental illness and co-existing conditions. He has had three admissions this year, and when last discharged was put on a six month Community Treatment Order (CTO). Ralph’s treatment plan includes monthly injections and regular checks at a clozapine clinic to monitor bloods/side effects of the medication. He is also required to attend two-weekly meetings with his case manager; monthly checks with the psychiatrist and he has been referred to three community managed organisations to assist with his complex mental and psychosocial needs. Ralph was discharged to crisis accommodation, but left after two days, has not attended his appointments and is now lost to services. The only places Ralph is known to frequent are a soup kitchen and Oxfam shop in Surry Hills.

What issues of concern is this vignette focused on:
1. Language being used concerning Ralph
2. Treatment from a medical model perspective – management and ‘compliance’ & breaching CTO
3. Homeless, left crisis accommodation & lost to services
4. Frequent relapses, cycling in and out of hospital
5. Physical health issues
6. Not engaging in services

Looking at Ralph through a TICP lens
1. Identify the possible traumas past and present for Ralph
   - Trauma regarding admissions/ police and mental health practice/ crises
   - Intrusive levels of control in involuntary settings and in the community
   - Abuse whilst on the streets
   - No stability, hungry, poverty
   - Physical ill health
2. How might the issues identified in this vignette be viewed if the service response was trauma-informed as opposed to not trauma-informed?

- Work with strengths, Ralph resourceful, identify strengths, how has he coped on the streets
- What has happened to Ralph, what does he need
- Medical model not working, what else might be done to engage Ralph that isn’t coercive
- Check support well matched to Ralph’s needs, what are they, what are his goals
- What are his social connections, not make assumptions or minimise the places that he feels safe to go to

3. How might those different responses affect outcomes for Ralph?

- Safety and feel safe and stable accommodation
- Mental and physical health needs met within a regime he can manage and agrees with
- Achieve the life he wants to lead

**TABLE 4: **

**Roy**

Roy is 22 years old. After completing his high school certificate, he became an apprentice electrician; successfully completed his training and worked for the same firm for five years. Then he was retrenched. His parents believe he was fired. A year earlier his behaviour began to concern his parents. He started to be absent from work and was cautioned several times by his employer. At this time he also began drinking heavily and taking cannabis. He was charged with driving under the influence and lost his licence, which also affected his ability to do his job.

His parents suggested Roy should see the family GP to get some help for his drinking and to ‘talk to someone’ but Roy declined. He became frequently argumentative, volatile and threatening, and Roy’s parents began to be concerned about their own safety as well as Roy’s. They were considering asking him to move out unless he changed his behaviour.

Two weeks ago Roy came to police attention after king hitting a stranger in the city in an unprovoked attack. He claimed when interviewed that the stranger had verbally abused him and was part of a conspiracy to ruin his life. Roy presented with a very flat affect with tangential thinking, had a severe leg tremor and was responding to internal stimuli. Appearing in court for his offence the magistrate referred him to mental health services under s 33 of the *Mental Health (Forensic Provisions) Act* 1990. The treating team brought Roy before the MHRT to review of his involuntary status. They requested a further four weeks because although he had responded well to anti-psychotic medication, his lack of understanding about his possible ‘ongoing condition’ and the risk that he would not engage with the community health team once discharged, were concerning, without him spending some time in rehab for what was now assessed as problem alcohol and substance abuse, so that he could receive counselling support and psycho-education.
What issues of concern is this vignette focused on:

1. Problem behaviour, what triggered the change 12 months ago
2. Parents perspective of Ralph
3. Unprovoked aggression, psychotic episode, confounded by substances, interaction CJS
4. Medical model, diagnosis, scheduling and locked into mental health system – not trauma informed
5. Safety and connectedness, what happening in the family, past, recent past and now

Workshop - Looking at Roy and his family through a TICP lens

1. Identify the possible traumas past and present for Roy and his family
   - What happened to Ralph in his earlier life, his recent life and at work – emerging behaviours including use of substances
   - Loss of job, shame, disconnected from friends
   - Parents and community fear
   - Police and mental health staff crisis/coercive responses

