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Implementing trauma-informed systems of care in health settings: The WITH study. *State of knowledge paper*

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Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper

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Contents

Introduction

Sexual violence is a common experience for women in the Australian community (Australian Bureau of Statistics, 2006, 2012; Mouzos & Makkai, 2004) and internationally (World Health Organization, 2005, 2013a). Sexual violence and intimate partner violence are associated with childhood sexual abuse and this multiple victimisation contributes to a range of mental health conditions, such as anxiety disorders, depression, eating disorders, and post-traumatic stress disorder (Campbell, Dworkin, & Cabral, 2009; Oram, Trevillion, Feder, & Howard, 2013; Rees et al., 2011; Trevillion, Oram, Feder, & Howard, 2012). In line with this research, practitioners working in a range of services – sexual violence, mental health, drug and alcohol, housing and homelessness, corrections – increasingly recognise that, in addition to the presenting issue bringing people into contact with those systems a significant proportion of their clients also bring complex trauma histories (Wall & Quadara, 2014). In many cases, one individual will be in multiple systems to access, for example, management of sexual assault, treatment services for mental illness and drug and alcohol addictions as well as support for other needs such as housing services, employment and parenting. Not only can this mean fragmented service responses and referral pathways, a lack of trauma awareness also means that victims/survivors can experience service provision itself as retraumatising (Mental Health Coordinating Council, 2013).

Integrated, coordinated or linked service and systems responses for survivors of sexual violence who have multiple or complex needs has thus been a priority for service development (KPMG, 2007, 2009; Olle, 2005; Queensland Health, 2001). More recently, mental health and human service agencies in Australia have explicitly considered how their service systems can become "trauma-informed" not only to strengthen inter-agency collaboration, but to also minimise the risk of consumers being retraumatised through standard operational practices (e.g. Bath, 2008; Kezelman & Stavropoulos, 2012; MHCC, 2013). However, there is little guidance about the extent to which services can embed "trauma-informed" care in their organisations or how this should occur. There is acknowledgment that, despite evidence of the prevalence of trauma histories among clients, there is little system level effort to address the relationship between trauma and mental health conditions, how to implement trauma-informed care when both sexual violence and mental health issues are present, and what systems-level infrastructure is required to support trauma-informed practice throughout and between service organisations (MHCC, 2013; Rose, Freeman, & Proudlock, 2012). Further, while there is often support for integrated or interagency service responses to victims/survivors of sexual violence, philosophical, structural and operational differences between agencies can make their translation into practice difficult (Axelsson & Axelsson, 2006; Axelsson & Axelsson, 2009; Darlington, Feeney, & Rixon, 2004).

Method

The purpose of this literature review is to contextualise and inform the *Women's Input to a Trauma-informed systems model of care in Health settings Study* (the WITH Study). WITH focuses on addressing the service needs of women with sexual victimisation histories that also experience mental health problems. The project, by promoting and embedding a trauma-informed systems model of care, aims to improve the experience for women by enhancing the service interface between sexual violence and the mental health sectors. This review examines the available literature on trauma-informed frameworks, models and guidelines that have been developed to guide organisations to improve service provision to survivors of sexual violence with mental health problems. The aim of the literature review is two-fold:

- to inform and refine the projects' aims and data collection; and
- to assist in the data analysis and implications assessment in subsequent stages.

The purpose of this state of knowledge paper was to synthesis the available current literature on three key topics:

1. trauma and consumer-informed approaches, frameworks and guidelines developed to guide service models and practices to improve service provision to survivors of sexual violence with mental health problems;

2. implementation and evaluation studies (including realist analyses) about the processes, outcomes and efficacy of consumer and trauma-informed service responses; and

3. change, collaboration and adaptation in complex human service systems.

We adopted a narrative review of the empirical and conceptual research on the above areas in order to identify key themes in the evidence base.[1] A narrative review provides a descriptive engagement of the literature to identify key findings of primary studies and concepts, gaps, and areas of debate in the analysis of findings (Jesson, Matheson & Lacey, 2011). This approach is useful when covering multiple research areas – in this case sexual violence, mental health, trauma-informed care and systems change.

Literature was initially located using the following databases: PsychInfo; SocIndex; ProQuest; Psychology and Behavioral Sciences Collection; PubMed; CINCH; Family and Society Abstracts; Health and Wellbeing and Women's Studies International. These databases and indexes were based at both the Australian Institute of Family Studies and University of Melbourne.

- Subjects: sexual assault AND mental health/mental disorders/mental illness/PTSD
- Subjects: sexual abuse AND mental health/mental illness
- Subjects: emotional trauma AND mental health
- Subjects: mental health services AND Subjects: trauma
- Subject: emotional trauma AND Abstract: mental health services
- Keyword: trauma-informed care AND Abstract mental health

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1   Unlike systematic reviews, diverse terms are used to describe "traditional" approaches to reviewing literature including narrative review, conceptual review, "state of the art" review (Jesson et al., 2011).

- Keyword: mental health AND keyword: trauma AND Abstract: model of care
- Keyword: mental health services AND Keyword: trauma

Literature was limited to a publication period of 2000-2015 and documents published in English.

As noted in a recent review of trauma-informed care, a significant proportion of the literature is grey literature.[2] Key sources of grey literature on trauma-informed care such as the Substance Abuse and Mental Health Services Administration (SAMHSA, US); the Mental Health Coordinating Council (MHCC, Australia) and the Women Coalescing (Canada) were searched. This was augmented by the following supplementary strategies:

- Google searches on trauma-informed care by region (Australia; United States; Canada, New Zealand, and the UK);
- hand searching of references and citations in academic and grey literature; and
- searches using Google Scholar.

Terminology used in this paper

There are several key terms used throughout this report, which we describe briefly below.

Child sexual abuse: The World Health Organization (WHO, 2014) defines child sexual abuse as the involvement of a child in sexual activity that:

> The child does not fully comprehend; cannot give informed consent to or is not developmentally prepared for and cannot give consent. It involves activity between a child and an adult, or another child who by age or development is in a relationship of responsibility, trust or power. Child sexual abuse can include the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or any unlawful sexual activity; the exploitative use of a child in a pornographic performance and materials. (WHO, 1999, p. 62)

Sexual violence:

> Sexual violence is any behaviour of a sexual nature that makes a person feel intimidated, threatened or frightened. It is behaviour that is unwanted and uninvited where another person uses physical, emotional or psychological forms of coercion. It is committed more frequently than many people realise and can include anything from sexual harassment through to life threatening rape. The latter is defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, and may also include oral penetration. (Royal Australian College of General Practitioners, 2014, p. 65)

Sexual victimisation: refers to unwanted sexual experiences that have occurred in both childhood and adulthood (e.g. child sexual abuse, sexual assault, rape), including victimisation perpetrated by an intimate partner.

Intimate partner violence: refers to "any behaviour within an intimate relationship that causes physical, emotional, sexual, economic and social harm to those in the relationship" (Krug, Mercy, Dahlberg, & Zwi, 2002, p.89).

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2   Grey literature is "material produced outside commercial publishing channels and of particular importance in the area of public policy" (greylitstrategies.info). This includes research reports, evaluations, presentations, research papers, position papers, toolkits and guidance and practice literature.

Paper structure

Family violence: This is a broader term that refers to "violence between family members, as well as violence between intimate partners. "Family violence" is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur" (Council of Australian Governments, 2012, p.2).

Trauma-informed care: This refers to an orientation in the human and social services by which components of a given service system have been considered, evaluated and organised in the light of a basic understanding of the role that violence plays in the lives of people seeking services, and alongside an awareness of the dynamics of trauma and how these may present in consumer populations (MHCC, 2013).

This review briefly describes what the research evidence tells about the relationship between sexual victimisation and adverse mental health outcomes, before discussing the concept of trauma-informed care. Specifically, it:

- describes the evolution and principles of trauma-informed care for women with trauma histories who experience mental health problems;
- describes current models and approaches that have been implemented at the organisational and systems levels to embed trauma-informed care in sexual violence and mental health settings to improve service provision to survivors;
- synthesises relevant implementation and evaluation studies (including realist analyses) about the processes, outcomes and efficacy of consumer and trauma-informed service responses; and
- discusses briefly, change, collaboration and adaptation in complex human service systems.

The relationship between sexual victimisation and adverse mental health outcomes

Prevalence of sexual violence in Australia

Nationally representative survey data show that significant proportions of women have experienced sexual violence over their lifetimes (ABS, 1996, 2006, 2013; Mouzos & Makkai, 2004). In terms of women's adult experiences, the most recent *Personal Safety Survey* (PSS) found that almost 1 in 5 women (19.4% had experienced sexual violence since the age of 15. Over a third (34.4%) had experienced physical violence. A key characteristic of both forms of violence is that they are perpetrated by people known to the victim. In the case of sexual violence, the PSS reported that women knew the perpetrator in 94.7 percent of the most recent incidents (since age 15), with current and previous partners and boyfriends/girlfriends comprising key perpetrator groups. This is also the case in relation to women's experience of physical violence, with the PSS reporting that 91.6 percent of incidents were perpetrated by a known person,[3] predominantly known males (specifically current and previous partners and boyfriends).[4] The breakdown of perpetrator gender shows that men experienced much less sexual and physical violence by a person known to them.[5]

In another nationally representative sample of women surveyed for the Australian National Mental Health and Well-being Survey, Rees and colleagues (2011) measured the lifetime prevalence of four types of gender-based violence: sexual assault, rape, stalking and physical intimate partner violence. Over a quarter of respondents (27.4%) reported experiencing at least one type of gender-based violence. Of these:

- 14.7 percent had experienced sexual assault
- 10.9 percent had experienced stalking
- 8.1 percent had experienced rape
- 7.8 percent had experienced physical intimate partner violence.

