



National Centre of Excellence
for Complex Trauma

Blue Knot Foundation Submission to Productivity Commission Mental Health Inquiry

Blue Knot Foundation is the Australian National Centre of Excellence for Complex Trauma, empowering recovery and building resilience for the five million adult Australians (1 in 4) with a lived experience of childhood trauma (including abuse), their families and communities.

Formed in 1995, Blue Knot Foundation provides a range of services. These include:

- Specialist trauma counselling, information, support and referrals
- Educational workshops for survivors and their family members, partners and loved ones
- Professional development training for workers, professionals and organisations from diverse sectors
- Trauma-informed supervision
- Trauma-informed consultancy
- Resources including fact sheets, videos and website information at www.blueknot.org.au
- Advocacy
- Research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it.

In 2012, Blue Knot Foundation released *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* <https://www.blueknot.org.au/resources/Publications/Practice-Guidelines>. These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice. In 2015, Blue Knot Foundation released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by *Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts*, and in 2018 the paper *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance of Trauma* was launched and released. In 2018-19 Blue Knot Foundation is releasing its *Talking about Trauma* series.

For more information, visit www.blueknot.org.au. If you need help, information, support or referral, call Blue Knot Helpline 1300 657 380 or email helpline@blueknot.org.au between 9am-5pm Monday to Sunday AEST/ADST.

Submitted on behalf of Blue Knot Foundation by Dr Cathy Kezelman AM, President

president

Dr Cathy Kezelman AM

patron

Thomas Keneally AO

ABN 49 072 260 005

ambassadors

Jane Caro

Rose Parker

Christine Foster

Detective Chief Inspector Peter Fox

blue knot helpline 1300 657 380

education & training

information & resources

advocacy & health promotion

other services

contact

T 02 8920 3611

E admin@blueknot.org.au

W blueknot.org.au

PO Box 597 Milsons Point NSW 1565

Childhood trauma and mental health

Prevalence

Childhood trauma is common, and affects around one-third of the population worldwide¹ and, by conservative estimates 1 in 4 adult Australians². The majority of people treated by public mental health and substance abuse services have trauma histories³ of which the majority have histories of multiple traumas⁴. Unresolved trauma often underpins mental health presentations. A history of childhood trauma is '[t]he single most significant predictor' of subsequent contact with the mental health system⁵.

However the underlying trauma often goes unrecognised, unidentified and hence inadequately treated. This means long-term impacts on mental health.

Single incident and complex trauma

Trauma is often viewed solely in terms of a single incident – a natural disaster, assault in childhood, war trauma - PTSD. However repeated extreme interpersonal trauma as a result of adverse childhood events ('complex' cumulative, underlying trauma) is more common, and more damaging than single incident trauma. Its effects are pervasive, and if unresolved, they negatively impact mental and physical health across the lifespan, and intergenerationally.

Childhood trauma and diagnosis

People with complex trauma histories receive diverse psychiatric diagnoses because their trauma presents in many forms, with severe, wide-ranging and comorbid symptoms.⁶ In one study child abuse was associated with between 26 and 32% of adolescent and adult psychiatric disorders⁷. 76% of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have been diagnosed with three or more psychiatric disorders⁸. Women sexually abused as children are also two to three times more likely to suffer a psychiatric or substance abuse disorder, and the risk increases with the severity of abuse⁹. The more severe and prolonged the trauma, the more severe are the psychological and physical health consequences¹⁰.

¹ Kessler, R. C., McLaughlin, K. A., Green, J. G., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., . . . Angermeyer, M. (2010). Childhood Adversities and Adult Psychopathology in the Who World Mental Health Surveys. *The British Journal of Psychiatry*, 197(5), 378-385.

² Kezelman C, Hossack N, Stavropoulos P, et al. (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*. Sydney, Australia: Adults Surviving Child Abuse and Pegasus Economics.

³ Hussain & Chapel, 1983; Emslie & Rosenfeld, 1983; Mills et al. 1984; Bryer et al., 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al., 1990. Read et al. (2004) compared 40 studies published between 1984 and 2003 that examined the prevalence of child abuse among female psychiatric inpatients and among outpatients where at least half the patients were diagnosed with a psychosis. Also see V. Sar, 'Epidemiology of Dissociative Disorders: An Overview' (Review Article) *Epidemiology Research International*, Vol 2011 (2011) Art ID 404538.

⁴ van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma'

⁵ Middleton, W. 'Foreword' to *The Last Frontier*, *ibid*: x: 'Numerous studies demonstrate that around two thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse. When emotional abuse and neglect are added to the mix, the percentage experiencing *some form of adverse traumatic childhood* becomes even higher' (*ibid*)

⁶ Which is the ground on which the CPTSD (Complex PTSD) diagnosis was initially proposed by Judith Herman: '*Rather than a simple list of symptoms, it [i.e. CPTSD rather than 'simple' PTSD] is a coherent formulation of the consequences of prolonged and repeated trauma*' (Herman, 2009: xiii).

⁷ Green JG, McLaughlin KA, Berglund PA, et al. (2010) Childhood adversities and adult psychiatric disorders in the National Comorbidity Survey Replication I: associations with first onset of DSM-IV disorders. *Archives of General Psychiatry* 67(2): 113-123.

⁸ Borger S, Cox B and Amundson G (2005) PTSD and other mental health problems in adults who report histories of severe physical abuse and neglect. In: Corales T (ed) *Trends in Posttraumatic Stress Disorder Research*. Hauppauge, NY: Nova Science Publishers, pp.249-261.

⁹ Kendler KS, Bulik C, Silberg J, et al. (2000) Childhood sexual abuse and adult psychiatric and substance abuse disorders in women: An epidemiological and cotwin control analysis. *Archives of General Psychiatry* 57(10): 953-959.

¹⁰ Kezelman CA and Stavropoulos PA (2012) *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*. Sydney, Australia: Blue Knot Foundation, formerly, Adults Surviving Child Abuse.

Mental health diagnoses commonly applied to survivors of childhood trauma, including abuse vary widely and include Posttraumatic Stress Disorder (PTSD), Borderline Personality Disorder, Depression¹¹ or other Affective Disorders, Anxiety Disorders or psychosis¹² including Schizophrenia and Bipolar Disorder, also Dissociative Disorders¹³ and Somatic Symptom Disorder, previously known as Somatoform Disorder¹⁴. While not all childhood trauma leads to psychosis, and not all psychosis is trauma-related, trauma is also a well-documented potential risk factor for psychosis¹⁵.

Other challenges include multiple coexisting conditions such as substance abuse, Eating Disorders, self-harming behaviours, and suicidality.¹⁶ Any diagnosis or comorbid diagnosis may be a manifestation of Complex PTSD, or may be related to a coping mechanism used to survive (e.g. substance abuse). With childhood trauma, comorbidity is the norm rather than the exception. Coexisting depression and anxiety are common, as is the diagnosis of personality disorder, particularly Borderline Personality Disorder. The developing minds of young children often respond protectively to extreme stress and the perception of threat, through the mechanism of dissociation.¹⁷

Impacts

Adults who were traumatised as children often experience social, psychological, educational, employment and relationship impairments. They are more likely to enter the criminal justice, healthcare and welfare systems, commit or attempt suicide and/or face debilitating challenges including self-harm, substance misuse etc. These have a significant cost to the individual, but their families, communities and government.

Mental health system

Our mental health system often does not identify, acknowledge or appropriately address the burden of complex trauma core to the complex needs of many consumers, who often present with comorbidity.

‘(F)or the most part, the issue of trauma is simply screened out organizationally and systemically... the reality of the traumatic origins of mental illness go unaddressed. And the patient, frequently diagnosed with chronic depression, borderline personality, or some other ‘axis II’ disorder, is labelled, everyone in the system colludes to support the reality and meaningfulness of the label in determining future behaviour and outcomes, *and the patient’s more fundamental – and treatable – trauma conditions go untreated.*¹⁸

¹¹ Widom CS, DuMont K and Czaja SJ (2007) A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry* 64(1): 49-56.

¹² Shevlin M, Dorahy MJ and Adamson G (2007) Trauma and psychosis: an analysis of the National Comorbidity Survey. *American Journal of Psychiatry* 164: 166–169.

¹³ Dorahy MJ, Middleton W, Seagar L, et al. (2016) Child abuse and neglect in complex dissociative disorder, abuse-related chronic PTSD, and mixed psychiatric samples. *Journal of Trauma and Dissociation* 17(2): 223-236.

¹⁴ Spitzer C, Barnow S, Gau K, et al. (2008) Childhood maltreatment in patients with somatisation disorder. *Australian New Zealand Journal of Psychiatry* 42(4): 335-41.

