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Quick Guide for Busy Clinicians

Integrated Trauma-Informed Care Framework:

My story, my health, my future

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Integrated Trauma-Informed Care Framework: *My story, my health, my future.*

What is trauma?

Trauma is the response to an event, series of events or set of circumstances that is experienced as physically or emotionally harmful or life-threatening, and which overwhelms an individual. It can be experienced at an individual or collective level and may be in response to a single incident or be more complex, arising from sustained, cumulative or unresolved events. Trauma can also be intergenerational, where trauma flows through generations.

Adaptive responses to trauma may impact a person's access to, and engagement with, services and may impact on overall physical and psychological health throughout their lives

People heal from trauma in different ways and this healing takes time – for some people it may be a lifelong process. **Addressing trauma in health care is an important part of supporting people** to be able to live the life they want to live. Delivering integrated trauma-informed care is one way that health systems, services and staff can support healing.

> Adverse childhood experiences (ACE) are potentially traumatic events that occur in childhood. ACEs include 'aspects of the child's environment that can undermine their sense of safety, stability, and bonding'.[1]

> "[Trauma is] pain that never goes away, not just on my skin."
>
> **– Young adult with an intellectual disability**

What is integrated trauma-informed care?

Integrated trauma-informed care brings together elements of trauma-informed care and integrated care to improve the experiences of clients and staff.

Trauma-informed care is a **systems-level** initiative where organisations are oriented towards **understanding, recognising and responding** to trauma. It considers people's symptoms, responses and behaviours in the context of their past experiences, and emphasises physical, emotional and psychological safety for clients and staff. A trauma-informed system uses trauma-informed care as a **'universal precaution'**, presuming that every person — clients and staff — may have experienced trauma.

'Integrated care' is the provision of **seamless, effective and efficient** care that responds to all of a person's health needs, across physical and mental health **in partnership** with the individual, their carers and family'. It places people at the centre of care, providing comprehensive wrap-around support for those with complex needs and enabling people to access care when and where they need it. For more information on integrated care see the NSW Health Strategic Framework for Integrating Care.

All trauma-informed care must be integrated, but integrated care is not necessarily trauma-informed. By highlighting integrated care as an explicit component of trauma-informed care, this framework seeks to emphasise the need for integrated ways of working in the provision of trauma-informed care.

Four assumptions underpin trauma-informed care. These can be referred to as the four Rs and apply to all areas of an organisation.

- **Realise** the impact trauma can have on families, carers, organisations, communities and individuals, and understand that all clients and staff may have their own experiences of trauma.
- **Recognise** the signs of trauma, that relationships can be the basis for healing, and that the service-delivery setting plays a role in facilitating the foundation for trauma-informed care.
- **Respond** appropriately and effectively by applying the principles of trauma-informed care.
- Seek to prevent **Re-traumatisation** of clients as well as staff.

You are not alone, ITIC is a systems approach! For more information on the ITIC Framework and how the system is supporting your work click the link.* **Click here**

Integrated trauma-informed care principles	
Culture, gender, history and identity	Services are responsive to a client's culture, gender, religious background, sexual orientation and ability, and recognise and address historical trauma, genocide and institutional racism. Services also leverage the healing value of traditional cultural connections. It is understood that each individual and family is unique. Care and treatment should address unique needs and preferences. However, it is also recognised that some population groups may be at increased risk of experiencing trauma, and trauma experienced within particular groups may be contextually different or manifest differently.
Safety	Service providers and clinicians work with clients to ensure they feel physically, culturally, religiously, socially and psychologically safe.
Trustworthiness	Service providers and clinicians are transparent, and seek to build and maintain trust among clients, staff and other services. Being trustworthy involves being reliable, accountable, respecting boundaries, and not sharing information that is not yours to share. It takes time and effort to build trust particularly where trust has been broken.
Collaboration	Staff recognise the importance of healing through relationships where power and decision making are shared. Collaboration occurs directly in client interactions and more broadly in service management.
Empowerment	The strengths and agency of children and young people, and their families, carers and significant others are recognised, built upon, and validated both in direct service provision and organisational management. Client voices and opinions are included in the development of resources, policies and procedures. Clients and staff are supported to develop new skills as required — for example youth leadership training and training for staff in child and youth participation.
Choice	Service providers and clinicians aim to strengthen the experience of choice for children and young people, and their families, carers and significant others.
Integration	Care is seamless, effective and efficient, responding to all of a person's health needs in partnership with the individual, their carers and family. It is person-centred, primary care based, continually improved and requires collective accountability and sharing of information.