2. How might the issues identified in this vignette be viewed if the service response was trauma-informed as opposed to not trauma-informed?
   - Ask what has happened to Ralph, strengths-based
   - Self-medicating, coping mechanisms, what does his presentation i.e. flat affect signify from a TI perspective
   - Does ralph feel safe, who best can engage with Ralph and work to his goals and support and validate his experience, holistic frame
   - Who does Ralph want involved, who does he trust
   - Work with family if that is what Ralph wants
   - Support family as carers

3. How might those different responses affect outcomes for them as individuals and as a family?
   - Ralph feels safe and trusts in those supporting him
   - Meeting his goals
   - Care coordination
   - Stop the potential cycle of problems
   - Ralph re-engaged with his life and work, self-esteem, independence
   - Family support
Lee is a 48-year-old long-term user of mental health services, who came to Australia as a Cambodian refugee. She spent the first 2 years in detention, during which period she was sexually assaulted, experienced panic attacks, flashbacks and was diagnosed with PTSD. She has been admitted on a number of occasions over the last 10 years to mental health facilities, and acquired a range of diagnoses and is on a range of anti-psychotic medication. She has gained a lot of weight over recent years and was recently diagnosed with diabetes for which she uses injections. She has struggled to learn English and communicate with mental health staff. Lee has no family connections, having lost her family during the Pol Pot era and has few friends. She wants to speak better English and finish school so she can get a good job and be ‘normal’. She recently moved to stable accommodation and seems to be much more stable mentally. However, her case manager is becoming impatient with her health crises and doesn’t understand why she can’t look after herself better. Despite her health issues, Lee has become much more communicative and is taking much better care of her ADLS. She has pride in her new home and now invites her case manager to visit her at home.

What issues of concern is this vignette focused on:

1. Mental health diagnoses not taking into account complex trauma experiences
2. Isolated and vulnerable, no family connections, language difficulties
3. Medication contributing to physical health problems
4. Stability of accommodation, poverty
5. Education, employment
6. Cultural dislocation

Looking at Lee through a TICP lens

1. Identify the possible traumas past and present for Lee
   - Refugee experience, grief and loss, violence, terror and abuse
   - Lack of safety in Australia – re-traumatisation and re-victimisation, adjustment issues

2. How might the issues identified in this vignette be viewed if the service response was trauma-informed as opposed to not trauma-informed?
   - What support would Lee like to make use of: grief counselling, culturally appropriate self-help support groups
   - Coordinated and holistic approach to care, someone working to pull services together
   - Not to just look at symptoms and medical management, but what may lie beneath the presenting problems – historical trauma, recent and very recent trauma including in mental health services
   - Strength based – Lee is doing well despite often misunderstood, culturally and in terms of language, there is a need for empathy, understanding and validation, give trauma a voice in native tongue if this is what Lee would like
• Important to have culturally competent support workers, interpreters, counsellors from her own community / connections to cultural peers

3. How might those different responses affect outcomes for Lee?
• Reduce re-traumatisation, reduce re-admissions
• Maintain stable housing,
• Meet lees goals - acquire language skills, education and employment, out of poverty
• Social inclusion, self-esteem, empowered, choice and voice
• Physical health improvements

**TABLE 6 : Rebecca J 8 Living long and strong**
Rebecca is 68 and came to Australia as a refugee from Eastern Europe in the early 1950s. A child of holocaust survivors she worked hard in their small but successful clothing business in Melbourne. The business provided the whole family with work and a good lifestyle over the decades. She married and she and her husband established a branch of the business in Sydney. They had 3 children, all grown up and married, scattered across the world. Last year her husband passed away after a long illness and Rebecca is living at home alone.

Rebecca has high blood pressure, diabetes and worsening osteoporosis. Rebecca’s bridge club friends have become very concerned about how fearful and paranoid she has become, especially following a road rage altercation in a car park. Since then she has become isolated, anxious and obsessive and has started to imagine that people are trying to steal from her and break into her home. Her closest friend is trying to persuade the family overseas to put Rebecca in a home, which Rebecca is adamant that she does not want. She gets very distressed at the suggestion.

