The implementation of trauma informed care in acute mental health inpatient units:

A comparative study

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Abstract

Trauma informed care (TIC); particularly related to interpersonal violence, is a burgeoning topic for mental health services in both New Zealand and Australia. This thesis compares the implementation of trauma informed care, particularly in relation to interpersonal violence, in an acute mental health inpatient unit in New Zealand and a similar unit in New South Wales, Australia. A policy analysis was undertaken of current policy documents that guide each unit, along with semistructured interviews with ten senior staff, five from each unit to investigate implementation of key features of trauma informed care, particularly in relation to interpersonal violence. Results showed a difference in overall implementation between the two units. Single interventions rather than a whole of service change of philosophy were evident. Differences were identified in relation to policies referring to interpersonal violence, staff knowledge and understanding of trauma informed care, access to training and resources, how safety was provided for, collaborative care arrangements and workplace power dynamics for both clients and staff. Across both units were identified a lack of guidance to inform implementation of TIC, consumer involvement and practice around diversity. Contributing factors for TIC implementation include having a clear definition of TIC, commitment at all governance levels, access to TIC training for all staff, and policies underpinned by TIC. Further research investigating these results may enhance service delivery, resulting in better outcomes for the promotion of recovery and healing of those with histories of interpersonal violence.

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Finally, for the consumer who kept asking me what was being done about sexual assaults occurring in the inpatient units, your words were heard. This may be long overdue, but may this thesis contribute to the vision of mental health services taking into account the impact of violence and trauma in all service provision to avoid reactivation of past trauma.

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Abbreviations

AHS	Area Health Service
AMHS	Area Mental Health Service
DHB	District Health Board
DV	Domestic violence
ECAV	Education Centre Against Violence
FV	Family violence
IPV	Interpersonal violence
LGBTI	Lesbian, gay, bisexual, transgender and intersex
NSW	New South Wales
NZ	New Zealand
PTSD	Posttraumatic stress disorder
SA	Sexual abuse/assault
TIC	Trauma informed care
VT	Vicarious trauma

Chapter 1: Introduction

The impact of interpersonal violence (IPV) on health outcomes is well recognised, particularly in relation to mental health (Fanslow & Robinson, 2004; Rees et al., 2011). Literature also highlights the impact on physical health outcomes (Felitti et al., 1998; Najman, Nguyen, & Boyle, 2007). Research has found a higher prevalence of IPV and revictimisation among people who experience severe mental health problems (Goodman et al., 2001). Those with histories of IPV access mental health services more often than the general population; however, international research highlights that traditional mental health care has often been inadequate for those with histories of IPV (Harris & Fallot, 2001a).

The tasks of the modern inpatient unit defined by Elder, Evans and Nizette are to "keep patients safe; assist patients' problems; treat patients' mental illness; meet patients' basic care needs; and provide physical health care" (2009, p. 397). National mental health documents in both New Zealand (NZ) and Australia suggest that mental health services are to provide the best possible care for those that are vulnerable. There is some recognition in mental health services internationally for the need to redress the mental health impact of abuse, and provide safer services. To address this, trauma informed care (TIC) principles for service development and delivery have been developed. TIC incorporates an understanding of a consumer's past trauma including IPV, and the need to minimise retraumatisation. In NZ, policy documents and workforce competencies mandate the integration of TIC into mental health services (Ministry of Health, 2008). In Australia, consensus is growing about the necessity to develop a national strategy for trauma informed care and practice in mental health. Promoting TIC within mental health settings has been shown to improve mental health outcomes alongside the provision of safer service environments (Bills & Bloom, 2000). Implementing TIC requires a paradigm shift in the treatment milieu and culture of mental health care from the current predominantly medical model to that of a biopsychosocial framework.

There has been little research into the implementation of TIC in acute mental health inpatient settings. No research is currently available on the implementation of TIC in NZ or New South Wales (NSW), Australia. Anecdotal evidence shows that elements of TIC have been implemented to address specific issues in various units. The lack of research highlights the need for further investigation.

The aim of this research is to explore and compare how TIC is currently implemented in two acute mental health inpatient units. The researcher hypothesised that the implementation of TIC in relation to IPV would appear differently at each unit in response to the presence or absence of policy, and the contribution by a number of 'drivers' (e.g. people, number of sexual assault (SA) on the unit). To address the aim of this study led to the following research questions.

1. How is TIC in relation to IPV implemented across two acute mental health inpatient settings?
2. How does this implementation compare with literature?
3. What contextual factors may assist or hinder such implementation?

To answer these questions, the researcher utilised a qualitative research design underpinned by social constructionism theory and applied two specific research methods. Firstly, a document analysis of current policies from national, state, and local sources explored the degree to which TIC in relation to SA and family violence (FV) is incorporated into policy at each unit. Secondly, a semistructured interview for senior staff was used to identify practices that incorporated key features of TIC as described in the literature review. The findings of the policy document review and the implementation were then compared with the theory of TIC as identified in literature.

It is envisaged that the knowledge gained from the comparison between a unit in NSW and one in NZ could contribute to the development of processes for the implementation of TIC in acute mental health inpatient units.

Two acute mental health inpatient units were chosen as study sites for this comparative study. The selected units had both been identified by trauma informed professionals as having implemented elements of TIC into their practice over the last 10

years. The two units were chosen from two countries to enable comparison of
implementation along with contextual features that may aid in facilitating the
implementation of TIC. Attempts were made to source two units of similar size and
geographical location who were identified as implementing TIC. Both units were based
in a metropolitan area; however, the NZ unit was approximately one-third larger than the
one in NSW. The unit in NZ had a more culturally diverse population than the NSW
unit. While attempts were made to compare two units of similar size and geographical
location this was only partly achieved.

The thesis is divided into 7 chapters. This chapter provides the background
information to this research and the NZ and NSW context for mental health service
provision in relation to IPV. Further, this chapter provides the rationale for research into
TIC providing an overview of the methodology, and outlines the qualitative research
question and aims of this research. Chapter 2 provides an overview of literature
regarding TIC, particularly in relation to IPV.

Next, the methodology and process of thematic analysis are overviewed along
with a reflection of the research process and ethical considerations in Chapter 3. Having
set the context, the results of the policy review identifying how IPV is addressed in a
context of TIC are presented in Chapter 4. Chapter 5 presents the results from the
semistructured interviews that look at the implementation of TIC in mental health
inpatient units. Chapter 6 presents the integration of findings from both the policy
review and the semistructured interviews. Finally, Chapter 7 presents a discussion of
the findings along with recommendations from this study.

Chapter 2: Literature review

Introduction

Recognition of the prevalence and impact of IPV and the potential for
retraumatisation by service practices is a key feature of TIC. This literature review
highlights the need for TIC in acute mental health inpatient services, due to histories of
IPV, and the possibility of revictimisation and retraumatisation in mental health
inpatient settings. Key aspects of TIC as outlined in this literature review are trauma
awareness; safety; choice, control and empowerment; and collaboration.

To provide context to the implementation of TIC, this chapter briefly describes
key influences on mental health service provision in relation to IPV and TIC. First, a
history of mental health service provision and definition. Second, an overview of the
epidemiology of IPV, the impact of IPV, and the sequelae of relational links between
IPV and mental health. Third, a discussion of violence and traumatisation from IPV and
workplace practices within acute mental health settings. Fourth, a definition, and review
of the implementation of TIC in public mental health settings. Lastly, this chapter
briefly outlines challenges to the implementation of TIC.

History of mental health service provision

Key elements associated with or influencing mental health provision historically
include understandings of mental illness across time, intervention models, and
movements that have influenced mental health systems. Dysfunction in behaviour due
to varying mental states has been recognised since ancient Egypt (Nasser, 1987).
Preconisation Māori held a supernatural view of mental illness and discerned the insane
from the demented (Brunton, 2012). During the Middle Ages, mental illness was
viewed as a spiritual disease brought on by ignorance of God, sorcery, and demonic
possession (Haque, 2004; Laffey, 2003). The perception of mental illness during the
20th century moved from a condition of the soul to a physical illness, addressed by
psychiatry and dominated by the medical model. Electroconvulsive therapy, still in use
today, was a common practice and in following years came the development of
antipsychotic medication (Fink, 1984; Swayze, 1995). Institutional care continued to be

the mainstay of treatment until reforms in the 1950s and 60s culminated in the
deinstitutionalisation of psychiatric hospitals in NZ, Australia, and internationally
(Brunton, 2012; Department of Health and Ageing, 2007; Fakhoury & Priebe, 2007).

Although predominant, the medical model view of mental illness is not held by
all. Māori in NZ and Aboriginal peoples in Australia have held concepts of health
involving the interrelationship of spiritual, environmental, ideological, political,
economic, social, mental, and physical factors. Both Māori and Aboriginal peoples
experienced the impact of colonisation, removal of tribal land, and in Australia the
'stolen generation' (Durie, 2001; Purdie, Dudgeon, & Walker, 2010). These
breakdowns in relationships have led to social and economic exclusion of these groups,
and unacceptable gaps in education, health, and resources (Herring, Spangaro, Lauw, &
McNamara, 2013). It is understood these breakdowns have also led to prevalence rates
of mental illness in these groups exceeding the general population (Australian Bureau of
Statistics, 2004a; Australian Bureau of Statistics & Australian Institute of Health and
Welfare, 2010; Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Wells et al., 2006).
Mainstream mental health interventions are still identified to fall short of addressing the
integral nature of these interrelationships and the resulting trauma (Bishop, Vicary,
Mitchell, & Pearson, 2012; Herring, Spangaro, Lauw, & McNamara, 2013; Isaacs,
Maybery, & Gruis, 2012; Rickwood, 2006; Westerman, 2004a).

Structuralist perspectives, the anti-psychiatrist movement, and the feminist
movement's adoption of the biopsychosocial approach also provided alternatives to
seeing mental illness as primarily a genetic or medical condition (Marecek & Hare-
Mustin, 1991; McDermott & Meadows, 2004). In the 1990s, challenges to the
institutionalised medical model came from psychiatrists themselves (Browne, 1990;
Read, Mosher, & Bentall, 2004; Read, Perry, Moskowitz, & Connolly, 2001), as well as
proponents of the consumer movement and the recovery oriented movement. These
movements advocated for change from the medically dominated mental health system,
to a system that was consumer centred, focussed less on illness, and emphasised the
promotion of recovery.

Acute mental health inpatient services are provided through hospital based care in both NZ and NSW. Adult acute mental health care predominantly caters for those aged between 18 and 65 years in mixed sex units. In both countries, these units are attached to a general hospital in most cases, although there are several large psychiatric institutions still functioning in NSW. Models of care in both NZ and NSW identify predominantly with a medical or biological model of practice. Staff in each unit are predominantly nursing and medical professionals, with smaller numbers of allied health professionals in each unit. Service provision faces ongoing challenges by consumers and allied health staff, amongst others, to implement services more aligned to a biopsychosocial model and incorporate recovery-oriented models which incorporate partnering with consumers and engaging them in self-directed recovery (Elder, et al., 2009). While ongoing work on incorporation of bicultural practice is evident in NZ mental health services, calls are made to address the lack of cultural competence in relation to Aboriginal and Torres Strait Islander peoples in Australia (Herring, et al., 2013).

Definition and prevalence rates

This section describes definitions of mental illness/mental disorders currently used in NZ and Australia, followed by an overview of the prevalence rates of mental illness. At this time, there is no universal definition of mental illness or mental disorder. The term *mental disorder* is used in NZ to define an abnormal state of mind characterised by delusions or by disorders of mood, perception, volition, or cognition (Mental Health (Compulsory Assessment and Treatment) Act 1992). In NSW, a person is classified as having a mental illness, a mental disorder, or mental health problems according to the severity of impairment of behaviour and functioning (Mental Health Act §4 (2007)). In both countries, the definition incorporates safety of the person and others due to a reduced capacity to care for oneself. The researcher uses the term *mental illness* to encompass mental illness, mental disorders, and mental health problems.

Experiencing a mental illness is a common phenomenon (World Health Organization, 2004). Lifetime prevalence rate for a mental disorder is 39.5% in the NZ population (Wells, et al., 2006) and 45% in the Australian population (Slade et al.,

2009). The prevalence of mental illness differs across gender and culture. Although
rates are similar for females and males, females are more likely to experience depression
or anxiety whilst males are more likely to be diagnosed with substance abuse or
antisocial disorders (Australian Bureau of Statistics, 2008; Eaton et al., 2012).
Prevalence rates of mental illness are higher for those identifying as lesbian, gay or
bisexual (Meyer, 2003), as well as those identifying as Māori, Aboriginal, and Torres
Strait Islander (Australian Bureau of Statistics, 2004a; Australian Bureau of Statistics &
Australian Institute of Health and Welfare, 2010; Baxter, et al., 2006).

Interpersonal violence (IPV)

As with mental illness, there is no universal definition of IPV (Finkelhor, 1990;
Goldman & Padayachi, 2000). The World Health Organization (2002) defines IPV as
either family and intimate partner violence or community violence. Family violence
includes child abuse and neglect, intimate partner abuse, family violence, domestic
violence, or elder abuse. Community violence may include torture, war, or sexual or
physical assault by a stranger (World Health Organization, 2002).

The most common form of violence is violence against women, predominantly
by male intimate partners or other known males (Victorian Health Promotion
Foundation, 2008). In acknowledgement of both male and female consumers who have
experienced forms of IPV, the researcher uses the term *interpersonal violence* (*IPV*) to
indicate the inclusion of both males and females. The definition of IPV in this study
refers to the types of violence predominantly linked in literature with mental illness:
child abuse and neglect, family and intimate partner violence, and sexual and physical
violence.

The lack of an overarching definition of IPV presents methodological challenges
in the collection of data, resulting in variances of the prevalence rates of IPV (Finkelhor,
1990; Goldman & Padayachi, 2000). However, research findings reveal those who have
experienced mental illness have significantly higher rates of subjection to one or more
forms of IPV (Beitchman et al., 1992; Briere, Woo, McRae, Foltz, & Sitzman, 1997;

Cusack, Frueh, & Brady, 2004; Lothian & Read, 2002; McLaughlin et al., 2010; Mueser
et al., 1998; Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001; Rees, et al., 2011).

     The terms *abuse* and *assault* also lack universal definitions and are used
interchangeably in the literature to describe forms of IPV. Although assault is more
often referred to as a legal term, much literature uses the term abuse. Both terms
generally refer to acts of violence, exploitation, or neglect. Most forms of abuse
associated with a mental disorder occur within intimate relationships; however, abuse
can also occur by a stranger or through systemic practices.

     While there is no standard definition of child abuse and neglect, in both NZ and
Australia these terms refer to the maltreatment of a child which may lead to physical or
psychological harm (Children and Young Persons (Care and Protection) Act 1998
(NSW); Children, Young Persons, and Their Families Act 1989 (New Zealand).
Multiple studies have reported mental health consumers, both male and female, have
higher rates of one or more forms of child abuse than the general population (Cloitre,
Tardiff, Marzuk, Leon, & Portera, 2001; Lipschitz, Kaplan, Sorkenn, & Faedda, 1996;
McLaughlin, et al., 2010; Metcalfe, Oppenheimer, Dignon, & Palmer, 1990;
Muenzenmaier, Meyer, Struening, & Ferber, 1993; Read, 1997, 1998b; Rose, 1991;
Wurr & Partridge, 1996).

     As with the above terms, there is also no universal definition of the terms family
violence or domestic violence (DV) (Australian Bureau of Statistics, 2011). In both NZ
and NSW, the term *domestic violence* refers to violence that includes physical, sexual, or
psychological abuse, or financial deprivation of a current or ex-intimate partner (Crimes
Act, 1900; Domestic Violence Act. 1995). *Family violence* is a term employed more
recently and includes extended family members or others that assume the role of a
family member. Common characteristics of family violence and domestic violence
identified by the New Zealand Ministry of Social Development (2002) and the
Australian Family Law Act (1975 s.4) include a broad range of controlling behaviours
involving fear, intimidation, or deprivation. The researcher uses the term *family
violence (FV)* in reference to both family violence and domestic violence, unless the
term *domestic violence* is specifically used in policy. Approximately one third of NZ

and Australian women stated they had been subjected to SA or physical abuse from a partner during their lifetime (Mayhew & Reilly, 2007; Mouzos, Makkai, & Australian Institute of Criminology, 2004). Several studies have found significantly higher rates of FV among those with a serious mental illness, or mental illness associated with experience of FV (Cascardi, Mueser, DeGirolomo & Murrum as cited in Goodman, et al., 2001; Humphreys & Thiara, 2003; Kazantzis, Flett, Long, MacDonald, & Millar, 2000; Trevillion, Oram, Feder, & Howard, 2012).

Physical assault as an adult is common. The Australian Personal Safety Survey (2006) estimated 35% of men and women had been physically assaulted at least once since the age of 15 years. Whereas women were more likely to be assaulted by a current or previous partner, men were more likely to be assaulted by a stranger (Australian Bureau of Statistics, 2006; Fanslow & Robinson, 2004; Mouzos, et al., 2004). Prevalence rates of physical abuse are higher for those with a mental illness than the general population (Goodman, et al., 2001).

The terms sexual abuse, sexual assault, and sexual violence are used interchangeably in the literature; however there is a lack of consensus on the definition of these terms (Scott, 1996). In legislation, the New Zealand Crimes Act 1961 refers to *sexual violence* and the NSW Crimes Act 1900 refers to *sexual assault*. Both terms include non-consensual contact sexual acts (Ministry of Justice, 2004; NSW Department of Health). Wider definitions of sexual abuse in both societies refer also to non-contact sexual acts. The researcher uses the term *sexual abuse (SA)* unless referenced as *sexual assault* in policy documents, to incorporate any non-consensual or coerced sexual act, both contact and non-contact.

In Australia and NZ, SA by someone known is a common experience (Australian Bureau of Statistics, 2004b, 2006; Cook, David, & Grant, 2001; Fanslow & Robinson, 2004; Tjaden & Thoennes, 1998). Shame, embarrassment, and fear of not being believed or of further acts of violence set a context for a reluctance to report SA, making it difficult to determine the true incidence rate (Australian Bureau of Statistics, 2004b; United Nations, 2006; Williams, 2004).

Research indicates that both women and men with a serious mental illness have been subjected to higher rates of sexual violence than the general population (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Goodman, Dutton, & Harris, 2010; Goodman, et al., 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Those who have been subjected to child abuse in early years are often subjected to repeated violence and abuse over the lifespan (Rees, et al., 2011; US Department of Justice, 2004; Van der Kolk, 2003), as are those with an experience of mental illness or comorbid substance abuse (Brown, Read, & Kahler, 2003; Cocozza et al., 2005; Dulin & Passmore, 2010; Finklestein et al., 2004; Goodman, et al., 2001; Rees, et al., 2011).

The impact of IPV

This section overviews the impact of IPV on psychological and physical health. Such impact is not determined by the traumatic event itself, but by how the individual perceives and is supported to respond to the traumatic event (Creamer, 1995). This perception is dependent on a complex relationship between social, psychological, environmental, biological, and economic factors. Adding to the complexity is the influence of individual characteristics, assault characteristics, microsystem factors (e.g. family support), mesosystem and exosystem factors (e.g. legal and health services), macrosystem factors (e.g. societal beliefs on abuse), and chronosystem factors (e.g. revictimisation, trauma history) (Campbell, Dworkin, & Cabral, 2009). Writers in the field also highlight the layering of one trauma on another exacerbating the impact of any or all types of trauma (Burstow, 2003; Herman, 1997).

The majority of studies find an association between IPV and the risk for ongoing and severe mental health outcomes (Fanslow & Robinson, 2004; Felitti, et al., 1998; Fergusson, Boden, & Horwood, 2008; Lommen & Restifo, 2009; Lysaker, Outcalt, & Ringer, 2010; Manning & Stickley, 2009; Read, Agar, Argyle, & Aderhold, 2003; Read, Perry, et al., 2001; Rees, et al., 2011; Scott, Smith, & Ellis, 2010; Üçok & Bıkmaz, 2007). Additionally, this risk increases for women subjected to multiple and accumulated forms of IPV (Rees, et al., 2011).

Subjection to trauma impacts on fundamental neurochemical processes creating imbalance in hormone levels in the brain (Cozolino, 2010). These hormone imbalances along with the neurobiology in relation to poor attachment may produce secondary reactions in the body, for example increasing hypervigilance, paranoia, or affect dysregulation, which may be pathologised as part of a mental illness (Kezelman & Stavropoulos, 2012).

Fallot and Harris (2002) identify six areas of difficulty attributable to the impact of trauma. The first area is difficulty with emotion control. Evidence shows that trauma impacts on the neurological function and structure of the brain, particularly the developing brain (Cozolino, 2005; Read, Perry, et al., 2001; Weniger, Lange, Sachsse, & Irle, 2009). This may impact on sensory modulation (whereby the brain organises and interprets sensory input), which lessens the ability to regulate and control emotions (Schore, 2003; van der Kolk, 2005). Inability to regulate emotions or sensory input may lead to intensified emotional distress as well as maladaptive affective responses (Lysaker, Meyer, Evans, Clements, & Marks, 2001).

The second difficulty identified by Fallot and Harris (2002) is that of dissociation and emotional numbness. To continue with daily life, those subjected to IPV may compartmentalise parts of the brain such as memory, affect, sensory awareness, and consciousness (Van der Kolk, Van der Hart, & Marmar, 1996). The third difficulty relates to maintaining relationships: the fear and boundary violations that have been a part of the dynamic of abuse for many impact on the person's view of the world and embed an inaccurate appraisal of self and the world, resulting in poor attachment relationships and difficulties in maintaining relationships (Fallot & Harris, 2002; Schore, 2001). As a result of the above, a fourth difficulty may include reluctance to seek help, sensitivity to criticism, and difficulties with interpersonal relationships (Fallot & Harris, 2002). The fifth impact is the feeling issues cannot be resolved and experiencing loss of control over oneself or one's environment. These may affect the social and psychological development of a person in all areas.

As a way of trying to live with the above impacts, Fallot and Harris (2002) identify the sixth difficulty often present, that of substance abuse. To deal with ongoing

trauma, memories of past trauma, or the impact on structural and chemical changes, individuals may engage in risk taking behaviours such as alcohol and substance abuse (Kendall-Tackett, 2002). Harris and Fallot state that "the far reaching impact and the attempts to cope with the aftermath of the traumatic experience, come to define who the trauma survivor is" (Harris & Fallot, 2001a).

In a contemporary Australian study, both men and women subjected to child abuse had higher rates of psychiatric treatment and utilised the public mental health system more than three times the rate of the general population (Spataro, Mullen, Burgess, Wells, & Moss, 2004). Consumers with abuse histories also spend more time in seclusion, are more likely to receive psychotropic medication, relapse more frequently, self-harm, or commit suicide (Read, 1997, p. 450). Those with a history of IPV are also more likely than the general population to experience a wide range of physical health conditions (Felitti, et al., 1998; Najman, et al., 2007). Significant long-term effects of intimate partner abuse include higher rates of depression, anxiety, posttraumatic stress disorder (PTSD), and suicidal ideation (Campbell, 2002; Ellsberg M, Jansen H, Watts C, & Garcia-Moreno C, 2008; Olle & MacDonald, 2006; The Australian Longitudinal Study on Women's Health, 2005). Many identified health risk behaviours increase following exposure to IPV which in turn may lead to chronic health conditions (Campbell, 2002; Felitti, et al., 1998; Krug, Mercy, Dahlberg, & Zwi, 2002; Lang et al., 2003; Silverman, Raj, Mucci, & Hathaway, 2001). Living with such experiences and impacts, the survivor rather than the clinician is viewed as the expert (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005).

In summary, many of those with mental illness have a history of trauma, and in particular the trauma of IPV. There is recognition of attachment and relational outcomes of trauma, ecological factors in understanding the impact of trauma, neurobiological outcomes, and the comorbidity of mental health and physical health conditions. Although the issue has been debated, recent findings assert a causal relationship between trauma and mental health diagnosis.

IPV and the mental health system

This section overviews the relationship between mental health services and IPV.

Little acknowledgement was given in psychiatry to the prevalence or impact of violence until the 1960s. Dating back to Freud, sexual violence disclosures by women and children attracted considerable disbelief, and psychiatric theories developed to counter such disclosures (Masson, 1984). Since then, disclosures by consumers have been minimised and challenged due to disbelief about the abuse occurring as well as the degree of its impact on the person (Jennings, 1994; Lothian & Read, 2002; Young, Read, Barker-Collo, & Harrison, 2001). Responses to disclosures informed by a lack of belief impact on healing and recovery (Agar & Read, 2002).

Misdiagnosis occurs frequently for traumatised people within the mental health system when the presence of PTSD is not recognised and the trauma response is pathologised, leading to an incorrect diagnosis of mental illness (Harrison & Fowler, 2004; Herman, 1992a, 1997; Lysaker & LaRocco, 2008; Mueser, et al., 1998; Olafson, Corwin, & Summit, 1993; Rozee & Koss, 2001; Salter, 2008; Wells, 2004). The current consensus by those advocating TIC suggests mental health professionals should assume all consumers have a history of trauma and this be taken into account when attributing a diagnosis (SAMHSA, 2011).

Trauma within mental health units

The revictimisation and retraumatisation of consumers within a mental health inpatient setting is a consistent theme of research from Australia, NZ and internationally. While many believe violence within inpatient psychiatric settings occurred only in bygone times of large psychiatric institutions, consumers' stories of recent violence and trauma in acute mental health inpatient units continue to be told. Traumatic incidents and harm from systemic abuse are defined by others as 'Sanctuary Trauma' and 'Sanctuary Harm' (Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennett, 2003). 'Sanctuary Trauma' refers to incidents that meet the DSM-IV criteria for a traumatic event. 'Sanctuary Harm' applies to incidents or unit practices that do not meet DSM-IV criteria, however are frightening, distressing, or humiliating and may impact on

therapeutic outcomes (Cusack, et al., 2003). Exposure to both violence and systemic
abuse as discussed in this chapter may exacerbate present symptomology, reducing
treatment uptake and adherence to treatment plans (Cusack, et al., 2003). Working in a
mental health inpatient setting may also be traumatic for staff that witness or are the
victim of violence. This section provides an overview of findings in relation to the
retraumatisation of consumers and staff from both violence and systemic abuse in
mental health inpatient settings.

   **Consumers' experience of trauma and harm in mental health inpatient
units.** Studies of mental health inpatients revealed high rates of trauma occurring during
hospitalisation (Cusack, et al., 2003; Frueh et al., 2005). Trauma incidents occur more
notably among those where there is the sequelae of child abuse. A person's
vulnerability may be heightened due to past abuse, leaving them more vulnerable to
retraumatisation from boundary confusions, feeling powerless, or distressed mental state
(Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Reddy & Spaulding, 2010).

   Many studies report consumers feel unsafe in psychiatric inpatient units (Baker
& MIND, 2000; Clarke & Victorian Women and Mental Health Network, 2008; Cusack,
et al., 2003; Grubaugh, Frueh, Zinzow, Cusack, & Wells, 2007; Wood & Pistrang,
2004). Those with a previous history of IPV or PTSD reported feeling increasingly
unsafe, fearful, helpless, and distressed (Frueh, et al., 2005). In this context,
experiencing trauma and feeling unsafe are related predominantly to traumatisation from
acts of violence in inpatient units, and secondly to traumatisation from systemic abuse.