"When I was worried and crying, it was because I wasn't sure what was going on. Someone told me something was going to happen, and then something else happened instead. Plans changed and I wasn't told anything about it, or they didn't explain why. I started to think they might have even lied to me.

I would like the person who is telling me to be straightforward. Don't sugar coat it, just tell me what is going to happen."

— Male, aged 13

*www.health.nsw.gov.au/patients/trauma/Pages/default.aspx

Tips from children and young people, and their families, carers and support workers

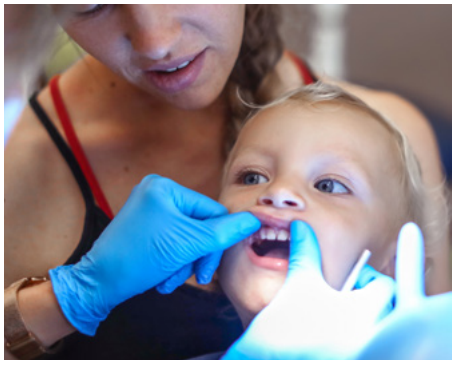
During community consultations, children and young people with experiences of trauma and their carers made the following recommendations for health staff:

- ***Make us feel welcome.***
- ***Don't make us tell our story over and over.***
- ***Speak honestly to us.***
- ***Minimise wait times.***
  Waiting may remind people of experiences of where the perpetrator took control away from them.
- ***Involve families and carers in planning (where appropriate).***
- ***Help us access other services.***
- ***Treat us as a partner.***
- ***Keep our GPs in the loop.***
- ***Know how the Out-of-Home Care system works.***
  Visit www.facs.nsw.gov.au/families to find out more.
- ***If you aren't sure if a child or young person is in OOHC, ask them about their living arrangements.***
- ***Own your own emotions and look after yourself.***
- ***Explain what's happening and why.***
- ***If appointments are running late, let the child or young person and their carer know.***
- ***Understand that children are experts at survival.***
  They may react unexpectedly or not share information when they are stressed. That is part of their survival skill set.
- ***Children feel safer with someone they know and trust.***
- ***Children and carers who are stressed may not remember details about healthcare afterwards.***
- ***Children may not feel safe in hospitals or health services.***

More detail can be found in *Tips for health staff from children and young people, and their families, carers and support workers* which can be found at www.health.nsw.gov.au/patients/trauma/Pages/itic-tips.aspx

Practice examples

Area of care	Not integrated or trauma-informed	Integrated trauma-informed practice
All care (All health care contexts and settings) Every interaction with a health service presents an opportunity for healing and can impact on future engagement with health services. It is therefore important that each and every interaction is trauma-informed. Some people may experience fear due to prior negative experiences of health services or intergenerational trauma. Every interaction with a health service should serve as an opportunity to heal from these experiences.	Signs and symptoms of trauma go unrecognised.	Staff are alert to signs and symptoms of trauma.
	Trauma is not understood as underpinning behaviour: 'what is wrong with them?	Trauma is considered as a potential explanation for behaviour: 'What has happened to you?'.
	Injury or illness is treated in isolation.	The whole of a person, not just the injury or illness, is treated.
	Parents or carers are the focus of communication.	Children and young people are engaged, not just their family or carer.
	Working in a culturally responsive way may be seen as the domain of specialised services only.	Specialised services are consulted or referred to where required, but all services provide culturally appropriate care.
Virtual Care (e.g. telehealth, virtual care clinics, virtual hospital) Appropriate virtual care has the potential to provide opportunities for protective and healing connections. However, the delivery of services virtually can increase opportunities for perpetrators of violence to monitor victims' activities and conversations within the home, and increase the risk of technology facilitated abuse. Use of virtual care modalities should recognise and seek to mitigate against these risks.	The virtual nature of the encounter may lead clinicians to be less cognisant of the client's feelings and experience of the encounter.	Proceed according to patient comfort level; obtain consent for examinations, minimize removal of clothing, and proceed with follow-up discussions once the patient is clothed.[2]
	Clients are advised to make sure they have a private space to have their appointment.	Clinicians are aware that those present may not always be visible and are guided by body language and other cues as to how to navigate sensitive subjects.
	It is assumed that the client is in a safe and private space during the appointment.	Ways which the client can indicate they no longer feel they have sufficient privacy are established.
		Clients are reminded of the service modalities available, and of their rights to change service modality, including changing back to face-to-face services.
	Limited consideration is given as to the impact of technology on the patient experience, relationship and communication.	The clinician sits far enough away from the screen so the patient can see their body language and establish the appearance of eye contact.