**What issues of concern is this vignette focused on:**
1. Accumulation of grief and loss and isolation
2. Multiple health issues, access to services
3. Ability to stay in the community and feel safe
4. Societal attitudes to age, cope physically and psychologically

**Looking at Rebecca through a TICP lens**
1. Identify the possible traumas past and present for Rebecca
   • Passage of time, refugee experience
   • Inter-generational trauma – passed to her and onto her children
   • Road rage incident – trigger for PTSD / and past traumas
   • Isolation, mirroring past history
   • Lack of safety and people taking over
   • Respect Rebecca’s choices
2. How might the issues identified in this vignette be viewed if the service response was trauma-informed as opposed to not trauma-informed?
• Important to deal with immediate trauma first, create safety, give her power back. Therapeutic care not medical management.
• Support relationships, in care context and with friends and community that support her choices and autonomy
• Support physical health needs, good primary health care and coordinated care within a holistic framework
• Understand family connections overseas and help support connectedness

3. How might those different responses affect outcomes for Rebecca?
• Restore safety and trust
• Better mental and physical health
• Support in the community and promote Rebecca’s goals for the future
• Ongoing therapeutic support culturally appropriate
Appendix 2: Forum Evaluation Report

Event

<table>
<thead>
<tr>
<th>Date</th>
<th>Venue</th>
<th>Registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, 18 November 2013</td>
<td>Ariel UTS Sydney</td>
<td>73</td>
</tr>
</tbody>
</table>

Participants

65 participants attended and 14 participants completed the evaluation form. Note of the 21 profiles below, some participants reported two or more roles.

General Profile
Other:
- NGO Policy
- NGO employee
- NGO worker – Community Restorative Centre
- NGO

Evaluation

Evaluation for the forum was conducted through surveying the attendees. Evaluation forms were distributed which were collected after the event.

Results

The graphs that follow display the average percentage rating received for the. For example, “0%” would indicate that all participants rated the event as ‘Poor’ or ‘Strongly Disagree’ with the related statement, and “100%” would indicate that all participants rated the event as ‘Excellent’ or ‘Strongly Agree’ with the related statement. The number of responses received per rating, are further shown in graphs.

Ratings

Overall Score of Event

![Graph showing overall score of event with 96.88% rating]
Breakdown of Overall Scores

Has today improved your understanding of T1CP?

83.93%

Breakdown of Improved Understanding Scores

Mental Health Coordinating Council & Adults Surviving Child Abuse
T1CP Forum Report & Evaluation
December 2013
Relevance
Has relevant is TICP to your role?

- Also very relevant to family commitments & relationships
- Completely relevant
- It provides a basis for providing more effective & optimal holistic care for people with a positive trauma experiences
- Important to role as carer engagement officer
- Involved in developing a trauma-informed framework for Out of Home Care - not direct service delivery
- Absolutely relevant as I work with individuals with complex needs. The majority have suffered complex trauma/s
- Imperative

How relevant is TICP to your organisation?

- Completely relevant as our work needs to be underpinned by TIC.
- ARAFMI – therefore completely relevant
- As above ("Involved in developing a trauma-informed framework for Out of Home Care - not direct service delivery")
- Working in a hospital I witness stigma, pathologising & labelling almost daily. However, we are hopeful that we can effect change & move toward TICP
- Implemented, sustainability a challenge
Breakdown of Relevance Scores

Role Relevance

Org Relevance

Importance

Do you think TICP is an important consideration in the development of services and programs?

93.75%

Do you think that all those working in mental health and human services require professional development in TICP?

93.75%
Breakdown of Importance Scores

General Feedback

<table>
<thead>
<tr>
<th>Comments and Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Informative &amp; Interactive - good to look at Strategic Plan from TICP lens; - Thanks for going the extra mile with the food Carrie.</td>
</tr>
<tr>
<td>- Forum went over time which is challenging for people with other arrangements. Excellent Forum.</td>
</tr>
<tr>
<td>- I have seen goals &amp; progress in the willingness by individual services and the general community to discuss trauma.</td>
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<tr>
<td>- Would have liked more on how TIC&amp;P looks in policy e.g., how various resources relate to &amp; can contribute to the development of policy by people not familiar with TICP.</td>
</tr>
<tr>
<td>- What would TICP look like in a Juvenile Justice environment given coercive nature of detention; brief periods of supervision &amp; detention. How is TICP integrated with what we know about 'what works' to resolve juvenile offending?</td>
</tr>
<tr>
<td>- Excellent presentations, very informative and a good mix.</td>
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<tr>
<td>- It's great to see TICP on the agenda.</td>
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<tr>
<td>- A very informative &amp; useful day.</td>
</tr>
<tr>
<td>- More forums &amp; conferences.</td>
</tr>
</tbody>
</table>
Further Information

Would you like to have a more in-depth understanding of TICP?