In relation to prevalence rates of child sexual abuse, Price-Robertson (2012) synthesised the findings of five community-based studies that had comprehensive measures on types of sexual abuse. Females had prevalence rates of 4–12 percent for penetrative abuse and 14–36 percent for non-penetrative abuse (Price-Robertson, 2012). Males had prevalence rates of 1–8 percent for penetrative abuse, and 6–16 percent for non-penetrative abuse.

Surveys such as the Personal Safety Survey, the International Violence Against Women Survey, and other prevalence studies provide the most statistically reliable picture of sexual violence experienced in the national population. However, they underestimate the actual extent of sexual violence that is experienced. These surveys exclude "the experiences of the most vulnerable members of our community… such as children and young people, very remotely situated Australians, prisoners, people in residential care and other institutional settings" (Tarczon & Quadara, 2012). These are populations with high levels of sexual victimisation experiences (Stathopoulos, 2014; Stathopoulos, Quadara, Fileborn, & Clark, 2012).

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3   Table 5, Personal Safety Survey 2013.

4   Table 6, Personal Safety Survey 2013.

5   Note that men have higher lifetime prevalence rates of physical violence overall compared to women (48% compared to 34.5% respectively). However, women are significantly more likely to experience such violence by perpetrators known to them.

Impacts of sexual victimisation on mental health

A significant body of literature demonstrates a strong, though complex, relationship between women's experiences of sexual victimisation and poor mental health outcomes. The following considers empirical studies that have aimed to test the association between experiences of sexual victimisation and mental health outcomes, and to determine the nature of that relationship (e.g. whether child sexual abuse uniquely predicts mental health problems). It is important to note that there is also significant feminist literature connecting women's experiences of sexual violence with mental ill-health, such as the work of Judith Herman (Herman, 1992a, 1992b; Herman, Perry, & Van der Kolk, 1989), Jill Astbury (Astbury, 1996, 2006), and Jane Ussher (Ussher, 1992, 2011).

The empirical research regarding the relationship between child sexual abuse and adverse mental health outcomes is particularly robust. A review of the literature by Tarczon (2012) noted that numerous studies have found that adult women with child sexual abuse histories have a higher risk of having mental health problems such as depression, anxiety, substance abuse and self-harm when compared to community populations (Banyard, Williams, & Siegel, 2001; Briere & Elliott, 2003; Henderson & Bateman, 2010; Horvarth, 2010). Comprehensive reviews of the literature were published by the Australian Institute of Family Studies in 1998 (Mullen & Flemming, 1998) and again in 2013 (Cashmore & Shackel, 2013). Cashmore and Shackel noted that mental health problems consistently associated with child sexual abuse included:

- anxiety disorders (including post-traumatic stress disorder);
- depression;
- substance abuse;
- conduct disorders, aggressive behaviour and negativity;
- eating disorders;
- psychotic disorders; and
- personality disorders.

Much of this research has been retrospective or cross-sectional in nature, and as such it is not possible to draw conclusions about causality (i.e. that experiences of child sexual abuse *cause* mental disorders).

More rigorous studies attempt to trace the trajectory of mental health (and other outcomes) following child sexual abuse such as a 45-year follow-up study by Cutajar and colleagues (Cutajar, Ogloff, & Mullen, 2011),[6] and the Christchurch Health and Development Study, a longitudinal study in New Zealand. This research suggests that child sexual abuse is a risk factor for the development of later mental health problems such as anxiety disorders, depression, substance use, and suicidality, as well as lower prevalence disorders such as psychotic disorders and conduct/anti-social personality disorders. Cutajar and colleagues found that the lifetime record of contact with public mental health services was 23.3 percent of victims compared to 7.7 percent of the control (the electoral roll) (Cutajar et al., 2010).

There are also several reviews investigating the relationship between child sexual abuse and mental health issues such as anxiety, depression, and suicide and non-suicidal self-injury (Campbell, 2001, 2008; Cias, Young, & Barreira, 2000; Cutajar et al., 2010; Department of Health, 2003). The consistent finding from Maniglio's reviews of meta-analyses, which were published between 1995 and 2010 is that child sexual abuse is a "statistically significant, although general and non-specific risk factor" for depression, anxiety disorders especially post-traumatic stress disorder, and suicidal and non-suicidal self-injury. Hillberg, Hamilton-Giachritsis and Dixon (2011) reviewed seven meta-analyses published between 1995 and 2001 examining the relationship between child sexual abuse and mental health and similarly found sexual abuse to be a non-specific risk factor for adult mental health problems such as depression, dissociation, borderline personality disorder[7] but found significant variation in the effect sizes (that is, the strength of the relationship between sexual abuse and mental health problems) across the studies.

Finally, Larkin and Read (2008) reflected on the state of the empirical evidence on the relationship between childhood traumas such as sexual abuse and the development of psychosis. In assessing nine large-scale studies they find sufficient evidence to support the notion that childhood trauma - including sexual abuse - is a causal factor in the development of psychosis.

There is comparatively less certainty about the relationship between adult experiences of sexual violence and mental health problems. Research certainly demonstrates a

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6   This study used data linkage analysis techniques to follow mental health, criminal justice, and alcohol and drug service encounters after reporting child sexual abuse. This information was compared to control matched population drawn from the electoral roll.

7   The studies reviewed by Hillberg et al. (2011) looked at 41 mental health problems, which Hillberg et al. aggregated into 25 symptoms or disorders.

correlation between sexual assault and poor mental health (Bloom, 2013; Fallot & Harris, 2002; Cadwallader, 2013),[8] with PTSD being the most common, and most commonly researched, mental health issue (Hurley, 2010), often co-occurring with depression, anxiety and other mental illnesses (Kezelman & Stavropoulos, 2012; Krakow et al., 2000). Several factors affect the availability of research that specifically isolates adult experiences of sexual assault and mental health impacts, which predominantly relate to the difficulty of disentangling previous victimisation experiences (such as child sexual abuse), other adult victimisation experiences, or pre-existing mental health issues from the analysis. Indeed the available research tends to suggest that chronic, multiple, and repeated experiences of gender-based violence, including sexual assault are strongly associated with mental health problems (Briere & Jordan, 2004; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013).

In their analysis of lifetime experience of four types of gender-based violence and connection to mental health problems, Rees and colleagues (2011) found that gender based violence was strongly associated with mental health disorders (anxiety, mood disorder, substance abuse disorder and post-traumatic stress disorder). For women who reported one type of gender-based violence (sexual assault; stalking; rape; intimate partner violence), well over half (57.3%) also reported experiencing a mental health disorder, compared with 28 percent for women who had not experienced gender-based violence. Anxiety was the most commonly reported single classification (38.5%), followed by mood disorders (30.7%), substance abuse (23%) and PTSD (15.2%). Of the women who reported experiencing three to four types of gender-based violence, 89.4 percent reported mental health problems. Anxiety was the most common single classification with over three-quarters (77.3%) experiencing anxiety disorders followed by mood disorders (52.5%), PTSD (56.2%) and substance abuse (47.1%).

There is also research showing that individuals seeking mental health treatment or with severe mental illness have high rates sexual victimisation in both child and adulthood (Maniglio, 2010; Mueser, Rosenberg, Goodman, & Trumbetta, 2002).

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8   A lot of this research was published during the 1990s and thus prior to our publication start date of 2000.

Service needs and service responses

Interpersonal victimisation, trauma responses and mental health

That sexual victimisation occasions post-traumatic stress responses is well established (for a summary of the impacts see Boyd, 2011). Over thirty years ago, Burgess and Holstrom termed the effects of sexual assault on victims Rape Trauma Syndrome in which the kernel of anxiety was "a subjective state of terror and overwhelming fear of being killed" (Burgess & Holstrom, 1974, in Burgess 1983, p. 100) and involved an acute or disruptive phase that could last from days to weeks characterised by general stress reactions and a second phase of a longer-term process of re-organisation lasting months to years. More recent work on the relationship between acute stress reactions and longer-term trauma responses supports these phased reactions (Elklit & Brink, 2004; Harvey & Bryant, 1999, 2002) Breslau, 2009; McFarlane et al., 2005; Ullman et al., 2013). Post-traumatic stress disorder is the psychiatric diagnosis given to this latter, more persistent form of trauma response.

However, the diagnostic category of PTSD was originally developed in response to the symptoms seen in survivors of one-off, extreme or out-of-the ordinary experiences, such as military conflict or natural disasters. Many researchers in the fields of psychiatry, traumatology, and social work have argued that PTSD does not adequately capture the effects of early onset, chronic and/or multiple types of interpersonal victimisation in which perpetrators are in profoundly intimate relationships with survivors – parental figure, family member, partner (Briere & Spinazzola, 2005; Herman, 1992a; Higgins & McCabe, 2000; (Van der Kolk, 1996) or the relationship between traumatic stress responses and other psychological conditions:

> Despite the ubiquitous occurrence of numerous posttraumatic problems other than PTSD, the relationship between PTSD and the multiple other symptoms associated with early and prolonged trauma has received surprisingly little attention. In the PTSD literature, psychiatric problems that do not fall within its framework are generally referred to "comorbid conditions" *as if they occurred independently from the PTSD symptoms*. (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005, p. 390, emphasis added.)