¹⁵ Schäfer I, Fisher HL (2011) Childhood trauma and psychosis - what is the evidence? *Dialogues in Clinical Neuroscience* 13(3):360-365.

¹⁶ Cutajar M, Mullen P, Ogloff J, et al. (2010) Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study. *Medical Journal of Australia* 192(4): 184-187.

¹⁷ Traumatised children, in particular, often cannot ‘fight’ or ‘flee’. This can activate the ‘freeze’ response which also paves the way for dissociation and the risk of subsequent dissociative disorders if the trauma is not resolved (‘[Y]oung survivors of early trauma.... often rely on dissociative strategies to cope with the dilemmas in their world. They use automatic programs such as rage, retreat, or regression that help them avoid authentic emotional engagement’ (Silberg, *ibid*, pp. xiii-xiv). Although protective and adaptive in the first instance; if the initial and underlying trauma is not resolved, the defence will negatively impact well-being over time.

¹⁸ Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. New York: Oxford University Press.

The prevalence, impact, costs and stakes of complex trauma, and informed responses to the treatment of the public health issue must inform our mental health system responses. The costs of unrecognised and untreated complex trauma are enormous in terms of reduced quality of life, life expectancy and lost productivity, and in 'significant increases in the utilisation of medical, correctional, social, and mental health services'.¹⁹

Current service responses

- Complex trauma and its mental health and other effects are often unrecognised, misdiagnosed and unaddressed.
- People impacted by trauma present to multiple services over a long period of time; care is fragmented with poor referral and follow-up pathways
- A 'merry-go-round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma
- Escalation and entrenchment of symptoms is psychologically, financially and systemically costly

Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted.²⁰ People can and do recover and their children can do well. For this to occur, mental health service delivery needs to reflect the current research and clinical treatment insights into complex trauma, often as a result of adverse childhood experiences, including dissociation.

Question: Assessment

What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment. P.10

Please see uploaded document: Kezelman, C., Hossack, N., Stavropoulos, P., Burley, P., (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*, Adults Surviving Child Abuse (now Blue Knot Foundation) and Pegasus Economics, Sydney

Childhood trauma, a broader more comprehensive category²¹ than child abuse, is a significant public health issue which substantially erodes national productivity and wellbeing, and affects an estimated five million Australian adults. It has significant individual and community health, welfare and economic repercussions.

In 2015 Pegasus Economics and then ASCA (now Blue Knot Foundation)²² estimated that if the impacts of child abuse (sexual, emotional and physical) on an estimated 3.7 million adults are adequately addressed through active timely and comprehensive intervention, the combined budget position of Federal, State and Territory Governments could be improved by a minimum of \$6.8 billion annually. In the population of an estimated 5 million adult survivors of childhood trauma more broadly this estimate rises to \$9.1 billion. These figures were based on a highly conservative set of assumptions and represent a combined effect of higher Government expenditure and foregone tax revenue; the annual budgetary cost of unresolved childhood trauma could be as high as \$24 billion.

¹⁹ Bessel A. van der Kolk, 'Foreword', in Stephen W. Porges, *The Polyvagal Theory* (New York: Norton, 2011), p.xiii.

²⁰ Daniel J. Siegel, citing Roisman et al, 2002; Phelps, Belsky & Cicchetti, 1998, 'An Interpersonal Neurobiology of Psychotherapy', in Marion F. Solomon & Daniel J. Siegel, *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003), p.16.

²¹ Wider definitions of childhood trauma include, in addition to abuse in all its forms, neglect, growing up with domestic and community violence and the traumatic impact on children in experiencing a parental divorce or other relationship breakdown, death of a parent, an alcoholic or drug addicted parent, or a parent affected by mental illness or other significant mental health problem (Felitti and Anda, 1998)

²² Kezelman, C., Hossack, N., Stavropoulos, P., Burley, P., (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*, Adults Surviving Child Abuse (now Blue Knot Foundation) and Pegasus Economics, Sydney

The calculations considered 4 possible impacts of childhood trauma - suicide and attempted suicide, alcohol abuse, anxiety and depression, obesity, and considered that each affected person experienced only one of these impacts. Many people with the lived experience of complex trauma experience multiple cumulative impacts. Active timely and comprehensive intervention, with appropriate support, resources, services and treatment enables adult survivors to participate more fully and productively in the Australian community, and make a positive contribution to health budget challenges and those related to the welfare and criminal justice systems, and the lower taxation revenue associated with the impact.

Question: Structural weakness in healthcare (1)

Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms? P.13

Power Threat Meaning Framework

Please see uploaded document: Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

The Power Threat Meaning Framework published in 2018 by the Clinical Division of the British Psychological Society²³, conceptualises a holistic human approach to mental health. Currently the conceptualisation of mental illness is predicated solely on the biomedical diagnostic model of disorder. This often pathologises and further isolates people from the communities, cultural contexts and social supports critical to their recovery. In this system the context of people's lives, what happened or is happening to them, is/are rarely considered. Already isolated people experiencing mental distress are often isolated further in systems of treatment, which exclude, stigmatise and label.

This framework is based on a great deal of evidence. It suggests that if we know enough about people's relationships, social situations and life stories, and the struggles they have faced or are still facing, it is possible to make sense of these experiences. That's because we are all social beings and our distress and troubled or troubling behaviour are inseparable from our cultural, social, economic, and environmental contexts. There is no separate 'disorder' to be explained²⁴.

The Power Threat Meaning framework encourages us to look at the causes behind people's distress and also think about people's skills, strengths and supports. It suggests a system can support them to create meaningful narratives of their lives, we may be able to come up with new ways forward e.g. engaging supportive partners, friends, family, sense of belonging, access to information, recreational and educational opportunities, belief systems, cultural rituals, connection to nature, creativity, talents, faith, beliefs.

The mental health system needs to support people to identify their strengths, build on them and their resources by:

²³ Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

²⁴ Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Overview*. Leicester: British Psychological Society. ©

- Supporting experiential ways to help manage feelings – art, writing, working with the body, exercise, psychotherapy, mindfulness
- Self-care... individualised
- Developing meaningful stories, beliefs, sense of purpose
- Identifying and building constructive supportive relationships
- Finding meaningful roles, participation
- Cultural engagement and activities

Question: Structural weakness in healthcare (2)

What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity? Page 13.

Empowering Recovery from Childhood Trauma

Blue Knot Foundation proposes that an ‘empowering recovery from childhood trauma’ model should be integrated into and across the mental health system. This will necessitate transformative change across and within services, systems and sectors to which consumers, experiencing mental distress, with a lived experience of childhood trauma present. Doing so will intervene in high morbidity and mortality rates, promote workforce participation, reduce welfare dependency, and contribute to budget bottom line.

Overarching goal

To empower recovery from childhood trauma²⁵ and enable consumers with lived experience of childhood trauma across the life span to live healthy, meaningful, connected and participating lives.

Primary goals

- To enable consumers with the lived experience of childhood trauma to become active participating members of their communities and society
- To break intergenerational cycles of childhood trauma
- To promote help-seeking and pathways to mental and physical health and wellbeing for every person impacted, including partners and family members
- To build the capacity of all elements of the professional and support workforce to empower recovery for consumers with childhood trauma history, across the life cycle – access to specialist support and community managed and primary care pathways
- To enable equity of access to all regardless of geography, socio-economic circumstances, gender, diversity
- To build a mainstream peer survivor workforce

Challenge and opportunity

Unresolved childhood trauma is substantial public health issue with significant psychosocial and mental and physical health impacts and is in urgent need of redress. Despite the prevalence and stakes of the problem, service provision for those directly and indirectly affected remains largely inadequate – inaccessible, unaffordable and poorly matched to need. There has been an endemic failure to invest in person-centred trauma-informed recovery-oriented services across the life span.

²⁵ Childhood trauma includes, in addition to abuse in all its forms, neglect, growing up with domestic and community violence and the traumatic impact on children in experiencing a parental divorce or other relationship breakdown, death of a parent, a parent living with alcohol/and other drug issues, or a parent affected by mental illness or other significant mental health problem.

Primary care and frontline services are not equipped to identify, appropriately respond to, and/or comprehensively address the complex needs of trauma survivors, including comorbidity. Significant gaps and inequities in accessibility to, affordability of, specialist services and trauma-informed supports are compounded by poor care coordination and limited referral pathways. Additional challenges relate to these consumers' difficulties in seeking and sustaining help, due to difficulties around trust, safety and prior experiences of re-traumatisation.

