Children's Health Queensland Hospital and Health Service

Queensland Government

phn BRISBANE SOUTH

An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT FOR GENERAL PRACTICE

Mental health

Trauma

MODULE

Version 1

May 2021

Introduction

The Quality Improvement (QI) toolkit

This QI toolkit is made up of modules that are **designed to support your practice to make easy, measurable and sustainable improvements to provide best practice care for your patients.** The toolkit will help your practice complete QI activities using the Model For Improvement (MFI).

Throughout the modules, you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the MFI.

The MFI uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- A simple approach that anyone can apply.
- Reduced risk by starting small.
- It can be used to help plan, develop and implement change that is highly effective.

The MFI helps you break down your change implementation into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and minimal effort is wasted.

There is an example using the MFI to improve the number of practice team members who have participated in trauma informed training and a blank template for you to complete at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on support@bsphn.org.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Brisbane South PHN if you have any feedback regarding the content of this document.

Acknowledgements

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Brisbane South PHN, 2021

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Trauma

Trauma is a response to a deeply distressing or disturbing event that overwhelms a person's ability to cope. Trauma affects us all, directly or indirectly. The original Greek meaning of the word trauma is 'wound'. In a medical setting it can involve physical, emotional, relational, or even existential wounding that impacts physiological, relational and emotional health.

Many people live with the ongoing effects of past and present overwhelming stress (trauma). Despite the large numbers of people affected, we often don't think of the possibility that someone we meet, speak with or support may have experienced trauma. This makes us less likely to recognise it. Being conscious of the possibility of trauma means keeping the sensitivities and vulnerabilities of people who may be trauma survivors in mind. It means being respectful, acknowledgment and understanding. [1]

Trauma as an event

Trauma can be caused by precipitating event/s that overwhelm an individual's capacity to cope. If not resolved, trauma has a range of negative impacts on physical and emotional health. Trauma can be both 'single incident' (post-traumatic stress disorder (PTSD)) and cumulative, underlying and interpersonally generated ('complex').[2]

Strong longitudinal and epidemiological data suggests that on a daily basis, and often unknowingly, general practitioners see a number of patients who experience the effects of complex trauma. People with diverse presentations, high comorbidity, and/or unspecified pain (i.e. medically unexplained symptoms) can receive discrete diagnoses based on presenting symptoms, which means that the underlying trauma remains unrecognised and thus untreated.

Childhood trauma

Childhood trauma is complex trauma of which child abuse in all its forms (i.e. sexual, emotional, physical and neglect) is an insidious variety. For example, care-givers with unresolved trauma histories are at greater risk of this negatively affecting their parenting, affecting the next generation as well.

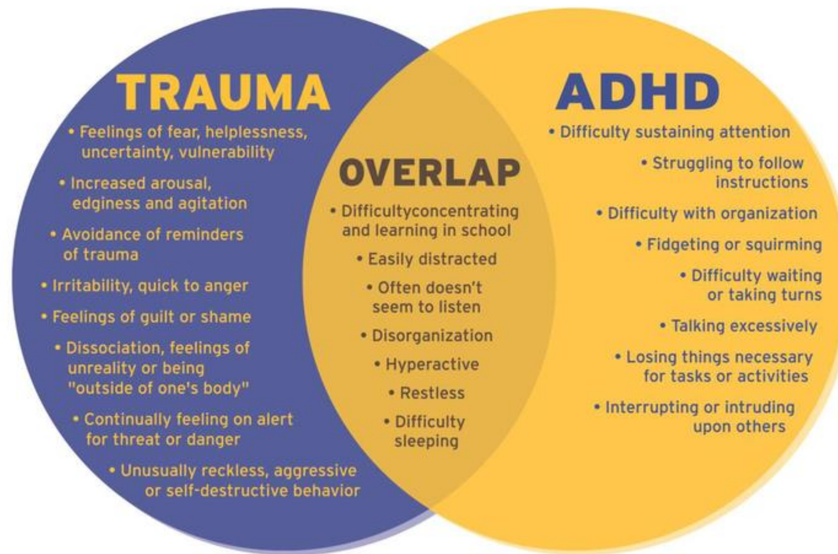
Early life trauma during formative brain development in infancy is particularly damaging. It affects development of the self and a range of physical, developmental and psychological functions including increased sensitivity to stress and vital brain functions associated with survival. Unresolved trauma radically restricts a young child's capacity to adapt and respond to daily demands and life challenges, learn to regulate their emotions, and impairs physical and mental functioning.[3]

Confusion around trauma and ADHD

- In response to trauma, a child's developing brain can become programmed to "look out" for behaviour, activities or events that they perceive as threatening. This "hyper-vigilance" can often mimic hyperactivity and distractibility associated with ADHD.
- What may appear as inattention and "daydreaming" behaviour often seen in children with ADHD may actually be symptoms of dissociation or subconscious avoidance of trauma triggers.
- Intrusive thoughts, memories or other reminders of trauma may make children feel confused, agitated and nervous which may mimic the impulsivity and aggression often seen in children with ADHD.