More broadly, feminist engagements with the domains of psychiatry, psychoanalysis and mental health have highlighted the way in which PTSD and other diagnoses have historically failed to attend to the broader socio-cultural context in which women's experiences of interpersonal violence occur, and the extent to which the relationship between victimisation and its impact on mental health was disavowed (as was the case with Freud's refutation of his original hypothesis for hysteria). Concerns about how well traditional models of mental illness acknowledge social contexts such as race, class, gender, and social relationships have also been articulated by those working with Indigenous populations in Australia and Canada (Haskell & Randall, 2009; Atkinson, 2013) and in community psychology (Prilleltensky & Nelson, 1997; Rappaport, 1977).

Thus in the last two decades there have been concerted efforts in many disciplines[9] to acknowledge and better understand: 1) the relationship between intimate forms of violence (such as sexual abuse, sexual assault, family and domestic violence) and mental health problems; 2) the role of power, control, coercion, complicity and secrecy (which these forms of victimisation typically involve) in the specific manifestations of trauma symptoms; and 3) the role of structural factors such gender inequality, racism, colonisation, and socio-economic disadvantage in healing and recovery. On this latter point, scholarship is available that suggests complex trauma as a useful construct for describing the impacts of sexual abuse on Aboriginal women and within Aboriginal communities (Haskell & Randall, 2009; Söchting, Corrado, Cohen, Ley, & Brasfield, 2007). Through the notions of "disrupted attachments" and collective trauma, the trauma of colonisation and the attendant loss of land, culture and identity is acknowledged (Haskell & Randall, 2009).

Increasingly, an empirical and clinical research base uses "complex trauma" or "complex post-traumatic stress disorder" as a construct that better captures the impacts of repeated or multiple forms of victimisation on mental health, cognition, interpersonal relationships, self-perception and

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9   For example, traumatology, neuropsychology and social work.

self-capacity (Briere & Spinazzola, 2005; Courtois, 2004; Goodwin, 2005; Herman, 1992; Kezelman & Stavropoulos, 2012; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Van der Kolk et al., 2005). Symptoms such as dissociation, amnesia, hallucinations and behaviours such as self-harm and substance use are seen less as pathological responses, and more as coping strategies survivors employ to tolerate the distress associated with interpersonal victimisation such as sexual abuse or intimate partner sexual violence.

However, complex-PTSD has not been included in the Diagnostic and Statistical Manual version 5 (DSM-5), which psychiatrists and others use as the basis for defining mental disorders and problems. In part, this relates to the difficulty of determining the distinctiveness of CPTSD from PTSD and other psychiatric diagnoses such Borderline Personality Disorder and Major Depressive Disorder when there are overlaps in symptomology (Resick et al., 2012). The absence of an over-arching construct for trauma-related behaviours can mean that individuals are often diagnosed with a range of other disorders such as major depressive disorder; anxiety; psychosis; borderline personality disorder; substance abuse disorder; schizophrenia; conduct disorders; or oppositional defiant disorder.

Implications for service responses

The complexity of the relationship between sexual victimisation and mental health outcomes has significant impacts on treatment approaches, and about what the most important element to address is, and at what point - the sexual abuse trauma, the mental health problem, or the substance use? As noted in Wall and Quadara, (2014), it is the secondary (e.g. substance abuse) or tertiary (e.g. drug-induced mental illness) expressions of trauma that result in treatment and/or support. Screening for histories of abuse has not traditionally occurred within the mental health services (Huntington, Jahn Moses, & Veysey, 2005). Often, the underlying trauma history is treated as a separate mental health need, is rarely integrated into treatment, and/or the complexity of symptoms results in multiple and changing diagnoses (Savage, Quiros, Dodd, & Bonavota, 2007).

It can also present challenges and conflicts for those working in the diverse support services women may be accessing. For example, mental health professionals may be reluctant or concerned about asking about sexual violence (McLindon & Harms, 2011) or intimate partner violence (Trevillion et al., 2012), or may not have the skills and training to respond appropriately to disclosures of sexual violence (Bell, 2007;

Campbell, Keegan, Cybulska, & Forster, 2007; McLindon & Harms, 2011). In McLindon and Harms' research with 15 Victorian-based mental health practitioners, while there was recognition that sexual assault had long-term detrimental impacts on survivors, respondents noted that training was inadequate, with participants stating that they had either never received professional training about sexual assault, or if they had, it was brief and undertaken a decade or more ago. Concerns were raised about mandatory screening for sexual assault during assessment with practitioners stating that it could be very distressing for the survivor but also that it may not be relevant to the presenting issue. Not having time to ask and appropriately respond to disclosures were also mentioned. The study concluded with recommendations for sexual assault training and cross-sectoral practice and referral (McLindon & Harms, 2011). Similarly, in a UK interview study of 20 mental health practitioners, professionals reported the medical and diagnostic treatment model was a barrier to enquiry, although disclosure could be facilitated by a supportive and trusting relationship (Rose et al., 2011).

Those working in specialist trauma and violence services such as sexual assault and domestic violence services can also demonstrate a reluctance to engage with mental health services (Laing, Irwin, & Toivonen, 2010; Laing & Toivonen, 2010; Woody & Beldin, 2012). This reluctance sometimes arises from characterisations of mental health and psychiatry as being too reliant on a bio-medical view of health (Woody & Beldin, 2012), and too individualising, medicalising or pathologising of women's mental ill-health following experiences of sexual violence (Hurley, 2010). This can result in women not receiving potentially helpful mental health interventions (Laing et al., 2010). It can also mean women experiencing multiple needs or acute distress slipping through service gaps (Rosengard, Laing, Ridley, & Hunter, 2007).

Alternative service approaches have been developed to address the challenges of siloed or fragmented service responses. In the Australian mental health field recovery-oriented care is an over-arching framework for rethinking the relationship between mental illness, the person, the professionals and the system. Drawing on the social determinants of health paradigm and the experiences of consumers, recovery-oriented mental health refers to the recognition that people with mental health problems can manage their mental health issues effectively and productively through empowerment, collaboration, hope

and strengths-based strategies (Ramon, Healy, & Renouf, 2007). The shift to and development of "recovery-oriented" mental health care acknowledges that trauma arising from experiences of violence and abuse is prevalent among mental health service users and is therefore something to which mental health services need to be responsive (Australian Health Ministers' Advisory Council, 2013; AHMAC, 2010). It also acknowledges the importance of relationships, lived experience and social context:

> Recovery occurs within a web of relations including the individual, family and community, and is contextualised by culture, privilege or oppression, history and the social determinants of health. Recovery also occurs within the context of gender, age and developmental stages. (AHMAC, 2013, p. 2)

This overarching approach includes within it concepts such as person centred care, which can be defined as:

> A highly individualized comprehensive approach to assessment and services is used to understand each individual's and family's history, strengths, needs, and vision of their own recovery including attention to the issues of culture, spirituality, trauma, and other factors. (Adams & Grieder, 2013, p. 21)

In recognition of the complex and fragmented nature of mental health and human services in which services are provided through government and non-government agencies at the state/territory and Commonwealth levels, as well as the interconnections between mental health, physical health, and other social needs, "care co-ordination" has emerged as a way of moving to connected, co-ordinated service delivery regardless of which service entry point people have accessed (MHCC, 2011). In a review of the literature, service or care co-ordination was broadly defined as the delivery of systematic, responsive and supportive care to people with complex chronic care needs (MHCC, 2011). Coordination is intended to occur across a range of care providers including not only professional service providers but also family and friends. Closely related to this conception are integrated service provision and wrap-around service models. In short, there is a broader context in which the interest in trauma-informed service systems and models of care is located, but this can present challenges in terms of balancing cross agency service provision with maintaining the privacy and confidentiality of clients. Compared to the US context, however, a national approach to mental health and recognition of the role of sexual victimisation on mental wellbeing is relatively recent

(Fernbacher, 2008). In her analysis of mental health policy development in Australia, Fernbacher noted that while there was acknowledgement in mental health policy documents that child sexual abuse, sexual assault and family violence were associated with negative mental health outcomes, most documents did not articulate what the implications of these trauma histories were for the mental health system generally or for direct service provision. Thus the work on trauma-informed care developed in the US is highly instructive for the Australian context.

The movement towards trauma-informed care

In 2001, Maxine Harris and Roger Fallot published a book and several papers exploring the utility of using trauma theory to design human service systems (Harris & Fallot, 2001a, 2001b). While these publications were not the first to use the phrase "trauma-informed" *per se* – the phrase can be found in a number of earlier publications – they were the first to explicitly set out how an understanding of the impact of trauma on the individual could (and should) be used to inform the operations of human service agencies not just at the therapeutic level with clients, but at the organisational, structural and systemic levels of such agencies.