Core components

This model has 5 core components:

- A. Information and education
- B. Trauma-informed systems, services, sectors
- C. Primary care
- D. Community managed care – specialist, allied health and psycho-social supports
- E. Peer support

Driving principles

This model is grounded in the following driving principles which are integrated throughout its articulation

- Consumers with lived experience of complex trauma at centre of system of care - planning, design and delivery
- Empowers consumers with trauma history in their own recovery
- Focusses on whole person in context of their lives
- Strengths-based rather than deficit-focused
- Trauma-informed recovery-oriented
- Engages all elements of system – primary care, specialist care, community based care
- Crosses systems of care including but not limited to community, mental health, health, AOD, family violence, suicide, homelessness, welfare, family and child protection, legal and justice, education, employment.
- Recognises the importance of families and loved ones - planning, design, delivery and, as service recipients
- Recognises the importance of whole of community education and involvement maps targets to actions

A. ACTION:

Widely disseminate information and education around complex trauma, dynamics and impacts, including mental health

TARGET AUDIENCE:

- Consumers with lived experience of childhood trauma
- Family members, friends, partners, loved ones
- Workers and practitioners working in different capacities across sectors
- Community members

TARGETS:

- All consumers experiencing mental distress and living with the impacts of childhood trauma will be educated in an age appropriate way about their trauma, its possible effects, ways of coping and pathways to recovery

- All supporters/carers will understand how trauma may be affecting the consumer, how best to support them while caring for themselves
- Every person working in a supporting or professional role with consumer living with the long-term impacts of childhood trauma will understand how trauma is affecting the person, to enable them to respond in a supportive trauma-informed manner
- Every person living in the community will have some understanding about the impacts of childhood trauma – mental health and distress, how to respond when someone discloses, and where to go for support

B. ACTION:

Embed trauma-informed practice across systems, services and sectors

TARGET AUDIENCE:

- Workers across diverse systems and sectors
- Practitioners across diverse systems and sectors
- Managers/leaders across diverse systems and sectors
- Diverse organisations/services/systems

Consumers with lived experience of trauma often experience re-traumatisation in mental health system. This model is predicated on 'doing no harm' and optimising client and staff health, safety and wellbeing.

- Building trauma-informed workforce capacity within and across the diverse services to which survivors may present is critical - including but are not limited to education, health, mental health, AOD, family violence, child protection, welfare, legal and justice, including criminal justice, emergency services housing
 - Embedding trauma-informed recovery-oriented principles into practice standards across service systems to establish a shared understanding and quality of practice within and across systems to which survivors present
 - Professional development training to all staff, across disciplines (workers, practitioners, managers) at all levels, across services, to enhance trauma and trauma-informed literacy, care and practice, and mental health implications
 - Trauma-informed non-clinical group supervision, debriefing, professional development for all staff interacting with clients, including peer debriefing
- An organisational trauma-informed systems change process needs to be undertaken to embed trauma-informed structure, policy and procedures across services and service systems. This entails assessment, planned implementation, monitoring and review
- A robust evaluation process which includes client and staff self-evaluation and independent external service/systems evaluation of trauma-informed implementation and embedding processes

TARGETS:

- Mandatory trauma-informed training for workers at all levels across service systems and sectors
- Mandatory trauma-informed training for practitioners of all disciplines – meeting regulatory requirements; including supervision, debriefing, professional development
- Organisations and services to comply with 'industry' standards in trauma-informed policy, processes and structure

C. ACTION:

Educate and train primary practitioners around trauma, support and pathways to recovery – ‘no wrong door’

TARGET AUDIENCE:

- General practitioners
- Practice nurses
- Physicians
- Dentists

Frontline practitioners: General Practitioners and nurse practitioners will, on a daily basis, inevitably see people who have been impacted by childhood trauma (‘every physician will see several patients with high ACE scores each day’²⁶). Thus there are multiple and ongoing opportunities to facilitate a process whereby the presenting person can start receiving appropriate support. Such support may be direct or via targeted referral/s (including specialist counselling/therapy, multi-disciplinary agency team or coordination of a range of support services to meet the needs of daily living) through a linked-up service system.

TARGETS:

All primary care services utilise screening, assessment, treatment, support and referral protocols in responding to complex trauma clients

D. ACTION:

Establish a coordinated pathway to specialist, community managed and support services.

TARGET AUDIENCE:

- Specialist trauma services
- Allied health services
- Community managed services
- Support agencies

TARGETS:

- Create, enhance and evaluate dedicated comprehensive complex trauma speciality services within mental health system across the life cycle
- Ensure that specialist services, including online, are equitable, universally available, and accessible to survivors and carers
- Assess and intervene early when possible and provide community based and primary care entry to specialist and support services appropriate to age and need
- Ensure continuity of care and response to diversity for all consumers with lived experience of childhood trauma who require specialist intervention through the life cycle

E. ACTION:

Peer engagement

TARGET AUDIENCE:

- Adult survivors of childhood trauma
- Family, friends, partners and loved ones of survivors of childhood trauma

²⁶ Felitti VJ, Anda RF. The Relationship of Adverse Childhood Experiences to Adult Health, Well-being, Social Function, and Health Care. Chapter 8 in *The Effects of Early Life Trauma on Health and Disease: the Hidden Epidemic*; Editors: Lanius R, Vermetten E, Pain C. Cambridge University Press. 2010:78

TARGET

- Survivors and their families participate fully in the planning, design and delivery of survivor services, and are engaged in partnerships within primary care and specialist services
- Every specialist service for survivors can demonstrate survivor and family participation in the planning and development of the service

Question: Specific health concerns

A. *Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs? p.16*

Two specific concerns are presented here.

- Screening for trauma
- What constitutes evidence to inform practice?

1. Screening for trauma

Please see uploaded document: Talking about Trauma: Guide to Conversations and Screening for Health and Other Service Providers © 2018 Blue Knot Foundation

Blue Knot Foundation recommends routine universal screening for trauma across the entire mental health and health system – settings, services and facilities, because of the high prevalence and adverse health impacts of unresolved ‘complex’ trauma. Currently there is minimal screening. Trauma screening is also applicable to some *non*-health services, depending on context and the choice of screening tool.

A recent Melbourne study found that the majority of patients admitted to a psychiatric ward are not asked whether they have experienced trauma, and that only 3% of patients had a specific description of their trauma recorded in their file.²⁷ Yet when patients were asked about prior trauma, 83% reported abuse trauma while only 17% did not.²⁸

The *disincentives* for widespread screening need to be addressed, including mental health clinicians avoiding screening ‘*because they don’t feel competent to do so, or they feel unable to follow up with appropriate management if they uncover a history of trauma, leading to avoidance of the whole issue*’. ‘Trauma histories go unrecorded’ <http://www.6minutes.com.au/psychiatryupdate/latest-news/trauma-histories-go-unrecorded>

This study also underlines that not ‘screening for trauma’ is problematic, despite some legitimate reasons for not screening.²⁹

- **Addressing the disincentives: for ‘screening for trauma’ in health settings**

Trauma is ‘overlooked’ by health professionals and services more broadly for reasons including a subconscious need to avoid confronting the unpalatable, and an individual or collective concern about the capacity to appropriately address any trauma revealed. This supports the need for additional

²⁷‘Trauma histories go unrecorded’ *Psychiatric Update* (19 February 2016) <http://www.6minutes.com.au/psychiatryupdate/latest-news/trauma-histories-go-unrecorded>

²⁸ Trauma histories go unrecorded’, *ibid*

²⁹ There is a need for clinician retraining, a trauma-informed care model, and the incorporation of mandatory inquiry in best practice guidelines to generate a shift in culture in the delivery of mental health care services’, ‘Trauma histories go unrecorded’, *ibid*.

training to upskill practitioners and workers in health services to support disclosures and respond appropriately.

- **Disincentives to screen for trauma: health professionals and services**

The following chart details some of the common grounds why health professionals and services may not screen for trauma:

The reasons health professionals/services may not screen for trauma:

- *They underestimate the impact of trauma on physical and mental health*
- *Relevant questions are not part of the standard intake procedure*
- *They lack knowledge about how to respond to any information received*
- *They are concerned that clients/patients may be upset*
- *They believe that treatment should focus solely on presenting symptoms rather than their possible origin*
- *They are concerned that a treatment may be required which they can't provide*
- *They believe that any substance abuse issues should be treated prior to the treatment of other issues*
- *There is not enough time to assess and explore trauma histories or symptoms.*
- *Practitioners, other staff members, and administrators may have their own untreated trauma-related symptoms*

(Points drawn from 'Screening and Assessment – Trauma-Informed Care in Behavioural Health Services', NCBI Bookshelf, 9/17)

- **Clients' disincentives to screen for trauma**

'[S]ome clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions aimed at identifying the occurrence of traumatic events' (NCBI Bookshelf; *ibid*, 8/17).