Area of care	Not integrated or trauma-informed	Integrated trauma-informed practice
Management, planning and care coordination, including collaboration with partner agencies (All health care contexts and settings) Management, planning and care coordination is crucial to integrated, trauma-informed care. It can help establish choice, give clients back control, reduce the likelihood of re-traumatisation and ensure care is focused on what is important to the client.	All clients manage and coordinate care on their own.	Assistance with case management and care coordination is provided where this is necessary to support the client.
	Children and young people needing specialist medical or therapy services are given a referral letter and advised to make an appointment.	The clinician asks older children or young people what information they would like shared about them, so they do not have to re-tell their story.
	Healthcare is provided as a discrete service, disconnected from other services the child or young person might be accessing.	Healthcare is provided as part of a coordinated, holistic care plan that has been developed with the child or young person, and their family, carer and other agencies involved.
		Collaborative multidisciplinary and multi-agency care is undertaken with appropriate case conferencing and case management to support seamless care.
Health promotion (e.g. Open days, community events, posters, social media and resources) Health promotion refers to any action taken to maximise health and wellbeing. Health promotion may be the first opportunity to build trust with an individual or community and can impact whether people will be comfortable using your service.	Health promotion resources and activities provide standard information to everyone in the same way.	Priority populations, children and young people, families and carers are involved in the development of health promotion initiatives.
		A person's culture, history, gender, religion and identity are considered, with location, design and content taking these into account.
	It is not seen as a worker's role to receive or respond to disclosures.	Staff are prepared to receive disclosures and respond appropriately (see trauma-specific responses).
Initial contact (e.g. Reception, emergency department entry and triage, community health front desk) Initial contact is the point at which the child, young person, family or carers accesses a health service. It may be virtual, over the phone or in person, and includes the service provider, clinician, receptionist, security and other front of house staff they first meet. It is critical that initial contact is trauma-informed, as this can influence a person's experience of the health care service received. In some cases, poor initial contact experiences can result in clients not receiving the service required.	The role of staff at initial contact is process-oriented only and it is not seen as the role of staff to build trust, provide choice or help establish safety.	Initial contact is used to build rapport, with all staff providing a welcoming environment and attending to safety factors, building trust through open and honest communication.
		Where possible, the client is provided with choices including those which may help them to manage their exposure to triggers.
	Clients exhibiting signs of trauma are described as 'difficult', 'aggressive' or 'uncooperative'.	Staff are aware that all clients may have experienced trauma and consider trauma as a potential explanation for behavior and flag potential signs with a clinician.

Area of care	Not integrated or trauma-informed	Integrated trauma-informed practice
Screening and assessment (e.g. All health care contexts and settings) Screening and assessment is an area that can make a significant difference to vulnerable children and young people. Over-assessment and repeated screening can be frustrating and cause children and young people to have to tell their story multiple times. If done well, screening and assessment can ensure people get responses that will be most helpful to them. However, if screening and assessment is not trauma-informed or the system lacks integration, this can result in re-traumatisation and may result in clients not receiving the services they need.	This may be done in the first instance as standard practice for all clients.	Clinicians review documentation to identify what screening and assessment information is available and identify known history of trauma. Clinicians review documentation to identify what screening and assessment information is available and identify known history of trauma.
	Clinicians show discomfort or impatience when a client is not speaking or is taking their time.	Clinicians focus on establishing a relationship and environment where the client feels safe to disclose experiences of trauma and participate fully in screening and assessment.
	Screening and assessment findings may not be available to other clinicians who need them, resulting in repeated screening and assessment.	Care plans and results are documented, tracked and an appropriate level of detail is available to other services as needed.
	Each clinician does their own isolated screening and assessment.	A multidisciplinary team approach is used where appropriate, and relevant information is shared with the team with the knowledge of the client.
Crisis and acute care (e.g. emergency departments, ambulance attendance, obstetric, psychiatric and paediatric emergency care) Integrated trauma-informed care in crisis and acute care is critical, as presentations to these services are often highly stressful and may remind people of previous presentations due to violence, abuse or neglect. Additionally, many acute care occasions of service relate to direct experiences of violence, abuse and neglect. Care in these scenarios can easily become disconnected from other aspects of a person's healthcare. In some services, the physical environment also presents particular challenges.	The focus is only on treating the immediate injury or presenting issue(s).	Safety, including cultural and psychological safety, is considered in the context of providing urgent care. Consideration is given to the whole client and their context. Additional information is sought from other health services and agencies as required to provide appropriate care.
	Limited consideration is given to the whole context in which care is provided.	Environmental factors that may re-traumatise clients are reviewed and exposure reduced. Examples include, flashing lights, loud noises, and the presence of other distressed patients. Transition between clinicians is seamless.
Inpatient/admitted patient care (e.g. paediatric ward, mental health unit, labour and post-natal ward) Similar to acute or crisis care, in many cases inpatient occasions of service can be particularly stressful. They also often follow on from an acute or crisis event that may have been particularly traumatic. If services are not integrated or trauma-informed, the period of care and exposure in these settings may also be prolonged, increasing the potential for harm.	Blood is drawn and procedures are undertaken at bedside.	Treatment rooms or other spaces are used for procedures, so a child's bed is maintained as a safe space.
	Mixed wards with adults and children and different genders.	Children and young people's safety is paramount. Generally, children and young people should not be accommodated in wards with adults, and for older children and young people, different genders should be accommodated separately. However, bed allocation involves critical decision making to provide a physically and emotionally safe environment for all clients. Staff also need to use their judgement in relation to individual situations and circumstances.