This work dovetailed with a collaborative initiative headed by the US federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) from 1998 to 2003 to develop integrated services for women who were the victims of violence and also diagnosed with both a psychiatric illness and a substance abuse problem. The Women with Co-occurring Disorders and Violence Study (WCDVS) was a five-year, multisite study that aimed to generate knowledge about the effectiveness of comprehensive integrated service models for women with co-occurring disorders and histories of trauma. A service framework was developed setting out the key characteristics of the service interventions, which required that all interventions be "gender-specific, culturally competent, trauma-informed and trauma-specific, comprehensive, integrated, and consumer/survivor/recovering (CSR) women involved" (Lang et al., 2003, p. 1). Each site provided a core set of services: "outreach and engagement; screening and assessment; treatment activities; parenting skills; resource coordination and advocacy; trauma-specific services; crisis intervention; and peer-run services" (SAMHSA, [n.d.], p. 1). Each program had strategies to integrate services at both the clinical/individual level and the program/systems level.

This initiative subsequently generated a significant body of research and practice literature, including:

- integrated therapeutic interventions for women with co-occurring disorders and trauma histories;
- organisational and systemic approaches to trauma-informed models of care;
- curricula, toolkits, training and self-assessment guides for diverse settings including children's services, homelessness services, criminal justice, correctional services, and schools;
- the establishment of a government funded National Centre for Trauma-Informed Care and the National Child Traumatic Stress Network to capacity build services in trauma-informed practice; and
- research publications.

There is now a large knowledge base on trauma-informed care, which includes the theoretical underpinnings of trauma-informed care, implementation studies and evaluations of intervention efficacy. The following sections review this literature to:

- provide a definition of trauma-informed care;
- describe its empirical, philosophical and conceptual underpinnings;
- describe principles of trauma-informed care and practice; and
- consider what models, approaches and interventions have been implemented and what is known about their effectiveness.

Defining trauma-informed care

Harris and Fallot noted that human service systems such as the mental health and alcohol and drug sectors often served survivors of trauma without "treating them for the consequences of that trauma", and, more significantly, "without even being aware of the trauma that occurred" (2001b, p. 3). In such a context, a system's usual operating procedures, practice standards and treatment response can inadvertently re-traumatise consumers of these services. As such, Harris and Fallot argued, a service system needed to be *trauma-informed*. This had two dimensions to it. First, it meant being aware of a consumer's history of past and current abuse. This was not the same as trauma-specific services or interventions, which are designed to treat the actual consequences of sexual or physical abuse trauma (such as grounding techniques, dialectical behaviour therapy, eye movement desensitization and reprocessing, exposure therapy, narrative or behavioural therapies).

The more crucial element, in their view, was about understanding the role violence and victimisation plays in the lives of consumers of mental health services and "to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that facilitates consumer participation in treatment" (Harris & Fallot, 2001b, p. 4).

Thus, from the outset, trauma-informed care was explicitly envisaged as a *systemic change* approach to be reflected at all levels of the service system and not simply as being aware of an individual's trauma history when working with them. This system, or organisational level, perspective is reflected in many of the current definitions of trauma-informed care. For example, the US Federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) describes trauma-informed in the following terms:

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

The key elements of trauma-informed care in the above definition – understanding the impacts of trauma and (re)organising service practices in light of that – are reflected in definitions used by most other human organisations.[10] Importantly in a trauma-informed system, a history of trauma is considered the *expectation* rather than the exception:

> the *possibility* of trauma in the lives of all clients/patients/consumers is a central organizing principle of trauma-informed care, practice and service-provision. This is irrespective of the service provided, and of whether experience of trauma is known to exist in individual instances. (Kezelman & Stavropoulos, 2012, p. 88, emphasis in original)

Thus, a trauma-informed system is one in which all components of a given service system have been considered, evaluated and organised in the light of a basic understanding of the role that violence plays in the lives of people seeking services and alongside an awareness of the dynamics of trauma and how these may present in consumer populations (MHCC, 2013).

Principles of trauma-informed care

The development of, and increasing desire for, trauma-informed care is seen by many as a paradigm shift in a) acknowledging the complex relationships between trauma, mental illness, substance abuse, and other complex needs, and b) developing ways of working organisationally and systemically that can attend to the interconnected nature of trauma with a range of other issues in women's lives. To guide this work, organisational principles have been developed.

Jennings (2004) initially developed seven principles. Services needed to emphasise:

1. safety from physical harm and re-traumatisation;
2. an understanding of clients and their symptoms in the context of their life experiences and history, cultures and their society;
3. open and genuine collaboration between provider and consumer at all phases of the service delivery;
4. an emphasis on skill building and acquisition rather than symptom management;
5. an understanding of symptoms as attempts to cope;
6. a view of trauma as a defining and organising experience that forms the core of an individual's identity rather than a single discrete event; and
7. a focus on what has happened to a person rather than what is wrong with a person. (Morrison, 2009, p. 7)

Following implementation, evaluation and inquiry with researchers and consumers as part of the WCDVS, Elliot and colleagues (2005) refined the initial seven principles, developing ten principles of trauma-informed care that services needed to demonstrate:

1. recognise the impact of violence and victimization on development and coping strategies;
2. identify recovery from trauma as a primary goal;
3. employ an empowerment model;
4. strive to maximize a woman's choices and control over her recovery;
5. are based in a relational collaboration;
6. create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance;
7. emphasise women's strengths, highlighting adaptations over symptoms and resilience over pathology;
8. aim to minimise the possibilities of re-traumatisation;
9. strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background; and
10. solicit consumer input and involve consumers in designing and evaluating services. (Elliot, Bjelajac, Fallot, Markoff & Reed, 2005, pp. 465-469)

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10   Australia (e.g. Kezelman & Stavropoulos, 2012; MHCC, 2013), Canada (British Columbia Centre of Excellence for Women's Health, 2013; CSAAP, 2012), New Zealand (Ministry of Health, 2007) and the UK (Power, 2014).

Since then, these principles have been rearticulated in slightly different ways (e.g. MHCC, 2012), but at base include the following:

- 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.

Thus, trauma-informed care is underpinned by the empirical evidence on the relationship between sexual victimisation and mental health, and a socio-cultural framework for understanding the factors that give rise to sexual victimisation such as gender inequality, power, colonisation and disenfranchisement (e.g. McLindon & Harms, 2011; Merritt, Tharp, & Furnham, 2014).

Design and implementation of trauma-informed care and practice at the systems level in mental health and human service settings

In a recent review of the trauma-informed literature and its application to the Australian mental health nursing context, Muskett (2014, p.1) noted that although trauma-informed care was emerging as fundamental to "effective and contemporary mental health nursing practice", mental health nurses were in fact struggling to translate these values into day-to-day practice and were confused about what individual actions they could take to support these values. This suggests that while there is growing awareness of the benefits of changing day-to-day mental health practice to become more trauma-informed, the focus remains on changing practice at the individual level at the expense of understanding how such change can be driven and supported at the organisational level. Academic, practice and guidance literature consistently point out that the provision and practice of trauma-informed care is a *systems-level* endeavour. This means that trauma-informed practice goes beyond providing skills and training to practitioners, or even implementing treatment interventions that integrate an awareness of trauma into the program, to evaluating and modifying all aspects of a system – workforce development, policies and protocols, funding structures, standard practices – in light of what is known about the effects of violence on women's mental health. As such, desired change is not limited to improved measures for consumers and patients or across particular types of practices, but necessarily includes changes to operational, organisational and structural features that shape the delivery of care.

This section reviews the research literature on the therapeutic, organisational and systems models of trauma-informed care that have been implemented and with what effects. This discussion makes the following distinctions:

- *Trauma-integrated interventions* refers to therapeutic and clinical interventions with consumers/survivors in which an awareness of violence and trauma impacts is integrated into the program, even though the intervention is not designed to treat the trauma symptoms itself (e.g. substance abuse).

- *Trauma-informed organisational and service models*, which aim to change operational, administrative, and cultural elements within an organisation, service or system such that a) those elements are themselves based on trauma-informed principles and b) therapeutic interventions and interactions are supported to be trauma-informed.

- *Trauma-specific interventions*, which are interventions expressly designed to ameliorate trauma symptoms. These are discussed where they have been implemented as part of a broader trauma-informed initiative.

It then considers the broader field of systems change in complex service environments to further develop our understanding of what a trauma-informed *systems model of care* involves and lessons learnt in implementing and evaluating such systems interventions.

Trauma-integrated interventions

Key findings from the WCDVS

The Women with Co-occurring Disorders and Violence Study arguably remains the largest study to implement and evaluate the effectiveness of trauma-informed care on addressing the needs of consumers/survivors. While the service models in the nine intervention sites were adapted to the needs of the particular client populations and were variously delivered in community-based or inpatient settings, all sites needed to demonstrate four common elements:

- comprehensiveness (this involved delivery of eight core service elements);
- integration at the clinical and organizational levels;[11]
- delivery of trauma-informed services; and
- consumer/survivor/recovering person involvement. (Huntington, Jahn Moses, & Veysey, 2005)

A cross-site methodology was developed to evaluate the effectiveness of the trauma-integrated interventions to see what differences, if any, integrated programs and service models had on levels of PTSD, substance abuse and mental health problems and on service use compared to standard care. A common interview tool was developed for use in all nine sites, and was administered at baseline and four follow-up points (3, 6, 9, and 12 months). The interview tool assessed multiple domains of personal history (including trauma history), behavioural health (namely alcohol and drug use, mental health status, PTSD), service utilisation and consumer satisfaction.[12] The original base line sample was 2729. The six-month sample size (i.e. women who completed interviews at baseline and at the six month mark) was 2006. Overall, the findings suggest that integrated, trauma-informed service provision does improve outcomes across the key domains compared to standard care sites. Published evaluation findings are discussed below.