![Bar chart showing the number of responses to the question: Would you like to have a more in-depth understanding of TICP? The chart shows 14 responses for 'Yes' and 0 for 'No'.]

Would you like to be on the TICP network to receive information in the future?

![Bar chart showing the number of responses to the question: Would you like to be on the TICP network to receive information in the future? The chart shows 11 responses for 'Yes' and 1 for 'No'.]
Recommendation

- MHCC can look to providing further information on applications of TICP as there is interest based from feedback received.

- Follow up email reminding participants of TICP microsite and resources, availability of National Strategic Directions position paper and TICP data collection survey.
Appendix 3
Forum Agenda

Trauma-Informed Care & Practice Forum

Monday 18 November 2013
Aerial UTS Function Centre - Level 7, 235 Jones St, Sydney

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>9.30am</td>
<td>Registration</td>
</tr>
<tr>
<td>10.00am</td>
<td>Welcome to Country</td>
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<td></td>
<td>Opening address</td>
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<td></td>
<td>John Parney, NSW Mental Health Commissioner</td>
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<tr>
<td>10.35am</td>
<td>Setting trauma into perspective</td>
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<td></td>
<td>Dr Cathy Kozolman, President - ASCA</td>
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<tr>
<td>11.15am</td>
<td>Morning Tea</td>
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<td>11.45am</td>
<td>Trauma Informed Care and Practice - towards a National Strategic Direction</td>
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<td>Corinne Henderson, Senior Policy Advisor - MHCC</td>
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<td>12.20pm</td>
<td>Becoming trauma-informed</td>
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<tr>
<td>1.00pm</td>
<td>Lunch</td>
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<tr>
<td>1.30pm</td>
<td>Survivor/ Thriver</td>
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<td></td>
<td>Bradley Fowle, NSW Deputy Mental Health Commissioner</td>
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<td>2.15pm</td>
<td>Life journeys and trauma: the difference being trauma-informed could make</td>
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<td>Dr Cathy Kozolman, President - ASCA</td>
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<td>2.45pm</td>
<td>Life Journeys Workshop</td>
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<td>3.30pm</td>
<td>Afternoon Tea</td>
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<td>3.45pm</td>
<td>Workshop Feedback</td>
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<td>4.15pm</td>
<td>Summing up</td>
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## Appendix 4 - Attendees