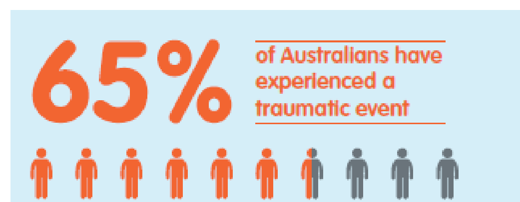
[1] https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care-and-practice
[2] https://www.sane.org/information-stories/facts-and-guides/traumatic-events
[3] https://www.blueknot.org.au/Resources/Fact-Sheets/General-practitioners-fact-sheet

- Brain development studies for ADHD and child maltreatment show significant similarities in the areas of the brain that are affected (areas responsible for emotional regulation, decision making, memory, social processing and concentration). [4]



[5]

Prevalence of trauma



Experiencing some trauma in life is common, with up to 65 per cent of Australians reporting that they have experienced a traumatic event at some stage in their lives.[6] Studies suggest that 57–75 per cent of Australians will experience a potentially traumatic event at some point in their lives. International studies estimate that 62–68 per cent of young people will have been exposed to at least one traumatic event by the age of 17.[7]

Trauma as a process

International research into Adverse Childhood Experiences (ACE's), childhood attachment and development, and adult romantic relationships have confirmed the long-term and lifelong health effects of traumatic processes. This is termed 'complex trauma' and is distinguished from single incident or event-based trauma by their interpersonal and developmental setting, and their impact on:

- physiological arousal and hypersensitivity to stress, (chronic altered immune, endocrine, and autonomic nervous system impact on development of neural architecture and connectivity as well and biomarkers of stress)
- self-regulation (altered capacity to self soothe)
- altered cognitive processing including, attention and consciousness (amnesias, dissociation and altered perceptions)

[4] https://www.childdevelopmentclinic.com.au/adhd-and-complex-trauma.html
[5] The National Child Traumatic Stress Network, 2016
[6] https://headspace.org.au/assets/Uploads/Trauma-web.pdf
[7] https://www.aihw.gov.au/reports/australias-health/stress-and-trauma

- sense and concept of self (shame, feeling unworthy, powerless or guilty)
- relationships (difficulties with accurate perceptions, trust, boundaries and intimacy)
- connection with their body (increased somatisation, body memories and/or dismissive ignoring).[8][9]

The 3 "E's" of trauma

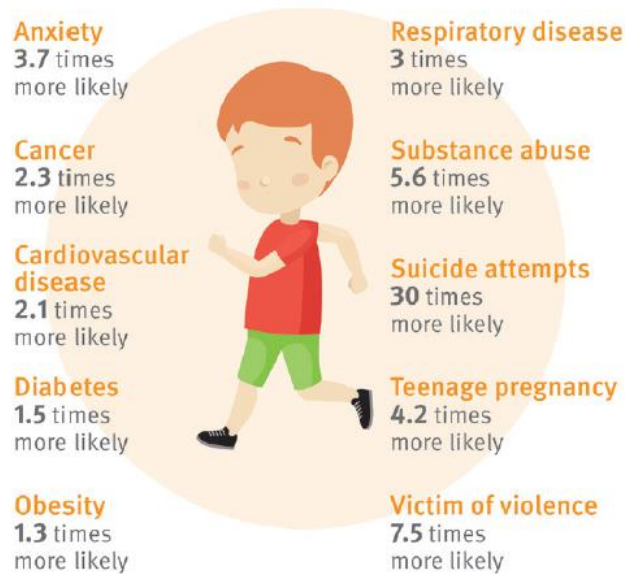
- Event (s) – Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect of a child that inhibits healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time.
- Experience of event (s) – The individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g. a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected).
- Effect - The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognise the connection between the traumatic event and the adverse effects.[10]

ACEs with physical impacts	
• Physical and emotional abuse and neglect • Physical abuse • Sexual abuse • Witnessing interparental violence • 'Missing' parent • Absent parent • Intoxicated parent • Hospitalised parent • Incarcerated parent	• Peer physical bullying • Witnessing violence against siblings • Non-verbal emotional abuse • Severe injury

[11]

[8] A Sequenced, Relationship-Based Approach - Courtois, Christine, Ford, Julian, Courtois, Christine and Ford, Julian
[9] A whole person approach to wellbeing – Johanna Lynch
[10] https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf
[11] Collated using information from (Felitti (1998) and * Teicher (2015). Used with permission from Lynch (2021)

Children in care can be disproportionately exposed to adversity and toxic stress.[12] Adversity such as abuse or neglect before the age of 18, known collectively as ACEs, can impact health outcomes across the lifespan.