Amaro, Dai and colleagues evaluated the effects of a trauma-integrated substance abuse treatment program delivered by the Boston Consortium of Services for Families in Recovery (Amaro et al., 2007). The trauma-informed model included:

- trauma and mental health diagnostic assessment, treatment planning, and case management;
- a 25-session modified version of the Trauma Recovery and Empowerment Model group; and
- four manualised trauma-informed skills-building groups developed by the Consortium that focused on leadership, economics, family reunification, and parenting skills. (Amaro et al., 2007, p.12)

The overall emphasis was on cognitive-behavioural and skill-building approaches, decreasing trauma symptomatology and negative coping such as drug use through the "use of active coping skills such as self-soothing, emotional modulation, and the development of safe, supportive and mutual interpersonal relationships" (Amaro et al. 2007, p. 510). The baseline sample was 181 in the intervention group and 161 in the treatment as usual group.[13] The intervention group were women receiving substance abuse treatment programs across: "three residential programs, one outpatient program, and one methadone program". Programs in the comparison sites provided "usual care, selected to represent similar programs, with similar length of treatment and similar populations" in nearby areas (2007, p. 512).

A key evaluation question was: "Compared to services as usual, does integrated trauma and substance abuse treatment result in better outcomes as measured by alcohol and drug use severity, mental health symptomatology, and PTSD symptoms?" (Amaro et al., 2007, p.509). In terms of alcohol addiction severity, there did not appear to be a difference in levels of abstinence between the intervention and comparison groups: both the intervention and control groups had a significant reduction in alcohol addiction severity over time. In relation to drug addiction severity, analysis found significantly higher drug abstinence rates among the intervention group compared to the care-as-usual group at both 6 and 12 months. Mental health symptomatology and PTSD severity showed statistically significant differences between the intervention and control groups, the intervention group scoring lower on both measures compared to the control group. Overall, the authors found

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11   Organisational integration was "defined as linkages across agencies for the purpose of ensuring that services were comprehensive, integrated, and trauma-informed". Clinical integration was defined as "the simultaneous and coordinated provision of substance abuse, mental health, and trauma services to women in the intervention condition" (Cocozza et al., 2005, p. 110)

12   Information about the instruments used to measure trauma history and severity of alcohol and substance abuse, mental health status and PTSD can be found in Nickerson et al. (2013).

13   Approximately one quarter of participants in both groups dropped out of the study.

support for the idea that addressing trauma and substance abuse in an integrated manner obtained "significant positive outcomes among [the] women" (Amaro et al. 2007 p. 518).

Gatz, Brown and colleagues (2007) evaluated the effects of integrating a trauma-specific program (Seeking Safety) into a treatment program for co-occurring mental health and substance abuse problems for the Los Angeles project site, which was PROTOTYPES (an integrated social services, mental health, health service). Services were delivered at large residential, outpatient, and small residential programs. The comparison treatment programs were delivered at a residential service, with the key difference being that consumers did not receive the Seeking Safety program. In the intervention group 187 women provided baseline data; 215 women in the comparison group did so. At the six month data collection point the sample sizes were 136 and 177 respectively. Statistical analysis of treatment outcomes showed that both groups of women (intervention and comparison) showed significant improvment on measures relating to alcohol and drug addiction, mental health status and PTSD severity. The intervention group, however, showed greater improvement on PTSD scores and greater use of coping skills (which decreased in the comparison group). Further analysis showed that coping skills mediated improvements in mental health status and PTSD severity. There was also a higher rate of program retention in the intervention group than in the comparison group. Based on the findings, the authors conclude that "women's learning [of] new coping skills is key to their recovery process" (Gatz et al., 2007, p. 876).

Meta-evaluations were also conducted across the nine sites (Cocozza et al., 2005; Morrissey et al., 2005). Cocozza and colleagues determined that, similar to the findings above women in both groups – intervention and comparison – reported improved outcomes across all four behavioural health measures at the six-month data collection point. However women in the intervention group reported better outcomes on drug addiction severity and PTSD severity (statistically significant). While just under being statistically significant, there were also greater improvements on mental health status. While the effect sizes between the better outcomes of the intervention group compared to the control were small they were still sufficient to suggest that comprehensive, integrated service provision generated the improvements (Cocozza et al., 2005).

However, there was significant diversity across the nine intervention sites in these outcomes. Morrissey and colleagues (2005) analysed the characteristics of all the participants to see if there were person-level characteristics that moderated outcomes across the sites. Their analysis suggested that women with more severe base line measures on behavioural health tended to report better outcomes at the six-month point. They cautioned against relying on this finding given the 12-month follow up data was not yet analysed and the relationship between greater severity on behavioural health scores and better outcomes may be "spurious" (Morrissey et al., 2005, p. 130). Further analysis by Cusack, Morrissey and Ellis confirmed this, finding that treatment effects were largest for women with the most severe substance abuse and PTSD presentation (Cusack, Morrissey, & Ellis, 2008).

McHugo and colleagues concluded that "site differences [were] at the heart of the diversity in the study group" (2005, p. 103) not only in that different services recruited different types of women but also in the extent to which the four common elements were achieved within each of the intervention sites. Thus, another dimension of analysis was to see if there were program-level factors (i.e. aspects of the way in which the program was implemented) that had a role to play in outcomes experienced. Researchers assessed whether:

- the intervention sites actually implemented the four key program elements;
- these program attributes were present at a greater level in the intervention condition than in the usual-care comparison condition; and
- these differences, if they did exist, had any impact on the outcomes experienced by study participants. (Cocozza et al., 2005, p. 112)

Eight "points of contrast" between sites were developed to see which of these were most salient in explaining the differences between the intervention and the control sites. The eight dimensions were:

1. Resource coordination and advocacy: services involving case management to advocate for the consumers and to identify and coordinate the various needed resources.
2. Parenting: services involving parenting skills training.
3. Woman-Focused: services involving strengths-based assessments and focus on empowering women and addressing needs specific to women's issues.
4. CSR Involvement: services involving CSRs in treatment (as peer-supports or facilitators of peer-run groups), as consumer advocates, and/or as advisors in the development or coordination of services.
5. Trauma-Informed: services involving trauma-specific group therapy where providers understand the

influence of violence and abuse in women's lives.

6. Integrated Treatment: Various services involving concurrent treatment for mental health problems, substance abuse, and post-traumatic stress symptoms;

7. Integrated Counselling: Integration of the three treatment foci—mental health, substance abuse and trauma— within individual and group counselling; and

8. Core Services Received: Number of six core services received. (in Cocozza, et al. 2005, p. 113)

Two of these eight elements demonstrated a pattern of significance across the four outcomes. First, integrated counselling, which measured how many of the three key treatment foci—mental health, post-traumatic symptoms and substance abuse—women reported receiving, was a key contributor to improved clinical outcomes. In contrast, element 8 – core services received (i.e. number of services) – made no contribution on its own to improved outcomes (Cocozza et al., 2005). The effects of the other elements varied across the sites. Thus the researchers reflected:

> Why is integrated counselling so important? Our earlier review of research findings suggests that this may be an example of an effective "bottom up" strategy for integrating services that focus on the client level. (p. 118)

The notion of integrated counselling as the "essential ingredient" in clinical level outcomes is supported in a more recent study examining the efficacy of integrated cognitive behaviour therapy (CBT) focusing on PTSD and substance abuse (McGovern, Lambert-Harris, Alterman, Xie, & Meier, 2011). In a randomised control trial, this was compared to individual addiction counselling. Fifty-three participants were randomly assigned to either treatment condition. As with the previous studies, both groups reported improved outcomes but the integrated cognitive behaviour therapy resulted in greater gains across PTSD symptom severity, particularly re-experiencing symptoms. However, the researchers noted that this study was "statistically under-powered and may have lacked sufficient sample size to detect actual differences between the groups" (McGovern et al. 2011, p. 223). Nevertheless, they conclude that there was justification for carrying out a larger scale study on integrated CBT.

However while integrated counselling provides the most proximal relationship to improved clinical outcomes there needs to be an organisational or system-level infrastructure to support this work. As noted in the previous section, the original initiatives implemented through the WCDV

Study were required to develop strategies at both the individual/therapeutic level and at the programs/systems level. Researchers, clinicians and consumers worked to develop several organisational and systems models to achieve this. Since then, considerable activity has occurred in the North American context to distil the key elements of what is required at the program and systems levels to achieve whole-of-organisation trauma-informed care (British Columbia Centre of Excellence for Women's Health, 2013; Jennings, 2004; SAMHSA, 2014) and to translate these learnings into toolkits, guides, curricula and resources for diverse settings including child and youth welfare services, behavioural health, mental health, homelessness services, correctional and criminal justice settings.

