Consumer Principles for Trauma-Informed Care
in Inpatient Mental Health Settings

1. **Ensure gender sensitivity, and safety from assault and self-harm**
   - Gender separated corridors (ideally locked)
   - Lockable bedroom doors
   - Supervision – staff out on the floor
   - Intervention in inappropriate situations
   - Reports of assault believed and responded to immediately as a serious incident
   - Reports of assault always followed with providing safety, debriefing, ongoing counselling, and access to justice system
   - Choice of gender in clinicians
   - Privacy for sleeping and grooming

2. **Acknowledge the high prevalence of trauma histories in patients - and potential triggers and impacts of involuntary treatment.**
   - Ask about trauma histories
   - Whether or not a trauma history is disclosed, acknowledge the prevalence and potential impacts during admission (many people don't feel safe or ready to disclose)
   - Administer interventions with sensitivity to trauma history
   - Only use potentially triggering interventions if absolutely necessary (ie, avoid generic practices, tailor to individuals)
   - Explain reasons for potentially triggering interventions
   - Always offer as many choices in treatment as possible
   - Offer debriefing after any potentially triggering interventions

   Potentially triggering interventions: being brought into hospital by force/by police, being restrained, being stripped, being forcibly injected or required to take medication against will, being searched, belongings being searched, being closely monitored/observed, being put into HDU or seclusion, having belongings confiscated.

3. **Maximise opportunities for self-efficacy and self-control, as opposed to passivity.**
   - Offer choices, and support patient to make own choices
   - Reinforce that recovery is not something that anyone can 'do for' a person, but rather something we can learn to 'do ourselves' – with help.
   - Remember that every time we 'do for' as a worker, we lose an opportunity for the person to learn ways to help themselves.
   - Support development of self-efficacy in coping with distress:
     - Self-soothing – hand creams, baths/showers, massage, soft music, soft lights, pillows and soft toys, blankets, fragrances, edible treats, clay work
     - Distraction – activities, media, conversation, puzzles
     - Emotional release – boxing, walking, running, crying, sad or angry movies, telling jokes
     - Emotional transformation – learning from others/peer support, making sense of 'symptoms', addressing past issues and traumas, challenging self to change, practising new skills and ways of thinking

- Self acceptance – sense of belonging, meditation/mindfulness, acknowledging self-defeating thoughts
- Support development of awareness and understanding of distress and links to life experiences
  - Exploring experiences
  - Making sense of experiences
  - Discussing with others
- Maximise opportunities for building hope and motivation
  - Offer genuine encouragement and honest feedback
  - Encourage reflection on strengths and achievements

4. **Work with, not on, the patient.**
   - Don't do observations behind glass – sit with the person and engage.
   - Explain what observations are, so the person can give you input. *Especially* if they are experiencing paranoia.
   - Do case notes with the patient. Use as an opportunity for joint reflection on progress and challenges.

5. **Respect the dignity, innate survival strength and capacity of every person.**
   - Believe that everyone can recover. If you can't believe this, change jobs.
   - Don't treat anyone other than how you would wish for yourself, your mother or your child to be treated.
   - Ask your patients for feedback, listen, then do something real with it.
   - Bad behaviour is bad behaviour – and it's important for people to take responsibility. But if people don't know they have a choice, then education is the priority. Remember that problematic behaviour seen today may once have had a very adaptive and protective function.

Recommended Ward Modifications

1. Materials and equipment to support self soothing, distraction, emotional transformation and emotional release (and easily available, not locked away)
2. Case notes stored close to patients/in rooms, rather than in nursing stations.
3. Self lockable bedroom doors/corridors.
4. Use of sensory stimulation to promote a healing environment.
5. Display materials to remind people of their options for self-help.
6. Comfortable environments for discussion and sharing.
7. Self help materials – leaflets, recovery stories, books, dvds, posters, journals
8. Ensure fully adequate supplies of personal hygiene products
9. Ensure clean underclothing is available for patients to preserve modesty while in hospital pyjamas.
10. Eliminate seclusion and restraint.

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Barriers to Trauma-Informed Services

We don't want to blame parents.
Good. Trauma-informed services are not about blaming parents – I hope that period stays in our history. While trauma can be related to the famiy environment, it often isn't. And being trauma-informed is just about responding to the needs and experiences of patients in our care. The research tells us that about 85% of patients have trauma histories. We must respond to that.

But what is trauma, anyway?
Well, it can be a lot of things, and it's defined by the individual. Typically we think of rape, sexual assualt and childhood abuse. There is also bullying, neglect, psychological abuse, physical trauma and disability, forced migration and refugee experiences, natural disaster, personal loss and grief, discrimination, being a victim of crime and many more types of experiences. Sometimes trauma is a layered affair - a series of different experiences of adversity which can have a cumulative effect.

But not everyone who experiences trauma gets mental illness.
True. But the impacts of trauma are felt within context. How well did life prepare us for this terrible event? Did we go into with a healthy sense of self, secure attachment and psychological resilience? And what happened afterwards? Were we believed and supported? Were we able to seek justice and redress? Sometimes, the way in which people respond to our trauma can create a new, and more painfu trauma. It can prvenet us from procesing the event, encourage us to suppress it, or teach us to internalise self-blame and shame for what happened.

Hey, not everyone with mental illness has experienced trauma.
Also true. But about 85% have, and that's significant enough to do something about it. And just because someone hasn't disclosed trauma, don't assume that they haven't experenced one. It took me 27 years to disclose my abduction and rape because my shame was so overwhelming. I have met many people who 'minimnise' their trauma. "Oh," they say, "I was bullied but that's not really trauma, not compared to what some people have been through." It is important to use these principles with everyone.

Do we have to be trauma-informed?
Actually, yes. In 2011 the Chief Psychiatrist of Victoria issued a Service Guideline for Gender Sensitivity and Safety. This guideline includes the requirement to provide 'trauma-informed' services. And if you are serious about recovery, it just won't happen until we address significant issues like trauma.

But I don't have the skills to work with trauma.
Then you need some training, and your workplace should provide it. But remember that being trauma-informed doesn't mean we all have to become trauma counsellors. It means we have to uderstand the issue and its impacts, how to create safe environments to disclose, know how to respond to disclosure, how to prevent re-traumatisation, and where and how to refer people for further help.

I'm not sure I want to hear about trauma all the time – it's upsetting.
Indeed it is. As we become more trauma-informed, we must be sure to use professional supervision effectively to debrief and take care of ourselves. But ultimately we are here to support people in distress – and that means being in uncomfortable situations sometimes. If you have your own history of trauma and are worried about being triggered then you really need to make sure you have good supports.

I'm scared I will make things worse – I don't want to open the 'can of worms'.
If we're in a psych ward, the can is already open and the worms are OUT. It's probably one of the best times to talk about it as we are contained and have lots of support. Secondly, not talking about it doesn't mean the can is closed, it just means that you're leaving us alone with the worms. But there are some really beneficial strategies which help to talk about trauma safely, and you should learn about these in training. How to help with dissociation, creating and using safe places, learning to 'apply the brakes', understand normal responses to trauma, and lots more.