   **Retraumatisation from acts of violence in acute mental health inpatient
units.** The acute mental health inpatient unit provides inpatient care for consumers who
are in an acute phase of their mental illness. Literature highlights the prevalence of
aggressive behaviour, particularly sexual and physical assaults, in acute mental health
inpatient facilities (Ketelsen, Zechert, Driessen, & Schulz, 2007; Kraus & Sheitman,
2004). It is suggested that sexual safety, referring to incidents ranging from
inappropriate sexual activity, to sex between two disinhibited consumers, to SA, is one
of the biggest issues in acute mental health inpatient units (Dent, 2007). International
research provides evidence that between 7% and 39% of consumers may be sexually

assaulted during an inpatient stay (Cusack, et al., 2003; Frueh, et al., 2005; Grubaugh, et
al., 2007; Reddy & Spaulding, 2010). Many instances of SA involved sexual coercion
(Weinhardt, Bickham, & Carey, 1999), and were perpetrated by other consumers or staff
members (Cusack, et al., 2003; Davidson, 1997; Frueh, et al., 2005; Grubaugh, et al.,
2007). Other research reveals SA continues to occur in Australian psychiatric
institutions (Clarke & Victorian Women and Mental Health Network, 2008).

A high prevalence of physical assaults by both consumers and staff occur during
inpatient stays (Cusack, et al., 2003; Frueh, et al., 2005; Grubaugh, et al., 2007; Reddy
& Spaulding, 2010). Witnessing sexual and physical assault, being around frightening
or aggressive patients, experiencing unwanted sexual advances, and name calling by
staff members is also traumatising (Frueh, et al., 2005; Smith & Altieri, 2005).
Although considered traumatic by consumers, the majority of traumatising events within
an inpatient setting are not reported due to minimisation or being silenced by either or
both staff and consumers (Clarke & Victorian Women and Mental Health Network,
2008; Grubaugh, et al., 2007).

Retraumatisation from systemic abuse. Systemic abuse refers to abuse
perpetrated either purposefully or unknowingly by staff through system practices,
policies, and protocols (Department of Health, 2000). Forms of systemic abuse are well
documented (Cusack, et al., 2003; Frueh, et al., 2005; Grubaugh, et al., 2007; Jennings,
1994; Meyer, Taiminen, Vuori, Äijälä, & Helenius, 1999), and can be described under
two key themes. Firstly, the mental health system has failed to implement policies and
practices to provide a safe environment (Harris & Fallot, 2001a; Jennings, 1994; Wells,
2004). Secondly, workplace practices exist that retraumatise consumers. Such practices
identified include restraint and seclusion, coercive practices, strip searches, inadequate
care planning, misdiagnosis, minimising past trauma, and use of stigmatising language
(Hamilton & Manias, 2006).

Physical restraint requires a consumer to be forcefully held by one or more staff.
Following such restraint, if a consumer is noncompliant they may be placed in seclusion
for a period of time. While such practices were once commonplace, new initiatives

underway in both NZ and Australia aim to reduce the use of restraint and seclusion (Department of Health and Ageing, 2005; Te Pou, 2008).

Consumers who felt they had no control concerning decisions around their care report high rates of frightening experiences (Clarke & Victorian Women and Mental Health Network, 2008). Identified were coercive practices, such as being forced to take medication on threat of seclusion or other negative outcomes (Grubaugh, et al., 2007), or ordered to have treatments such as electroconvulsive therapy, which is associated with possible memory loss and contraindicated for PTSD (Wells, 2004). Consumers also stated being frightened and having their sense of loss of control exacerbated by processes, such as being strip searched on arrival (Grubaugh, et al., 2007), being accommodated in a locked ward, and confiscation of personal items. Such loss of control can trigger memories or flashbacks of past abuse (Meyer, et al., 1999). McGregor writes, "Traumatized people are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete" (2001, p. 4).

The issue of risk management is at the forefront of traditional mental health services. Harris and Fallot (2001a) assert that risk management drives service provision and that this is abusive: treatment has become content specific, time limited, and outcome focussed, with the goal of stabilisation with fewest risks (Harris & Fallot, 2001a). Treatment options that give consumers more autonomy in care are avoided, due to potential legal threats leading management to consider them high risk (Harris & Fallot, 2001a).

Iatrogenic events and experiences such as those described in this section may add additional trauma to existing trauma. They may exacerbate current psychiatric symptoms and are therefore counter-therapeutic. The negative experience of a person's inpatient stay may also interfere with current or future adherence and delivery of treatment (Bloom, 2000; Cusack, et al., 2003; Frueh, et al., 2005; Grubaugh, et al., 2007; Reddy & Spaulding, 2010).

Staff experience of trauma in mental health inpatient settings

Working with consumers who may present with a dysregulated mood and aggression can be traumatising for staff. Systemic practices that pay little attention to the trauma implicit in the workplace may impact on the ability of staff to perform their duty of care. This next section will provide an overview of trauma experienced by staff working in inpatient settings, and conclude with a description and overview of vicarious trauma (VT).

Violence towards staff. Psychiatric care is associated with a high prevalence of violence towards staff (Soares, Lawoko, & Nolan, 2000). Violent events can be interpreted according to three models: firstly, risk factors that are internal to the person and related to their illness; secondly, risks relating to external and environmental factors in the unit; and thirdly, situational risks relating to the interaction between internal and external factors (Duxbury, 2002). Until the early 2000s, most research results suggested violent behaviour was due to the psychopathology of the consumer: however, results were inconsistent and additional factors are now recognised as contributing to violent events (El-Badri & Mellsop, 2006; Lawoko, Soares, & Nolan, 2004; Whittington & Wykes, 1996). Environmental factors highlighted as increasing risk of violence include timing such as handover times, reduced or understaffing, organisational structure, unsuitable environments, budget cuts, overcrowding, and inadequate staff training (Duxbury, 2002; Lawoko, et al., 2004). These factors listed create an environment that may not support staff in identifying and responding to early indicators of potential violence due to staff working beyond capacity due to the lack of resourcing and/or poor support. Recent studies highlight the situational risk factors for violent incidents such as misinterpretation of behaviour by both staff and consumers (Duxbury, 2002; Gillig, Markert, Barron, & Coleman, 1998; Rosenhan, 1973), or aversive stimuli from staff such as staff showing frustration, demanding engagement, or showing a lack of attention prior to the incident (Whittington & Wykes, 1996).

Systemic abuse toward staff. Environmental factors that place staff in an unsafe environment, as highlighted above, may be considered abusive. Combining these with a lack of supervision or training, factors shown to reduce burnout, may also be seen

as abusive (Reid et al., 1999; White & Roche, 2006). As consumers are seen to be silenced in the system, it is suggested that a parallel process exists whereby staff are also silenced in relation to their needs (Bloom, 2006).

Vicarious trauma (VT). The psychological impact on workers from listening and engaging with consumers can include terror, intrusive memories, loss of trust, low self-esteem, lack of power, somatic symptoms, dysregulated affect, and impairment in daily function (Collins & Long, 2003). Such effects are recognised as VT (Davies, 2009). While it is recognised that the relationship between health professional and patient is key to recovery, maintaining a close relationship with a consumer exposes the nurse to VT (Davies, 2009; White, 2006). Although a paucity of evidence is available on the prevalence and impact of VT on staff (Davies, 2009), several studies found VT was experienced not in relation to personal characteristics, but as a result of work conditions. Conditions contributing to experiences of VT include management issues, inadequate resources including staffing, undervaluing of staff, horizontal violence, lack of consultation with management in regard to changes, and inability to attend training (Bell, Kulkarni, & Dalton, 2003; Bloom & Sreedhar, 2007; Carson, Leary, De Villiers, Fagin, & Radmall, 1995; McLindon & Harms, 2011; Taylor & Barling, 2004). VT can be minimised through the use of supervision and supportive work environments (Bell, et al., 2003).

In summary, where previously IPV went unrecognised in mental health systems, it is now considered best practice for all to assume a history of trauma. Acute mental health inpatient units are often seen as traumatising to consumers and staff, predominantly due to systems and processes. Experiencing IPV along with abusive systemic practices may lead to an exacerbation of mental illness by consumers or VT by staff.

Trauma Informed Care

Human service systems become *trauma-informed* by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed

services are designed specifically to avoid retraumatising those who seek
assistance as well as staff working in service settings. These services seek
"safety first" and commit themselves to "do no harm" (Fallot & Harris, 2009, p.
2).

TIC principles were developed to assist mental health services work with the
sequelae of consumers with histories of trauma. This section firstly defines trauma
informed and trauma specific care. It then describes TIC and the underlying principles
and examples of how these have been implemented in practice. A summary of
evaluations of TIC implementation is provided and finally the chapter concludes with a
review of challenges to implementation.

Trauma informed or trauma specific care

To address the complexities that accompany those who have experienced trauma,
a systemic approach to mental health requires both *trauma specific* and *trauma informed*
services. Trauma specific services work with those who have been traumatised
specifically around their trauma to reduce symptomology and facilitate recovery (Harris
& Fallot, 2001a). Such services may be provided as part of a trauma informed service or
as a stand-alone service (Harris & Fallot, 2001b). Examples of trauma specific services
include SA or DV services. Trauma informed services do not specifically address
trauma, but acknowledge and take into account the impact of violence and trauma in all
service provision to avoid reactivation of past trauma (Harris & Fallot, 2001a; Hodas,
2006; Klinic Community Health Centre, 2008). Such care is not seen as highly
specialised and could potentially be provided by any staff (Hodas, 2006).

Key features of TIC

TIC was developed to support individuals and organisations working in a manner
that considers trauma. TIC also counters the inadequacies of services by meeting the
needs of those with a sequelae of trauma, and is used in a variety of settings such as DV
and homelessness services overseas (Guarino, Soares, Konnath, Clervil, & Bassuk,
2009; Hodas, 2006; Hopper, Bassuk, & Olivet, 2010; Moses, Reed, Mazelis, &
D'Ambrosio, 2003). The need for a TIC framework in mental health is based on the

recognition that many consumers have experienced IPV and revictimisation. The framework recognises the connection between trauma and the development of poor mental health: to address the needs of consumers, mental health services need to adopt a public health approach and implement a universal intervention that presumes a history of trauma, particularly that of IPV (Hodas, 2006; SAMHSA, 2011). There exists however no overarching definition of TIC (Hopper, et al., 2010). A paucity of literature exists on how TIC is operationalised in acute mental health inpatient services (Elliott, et al., 2005).

To be trauma informed, mental health services require a paradigm shift from dependence on the medical model (Harris & Fallot, 2001b). This shift requires recognising a patient's symptomology and risk taking behaviours as 'normal' in the sequelae of trauma, rather than pathologising. All aspects of service delivery would be informed by a 'trauma lens', which keeps the impact of traumatic experiences on consumers at the forefront, and as such implements best practice to support recovery and avoid retraumatisation (Womens Bureau U.S. Department of Labour, 2011).

Four principles common to most descriptions of TIC are identified by Hopper (2010). These are trauma awareness; safety; choice and control; and empowerment. In addition to these, other notable theorists discuss the necessity of collaboration within a trauma informed framework. The researcher has chosen to group the key features into four principles: trauma awareness; safety; choice, control, and empowerment; and collaborative practice. These principles are described below. An overview is also provided in Appendix F.

Trauma awareness

Being trauma informed means that a service acknowledges the extent and impact of IPV, and considers this in planning and service provision. Experts in the field identify practices and implementation of trauma awareness under five subheadings: philosophy and mission; staff education, training, and consultancy; trauma awareness for consumers; universal screening; and VT. The following describes how trauma awareness has been implemented.

A trauma informed service has embedded in its philosophy and mission that
trauma is assumed present and central to a person's issues (National Executive Training
Institute (NETI), 2005; SAMHSA, 2011). From this basis, a service programme takes
into account the dynamics, sequelae, and complexities of trauma presentations (Bloom,
1994; Elliott, et al., 2005; Harris & Fallot, 2001b).

Introducing a paradigm shift to TIC requires staff education, training, and
consultancy to change skills and knowledge, as well as values and attitudes towards
those who have been traumatised (Warne & McAndrew, 2005). Training is required in
responding to disclosure of SA and FV (McLindon & Harms, 2011); appropriate service
provision; improving interactions with consumers (Saakvitne, 2000); gender specific
treatment and trauma screening (National Mental Health Development Unit, 2010); and
early intervention and de-escalation (Huckshorn, Stromberg, LeBel, & National
Executive Training Institute (NETI), 2004; National Executive Training Institute
(NETI), 2005).

It is important that consumers as well as staff receive education about the
relationship between trauma and mental illness (Fallot & Harris, 2009). Validating a
consumer's experience and assisting them to understand the links between past trauma
and their current presentation may help reduce self-stigma and blame. Along with
availability of written information, psychoeducation groups within short stay inpatient
units have been utilised for raising consumer awareness of the connection between
trauma and mental health (Harris, Millet, Beyer, Anglin, & Wolfson, 2001). Trauma
screening is a prescribed way of engaging with consumers and their past trauma history
to identify and support more accurate diagnosis and care planning (Harris & Fallot,
2001a; Janssen, Dascal-Weichhendler, & McGregor, 2006; Lothian & Read, 2002;
Read, 1998a; Rhodes & Levinson, 2003).

Working with those who have experienced trauma and display challenging
behaviours is a risk factor for VT. In a trauma informed system, supervision and self-
care are prioritised so staff can avoid VT and continue to provide effective care (Bloom,
1994; Fallot & Harris, 2009; Klinic Community Health Centre, 2008).

Safety

The first task of recovery is to establish the survivor's safety. This task
takes precedence over all others, for no other therapeutic work can
possibly succeed if safety has not been adequately secured (Herman,
1992b, p. 159).

Theorists state that whereby traditional systems must be mindful to minimise
risk, trauma informed systems manage risk by incorporating treatment options that
create 'cultures of safety' and provide greater autonomy (Chandler, 2008; Elliott, et al.,
2005). There are seven primary areas identified to address safety in TIC systems: these
are physical and emotional safety; gender sensitive or gender specific services;
authentic, clear relationships; avoiding retraumatisation; an acceptance of diversity;
hiring practices; and lastly policy review. These are described below.

The risk of revictimisation emphasises the consumer's need for an environment
that is both physically and emotionally safe. Sexual safety policies exist in various
places to provide guidance on responding to disclosures of SA and promotion of sexual
safety (Agar & Read, 2002; NHS Executive, 1999; Queensland Health, 2004). Included
in the above-mentioned NHS guidelines are best practice principles for designing
inpatient units to promote safety. Instruments to record sexual aggression have also
been developed to promote safety (Hunter New England Area Health Service, 2011;
Jones N et al., 2007). In response to safety issues, single sex units for females have been
provided in some units, and this has decreased the incidence of SA and physical assault
(Mezey G, Hassell Y, & Bartlett A, 2005). Bloom (2007) asserts that staff require the
same focus on safety, nurture, and education that is provided for consumers.

TIC recognises the vulnerabilities and risks for women and provides gender
specific and gender sensitive services to address safety needs (Bartlett & Hassell, 2001;
Kohen, 2001). It is recognised there is a gender difference in psychopathology, as well
as in the help-seeking and coping strategies that may be utilised. It is viewed therefore
that women and men require different therapeutic responses (Eaton, et al., 2012).
Gender sensitivity projects, highlighting the needs of consumers identifying as lesbian,

gay, bisexual, transgender, and intersex (LGBTI) in policies, guidelines, and practice

examples have been implemented in Australia and internationally (Department of

Health, 2011; NHS Executive, 2000; Victorian Department of Human Services, 2008).

Paramount in TIC interventions are trust, rapport, and relationships (Fallot &

Harris, 2009; Klinic Community Health Centre, 2008). Importantly there is a need to

create sincere caring (Klinic Community Health Centre, 2008), and provide consistent

practices, clear roles, and boundaries between staff and consumers (Fallot & Harris,

2009).

Trauma informed services utilise a preventative approach and identify possible

retraumatising factors (Elliott, et al., 2005; Harris & Fallot, 2001b; Jennings, 2007).

Considerable discussion has been given to the reduction of violence, involuntary

treatment, and seclusion, with the need for fundamental changes required in order to

avoid retraumatisation identified (O'Brien & Cole, 2004). Policies and projects have

been implemented that promote least restrictive care, such as in the area of restraint and

seclusion (Grigg, 2006; Huckshorn, 2005; National Executive Training Institute (NETI),

2005; Substance Abuse and Mental Health Services Administration (SAMHSA), 2006).

This has included the use of sensory modulation or sensory integration to help

consumers maintain or regain control of emotions (Chalmers, Harrison, Mollison,

Molloy, & Gray, 2012; Department of Health and Ageing, Central Northern Adelaide

Health Service, Southern Adelaide Health Service, & Department of Health - South

Australia, 2009; Gay, Forssberg, & Cox, 2008).

Trauma informed policies and services show respect for diversity of culture,

race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status

(Jennings, 2007). Acknowledging racial and ethnic disparities in mental health

(McGuire & Miranda, 2008) requires trauma informed staff to be aware of the influence

culture has on clients. A currency of knowledge of culture issues and culturally

appropriate referral pathways is also necessary (Elliott, et al., 2005; Klinic Community

Health Centre, 2008). Ethnic and minority groups should also be included in staffing

and programme planning (Klinic Community Health Centre, 2008). To address the lack

of culturally appropriate mental health provision for Aboriginal and Torres Strait

consumers (Westerman, 2004b), Aboriginal specific mental health positions and training are now provided in parts of Australia (Harris & Robinson, 2007).

Although it is important that those working in mental health have the necessary training and skills to do the work, of higher importance in reducing the incidence of violence in inpatient units are the interpersonal skills and character of staff (Spokes et al., 2002). It is suggested that new staff be employed with respect to their experience in working with trauma survivors, as well as knowledge of indigenous or complementary practices (Klinic Community Health Centre, 2008).

As part of providing trauma informed services, policies and procedures are reviewed to ensure they promote safety and the reduction of retraumatisation (Jennings, 2007; Klinic Community Health Centre, 2008). Policy guidelines are available around aspects of TIC, as are service audit tools that incorporate practice and policy reviews (Fallot & Harris, 2009; Klinic Community Health Centre, 2008).

Choice, control, and empowerment

Empowerment and choice as identified in TIC literature refer to choice and control for consumers, strengths based models of practice, consumer involvement in service development and evaluation, and respecting consumer knowledge and experience. These features are described below.

Healing occurs within settings that counter the dynamics of abuse and provide opportunities for consumers to have choice and control of their therapy options (Bassman, 2001). This includes setting care plans in collaboration with consumers, having consumer input in designing and evaluating services, and sharing governance of service development and activities (Elliott, et al., 2005; Fallot & Harris, 2009; Honey, 1999; National Association of State Mental Health Program Directors, 2007; Peck, Gulliver, & Towel, 2002). Being trauma informed implies addressing overt power dynamics such as restraining a person or determining care and treatment. It also identifies and challenges subtle ways of minimising power, such as pathologising attempts at having a voice and advocating for the best interest of consumers rather than the health professional (Rose, Fleischmann, Tonkiss, Campbell, & Wykes, 2002). TIC

also emphasises information sharing and the devolving of hierarchies within mental
health that may exist, so consumers and all staff have an equal voice (Chandler, 2008).
This element of TIC is also clearly articulated in the recovery oriented models that
underpin mental health care in both NZ and NSW. Dallender, Nolan, Soares, Thomsen,
and Arnetz (1999) suggest that recognising the value of staff and the contribution they
make to health outcomes is essential to reducing stress. To value staff may mean
challenging the power imbalance inherent in a system with an overarching focus on the
medical model.

Trauma informed interventions focus on instilling a sense of hope and recovery
with an emphasis placed on the consumer's strengths rather than challenges (Elliott, et
al., 2005; Klinic Community Health Centre, 2008). This is informed by taking a 'what
has happened' rather than 'what is wrong' approach (Kezelman & Stavropoulos, 2012).
Interventions utilised in TIC are based on the principle that people can and do recover,
and give recognition and value to past coping mechanisms. Consumers are provided
opportunity for skill development and understanding, so as to empower themselves and
enable recovery through their own efforts (Davidson, Shahar, Lawless, Sells, &
Tondora, 2006; Elliott, et al., 2005).

Considerable literature on empowerment focuses on models of small group work
with women in mental health services. Features of these group work programmes
include skill building, self-regulation skills, cognitive based therapies, psychoeducation
and, for the majority, being gender specific and providing peer support (Frisman, Ford,
Hsiu-Ju, Mallon, & Chang, 2008).

> A truly mature mental health system would be one in which it is taken for
> granted that consumers/survivors are included and actively involved at all levels
> of mental health service delivery (McCabe & Unzicker, 1995, p. 61).

Consumer involvement is considered a key yet radical principle of TIC (Rose, et
al., 2002). Research suggests that professionals are supportive of having consumers
involved in services, however evidence points to inconsistencies in how support
translates into practice (Campbell, 2001; Hansen, Hatling, Lidal, & Ruud, 2004; Tait &

Lester, 2005). One area of involvement is the increase in consumer consultation for planning and management (Peck, et al., 2002; Rose, et al., 2002). Other examples of consumer involvement include consumers facilitating courses, participating in staff recruitment, and involvement in nurse training (Rose, et al., 2002). Examples of NZ consumer involvement in service evaluation and development include the National Mental Health Consumer and Carer Forum, or District Health Board (DHB) Consumer Advisors. Examples in NSW are the NSW Consumer Advisory Group – Mental Health Inc. (NSWCAG), and the Mental Health Consumer Perceptions and Experiences of Service framework MH-CoPES (Hinton, Anglicare Tasmania, & Tasmanian Mental Health Consumer Network, 2009; Phillips, 2006).

Examples of consumer involvement specific to the inpatient setting include transferring control from staff to the consumer, such as having input into care plans; however evidence shows that the involvement of consumers with their own care was reliant on the decision making of individual health professionals (Peck, et al., 2002). A trauma informed system considers the consumer an expert on their experience and staff work in collaboration with consumers to utilise this expertise (Fallot & Harris, 2009; Klinic Community Health Centre, 2008). With the extent of genuine consumer involvement in the mental health sector highly questionable, particularly in regard to leadership and management roles (Gordon, 2005), a TIC system is characterised by formal representation in all levels of the sector.

Implementation of TIC requires administrative empowerment to change. Harris and Fallot (2001b) identify that a commitment to implementing TIC is required from those in control of the resources in the unit. Jennings (2007) further insists that this commitment needs to be at the state level with finances, development of guidelines, and the establishment of a designated TIC position at this level. Chandler (2008) expands the support to include functional administrative participation, such as role modelling and supplying necessary tools, staff, and consumer resources.

Collaborative practice

The complexity of physical and psychological needs that may present from survivors of IPV is best met by services that collaborate with others (Finklestein, et al., 2004; Morrissey et al., 2005). This requires collaboration between trauma informed mental health, alcohol, and drug service provision, alongside trauma specific services (Breckenridge, Salter, Shaw, Adults Surviving Child Abuse and the Centre for Gender Related Violence Studies, & University of New South Wales, 2010). As chronic physical illnesses are associated with the outcomes of past trauma, the reintegration of both mental and physical health, with monitoring of physical health observed by mental health staff, alongside greater collaboration with specialists and other physical health professionals is also suggested (De Hert et al., 2011).

Evaluation of TIC

Mental health service provision is required to be evidence based in both NZ and NSW (Elder, et al., 2009; Ministry of Health, 2008). Such evidence may be gathered from evaluations of service/programme/initiative implementation. Evaluations of TIC in literature, although limited, have shown positive outcome measures for consumers and service providers. The implementation of TIC has shown improved outcomes in comparison to regular mental health treatment (Clark & Power, 2005; Cocozza, et al., 2005; Morrissey, et al., 2005). Consumers stated they felt safer, PTSD symptoms reduced, and fewer hospitalisation episodes occurred (Cocozza, et al., 2005). Trauma informed services were also found to have operated at equivalent costs to 'treatment as per usual' services (Domino et al., 2005). The evaluation of a number of group work models such as TREM (Fallot & Harris, 2002) and Seeking Safety model (Najavits, Weiss, Shaw, & Muenz, 1998) show consumers found them helpful and highlighted significant improvements across a range of symptoms. A paucity of evaluation literature was found relating specifically to mental health inpatient settings, however the integration of TIC principles in one psychiatric inpatient unit found a reduction in violence and self-harm and an increase in discharge rates (Bills & Bloom, 2000).

Hopper et al (2010) highlight four challenges in evaluating TIC: no clear definition on TIC; no capacity to measure cultural change and sustainability; a lack of evaluation outside those engaged in building trauma informed services; and inability to identify if outcomes are due to TIC, trauma specific services, or both due to integrated care.

Challenges to implementation

The implementation of TIC requires a philosophical shift on how mental health services are delivered (Harris & Fallot, 2001a; Jennings, 2004). Five challenges are highlighted in literature in relation to TIC: no consensus on a definition of TIC, a lack of literature on TIC in inpatient settings, individual staff practices, the facilitation of change management in a complex health system, and finally siloed funding.

A lack of consensus on TIC definitions and principles is a challenge for services considering implementing TIC, as there are varying understandings of what TIC is (Hopper, et al., 2010). The second challenge is that while there is a growing body of literature to inform the implementation of TIC in community settings, there is still a paucity of literature on what implementation of TIC would look like within inpatient settings, in relation to issues of risk and safety. The third challenge is that although a unit may state they work from a particular framework, individual staff may implement different practices (Cleary & Edwards, 2001; Muskett, 2013).

The fourth challenge in implementing TIC is the limited information available on facilitating organisational change in a complex public health system with vested professional interest groups (Callaly & Arya, 2005; Garside, 1998). Staff may also be exposed to 'change fatigue' from ongoing change implementation (Garside, 2004). Finally, the fifth challenge is the fragmentation in funding for service delivery which is a barrier to the establishment of work place culture and service delivery models incorporating integrated care required to meet complex physical and psychological health needs of consumers (Cumming, 2011).

Bills and Bloom (2000) also wrote of the challenges of working in a hierarchical system such as the mental health system, which is resistant to change and needs strong

leadership (Bills & Bloom, 2000). Factors highlighted as specifically challenging in the

mental health system include resistance, particularly from medical staff (Garside, 2004),

the demand for a 'whole of population' approach without reducing the standard of care

for patients (Callaly & Arya, 2005), and the imbalance of power between consumers and

professionals alongside the push for consumer input and consumer led organisations

(Rose, et al., 2002).

A facilitative organisational culture is identified as the most important single

factor for effective change management, followed by a comprehensive communication

strategy, and resource provisions that assist with implementation changes and training

(Rose, et al., 2002). Most failures in organisational change occur in relation to a lack of

respect, power imbalances, unresolved conflicts, lack of ongoing commitment (Bloom,

1994; Narine & Persaud, 2003), and the imposition of change on staff prematurely,

without recognising stages of change (Prochaska, Prochaska, & Levesque, 2001).

Change is most effective where organisational culture changes occur alongside changes

in service structure and systems (Chalmers, et al., 2012; Rose, et al., 2002). Identified

within implementation of trauma informed practices in mental health is also the presence

of identified champions (Chandler, 2008; Jennings, 2007). Findings by Fernbacher

(2008) showed that in addressing SA in mental health, a state wide approach had

resulted in movement towards a cultural change and local implementation.

Chapter summary

In summary, this chapter has reviewed the context underpinning the need for TIC

and the key features of the TIC framework developed to address this need. Though

there is no consensus on definition, key features from literature are highlighted by the

researcher. Evaluations of TIC show positive outcomes. Challenges to implementation

include a lack of definition, lack of information, and the challenge of change

management. Finally with the paucity of information specifically relating to mental

health inpatient settings it is clear further research is required to provide guidance on

integrating TIC into practice.