Area of care	Not integrated or trauma-informed	Integrated trauma-informed practice
Care in the community/outpatient care (e.g. child and family health, youth health, allied health and oral health services) For some clients, care in the community or outpatient care may be the only contact that they have with NSW Health services. These service contexts are easier to make integrated and trauma-informed than acute care or in-patient settings. They can be used to build trust with clients and help to ensure that when urgent care or inpatient care is required, clients are more likely to access it and feel comfortable doing so.	Clients are expected to arrive at the service without any prior relationship building. They are also expected to research for themselves to better understand the services available.	Trust is built and relationships formed before appointments — e.g. a phone call the day before to confirm an appointment, providing information packs, videos and contact numbers to answer any questions.
	Each discipline and clinician works with the client individually and with limited coordination.	A multidisciplinary team care approach, including social care support networks, is provided.
Trauma-specific responses (e.g. All health care contexts and settings) A trauma-specific response is the response of a clinician to disclosures of trauma, violence, abuse or neglect. Disclosures of trauma or violence, abuse or neglect are a time of great vulnerability for clients. It often takes significant courage to disclose such experiences and it is critical that clients receive a trauma-informed response from staff regardless of their role. Failure to implement trauma-informed care at such times may leave a client feeling re-traumatised, helpless and unwilling or unable to disclose to someone else.	Clinicians fear saying or doing the wrong thing so are tentative in their response or deflect the issues.	Clinicians listen calmly and patiently, free of distractions, allowing a child or young person to be heard in their own words.[3]
		Clinicians know that 'listening supportively is more important than what you say'.[4]
		Clinicians reassure the client, recognise their bravery and manage their own emotions.[5]
		When what a child or young person has said needs to be passed on to someone else, this is explained.
	Mainstream services focus on referring clients on to specialised services and provide a limited response to trauma.	Clinicians know what services are available, work with the client to identify if specialist services are required, offer warm referrals and ensure clinical documentation is respectful.

Endnotes

1 Centers for Disease Control and Prevention. (2021). Preventing Adverse Childhood Experiences. https://www.cdc.gov/violenceprevention/childabuseandneglect/aces/fastfact.html

2 Gerber, M. R., Elisseou, S., Sager, Z. S., & Keith, J. A. (2020). Trauma-Informed Telehealth in the COVID-19 Era and Beyond. Federal practitioner : for the health care professionals of the VA, DoD, and PHS, 37(7), 302–308.

3 Australian Institute of Family Studies Child Family Community Australia. (n.d.) *Responding to children and young people's disclosures of abuse.* https://aifs.gov.au/cfca/sites/default/files/disclosure-infographic.pdf

4 Australian Institute of Family Studies Child Family Community Australia. (n.d.) *Responding to children and young people's disclosures of abuse.* https://aifs.gov.au/cfca/sites/default/files/disclosure-infographic.pdf

5 Australian Institute of Family Studies Child Family Community Australia. (n.d.) *Responding to children and young people's disclosures of abuse.* https://aifs.gov.au/cfca/sites/default/files/disclosure-infographic.pdf

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