Organisational and systems models of trauma-informed care

Publications generated by the WCDVS (Heckman, Hutchins, Thom, & Russell, 2004; Markoff, Finkelstein, Kammere, Kreiner, & Prost, 2005), Jennings (2008), and recent literature reviews (Muskett, 2014; van Veen & Lafreniere, 2012) describe a variety of organisational and systems models of trauma-informed care. Together, this literature yielded eight organisational and systems level models that have been designed and implemented in a range of mental health and human service systems. Unlike the trauma-integrated interventions discussed above, there is limited evaluation material publically available about their effectiveness at the organisational or system level. What does exist tends to evaluate effects for the individual consumer/survivor, or at best, uses proxy indicators such as reduction in seclusion and restraint practices/incidents to suggest changes in organisational practice (e.g. Rivard, 2004; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003). Additionally, a small body of research is available that describes the "lessons learnt" in implementing organisational and systems models of trauma-informed care. Thus only four of these models are discussed below, those which undertook some qualitative evaluation to identify key learnings about change at the organisational and systems level.

This lack of research may reflect the challenges of evaluating whole-of-organisation or systems changes more generally in that there is a disconnect between the aims and practices of systems change and standard evaluation methodologies, which largely measure individual level changes (Emshoff et al., 2007; Foster-Fishman & Behrens, 2007; Foster-Fishman, Nowell, & Yang, 2007).

Lessons learnt in the implementation of organisational and systems models of trauma-informed care

Allies

"Allies" was one of the nine sites participating in the WCDVS. Its purpose was to develop, implement, and evaluate "comprehensive, integrated, trauma-informed and trauma-specific services for women with alcohol or other drug use and mental disorders and physical and/or sexual abuse histories". Its primary goals were to reduce women's alcohol and drug abuse, mental health and trauma-related symptoms, and to increase parenting abilities" (Heckman et al., 2004, p. 162).

At the system level it aimed to integrate trauma-informed practice across mental health and alcohol and other drug programs, and focused on including trauma/violence services

in broader mental health and other social services networks. The goal was to increase provider awareness of the needs and benefits of effectively collaborating across disciplines for the well-being of their mutual clients. Providers needed to: expand their treatment philosophies; work with clients in new ways; increase their collaboration; and maximise available resources. Community-wide strategies for accomplishing this included: 1) presentations, newsletters, pamphlets and posters on the importance of integrated, trauma-informed and trauma-specific services for the target population; and 2) training events. The activities included the involvement of consumers/survivors, for example in outreach activities and in the development of guidelines for volunteer position descriptions (Heckman et al., 2004).

A key observation from this study site was that "significantly altering service delivery philosophies and approaches across large numbers of providers require[d] time", and that the two years to accomplish awareness, buy-in and changed practices may not have been sufficient (Heckman et al. 2004, p. 175). For this to be effective, involvement of all key stakeholders, including consumers/survivors, was essential.

Involvement and collaboration across providers and between providers and consumers needed to be meaningfully supported with the training and leadership. This extended to training non-consumer staff in approaches for supporting consumer colleagues. In light of staff turn-over, training needed to be ongoing.

Anticipation of the target population's barriers to service engagement was also necessary. This referred to practical issues such as transportation and childcare responsibilities, as well as therapeutic issues such as where on the "recovery journey" a client was. Proactive reminders and engaging women shortly after expressing interest were essential. Heckman and colleagues also observed the influence of resource constraints on large-scale change efforts. This meant being realistic about what goals could be achieved within the organisational setting as well as acknowledging how resource constraints in other service systems (e.g. public housing) impacted on the needs and priorities of client populations. Other challenges experienced by the Allies' site such as resistance to change and unexpected barriers, despite planning processes, were also noted.

Risking Connection

Risking Connection was designed as a training curriculum for professionals working with survivors of child abuse in mental health, substance abuse, and domestic violence services, child

welfare services and correctional settings. Five core modules examine:

- the concepts of trauma;
- collaborative and co-operative treatment goal setting with consumers;
- maintaining a trauma framework when responding to crises and life-threatening behaviours;
- working with dissociation; and
- vicarious trauma. (Brown, Baker, & Wilcox, 2012; Giller, Vermilyea, & Steele, 2006; Saakvitne, Gamble, Pearlman, & Lev, 2000; Saakvitne & Gamble, 2002)

The curriculum is informed by relational therapy work in which the treater and the consumer build co-operative therapeutic alliances, self-awareness and self-care skills (Giller et al., 2006). A recent study examined the impact of the curriculum-based Risking Connection trauma training on the knowledge, beliefs, and behaviours of 261 staff trainees in 12 trainee groups at five child congregate care agencies. Results showed an increase in knowledge about the core concepts of the training consistently across groups, an increase in beliefs favourable to trauma-informed care over time, and an increase in self-reported staff behaviour favourable to trauma-informed care. Train-the-trainer was an effective model for the dissemination of the program.

Women Embracing Life and Living (WELL)

The Women Embracing Life and Living (WELL) Project (Finkelstein & Markoff, 2005) was implemented in Massachusetts, where mental health and alcohol and other drugs (AOD) services were largely directly funded by the state (rather than through counties). Funding streams for mental health, AOD and violence services were separate, which resulted in treatment being provided in a parallel, non-integrated fashion. The WELL project was expected to eventually impact the whole service system and therefore had a statewide focus. They did this by fostering integration at the agency, community and state-level by developing or enhancing linkages among state agencies and among provider organisations, and educating providers to integrate an understanding of trauma into their services. The project focused on including trauma/violence services in broader mental health and other social services networks. The key strategy was to focus on relationships and collaborative practices with consumers, providers, policymakers, advocacy organisations and clinicians to determine in the first instance the best strategies and mechanisms as the vehicle for change.

A cross-training curriculum was developed for all stakeholders, a process that highlighted the diverse perspectives different agencies brought to understanding the role of trauma in women's lives, and what their role was in engaging with it. The strategy thus became to engage in a values clarification exercise conducted by an outside facilitator to arrive at a consensus statement of principles, which was then used to inform service delivery. The next step was to determine what *core* knowledge all agencies needed to know about the issues so that there was a basic, shared knowledge base. This was done through focus groups with providers and consumers, and resulted in the development of a series of training modules. Topics covered included domestic violence, trauma, impact of violence on children, PTSD and alcohol and other drugs, diversity, the trajectory of recovery from multiple issues, gender-specific treatment and consumer integration.

To develop integration at the agency level, the role of an Integrated Care Facilitator was initiated. This role worked within an agency and across agencies, attending meetings, participating in case conferences, and hosting training to embed an integrated view into day-to-day practice, and was the central contact for women for service coordination and advocacy. While staff across different agencies were more knowledgeable about the impacts of trauma, they did not feel able to implement what they had learned. This led to the development of more structured supervision and capacity building by the WELL project staff where implementation issues could be workshopped more explicitly.

To develop integration at the community/sectors level, the Integrated Care Facilitator convened a local leadership council. This had a broad membership of consumers and providers across violence services, mental health and AOD services. The purpose of this structure was to foster dialogue and relationship building among the members where differences, specialisations and shared values could be constructively discussed. From here, members would participate in the cross-curriculum training.

State-level integration built on these structures. A high-level State Leadership Council was instigated with representation from the core state departments that serve women with co-occurring disorders and trauma histories. Similarly, this group engaged in a values discussion before undertaking training. This group produced the *Principles for the Trauma-Informed Care of Women with Co-Occurring Mental Health and Substance Abuse Disorders* for a range of service providers to sign on to.

Consumers were involved in all three of these structures. As with the Allies' experience, training and support was required for both consumers and providers to ensure mutual understanding of the values and priorities they each brought. A final component was the availability of Seeking Safety through group counselling. Finkelstein and Markoff (2005) saw this as crucial in that it provided women with skills and coping mechanisms to manage trauma symptoms affecting their ability to self-regulate and deal with triggering experiences.

In examining the extent to which trauma/violence service providers became more central in each mental health and substance abuse client referral provider network, researchers found a shift toward greater centrality of the trauma/violence service providers in the client referral networks at each of the three sites that were involved in WELL. This resulted in greater referral from mental and substance abuse services to trauma/violence services as well as greater referral from the trauma/violence services back to mental health and substance abuse services (Finkelstein & Markoff, 2005).

Overall lessons from WCDVS about implementing the trauma-informed care

Drawing on several overview articles, the following section summarises the key lessons learnt in the WCDVS and in particular in implementing interventions that demonstrated, organisationally:

- comprehensiveness (this involved delivery of eight core service elements);
- integration at the clinical and organizational levels;
- delivery of trauma-informed services; and
- CSR involvement. (Huntington et al., 2005)

Comprehensiveness of services

Service sites found that alongside the comprehensive services they delivered, they also needed to develop:

- trauma-specific services (i.e. services designed to address the specific consequences of exposure to traumatic events);
- peer-run services, and
- resource coordination and advocacy approaches (e.g. wrap around, case management and care co-ordination. (Huntington et al., 2005, p.405)

In relation to trauma-specific services, each site provided a "psychoeducational group integrating education and treatment for mental health, substance abuse, and trauma-related issues". Four models were used across the sites (Seeking Safety; TREM;

ATRIUM; Triad). Service providers were initially resistant to the specific attention on women's trauma issues, which the researchers saw as stemming from:

- a lack of knowledge about trauma;
- a fear of opening a "Pandora's box" and being confronted with trauma issues that were difficult to address; and
- the belief that trauma could not be addressed until other issues e.g. substance use were first dealt with. (Huntington et al., 2005, p. 406)

In order to shift this resistance, the following strategies were useful:

- training on the basic concepts of trauma;
- having staff with "experience in trauma co-lead psychoeducational groups with less experienced staff from other agencies";
- setting up case-conferences in which trauma issues were discussed; and
- providing strong support and supervision. (Huntington et al., 2005, p. 406)

Another learning was the need for "strong ongoing community-based support for women once they left the psychoeducational trauma groups". This led to the provision of peer led support groups.