Chapter 3: Research methodology

The previous chapter provides an outline of the context and the literature surrounding the implementation of TIC in mental health. As discussed in Chapter 2, there is a gap in the literature on the implementation of TIC in acute mental health settings. To address this void, this research seeks to build on the current knowledge base by providing evidence of how TIC, with particular attention to SA and FV, is currently implemented in two acute mental health inpatient units, one in NZ and one in NSW, Australia. The researcher has utilised a qualitative research design underpinned by social constructionism theory. Two methods were undertaken as part of this design, a document analysis of current policies in each unit and semistructured interviews of senior staff in each unit.

This chapter firstly explains the rationale for using this research design and then describes each method utilised in this study. The policy document analysis and methods used for data collection and analysis are overviewed followed by the semistructured interviews, including recruitment, data collection, and analysis. The two diverse methods and analysis are brought together using the rationale and process of triangulation.

Methodological approach

Social constructionism

The work of Berger and Luckman (1971) guided the methodology for this research into the question of how TIC is implemented in two different inpatient settings. Social constructionism originated from the discipline of sociology and the postmodern era of qualitative research, and has now gained a significant presence in social sciences (Young & Collin, 2004). In understanding the world, social constructionism views knowledge as constructed from experiences, rather than created, and such constructions are based within the context of culture and history (Andrews, 2012; Burr, 2003). Perspectives and knowledge can be learned and organised through our activities and interactions, forming shared social understandings and behaviours (Berger & Luckmann, 1971; Moghaddam, 2005). Social constructionism takes a critical stance on assumed

knowledge or ways things are performed, recognising that these are constructed and inform negotiated understandings (Burr, 1995). Burr (1995) further states that knowledge is sustained by the processes in place and that such knowledge informs social actions.

Concepts inherent in this research, for example abuse, consumer rights, and power, are influenced by a person's experience and societal norms, as well as current psychological theories. The subject of IPV is a complex and provocative one for many people (Gunter, 2007), and its complexities play out within the mental health system based on negotiated understandings, resulting in diverse interventions at various levels. It is suggested that research in the field of IPV analyse these multiple levels along with attitudes and behaviours (Murray & Graybeal, 2007).

Qualitative research

Having a focus on society's comprehension of a subject, qualitative researchers are interested in individual perspectives of reality and how they lend meaning to life (Flick, 2008). Qualitative research is underpinned by the notion that reality is not rigid, but is created by individuals and influenced by their context; accordingly, many perspectives of reality are possible (Crossan, 2003). Constructs of reality change over time with experience, therefore qualitative research focusses on developing an understanding and perception of a person's reality at a specific point in time (Wiseman, 1999).

Qualitative research enables the eliciting of a contextual understanding of complex dynamics from the perspective of the participant (Mahlstedt & Keeny, 1993). It achieves this by investigating phenomena in an in-depth and holistic fashion, by collecting rich narrative material using a flexible research design (Polit & Beck, 2012). This narrative data is organised, interpreted, and analysed, with the objective to discover the important underlying themes, categories, and patterns of relationships (Polit & Beck, 2012). Qualitative research explores individual values and beliefs inductively or deductively in order to create research from the perspective of the participant rather than the researcher (Carr, 2008). Qualitative research may be undertaken at an individual

level, exploring how a person makes sense of their experiences, and at a systems level,
exploring social and cultural experiences (Berg, 2007; Denzin & Lincoln, 2005a). To do
this, qualitative research prioritises the views of participants and asks questions of social
experience, how they are created, and the meanings given to them (Denzin & Lincoln,
2005b; Hood, Mayall, & Oliver, 1999).

Researcher bias is considered inherent in qualitative research (Fontana & Frey,
2005). As the interpretation of qualitative research is dependent upon the prior
understandings of the researcher, engaging in qualitative research requires reflection on
the social and historical context in which the researcher is based (Liamputtong & Ezzy,
2005; Merriam et al., 2002). Qualitative research underpinned by social constructionism
is relevant in this study: practice and policy development in TIC arise from
understandings of IPV that are constructed individually in the context of complex
dynamics around issues such as gender, violence, and one's past experience.

Researcher's background

Mason (2002) states that the qualitative researcher needs to apply a reflexive
position. Reflexivity entails "thinking critically about what you are doing and why,
confronting, and often challenging your own assumptions, and recognising the extent to
which your thoughts, actions and decisions shape how you research and what you see"
(p. 5). Denzin and Lincoln (2005b) agree, recognising that researcher or the 'bricoleur'
must understand research as an interactive process: research is influenced by one's own
gender, culture, values, and norms, as well as by exposure to current literature
surrounding the topic and the context in which the researcher works. Although most
research projects start from the researcher's interests, the researcher must 'bracket' their
experiences, values, and assumptions by identifying these as possible influencing factors
and then consciously putting them aside.

The researcher has identified that her gender may influence how participants
responded to interview questions relating to IPV, which is a gendered crime.
Understanding of the responses is also filtered by gender, as stated by Denzin in Fontana
and Frey (2005). Factors that may impact also include the researcher's current beliefs

and understanding of mental health and IPV that have been developed through working
with, and training, mental health staff in their interactions with consumers subjected to
IPV. The considerable exposure to sociological, psychological, and public health
principles have informed the researcher's worldview, which emphasises the impact of
social determinants on health and the role of individual and collective action in
addressing these social determinants for better health outcomes. To understand the
strengths, limitations, and potential impacts of these possible biases, the researcher
reflected on these factors, then discussed them with, and had them challenged by, peers
and supervisors.

Methods

This research compares the policy and practice of how TIC in relation to IPV,
specifically SA and FV, is currently implemented in two acute mental health inpatient
units, one in NZ and one in NSW, Australia. To achieve this, a qualitative research
design was used to obtain and analyse data. Two methods were undertaken as part of
this design. A document review of policies was undertaken to identify the degree to
which TIC in relation to SA and FV was incorporated into policy. Secondly, this
research utilised semistructured interviews identifying trends in both individual and
shared social understandings and attitudes of participants at each unit, relative to key
features of TIC described in the literature review.

Policy document analysis

The researcher undertook a policy document analysis to ascertain the inclusion
of TIC in policy documents across both units. A document analysis is a systematic
process to reviewing printed or electronic documents (Bowen, 2009). As with other
qualitative research methods, a document analysis examines data to elicit meaning and
develop understanding of a topic (Corbin & Strauss, 2008). A document analysis is
frequently used alongside other qualitative research methods as a means of triangulation
(Bowen, 2009). Triangulation was also undertaken in this research study and is
described in the section *Comparing the findings* on page 41. The rationale for using a
document analysis alongside a qualitative method such as the semistructured interviews

lies in recognising the value of documents to provide further context to assist in understanding responses (Bowen, 2009).

Semistructured interviews

The researcher utilised semistructured interviews to gather data for this study. An interview can be used to discover "the subject meaning and interpretations that people give to their experience" (Rice & Ezzy, 1999, p. 67). The researcher chose to gather qualitative data by the use of semistructured interview firstly as this approach was well suited to explore and seek perceptions on complex issues, as answers could be probed further for clarification (Barriball & While, 1994; Denscombe, 2010; Neuman & Kreuger, 2003; Rice & Ezzy, 1999). The semistructured interview provides a focussed guide for the questions that can be adapted depending how the interview progresses. Secondly, as there were varied professional histories of the participants, a semistructured interview approach provided opportunity to change wording to suit different languages of professions without changing the meaning of the questions (Denzin, 1989).

A limitation of using semistructured interviews is that flexibility in wording and sequence of questions may lead to different participant responses. In contrast to an in-depth interview, a semistructured interview means that topics that were not anticipated cannot be pursued. A limitation of interviews is that they may be time consuming and expensive to conduct (Klenke, 2008; Neuman & Kreuger, 2003). For this study, the researcher travelled between Australia and NZ to undertake the interviews. Because interviews are resource intensive, the number of interviews was limited, which impacts on the size of the study and the possibility that data is not representative (Denscombe, 2010). Another limitation of interviews is the impact the interviewer effects on participant responses (Denscombe, 2010). Participants may respond to what they feel a situation demands (Gomm, 2004). This impact can be compounded if the interviewer unconsciously guides the interviewee with behaviour cues (Denscombe, 2010). This disadvantage can be limited by using an interview schedule and a single interviewer, whose self-awareness and recognition of this issue allows them to check their behaviour accordingly (Opdenakker, 2006).

Data collection. A purposive sampling scheme was used to identify a small number of individuals to participate in the semistructured interviews. Purposive sampling identifies a specific qualified population to participate and is utilised to ensure information rich data (Patton, 1990) when research involves "studying a certain cultural domain containing knowledgeable experts" (Tongco, 2007, p. 149). The research design incorporated a purposive sampling scheme in which only senior staff with extensive knowledge of their unit were invited to participate in the interviews. The researcher determined that due to their position of influence and decision making, senior staff in acute mental health inpatient units would have common experiences and could provide meaningful insight into the research topic. In recognising cultural differences between health professions on TIC, senior staff from nursing, medical, and allied health were invited to participate in the semistructured interviews.

This research used parallel sampling across two subgroups, with Onwuegbuzie & Leech (2007) suggesting that such a design should have no less than three cases per subgroup. It was determined the sample for this research would consist of no less than three and no more than five senior staff from each inpatient unit who held responsibility and leadership positions. The limit of five participants for each unit was appropriate in relation to time constraints of this thesis.

Data analysis

Both an inductive and deductive approach were taken to analyse the policy documents and the semistructured interviews. Induction is used to study unexplored phenomena from which theories can be created (Trochim, 2006). It explores facts in a neutral manner, free from expectations. Deduction is used where there is a theoretical foundation and a hypothesis generated, to test relationships between one or more occurrences to discover a pattern that defines the topic of research. For this research, while there is a theory on TIC implementation in general, there is little information about implementation in the acute mental health inpatient setting. Applying the deductive approach to knowledge extracted from the literature on this topic, a hypothesis was formed that there would be implementation of TIC currently in the acute mental health inpatient unit. This underpinned the preparation of the semistructured interview

form. This knowledge also informed the generation of codes relating to themes within
the policy documents analysed. The inductive approach was applied to explore both the
policy documents and the interviews, revealing themes about how TIC is implemented.

      Thematic analysis. This research used thematic analysis to analyse the data for
both the policy document analysis and the semistructured interviews. Thematic analysis
is seen as the foundation for qualitative analysis, as it enables analysis of meanings
within interview transcripts without being subverted by theoretical interpretation
(McLeod, 2011). A thematic analysis enables comparison and contrasting of similarities
and differences between participants' perspectives on an area of interest (Polit & Beck,
2012; Streubert & Carpenter, 2011). Findings are achieved by analysing recurring
patterns in themes that arise, allowing hidden or inferred themes to emerge (Harper &
Thompson, 2011; Joffe, 2012). Neuman and Kreuger (2003) describe this method of
analysis occurring when the "researcher organises the raw data into conceptual
categories and creates themes or concepts which he or she then uses to analyse data,
themes, and concepts" (p. 441). For this research, data was analysed in relation to
existing key features of TIC as identified in the literature. Data gained from the research
was then analysed using an inductive technique of constant comparative method (Strauss
& Corbin, 2007), whereby each sentence and paragraph segments of the policy
document analysis and the transcribed semistructured interviews were reviewed to
determine codes which corresponded to concepts in the data. Negative case analysis is
utilised to enhance rigour and verify data coding (Strauss & Corbin, 2007). This
involved the researcher searching for components in the data that did not support the
emerging themes.

      Data triangulation. Both sets of analyses – from the policy document analysis
and the semistructured interviews – are finally brought together using triangulation.
Triangulation is often used by qualitative researchers to take into account multiple
perspectives (Denzin, 1970; Polit & Beck, 2012). Data triangulation analyses
information gathered from distinct sources to verify and establish validity (Guion, Diehl,
& McDonald, 2011). It is identified as a strategy to add 'rigor, breadth, complexity,
richness, and depth to any enquiry' (Denzin & Lincoln, 2005a, p. 5).

Method 1: Policy document analysis

Data collection

The first step of the data collection was to identify policy documents relevant to the acute mental health inpatient setting. The policy databases at each unit contained policy documents comprised of national, state, DHB, Area Health Service (AHS), or Area Mental Health Service (AMHS) sources. The policy database at each unit was scanned using the 'find' function for policies with the keywords "mental health" or "psychiatric" to produce relevant mental health policies. On accessing the relevant policies, the researcher read each document, identifying if the policy document related to the acute mental health inpatient setting.

The second step in the collection of policies was to identify whether or not policies referred to trauma, SA, and FV. The policies identified in step one were filtered using the 'find' function to locate the terms "trauma", "sexual assault", "sexual abuse", "domestic violence", "family violence", "assault", and "violence". To ensure accuracy, the researcher repeated the database search twice. Policy documents that referred to trauma, SA, or FV constituted the sample for method one. The sample consisted of 23 NZ policy documents and 39 NSW policy documents. The dates of collection of policy documents were April 2011 for the NZ unit and May 2011 for the NSW unit, these being the dates semistructured interviews were conducted at each unit.

Data analysis: Thematic analysis

A thematic analysis of the policy documents sourced was undertaken to answer the question 'what is this policy or procedure saying about trauma, IPV, and abuse?' Neuman (2011) states that in undertaking a thematic analysis (also referred to as content or discourse analysis), the researcher identifies the material to analyse, and then creates a system for recording aspects of the analysis. As described above, the first step of the analysis gathered national, state, and organisational policy documents referencing trauma, SA, or FV that were in place at each unit at the time of the interviews. The units were adult acute mental health units, so policies relating to children and older persons were excluded as they fall outside the age range for admission into the two units. The

second step involved investigating the content to identify what the policy documents
were saying about trauma, SA, and FV. This step, Lupton (1999) states, identifies the
underlying themes and patterns. In undertaking this step, the researcher read all policy
documents for each unit separately to determine how each policy referred directly or
indirectly to trauma, SA, or FV. When all policy documents were read for that unit, the
researcher reread all documents and applied computer coding to each policy document
using HyperRESEARCH™. The first phase of analysis identified 155 codes. During
the second phase of coding, these codes were categorised under 28 conceptual headings.
Once initial coding was completed for each unit, the codes were analysed using the
mapping capacity within the program HyperRESEARCH™ to determine relationships
between the conceptual themes. A comparison of the resulting conceptual headings was
undertaken for each unit and compared with the findings of the literature review,
resulting in 11 key themes. These themes are: SA and FV as a risk factor for the
development of a mental illness; safety from IPV; specific service provision in relation
to SA, FV, and trauma; universal screening; responding to disclosures; retraumatisation;
inconsistent use of terminology; staff training; VT; gender specific services; and choice
and control.

Method 2: Semistructured interviews

Recruitment process

It was determined that the sample for the semistructured interviews would be
made up of five senior staff who had worked more than three years in mental health, had
knowledge of mental health inpatient settings, and had a higher level of responsibility
within the unit. This was determined sufficient to establish a consensus on TIC
implementation due to the experience of the staff, and this number being approximately
one third of all senior staff on the unit. In order to gain access to interviewees, the
researcher was advised of a key person to contact in each unit. This person was
provided the survey information to email to senior staff members who would be
available on the day of interviews, inviting them to be interviewed. The key contact
person also agreed to schedule the interview times around the unit workload. The

invitation to staff contained a copy of the information sheet, a consent form, and a
revocation of consent form.

Participants

Ten participants expressed interest across both units – five participants from each
unit. The participants included four males and six females. Six participants had a
nursing background and two had an allied health background. One participant had both
an allied health and nursing background, and one participant had a medical background.

Interview schedule

The interview schedule was compiled around the key features of TIC as
identified by key writers in the field, Harris and Fallot (Harris & Fallot, 2001a). The
development of the interview schedule was peer reviewed by colleagues in the field as
well as by the two supervisors to ensure minimisation of any bias. The interview
schedule was then piloted with two mental health professionals working in inpatient
settings. A change was made to the wording of two questions to improve clarity. A
copy of the interview schedule is included in Appendix C.

Conducting the interviews

Interviews were arranged with participants who had given informed consent.
They were conducted in the office of the participant or an interview room on unit. At
the beginning of each interview, the researcher provided the participant with another
copy of the information sheet, consent form, and revocation of consent form. The
researcher went through these ensuring the participant understood the process being
undertaken, what was required of them, their rights, and agreement to audio record the
interview. The use of quotes was discussed, and permission was given by all
participating clinicians working in the inpatient setting to be quoted. Confidentiality
was also discussed at the outset of interviews, and the researcher invited participants to
advise if they wished to strike anything out of the transcript during and following the
interview process. Following this, participants were provided the opportunity to ask

questions. Finally, when both parties were satisfied, participants were asked to complete the informed consent form.

The interviews were conducted in English and lasted approximately one hour. They were recorded using a Phillips audio voice tracer. As the recording provided the means for the researcher to analyse detailed transcripts of the interview at a later time, it enabled the researcher to listen to and engage with the content while paying attention to the interview structure. In addition to checking with the participant to confirm the accuracy of the researcher's understanding, the researcher took brief field notes, which highlighted questions that arose during the interviews. Following the interviews, the researcher presented an open seminar to all DHB staff on a TIC approach to sexual safety. This was presented to recognise staff involved and the importance of reciprocation (Edwards & Ribbens, 1998). A 'thank you' card was also provided to participants for their participation.

Data analysis

A thematic analysis was undertaken on the interview data. Interviews recorded were transcribed using the HyperTRANSCRIBE™ program. The researcher rechecked words or meanings, and verified data by reviewing field notes. The first step of the analysis involved the researcher reading the transcripts several times in order to become familiar with the data. In the next stage, the researcher worked intensively with each transcript in a first attempt to condense the data into categories (Neuman & Kreuger, 2003, p. 442). To do this, the researcher coded the transcripts and identified 120 codes. When all transcripts were read, the researcher reread all the transcripts and applied all coding to all transcripts. Once initial coding was completed, the codes were mapped using the program HyperRESEARCH™ into 22 themes that were then mapped to the five key themes, and aligning subthemes of TIC as identified in the literature review. Transcripts were analysed for each unit, followed by the comparing of the results between the units. Rice and Ezzy (1999) state that "Interpretive rigor requires the researcher to demonstrate clearly how interpretations of the data have been achieved and to illustrate findings with quotations from, or access to, the raw data". In keeping with this, the findings and discussion incorporated quotations from participants.

Comparing the findings

The aim of this study was to compare how TIC is implemented across two acute mental health inpatient units. Implementation of TIC occurs on various levels, thus to answer the question, the results of both methods were analysed for each unit, focussing on relationships between the core categories identified in each method for each unit. This was achieved by firstly identifying agreement or disagreement of open codes between policy documents, and the open codes obtained for the semistructured interviews for each research unit. Next, both sets of codes were compared with the features of TIC for agreement or disagreement. Finally, the researcher compared the findings for the policy analysis and the semistructured interviews for each research unit. This identified a core category of *Selective alignment of TIC implementation* whereby few but not all features aligned between policy and practice within the unit, between units, or with the findings of the literature review.

Ethical considerations

Potential ethical challenges evident in this research relate to the nature of the topic, maintaining confidentiality of staff, and de-identification of the acute mental health units.

Sensitivity of the research topic

The researcher recognises the challenges for individuals in talking about SA and FV due to societal beliefs as well as the high prevalence rate which may mean participants have experienced these forms of violence themselves. To provide a safe forum for discussion, the researcher identified in the information sheet that these topics would be discussed. Following rapport building at the start of the interview, the researcher again highlighted that SA and FV would be discussed, and addressed any concerns participants had. During the interviews, disclosures of SA occurred. The researcher responded to these in a supportive manner that validated participants. Locally sourced referral information was also provided to the participants.

Confidentiality of participants

Confidentiality of participants was maintained by several means. Firstly, it was recognised that as interviews were held in the unit, participants were aware that other staff knew they were being interviewed. This was discussed and it was agreed that no identifying information such as name, role, gender, or period staff had worked would be identified in the research. Confidentiality was discussed at the outset of interviews, and the researcher invited participants to advise if they wished to strike anything out of the transcript during the process and following the interview. The use of quotes was discussed and permission was given by all participants to be quoted.

In addition to shared understandings by participants, there were individual perspectives necessitating confidentiality, especially where individually held perspectives opposed others in the unit. It was important that when participants commented on what they thought their (named) colleagues might say, the researcher avoided confirming or denying the comment by maintaining neutral discussion and an open stance in body language, including facial expression.

Confidentiality of the research units

To maintain confidentiality of the interview units, the units are identified only as NZ or NSW. Although all national and state policy (applicable to NSW) are identified by their title, policy documents specific to the DHB, AHS, or AMHS are named only by content rather than title. A challenge arose in relation to implementation of practices in both units, which may not be present at other inpatient units leading to identification of the unit. These practices are key principles for this research topic and thus are addressed; however, these are described in minimal detail to avoid identification.

To maintain confidentiality of both participants and the research unit, data will be stored electronically on a locked computer as well as a backup copy on CD-ROM which will be stored in a locked filing cabinet. Access to the interview data and policy documents was limited to thesis supervisors and the author. All electronic documents and emails were password protected to prevent unauthorised access and all hard copies

were locked in a filing cabinet to prevent unauthorised access. Data will be held
following the finishing of this thesis for 7 years.

Ethics committee approval

As this research was conducted across two units in two separate countries, this
research involved seeking approval through two different ethics processes requiring
different documentation. Approval was given for the NSW unit by the appropriate Area
Health Service Human Ethics Committee and in NZ by the appropriate District Health
Board Ethics Committee as well as the designated Regional Health Ethics Committee.
Ethics approval at the NSW unit was submitted shortly before a major restructure in
jurisdictions from Area Health Services to Local Health Networks. Notification of
ethics approval was delayed several months due to the changes in administration. As
this research was undertaken as part of a master's programme through Massey
University, the Massey University Human Ethics committee was also advised and
provided with the ethics approval for both units. With the extension of the research for a
further year, notifications of extension were submitted to the designated Ethics
Committee and Massey University as required.

Informed consent was gained from the participants by first providing an
information sheet and consent form outlining brief details about the research project,
including the process to be undertaken by the research, aims of the study,
confidentiality, ethics approval, and rights of participants. At the interview, participants
were given the information sheet and consent form which was signed in front of the
researcher. A copy of the consent form, participant information form, and interview
schedule are provided in Appendices A, B, and C.

Chapter 4: Document review of policies

Introduction

Acute mental health inpatient units in NZ are guided by national and DHB
policies, while NSW inpatient units are guided by national, state, AHS, or AMHS
policies. Policy development in both countries is informed by literature from the
past 20 years, as well as by national documents identifying prevalence of IPV,
retraumatisation by mental health systems, and the need to incorporate TIC
principles.

The policy document analysis, as detailed in Chapter 3, reviewed the
national, state, and local health policies that guide each unit to determine how each
policy referred directly or indirectly to trauma, SA, DV, or FV. The documents
consisted of active policy documents from national, state, DHB, AHS, or AMHS
sources for each unit, accessible through the unit's policy database that referred to
trauma, SA, and FV. The sample contained 23 NZ policy documents and 39 NSW
policy documents. In this first phase of analysis, 155 codes were identified. During
the second phase of coding, these codes were categorised under conceptual
headings. This process was completed for both units, identifying 28 conceptual
themes. The resulting conceptual headings from each unit were then compared,
revealing 12 key themes in the findings from the literature review. These key
themes are: SA and FV as a risk factor for the development of a mental illness;
safety from IPV; specific service provision in relation to SA, FV, and trauma;
universal screening; responding to disclosures; retraumatisation; inconsistent use of
terminology; staff training; VT; cultural awareness; gender specific services; and
choice and control.

This analysis identified three overarching themes. Firstly, national level
policy documents give some recognition of the need to address SA and FV in mental
health care, but less recognition is given at a state or local level. Secondly, selective
alignment between policy and practice addressing SA and FV is evident at both
units. Thirdly, selective alignment with the key features of TIC is evident in policy

documents at both units, with greater emphasis on trauma awareness and safety and
less emphasis on collaboration and choice, control, and empowerment.

This chapter outlines the findings of the policy document analysis. The 12
themes relating to the key features of TIC, as identified in the literature review, are
outlined in the following sections, grouped under the key features of TIC. For each
theme, the results from the NZ unit are overviewed first, followed by the results
from the NSW unit. Under the overview for each unit are descriptions of the
respective national or federal policy content referencing SA, FV, or trauma,
followed by respective DHB or, for NSW, AHS and AMHS policies. To maintain
confidentiality, the national, federal, and NSW policies have been named, however
DHB or AHS/AMHS policies are identified only by their content matter. Tables
listing the policy documents referenced in this chapter are provided in Appendices G
to K.

Trauma awareness

Recognising SA and FV as risk factors for the development of a mental illness

The literature review in Chapter 2 provides evidence for the relationship
between SA and FV and the development of mental illness. Trauma informed
services acknowledge the link between IPV and mental illness and consider this in
planning and delivery. This policy document analysis found national health policy
documents available at both units identified SA and FV as risk factors for
development of a mental illness. Overarching health policies that guide the NZ unit
refer to SA and FV, as do policy guidelines on screening for FV. In NSW, there
exists a state policy to identify and respond to DV, and policy guidelines for sexual
safety in mental health inpatient units. However, overarching state health policies in
NSW do not refer to SA or DV and the association with mental illness. At a local
level, both units had specific sexual safety or FV documents that recognise the
prevalence of SA and FV and their link with mental illness; however, few references
are made in other policy documents.

NZ unit. Several key NZ health documents identify links between trauma
and mental health. One of the population health priorities in the *New Zealand
Health Strategy* (Ministry of Health, 2000) is the reduction of violence, including
SA and FV, in interpersonal relationships, families, schools, and communities (pg.
13). *He Korowai Oranga Maori Health Strategy* (Ministry of Health, 2002b)
establishes violence as a public health issue and a barrier to improving whanau ora
(family health). Another national strategy, the *Family violence intervention
guidelines: Child and Partner Abuse* (Ministry of Health, 2002a) highlights the high
prevalence of FV and its impact on both consumers and health care providers. It
states, "Any treatment should also convey to the patient that abuse is likely to be a
causative factor in their mental health problems" (p. 46). This document identifies
Mental Health services for implementation of FV intervention.

Three DHB policies refer to SA or FV affecting mental health. First, as
recommended by the national guidelines, the DHB has developed a 'family violence
policy' aligned with the national guidelines. Second, the 'abuse and trauma policy'
acknowledges the impact and need for specific services for those with histories of
abuse and trauma within or outside FV; however this policy is past its review date
and participants stated that management deemed this policy unnecessary to review.
Third, the 'suicide management policy' recognises a relationship between childhood
abuse and the development of mental illness or suicidality.

NSW unit. A number of national policy documents that guide the NSW unit
identify links between SA, DV, and mental health problems. The *National Women's
Health Policy* (2010b) identifies women who experienced violence such as SA or
DV as more likely to engage in health risk behaviours and have negative physical
and psychological health outcomes. The National Mental Health Strategy document
Mental Health Statement of Rights and Responsibilities (Australian Health
Ministers, 1991) identifies both SA and physical assault as risk factors for
developing a mental illness, while the *National Mental Health Policy 2008*
(Commonwealth of Australia, 2009b) and *Time for action: The national council's
plan to reduce violence against women and their children, 2009-2021* (The National
Council to Reduce Violence against Women and their Children, 2009) describe how

those exposed to traumatic events have an increased risk of mental illness. The
Fourth National Mental Health Plan (Commonwealth of Australia, 2009a)
acknowledges that some people are vulnerable to developing a mental illness due to
abuse or trauma. SA and DV are not defined in any of these documents, nor is any
definition given for a traumatic event.