Consumers are understandably reluctant to disclose prior traumatic experience given the risks, stakes, and potential consequences of disclosure.³⁰ Such reluctance is self-protective. Reasons for not disclosing range from fear of retribution by perpetrators to the possibility of unempathic responses and not being believed.

Some people may not regard their prior overwhelming experience/s as traumatic. Others may not consciously recall it/them or are unable to verbalise it/them. Traumatic memory is very different to conscious 'autobiographical' memory.³¹ Additionally, if the trauma was experienced in early childhood it may be pre-verbal, which explains the subsequent difficulty in expressing it in words.

'[A]ll individuals who administer screenings, regardless of education level and experience, should be aware of trauma-related symptoms, grounding techniques, ways of creating safety for the client, proper methods for introducing screening tools, and the protocol to follow when a positive screen is obtained'. NCBI Bookshelf 15/17 www.ncbi.nlm.nih.gov/books/NBK207188/

³⁰ For elucidation of the 'politics' of disclosure of childhood trauma in general and childhood sexual abuse in particular, see Freyd & Birrell, *Blind to Betrayal* (NJ: John Wiley & Sons, 2013), pp.122-129.

³¹ See, for example, Peter Levine, PhD *Trauma and Memory: Brain and Body in a Search for the Living Past* (Berkeley, CA: North Atlantic Books, 2015).

The core trauma-informed principles are simple. But service cultures need to embed them *at all levels* of service delivery (i.e. formal and informal, 'bottom up and top down').

Staff who administer trauma screening need to have the requisite foundational knowledge and be alert to *their manner of engagement* with clients.

Comprehensive trauma screening also needs to be introduced for all patients in primary care settings (i.e. subject to a trauma-informed context and appropriate follow up) would have multiple benefits (*'If ever there were a need for true primary prevention, this is the area'*).³² Yet trauma can also be identified without a formal trauma screen.

The ACE Study³³ provides the evidence base for the benefits of trauma screening. As part of the study, 440,000 people undergoing routine comprehensive medical evaluation completed a questionnaire, which included questions related to prior trauma. This questionnaire was completed at home and then either presented to or analysed for review by their primary care physicians. The data from 100,000 respondents over a 2 year period was analysed. It showed a 35% reduction in visits to doctors' surgeries the following year (as compared to year prior), 11 % reduction in visits to emergency departments and 3 % reduction in hospitalisations i.e. a profound and substantial outcome in terms of health service utilisation³⁴.

These outcomes were not attributable to participants receiving psychotherapy (follow up counselling was rare) but showed the profound importance of assisting people to talk about their trauma and return home feeling accepted. It showed the power of empathic asking, listening, and validation which would otherwise be unarticulated to the treating health professional.

'We have demonstrated in our practice that this approach [ie carefully designed questionnaires ...] is acceptable to patients, affordable & beneficial in multiple ways'.³⁵ The development of a culturally attuned trauma screening tool for use within the Australian primary care and wider mental health system would build on overseas evidence which has established the benefits and applicability of this approach.

In the ACE Study the introduction of the questionnaire was coupled with 'trauma sensitive' training for primary care physicians for trauma-informed responses to affirmative replies to the screening. It is proposed that education and training of relevant practitioner and worker groups, focussed on the policy and practice requisites will help establish trauma-informed service responses within primary care and mental health settings across Australia.

Research has established the patient and economic benefits of trauma-informed service settings. A variety of studies³⁶ establish that settings using a trauma-informed model report an improvement in patients' daily functioning and a decrease in trauma symptoms, mental distress, substance use, and mental health presentations. The ACE study approach incorporated trauma-informed principles of practice. Its lead investigator reports extraordinary cost savings: in the Kaiser Permanente system in which study was conducted and which has 3.5 million members, where the outpatient budget is \$ 6.5 billion US/year, Vincent Felitti, the author of the study has projected savings of the order of \$2.4 billion USD/year.

³² Felitti 2011-18

³³ Felitti, V. J. Anda, R. F. et. al (1998) 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine*. 14 (4), pp.245-258.

³⁴ Felitti, V.J. & Anda, R.F. (2010) 'The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare'. Ch. 8 in Lanius, R.A., Vermetten, E. & C. Pain, *The Impact of Early Life Trauma on Health and Disease*. Cambridge University Press, pp.77-87.

³⁵ Felitti, Vincent J. (2010). Forward. In Lanius, R. A., Vermetten, E. and Pain, C. *The impact of early life trauma on health and disease: The hidden epidemic*. Cambridge UK; Cambridge University Press.

³⁶ Coccozza, J.J., Jackson, E. W., Hennigan, K., Morrissey, J. P., Reed, B.G., Fallot, R., & Banks, S. (2005). Morrissey, J. P., Ellis, A. R., Gatz, M., Amaro, H., Reed, B. G., Savage, A., ... Banks, S. (2005)

2. Considering evidence

Evidence to support particular treatments and claims of their effectiveness is paramount. However this can consider *an* evidence base, as opposed to being 'evidence-based'. The sole use of 'evidence-based' treatments, especially for complex trauma, and the need to carefully scrutinise the basis and criteria for assessing treatment effectiveness can be unhelpfully restrictive. Given that complex trauma treatment, including dissociation is challenging it is important for clinicians and researchers to remain receptive to potential 'new' treatment options.

*'The evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities...The over-optimistic claims for the effectiveness of cognitive-behavioural therapy (CBT) and misrepresentation of other approaches do not best serve a group of patients greatly in need of help; excluding individuals with such disorders as untreatable or treatment-resistant when viable alternatives exist is not acceptable.'*³⁷

Evolving neurobiological and other research necessitates reviewing the conceptualisation of psychological treatment. The growing recognition of the integral relationship of physiological and somatic processes and experience to well-being, challenges unqualified reference to 'mental' health. Recognition of the inextricable interrelationship of body and brain is potentially game changing for the design and validation of studies of effective 'psychological' treatments.³⁸

Some claims and findings suggest that³⁹ current 'evidence-based' psychotherapeutic treatments for trauma, specifically 'first line', 'trauma-focused', short-term and exposure-based treatments (as currently privileged under MBS system) can be problematic for people with complex trauma and dissociative disorders.

*'Psychotherapists in many services are required to restrict their approaches to those therapies recommended in guidelines or expert consensus irrespective of the oversimplified misrepresentation of the evidence base that result in service constraints such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. Psychotherapy therefore is often protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control. Patients unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance'*⁴⁰.

Question: Specific health concerns

- B. Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this? p.16

³⁷ Frank M. Corrigan & Alastair M. Hull, 'Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions', *BJPsych Bull.* (39, 2, 2015), pp.79-86. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478907/>

³⁸ This point is elaborated further in ch.7.

³⁹ See, for example, M. A. Hagens, A. van Minnen, et al 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy* (48, 1, 2010), pp.19-27) and the detailed discussion in ch.3 of this document.

⁴⁰ Lisa Schwarz, Frank Corrigan, et al, citing Corrigan & Hull, 2015, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (Routledge, New York, 2017), p.140.

Broad-based embedding of trauma-informed practice

Already traumatised people are often retraumatised *by and within diverse services of the health sector* exacerbating their mental distress rather than fostering recovery.⁴¹ This is supported by growing research.⁴² Recognising that *'[t]rauma has often occurred in the service context itself'*⁴³ is a major impetus for 'trauma-informed' practice. Trauma-informed services 'are informed about, and sensitive to, trauma-related issues'.⁴⁴ They do not directly treat trauma or its impacts. The *possibility* of trauma in the lives of all clients/patients/consumers is a central organising principle of trauma-informed care, practice and service-provision, irrespective of the service.

A trauma-informed service:

- Commits to and acts upon the core organising principles of *safety, trustworthiness, choice, collaboration and empowerment*.⁴⁵
- Has reconsidered and evaluated *all components of the system 'in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services'*.⁴⁶
- Applies this understanding *'to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatisation and... facilitate consumer participation in treatment'*.⁴⁷
- Requires ('to the extent possible') close *'collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical experience in 'traumatology'*.⁴⁸

Widespread lack of understanding of trauma and its mental health impacts *in the current mental health system* means that many practitioners, workers as well as consumers may be unaware of the links between 'past' traumatic experience and current problems of living. Since people living with the impacts of trauma often present to multiple services over a long period of time, the care they receive is frequently fragmented and lacking in co-ordination between services. Referral and follow-up pathways are often deficient. The resulting 'merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma, with significant emotional, financial and systemic costs.