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<th>First Name</th>
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<th>Organisation</th>
<th>Address</th>
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<td>Anne-Louise</td>
<td>Lagudi</td>
<td>Family Caseworker</td>
<td>Community Restorative Centre</td>
<td>174 Broadway</td>
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<td>2007</td>
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<td>02 9288 8700</td>
<td><a href="mailto:anne-louise@crcnsw.org.au">anne-louise@crcnsw.org.au</a></td>
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<tr>
<td>Becky</td>
<td>Salter</td>
<td>Family Caseworker</td>
<td>Community Restorative Centre</td>
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<td><a href="mailto:rsalter@crcnsw.org.au">rsalter@crcnsw.org.au</a></td>
</tr>
<tr>
<td>A/Prof Beth</td>
<td>Kotze</td>
<td>Associate Director</td>
<td>Mental Health &amp; Drug &amp; Alcohol Office</td>
<td>L4, 73 Miller St</td>
<td>North Sydney</td>
<td>NSW</td>
<td>2059</td>
<td>LMB 961</td>
<td>02 9391 9098</td>
<td><a href="mailto:egreg@doh.health.nsw.gov.au">egreg@doh.health.nsw.gov.au</a></td>
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<tr>
<td>Bi</td>
<td>YunHuang</td>
<td>Policy Officer</td>
<td>ARAFMI NSW Inc</td>
<td>L5, S 501, 80 William St</td>
<td>Woolloomooloo</td>
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<td>2011</td>
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<td>Bradley</td>
<td>Foxlewin</td>
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<td>Mental Health Commission of NSW</td>
<td>Gladesville</td>
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<tr>
<td>Carlton</td>
<td>Quartly</td>
<td>Principal Advisor, Accountability and Review</td>
<td>Mental Health Commission of NSW</td>
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<tr>
<td>Carrie</td>
<td>Stone</td>
<td>Community Engagement Officer</td>
<td>MHCC</td>
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<td><a href="mailto:carrie@mhcc.org.au">carrie@mhcc.org.au</a></td>
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<tr>
<td>Cassandra Hainsworth</td>
<td></td>
<td></td>
<td>The Children's Hospital</td>
<td>Cnr Hawkesbury Rd &amp; Hainsworth St</td>
<td>Westmead</td>
<td>NSW</td>
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<td>02 9845 2005</td>
<td><a href="mailto:cassandra.hainsworth@health.nsw.gov.au">cassandra.hainsworth@health.nsw.gov.au</a></td>
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<tr>
<td>Cathy</td>
<td>Kezelman</td>
<td>President</td>
<td>ASCA</td>
<td>Milsons Point</td>
<td>Milsons Point</td>
<td>NSW</td>
<td></td>
<td>PO Box 597</td>
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<td><a href="mailto:ckezelman@asca.org.au">ckezelman@asca.org.au</a></td>
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Mental Health Coordinating Council & Adults Surviving Child Abuse  
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<tr>
<td>Cherie</td>
<td>Carlton</td>
<td>Coordinator</td>
<td>NSW Institute of Psychiatry</td>
<td>Parramatta</td>
<td>NSW</td>
<td>2124</td>
<td>Locked Bag 7118</td>
<td>02 9840 3833</td>
<td><a href="mailto:cherie.carlton@nswiop.nsw.edu.au">cherie.carlton@nswiop.nsw.edu.au</a></td>
<td></td>
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<tr>
<td>Chioma</td>
<td>Etim</td>
<td>Registered Nurse</td>
<td>NSW Refugee Health Service</td>
<td></td>
<td>NSW</td>
<td></td>
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<td>MHCC</td>
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<td>2039</td>
<td>PO Box 668</td>
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<td><a href="mailto:corinne@mhcc.org.au">corinne@mhcc.org.au</a></td>
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<tr>
<td>Danielle</td>
<td>Keogh</td>
<td>Mental Health Commission</td>
<td></td>
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<td><a href="mailto:danielle.keogh@mhc.nsw.gov.au">danielle.keogh@mhc.nsw.gov.au</a></td>
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<tr>
<td>Danielle</td>
<td>Maloney</td>
<td>Senior Allied Health Program Advisor</td>
<td>Mental Health and Drug &amp; Alcohol Office</td>
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<tr>
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<td>Dept of Corrective Services NSW</td>
<td>L7, Henry Deane Bldg, 20 Lee St</td>
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<tr>
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<td>Chapagain</td>
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<td>Dr Senthil</td>
<td>Muthuswamy</td>
<td>A/Director</td>
<td>Mental Health Services</td>
<td>Parramatta</td>
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<td>Official Visitors Program</td>
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<td>HNE Mental Health</td>
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<td>Howe</td>
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<td>Joanne</td>
<td>Rhee</td>
<td>Policy Officer</td>
<td>Mental Health and Drug &amp; Alcohol Office</td>
<td>73 Miller St</td>
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<tr>
<td>Judy</td>
<td>Hunt</td>
<td>Principal Guardian</td>
<td>Dept of Attorney General and Justice</td>
<td>World Square</td>
<td>NSW</td>
<td>2002</td>
<td>PO Box 20487</td>
<td>02 9287 7660</td>
<td><a href="mailto:Judy_hunt@opg.nsw.gov.au">Judy_hunt@opg.nsw.gov.au</a></td>
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<tr>
<td>Karen</td>
<td>Burns</td>
<td>Chief Executive Officer</td>
<td>Uniting Care Mental Health</td>
<td>Parramatta</td>
<td>NSW</td>
<td>2124</td>
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<td>02 9845 2005</td>
<td><a href="mailto:karen.burns@ucmh.org.au">karen.burns@ucmh.org.au</a></td>
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<tr>
<td>Karen</td>
<td>Munro</td>
<td>Senior Clinical Psychologist</td>
<td>The Children's Hospital</td>
<td>Westmead</td>
<td>NSW</td>
<td>2145</td>
<td>Locked Bag 4001</td>
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<tr>
<td>Karen</td>
<td>Wells</td>
<td>Project Support Officer</td>
<td>NSW Consumer Advisory Group</td>
<td>80 William St</td>
<td>East Sydney</td>
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<tr>
<td>Kat</td>
<td>Armstrong</td>
<td>Director</td>
<td>Women In Prison Advocacy Network</td>
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<tr>
<td>Kate</td>
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<tr>
<td>Katrina</td>
<td>Davis</td>
<td>Analyst</td>
<td>Mental Health Commission NSW</td>
<td>Gladesville</td>
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<td><a href="mailto:katrina.davies@mhc.nsw.gov.au">katrina.davies@mhc.nsw.gov.au</a></td>
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<tr>
<td>Kelley</td>
<td>Yates</td>
<td>Deputy Director of Nursing</td>
<td>Justice Health &amp; Forensic Mental Health Network</td>
<td>Matraville</td>
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<td><a href="mailto:kerin.ohr74@gmail.com">kerin.ohr74@gmail.com</a></td>
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<tr>
<td>Kevin</td>
<td>Baron</td>
<td>Acting Nursing Unit Manager</td>
<td>Justice Health &amp; Forensic Mental Health Network</td>
<td>1300 Anzac Parade</td>
<td>Matraville</td>
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<td><a href="mailto:kevin.baron@justicehealth.nsw.gov.au">kevin.baron@justicehealth.nsw.gov.au</a></td>
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<tr>
<td>Lorna</td>
<td>Downes</td>
<td>Short Course Coordinator</td>
<td>MHCC</td>
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<td>PO Box 668</td>
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<td>Luke</td>
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<td>Lynda</td>
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<td>ARAFMI NSW Inc</td>
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<td>Maria</td>
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<td>Deputy President</td>
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<td>Maria</td>
<td>Fitzgerald</td>
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<td>Kingswood</td>
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<td>02 4784 6759</td>
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<td>Mary</td>
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<td>Legal Aid NSW</td>
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<td>02 9407 2955</td>
<td><a href="mailto:mary.jelen@legalaid.nsw.gov.au">mary.jelen@legalaid.nsw.gov.au</a></td>
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<tr>
<td>Michelle</td>
<td>Eason</td>
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<td>Justice Health &amp; Forensic Mental Health Network</td>
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<td>Moniqui</td>
<td>Phipps</td>
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<td>St Vincent's Hospital</td>
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<td><a href="mailto:mphpipps@stvincents.com.au">mphpipps@stvincents.com.au</a></td>
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## Appendix 4 - Attendees