Although reference is made to SA, DV, and trauma in national policy, few
references exist at state level. SA, DV, and trauma are not mentioned in the leading
mental health state policy documents, such as *New South Wales: A New Direction for
Mental Health, 2006 (NSW Department of Health, 2006b)* or *New South Wales
Interagency Action Plan for Better Mental Health (NSW Government, 2005).*
References to SA, DV, or trauma are made in six state and local mental health policies
about specific practices: DV routine screening, sexual safety, clinical documentation,
and suicide. *The Policy and Procedures for Identifying and Responding to Domestic
Violence* (NSW Department of Health, 2006c) and its corresponding AHS 'domestic
violence policy' refer to relationships between DV and mental health. Supporting these
two policies, the AMHS 'clinical documentation policy' recognises the importance of
considering DV in contextualising mental health symptomology. The *Guidelines for the
Promotion of Sexual Safety in NSW Mental Health Services 2nd Edition* (NSW
Department of Health, 2004b) and the aligning AHS 'sexual safety policy' recognise the
high prevalence of child sexual abuse and its impact on mental health problems. *The
Framework for Suicide Risk Assessment and Management for NSW Health Staff* (NSW
Department of Health, 2004a), the *Management of patients with possible suicidal
behaviour PD 2005 _121* (NSW Department of Health, 2005c) and aligning AHS
'suicide management policy' also acknowledges an association between childhood
abuse and suicide.

Universal screening

Universal screening for IPV is a key feature of TIC. Findings from the
policy document analysis show that both NZ and NSW units are guided by policy
documents at national or state as well as local level that prescribe the screening of
IPV. While screening for FV includes SA in NZ, this is not so for NSW. The NZ

unit also has provision in an out dated local policy for abuse and trauma screening of past trauma including SA.

   NZ unit. The *Family violence intervention guidelines: Child and Partner Abuse* (Ministry of Health, 2002a) and the corresponding DHB 'family violence policy' maintain that screening for partner abuse should be part of admission and discharge of all females to an acute mental health inpatient unit. Screening should also occur for males presenting with symptoms suggesting abuse. Four policies support the implementation of the DHB 'family violence policy'. These are; a family violence staff safety policy, family violence tikanga (Maori cultural principles) policy, family violence file alert policy and a family violence monitoring policy. Additionally, the out dated DHB 'abuse and trauma policy' states that routine mental health assessments at admission should inquire about SA and trauma, particularly childhood abuse, to ensure appropriate support and therapy is provided.

   NSW unit. Universal screening of DV is referred to but not mandated in Australian national policy documents. The *National Women's Health Policy* (2010b) refers to the good practice of Domestic Violence Routine Screening (DVRS) as identified in the *National Plan to Reduce Violence against Women and Their Children (Council of Australian Governments, 2010).* The state *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' both highlight how trauma can be minimised through identifying and responding to DV, and providing appropriate treatment. These policies require the use of the NSW DVRS process for all females over the age of 16 admitted into mental health inpatient units. No reference is made to screening males. This policy is supported by the AMHS 'clinical documentation policy', which states that DVRS must be completed as part of clinical documentation. No reference is made to universal screening for SA in any NSW mental health policies.

Specific service provision in relation to SA, FV, and trauma

A trauma informed system as identified in the literature review operates on
the premise that many consumers have experienced trauma, therefore services must
address physical or psychological needs that may be present in consumers as a result
of trauma. National policy documents guiding both units identified the need for
specific services addressing needs of those with trauma histories. National policy
documents in NZ specify the need for service provision to be trauma informed, a
specification that extends to one out-of-date DHB policy. In NSW, state policies
with reference to specific provision for SA or FV relate only to specific population
groups.

NZ unit. Two national mental health policies in NZ recognised the need for
specific services for consumers with histories of trauma. The policy statement *Te
Tähuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental
Health and Addiction Plan* (referred to as *Te Tähuhu*) (Ministry of Health, 2005)
states that consumers with histories of trauma require expert services and specific
focus to meet their needs. One leading challenge in *Te Tähuhu*, titled *Workforce
and Culture for Recovery*, gains support for implementation through the workforce
competency framework *Let's get real: Real skills for people working in mental
health and addiction* (Ministry of Health, 2008). This framework identifies values
and attitudes that align with TIC principles that underpin mental health provision.
The framework states that clinicians, leaders, and services will be trauma informed
and practice TIC principles to reduce the impacts of trauma and abuse. The
framework states that TIC would be integrated into organisational policies,
processes, systems, and training by 2011, with consolidation until 2013.

One priority action identified in *Te Kokiri: The Mental Health Addiction and
Action Plan* (Ministry of Health, 2006) to support *Te Tähuhu* is the revision of the
Nationwide Service Framework to ensure consumers with histories of trauma
receive a service sensitive to their specific trauma-related needs. The DHB 'abuse
and trauma policy' acknowledges the need for specific services for those with

histories of abuse and trauma. No local policy identifies the implementing of a
whole of service application of a trauma informed service approach.

NSW unit. Two national level policy documents guiding the NSW unit
referred to the need for specific service provision for consumers who have
experienced trauma. The *Fourth National Mental Health Plan* (Commonwealth of
Australia, 2009a) specifically identifies issues faced by women with histories of SA
or trauma and states that the mental health care workforce and services both need an
awareness of these issues to provide a safe and respectful care environment for
women. This document highlights the need for intersectoral partnerships between
mental health services, sexual assault services, and women's services. Although the
plan cites the development of a specific mental health response for children who
have experienced abuse including SA and trauma, no specific service provision is
given for adults who have experienced child abuse or trauma. *Time for action: The
national council's plan to reduce violence against women and their children, 2009-
2021 (The National Council to Reduce Violence against Women and their Children,
2009)* identifies an under resourcing of services for complex needs related to trauma
and states that mental health services require enhancing to support women with
experience of trauma.

Specific service provisions for SA and DV are identified in two state policy
documents; however, reference is made only to two specific population groups. The
state health plan *A New Direction for NSW: State Health Plan towards 2010* (NSW
Department of Health, 2007b) refers to the need for early intervention programmes
aimed at reducing violence and SA among Aboriginal peoples. The *Multicultural
Mental Health Plan 2008-2012* (NSW Department of Health, 2008b) identifies DV
and trauma as areas requiring specific service provision that particularly meet the
needs of the Culturally and Linguistically Diverse (CALD) and refugee
communities.

Inconsistent use of terminology

Literature highlights the necessity to respond to SA and FV. Although key
national health policy documents in NZ and Australia both refer to SA and FV,
national mental health policy documents vary on the inclusion of SA and FV.
National mental health documents in NZ utilise the term *trauma*, but contain only a
single reference to SA or FV. In Australia, national mental health policy documents
make general reference to trauma as well as to SA and DV.

Alongside this inconsistency, the term trauma is used in several documents
without definition. References to trauma were usually in the context of references to
CALD, refugee, or indigenous communities rather than the context of SA or FV,
which the literature review in Chapter 2 identified as prevalent in relation to trauma.

NZ unit. Three NZ national policies refer to trauma, however either no
definition of trauma is given, or no reference is made to SA or FV. The national
policy document *Te Tāhuhu* (Ministry of Health, 2005) identifies how consumers
with trauma histories require expert services and specific focus to meet their needs.
No definition of trauma is provided, although reference is made to refugees who
have experienced trauma. As the document makes no specific reference to SA or
FV, it is unclear whether the definition of trauma incorporates these forms of
violence. *Te Kokiri* (Ministry of Health, 2006) identifies the need to revise the
Nationwide Services Framework to ensure people with histories of trauma have their
needs met, however no definition of trauma is provided. While a definition of TIC
is included in *Let's Get Real: Real skills for people working in mental health and
addiction* (Ministry of Health, 2008) that incorporates understanding the impact of
trauma and reducing retraumatisation in mental health services, no reference is made
to SA or FV.

FV is clearly and explicitly defined in the national *Family Violence
Intervention Guidelines: Child and Partner Abuse* (Ministry of Health, 2002a) and
the aligning DHB 'family violence policy'. The DHB 'sexual behaviour policy'
defines sexual behaviour as "all forms of sexual behaviour regardless of validity,

capacity, or consent issues". Although sex without consent is deemed SA, it appears
to be contextualised first as sexual behaviour. Further, SA is defined in the
document separately as a sexual act where a consumer did not consent, could not
consent, or was coerced into consenting. No reference is made to the legal
definition or other prominent definitions of SA.

     NSW unit. Eight national policy documents utilise the terms trauma, SA, or
DV; however, only *Time for action: The national council's plan to reduce violence
against women and their children, 2009-2021* (The National Council to Reduce
Violence against Women and their Children, 2009) and *The national plan to reduce
violence against women and their children* (Council of Australian Governments,
2010) use all three terms. No definition of these terms is given in these documents.
The *National Mental Health Policy 2008* (Commonwealth of Australia, 2009b)
states those exposed to traumatic events are at increased risk of mental illness,
however no definition of traumatic events is provided. The *National Practice
Standards for the Mental Health Workforce* (Department of Health and Ageing,
2002) states mental health professionals have an understanding of the specific needs
of those with mental illness and trauma.

     The *Fourth National Mental Health Plan* (Commonwealth of Australia,
2009a) states that SA and DV are a factor for the development of an illness that can
be prevented. It states that the mental health workforce needs to be aware of
consumers with experience of SA and other trauma as a child or adult, with services
ensuring a safe and respectful environment. It also states it is important to maintain
connection and support where there is DV. The *National Action Plan on Mental
Health* (Council of Australian Governments, 2006) makes provision to develop
guidelines to manage inpatient violence, however the term violence is undefined.
The *National safety priorities in mental health: A national plan for reducing harm*
(National Mental Health Working Group, 2005) acknowledges violence in mental
health inpatient settings, however no definition of violence is given, nor reference to
SA or DV. Finally the *Implementation Guidelines for Public Mental Health
Services and Private Hospitals (Department of Health and Ageing, 2010a)* states
services must have procedures to respond to traumatic incidents in the unit, and staff

are to be skilled in accessing sociocultural and historical information from those
with a CALD background, particularly those who have had traumatic experiences.
This document does not define traumatic experiences.

At the state level, the *Guidelines for the Promotion of Sexual Safety in NSW
Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) clearly
defines SA, and the state *Policy and Procedures for Identifying and Responding to
Domestic Violence* (NSW Health, 2003) provides a clear definition of DV. The
Reportable Incident Definition under section 20L of the Health Administration Act
policy directive (NSW Department of Health, 2005d), on the other hand, uses the
terms violence and assault but does not specifically name SA or DV.

At an AMHS level, the 'domestic violence policy' defines DV as a
behavioural problem focussed on controlling another person and highlights the
extent of females as victims. However, this policy emphasises that men and those in
same sex relationships may also be victims.

Staff training

NZ unit. The *New Zealand Health Strategy* (Ministry of Health, 2000)
recognises that to reduce violence, protocols and training are required to enable
health professionals (including mental health professionals) to recognise and
respond to these forms of violence. *Let's Get Real: Real skills for people working in
mental health and addiction* (Ministry of Health, 2008) identifies training required
to provide a trauma informed response to those with histories of trauma. The
*Family Violence Intervention Guidelines: Child and Partner Abuse (Ministry of
Health, 2002a)* along with the corresponding DHB 'family violence policy' state
that training and education will be provided to staff to enable them to be competent
in identifying and responding to FV. At the DHB level, policy relating to 'abuse
and trauma' states that training is required to aid clinical staff to provide appropriate
responses to disclosures. Although comprehensive in its coverage, this policy is
outdated and not considered for review.

NSW unit. State and AHS policy documents both identify the need for staff training for SA and DV. The *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' maintain that to effectively ask and respond to DV screening questions, mandatory training for all mental health staff involved in DVRS is required. *The Multicultural Mental Health Plan 2008-2012* (NSW Department of Health, 2008b) states that training on working with trauma in CALD and refugee communities is to be provided to mainstream mental health workers.

Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services -2nd Edition (NSW Department of Health, 2004b) and the aligning AHS 'sexual safety policy' state that staff training in sexual safety is mandatory. This training covers promotion of a safe environment and responding to disclosures of abuse. The guidelines state that training, policies, and procedures are to be developed and implemented at an AHS level.

Vicarious trauma (VT)

The literature recognises vulnerability to VT in staff who work with traumatised consumers. However, VT is not identified in any policy documents, although some recognition is given to the impact of working with people who have experienced violence.

NZ unit. Although national policy documents do not mention VT, several references are made to the impact of working with violence in DHB policies. The DHB 'family violence staff safety policy' states that the physical and psychological safety needs of staff are to be considered for those working with screening and responding to FV. The DHB 'sexual behaviour policy' asserts that staff are to be supported when working with clients where risk issues were associated with substantial problems. It is unclear however if this support refers to VT or physical safety issues, as no further qualification is provided.

NSW unit. Although reference is made to staff safety in NSW policy documents, it is unclear whether safety is in relation to VT or physical risks when

working with potentially aggressive consumers. Staff safety is recognised in the *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the aligning 'domestic violence policy directive', however there is no identification of the need for psychological safety and the impact of working with those who have been subjected to DV. The *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) requires support to be provided for staff who report SA, but does not state what this consists of, or why such support is needed. Where violence is experienced, the *Zero Tolerance Response to Violence in the NSW Health Workplace* policy (NSW Department of Health, 2005e) states that management are to assist the staff or consumers involved to access required supports.

<div align="center">**Safety**</div>

Safety from IPV within the inpatient setting

The document review located several policy documents that suggested or prescribed that both units identify safety issues and service requirements to protect consumers from abuse. This was stated as a fundamental right of all consumers in both NZ and Australian national policy documents. More references to the need for safety from IPV were found in the NSW national, state, and local policy documents than in the documents from the NZ unit. Although literature identifies a range of factors that heighten vulnerability of women to SA, policy in the NZ unit refers to placing vulnerable women in a separate area, with limited references to other contributing factors. In contrast, NSW participants spoke of unit wide environmental safety in the NSW unit and identified mental illness and other factors as safety risks. While NSW documents regard SA being the responsibility of the perpetrator, no such statements are made in NZ mental health policy documents.

NZ unit. At a national level, the *Health and Disability Commissioner Act 1994* and *The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights 1996* declare consumers have a fundamental right to freedom from exploitation, with the former explicitly stating 'sexual exploitation'.

At the DHB level, eight policies identified SA, FV, or trauma. The 'draft vulnerable women's area policy' identified the need for a specific area for vulnerable women to receive care in. According to policy criteria, women are admitted to the area if they are having difficulties with males; present with inappropriate sexual behaviour that places themselves or others at risk; for cultural or religious reasons; or to respect their choice to be in a gender specific environment. The language used in establishing these criteria indicates that safety from SA relates to the women's inappropriate sexual behaviour rather than the responsibility of the perpetrator.

The 'sexual behaviour policy' affirms consumers have the right to a safe environment, dignity, and privacy. It states any sexual behaviour including SA is not appropriate and will be treated seriously. To provide safety, the 'abuse and trauma policy' along with 'high risk service user policy' states that a risk assessment of the likelihood of sexual behaviour is to be undertaken as part of routine admission assessment. If this assessment identifies risk issues such as past sexual and physical abuse, specific management plans are to be established to meet presenting needs.

Three of the eight policies communicate administrative action to reduce or respond to identified risks of SA or FV. The 'family violence policy' and accompanying 'family violence file alert policy' state that where FV is present, a 'file alert' must be used to identify the consumer's file. To promote a safe environment for consumers, the 'police vetting policy' states that prior to employment or a contract with DHB services, all persons with direct patient care, or in position of unsupervised access to patients, will be vetted using a police check for assault and violence with particular reference made to violence and behaviour of a sexual nature. Finally, the 'serious incident review policy' states that where an incident of violence has occurred in the unit, a report is to be made ascertaining why such an event occurred and ways to minimise the reoccurrence. No definition of violence is provided in this policy; however it is assumed that SA and FV are included.

NSW unit. Several national policy documents recognise and/or provide guidance on safety risks associated with SA or FV to the NSW unit. The *Mental*

Health Statement of Rights and Responsibilities (Australian Health Ministers, 1991)
affirms consumers' right to protection from the threat of SA in health care
environments. It also recognises the increased vulnerability to sexual or physical
assault a mental illness may create. No reference is made to DV or FV. The
National Action Plan on Mental Health 2006 – 2011 (Council of Australian
Governments, 2006) makes provision to develop guidelines to manage inpatient
violence, although the term violence is undefined. The *National Safety Priorities in
Mental Health: A national plan for reducing harm* (National Mental Health
Working Group, 2005) also acknowledges the need to address safety issues and
violence in mental health inpatient settings. This policy, too, has no definition of
violence.

State policy documents address both SA and DV. The *Guidelines for the
Promotion of Sexual Safety in NSW Mental Health Services - 2nd Edition* (NSW
Department of Health, 2004b) and the corresponding AHS 'sexual safety policy'
provide principles to prevent and respond to SA. This includes identifying a
consumer's revictimisation risks and need for a care environment that provides
protection from SA and retraumatisation. Both policy documents refer to a strict 'no
sex' policy in the unit. These policies maintain that the responsibility for SA lies
with the offender.

The *Policy and Procedures for Identifying and Responding to Domestic
Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence
policy directive' identify DV as a safety risk for women. These policies require
staff to identify DV in presenting consumers and make every effort to discharge the
woman into a safe environment. On discharge, information regarding DV is also to
be communicated to the community mental health service for follow up.

Five policies referencing SA at the NSW state level relate directly to staff. The
NSW Health Code of Conduct (NSW Department of Health, 2005a) and the aligning
AHS code of conduct policy state that SA is inappropriate conduct. *The Framework
for managing disciplinary process in NSW Health (NSW Department of Health, 2005b)*
and the *Criminal Allegations, Charges and Convictions Against Employees Document*

Number PD2006_026 (NSW Department of Health, 2006a) both state that all
allegations of sexual activity will undergo an investigation and risk assessment and
managed accordingly. The *Employment Screening* policy (NSW Department of
Health, 2008a) states that a national criminal record check will be undertaken prior to
employment for all staff of NSW Health, to include identification of sexual offenses
such as SA. Finally the *Zero Tolerance to Violence in the NSW Health Workplace*
policy (NSW Department of Health, 2005e) identifies SA as an act of violence not
tolerated in the workplace. The aligning AHS zero tolerance to violence does not
specifically identify SA. Both the state and local policy document identify
environmental factors such as staffing levels and training in communication and
minimising violence are to be employed to prevent violence.

Three additional AHS policies refer to safety risks associated with SA or DV.
The 'Risk Assessment and Management policy' and the 'patient care levels policy'
categorise sexual safety as a risk requiring assessment, management, and careful
observation. Where a sexual safety risk is identified, management practice is to increase
the level of observation. The 'guidelines regarding relationships with consumers' policy
states there are to be no sexual relationships with clients. The AHS 'Disclosing health
information policy', states that where SA and DV are identified in clients, records are to
be classified as sensitive to maintain safety of information and avoid such information
being forwarded to others inappropriately.

Gender specific service provision

The literature highlighted the need for gender specific or gender sensitive
service provision. Provision of gender specific or gender sensitive services in policy
documents varied across the two units. The NZ unit had an area for vulnerable
women for which there was a 'draft vulnerable women's area policy'. No such
provision for gender specific services existed in NSW policy. Few references
appeared in policies at either unit about men or consumers identifying as LGBTI in
relation to SA or FV.

NZ unit. Although there was no provision at a national level for gender specific services or care in mental health in relation to SA or DV, the NZ unit had implemented an area specifically for vulnerable women. The 'draft vulnerable women's area policy' identified the need for gender specific service provision to address the vulnerability present for women due to past and current SA and FV. To "increase the safety and dignity of vulnerable female service users", this policy states that staff in the vulnerable women's area are to be female, although skilled male staff may be appropriate. Staff in the vulnerable women's area also require knowledge of TIC principles, training in communication, and an understanding of Dialectical Behavioural Therapy/Cognitive Behavioural Therapy/Solution Focussed Brief Therapy principles. This knowledge is not required for work in the general mental health ward.

NSW unit. The *Fourth National Mental Health Plan* (Commonwealth of Australia, 2009a) identifies issues faced by women with histories of SA or trauma, and states that both workforce and services need awareness of these issues to provide a safe, respectful care environment for women. At a state level, the *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) highlights the need to provide a safe environment, addressing vulnerabilities for women in particular. It identifies that females who have been sexually assaulted may prefer female staff. Where possible there is to be provision of single sex bedrooms and bathrooms, although neither is mandated.

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' highlight the extent of females as victims. The only gender specific service provision identified in this policy is the requirement to screen all female consumers for exposure to DV, while male consumers are only screened if indicators of DV are present.

Retraumatisation

The literature review identifies several factors that may cause
retraumatisation of consumers with SA or FV histories. These include
revictimisation, mental health practices such as the use of restraint and seclusion,
and admission to a unit. Policies that provide guidance to both units identified
retraumatisation around the practices of restraint and seclusion for which there are
both national and local policies. Risk of revictimisation where there were histories
of SA and FV were identified in policies guiding both units; however, service
response was different. Although research highlights that retraumatisation may
occur from many mental health service practices, the only reference to another
mental health practice related to involvement of police and court procedures.

NZ unit. Two national policy documents recognise histories of trauma and
possible retraumatisation in mental health services. The *Seclusion under the Mental
Health (Compulsory Assessment and Treatment) Act 1992* (Ministry of Health,
2010), states that extreme caution should be taken when secluding a person with a
"history suggestive of significant trauma" (p. 5). In association with this, the *Health
and Disability Services (restraint minimisation and safe practice standards*) (NZS
8134.2:2008, 2008) acknowledges that the use of restraint where there is a history of
abuse may be retraumatising.

The DHB 'restraint minimisation policy' aligns with the national *Health and
Disability Services (restraint minimisation and safe practice standards*) (NZS
8134.2:2008, 2008) which reinforces the need to consider the psychological and
physical impacts of trauma on the consumer when considering restraint. The DHB
'seclusion policy' parallels the national policy; however, whereas the national
guidelines suggest seclusion is to be used with extreme caution, the DHB 'seclusion
policy' states that seclusion *must not* be used (italics inserted).

NSW unit. Two NSW policies refer to retraumatisation for those with
histories of SA, DV, or trauma. The *Seclusion Practices in Mental Health Facilities
Policy Directive* (NSW Department of Health, 2007c) states that a history of abuse

needs to be taken into account when considering seclusion, as seclusion may
compound trauma. The *Guidelines for the Promotion of Sexual Safety in NSW
Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) and the
aligning AHS 'sexual safety policy' identify the need for appropriate responses to
reduce the impact of trauma. Retraumatisation by police investigations and court
hearings in relation to SA is also referenced.

Responding to disclosures

Responding appropriately to disclosures is important to minimise trauma of
the event and avoid retraumatisation. Both units had policy documents that
prescribed the need to appropriately respond to disclosures of FV and SA, with
NSW policies providing more information on how to respond appropriately.

NZ unit. Three policies articulated action in response to disclosures of SA
or FV. The national *Family Violence Intervention Guidelines: Child and Partner
Abuse* (Ministry of Health, 2002a) and the aligning DHB 'domestic violence policy'
state that where FV is suspected or disclosed in the unit, the person should be
responded to appropriately and their experience validated. An immediate referral is
to be made to social workers and a referral to a DV support centre on discharge.

The 'sexual behaviour policy' states that in response to incidents of sexual
behaviour (including SA), actions are to be implemented that ensure physical health
protection, risk reporting, and provision of education for consumers. No reference is
made to the priority of re-establishing safety for the consumer, identified as best
practice in the literature review. The 'abuse and trauma policy' identifies that
appropriate responses to disclosures are important; however, the policy referred staff
to a training manual inaccessible to the researcher at that time.

NSW unit. Following a disclosure of SA, the *Guidelines for the Promotion
of Sexual Safety in NSW Mental Health Services - 2nd Edition* (NSW Department of
Health, 2004b) and the AMHS 'sexual safety policy' maintain that the first response
is belief, then ensuring safety, followed by privacy and providing support for the
victim. The policies assert that appropriate responses create an understanding that

consumers need to regain their sense of control and safety in the first instance. After staff have attended to this need, physical health assessments and administration actions are to be taken. The AMHS 'sexual safety policy' highlights sources for appropriate referral. The state *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' both provide in-depth information on appropriate responses to DV that aligns with literature on best practice. The state *Incident Management PD 2007 _ 06* (NSW Department of Health, 2007a) states that all incidents of sexual or physical violence are to be reported and investigated.

Cultural awareness

Reference in national, state, and/or local policies to cultural awareness in relation to SA and FV differed across the two units. National and local documents guiding the NZ unit refer to the need to incorporate tikanga (Maori cultural principles) in working with FV. The only reference to cultural awareness in NSW is the specific service provision of SA or DV for Aboriginal and Torres Strait Islander peoples and CALD and refugee communities. Training in working around trauma with CALD and refugee communities is also mandated.

NZ unit. The *Family Violence Intervention Guidelines: Child and Partner Abuse* (Ministry of Health, 2002a) along with the corresponding DHB 'family violence policy' identify the need to consider culture in working with FV. Supporting the local DHB family violence policy is a family violence tikanga policy, which states staff are to seek cultural support to implement tikanga and bicultural principles when screening for FV.

NSW unit. Four NSW policy documents refer to culture in relation to SA or DV. Two of these relate only to specific population groups. The state health plan *A New Direction for NSW: State Health Plan towards 2010* (NSW Department of Health, 2007b) refers to the need for early intervention programmes aimed at reducing violence and SA among Aboriginal peoples. The *Multicultural Mental Health Plan 2008-2012* (NSW Department of Health, 2008b) identifies specific DV

and trauma service provision required for consumers from CALD and refugee
communities. The third policy document, *Guidelines for the Promotion of Sexual
Safety in NSW Mental Health Services - 2nd Edition* (NSW Department of Health,
2004b) and aligning local 'sexual safety policy' highlight Aboriginal and Torres
Strait Islander peoples and those from other diverse cultural backgrounds may be
more reluctant to disclose abuse.

Choice, control, and empowerment

Choice and control

Although literature addresses the importance of choice and control for those
who have experienced SA and FV, findings show there is little reference made
specifically to choice and control for those who have histories of abuse and violence
in NZ. Across both units, guiding policy documents refer to the requirement to
provide consumers with information, which the researcher assumes is to enable
informed choice making. Two documents guiding the NSW unit point out the
importance of choice and control for consumers with recent or past SA or DV.

NZ unit. The *Family Violence Intervention Guidelines: Child and Partner
Abuse* (Ministry of Health, 2002a) along with the corresponding DHB 'family
violence policy' state it is important that people are able to choose their actions and
such choices must be respected. Information on options is to be available from
which consumers can make choices.

NSW unit. The *Guidelines for the Promotion of Sexual Safety in NSW
Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) and the
aligning AHS 'sexual safety policy' highlight the importance of providing choice
and reinstating a sense of control to consumers who may have histories of SA. To
promote choice and control following SA, information is to be provided to
consumers on their rights and options. The policy references the *National Standards
for Mental Health Services* (Department of Health and Ageing, 2010) which states
that mental health services are to provide choice.

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' state that to promote empowerment, consumers must be given information in relation to DV. Following a disclosure, the consumer must have choice concerning any action to be taken, excepting where child protection risks are indicated. Alongside these policies the *NSW Health Victims of Crime Policy 1995* (NSW Department of Health, 1995) and the aligning policy directive state that victims of a crime (SA and FV are considered crimes by the NSW *Crimes Act 1900*) have a right to access appropriate options, referrals, services, and remedies.

Strengths based practice

National, state (for NSW), and local policies made reference to strengths based responses to DV or FV and were available to staff in both units. Specific reference was made in relation to sexual safety in NSW. No reference is made in any guiding policies for staff to specifically take a strengths based approach.

NZ unit. The *Family Violence Intervention Guidelines: Child and Partner Abuse* (Ministry of Health, 2002a) along with the corresponding DHB 'family violence policy' identify ways by which staff can support and empower victims of FV. These include listening, validation, normalising impact, and provision of information. Self determination concerning information provided and action taken is also identified. No reference is made to staff taking a strengths based approach.