Successive National Mental Health Strategies have moved towards more decentralised models of care, community-based services, consumer participation and recovery-oriented practice.⁴⁹ They are now embedded principles in mental health care, and in the National Mental Health Plan but there is a continuing gap between these goals and their implementation. To foster client recovery, the envisaged principles and practice need to be embedded into the philosophy and functioning of all levels of service-delivery.

⁴¹ 'Individuals with histories of violence, abuse and neglect from childhood onward make up *the majority of clients served by public mental health and substance abuse service systems*' (Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...', p.6 (emphasis added). In relation to the context of the United States, Jennings notes that '90% of public mental health clients have been exposed to (and most have actually experienced) multiple experiences of trauma', and that '75% of women and men in substance abuse treatment report abuse and trauma histories' (Ibid)

⁴² See, for example, Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011). While addressed to the context of the United States (where the introduction of 'managed care' has been particularly destructive in a range of respects) this analysis is also relevant to the Australian context. See, for example, Jane Davidson, *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions* (NSW Department for Women and the NSW Health Department, 1997).

⁴³ Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...', p.6.

⁴⁴ Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.15.

⁴⁵ Fallot & Harris, 'Creating Cultures of Trauma-Informed Care', p.3.

⁴⁶ *ibid*(citing Harris & Fallot, 2001)

⁴⁷ *ibid*

⁴⁸ *ibid*

⁴⁹ In reviewing the ten years between 1993 and 2003, with reference to both the first and second national mental health plans, the *National Mental Health Report 2005* noted that '[i]nitial concern during the Strategy revolved around concepts of protection from human rights abuses, but progressively, these concerns evolved to incorporate more modern concepts of consumer empowerment and participation'. Also noted was a shift towards 'a recovery orientation in service delivery'.

Responding to the public health challenge of complex trauma:

- Requires *integration of vision and research into practice*
- Means engaging an *array of services and professions to achieve a paradigm cultural shift in mental health and human service delivery*
- Requires *specialised knowledge, workforce education and training, and collaboration between consumers, carers, policymakers, and service providers*
- Necessitates *national training programs* for systemic quality improvement, cultural re-orientation and workforce development

Benefits and outcomes of trauma-informed practice:

- Trauma-informed service settings, with trauma-specific services available, have better outcomes than “treatment as usual”. A variety of studies^{50,51}and pilot programs⁵²using a trauma-informed model report a decrease in psychiatric symptoms and substance use. Some of these programs have shown an improvement in consumers’ daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms. These findings suggest that integrating services for traumatic stress, substance use, and mental health leads to better outcomes.⁵³
- Early indications suggest that TIC may have a positive effect on housing stability. A multi-site study of TIC for homeless families found that, at 18 months, 88% of participants had either remained in Section 8 housing or moved to permanent housing.⁵⁴An outreach and care coordination program that provided family-focused, integrated, trauma-informed care to homeless mothers in Massachusetts found that the program led to increased residential stability.⁵⁵
- TIC may lead to a decrease in crisis-based services. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed care.⁵⁶
- Trauma-informed, integrated services are cost-effective because they have improved outcomes but do not cost more than standard programming.⁵⁷
- Qualitative results find that providers report positive outcomes in Trauma-Informed Care in Homelessness. Providers report greater collaboration with consumers, enhanced skills, and a greater sense of self-efficacy among consumers, and more support from their agencies.

⁵⁰ Coccozza JJ, Jackson EW, Hennigan K. Outcomes for women with co-occurring disorders and trauma: Program-level effects. *J Subst Abuse Treat* 2005; 28: 109-19.

⁵¹ Morrissey JP, Ellis AR, Gatz M. Outcomes for women with co-occurring disorders and trauma: Program and person-level effects. *J Subst Abuse Treat* 2005; 28: 121-33

⁵² Kammerer N. Project RISE evaluation report. Unpublished program evaluation report. Boston, MA: Health and Addictions Research, Inc. and Health Institute for Recovery n.d.

⁵³ Morrissey JP, Jackson EW, Ellis AR. Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatr Serv* 2005; 56: 1213-22.

⁵⁴ Rog DJ, Holupka CS, McCombsthornnton KL. Implementation of the Homeless Families Program.1. Service Models and Preliminary Outcomes. *Am J Orthopsychiatry* 1995; 65: 502-13.

⁵⁵ Kammerer N. Project RISE evaluation report. Unpublished program evaluation report. Boston, MA: Health and Addictions Research, Inc. and Health Institute for Recovery n.d.

⁵⁶ Community Connections. Trauma and abuse in the lives of homeless men and women. Online PowerPoint presentation. Washington, DC2002. Available from: http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

⁵⁷ Domino ME, Morrissey JP, Chung S, Huntington N, Larson MJ, Russell LA. Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatr Serv* 2005; 56: 1223-32.

Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events, and more effective services.⁵⁸

- Qualitative results indicate that consumers respond well to TIC. Within the D.C. Trauma Collaboration study, consumers reported an increased sense of safety, better collaboration with staff, and a more significant “voice.” Eighty-four % of consumers rated their overall experience with these trauma-informed services using the highest rating available⁵⁹. Survey results suggest that consumers were very satisfied with trauma-informed changes in service delivery⁶⁰.

Question: Specific health concerns

- C. *What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity? P.16*

Two concerns are raised here:

- Comorbidity
- Suicide

1. Co-morbidity

Diagnosis as categorised in the DSM and ICD is fundamental to thinking about and responding to people’s mental health difficulties. In them people are diagnosed with categories of ‘mental disorder’. For many people diagnoses have not been helpful, and particularly for people with multiple comorbid diagnoses. Many people with complex childhood trauma often meet the criteria for multiple co-morbid diagnoses, which is problematic for consumers and practitioners alike.

“Critics have also focused on the low levels of agreement amongst clinicians making diagnoses (unreliability) and on the lack of validity or usefulness of diagnostic categories within their own conceptual terms, including their failure to produce successful research on the assumed biological causes of ‘mental disorders’ or to predict effective treatments, as well as the fact that they generate extensive ‘comorbidity’, so that people might fit several categories simultaneously (Bentall, 2003; Boyle, 2002a; Kirk et al., 2013; Moncrieff, 2008).^{61”}

While medical diagnosis focuses on bodily problems, psychiatric diagnosis focuses on people’s beliefs, thoughts, feelings and actions, and are based on subjective ‘symptoms’ without any objective signs as occurs in physical medicine.

A formal diagnosis of Complex PTSD announced on 18 June 2018 in the *International Classification of Diseases (ICD-11)* of the World Health Organisation (WHO) release will come into effect on 1st January 2022. While welcome, formal diagnosis of Complex PTSD does not encompass the range of challenging

⁵⁸ Community Connections. Trauma and abuse in the lives of homeless men and women. Online PowerPoint presentation. Washington, DC2002. Available from: http://www.pathprogram.samhsa.gov/ppt/Trauma_and_Homelessness.ppt

⁵⁹ Jennings A. The damaging consequences of violence and trauma: facts, discussion points, and recommendations for the behavioral health system. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning 2004.

⁶⁰ Community Connections. Final report: Trauma-informed pilot project at the Rumford (Maine) unit of tri-county mental health services 2003.

⁶¹ Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

presentations, especially around dissociation, of complex trauma⁶². The diagnostic lens is not adequate to fully address the many dimensions of complex trauma and implications for treatment⁶³.

A 'trauma-informed' approach regards 'symptoms' as the outgrowth of self-protective strategies to deal with traumatic overwhelm which, when trauma is unresolved, have lost their protective function. The underlying trauma needs to be addressed not only for 'remediation of symptoms' but to resolve the underlying trauma. This contrasts to the understanding of symptoms within the biomedical model. Symptom-based' approaches to treatment often fail to recognise 'the whole person'. As complex trauma is often interpersonally generated, it is *relational* and needs to be healed *in relationship*. A sole focus on symptoms detaches from the context which gave rise to them. This also suggests the limits of 'techniques' administered outside of a relational context.

2. Suicide

An increased rate of both completed and attempted suicide is associated with childhood trauma, particularly child sexual abuse. Yet when considering prevention and early intervention strategies the issue of trauma in general and complex childhood trauma, in particular, is not prioritised, as a risk factor.