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<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Position</th>
<th>Organisation</th>
<th>Address</th>
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<tr>
<td>Patricia</td>
<td>Tumeth</td>
<td>Psychologist Team Leader</td>
<td>Dept of Family &amp; Community Services</td>
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<td></td>
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<td><a href="mailto:patricia.tumeth@facs.nsw.gov.au">patricia.tumeth@facs.nsw.gov.au</a></td>
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<tr>
<td>Paul</td>
<td>Beckett</td>
<td>Clinical Nurse Consultant</td>
<td>St Vincent's Hospital</td>
<td>L6, O'Brien Centre, 394 - 404 Victoria Street</td>
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<td>Prof Alan</td>
<td>Rosen</td>
<td>Deputy Commissioner</td>
<td>Mental Health Commission</td>
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<tr>
<td>Robyn</td>
<td>Maurice</td>
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<tr>
<td>Samantha</td>
<td>Pearce</td>
<td>Coordinator Partnerships</td>
<td>Murrumbidgee LHD Mental Health</td>
<td>Bent St</td>
<td>Jindabyne</td>
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<td>02 6456 1473</td>
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<td>Sarah</td>
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<td>Sharlene</td>
<td>Harkness</td>
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<tr>
<td>Solange</td>
<td>Frost</td>
<td>Senior Policy Officer</td>
<td>Council of Social Service of NSW</td>
<td>66 Albion St</td>
<td>Surry Hills</td>
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<tr>
<td>Sophie</td>
<td>Norrish</td>
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<td>SLHD Mental Health Services</td>
<td>Hospital Rd</td>
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<td>Susan</td>
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<td>Policy Team</td>
<td>NSW Consumer Advisory Group</td>
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