NSW unit. As with NZ, the *Policy and Procedures for Identifying and Responding to Domestic Violence* (NSW Health, 2003) and the corresponding AHS 'domestic violence policy directive' promote wellbeing by implementing early identification and appropriate interventions. Support provided is non-blaming and promotes consumer's self-determination concerning choices available after disclosing DV. The *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services - 2nd Edition* (NSW Department of Health, 2004b) and the aligning AHS 'sexual safety policy' highlight the importance of validation, empathy, and

placing responsibility on the perpetrator rather than the victim. No reference is made to staff taking a strengths based approach.

Collaborative practice

Guiding policies at both units identified the need for collaborative practice in relation to responding to SA or DV/FV in almost all policies. As this is a consistent practice across both units, this has not been discussed further.

Selective alignment

A central theme evident throughout the twelve themes was *selective alignment*. The findings show that policies that guided or prescribed actions to each unit did not align with the key principles of other policies relevant to the same unit. Overall, frequent references were made to trauma awareness, safety, and collaborative practice, with fewer references to choice, control, and empowerment. Both units had available to staff national policies that referred to SA and DV/FV and stated a need for specific service provision, however this theme did not continue through to a state or local level, apart from specific policy on universal screening or restraint and seclusion.

Summary of document review findings

The document review produced 12 themes in relation to references to SA, DV/FV, and trauma. Staff at both units had the availability of national policy documents, mainly in the form of guidelines that referred to SA and DV/FV and stated a need for specific service provision. At a DHB, AHS, and/or AMHS level, policy documents provided no reference to 'whole of service' working in a trauma informed manner. Several policy documents specific to mental health service issues such as universal screening, responding to disclosures, retraumatisation, and staff training named practices and processes that aligned with TIC principles, however the implementation of these varied across the two units. Differences existed in the provision of gender specific services and recognition of choice and control in policies that guided two units. Difference in recognition and use of the terms SA,

DV/FV, and trauma was also evident across the two units. A central theme across
all 12 themes was that of selective alignment.

      Having provided an overview of the findings of the document analysis in this
chapter, the next chapter describes the findings of the key informant interviews.

Chapter 5: Semistructured interview findings

Introduction

Method two aimed to compare the implementation of TIC within an acute mental health inpatient unit in NSW, Australia with a unit in NZ. The data gathering method for this study consisted of key informant interviews with senior staff, which were recorded and transcribed. The transcripts were coded then categorised into themes aligning to the key features of TIC implementation in mental health systems: trauma awareness; safety; choice, control, and empowerment; and collaborative practice. The themes were then compared between the two units. The key features of TIC to which the themes are aligned are used to structure this chapter. Overall, the results showed that aspects of most key features were present in both units but were not necessarily fully implemented. It was evident that the two units perceived TIC differently in both units resulting in different levels of implementation.

This chapter includes quotes from participants both within the text (indicated by quotation marks) and as indented paragraphs. A unique participant identifier follows each quote.

Trauma awareness

The research identified eight themes relating to trauma awareness: adopting a philosophy of TIC; staff understanding of the relationship between the trauma of SA and FV and mental health; TIC or risk aversive care; professional development; access to information and resources; consumer awareness raising; universal screening; and VT.

Trauma awareness was evident to varying degrees between units. Notably, there was less consensus about the impact of IPV and awareness of TIC, along with fewer opportunities for professional development and access to information and resources at the NZ unit than at the NSW unit. While the NSW unit screened consumers for FV, no screening for any form of IPV was undertaken at the NZ unit. Recognition of VT also varied in and between units.

A philosophy of TIC

The findings showed inconsistency in definition of TIC and perspective on
whether TIC underpinned practice at the NZ unit. In contrast, NSW participants agreed
that TIC underpinned practice at the NSW unit. The complexity of being trauma
informed yet managing risk in an acute inpatient unit environment was a key theme that
emerged at both units. The NZ unit appeared to focus on risk reduction through
reducing risk situations while the NSW unit had a focus on mitigating risk through TIC.

NZ unit.

Trauma informed care is a good thing but the devil's in the detail when it
comes to knowing what people mean when they say trauma informed care
(Participant C).

An important finding was a lack of consensus among the participants as to
what TIC entailed and whether unit practices were underpinned by a TIC
philosophy. Some participants stated that being trauma informed meant that risk
management needed to be prioritised due to consumers' vulnerability. Other
participants disagreed and suggested that unit practices focussed primarily on risk
aversion rather than TIC. They felt that increasing safety in the unit was typically
responded to by decreasing consumer control and therefore did not constitute a TIC
approach. Participants identified there was no framework to understand and apply
TIC to practice, making it difficult for staff. Some participants spoke of the
challenge of navigating different perspectives of trauma held by staff, based either
on a medical model or on a biopsychosocial model.

Two initiatives were cited as evidence of TIC implementation: sensory
modulation practices and a vulnerable women's area. In line with national directives to
reduce restraint and seclusion, the unit implemented sensory modulation strategies
including sensory modulation equipment and room to assist consumers maintain
emotional control and prevent retraumatisation. The second TIC initiative identified
was a specialised area where women identified as vulnerable were admitted to provide
additional safety away from the mixed sex ward.

Despite these positive initiatives, some participants felt the unit did not operate from an overarching TIC philosophy. Evidence included no formal process for identifying and responding to disclosures of abuse; a lack of TIC training; lack of knowledge amongst staff of TIC; staff confusion over whether specific practices were trauma informed; lack of focus on TIC at management level, and interactions with consumers considered inappropriate or retraumatising as past trauma was not considered. Participants stated that management support for the implementation of TIC had diminished and there was now a lack of an agenda for TIC implementation.

NSW unit.

Some of us are just still in that custodial mould … so it's trying to move people into the 21st century of we're not here just to be custodians, we're here to be therapeutic with patients and we're here to provide a caring and safe environment (Participant M).

The director's catchcry is 'I think about if I had my wife or my mother or my sister in hospital how would I feel if this [practice, incident] happened to them?' (Participant M).

Unlike the NZ unit, the NSW unit provided examples of how TIC underpinned their philosophy, procedures, and practices from management through to frontline staff. Statements such as those above were similar between participants and indicated a TIC philosophy of care underpinned their perspectives. Risk management was important but participants suggested this was addressed through being trauma informed, not risk averse. Safety risks were seen to occur when a consumer was retraumatised, therefore past and current trauma experienced by consumers was acknowledged and practices implemented to minimise retraumatisation. An example was given of a client self-harming due to feeling she had no control over herself or her environment. Staff responded to the client's distress and feeling "caged in" by providing strengths based support to address her feeling unsafe rather than adopting a risk aversion approach focussed on stopping self-harm. Concern was expressed that working with a 'least

restrictive care' approach, where minimum interventions for effective treatment are
provided, may increase safety risks if not underpinned by a TIC philosophy.

**Staff understanding of relationship between trauma of SA and FV and mental
health**

All participants at both units identified a link between IPV and mental illness
and the impact on a person's presentation. However, there was a greater consensus on
the degree of impact of trauma on mental health amongst participants at the NSW unit.

NZ unit.

A lot of the people we see here have some kind of trauma in their
background, almost everybody, so I mean it's almost assumed.

The people are doing the best that they can, and actually, when you see their
brain and you think, oh yes, they are doing the best they can (Participant T).

It was recognised or assumed by most participants that many consumers
admitted into the unit had experienced some form of trauma over their lifetime. All
participants at the NZ unit understood there to be a relationship with trauma (identifying
specifically child abuse and SA) and mental health. There was no consensus however
on the degree trauma impacted on or contributed to the genesis of mental health
conditions. Some participants identified that consumer presentations were sometimes
misunderstood, as the impacts of trauma were not recognised. Although the link
between child abuse and mental health conditions was identified, no participant
identified FV as having an impact on mental health.

NSW unit. In comparison to NZ participants, NSW participants' responses
demonstrated in-depth knowledge of the impact of trauma and presentations that may
constitute a trauma response, and an understanding of the therapeutic needs of survivors
of past trauma. Participants were clear about the distinction between their role in the
unit as being trauma informed and the role of other services such as the sexual assault
service being trauma specific.

Participants stated that all staff understood that people who have experienced some form of trauma or SA might be at greater risk of developing a mental illness. Participants suggested that those from an allied health background find it easier to incorporate a trauma informed approach compared to those trained in a medical model.

Professional development

There is a significant difference in the quantity and quality of professional development provided to staff on TIC. Professional development was more available in the NSW unit than the NZ unit.

NZ unit. Participants at the NZ unit said that TIC training in relation to trauma and abuse had been accessible in the past, but is no longer available. While some said this training was no longer necessary due to staff knowledge, others insisted that fundamental core training in relation to trauma and abuse was needed, and little or no access to training was a barrier to TIC implementation.

One source of TIC training identified by participants was undergraduate studies. It was stated that social workers had basic exposure to TIC as part of their undergraduate training; however, medical, nursing, and psychology staff had little. The DHB's new graduate mental health nursing programme included one-day training on TIC. However, a gap still exists for long term staff who were less likely to have received training on TIC.

Participants spoke of learning about TIC through the implementation of new initiatives such as FV screening (in other areas of the DHB), reduction of restraint and seclusion, and the implementation of sensory modulation. Other informal sources identified were mentoring by senior staff and nurse educators, consumers sharing their experiences of trauma, and staff meetings.

NSW unit.

In the general hospital … you have to make sure you maintain your
equipment and all the things you use, doctors are safe to practise, and your

surgeons have the skills. For us those sorts of skills are often about our

human resource and our people knowing and understanding as opposed to

machines … and so our responsibility is to make sure we have them, as our

people, as shiny and sharp (Participant M).

Training was considered crucial to implementing TIC in the NSW unit and

participants suggested that for change to occur, training needed to be provided to all

staff in order to develop champions of TIC and build collective understanding. It was

stated that 75% of staff at the NSW unit had attended a trauma informed sexual safety

workshop conducted by NSW Health Education Centre Against Violence (ECAV) as

part of a NSW state commitment to implementing safe units. Other well attended

workshops incorporating TIC were the sensory modulation component of the restraint

training workshop, workshops on de-escalation, and training for working with clients

with Borderline Personality Disorder. Further in-house professional development

opportunities identified were senior staff modelling, participating in case reviews, ward

rounds where trauma was identified, and in-service training incorporating TIC

following a safety incident.

Access to information and resources

The units differed considerably on staff access to information and resources, with

the NSW unit having a greater access to information and resources. Overall, it was felt

that more information and resources relating to implementation of TIC in mental health

inpatient settings were needed to ensure evidence based practice.

NZ unit. Few resources on TIC were identified as available either in the unit or

nationally. A regional study day on TIC provided as part of the national *Let's get real*

(Ministry of Health, 2008) workforce competency training was said to lack information

on implementation in inpatient settings. Participants spoke of learning about TIC

practice through observing implementation in other units. This enabled two TIC

practices to be implemented in the unit (sensory modulation and the vulnerable women's

area); however, no formal process was identified for information sharing between units.

The lack of resources and information meant that trauma informed practice may rely on individual experience rather than evidence based practice.

NSW unit. In contrast to the NZ unit, NSW participants identified several sources of TIC information. The staff orientation manual contained information and guidance on managing risk in the inpatient unit and sexual safety. A manual for working with people with Borderline Personality Disorder provides information on TIC. Access to literature, articles, and resources is also available to NSW staff through ECAV. Participants knew other states were implementing aspects of TIC and would like access to the resources and information used by those states; however, there is currently no formal forum for this.

Consumer awareness raising

Raising awareness of IPV and its connection to mental health with consumers varied between the two units. More opportunities for raising awareness with consumers were identified at the NSW unit.

NZ unit. It was unclear whose clinical role, if any, it was to talk with consumers about the link between IPV and mental health. One participant stated that consumers were already far more aware than staff of the relationship between IPV and their current mental state. Rather than consumer awareness raising, it was stated consumers needed validation from staff.

NSW unit. Several forums for providing information to consumers were identified in the NSW unit. A pamphlet is provided to consumers on admission incorporating sexual safety and what a consumer can do if they feel unsafe, are sexually assaulted, or harassed while in the unit. Regular unit meetings provide a forum for staff and clients to identify and discuss safety in the unit. Participants suggested that talking with consumers about sexual safety and boundaries did not occur outside these forums unless there was an identified need to do so.

Participants recognised some consumers did not identify they had been or were in a DV relationship due to dynamics inherent in abuse, or a lack of knowledge about

DV. Some consumers did not recognise the impact of DV on their mental health. To increase consumer understanding and awareness of the impact of DV, psychoeducation was provided during the admission process when screening for DV.

Universal screening

The only screening for IPV implemented in either unit was DV routine screening in the NSW unit.

NZ unit. At the time of interviews, FV routine screening was not implemented at the acute mental health inpatient unit. One participant stated that screening for past trauma including FV, child abuse, and SA was undertaken "as a part of what you do in terms of medical practice and assessments". Others however were unsure whether consumers were asked questions on past trauma, and if so by whom. It was suggested that trauma screening might not be conducted due to lack of training, staff not willing, or staff being frightened to ask questions fearing this might retraumatise the consumer. One participant stated that screening for trauma during assessment without having follow up processes in place might be more traumatising to the consumer than not asking and therefore thought it was inappropriate to ask.

NSW unit.

It's been part of culture around here to get a thorough assessment … just gets passed down as the culture we nurture (Participant L).

In contrast to the NZ findings, screening for DV occurred on admission to the NSW unit as part of the state mandated Domestic Violence Routine Screening (DVRS), with staff utilising the mandated DVRS tool to ask about current and past histories of DV. Asking about other forms of IPV such as SA and childhood abuse was stated as being discussed as part of family history taking. No specific screening tool was identified for IPV occurring outside a partner relationship. Some participants considered asking about past abuse important in order to gain a clearer picture of what might be the "originality of the consumer's illness" (Participant M) or causal factors contributing to a consumer's current mental distress, and thus inform therapeutic care planning.

Vicarious trauma and staff care

Recognition of the potential for VT when working with clients who have been traumatised is a key feature of TIC as identified in Chapter 2. Participants at both units recognised the potential for VT through working with traumatised consumers. Participants in the NSW unit identified organisational approaches to minimise trauma, while more emphasis was placed on the role of individual responsibility for self-care in the NZ unit. Group supervision was available in the NZ unit, and one-on-one supervision available at both units. Supervision was utilised regularly by allied health staff, however not by nursing staff.

NZ unit.

Initially it can be hard to get people having supervision. They just think 'oh somebody's spying on me or trying to brainwash me or whatever', a bit of a paranoid position and then after a while they realise it really is meant to be supportive (Participant C).

Strategies to minimise VT were primarily related to supervision in the NZ unit. Clinical group supervision is mandatory for nursing staff with individual supervision also available. However, few nursing staff utilise this option. It was suggested that nursing culture still did not recognise the supportive role of supervision and instead saw it as disciplinary or 'spying' on staff. Debriefing from senior staff or the Employee Assistance Programme was also available to staff where there had been an incident in the unit.

It was stated by some that management and some staff saw VT as resulting from an individual's lack of resilience and emotional management. On this premise, management had initiated one-on-one sessions for staff with the charge nurse or nurse educator to develop self-care strategies for building individual resilience.

NSW unit. VT was considered to potentially affect all staff but some were not sure that medical staff had the same awareness of VT as other staff. To address the risk of VT, supervision was strongly encouraged, however not mandatory. Similar to the NZ

unit, allied health staff were said to utilise supervision "as a basic right" (Participant M) while nursing staff still considered supervision punitive rather than positive self-development and reflection. The minimal uptake was suggested to reflect the lack of understanding of the inherent risk of VT in mental health service settings, along with little or no emphasis on supervision in undergraduate nursing courses.

Participants related VT to individual resilience but also to organisational practices. An example of an organisational practice implemented in the unit to address possible VT was the hybrid team nursing/primary nursing model. In comparison to other models, the hybrid model allows staff to work with different consumers, allowing staff variety and separation from ongoing challenging work, which carries a higher risk of VT.

Another organisational practice in place was the normalisation of staff experience of shock, distress, or reminders of own past trauma triggered by consumers' disclosures. To support staff, a 'hot debrief' where a staff member could talk immediately to a senior staff member was available. Other support opportunities included the Employee Assistance Programme, and follow up from a senior staff following an incident.

Safety

The literature identified seven subthemes in relation to safety in the context of TIC. They are: physical and emotional safety; minimising retraumatisation; gender sensitive care provision; respectful relationships; acceptance of and respect for diversity; hiring practices; and review of policies and procedures. Implementation of practices relating to safety varied between the two units in the majority of these subthemes.

Physical and emotional safety

Participants spoke more about physical safety than emotional safety. All participants in both units viewed risk assessments relating to IPV as essential at admission and ongoing.

NZ unit. Three risk assessments are undertaken routinely on admission to the
NZ unit. These are risk assessments for vulnerability of harm to self or from others; risk
assessments for predatory behaviour; and identification of risk of vulnerability and need
for admission into the vulnerable women's area. Participants identified five further
ongoing risk assessments relating to IPV. First, staff were said to be "constantly on high
alert around males with predatory behaviours" (Participant U) to ensure the safety of
other consumers, particularly women. The second ongoing risk assessment was
assessing consumers for early warning signs of emotional dysregulation, which often
precedes a safety incident. The third was identifying sexual safety risks, such as sexual
disinhibition. Participants stated that while sexual incidents were once considered
inherent to mental health inpatient settings, staff now understood sexual incidents should
not be tolerated.

The fifth risk assessment undertaken was hourly observations. All consumers
were assessed for possible risk of harm on an hourly basis, with women in the
vulnerable women's wing observed every 15 minutes. The observation assessed the
person and their state of distress, possible need of assistance, as well as the environment
including risk of harm by others. No tools were identified to assist staff with these risk
assessments.

NSW unit.

We're very much risk orientated, you know, risk is the word that flashes on
our forehead the whole time and for all sorts of risks, so we're all very
conscious about it, so I think we're also very much committed to try to
mitigate any risk whether it's around aggression, whether it's around the
physical environment, or it's sexual safety (Participant G).

As in NZ, participants in the NSW unit spoke of risk assessments for consumer
safety being undertaken on admission and as part of ongoing practice. Assessing risk of
vulnerability (specifically identifying sexual disinhibition) as well as risk factors for
violence and aggression were said to be required as part of admission documentation.
Particular note was taken of previous sexual or physical aggression during an earlier

inpatient stay. Risk of vulnerability as well as risk factors for perpetration of aggression were assessed continuously in the unit with handover sheets identifying specific risks that were to be assessed.

> I think part of the thinking around is that they're in a unit so they are safe …
> but being here you're just as at risk of being exposed to a particular
> perpetrator or other sorts of risks (Participant D).

One participant felt that staff now understand the vulnerability of consumers while staying in the unit. It was felt that risk of SA was being minimised by increasing staff education about SA and highlighting better risk assessment. One approach to mitigating risk was to undertake higher levels of observations for those assessed as vulnerable. It was stated however, that some consumers experienced increased observations as retraumatising as it felt they were being watched all the time.

Minimise retraumatisation

Participants in both units were aware of possible retraumatisation within the inpatient units and spoke of a range of practices that may retraumatise a consumer or alternatively minimise retraumatisation. Participant responses from both units showed more awareness of the need to minimise trauma related to physical acts such as sexual or physical assault than the recognition of the impact of psychological trauma.

NZ unit.

> 10 years ago, I have seen nurses who have under a restraint situation
> whipped off pants and underpants down to ankles to give IMIs [Intra
> Muscular Injections]. I would find it incredibly difficult to believe that
> would occur these days (Participant T).

Five themes related to minimising retraumatisation were identified from NZ participants. These were reduction of physical restraint and seclusion; use of sensory modulation; timing and use of interventions or assessments; impact of the care environment; and the need for consistency and routine. First, participants described unit

management commitment to the reduction of physical restraint and seclusion, once
commonplace but now rarely used. When seclusion is used, seclusions occur for short
periods and a nurse stays at the observation window to minimise a sense of isolation that
may be retraumatising. Following seclusion, staff debrief consumers about their
experience as soon as appropriate.

The second practice identified to minimise retraumatisation was sensory
modulation. Sensory modulation experiences were introduced into the NZ unit as an
early intervention measure to assist with regulating emotions. Sensory profiling is also
undertaken in the vulnerable women's area to identify specific sensory modulation
equipment that might best meet the needs of women.

Along with sensory modulation equipment, a sensory modulation room
containing sensory items and equipment is available where consumers may go for
quietness and reduced emotional stimulation. However, it was stated the room was
underutilised due to consumers not wishing to go there, or staff being unavailable to
provide the supervision required in the room.

The third area of practice identified was the consideration by staff of the timing
and use of interventions and assessments. An example was provided of the 'early
warning signs and strategies' form which enabled staff to identify early intervention
strategies in order to assist consumers with emotion regulation before incidents
occurred.

The fourth theme was possible retraumatisation through aspects of the physical
environment of the unit. Recognising challenges experienced by consumers to engage
with staff, the nurses' station desk, identified as a physical barrier between consumers
and staff, was removed. Other adaptations to make the unit environment less
threatening and "more humane" included a massage chair, cushioned recliner chairs, and
"soft fluffy things" (Participant N) in the vulnerable women's area. One participant
acknowledged that although changes had been made, the unit environment would still
feel cold and prisonlike for someone with a trauma history. It was said to be difficult to

implement TIC utilising the current layout and that a new unit may need to be built that
is more conducive to TIC.

The final area of practice identified to minimise retraumatisation was providing
consistency and routine. A primary and associate nursing model where each consumer
was allocated one nurse and assistant was implemented to provide continuity of care and
an identified support person. Uniformity in practice across the team was also seen to be
important for consistency for consumers. The unit tried to maintain consistency by
working with outside providers the consumer had engaged with prior to admission so
engagement could continue during their stay.

NSW unit. NSW participants reported the need to consider current safety issues
due to consumer vulnerability and the need for safety as part of a consumer's recovery.
Eight areas of practice were identified to minimise retraumatisation: recognition of the
trauma of being admitted to the unit; reduction of restraint and seclusion practices;
sensory modulation; recognition of at-risk times and locations for possible traumatising
incidents; assessment of vulnerability; incident management meetings; understanding
the impact of the building design on consumer safety; and creating staff consistency in
care planning.

Participants identified firstly that being admitted to the unit might be
traumatising for the consumer due to the rules and regulations of the unit. This impact
was said to be minimised by providing opportunities for consumer choice and control
where possible.

The second area of practice to minimise retraumatisation was the reduction of
physical restraint and seclusion. The majority of participants understood that consumers
with a history of previous trauma are more likely to be secluded and experience further
traumatisation from this practice. Statewide policies and initiatives assisted the NSW
unit to reduce restraint and seclusions. One measure put in place to reduce the use of
restraint and seclusion was recognition of early intervention to assist consumers regulate
their emotions. Where restraint was required, gender appropriate teams are used and
male security guards are a secondary not primary response. Restraint and seclusion

were viewed as traumatic for staff and consumers and debriefing was available to all involved.

The third area of practice identified to minimise retraumatisation was the use of sensory modulation. At the time of the interviews, the NSW unit had recently acquired sensory modulation equipment and management was developing procedures to provide staff with training on use and possible safety risks prior to implementation.

The fourth practice identified was the recognition of high safety risk times and locations such as staff handover and bathrooms, respectively. To address this, handover was changed from a whole team handover to one nurse giving handover allowing more staff to be available in the unit to mitigate any safety incidents. High-risk locations were also identified and supervision increased in these areas.

The fifth area of practice to minimise retraumatisation was assessing and putting strategies in place to address consumer vulnerabilities for physical and sexual safety. Assessing vulnerability occurred at admission as well as throughout the inpatient stay.

The sixth practice identified by participants was the facilitation of monthly incident management meetings where staff identified and implemented specific safety projects to promote safety.

Building design and layout of the unit was the seventh area identified by participants as potentially retraumatising for consumers. Participants identified a lack of open space and quiet areas. Although participants were unable to change this, possible traumatisation was acknowledged when talking with consumers. To address possible traumatisation to visiting family members, the family room was located in an area that ensured that family members did not have to enter the main part of the unit.

The final practice implemented to reduce retraumatisation was the application of a hybrid team nursing/primary nursing approach. Consumers had an allocated staff member who liaised with their consultants and others involved in their care, creating consistency in care planning.

Gender sensitive care provision

Providing gender sensitive care was important to participants at both units, although implementation differed. One common feature was a lack of consensus and clarity about the definition of gender sensitive care. Additionally no participants at either unit spoke of practices being sensitive to the needs of those who identified as LGBTI.

NZ unit.

They're very mindful around being gender appropriate even if they don't get Trauma informed care, they would probably come and say, Betty Boop's down there and she's pressing her buzzer for some attention, can a female nurse please go (Participant T).

Participants identified that women were more vulnerable to SA when presenting as sexually disinhibited or had a history of past abuse. To reduce the risk of retraumatisation, the NZ unit established an area for vulnerable women. Since implementation of the vulnerable women's area, it was stated that no SA had been reported. Although the vulnerable women's area addressed sexual safety issues, some participants felt it did not address emotional safety. It was suggested that the lack of focus on women's emotional safety is partially due to a lack of training for staff about gender sensitive care. Another example of gender specific practice was the separate men and women's occupational therapy groups provided in recognition of the different needs of men and women.

Several participants described staff as recognising the need for gender sensitivity, however there was a lack of clarity about what this meant. Some suggested gender sensitivity meant considering a consumer's gender when appointing their primary nurse. One participant questioned whether gender sensitivity meant that men should not work with women. No participant spoke of the need to be sensitive to the varying needs or issues that may be experienced by those identifying as LGBTI.

NSW unit. Unlike the NZ unit, the NSW unit did not have a separate area for women as the building design did not allow it. As the unit was a mixed sex unit, all participants spoke of the possibility of SA and the need for staff to be vigilant about sexual safety to protect female consumers.

All participants suggested that gender is considered when working with consumers, however participant responses showed no consensus on the understanding of the term gender sensitivity. Similar to the NZ unit, one participant thought most staff understood working in a gender sensitive manner meant that staff should only work with consumers of the same gender. Several participants spoke of gender being considered when female consumers required seclusion, by involving an all-female team of staff in the seclusion, with inclusion of male staff as a last resort. Another example of gender sensitive practice was staff recognising that female consumers with past abuse issues may be triggered by the presence of male staff. Some practices considered not gender sensitive or appropriate were said to still occur at times, such as a male staff entering a female consumer's room and closing the door behind him. As with NZ participants, no participant spoke of the need to be sensitive to the varying needs or issues of consumers identifying as LGBTI.

Respectful relationships

Participants at both units highlighted examples of respectful relationships between consumers and staff and the need for such respect in recovery.

NZ unit.

If you just have a basic understanding of 'that's how it is' and they're not doing it on purpose to wind you up, well that's half the battle (Participant T).

NZ participants spoke of improvements in consumer treatment over the last 10–20 years. Participants stated staff are generally more respectful of consumers than in previous years. It was suggested this was apparent in staff–consumer interaction, where staff considered the context, content, and delivery of communication more. Several participants identified the way staff engaged with consumers as an important part of

showing respect. One participant suggested that it did not really matter in what context the engagement with consumers occurred, but how a consumer felt following an interaction with a staff member was important.

Participants identified that most, albeit not all, staff now recognise a consumer's behaviour as a possible reaction to events, and not misbehaviour intended to annoy staff. It was suggested that understanding this dynamic enabled staff to be more respectful towards consumers.