A number of rigorous studies have identified significant links between child sexual abuse and subsequent suicidality.⁶⁴ An Australian study into child sexual abuse victims found that 32% had attempted suicide, and 43% had considered it with observed suicide rate in sexually abused children was 10.7-13.0 times that of the Australian national rate.⁶⁵

A more recent study of over 2,500 medically established that Australian victims of child sexual abuse (CSA) has significantly higher rates of suicide compared to the general population, with females at 40 times risk of suicide and males, 14 times.⁶⁶ The ACE Study identified that adults who have experienced four or more adverse childhood experience categories, out of the 10 identified are 12 times more likely to have attempted suicide than those who have not experienced any forms of childhood trauma or abuse.⁶⁷ A meta-analysis of people's recollections of past traumas showed a strong association between child abuse and neglect, and attempted suicide in adults.⁶⁸

Dube et al. identified a powerful graded relationship between adverse childhood experiences and risk of attempted suicide throughout the lifespan. Alcoholism, depressed affect and illicit drug use which are strongly associated with such experiences appear to partially mediate this relationship.⁶⁹ Significant associations to suicide attempts from large, population-based studies have been found for parental mental health and substance abuse issues, parental suicide and socio-economic disadvantage.⁷⁰ While

⁶² Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation*: Routledge.

⁶³ Frewen, P., & Lanius, R. (2015). *The Norton series on interpersonal neurobiology. Healing the traumatized self: Consciousness, neuroscience, treatment.*

⁶⁴ Dube SR, Anda RF, Whitfield, CL, Brown DW, Felitti VJ, Dong M, Giles WH. Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim. *American Journal of Preventive Medicine.* 2005; 28: 430-438.

Fergusson D.M., Boden J.M., Horwood L.J. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse Neglect.* 32(6):607-19.

Molnar, B.E., Berkman, L.F., Buka, S.L. (2001). Psychopathology, child sexual abuse and other childhood adversities: relative links to subsequent suicidal behaviour in the US. *Psychological Medicine.* 31:6. 965-977.

⁶⁵ Plunkett, A., O'Toole, B., Swanston, H., Oates, R., Shrimpton, S., & Parkinson, P. (2001). Suicide risk following child sexual abuse. *Ambulatory Pediatrics,* 1(5), 262-266.

⁶⁶ Cutajar, M., Mullen P., Ogloff J., Thomas S., Wells D., Spataro, J., (2010). Suicide and Fatal Drug Overdose in Child Sexual Abuse Victims: A Historical Cohort Study *Medical Journal of Australia,* 192(4), 184.

⁶⁷ Felitti and Anda, 1998

⁶⁸ Gilbert, R., Spatz, Widom, C., Browne, K., Fergusson, D., Webb, E., & Janson, J. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet,* 373, 68-81.

⁶⁹ Dube et al., 2010

⁷⁰ Fergusson, D.M., Woodward, L.J., Horwood, L.J. (2000). Risk factors and life processes associated with the onset of suicidal behaviour during adolescence and early childhood. *Psychological Medicine.* 30 (1): 13-39.

the top risk factor for completed suicide is a history of previous attempts, childhood trauma and impulsivity have also been found to increase the risk of suicidality in adults⁷¹. This needs to be considered in its own right in responding to issues of suicide in health care.

Question: Specific health concerns

D. *What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs? p.16*

Numerous studies demonstrate that around two thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse.⁷² When other forms of childhood trauma are added, the percentage experiencing some form of adverse/ traumatic childhood becomes even higher. The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences.

The mental health burden of complex childhood trauma has not been a priority of our mental health system. Complex trauma, of which there are many varieties, is *cumulative, underlying, and often interpersonally generated*.⁷³ Complex trauma, especially if interpersonally generated,⁷⁴ is established to often have more extensive impacts than 'one-off', 'out-of-the-blue' events (i.e. 'single-incident' PTSD). The more extensive impacts of complex trauma are well-documented.⁷⁵

'The client labelled 'difficult' is almost always the person who has survived the most difficult experiences'⁷⁶. Yet our healthcare system does not even begin to adequately address the needs of people with experiences of complex trauma, most commonly as a result of adverse childhood events.

The new ICD-11 diagnosis of CPTSD⁷⁷ shows the limitations of confining the definition and diagnosis of trauma to exposure to 'single incident' events.⁷⁸ Yet there is also more to complex trauma than Complex PTSD. While the breadth of complex trauma demands an inclusive diagnosis, diagnosis is only one of several lenses through which to view complex trauma. In contrast to the ICD-11, the *Diagnostic and Statistical Manual of Mental Disorders* does not yet recommend the diagnosis of Complex PTSD.

Molnar, B.E., Berkman, L.F., Buka, S.L. (2001). Psychopathology, child sexual abuse and other childhood adversities: relative links to subsequent suicidal behaviour in the US. *Psychological Medicine*. 31:6. 965-977.

⁷¹ O'Brien B.S., Sher, L. (2013). Child sexual abuse and the pathophysiology of suicide in adolescents and adults. *International Journal of Adolescent Medicine and Health*. 2013;25(3):201-205.

Wedig, M.M., Silverman, M.H., Frankenburg, F.R., Reich, D.B., Fitzmaurice, G., Zanzarini, M.C. (2012). Predictors of suicide attempts in patients with borderline personality disorder over 16 years of prospective follow-up. *Psychological Medicine*. 42(11):2395-2404.

⁷² Hussain & Chapel, 1983; Emslie & Rosenfeld, 1983; Mills et al. 1984; Bryer et al., 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al., 1990. Read et al. (2004) compared 40 studies published between 1984 and 2003 that examined the prevalence of child abuse among female psychiatric inpatients and among outpatients where at least half the patients were diagnosed with a psychosis. Also see V. Sar, 'Epidemiology of Dissociative Disorders: An Overview' (Review Article) *Epidemiology Research International*, Vol 2011 (2011) Art ID 404 538.

⁷³ For an authoritative account of complex trauma, see 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', ch. 1 in Christine A. Courtois & Julian D. Ford, ed. *Treating Complex Traumatic Stress Disorders: Scientific Foundations and Therapeutic Models* (New York: The Guilford Press, 2013), pp.13-30.

⁷⁴ Betrayal of trust in intimate relationships and violations of duty of care (often termed 'betrayal trauma') is recognised to be particularly damaging. See Jennifer Freyd, 'Betrayal Trauma', in G. Reyes, J.D. Elhai, & J.D.Ford, eds. *Encyclopedia of Psychological Trauma* (New York: John Wiley & Sons, 2008), p.76.

⁷⁵ '[I]t is clear from many studies that interpersonal violence is more likely to have long-term consequences than natural disasters or accidents' (Sandra Bloom & Brian Farragher, *Destroying Sanctuary*, OUP: New York, 2011, p.67) and see subsequent discussion.

⁷⁶ Danylchuk & Connors, *Treating Complex Trauma and Dissociation* (Routledge, New York, 2017).

⁷⁷ WHO releases new International Classification of Diseases (ICD 11) 18 June 2018 News Release Geneva

[http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-\(icd-11\)](http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11))

⁷⁸ For example it risks de-emphasising the role of perception about what the 'events' comprise (i.e. trauma is not determined by the 'size' of the event/s). Note there is still confusion about the definition of trauma, to variously describe events, the individual's experience of events, and/or response to the event/s.

Its 2013 version, DSM-5 did, however, include a new 'dissociative subtype' of PTSD. This expanded the range of impacts with which PTSD is associated⁷⁹, thereby acknowledging the need to expand its prior PTSD classification.⁸⁰ The current DSM-5 criteria for the diagnosis of PTSD does not recognise the range and depth of impacts of complex trauma.⁸¹ The inclusion of the diagnosis of Complex PTSD in the new ICD-11, on the other hand, makes recognising and more appropriate treatment of Complex PTSD more likely.

There is a need for new effective trauma treatments, especially for complex trauma. 'Standard PTSD' treatment has previously been prioritised over complex trauma treatment.

*'Currently existing treatment methods are ineffective for 25–50% of patients enrolled in clinical trials...the economic costs of PTSD and trauma- and stressor-related disorders are estimated to amount to 43.2 billion dollars annually... The necessity for more effective treatments efficiently reducing current treatment failure rates thus becomes apparent.'*⁸²

Some claims and findings suggest that⁸³ current 'evidence-based' psychotherapeutic treatments for trauma, specifically 'first line', 'trauma-focused', short-term and exposure-based treatments can be problematic for people with complex trauma and dissociative disorders.

*'Psychotherapists in many services are required to restrict their approaches to those therapies recommended in guidelines or expert consensus irrespective of the oversimplified misrepresentation of the evidence base that result in. service constraints such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. Psychotherapy therefore is often protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control. Patients unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance'.*⁸⁴

Question: Specific health concerns

- A. What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation? p.16

⁷⁹ The current 'dissociative' subtype of PTSD in DSM-5 specifically addresses the dimensions of depersonalisation (sense of self-estrangement) and derealisation (perception of the external world as strange or unreal). For more detailed consideration of diagnosis in relation to complex trauma, see ch.1.