[13]

Figure 1. The likelihood of health risks with four or more ACEs (Hughes et al., 2017). Image courtesy of Centre for Children's Health and Wellbeing, Children's Health Queensland (CCHW, 2019).

Trauma and physical illness

Ongoing research is exploring the link between the body and subjective experiences of threat to physical body, social belonging, and existential distress. The prospective studies (over 20 years) of ACEs have shown significant impact of ACEs on physical health – including life expectancy. Nadine Burke Harris discusses this further in her TED talk.

Trauma and mental illness

Experience of trauma can contribute to development of many different forms of mental illnesses and distress such as, psychosis, schizophrenia, eating disorders, personality disorders, depressive and anxiety disorders, alcohol and substance use disorders, self-harm and suicide-related behaviours. Childhood trauma experiences not only increase the risk of mental illness but also affect clinical course and responses to treatment. Previous research has shown that 90 per cent of public mental health clients have either been exposed to or experienced multiple events of trauma.[14] Given this prevalence, all approaches to mental distress need to be trauma-informed.

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[12] : https://pubmed.ncbi.nlm.nih.gov/28086178/
Turney K, Wildeman C. Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. Child Abuse Negl. 2017 Feb;64:117-129. doi: 10.1016/j.chiabu.2016.12.009. Epub 2017 Jan 10. PMID: 28086178.

[13] Centre for Children's Health and Wellbeing. Dream Big, Act Big for Kids: ACEs. Children's Health Queensland [Internet]. 2019 March. Available from: https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/dream-big/Dream-Big-Act-Big-for-Kids-Issue-1-ACEs-Toxic-Stress.pdf

Hughes KP, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. Lancet Public Health [Internet]. 2017 Aug [cited 2018 Dec 04]; 2(8): e356-e366. Available from: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/ fulltext doi:10.1016/S2468-2667(17)30118-4

[14] https://www.aihw.gov.au/reports/australias-health/stress-and-trauma

Distress tolerance behaviours

Distress tolerance is an individual's ability to cope with actual or perceived emotional stress.

People vary substantially in how they respond to painful events. Some people are able to cope with negative experiences and emotional pain better than others. They have a high tolerance for painful feelings and distress, are able to cope, manage to contain it, and carry on with their usual day-to-day activities. At the other end of the spectrum, some people are overwhelmed by painful feelings that accompany negative experiences, and they develop maladaptive strategies to cope with these feelings such as self-harm, substance abuse, and suicide attempts.[15]

After trauma, people can develop a dependence on alcohol or drugs to manage the distress they feel.[16]

How childhood trauma leads to addictions by Gabor Mate provides information about how untreated traumatic memories and physiological arousal can lead to the development of many types of coping behaviours both positive and negative. These distress reduction or distress tolerance behaviours can be constructive organising and soothing processes, or destructive behaviours including the development of obsessions, compulsions, and addictions, as well as avoiding and minimising behaviours, amnesic thought processes or hypervigilant sensitivity to environmental cues or "triggers". Understanding coping and addictions as responses to overwhelming experiences or life events can help us to understand their salience in someone's life.

Brisbane South PHN have developed a QI toolkit with a focus on alcohol and other drugs. This toolkit is designed to identify systems to be able to assist patients who may be affected by alcohol and other drugs.

Trauma, suicide and non-accidental self-harm

Suicide has a devastating impact on families, friends and whole communities.

- Every year over 65,000 Australians make a suicide attempt.
- More than 3,000 Australians died by suicide in 2017.
- Suicide is the leading cause of death for Australians between 15 and 44 years of age.
- Young Australians are more likely to take their own life than die in motor vehicle accidents.
- In 2017, about 75% of people who died by suicide were males and 25% were females.
- In 2017, the suicide rate among Aboriginal and Torres Strait Islander people was approximately twice that of non-Indigenous Australians.
- Suicide is 30 times more likely if the person suffers 4 or more adverse childhood experiences.[17]

Causes of suicide

The causes of suicide are complex. Factors that may contribute to suicide include:

- stressful life events
- trauma
- mental illness
- hopelessness
- powerlessness
- physical illness
- drug or alcohol abuse
- poor living circumstances.[18]

[15] https://www.youthaodtoolbox.org.au/introduction-distress-tolerance
[16] https://www.phoenixaustralia.org/recovery/effects-of-trauma/alcohol-and-substance-use/
[17] https://pubmed.ncbi.nlm.nih.gov/9635069/
[18] https://www.blackdoginstitute.org.au/resources-support/suicide-self-harm/facts-about-suicide-in-australia/

Non-accidental self-harm

The term non-accidental self-harm is used to refer to situations where self-injury is not intended to result in death.