Acknowledging a lack of consistency on what constituted respectful behaviour, it was suggested more could be done in the unit to highlight and address the need for relationship building and staff engagement. Some participants at the NZ unit reflected that little interaction occurred between staff and consumers. One barrier identified was the lack of consumer access to staff due to staff being more often in the nursing station than 'on the floor' with consumers. It was stated that some staff did not know, had forgotten how, or did not have the confidence to engage with consumers. To address this, management has introduced training on how to interact with consumers.

NSW unit. All participants stated that consumers were entitled to respect. Evidence of respect to consumers was said to be shown in the way relationships are conducted and the willingness of staff to understand a consumer's perspective. To build relationships, management encouraged staff to sit with consumers and join in or facilitate daily groups. It was said that for respect to develop there needed to be consistency in staffing that allowed time for relationships to be built with consumers. Participants identified that such consistency was provided within the hybrid team nursing/primary nursing approach.

Participants described including a consumer in developing their care plan as an expression of positive engagement and showing respect, which in turn would make a difference to the consumer's experience of the unit. A barrier identified for staff engaging with consumers was the priority given to administrative matters and paperwork. This focus on paperwork rather than on consumers was seen as disrespectful to consumers.

Acceptance of and respect for diversity

Overall little mention was given to the role culture, religion, or sexuality played
in TIC.

NZ unit. No comment was made by participants at the NZ unit about
acceptance of and respect for diversity constituting an important aspect of TIC.

NSW unit. One participant stated that taking the consumer's culture into
account was important, however there was no need for emphasis as the catchment area
for the unit did not have very high ethnic diversity and Culturally and Linguistically
Diverse (CALD) populations. Few staff also had received training in cultural
competency. Resources were available on how to work with interpreters; however, no
staff had any formal training in working with interpreters. No further mention was made
of the inclusion of diversity in TIC.

Hiring practices

The majority of participants at both units stated that individual staff members
were a key determinant in the implementation of TIC. Only the NSW unit identified
specific hiring practices.

NZ unit. No specific hiring practices were identified in the NZ unit in relation
to TIC principles to ensure the right staff were employed.

NSW unit.

The biggest barrier to trauma informed care implementation is individuals. I
think that one can't discount the effect an individual can have within a
service (Participant M).

Several participants at the NSW unit stated the biggest barrier to
implementation of TIC was lacking the right staff and hence the recruitment process was
crucial. It was stated that it was necessary for new staff to have skills and ability to
perform the practical tasks of their role, however it was important to also recruit staff

who worked from or were open to working from a TIC philosophy. Many new staff had

been employed in the unit over the last two years, and were identified as willing to learn

about TIC. This was felt to have enabled opportunities for implementation of TIC

principles, which would have been a challenge for those who were "jaded or burnt out"

(Participant G). New graduate staff were identified able to more readily take on a TIC

perspective than staff who had worked in the mental health system for many years. It

was stated that to find the right staff, the hiring process needs to incorporate selection

criteria that focusses on knowledge and experience as well as values and qualities in line

with TIC.

Review of policies and procedures

Participants were uncertain as to which policies incorporated TIC, and were

unclear if policy reviews considered TIC.

NZ unit. Overall, there was little awareness of policies that incorporated TIC.

Over half the participants stated that they did not know of, or were not sure of, any such

policies. Participants identified five policies relating to TIC. Policies, along with the

percentage of participants identifying the particular policy were draft vulnerable

women's area guidelines (60%); policy in regards to sexual contact and sexual safety

(40%); restraint and seclusion policy (40%); policy around checks and observations

(20%); abuse and trauma policy (20%); and child protection policy (20%).

Although the vulnerable women's area had been open for over a year, guidelines

are still in development. Several participants identified the draft sexual safety policy

was necessary to provide clear guidelines so "that staff do not have to rely on their own

background or belief systems to make the right decision as the right time" (Participant

T). The restraint policy identified that previous trauma was to be taken into account for

restraint and seclusion practice, and highlighted the use of restraint and seclusion only as

a last resort to avoid traumatising a consumer. The observation levels policy was said to

identify previous trauma as a risk factor, with the abuse and trauma policy identifying

clearly the need for screening and appropriate response. Finally, the DHB child

protection policy mandated staff to report child protection issues to minimise further
trauma.

Participants acknowledged that policy development and review may not include
reviewing policy alignment with TIC. It was stated that the policy on abuse and trauma,
which focussed on the need for staff to ask about abuse and the provision of training for
staff on asking and responding to disclosures, was out of date. It was stated that
management had decided this policy was unnecessary and would not be reviewed, as all
staff were aware of trauma and how to respond. Participants identified that not all staff
however were aware of the impact of trauma or how to ask about and respond to
disclosures of abuse, thus the policy required a review.

NSW unit. The awareness of policies relating to TIC by NSW participants was
limited. Just over half the participants identified the unit sexual safety policy, with
fewer participants identifying other related policies. Those with knowledge of the
policies did however speak in detail about policy content and how it was linked with
TIC. Policies and the percentage of participants identifying the particular policy were
local sexual safety guidelines (60%); state restraint policy (20%); state seclusion policy
(20%); patient care level policy (40%) and state sexual health policy (20%).

Policy development and review was stated to be up to date and a clear review
process for ensuring this was described. It was suggested that any review of policies
needed to consider the risk inherent in a policy's practice and alignment with TIC
principles. With the arrival of the sensory modulation equipment it was clearly
identified that prior to working with this equipment policy and procedures needed to be
developed to inform staff of its purpose and to mitigate any risks.

Several participants highlighted the need for consistency in local and state
policies. Several participants at the NSW unit were concerned that although local
policies were developed to align with TIC principles, state policies may not align with
such principles. One policy that exemplified this disjoint was a recent state policy
stating that all consumers in the unit were to be photographed for identification
purposes. Participants suggested that no local consultation or consideration was given to

possible retraumatisation of consumers who had been photographed as part of abuse. To implement the policy would also increase staff workload and work-related stress for staff already working to capacity. Another state policy seen as not aligning with TIC was the seclusion policy. Although the local unit was trying to implement trauma informed therapeutic practice to reduce seclusion episodes, the state policy was seen to focus instead on preparing staff for seclusions to occur, thus considered not trauma informed.

Choice, control, and empowerment

The third overarching key feature in TIC is that of choice, control, and empowerment. This encompasses promoting choice and control as well as empowerment of consumers, respecting consumer knowledge, involving consumers in service development and evaluation, and utilising strengths based approaches. TIC also takes into account staff empowerment and organisational support for change.

Choice, control, and empowerment

Participants at both units identified that the 'Recovery Model', which included choice and empowerment as two key principles, underpinned national and state principles of mental health care. Although participants at both units stated that their unit adhered to these principles, the implementation of these principles was different at each unit. Key findings were the lack of consensus on providing consumers with as much choice as possible in the NZ unit, the difference in equality of staff between the two units, and a lack of established processes in both units for consumer involvement in service development and evaluation.

NZ unit. Responses from NZ participants showed little consensus on how and when a consumer should be given choice. Some participants strongly believed that while a consumer was unwell they lacked the capacity to make decisions, and therefore it was not appropriate to provide choice in decisions about their care. Others felt there was a lack of clarity around provision of choice when a consumer is unwell. An example was provided where the clinician's judgement is that the consumer should stay in the unit but the consumer wants to leave. The participant

stated that "it is not likely the doctor is going to give up control and say 'it's your journey, if you want to leave, yep, if you feel up to it, ok go'" (Participant T). To take such an approach might be detrimental to a doctor and their registration if the person harmed another person and it was considered the doctor had not fulfilled their duty of care to detain a person. The second example provided concerned the health professional's duty of care when a consumer required forced medication that went against the consumer's choice.

It was suggested a history of trauma disempowers a person, therefore staff needed to work in ways that allow the consumer to regain a sense of power and control. One aspect of empowering consumers was to change the power dynamics between staff and consumers. Although it was felt this dynamic was changing, it was considered that not all staff were used to reducing the imbalance of power and including consumers as equal partners in care planning or service development.

For one participant, promoting choice and empowerment meant that the consumer was allowed to take responsibility for determining and implementing actions to address a problem. It was said that frequently an attitude of task orientation prevails and staff feel "I should do something, I should fix this, and I should solve it" (Participant T) instead of asking the consumer what they want to do about a particular issue and how the staff member could assist.

Empowerment of staff was also seen as important to implementation of TIC; however, several participants highlighted that there was no equality between professional disciplines in the NZ unit. It was identified that doctors, for example, were considered above other staff and therefore could not be made to do things like read guidelines. Changing this imbalance of power was identified as necessary for empowerment of staff members.

NSW unit. NSW participants acknowledged the power imbalance between staff and consumers as well as between staff of various professions. Participants stated that being in the unit with a controlled regime of activities and limited ability to leave might be traumatising for consumers: it removes a sense of power and control, which

may also trigger memories of loss of power and control through experiences of IPV.
This was identified as particularly relevant for those admitted involuntarily.

     To counter the lack of control, participants identified several practices. Firstly,
the admission process focussed on ensuring a sense of choice and control for consumers.
Promoting choice and empowerment meant it was important that the consumer be
considered the expert in what had happened to them, and assuring them that they had
been heard. Consumers thus played an important role in deciding on their care options
during the admission or discharge process. Providing this choice sometimes meant a
consumer who did not want to be admitted went home with a management plan,
contrary to a clinician's opinion. Participants recognised that implementing strategies to
increase a sense of control were not always possible with all consumers, but that staff
would identify opportunities to provide choice and control, no matter what state a person
presented.

> When I trained, I guess we were seen as, even by our tutors, sort of the
> lowest of the low in the pecking order. We were made to be subservient to
> the medical staff, all that sort of thing, so you never gained that sense that
> you were really a valued part of the team, and that your opinion mattered and
> that you could think for yourself (Participant M).

     In contrast to the inequality of staff mentioned in some of the NZ responses, the
NSW participants spoke of increased equality among unit staff. It was suggested that
current unit management was influential in the move towards equality. Although
traditionally this unit had a medical director only, it now runs with a non-medical
clinician as director, supported by a medical director. It was stated that medical staff
were not seen as the only experts in consumer care. One participant felt that doctors in
this unit were now working as part of the team. As with all staff, doctors were
addressed by first name by both consumers and other staff to diminish power
imbalances.

     It was stated that implementing TIC empowered all staff. Evidence of this was
shown in the increase in expectation that nurses would spend time getting to know and

understand a consumer, and in turn provide input to inform better care planning and information gathering. This increase in responsibility was felt to have created room for staff growth. The increase in confidence and value also empowered nursing staff to feel comfortable advising doctors on unit operation or inappropriate practice, rather than avoiding questioning doctors' medical practice due to power inequity.

Auxiliary staff, such as cleaning and administrative staff, were also given the same value as other staff and it was said the unit could not operate without them. It was stated management recognised auxiliary staff such as cleaners sometimes had more knowledge of what occurs in the unit than medical or nursing staff hence they were asked by management for input on specific issues. The role of auxiliary staff was also seen to be important to a consumer's recovery. An example was given of an auxiliary staff member engaging consumers in conversation while assisting with food preparation and this making a positive difference to consumers. As described by one participant, all staff were valued as individuals for the role each played in the unit. This resulted in staff valuing their own practice, becoming more innovative in reflection, and implementing new ideas.

Consumers' knowledge respected

Participants at both units identified the importance of respecting consumers' experience and knowledge, however few examples were provided of how this was demonstrated in the unit.

NZ unit. Several participants reflected upon the importance of consumer knowledge. One participant highlighted that their first understanding of the link between trauma and mental illness came from a consumer who shared their history and understanding of their presentation. Another participant spoke about the fact that management placed junior nurses with "high functioning" consumers, because "those women can teach those nurses about how to engage with them" (Participant T). The perspective evident was that consumers have something to teach staff and are able to do so when provided the opportunity.

NSW unit. The majority of NSW participants gave an example of valuing
consumer knowledge through having two consumer workers in the unit to facilitate
groups with consumers. Consumers' understanding of recovery and experience of
mental illness was thought to be helpful for both staff and consumers. Although
consumer workers are employed to facilitate groups in NSW, there was little mention of
employment of nursing, medical, or allied health staff with experience of mental illness.

Consumers involved in service development and evaluation

Examples were provided of consumer involvement in service development and
evaluation across both units but no mention was made of consumer input into the
management structures and systems that underpinned unit practice.

NZ unit. Participants at the NZ unit stated that many consumers were highly
functional and could be involved in service development and evaluation by providing
feedback: for example, consumers were asked for formal and informal feedback on
practice in the vulnerable women's area and sensory modulation tools.

NSW unit. NSW participants identified the power imbalance between staff and
consumers and spoke of engaging consumers in care planning, but provided no
examples of consumer involvement in service development or evaluation.

Organisational support and challenges for change

All participants stated that having leaders, managers, and systems that were
supportive of TIC was necessary for implementation. It was felt that such support had
been provided regarding implementation of some trauma informed practices but lacked
overall in implementing TIC in a holistic way.

NZ unit. An example identified of a successful change was the change from
restraint and seclusion to *seclusion reduction*. Participants stated that the unit
management team had addressed staff anxiety about the change through providing
education on the need for the change and how it was to be done, as well as role
modelling best practice approaches. Creativity in thinking around current barriers and

desired outcomes was also said to have assisted in implementing change in practice.
One participant stated such creativity was evident in the introduction and development
of the vulnerable women's area, which was not confined to the current building design,
but could be relocated or expanded and contracted depending on numbers.

Participants identified challenges to implementing TIC. The first challenge
identified was, a lack of support from management to implement TIC. It was stated that
the impetus for TIC needed to come from the management team and then filtered down
through the various disciplines. Secondly, there was a need for an identified champion
to promote the TIC agenda. It was felt the lack of both management support and a
promotional champion had caused TIC to lose its impetus.

> So I guess what we've found [works] is implementing change slowly but
> inexorably and pushing it forward over a period (Participant C).

A third challenge highlighted was staff resistance to change. It was identified the
importance of being informed about what may traumatise staff when implementing
change. It was suggested that when staff are traumatised "they tend to retreat into
simplistic black and white thinking and the past is good and whatever management are
trying to put on us now is bad and all that kind of thing" (Participant C). Several
participants suggested that dealing with staff anxiety around change was difficult and
challenging. People in general do not like change, especially those with embedded
practices who found change more difficult. It was suggested that those with
administrative power not be too ambitious in introducing change but to allow time for
staff to adjust and address barriers to implementation. Important to implementation is
the opportunity for staff input and management responding to feedback. This was seen
to encourage more involvement from staff.

A fourth challenge to implementing TIC was the level of paperwork involved
with everyday practice being too overwhelming for staff to have the time or energy
required for change. It was identified changing one practice often necessitates changing
another process, which requires more energy and raises anxiety around change.

NSW unit.

They know there is clear support from management … kind of 'we're all in
this together' is the vibe I get here which I haven't experienced elsewhere
(Participant W).

I think what makes the nurses here very willing to … to put themselves in
the shoes of the person they are talking to … is the staff are quite secure here
(Participant W).

TIC was identified as having been part of the culture in the NSW unit for many
years, and it was suggested that the culture of TIC continues from a position of strength.
TIC philosophy and structures are firmly embedded in the underpinning of service
delivery, and each new staff member is provided with the modelling, information, and
resources required to implement TIC.

Support from management was identified as critical for any culture change to
succeed. Participants stated that the principles underpinning TIC emanated from the
director, who established and modelled TIC principles to staff implementing practice
with consumers. Participants spoke of management support including administration,
allocation of funds, and personal support. This was evidenced by education and training
being prioritised, budget commitments for appropriate equipment purchases,
establishment of leadership forums, and the emphasis on developing policies and
procedures.

Organisational support from national, state, and local governance level was
considered necessary. It was suggested that to implement TIC, both area and state level
management must recognise the issue, provide resources to address the issue and
develop directives for new practice. Doing so meant the decision to implement TIC
amongst competing priorities was not left to the local management team. Participants
also suggested that state level policies be reviewed to ensure alignment with TIC.

Strengths based approaches

There was no specific identification of strengths based approaches by
participants at either unit, however responses in both units identified the need to
work with consumers' strengths and recognise role of past coping mechanisms.

NZ unit. The majority of the participants identified the need to value the
role of consumers' coping mechanisms and encourage skill building, as well as
utilise and strengthen resources with which consumers presented. The use of
sensory modulation and the 'early warning signs and strategies' form were identified
as key tools. Participants felt that staff generally focussed on what had gone wrong
when a consumer was readmitted into the unit rather than what had enabled them to
stay out of the unit for the period they had, recognising the latter as a strengths based
approach. Participants identified the strength that comes from staff remaining
hopeful that consumers can change, given the right supports.

NSW unit. As with the NZ unit, the majority of participants spoke of valuing
past coping mechanisms for the role they had played in the consumer's life. It was
identified that staff played a role in enabling skill building and assisting the consumer to
identify their strengths. Sensory modulation was being explored as a means of assisting
with this. Participants spoke of the need to identify the impact of trauma on mental
health and the healing that can occur from this which can reduce mental health
symptomology. It was stated that holding hope for the consumer was paramount.

Collaborative practice

The findings related to collaborative practice with consumers has been reported
in the subsection titled *Respectful relationships*, pg 84. As such, this section looks at
collaborative practice between staff and interagency practice. Collaborative practice
was evident between staff and between agencies at both units, however more so at the
NSW unit. All participants at both units identified both formal and informal
communication strategies to enable staff to collaborate in-house and be consistent in
care.

NZ unit. One strategy identified as important for collaborative practice at the NZ unit was communication. Weekly staff meetings, monthly open nursing forums, and the charge nurse attending handovers were forums where issues and strategies for working better together could be discussed. An example was given of staff of two disciplines working on a joint care plan around a consumer's needs. One challenge identified was staff not knowing the scope of another's discipline, therefore not knowing how to work collaboratively with them. This challenge was greater if a particular discipline was located outside the unit.

One participant questioned whether staff fully understood the concept of collaborative practice. It was stated that some staff thought collaborative practice meant that everybody had to agree before change was implemented.

Working in collaboration with external providers was important for the NZ participants. If a consumer were attending therapy with an external agency prior to being admitted to the unit, staff would facilitate the continuation of such therapy during the consumer's stay. Participants stated consumers disclosing SA would be referred to an appropriate agency; however, no person identified an appropriate agency to refer a SA victim. One challenge identified in working collaboratively between agencies was the lack of appropriate services available to work with people who have experienced IPV and have mental health issues.

NSW unit. Participants suggested that collaborative practice was core business and evident in practice in the NSW unit. Admission is facilitated through collaborative arrangements with the Emergency Department. Where a consumer discloses current DV or SA at admission, the appropriate mental health social worker or SA service worker is contacted and attends immediately. If a SA occurs in the unit, staff consult with SA services and police as required.

Collaborative arrangements exist with the community mental health team to reinforce the clinical relationship with the client prior to discharge. Other collaborative arrangements include working with professionals on coexisting health concerns such as alcohol and drug services, sexual health services, and the mental health family team. As

identified at the NZ unit, where disciplines and services were situated away from the
inpatient unit, this impacted negatively on collaborative care.

Chapter summary

The findings in this chapter highlighted a difference in culture in the two units
around the implementation of TIC. The majority of participants across both units stated
they are trauma informed and findings show evidence of key principles outlined in
literature in practice to varying degrees. Overall, there was a better understanding and
depth of knowledge around TIC in the NSW unit; however, examples of good practice,
although without the understanding of TIC that underpinned such practice, were evident
in the NZ unit.

Safety of consumers was paramount to both groups of participants, with the NZ
unit implementing a vulnerable women's area and a sensory modulation room to address
safety issues. One difference was the perceived focus on risk aversion in the NZ unit,
versus the focus on safety as part of therapeutic provision in the NSW unit. A lack of
clarity also existed around gender sensitive care and the provision of choice. Although
participants at both units spoke of choice and empowerment as important, the lack of
identification of consumer input into service development was noticeable. Both units
collaborated with external agencies but staff at the NSW unit appeared to have greater
knowledge of external agencies with which staff collaborated. Overall, each unit had
implemented various principles of TIC to varying degrees.

Chapter 6: Integration of findings

The aim of this study was to compare how trauma informed care TIC is implemented at two acute mental health inpatient units. This chapter provides the results of the two methods employed in this research. The results of both methods were analysed for each unit, focussing on relationships between the core categories identified in each method for each unit. The results of each method were further analysed to identify agreement or disagreement of open codes between policy documents, and the open codes obtained for the semistructured interviews for each unit. Next, both sets of codes were compared separately for agreement and disagreement with the features of TIC as overviewed in the literature review. Finally, the researcher compared the findings of the code comparison for each unit. The results identified partial alignment on aspects of TIC. Through this analysis, two themes were identified: firstly, that of selective alignment between policy and practice within each unit; and secondly, the difference in implementation of TIC in both policy and practice between the units.

This chapter outlines the findings of this research under the headings *Selective alignment in unit policy and practice* and *Selective alignment between units.*

Selective alignment in unit policy and practice

This section overviews the finding of selective alignment of unit policy and practice in relation to TIC. National, state, and local policy did not always align with each other and current practice did not always align with unit policy. Findings showed less alignment between practice and policy in relation to TIC at the NZ unit than the NSW unit. The NZ unit implemented TIC in practice: however, not all practices had aligning policies. Although the area for vulnerable women had been in operation in the NZ unit for over 18 months, there was only a draft policy available at the time of the interviews. Sensory modulation equipment, room, and profiling were also in place in the NZ unit; however, no policies were in place to guide their use. In comparison, participants at the NSW unit identified the need for underpinning policy before implementing practices.

Another finding was the lack of alignment between practice and policies existing at national, state, and local policy levels. There were more national and local policies addressing IPV in the NZ than the NSW context, however fewer of these policies were implemented in the NZ unit. Here, the need for TIC implementation and training was mandated at a national policy level, although there was little evidence of TIC principles in local policies or practices implemented. Two local policies identified the need to screen, one for abuse and trauma, the other for FV; however, no screening was practised in the unit.

In comparison, all policies at the NSW unit identifying elements of TIC were applied in practice. Although national policies identified the need to take trauma into account, few references in local level policies identified how TIC is implemented in practice. Two state policies were identified as conflicting with TIC principles, placing staff in a position of needing to determine whether to work in accordance with TIC or with state policy.

In summary, whilst practice and policies addressing features of TIC were present at each unit, implementation of TIC occurred predominantly when national, state, and local policies aligned.

Selective alignment between units

A significant finding in the implementation of TIC between the two units was a difference in perspective toward TIC in each unit. For example: more emphasis was placed on trauma awareness in the NSW unit than the NZ unit; different perspectives existed around addressing safety; both units appeared to struggle to implement practices that highlighted choice, control, and empowerment; and differences were evident in collaborative practice. These are discussed below under the headings *Trauma awareness*; *Safety*; *Choice, control, and empowerment*; and *Collaborative practice*.

Trauma awareness

A difference in culture around TIC was evident between the two units, which seemed to influence, and be influenced by, staff consensus on the impact of IPV.

Responses from the NZ participants showed a lack of consensus on the impact of IPV, which was associated with a lower degree of training on IPV and implementation of TIC practices such as screening. Conversely, the NSW participants all highlighted the impact of IPV, had access to training and resources, and implemented screening for DV.

Professional development. Although both units have policies requiring staff to undertake training incorporating TIC, access to training relevant to the inpatient setting was not consistent between the two units. Although training in TIC is identified as part of national workforce competency in NZ, only one regional TIC training was accessible in the unit region, which two staff from the unit attended. Although one policy states training in abuse and trauma is compulsory for all mental health inpatient staff, no local training was currently accessible. In contrast, participants at the NSW unit identified that it was compulsory for all staff to attend training on sexual safety. Training was available regularly throughout the year and 75% of staff had attended training. Staff also had access to resources on TIC, SA, and DV through the NSW Health ECAV.

Screening for IPV. Screening for FV was mandated in both units but implemented only at the NSW unit. Screening for trauma and SA was also mandated in NZ unit policy, however, was not practised in the unit.

Consumer awareness raising — just not there yet! Raising consumer awareness of the links between trauma and mental health varied between the two units. NZ participants gave examples of consumers recognising a connection between trauma and their mental health and seeking validation of the relationship from staff. No formal opportunities to increase consumer knowledge were available for those that did not recognise the relationship between trauma and mental health. In contrast, explicit opportunities for consumer awareness raising were provided in the NSW unit through the use of universal screening, psychoeducation addressing the issues of trauma and mental health impact, and regular consumer meetings in the unit. A lack of discussion on these topics outside of these forums was identified and described as staff "just not there yet".

Addressing VT. Participants at both units recognised that staff may be traumatised themselves through their work with traumatised consumers. Participant responses in the NZ unit showed their understanding of VT was predominantly related to an individual's resilience and coping strategies, and this informed the implementation of strategies to address self-care in the unit. In contrast, the NSW unit identified risk factors for VT were related to organisational practices. Strategies were implemented primarily to address organisational issues rather than individual factors.

Safety

The issue of risk. All participants identified risk issues inherent in the inpatient setting. The two units showed differing focus on risk. The NZ unit appeared to focus on risk aversion, and some participants saw this as limiting the implementation of TIC. Risk issues were addressed in the NSW unit by focussing on reducing retraumatisation. Risk issues were not avoided but reframed as issues that needed mitigation by the implementation of TIC principles around least restrictive care, choice, and control.

Risk assessments were undertaken at both units, both on admission and throughout a consumer's stay. Participants identified formal ongoing assessment of risk on a greater range of potential risks and on a more regular basis at the NZ unit than the NSW unit. No rigorous tools were available at either unit to assist staff in undertaking risk assessments.

Gender sensitive care provision. One way that gender specific inpatient care was promoted at the NZ unit was through the designated vulnerable women's area. Several NZ participants identified that while the vulnerable women's area addressed physical safety issues, and was staffed predominantly by female staff, there was no apparent difference in therapeutic care to meet gender specific needs. Although the NSW unit lacked a dedicated space for women, staff demonstrated awareness of the needs of female consumers in relation to restraint and seclusion where there had been past IPV by giving priority to utilising female staff.

Although TIC acknowledges the need to implement practice in regard to gender, one feature common to both units was the lack of consensus on what constituted gender

specific care. Participants and policy also did not identify any specific practice in
relation to gender for consumers who identified as LGBTI.

  Sensory modulation. Recognition of the potential for retraumatisation was
identified particularly in regard to restraint and seclusion. Both units had national, state
(NSW), and local policies and practices in place to reduce restraint and seclusion.
Participants in the NZ unit identified the use of the 'early warning signs and strategies'
form to enable staff to identify emotion dysregulation warning signs and implement
strategies. No similar assessment tool was available at the NSW unit. The NZ unit
implemented sensory modulation techniques including equipment, a sensory modulation
room, and sensory profiling. These were not in place at the NSW unit at the time of
interviews.

  Environment. Participants at both units identified the acute mental health
inpatient unit as being threatening and not feeling humane. It was strongly felt that
admission into the environment was a possible means of traumatisation. Specific
measures had been introduced into the NZ unit to make the unit less threatening. In
contrast, participants at the NSW unit did not identify design strategies to change the
possibility of traumatisation, except suggesting that a new building design could deal
with these issues. There are currently no plans to do this.

  Hiring practices. The majority of participants at both units stated that
individual staff members were a key determinant in the implementation of TIC.
Participants at both units identified that not all staff practice TIC equally. No specific
hiring practices to ensure staff had the appropriate attitude and skills required for TIC
were identified in the NZ unit. However, in NSW the hiring process was said to
incorporate values and qualities in line with TIC alongside knowledge and experience in
the selection criteria. This practice was not identified in any policy.