Service integration

Service integration was defined as the process by which "two or more agencies, service providers or community groups establish linkages to share information, resources, funding and policy development" (Huntington et al., 2005, p. 402). Strategies to enhance integration at the organisational level were widely adopted, with services finding them to be effective. The key strategies used were:

1. the establishment of coordinating bodies of interested organisations to participate in the project;
2. formalisation of arrangements with participating organisations into written memoranda of understanding, which outlined agency roles and responsibilities; and
3. cross-training of mental health and substance abuse providers and training on trauma provided to both groups. (Huntington et al., 2005)

Regardless of the size of the organisations and whether the integration was across services or within a large system, "all the sites reported that integrative work took significant time, effort, and perseverance" as it involved bringing people together who

had "limited understanding of other's work and sometimes worked within conflicting models or philosophies" (Huntington et al., 2005, p. 402). Finding ways to build shared understandings and collegiality included having values clarification exercises, team building exercises, and outside facilitators for key meetings. Taking time to develop a "common language and philosophy" was seen as particularly important (Huntington et al., 2005). In addition, the role of consumers was essential both to the work of coordinating bodies and in fostering the participation and continued involvement of other stakeholders. The final lesson related to the extent of integration, with a key insight being the value of casting a "wide net" when partnering with other organisations. For example, with the range of support needs women with co-occurring disorders sites had, to broaden their partners beyond the mental health sector, it was necessary to involve "child protective services, criminal justice authorities and medical facilities" (Huntington et al. 2005, p. 402).

Trauma-informed service provision

Although some specialists were integrating trauma-informed care into their work at the time of the WCDVS, neither the mental health nor substance treatment field had a "meaningful history of incorporating knowledge about trauma into its standard practices" (Markoff, Fallot, Reed, Elliott, & Bjelajac, 2005, p. 528). Integrating trauma awareness into mental health and substance abuse treatment programs was the major message arising from the WCDVS:

> Because trauma is so pervasive among women in both kinds of settings and because trauma is such an important experience linked to both mental health and AOD difficulties, our major message is that services for mental health, AOD, and trauma need to be *integrated*, not provided separately. Each affects the others, and they must be addressed together…Although the mix and sequence may need to differ substantially across individuals, depending on the severity of problems in each area. This includes providing, or at least providing access to, trauma-specific services. (Markoff et al., 2005b, p. 528)

Following on from this, a key lesson was understanding the complex relationship between substance abuse, mental illness and trauma, in which mental health problems and substance use issues can be adaptations to traumatic environments. In practice this meant:

- Creating emotionally and physically safe environments in which trauma is asked about and acknowledged; organisational practices are predictable, transparent and discussed with consumers.

- Using a collaborative, strengths-based approach in which service relationships need to be built on "principles of clear boundaries and shared power in regard to the goals, structure, and process of services" (Markoff et al., 2005b, p.530)
- Confidentiality being a "particularly important arena for expanding the sense of collaboration and consumer choice". This involved clarifying procedures with clients for gathering, keeping, and sharing information to "allay concerns consumers may have had about the ways "secrets" are handled, especially by people with authority and power". (Markoff et al., 2005b, p.531)
- Outreach needed to be the responsibility of the trauma-informed staff. Practitioners need to create as "many bridges to service involvement for the CSR as possible". CSR peers may be especially helpful in this early phase of outreach. (Markoff et al., 2005b, p.532)
- Screening and assessment needed to be common practice, with recognition women may fear the consequences of revealing substance abuse or symptoms, of "involuntary treatment, of loss of custody of children, or of being labelled in a way that will be harmful to them". (Markoff et al., 2005b, p.532)
- In contexts of crisis intervention, involuntary and coercive interventions needed to be avoided. Crisis planning in advance in a collaborative way with consumers/survivors was seen as particularly helpful.
- CSRs can be effective in a variety of roles: as co-facilitators of "groups, as researchers, as outreach workers, and as resource specialists, helping other women to access services".
- Linkages and referrals needed to be balanced against the need to not become "case managing experts"; and
- Ongoing cross-sector training. (Markoff et al. 2005b; see also Elliot et al., 2005)

Collaborating with Consumer/Survivor/Recovering Women

The Substance Abuse and Mental Health Services Administration emphasised integrating consumers into the WCDVS, requiring their inclusion in "all levels of problem definition, program planning, implementation, and evaluation" (Huntington et al., 2005, p. 403). Huntington and colleagues identified six strategies to integrate CSR women, which were a mixture of support (e.g. material support such as stipends, transportation, and child care to facilitate involvement), capacity building (e.g. training to CSR women on topics such as trauma,

research, and leadership skills), and creating opportunities for meaningful participation in the project (e.g. ensuring CSR women's representation on project coordinating bodies and governing committees, convening CSR advisory boards, and hiring CSR women as staff members in full or part-time positions).

The use of these strategies changed over the course of the WCDVS timeframe. The early stages saw greater use of volunteer-based strategies. Integration of CSR women's input was "more challenging in the second phase, where the focus of the sites' work shifted from design towards day-to-day operation" of the interventions where there were fewer opportunities for their involvement. Sites reported "encountering resistance to consumer integration from other project stakeholders" such as counsellors, agency heads, and policy makers (Huntington et al., 2005, p. 403). As such training and support were essential for supporting integration of CSR contributions over the longer term. Other strategies included:

- balancing consumer representation by having more than one consumer serve on a committee;
- creating non-confronting spaces for dialogue such as making time for consumers to ask questions before and after meetings;
- capacity building by having consumer pre-training sessions; and
- minimising division such as encouraging professionals to eliminate their use of jargon.

Strategies for trauma-informed systems change

As noted by others, trauma-informed organisational and systems change is not nearly as developed in Australia, the UK or Canada compared to the United States (Muskett, 2014; van Veen & Lafreniere, 2012). While there may be growing desire for and provision of training for trauma-informed care and practice among mental health professionals and other human service practitioners a national or coordinated approach to reform, practice and policy development such as that driven through the SAMHSA mechanisms is absent. In recognition of this, a National Trauma Informed Care and Practice Advisory Working Group, convened by the Mental Health Co-ordinating Council released a position paper and recommendations for a national strategic direction (MHCC, 2013) and the national specialist organisation for adult survivors of child abuse developed practice guidelines for the treatment of complex trauma and guidelines for trauma-informed service agencies (Kezelman & Stavropoulos 2012).

The National Strategic Direction paper argued that substantial progress had been made in developing a research and practice base for undertaking trauma-informed care and practice and in translating that research into practice guidelines. A key area of future focus was on *implementation of trauma-informed practice at a scale enough to create measurable cultural change* (MHCC, 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 elements need to be in place to support this (Jennings 2008; MHCC 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 CSR involvement in trauma-informed practice implementation.

Adults Surviving Child Abuse developed and released *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery,* in 2012. The guidelines on trauma-informed care are based on the key principles adapted from the work of Fallot and Harris (2002). These are: "safety", "trustworthiness", "choice", "collaboration" and "empowerment". 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.

Summary

Despite the research generated by the WCDVS study, the development of models, toolkits and service guides for trauma-informed care, and the articulation of organisational, administrative and policy strategies to embed trauma-informed care into human service settings, 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.

Lessons learnt from systems-change initiatives for complex service settings

Systems change and systems models of care have emerged as key areas of service, policy and research interest in recognition of the fragmented, siloed and uncoordinated systems of care individuals experience when accessing services to manage mental health, substance use, income support, housing, and legal services (Foster-Fishman et al., 2007). *Systems change* refers to an intentional process designed to alter the current state of affairs and "realign the form and function of a targeted system" to achieve the desired change (Foster-Fishman et al., 2007, p. 197). *Systems models of care* refers to the concrete translation of key principles into a practice using overarching design for the provision of a particular type of care service that is informed by a theoretical basis, evidence-based practice and defined standards (Cook & Kilmer, 2012).

Such initiatives are based on the assumption that significant improvements in the outcomes of a targeted population will not occur "unless the surrounding system (e.g. service delivery system) adjusts to accommodate the desired goals" (Foster-Fishman et al., 2007, p. 197). This involves adjusting the underlying structures and supporting mechanisms that operate within a system, such as the policies, routines, relationships, resources, power structures, and values (Allen, Foster-Fishman & Salem, 2002).

This section will focus on research and evaluation that has considered what is meant by "systems level" change and/or models of care and lessons learnt from their implementation, much of which comes from the community psychology field.