⁸⁰ It is ironic that the ICD-11 2013 working group for stress-related mental disorders found sufficient empirical evidence for a diagnosis of Complex PTSD (Maercker et al, 2013) and a DSM-IV working group decided that the diagnosis of Complex PTSD should go ahead. See ch. 1 for more detailed discussion of the diagnostic issues.

⁸¹ 'To date, the dissociative subtype of PTSD has been defined specifically in relation to symptoms of depersonalization and derealization' (Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (New York: Norton, 2015), p.166.

⁸² S.B. Thal, & M.J. Lommen, ref Foa et al. 2009; Stein et al. 2009; Mithoefer et al. 2011; Greenberg 1999, 'Current Perspective on MDMA-Assisted Psychotherapy for Posttraumatic Stress Disorder', *Journal of Contemporary Psychotherapy* (48, 2, 2018), 99–108. doi: [10.1007/s10879-017-9379-2](https://doi.org/10.1007/s10879-017-9379-2) <https://link.springer.com/article/10.1007/s10879-017-9379-2>

⁸³ See, for example, M. A. Hagedaars, A. van Minnen, et al 'The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD', *Behavior Research and Therapy* (48, 1, 2010, pp.19-27) and the detailed discussion in ch.3 of this document.

⁸⁴ Lisa Schwarz, Frank Corrigan, et al, citing Corrigan & Hull, 2015, *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* (Routledge, New York, 2017), p.140.

Treatment of Patients with Dissociative Disorders Study

Research on effective treatment for complex trauma has traditionally been limited by the restrictive entry criteria for outcome studies (which has precluded people with high comorbidity characteristic of complex trauma). Treatment of Patients with Dissociative Disorders Study (TOP DD) is a pioneering international study led by clinical psychologist Professor Bethany Brand (who specialises in the research and treatment of complex trauma and dissociative disorders)⁸⁵ which is challenging that limitation.

This TOP DD has generated a number of publications, and constructed an innovative web-based program for clinicians and their dissociative disorders' clients.⁸⁶ The January 2019 *Journal of Traumatic Stress* published a paper around this program.⁸⁷ This program is now being developed into a book for people not participating in the study to gain access to the materials as an adjunct to their therapy.

Planning a Randomized Control Trial (RCT) to further substantiate the effectiveness of the TOP DD treatment frame is a big achievement. This is because research into the treatment of dissociative disorders, despite their prevalence and many costs, is not a United States funding body priority (nor is it elsewhere).⁸⁸ TOP DD depends on private funding. Designing a RCT thus heralds wider recognition of the prevalence, costs, and disabling impacts of trauma-related dissociation.⁸⁹ It also raises hopes that effective treatment of dissociative disorders will become increasingly accessible.

Treatment of Patients with Dissociative Disorders (TOP DD) study is ground-breaking.⁹⁰

Question: Health workforce

- A. *Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity? p.17*

Research into Practice

There is a wide gap between widely accessible nuanced research findings around the nature, effects and potential treatment of trauma, and translation of these insights to treatment programs and organisation of service delivery. The professional health workforce requires extensive training around trauma in general and complex trauma in particular, to ensure a fully trauma-informed system, which reflects the current research insights, and which has the specialist expertise to provide clinical services to complex trauma clients regardless of where they live.

⁸⁵ Bethany Brand, Martha A. Mitten Professor of Psychology at Towson University, received the University of Maryland Board of Regents' Faculty Award for Excellence in Research for her work with complex trauma and dissociation.

⁸⁶ Bethany L. Brand, Principal Investigator, 'TOP DD Network Study', Researchgate, <https://www.researchgate.net/project/TOP-DD-Network-Study>

⁸⁷ Bethany L. Brand, Hugo J. Schielke, et al, 'An Online Educational Program for Individuals With Dissociative Disorders and Their Clinicians: 1-Year and 2-Year Follow-Up', *Journal of Traumatic Stress* (January 2019) <https://onlinelibrary.wiley.com/doi/full/10.1002/jts.22370>

⁸⁸ 'Several medical economics studies find that dissociative disorders are among the most costly of all psychiatric disorders in terms of their rates of treatment utilization' (Frank Putnam, *The Way We Are*, IPBooks, New York, 2016, p.247, ref Brand, Classen, McNary, & Zaveri, 2009; Brand et al, 2013).

⁸⁹ 'The study has important implications for the mental health field because DD [i.e. dissociative disorders] are prevalent and associated with severe symptoms and dysfunction, as well as high treatment costs' 'What is the TOP DD Study?' <https://www.towson.edu/cla/departments/psychology/topdd/>

⁹⁰ For full details of the Treatment of Patients with Dissociative Disorders (TOP DD) Study see <https://www.towson.edu/cla/departments/psychology/topdd/> Also see subsequent discussion of this report.

Responding to the public health challenge of complex trauma:

- Requires *integration of vision and research into practice*
- Means engaging an *array of services and professions to achieve a paradigm cultural shift in mental health service delivery*
- Requires *specialised knowledge, workforce education and training, and collaboration between consumers, carers, policymakers, and service providers*
- Necessitates *national training programs* for systemic quality improvement, cultural re-orientation and workforce development.

Blue Knot Foundation *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* ⁹¹ inform a diverse audience about new ways of *conceptualising and responding to trauma in clinical practice and health and human service settings:*

- To enable *new possibilities for recovery for survivors of trauma, and their children*
- To highlight the *need for service and practitioner cultures and practice to be sensitive to the needs of complex trauma consumers*

In the first half of 2019 Blue Knot Foundation will be releasing

- *Practice Guidelines for the Clinical Treatment of Complex Trauma* (based on additional research since 2012)
- *Guidelines for Treating Structural Dissociation in Complex Trauma*

Question: Health workforce

- B. *What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits? p.17*

Clinical complex trauma treatment – competencies

In the area of complex trauma it is not the particular disciplines which determine efficacious practice but particular skills, knowledge and expertise additional to undergraduate training programs, which draw across modalities to build a flexible complex trauma toolkit.

It is proposed that the new *Practice Guidelines for the Clinical Treatment of Complex Trauma* will include the following 2 appendices to inform clinical complex trauma work.

- **Appendix A: Guidelines to Differences between Complex Trauma Therapy and Standard Counselling**
- **Appendix B: Guidelines to the skills and knowledge recommended for working with complex trauma and dissociation**

Question: Health workforce

- A. *What could be done to reduce stress and turnover among mental health workers? p.17*

⁹¹ Blue Knot Foundation (formerly Adults Surviving Child Abuse) 2012 *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* Blue Knot Foundation: Authors Kezelman C.A. & Stavropoulos P.A.

There are lots of issues here but of importance is the issue of the lived experience of trauma amongst mental health workers and professionals, as well as the risk of Vicarious Trauma from exposure to the traumatic material and stories.

'Vicarious trauma is negative transformation in helper that results [across time] from empathic engagement with trauma survivors & their trauma material, combined with commitment or responsibility to help them'.

It's the impact of bearing witness and it can have same effects as direct trauma. Vicarious trauma leads to a change in own world view and functioning as a result of exposure to another person's trauma or traumatic material. VT is a work, health and safety issue. It is important to understand the difference between VT and burnout.

'Burnout' is a prolonged response to chronic emotional and interpersonal stressors on the job. It reflects general stressors in the workplace and is not necessarily trauma related. *'the gap between what the helper is expected to do and what he or she is able to do'*⁹².

Members of the workforce need to be attuned to the early warning signs of VT, as they can be subtle, easily ignored and therefore missed with significant costs. The challenge is recognising and managing VT. It is also understanding the impacts of stress and the sensitivity of people with the lived experience of trauma to subsequent stress as well as the contagion of stress in a workplace. Stressed staff and stressed clients can create a toxic environment which impacts health, wellbeing for all and recovery for those seeking services.

Training and professional development

Blue Knot Foundation recommends broad based training at undergraduate and post graduate levels for professionals, as well as for workers in trauma-informed practice, vicarious trauma mitigation and where appropriate clinical treatment of complex trauma clients.

Paralleling the 'bottom-up' as well as 'top down' approach to optimal psychotherapy for trauma,⁹³ 'a truly trauma-informed' health system requires *'a process of reconstitution within our organizations top to bottom'*.⁹⁴

Australia has no equivalent to the National Centre for Trauma Informed Care (NCTIC) which exists in the United States.⁹⁵ Blue Knot Foundation's development of national guidelines in this area builds on the momentum for services which are 'trauma-informed' (as well as services designated as 'trauma-specific'). But *omission of trauma as a public health policy priority in this country, and of the requisite funding for the spectrum of services this would entail*, remains lacking, and in urgent need of redress. In the absence of both the prioritising of trauma and informed operationalisation of the now solid research insights which relate to it, the prevalence of unrecognised complex trauma – and the stakes in terms of the distress and multiple individual and public health costs which stem from this – will continue.