Choice, control, and empowerment

  Respectful relationships. The need to respect consumers' knowledge and
experience is identified in national and local policy documents for both units.
Participants at the NSW unit spoke more frequently of the need to include consumers in

decision making and development of care plans as a matter of respect. Although
participants identified examples of respectful relationships, several challenges to
developing such relationships were highlighted. The first challenge to respectful
relationships was the lack of engagement with consumers. Several reasons stated for
this included staff's lack of capacity to engage due to lack of confidence or knowledge
on talking with consumers, as well as lack of time due to administrative tasks. To
address this, management of the NZ unit had implemented communication training.

Participants at both units identified a general approach incorporating value and
respect for consumers' knowledge. Participants in the NSW unit identified the
employment of consumer workers to facilitate groups as a way of respecting knowledge
gained through a consumer's lived experience.

The issue of choice and control. Policies and practices that promoted choice,
control, and empowerment were limited at both units. There was less consensuses on
when and how much choice and control a consumer should be given at the NZ unit than
the NSW unit. Some participants stated that whilst a consumer was unwell they lacked
the capacity to make decisions; therefore, it was not appropriate to provide choice in
decisions around care. In contrast, all participants in NSW spoke of the need to
reinstate choice and control and seek engagement and consumer input at all times.

It was stated that the power imbalance between staff and consumers in the NZ
unit was changing, however not all staff were accustomed to viewing consumers as
equal partners. In contrast, the NSW participants identified that the consumers were the
experts in what had happened to them.

Empowerment of staff. Some NZ participants identified that staff were not all
treated equally in the unit, with medical staff given higher status than other staff. In
contrast, the NSW participants spoke of the equality among staff in their unit. This
equality was attributed to the unit being directed by a non-medical clinician, which
challenges the hierarchy traditionally present with a medical director. Participants
stated that staff at the NSW unit felt valued as individuals for the role each played in the
unit.

Management support. Results showed a difference in workplace culture between the two units, specifically in relation to management and procedural understanding and support of TIC. Participants at the NZ unit stated that management support for the implementation of TIC had diminished and there was now a lack of an agenda for its implementation. It was felt there was no consensus of management to recognise the impact of violence on mental health, and thus little support for TIC. This differed significantly from the NSW unit where participants identified consensus on understanding and awareness of prevalence and impact of IPV on mental health by management. Management support was evident through prioritising the provision of education and training on sexual safety and DV, budget commitments for the purchase of appropriate equipment, and the emphasis on developing policies and procedures. TIC was said to have been part of the culture in the NSW unit for many years and this culture continues from management taking a strong position on TIC to drive practices and procedures.

Collaborative Practice

Policies at national, state, and local levels focussed on the need to implement collaborative practice for both units. However, participants at the NZ unit identified challenges rather than evidence of collaborative practice. For example, the lack of identified referral services for consumers who had experience of IPV was a significant challenge to working collaboratively with external services in NZ. In contrast, all participants at the NSW unit knew where and how to refer a person if they disclosed DV or SA.

It is clear from the comparison of the two units that there is a higher availability and uptake of training in the NSW unit. Alongside this, findings showed a greater understanding among NSW participants on the knowledge of TIC, the impact of IPV, the implementation of screening, and a broader recognition of individual and organisational factors contributing to VT. Findings showed a greater sense of the need for consumers and staff to have choice and control at the NSW unit. The difference in findings related to the degree of support participants perceived management showed for TIC in each unit.

Chapter summary

The comparison of findings showed that there was selective alignment on aspects of TIC rather than TIC providing the commonality for implementation of practice at both units. Two themes were identified; firstly, selective alignment between policy and practice within each unit. Secondly, difference in implementation of TIC between the two units.

Chapter 7: Discussion

The primary purpose of this research has been to investigate and compare how TIC has been implemented in an acute mental health inpatient unit in NSW, Australia and a similar unit in NZ. This chapter will firstly address the research questions posed in the introduction. The strengths and limitations of this research will be overviewed followed by recommendations and implications for further studies.

Internationally, many studies have identified the relationship between a history of IPV and the development and exacerbation of a mental illness (Felitti, et al., 1998; Fergusson, et al., 2008; Rees, et al., 2011; Scott, et al., 2010). Key theorists identify TIC in mental health services as the appropriate response to support and work with consumers with histories of IPV who may be vulnerable to retraumatisation either through IPV or systemic practices (Elliott, et al., 2005; Harris & Fallot, 2001a). A TIC framework has been developed by theorists, including those above, to guide mental health services in providing an environment that meets the needs of consumers presenting with trauma histories and who are vulnerable to revictimisation. There is a growing body of knowledge on the principles underpinning TIC in mental health systems for community mental health settings: however, there is a paucity of literature on the nuances of acute mental health inpatient settings.

The questions posed by this research were:

1. How is TIC in relation to IPV implemented across two acute mental health settings?
2. How does this implementation compare with literature?
3. What contextual factors may assist or hinder such implementation?

To answer question 1, the results of this study, outlined in Chapters 4 and 5, showed partial implementation of TIC in the two acute mental health inpatient settings. The findings in relation to question 2, overviewed in Chapter 6, identified different perceptions of what constituted TIC, and thus specific aspects of TIC

implemented at each units. Implementation of these aspects of TIC did not
incorporate whole of service provision and were overarched by a trauma informed
philosophy, as the literature argues is most appropriate. Overall, there is
incongruence between the theory and practice of TIC in the two units explored in
the study. This chapter discusses the key features of this incongruence and outlines
four themes in relation to contextual factors underpinning the incongruence in
implementation of TIC. The four key themes are the lack of definition and guidance
on the implementation of TIC in an acute mental health inpatient unit; attitudes and
organisational culture on the impact of trauma; the inequality of power; and
national, state, and local management commitment to TIC.

The incongruence between theory and practice

This study also found differences in the implementation of TIC between the
two units, and only partial implementation of some features of TIC in both units.
One example highlighted in literature was the necessity of an underpinning service
philosophy that recognises the prevalence and centrality of the impact of IPV to a
person's issues, along with possible retraumatisation (Bloom & Sreedhar, 2007;
Harris & Fallot, 2001a; Jennings, 2007; Klinic Community Health Centre, 2008;
National Executive Training Institute (NETI), 2005; SAMHSA, 2011). Although
several participants stated trauma issues needed to be central to mental health care
provision, no overarching centrality of trauma in mental health was identified within
policies or practice. Both units and their broader policy context was medical model
based, rather than a biopsychosocial model as identified in TIC literature. In both
units, implementation of TIC features appeared as single unrelated projects rather
than part of implementing a trauma informed system.

The researcher identified five themes that may account for the difference in
implementation of TIC and incongruence of such implementation with theory.

Lack of definition and guidance on the implementation of TIC in an acute mental health inpatient unit

Previous research by Hopper, Bassuk, & Olivet, (2010) has identified that implementation of TIC requires a clear definition of what is meant by *trauma informed care* in order to translate TIC principles into concrete practice. Only one NZ national document had a definition of TIC, however as with other policy documents, it does not define trauma. Participant responses from NZ also showed no consensus in defining TIC. Adding greater complexity to the implementation of TIC and the lack of definition of TIC is the absence of a standard definition of IPV, and no national definition of DV or SA within NZ or Australia. Without formal definitions to defer to, participants highlighted difficulties for staff in identifying whether IPV had occurred. Also identified was a lack of clarity on gender sensitive care, and collaboration.

Hopper et al (2010) concludes that a lack of definition provides no reference for evaluation of TIC in programme delivery, allowing variations in practice to continue. Shearer (2012) states that what cannot be measured cannot be managed due to the inability to identify and address unmet needs. Prior to evaluation, as Hopper et al (2010) states, services would need to agree on a definition of what TIC looked like in practice. To evaluate across services, there would need to be a jointly agreed definition of TIC at state, national, or international level and guidelines or audit tools developed.

Inconsistencies in practice were identified in this research as was stated by Muskett (Muskett, 2013). Two examples highlight such differences. Firstly, literature and national policies state that mental health services should provide both trauma informed and trauma sensitive services to support those with experience of trauma (Elliott, et al., 2005; Harris & Fallot, 2001a; Ministry of Health, 2005; The National Council to Reduce Violence against Women and their Children, 2009). Neither unit provided trauma specific services as part of mainstream mental health care. However, referring to trauma specific services were embedded in the NSW unit policy and practice.

Gender sensitive care is a key feature of TIC to meet the needs of women in mental health services (Bartlett & Hassell, 2001; Eaton, et al., 2012; Kohen, 2001). While there was no specific area for women in NSW, the NZ unit provided a separate area for vulnerable women. Previous research by Mezey et al (Mezey G, et al., 2005) found gender specific areas decreased the incidence of SA. This was supported by the NZ unit findings, which also reported a reduction in SA in the unit. Though providing for physical safety, participants identified the women's area provided no separate therapeutic programme for women as specified important by Kohen (2001) or training for staff on specific needs of women. This may reflect a lack of recognition of the particular needs of women in mental health.

Hopper, Bassuk and Olivet (2010) report a lack of information on TIC implementation. Study findings also highlight the paucity of information on TIC implementation particularly for acute mental health inpatient units. Participants stated the lack of information limited the implementation of TIC that is evidence based. This finding harmonises with Warne and McAndrew (2005) who argued there was a gap between the discourse of being evidenced based and the implementation of practice.

While acknowledging the paucity of literature, unit practice did not always align to key principles in literature available. Policy guidelines and service audit tools are available to aid TIC implementation (Fallot & Harris, 2009; Klinic Community Health Centre, 2008), however neither unit utilised these. As participants identified, few of these resources directly addressed issues in the acute mental health inpatient unit, therefore were unclear as how to implement in practice.

Addressing safety in a trauma informed manner may be difficult for staff due to a lack of clarity and guidance on implementing TIC in the acute inpatient environment. Examples of staff utilising their own experience instead of evidence-based practice makes this a valid safety concern. Practices that were deemed trauma informed by some staff and unsafe by others were identified in the NZ unit in the past and strongly influenced a highly risk averse focus from management. Rather

than taking a risk averse approach, Chandler (2008).emphasises instead the need for
further policy and practice development.

The study findings showed that a lack of TIC definition and framework,
along with a paucity of information specific to the acute mental health inpatient
setting, are associated with challenges and inconsistency in implementation.

Attitudes and organisational culture regarding the impact of trauma

Evident across the two units were different organisational cultures regarding
the impact of IPV on mental health and thus the need of TIC. The researcher
concludes from this research that attitude and organisational culture regarding the
impact of trauma influence the implementation of TIC. These findings support
Hopper et al (2010) and Chandler (2008), who also found belief on the impact of
trauma influenced decision making and implementation of features of TIC.

Previous findings show disclosures by consumers have been minimised and
challenged due to disbelief about abuse occurring as well as the degree of its impact
on the person (Jennings, 1994; Lothian & Read, 2002; Young, et al., 2001). All
participants in this research acknowledged the high prevalence of clients having past
IPV histories, however there was little consensus among NZ participants on the
impact of IPV and this is seen to inform care planning decisions.

It was evident from responses that the recognition of the impact of trauma-
enabled staff to understand presentations and implement a trauma informed
response. NZ findings highlighted that staff perceived to have less understanding of
the impact of trauma were less likely to implement TIC principles. Staff whose
disciplines aligned with the medical model of traditional mental health provision
rather than a biopsychosocial model of care were identified as more challenged with
acceptance of the degree of impact therefore need of TIC. The lack of consensus on
the degree of impact of trauma in the NZ unit was associated with a reduced
consideration of the need for TIC responses.

The difference in attitude and organisational culture are discussed below in relation to eight findings. These are FV screening, collaborative partnerships, cultural diversity, professional development, and training, minimising SA on the unit, management of risk, VT, and staff speaking about abuse.

TIC literature states screening should be undertaken on admission for all forms of IPV due to the interrelationship with poor mental health and to correctly inform diagnosis and appropriate therapeutic care (Harris & Fallot, 2001a; Janssen, et al., 2006; Lothian & Read, 2002; Read, 1998a; Rhodes & Levinson, 2003). Findings showed routine screening of DV is mandated by state and local policy and implemented in NSW practice. Whilst the NZ unit had a policy to screen for FV, and had implemented screening for trauma and abuse in the past, no screening was currently undertaken. The reasons for not screening in NZ varied. Some participants agreed with theorists that due to the prevalence of IPV, staff should assume a history of IPV with consumers (Elliott, et al., 2005; Harris & Fallot, 2001b; SAMHSA, 2011). This assumption of a trauma history informed a 'no screening' practice, although policy identified screening was to occur. One participant argued, as did Agar and Read (2002), that no screening may be more trauma informed than screening if there was no appropriate response and referral process. Having no process in the unit to respond to a disclosure of FV, along with the lack of confidence in staff ability to respond appropriately, it was stated IPV screening should not occur.

Alongside these theories, this research identified that very few participants identified the impact of FV on mental health. This lack of identification may inform a decision not to screen.

The attitude surrounding the impact of IPV on physical and psychological health of clients is seen by the researcher to influence the presence of collaborative partnerships with trauma specific services, and physical health services. NSW policy and participants' responses showed recognition of the impact of DV on consumers and clear referral pathways between the NSW unit and the appropriate

trauma specific service were identified. NZ participants' responses lacked an awareness of appropriate referral pathways for SA services.

Although complex comorbid needs are well identified in literature (Breckenridge, et al., 2010; Felitti, et al., 1998), collaborative practices with physical health systems were not evident in participant responses at either unit. The lack of identification of the likelihood of coexisting complex physical health needs for those with histories of IPV, and the need to work collaboratively around such needs, was in direct contrast to De Hert (De Hert, et al., 2011) who suggests greater collaboration with physical health specialists.

Within a TIC framework, acknowledging and addressing cultural diversity is essential for consumer care (Elliott, et al., 2005; Jennings, 2007; Klinic Community Health Centre, 2008). Practices incorporating cultural diversity were inconsistent in participant responses and unit policies. Cultural considerations such as tikanga practice (Maori cultural principles) in relation to Māori culture were explicit in national and local policies in NZ. In contrast, minimal recognition was seen in national, state, or local policy for care in relation to Aboriginal and Torres Strait Islander mental health to attend to the breakdown in the interrelationships inherent in IPV and intergenerational trauma as identified in literature (Bishop, Vicary, Mitchell, & Pearson, 2012; Herring, Spangaro, Lauw, & McNamara, 2013; Isaacs, Maybery, & Gruis, 2012; Rickwood, 2006; Westerman, 2004a). Non-attendance due to breakdown in interrelationships may also be a retraumatising factor for Aboriginal and Torres Strait Islander people entering the unit. A lack of admission of Aboriginal and Torres Strait Islander people may also be due to Aboriginal and Torres Strait Islander peoples' lack of confidence in the cultural competence of mainstream services as previously identified in literature (Bishop, Vicary, Mitchell, & Pearson, 2012; Isaacs, Maybery, & Gruis, 2012; Rickwood, 2006; Westerman, 2004a).

Notably, there was less consensus about the impact of IPV and awareness of TIC at the NZ unit than at the NSW unit. The lack of consensus was associated with less access to professional development and resources at the NZ unit. Theorists identify the need for training to work with those who have experienced or are at risk

of retraumatisation of IPV (Agar & Read, 2002; McLindon & Harms, 2011;
Saakvitne, 2000; Warne & McAndrew, 2005). Although training in relation to SA
and DV is readily available in NSW, this was not the case in NZ. The lack of
provision of TIC training may be perceived as an indicator of the service culture's
lack of belief regarding the impact of IPV as identified by other theorists (Jennings,
1994; Lothian & Read, 2002; Young, et al., 2001).

Participants acknowledged, as did previous research, that SA still occurs
within acute mental health inpatient settings (Clarke & Victorian Women and
Mental Health Network, 2008; Frueh, et al., 2005). Two models of prevention of
SA are provided in literature: provision of single sex areas in some units (Mezey G,
et al., 2005), and promotion of a safe environment (NHS Executive, 1999;
Queensland Health, 2004). The implementation of a gender specific area in NZ is in
response to the need to provide physical safety of women. NSW focussed on the
promotion of a safe environment, with all consumers in mind. Policy documents in
relation to both units identify a different perspective on the responsibility for SA.
The draft vulnerable women's area policy in NZ, along with several participant
responses, identified the vulnerable state of women due to their own behaviour,
medication, or mental illness. Such perspective identified in the policy does not take
into account the need to locate responsibility for SA with the perpetrator as was
clearly stated in both NSW participant responses and policy documents. Placing
responsibility for SA on the perpetrator resulted in more stringent screening and
monitoring of perpetrating behaviour at the NSW unit than identified at the NZ unit.
Alongside screening and monitoring was recognising and addressing environmental
factors such as handover times, at which incidents often occur, as literature
identifies (Duxbury, 2002; Lawoko, et al., 2004).

The creation of safety cultures and increasing autonomy are features of TIC
identified by Chandler (2008) and Elliot et al (2005). Risk taking behaviours are
understood as 'normal' in the sequelae of trauma with risks managed by responding
with a trauma informed response which supports recovery rather than pathologising
(Womens Bureau U.S. Department of Labour, 2011). In NSW, participants
discussed how unit management was trying to create a culture of safety and increase

consumer autonomy within the acute mental health inpatient setting. In contrast, there was no consensus among NZ participants on whether risk minimisation was attributable to a risk averse focus of the treatment regime or an aspect of being trauma informed.

Several participant responses from NZ highlighted the perceived risks of implementing TIC, such as increasing autonomy without an underpinning framework; inadequate staffing ratios; or staff that lacked training in TIC. These concerns are supported by Chandler (2008), who states that without an overall framework a consumer may be at higher risk due to inappropriate treatment options. Harris and Fallot (2001a) on the other hand state that practices placing more autonomy with consumers may seem more risky, and not pursued as the potential cost of a lawsuit may outweigh the benefits of an individual's choice. This research supported this finding whereby a trauma informed response is negated due to possible litigation.

Literature identifies workplace conditions that contribute to VT including management issues, inadequate resources, and inability to attend training (Bell, et al., 2003; Bloom & Sreedhar, 2007; Carson, et al., 1995; McLindon & Harms, 2011; Taylor & Barling, 2004). Research findings state that addressing the above factors along with provision of staff supervision and self-care are important to minimise incidence of VT (Bell, et al., 2003; Bloom, 1994; Fallot & Harris, 2009; Klinic Community Health Centre, 2008). Although in this research participants identified the inherent risk of VT when working in mental health services, the factors causative of this risk were understood and addressed differently at each unit (Bell, et al., 2003). Whereas the focus of the NSW unit was on addressing organisational issues rather than mandating supervision, the focus in the NZ unit was primarily on increasing individual resiliency through mandatory supervision and focus on self-care. By focussing the cause of VT on individual circumstances, it may be likened, as Bloom (2006) states, to a parallel process between consumers and staff. Where consumers are silenced on IPV that may be part of the genesis of their mental illness, staff similarly may be silenced on matters related to organisational practice that may in turn lead to VT (2006).

Warne and McAndrew (2005) found reluctance by mental health nurses to acknowledge and discuss abuse. This study also found a reticence by staff to talk or ask about abuse. It was stated staff may not raise the issue of abuse due to the lack of confidence in saying the right thing, or the absence of clear pathways for referral if a disclosure was made. Keating and Brown (1998) questions such reticence for change and asks if there is a deeper resistance to acknowledging abuse issues due to the burden placed on overstretched staff if they did recognise these issues.

The inequality of power

Clinical mental health services are historically characterised by clear and observable power differences (Daya, 2012). TIC emphasises the devolving of hierarchies within mental health so consumers and all staff have an equal voice (Chandler, 2008). Countering the powerlessness that is inherent in dynamics of IPV, Bloom and Sreeder (2007) and Bassman (2001) highlight the necessity of power sharing and democratic decision making with consumers.

Two power imbalances were evident in the findings. The first power imbalance related to staff and consumer relationships. This study found, as identified by previous research (Bloom, 1994; Daya, 2012; Gordon, 2005) that although the balance of power and choice between consumer and staff had improved, they remained far from equal. As identified by some participants, collaboration with consumers is an area that is slowly changing, and currently there is no consensus among staff as to how much control to transfer to consumers. Chandler's study (2008) further describes staff as being challenged by the concept of passing control to consumers as part of their journey to becoming trauma informed.

These findings also align with prior research, which also found few meaningful opportunities for participation with consumers, especially in leadership or staffing roles (Gordon, 2005; Hinton, et al., 2009). Although there may be structures present, no participants identified formal practices of consumer input into local management structures and systems. No local or regional structures for input

into management systems were identified by participants such as the DHB

Consumer Advisors and National Mental Health Consumer and Carer Forum (NZ),

the NSW Consumer Advisory Group – Mental Health Inc. (NSWCAG), or the

Mental Health Consumer Perceptions and Experiences of Services (MH-CoPES)

(NSW). A lack of recognition may not enable staff to promote these opportunities

for consumer involvement.

A second power imbalance evident in this study occurred between staff.

History shows that psychiatrists have been at the top in relation to power imbalances

amongst mental health staff (Daya, 2012). While this finding was still evident in the

NZ unit, responses from NSW participants identified practices they felt lessened the

power imbalance between staff. These were placing a higher emphasis on the

biopsychosocial model than the medical model; valuing all staff for their unique and

important role in the unit; identifying all staff, no matter what position, by their first

names; and establishing a non-medical person as the director of the unit.

National, state, and local management commitment to TIC

Participants identified several organisational requirements as essential for

implementing change in practice such as TIC. Firstly, the impetus for change needs

to come from national and state levels, needs to be mandated by national or state

governments, and must be well resourced. Bloom and Sreedhar (2007) state

extensive leadership involvement is required in the implementation of TIC.

Jennings (2007) states that a commitment of finances, development of guidelines,

and the establishment of a designated TIC position needs to be made at a state level.

In the USA there are funded TIC state resource centres that provide information,

research, and training to mental health services.

A commitment to implementing TIC is evident in the workforce competency

framework *Let's get real: Real skills for people working in mental health and

addiction* (Ministry of Health, 2008), with TIC to be integrated into organisational

policies, processes, systems, and training by 2011, with consolidation until 2013.

Such integration of TIC was not seen in the NZ unit, and there was little evidence of

the implementation of TIC being well resourced. In NSW, no commitment has been made to implement TIC in an overarching framework at a national or state level. Trauma specific services are identified at a state level, however only for Culturally and Linguistically Diverse (CALD) and refugee communities (NSW Department of Health, 2008b), while provision is also in place to address SA and DV in mental health services. To honour this commitment to mental health services, NSW government funds a government body, the ECAV to provide mental health staff with access to training on DV and sexual safety, along with workshops and extensive resources on TIC. With training, policy development on DV and sexual safety mandated and funded by state government, and support by unit management, participants in the NSW unit showed a greater understanding of TIC. This aligned with Fernbacher (2008) also found workplace culture change concerning SA was associated with the implementation of state wide approaches to addressing SA in mental health units.

Elliot et al (2005) suggests that the initial step for implementation of TIC is training for all staff. Training incorporating TIC had been compulsory and accessible in a NZ unit in the past, and was found to have "significant impact on confidence, and self-perceived abilities in relation to both asking about abuse and responding to disclosures" (Cavanagh, Read, & New, 2004). Findings from this research showed many participants in NZ spoke of themselves and other staff lacking such confidence which may be enhanced through a management commitment to training.

A major recent cultural shift was the recognition of the retraumatisation of service practices such as restraint and seclusion (National Executive Training Institute (NETI), 2005). Both units had implemented strategies including training and policy development focussed on restraint and seclusion reduction and gave recognition to the fact consumers with abuse histories spend more time in seclusion. (Read, 1997, p. 450). The implementation of practice to reduce restraint and seclusion was strongly supported through national and state policy development alongside local policy development, and provided with funding and resources.

Along with greater implementation when there is support from national and
state level, this research supports previous findings by Fernbacher (2008) that
although there may be no state mandate, local managers can implement practices on
their own accord. This was evident where there was a policy on screening for
trauma at the NZ unit, although it was not implemented.

Practice without policy was also evident in the NZ unit with only a draft
policy for the vulnerable women's area. Such practice may not however be trauma
informed. The lack of policy has left staff without guidelines since the date of
implementation more than 18 months prior to this research. An absence of
guidelines allows for practice that may not be evidence based or best practice. This
lack of guidance in policy on practice provisions within mental health services is not
new and has similarities with findings identified by the Victorian Department of
Human Services (2008), which found a lack of guidance across mental health
services in Victoria, Australia.

Whilst differences in local implementation are likely, some features of TIC
may not be implemented in some units due the lack of management capacity to
introduce a philosophical change in the unit. Implementing TIC in a unit that is
traditionally underpinned by the medical model and a powerful professional body
such as psychiatrists and doctors who have had a dominance in the field of mental
health (Bills & Bloom, 2000; Garside, 1998) may be beyond the capacity of the
manager. This may be particularly so where there is no understanding of the value
of such a change, and little accessible information on how implementation of TIC
should be undertaken.

Change is most effective when implemented in line with best practice change
management principles, including a facilitative organisational culture, resources,
training and support from all administrative levels (in this case, national, state, and
local levels), as well as having a local champion (Chalmers, et al., 2012; Chandler,
2008; Jennings, 2007; Rose, et al., 2002). Within a system focussed on outputs
instead of care provisioning (Alford and O'Neill cited byFernbacher, 2008), TIC is
also out of alignment.

Supporting the implementation of TIC may require a remodelling of the mental health system. Firstly, these findings, and previous work by Cumming (2011), suggest the lack of collaborative relationships with physical health specialists as highlighted by De Hert (2011) is reinforced by the siloing of funding throughout health systems. There is a need to address fragmentation in funding to improve integrated care for consumers presenting with complex health needs (Cumming, 2011).

The construction of TIC in mental health services

The finding of partial alignment in implementation of TIC as seen in this study may be understood through the lens of social constructionist theory where knowledge is constructed from experiences based in culture and history (Andrews, 2012; Burr, 2003). NZ participants spoke to past historical incidents paving the way for the need to be more risk averse and maintain the control of care with mental health staff. In NSW, screening for DV has been in place many years and is now regarded as part of the culture of the unit. The description of different disciplines having varying understandings reflected the influence of training, and psychological theories inherent in their courses.

Participants identified, as does Gunter (2007), that IPV and how it is understood and responded to is a complex and provocative subject for many people. Practice and policy is seen, in line with social constructionist theory, to be informed by negotiated understandings (Burr, 1995). NSW participants had more access to activities in the unit that helped form shared understandings, as seen as important by social constructionist theorists in forming negotiated knowledge (Berger & Luckmann, 1971; Moghaddam, 2005). Participants identified training, DV routine screening tools, and forums for discussing IPV and responses in mental health that helped facilitate a negotiated understanding amongst participants. Such knowledge was supported through state policies. Not having clear implementation of policies present in the NZ unit may imply a negotiated knowledge that the topic, as viewed in society, is not one that is talked about. It was clear the negotiated knowledge was different for each unit, resulting in different interventions at both units.

Integrating TIC further into practice in mental health may benefit from social constructionist theory understanding where knowledge is sustained through the processes in place and these inform social action (Burr, 1995). Theorists have highlighted the whole of service changes and processes required to implement TIC however it was evident that single interventions (i.e. sensory modulation, vulnerable women's area).rather than a whole of service change of philosophy to implement universal trauma precautions as theorists suggest (Elliott, et al., 2005; Fallot & Harris, 2009; Hodas, 2006). To implement such a philosophy would require a clear definition of TIC, commitment at all governance levels, access to TIC training for all staff so that there was a negotiated understanding of TIC, and policies underpinned by TIC.

Strengths and limitations of this study

This research has several strengths and limitations, discussed below.

This research was undertaken as part of a master's thesis to be completed within a given timeframe and word limit of 40,000 words. As this thesis looked at practice at a particular point in time 18 months ago, the researcher cannot be certain that the findings reflect what is current within the two units. This would require follow up research to determine any changes that have been made.