Understanding systems change in complex environments

Despite the popularity of systems-level initiatives, the research tends to demonstrate only modest changes compared to expectations (Foster-Fishman et al., 2007). Evaluators of systems change in human service environments argue that many systems change efforts have not in fact attended to the dynamics and characteristics of the systems they are trying to change:

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

In addition, research and evaluation methodologies have not been appropriately matched to demonstrating system level outcomes or theorising the connections between interventions and outcomes (Foster-Fishman & Behrens, 2007).

The dynamics of systems

Broadly defined, a system is comprised of both its parts and the relationships between them (Brannan, Brashears, Gyamfi, & Manteuffel, 2012; Foster-Fishman & Behrens, 2007; Foster-Fishman et al., 2007; Parsons, 2007). Together, the parts and their inter-relationships form the whole. A system can thus be used to refer to a variety of social and organisational contexts such as neighbourhoods, organisations or a service delivery network (Foster-Fishman et al., 2007). A key area of interest is on understanding the nature, properties and dynamics of the inter-relationships and inter-dependencies between the parts (Parsons, 2007), which can include individual actors, roles or positions, activities, resources and settings. While the complexity between these components is acknowledged "the mental models that guide most systems change frameworks continue to view the relationship between a systems change intervention and outcome as predictable, unidirectional, and sequential" (Foster-Fishman et al., 2007, p. 199). Researchers and evaluators seeking to understand effective systems change efforts argue that designers, funders, implementers and evaluators need to more explicitly acknowledge the properties of complex systems in order to better conceptualise and effect change (Emshoff et al., 2007; Foster-Fishman et al., 2007; Hirsch, Levine, & Miller, 2007; Peirson, Boydell, Ferguson, & Ferris, 2011).

The fields of systems thinking (e.g. dynamic systems, complex adaptive systems) and organisational change provide concepts that are used to do this, with key areas of consideration being:

- The relationships between parts of the system and implications for the whole. This includes considering whether the relationships are networked, hierarchical or "nested" as this effects how the different parts interact, and what the points of influence are (Parsons, 2007).
- Apparent structures (organisational hierarchy, guidelines, protocols) and tacit ones (norms, values, beliefs, attitudes, worldviews). While change can be implemented through apparent structures, the tacit or deeper structures can undermine or alter the stated aims of an initiative (Parsons, 2007).
- The degree of uncertainty or complexity within a system. Complex systems such as mental health settings involve multiple actors, different sub-groups or units, interactions with the broader mental health system and policies with other social services. This means that the relationship between cause and effect – intervention and outcome – is unpredictable (Parsons, 2007). It also implies that systems change is as much about process as it is about achieving an end state (Foster-Fishman et al., 2007).
- The "subjective" or partial perspectives of stakeholders involved in systems change initiatives: individuals are likely to hold different worldviews about the change depending on their position, role and experience (Foster-Fishman et al., 2007).
- The nature of change – whether it is focused on improving how things are done or to change how problems or issues are viewed (e.g. the relationship between violence, trauma and mental health and other disorders (Foster-Fishman et al., 2007).

Implications for implementing systems change

Research on systems change in areas such as child and youth mental health, disability, obesity and violence prevention suggests a number of key steps in implementing systems change efforts. The most important of these relates to definition and scope of the system (Behrens & Foster-Fishman, 2007). This involves:

1. **Defining problem and scope.** Identifying the problem (e.g. fragmented referral pathways between violence/trauma services and mental health

services) and identifying who or what is relevant to targeting the problem (Foster-Fishman et al., 2007). In the problem identification, it is important to consider the various causes for the issue, which may vary depending on the perspective of stakeholders. Who is included in the system boundaries can provide points of challenge (e.g. including marginalised actors) and leverage (including high-level leaders) (Foster-Fishman et al., 2007). A second step is to identify what elements of the system are the targets of change – regulatory processes and policies, business operations and decision-making, resources and norms – as well as the interconnections between them, as a change in one element may not translate to an overall systems change (Foster-Fishman et al., 2007).[14] It is also necessary to clarify the purpose of the initiative, which should be informed by how the problem has been articulated (Behrens & Foster-Fishman, 2007). This process enables the identification of appropriate tools to achieve the purpose. For example, if the purpose is to increase cross-sector referrals then collaborative interventions and cross-sector engagement activities may be a relevant strategy.

2. **Understanding the system components and their relationships**. This includes identifying whether the change initiative is targeted at an existing, well-defined system or instead aims to create a new system out of disparate parts (Behrens & Foster-Fishman, 2007). It also involves a mapping of the interactions between different parts of the system in terms of whether they reinforce, contradict, or dampen activity in another area.

3. **Locating strategic levers for facilitating systems change.** The above two steps enable change agents and researchers to identify system parts and system interactions that can serve as these strategic leverage points (Foster-Fishman et al., 2007). This could mean:

   - changing elements of the system to make them consistent with the change goals;
   - strengthening elements that are already consistent with the change goal;
   - locating elements of the system that have extensive or dense ties to other parts of the system; or

- defining concrete, feasible "starting points" that produce visible, measurable effects to maintain momentum (Minkoff & Cline, 2004).

4. **Identifying how change at the systems or organisational level will be measured.** There are two dimensions to this. The first relates to the identification of appropriate measures or indicators that may point to the effectiveness of the intervention. One framework that has been used to understand how individual and social processes facilitate the embedding of innovations in day-to-day practice is Normalisation Processing Theory (NPT), which posits that practices become embedded, or normalised, because people individually and in groups, perform them, and their performances are either supported or challenged by mechanisms requiring continuous investment (May et al., 2009). NPT provides a framework for both developing and evaluating interventions, and has been used in Australian research looking at domestic violence screening within a health context (Spangaro, Poulos, & Zwi, 2011). Normalising Processing Theory focuses on:

   - coherence (how do staff interpret, accept and value their role in the systems model of care?);
   - cognitive participation (how do staff engage with the work: who introduces, leads, maintains the agenda?);
   - collective action (e.g. staff engagement and team organisation; accountability, trust in the intervention and relationships; staff perception of skills, resources and rewards to undertake the work; organizational support for the intervention); and
   - reflexive monitoring (how will staff know how effective or well their work is going?).

Depending on the purpose of the intervention (and associated activities) other dimensions of measurement may include the strength of administrative leadership; density of collaborative networks or cross-referral patterns; change in patterns over time. A second dimension of evaluating effectiveness is that outcomes achieved will be influenced in large part by the system itself (not just the intervention). This presents challenges for evaluations focusing on measureable outcomes, as the tools used for this often assume that systems are fairly stable and mechanistic, and can produce predictable results (Parsons, 2007).

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14   In this article Foster-Fishman et al. (2007) provide a series of questions implementers should ask around each of these four dimensions. They also function as a useful tool for evaluators. See page 206.

In the Australian context there is arguably an underdeveloped theorisation of systems change in complex human service environments relative to work generated in the US and European contexts. This is despite many initiatives that aim to achieve precisely this, as evidenced by the investment in integrated, co-ordinated and wrap-around models of care in numerous settings (sexual assault crisis responses, mental health and alcohol and other drug sectors, child protection and family violence services). As noted in a recent comparative study of trauma-informed care in inpatient mental health settings, "the implementation of trauma-informed care requires a philosophical shift on how mental health services are delivered" (Price, Davidson, Ruggiero, Acierno, & Resnick, 2014, p. 28) systems wide. Yet this change process faces several challenges. The first is that while there is a degree of consistency about trauma-informed care, there is variation in how underlying principles are defined, which can create issues in trying to translate them into objectives and organisational practice. There is a lack of knowledge about translating trauma-informed care into acute and inpatient settings: how does one do trauma-informed care in a crisis context where restraint is required, for example? There is also limited knowledge on "facilitating organisational change in a complex public health system with vested professional interest groups" (Ashmore, 2013, p. 28). Finally, funding is often siloed, making integrated service provision a challenge. Learnings and concepts from systems change in other complex human service systems could be useful for the next phases of trauma-informed care in Australia.

Conclusion

Based on empirical, clinical and theoretical scholarship about the relationship between violence, trauma and mental health problems, trauma-informed systems of care has emerged as a key area of interest for those working in mental health and other human and social service sectors. While this is significantly well developed in the US context, Australia and other similar countries have not yet moved to a whole-of-system approach to implementing trauma-informed care and practice.

Both the academic and the grey literature demonstrate consistent themes about the principles of trauma-informed care, however there is little evaluative evidence to inform organisational and systemic change. In part this is because evaluating change at these collective levels is challenging, and many standard methodologies are not well suited to the task. It is also related to what conclusions can be drawn about effective systems-level change when systems often have their own contexts, ways of working, points of articulation and points of leverage. This means that on their own, measurable outcomes may not be very meaningful in assessing "what works", and consideration of the models and processes informing implementation and research is equally relevant.

To address these issues, it is recommended that future research examine the following questions:

- How can we ensure that trauma-informed care is meeting the needs of women who have experienced both mental health issues and sexual violence?;
- How can we better integrate mental health and sexual violence service paradigms and approaches to trauma-informed care?;
- How can we enact trauma-informed care in practice when dealing with women who have experienced both mental health issues and sexual violence? and;
- How can we successfully implement trauma-informed care at an organisational level within complex health systems?

Cognate areas of implementing and evaluating human service systems change in the areas of child and youth welfare, disability and models of care for families and children have developed a strong thread of investigation and associated methodologies about how change can be effected at the whole of system level.

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