Trauma-informed services 'are informed about, and sensitive to, trauma-related issues'.⁹⁶ They do not directly treat trauma or the range of symptoms with which its different manifestations are associated. The *possibility* of trauma in the lives of all clients/patients/consumers is a central organising principle of trauma-informed care, practice and service-provision.

⁹² Ibid 2009:204

⁹³ Diana Fosha referencing van der Kolk, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', Siegel & Solomon, ed. *Healing Trauma*, p.229.

⁹⁴ Sandra L. Bloom, 'Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation' Alexandria, VA: National Technical Assistance Centre, 2006, p.2 (emphasis added) nasmhpd.org

⁹⁵ The National Center for Trauma Informed Care (NCTIC) <http://www.nasmhpd.org/NCTIC.cfm>

⁹⁶ Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.15.

Trauma-specific services are designed to directly treat 'the actual sequelae' of trauma experiences and related symptoms and syndromes. Interventions of services which are trauma-specific include provision of 'grounding techniques which help trauma survivors manage dissociative symptoms, desensitisation therapies which help to render painful images more tolerable, and behavioural therapies which teach skills for the modulation of powerful emotions'.⁹⁷

Trauma-specific services (among which programs designed for survivors of child abuse would be included) are 'consistent' in emphasising:

- Client and worker safety, both physical and emotional
- The importance of respect for clients, provision of information, possibilities for connection and instillation of hope
- Recognition of symptoms as *adaptive* rather than pathological
- The need for collaborative work with clients which is affirming of their strengths and resources⁹⁸

Question: Social participation and inclusion

Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?
p.22

Childhood trauma and the capacity for social participation and inclusion

When a child is abused or neglected, or when a caregiver has their own experiences of trauma and victimisation they may face challenges in their own lives, and in meeting their child's needs, particularly their emotional needs. This can mean that the child might not develop the capacity to self-soothe and self-regulate.

Unlike single incident trauma, complex trauma disrupts a person's identity – their relationship to themselves and others as well as their self-integrity i.e. the state of being whole. With complex trauma the person can experience low self-esteem and intensely negative self-attitudes, one of the most pervasive of which is shame.⁹⁹

Currently the conceptualisation of mental illness is predicated solely on the biomedical diagnostic model of disorder. This often pathologises and further isolates people from the communities, cultural contexts and social supports critical to their recovery.

People with unresolved complex trauma histories, often from childhood are often isolated and withdrawn, unable to engage socially and excluded individually and as a group. Addressing this requires awareness, identification and appropriate addressing of unresolved childhood trauma impacts across the life cycle.

Question: Child safety

What, if any, alternative approaches to child protection would achieve better mental health outcomes?
p.25.

⁹⁷ ibid

⁹⁸ ibid

⁹⁹ Adriano Schimmenti (2012) Unveiling the hidden self: Developmental trauma and pathological shame, Psychodynamic Practice, 18:2

Expanding the reach of child protection

Only a small percentage of children harmed or at risk of harm are in contact with the child protection system. This child protection system depends on reports, notifications, investigations and substantiations. As we know child abuse and neglect often go unrecognised. Many children are also harmed in the context of parents who as a result of their own unresolved trauma, and without overt abuse and neglect, are unable to attune to their child and provide the care and nurture necessary to optimise healthy development.

We also know that even when a risk of harm or harm are reported, and a notification is made children often still fall through the cracks and actual substantiations do not capture the large numbers of children who don't receive the care, nurture and protection they need.

The newly established National Office of Child Safety is one step in developing a national system of standards, policies, strategies to enhance child safety and minimise harm. It builds on the National Framework for Protecting Australia's Children. While these are significant initiatives with the potential to drive real change more needs to be done to engage the whole community.

A broad population-based mass media, social media and education campaign is needed to drive the cultural change required to keep children safe, to enable all Australians to have the knowledge and tools to respond promptly and appropriately to any risk of harm or actual harm, to respond well to disclosure and promote help seeking as required.

So too are initiatives to address intergenerational and transgenerational cycles of individual and collective trauma across groups at particular risk eg. Aboriginal and Torres Strait Islander peoples, children with disability, CALD communities etc.

Also important are initiatives to support parents and prospective parents to heal from unresolved trauma and its impacts, to intervene in intergenerational cycles of compounded disadvantage, marginalisation and maltreatment, and promote the health, wellbeing and safety of the next generation.

Question: Education and training

How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?

Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health? p.26

Trauma-informed education systems

There is a need for widespread education and training which alerts school teachers and other school staff to the possibility that students may have experiences of trauma which are affecting their health, wellbeing, daily interactions and functioning.

This includes the knowledge and skills needed to better support the sensitivities and vulnerabilities of children with lived experience of trauma, minimise re-traumatisation and enhance possibilities for engaging in an educational system.

Teachers and other school personnel need to reformulate their daily work practice and to ask: “What happened to you that might be causing you to experience the world from this perspective?” Training would enhance insights and tools which foster hope, enhance student and staff wellbeing and minimise the risks of re-traumatisation of students.

Question: Mentally healthy workplaces

What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views? p.30

Workplaces informed about and responsive to childhood trauma

Childhood trauma often impairs educational attainment which in turn, and in its own right can result in work impairment. Many people with the lived experience of childhood trauma underachieve in the workplace – working part-time instead of full-time or attaining a role that arguably is less senior than it might have otherwise been. This is a combination of difficulties during school, and other common challenges, such as depression and anxiety, and other mental health problems limiting the capacity to achieve full ‘human and economic potential’.

A strong, graded relation between eight categories of adverse childhood experience has been found with three indicators of worker performance¹⁰⁰. Four areas of health and well-being – relationship problems, emotional distress, somatic symptoms and substance abuse - that challenge employers¹⁰¹ have been identified as possible intermediate variables.

The impact of domestic violence on children has been associated with reduced productivity, welfare receipt, and unemployment as an adult¹⁰². A more recent Irish study¹⁶ (2009 – 2011) found that male victims of child sexual abuse are twice as likely to be out of work due to illness. A newspaper report on the research noted:

Men who have been sexually abused in childhood are twice as likely to be out of work due to sickness and disability, a major ESRI study reveals. It is the first research into the economic impact of abuse on the lives of adult survivors and confirms the knock-on effects for household income are "real and substantial".¹⁰³

Raising awareness about Adverse Childhood Experiences (ACEs) in the workplace:

- Helps managers and staff understand the issues which underlie ‘challenging’ behaviours e.g. bullying, lack of conflict resolution, poor impulse control, emotional reactivity, and physical health issues including related to substance misuse and mental health challenges;
- Intervenes in unresolved trauma impacts on worker performance – productivity, absenteeism and presenteeism and its financial implications
- Helps the company become trauma-informed, with sensitivity at all levels to the impacts of unresolved trauma and the importance of healthy relational interactions to promote healing

¹⁰⁰ Anda R. et al., Childhood Abuse, Household Dysfunction, and Indicators of Impaired Adult Worker Performance *The Permanent Journal* 2004 Winter; 8(1): 30–38.

¹⁰¹ Cohen GS, Gard LH, Heffernan WR. Employee assistance programs: a preventive, cost-effective benefit. *J Health Care Finance*. 1998 Spring;24(3):45–53.

Turpin SC. Employee assistance programs pay off. *Warehousing Management*. 1998 Jun 1; Available from: www.manufacturing.net/cti/index.asp?layout=article&articleid=CA149037 (accessed November 20, 2003).

¹⁰² Flood, M. and Fergus, L. (2008) *An Assault on Our Future The Impact of Violence on Young People and Their Relationships*. White Ribbon Foundation, Sydney.

¹⁰³<http://www.independent.ie/irish-news/male-victims-of-child-sexual-abuse-are-twice-as-likely-to-be-out-of-work-due-to-illness-30510056.html>

Blue Knot recommends widespread training for all staff and managers at all levels of any workplace to alert them to the possibility that their clients and/or co-workers may have experiences of childhood and/or other past or current trauma(s), which are affecting their health, wellbeing, daily interactions and functioning.

Current research needs to be used to provide a basic understanding of trauma, trauma dynamics and the core principles of trauma-informed practice, a strengths-based approach vital for every person working in in any workplace. This would enable workers to reformulate their daily work practice and ask: “What happened to you?” rather than “What is wrong with you?” and to ‘work with’ clients rather than ‘doing to’ them. It fosters client and staff safety, and would promote workforce participation, minimise absenteeism and presenteeism and enhance productivity.