This research was an exploratory study portraying a snapshot of the implementation of TIC policy and practice in acute mental health inpatient units. Having access to two acute mental health inpatient units in different geographical and national policy contexts provides insight into implementation in different settings, along with possible enablers and barriers specific to unique contexts. The topic of TIC is innovative in mental health practice and one of interest to management and staff. Utilising a key person on the unit to identify which senior staff were available on the day of the interviews and thus could be approached saved time. This person also provided assistance in coordinating rooms and appointment times to fit in with the inpatient daily routine.

While interviewing staff, one NSW participant identified they had undertaken training with the researcher several years prior on sexual safety in

mental health inpatient units. It is recognised that such knowledge may have influenced responses from this participant to provide answers compatible with these prior education sessions.

The design of this study examined two unique acute mental health inpatient settings. This is regarded as a strength as it compares units across two different contexts. A limitation of such a design is that the findings are also constrained by these two contexts. This study involved a moderately small sample size. Five senior staff from each unit were interviewed due to the need to keep the sample size manageable whilst meeting time limitations. The interviews were held on only one day per unit, and staff could only participate if they worked on that day and self-selected for participation. In both units, approximately one third of total senior staff were interviewed. Data on staff that chose not to participate is unavailable for this study. It is possible that those with no interest in TIC chose not to participate in this study. Due to the small numbers of participants, and the inability to interview all staff, results may not be fully representative of all staff within the unit. Results also may not be representative across wider acute mental health inpatient settings.

As this research was an exploratory study, consumers were not involved given the size of the study, time, and financial constraints. It is essential consumers are given voice in research studies which impact on and evaluate service provision (Beresford, 2005; Hinton, et al., 2009). The fact that consumers were not involved in the study clearly limits the findings and statements that can be made.

Recommendations and implications for future studies

This study has provided a snapshot of implementation of TIC in two different acute mental health inpatient units. Efforts have been made in both units to implement features of trauma informed practice; however, results show partial implementation of TIC principles. A lack of guidance on implementation of TIC has left practice development up to individual interpretation of theory, producing potential safety risks and systems that may not be trauma informed.

Findings show a lack of accepted definition, along with a difference in culture and implementation of several key features of TIC within a context of little guidance from policy or research. The findings of this study show that TIC implementation in NZ and Australia is still in the initial steps as defined by theorists (Elliott, et al., 2005; Markoff, Fallot, Reed, Elliott, & Bjelajac, 2005). To facilitate the development of a clear definition of TIC and guidance for practice in acute mental health inpatient settings, high level international and national research may be undertaken. Future studies may focus on specific implementation of features of TIC, with, for example, a larger sample of acute mental health inpatient settings, staff, or diversity of staff. Research that incorporates consumer and carer voices will model TIC principles and be able to provide valuable perspectives not attainable in this study. Elliot (2005) suggests developing operational measurements that permit evaluation across units such as with other complex interventions models. To assist implementation of TIC, more support is required from national, state, and local governance.

It appears that local policy aligned with national policy and research is helpful not only for managers, but also for staff: thus future research may also identify means of creating consistency in policy direction from national, state, and local level. To further develop and implement a TIC model Markoff et al (2005) suggests revising organisational mission to incorporate TIC. It is suggested that the implementation of TIC would be assisted by a national agenda to pursue trauma informed changes to mental health systems. Such support needs to consider the reframing of mental health services and look at measures to challenge the current siloed funding arrangements in order to facilitate partnerships that are more effective. Access to resources and training, supported by adequate funding to guide the implementation of TIC specifically in acute mental health inpatient settings has been found useful in other settings (Fallot & Harris, 2009; Guarino, et al., 2009). Such access may be supported by the development of a forum to share TIC implementation and learning, and promote the development of trauma informed systems situated in evidence based practice.

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Appendices

Appendix A: Consent form

Appendix B: Participant information sheet

Appendix C: Schedule of interview questions for NZ and NSW

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Appendix F: Principles of trauma informed care

Appendix G: New Zealand national policies identifying trauma, sexual assault / abuse
              and Family violence relevant to the research unit.

Appendix H: New Zealand District Health Board policies identifying trauma, sexual
              assault / abuse and family violence relevant to the research unit.

Appendix I: Australian national policies identifying trauma, sexual assault / abuse and
              family violence relevant to the research unit.

Appendix J: New South Wales health policies identifying trauma, sexual assault / abuse
              and family violence relevant to the research unit.

Appendix K: Local Area Health Service policies identifying trauma, sexual assault /
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Appendix A: Consent form (NZ)

MASSEY UNIVERSITY

CONSENT FORM

[To be completed at time of interview]

Trauma Informed Care: Implementation in Mental Health Inpatient Units

1.   I, ...
     of...
     ....agree to participate in the study described in the Participant Information Sheet dated
     30/3/2011.

2.   I acknowledge that I have read and understand the Participant Information Sheet dated 30/3/2011
     which explains why I have been selected, the aims of the study and the nature and the possible
     risks of the investigation, and the statement has been explained to me to my satisfaction.

3.   Before signing this consent form, I have been given the opportunity of asking any questions
     relating to any possible physical and mental harm I might suffer as a result of my participation
     and I have received satisfactory answers.

4.   I understand that I can withdraw from the study at any time without prejudice to my relationship
     to Massey University and (name) District Health Board.

5.   I agree that research data gathered from the results of the study may be published, provided that I
     cannot be identified.

6.   I understand that if I have any questions relating to my participation in this research, I may
     contact Toni Ashmore on telephone 0061 2 9840 4054 or email
     toni.ashmore@swahs.health.nsw.gov.au

7.   I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to the Chairperson of the [Name] Regional Ethics Committee which is
nominated to receive complaints from research participants. You should contact them on [Phone] or email
[name and email address] and note the reference number [reference number].

Signature of participant	**Please PRINT name**	**Date**
_____	_____	_____
Signature of witness	**Please PRINT name**	**Date**
_____	_____	_____
Signature of investigator	**Please PRINT name**	**Date**

_____   _____   _____

MASSEY UNIVERSITY

[Name] Hospital / District Health Board

Trauma Informed Care: Implementation in Mental Health Inpatient Units

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with the (*University...[insert name of university], Hospital or my medical attendants*).

Signature of participant   **Please PRINT name**   **Date**

_____   _____ _____

The section for Revocation of Consent should be forwarded to Toni Ashmore, C/O Education Centre Against Violence, Locked Bag 7118, Parramatta BC, NSW 2150, Australia

Appendix B: Participant information sheet

[Name] District Health Board/ Area Health Service

PARTICIPANT INFORMATION SHEET

Trauma Informed Care: Implementation in Mental Health Inpatient Units

Researcher: Toni Ashmore,
Education Centre Against Violence,
Sydney, Australia
toni.ashmore@swahs.health.nsw.gov.au
Phone 0061 2 9840 4054.

Supervisor: Dr Anna Matheson,
Centre for Public Health, Massey University
Wellington, New Zealand
a.g.matheson@massey.ac.nz
Phone 04 380 0602.

Invitation
You are invited to participate in a research study into the implementation of trauma informed care in mental health inpatient units, particularly focussing on sexual abuse and family violence

The study is being conducted by Toni Ashmore, Senior statewide educator – Mental Health and Sexual Assault Project, Education Centre Against Violence – NSW Health, Australia. The researcher is enrolled as a student for the degree of Masters in Public Health at Massey University. This study is being supervised by Dr Anna Matheson, Centre for Public Health, Massey University.

Before you decide whether you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. **'What is the purpose of this study?'**
The purpose is to conduct a comparative analysis of the integration of trauma informed care in both New Zealand and New South Wales, Australia. This

study will look at policies and practice the District Health Board has in place
around trauma informed practices including policies on sexual assault and family
violence.

2. **'Why have I been invited to participate in this study?'**
    You are eligible to participate in this study because you are a current staff
member in [Name of Unit].

3. **'What if I don't want to take part in this study or if I want to withdraw later?'**
    Participation in this study is voluntary. It is completely up to you whether
you participate. If you decide not to participate, it will not affect your work role or
position now or in the future. Whatever your decision, it will not affect your
relationship with the staff caring for you.

    New information about the implementation of policies and procedures and
how this could look in practice may become available during the course of the
study. You will be kept informed of any significant new findings that may affect
your willingness to continue in the study.

    If you wish to withdraw from the study once it has started, you can do so at
any time without having to give a reason.

4. **'What does this study involve?'**
    If you agree to participate in this study, you will be asked to sign the
Participant Consent Form.

    If you agree to participate in this study, you will then be asked to participate
in an interview with the researcher. If you are a Nursing Unit Manager, the
researcher will also ask you to complete a Sexual Safety Audit and forward this to
the researcher.

    This study will be conducted over 12 months starting February 2011.

5. **'How is this study being paid for?'**
    The study being undertaken by the researcher as part of the completion of a
thesis for a Masters in Public Health. No money is paid directly to individual
researchers.

6. **'Are there risks to me in taking part in this study?'**
    There are no risks to you in taking part in this study

7. **'Will I benefit from the study?'**
    This study aims to further knowledge and may improve future treatment of
consumers of mental health services who have either been subjected to child and/or
adult sexual assault, and/ or family violence and may highlight for yourself areas of
care you as a staff member may consider in working with consumers.

8.   'Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything. As this is expected to be undertaken in work hours, you will not be paid for this.

9.   'How will my confidentiality be protected?'

Of the people you work with, only your nursing unit manager will know whether you are participating in this study. The information you provide will not be made available to employer and will not affect your employment.   Any identifiable information that is collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only the researchers named above will have access to your details and results that will be held securely at the researcher's primary residence.

10. 'What happens with the results?'

If you give us your permission by signing the consent document, we plan to discuss/publish the results in peer reviewed journals, presentation at conferences and other professional forums. Information will not name specific individuals or institutions but talk generally to the findings as they relate to both New South Wales and New Zealand.

In any publication, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

11. 'What should I do if I want to discuss this study further before I decide?'

When you have read this information, the researcher Toni Ashmore will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her by email toni.ashmore@swahs.health.nsw.gov.au or by phone 0061 2 9840 4054. Alternatively contact can be made with the supervisor Dr Anna Matheson on phone 04 380 0602.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

This study has been approved by the [Name] Regional Ethics Committee. Ethics Reference number: [reference number]

Thank you for taking the time to consider this study.
If you wish to take part in it, please sign the attached consent form.
This information sheet is for you to keep.

Appendix C: Schedule of interview questions for NZ and NSW

Trauma informed care: Implementation in mental health units

Questions for discussion

1.   What type of unit are you now working in (related to research):

2.   How long have you worked in Mental Health (related to research):

3.   What is your understanding about the link between abuse and mental illness?

4.   Can you tell me how this understanding about the links between abuse and
      mental illness may have an impact on the work you currently do with
      consumers?

5.   Thinking of staff in your unit, what do you think is the level of understanding
      about the link between sexual abuse / family violence and mental illness?

      5a.   How did they come to that understanding?

6.   What internal policies and procedures are you aware of that talk to the issues of
      sexual assault/ family violence and mental illness that inform practice?

7.   How has your unit responded to the issues of abuse and mental illness?

      7a   (If 'little has been implemented') What has contributed towards the lack
of implementation of practice around abuse and mental illness?

      7b   (If 'there has been a response') What are some of the issues in regards to
implementing these policies?

8.   What were the barriers that had to be overcome (or would have to be overcome)
      for practice to be implemented?

9.   Is there anything else you would like to add?

Appendix D: Ethics approval for NZ *(identifying details blocked)*

**Health
and
Disability
Ethics
Committees**

31 March 2011

Ms Toni Ashmore
122 Chippendall Cres
Theodore, ACT 2905
Australia

Sent by email:

Dear Toni

Re:		
	Ethics ref:	**NTX/11/EXP/061** (please quote in all correspondence)
	Study title:	Trauma informed care: implementation in mental health inpatient units:
	Investigators:	Ms Toni Ashmore, Dr Anna Matheson (Supervisor)
	Locality:	Massey University

This study was given ethical approval by the Deputy Chairperson of the Northern X Regional Ethics Committee under delegated authority.

Approved Documents
   — Participant Information Sheet/Consent Form V#4, 30/03/11
   — Questionnaire Schedule V#2, 7/12/10
   — Revocation of Consent V#3, 28/93/11

This approval is valid until 31 March 2012.

Amendments and Protocol Deviations
All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:
   — the researcher responsible for the conduct of the study at a study site
   — the addition of an extra study site
   — the design or duration of the study
   — the method of recruitment
   — information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Appendix E: Ethics approval for NSW

HUMAN RESEARCH ETHICS COMMITTEE –

7 February 2011

Ms Toni Ashmore
Education Centre Against Violence
Locked Bag 7118
Parramatta BC
NSW 2150

Dear Ms Ashmore

HREC ref no: 10/232
Project title: Trauma informed care: implementation in mental health inpatient units

Thank you for submitting the above Low/Negligible Risk Application for review by the Human
Research Ethics Committee (HREC). Based on the information you have provided and in
accordance with the NHMRC guidelines [National Statement 2007 – Section 5 Institutional
Responsibilities and *"When does quality assurance in health care require independent
ethical review?"* (2003)], this project has been assessed as low risk and is therefore exempt
from full HREC review.

The project was considered by the Executive Committee on 2 December 2010. The
Committee asked for clarification of certain matters/modifications and delegated authority to
grant final approval to the Executive Officer.

I am pleased to advise that with your correspondence dated 2 February 2011 the requested
information and revised documents were received incorporating the recommendations of the
Executive. Ethical approval has been granted for the above project.

The following documentation has been approved:

- Low/negligible risk research application dated 25 November 2010
- Information sheet and consent form version 2, dated 7 December 2010
- Participant Questionnaire Schedule, version 2, dated 7 December 2010
- Mental health facilities sexual safety checklist dated 2010

Conditions of approval

1. This approval is valid for 5 years from the date of this letter.

P:\Correspondence\2010\232\7.02.10 EO Approval of LNR after
Page 1 of 2

Appendix F: Principles of trauma informed care: Adapted from Hopper, E. K., Bassuk, E. L., & Olivet, J.(2010)

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Trauma awareness	Program philosophy and mission	Services must be aware and take into account trauma dynamics and impacts on all areas of functioning. Trauma informed care allows holistic and integrated treatment planning	The centrality of trauma to mental health to be included philosophy and mission statements.	Recognize the impact of violence and victimization on development and coping strategies. Recovery from trauma is the primary goal.	Herman's model of recovery - safety, remembrance, and reconnection. Multidimensional assessment	Services to be based on research & data on trauma & evidence-based & best-practice treatment models	Services to recognise links between trauma, mental health, & addictions; acknowledge trauma in specific population groups	Trauma services incorporate understanding of prevalence and impact of trauma
	Staff education, training and consultation	Training stated as a requirement	Training and education at all levels to produce fundamental shift in how trauma and consumers are viewed. Staff require education in understanding triggers, responding to triggers and creating safe spaces.	First step is to train all staff from administrators down to clerical staff	Active in-service training program	Workforce orientation, training, support, competencies and job standards related to trauma; Universities and organisation to have curriculum that promotes working with trauma	Provide training for co-morbidities; Communication & relationship building skills; Dynamics & impact of trauma. Assessment	Prioritise staff skill building in understanding trauma for all staff , staff support and care, and promoting culture shift

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Trauma awareness	Trauma awareness for consumers	To participate in trauma specific service consumer must be aware or trauma and sequelae	Screening acknowledges service prepared to hear and respond to trauma histories; Reframing strategies provide information on trauma and responses	Provide awareness to consumers to minimise the possibilities of retraumatisation	Psycho-education group sessions			Open communication and provision of information openly to educate consumers about trauma
	Universal trauma screening	Trauma screening stated as a requirement	Services to screen for and respond to consequences of past and current violence and related trauma	All consumers are to be screened		Trauma screening and assessment	Enquire about trauma; trauma assessment where addiction issues present	Universal trauma screening, with more intensive assessment dependant on specific relationships established with staff members
	Vicarious trauma and staff care		Staff need support to manage own reactions to trauma stories and own trauma history; supervision is important		Staff must feel respected and included. Management to be nurturing and supportive	Clinical guidelines to address self-care and secondary trauma	Recognises vicarious trauma & offers staff supervision, workshops & confidentiality; willingness of staff to debrief	Recognises vicarious trauma is common amongst staff and consumers

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Safety	Physical and emotional safety	Focus on prevention of further victimisation, planning for crisis and early intervention	Safety to be priority. Initial and ongoing screening for possible active violence. Service awareness of how practices and policy may place women in danger	Need for safety and safety must be emphasised	Recognise importance of safety. Clear expectations of behaviour. Safety from own injurious behaviour; Staff must feel physically and emotionally safe	Ensure safety from sexual offenders and retraumatisation	Suicide intervention & prevention; staff ability to regulate own emotions	Physical and emotional safety important; Recognition of re-victimisation and that violent trauma can be self- perpetuating
	Minimise Retraumatisation	Service to put a focus on prevention of retraumatisation	Services should aim to do no harm to avoid retraumatising consumers	Goal of service is to minimise possibility of retraumatisation; Necessity to treat all women as if they might be trauma survivors; Recognise staff may parallel interpersonal dynamics of abuse	Full system approach focused on creating an organisational culture designed to help injured clients recover	Procedures developed to avoid retraumatisation and reduce impacts of trauma	Recognition of possible trauma in disclosing past or current abuse	Recognises possibility of retraumatisation for consumers and staff. Has policy, education, and supervision available to minimise the possibility of retraumatisation of staff
	Gender Sensitive or Specific Services		Women likely to require women-only space/ groups to avoid disempowerment that may present with co-gender provision	Gender specific service for women	Gender specific service for women	Gender specific service for women	Services sensitive to needs of males	Gender sensitive services

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Safety	Relationships: authentic, respectful and clear boundaries	Trust needs to be built over time; Consumers and staff to be viewed as equal partners	Healing can occur in relationships that are empowering and strengths based. Need for respect for boundaries	Relational collaboration to develop safety & trust; Respects the potential in all people. Clear boundaries essential for safe environment; Staff respectful of consumers need for acceptance, respect, and safety	Establishing healthy attachment relationships, enhancing self-protective and self-correcting skills, teaching healthy boundaries	Staff to be educated in maintenance of personal and professional boundaries	Primary focus on rapport and relationship building; Establish trust & safety as a priority. Genuine caring connection established; language important	Trustworthiness (clear tasks, consistent practices, staff-consumer boundaries)
	Acceptance of and respect for diversity		Healing takes place within cultural and relational context therefore cultural competence important. Staff should explore and reframe the meaning of violence within culture and family	Awareness of the role of culture for the client		Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status	Acknowledge trauma in specific population groups Culturally appropriate understanding & referrals; Staff encouraged to have currency of knowledge on minority issues; acceptance of sexual orientation	

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Safety	Hiring practices	Hiring staff who are trauma informed	Hiring to give priority to candidates with understanding of and commitment to trauma informed services; Hiring consumers as staff/committee members/peer support/trainers; Involving consumers in program delivery aids in facilitating empowerment	Hiring to target individuals with knowledge of trauma	Staff evaluated for effectiveness in utilising a TIC model and such included in annual performance appraisal	Workforce recruitment, hiring and retention of those with lived trauma experience; Hiring practices to ensure safety from sexual offenders	Job description includes experience in working with trauma survivors, hires trauma survivors & indigenous elders or those with knowledge of complimentary practices	Services to hire trauma champions sensitive to trauma informed care
	Review of policies and procedures	Policy to be trauma informed	Necessity to review policies and practice for allowing unsafe practice. Policy development to require and facilitate consumer inclusion in all aspects of service	Policies to ensure safety	Ensure policy and practices not creating unintended secondary trauma	Policies, procedures, rules, regulations and standards audited on their alignment to TIC and minimisation of traumatisation	Policies and protocols reviewed to ensure minimisation of further trauma by their implementation	Policies reflect understanding of survivors' and staff's needs, strengths, and challenges; Policies monitored, reviewed and implemented consistently by all to facilitate agency change

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Choice, control and empowerment	Choice and control	Goal to return control to the consumer. Emphasis on skill building and acquisition, secondarily on affect regulation	Recognise choice and control are major issues; Involve women in making choices about care	Maximise choice and control over recovery		Special attention paid to consumer rights to choice, collaboration and empowerment	Provide choice as all aspects of care as possible	Service maximises consumer choice and control
	Strengths based/ Empowerment model	Recognition of role of coping and defence mechanisms; Value of strengths a person has to make change	Adaptive behaviour viewed as a strength and reframed as positive coping responses while learning alternative responses. Validation of feelings important in first instance. Understanding and reframing of interpretations of behaviours as reactions to fear; Staff to provide hope for change	Emphasize strengths, highlighting adaption over symptomology, resilience over pathology; Staff aware of power imbalance	Perspective that recovery is possible	Programmes should be recovery oriented	Trauma survivors are resilient and able to recover. Focus on client's strengths & resources. Staff affect positive change and instil sense of hope and resilience.	Trauma survivors are resilient and able to recover; prioritize consumer empowerment, skill-building, and growth

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Choice, control and empowerment	Consumer knowledge and experience respected	Respecting consumers knowledge and insight	Value consumer knowledge of what is helpful.	Services are based on relational collaboration; Equal regard for value of staff and consumers		Services to assess trauma survivor satisfaction, service utilization and needs; Consumers involved in development of training, state plans, reorienting services to trauma and recovery, and initiatives for improving access	Client is the expert in their own lives; Willingness to learn from survivors	Shared power based on a respect of consumer knowledge and experience
	Consumers involved in service development and evaluation	Service provision set in collaboration with consumer	Involve women in making choices about care; Seek involvement in all aspects of policy, planning, and implementation	Consumer input and involvement in designing and evaluating services	Services to provide consumer governance of consumer group meeting	Services to assess trauma survivor satisfaction, service utilization and needs; Consumers involved in development of training, state plans, reorienting services to trauma and recovery, and initiatives for improving access	Survivor involvement in care planning and development of policies, programme development and evaluation	Shared power and governance between staff and consumers

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Choice, control and empowerment	Administrative empowerment to change	Commitment required from those who control resources	Change to occur at service and systems level; Administration commitment to facilitate, support and reinforce change	Administrators to work with consumers and providers to make services trauma informed	All managers must provide for the unit what the unit must provide for patients: protection, nurturance, and training.	Financing criteria and mechanism to support TIC models. Clinical practice guidelines. State trauma policy or procedures paper. Designated trauma function and focus in state mental health department. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma at state level	Effort to minimise re-traumatisation. Staff encouraged to have currency of knowledge on minority issues	Commitment required from those who control resources; Prioritise staff empowerment and skill building; administrative support for staff to fulfil tasks; attention to staff Review of working group in collaboration with change management facilitators
Collaborative practice	Collaboration with other services	Providers key to resources and need to make appropriate referrals to trauma specific and other services	Care planning to address all health /social issues concurrently; Development of formal collaborative agreements and cross agency workgroups	Trauma-informed programs offer either specialized services that directly address recovery from past trauma or refer to an agency that does	Service to address physical needs also	Services should provide integrated trauma, mental health, substance abuse services and counselling,	Familiar with community resources, referral, & advocacy.	Service offers and /or refers to trauma specific services

Common Principles		Harris and Fallot 2001	Moses,Reed, Mazelus, D'Ambrosio, 2003	Elliot et al 2005	Bloom, 1994; Bloom and Shreedhar 2007	Jennings 2007 (adapted from Blanch 2003)	Klinic Community Health Centre 2008	Fallot and Harris 2009
Collaborative practice	Collaboration with consumers	Service provision set in collaboration with consumer	Involve women in making choices about care; Seek involvement in all aspects of policy, planning, and implementation	Services are based on relational collaboration	Trauma informed interactions between staff and clients, and clients with each other creates the 'heat' to generate change; Consumer governance of consumer meetings	Consumer involvement in all aspects of care and service delivery	Survivor involvement in care planning. Willingness to learn from survivors	A core value in culture change; Staff work with consumers, and consumers feel like partners; Maximise sharing of power with consumers
	Collaboration with staff							Maximising sharing of power with staff; Collaboration a key part of leadership style.

Appendix G: New Zealand national policies identifying trauma, sexual assault/abuse, and family violence relevant to the research unit

Year	New Zealand National Policies
1992	Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 guidelines,
1994	Health and Disability Commissioner Act 1994
2000	NZ Health Strategy
2002	He Korowai Oranga: Maori Health Strategy
2002	Family Violence Intervention Guidelines: Child and Partner Abuse
2005	Te Tähuhu – Improving Mental Health 2005−2015
2006	Te Kokiri: The Mental Health and Addiction Action Plan 2006–2015
2008	Health and Disability Services (restraint minimisation and safe practice standards)
2008	Let's get real: Real skills for people working in mental health and addiction

Appendix H: New Zealand District Health Board policies identifying trauma, sexual assault/abuse, and family violence relevant to the research unit

NZ District Health Board Policies (named by content not official title)
Abuse and trauma policy
Draft vulnerable women's area policy
Family violence – file alert policy
Family violence – staff safety policy
Family violence – tikanga policy
Family violence policy
Family violence policy – monitoring policy
Police vetting policy
Restraint minimisation policy
High risk service user policy
Seclusion policy
Serious incident review policy
Sexual Behaviour
Suicide management policy

Appendix I: Australian national policies identifying trauma, sexual assault/abuse, and family violence relevant to the research unit.

Year	Australian National policies
1991	Mental Health Statement of Rights and Responsibilities
2002	National Practice Standards for Mental Health Workforce
2005	National safety priorities in mental health: A national plan for reducing harm
2006	National Action Plan on Mental Health 2006 - 2011
2009	Fourth National Mental Health Plan
2009	National Mental Health Policy 2008
2009	Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and their Children, 2009 - 2021
2010	Implementation Guidelines for Public Mental health services and private hospitals
2010	National Standards For Mental Health Services
2010	National Women's Health Policy 2010
2010	The National Plan to Reduce Violence Against Women and Their Children 2010 - 2022

Appendix J: New South Wales health policies identifying trauma, sexual assault/abuse, and family violence relevant to the research unit.

Year	NSW State policies
1995	NSW Health Victims of Crime Policy
2003	Policy and Procedures for Identifying and Responding to Domestic Violence
2004	Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services - 2nd Edition
2004	The NSW Framework for Suicidal Risk Assessment and Management for NSW Health Staff
2005	Management of patients with possible suicidal behaviour PD 2005 _121
2005	NSW Health Policy Directive PD2005_ 315 Zero tolerance response to violence in the NSW Health Workplace
2005	NSW Health Policy Directive PD2005_626 Code of Conduct
2005	New South Wales Interagency Action Plan for Better Mental Health
2005	Reportable Incident Definition under section 20L of the Health Administration Act policy directive 2005
2005	The Framework for managing disciplinary process in NSW Health
2006	Criminal Allegations, Charges and Convictions Against Employees PD2006_026
2006	Incident Management PD 2007 _ 06
2006	NSW: A New Direction for Mental Health 2006
2007	A New Direction for NSW: state health plan 2010
2007	Seclusion practices in psychiatric facilities PD 2007_054
2008	Multicultural Mental Health Plan 2008 - 2012
2008	The Employment Screening Policy

Appendix K: Local Area Health Service policies identifying trauma, sexual assault/abuse, and family violence relevant to the research unit.

NSW Area Health Board Policies (named by content not official title)
Sexual Safety
Code of conduct for staff
Risk assessment and management policy
Suicide management policy
Zero Tolerance Response to Violence
Guidelines regarding relationships with consumers Policy
The Seclusion Policy
Clinical documentation policy
Patient care levels
Disclosing health information policy