The most common methods of self-injury are:

- Cutting (41%)
- Scratching (40%)
- Deliberately hitting body on hard surface (37%)
- Punching, hitting or slapping self (34%)
- Biting (15%)
- Burning (15%).[19]

Post-traumatic stress disorder (PTSD)

Following a traumatic event, many people develop post-traumatic symptoms. A minority develop post-traumatic stress disorder (PTSD), which is a severe reaction to an extreme and frightening traumatic event. PTSD is typically characterised by all of the following:

- Re-experiencing the traumatic event or events in vivid intrusive memories, flashbacks, or nightmares, typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations
- Avoiding thoughts and memories of the event or events, or avoidance of activities, situations or people reminiscent of the event or events.
- Persistent perceptions of a heightened current threat which, for example, might lead to hypervigilance or reacting beyond what would normally be expected to something like an unexpected noise.

The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. These symptoms are also signs of chronic levels of arousal and activation of stress physiology.

Complex PTSD

Complex PTSD describes the long-term effects of severe, prolonged or repeated trauma, particularly in Australia, due to child abuse or domestic violence. This has a wide range of effects on personality, identity, memory, mood change and emotional regulation.

Symptoms of complex PTSD are similar to the symptoms of PTSD. They include:

- difficulty with regulating emotions
- periods of losing concentration (dissociation)
- blanking out or losing memories
- difficulties with a sense of identity or body image
- physical symptoms that can't be explained medically, such as headaches, stomach aches, dizziness and chest pains
- disturbed relationships and cutting oneself off from other people
- an inability to trust others
- being vulnerable to abuse or exploitation

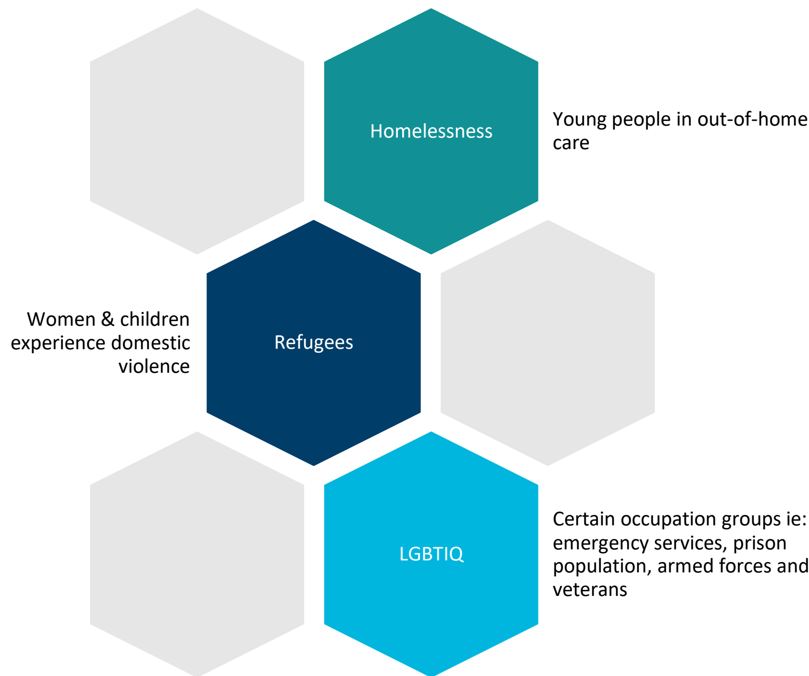
[19] https://mhfa.com.au/sites/default/files/MHFA_selfinjury_guidelinesA4%202014%20Revised_1.pdf

- self-harm, suicide attempts and substance abuse
- feeling ashamed or guilty.[20]

The ICD-II definition of C-PTSD has outlined the key diagnostic indicators of this more complex developmental form of trauma. The ICD diagnosis is an acceptable diagnosis for Medicare purposes and incorporates much of the new science integrating mind and body.

How common is trauma and PTSD?

Trauma exposure is more common among specific groups such as people who experience homelessness, young people in out-of-home care or under youth justice supervision, refugees, First Nation peoples, people with a mental illness, alcohol and other drugs use, women and children experiencing family and domestic violence, LGBTIQAP+ people, and intergenerational and certain occupation groups (for example emergency services, prison population, armed forces and veterans).



As cumulative exposure to work-related traumatic events is associated with increased risk of PTSD, the rates of the disorder may be more likely among long-term emergency services employees than new recruits. This is also supported by a study of the mental health of current and retired Australian firefighters, where prevalence of PTSD was more than two times higher in retired than current firefighters (being 18% and 7.7% respectively).

Historical and current trauma experienced as a result of separation from family, land, and cultural identity has also had a serious impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.[21]

[20] https://www.healthdirect.gov.au/complex-ptsd
[21] https://www.aihw.gov.au/reports/australias-health/stress-and-trauma

Signs and symptoms of trauma

Distress from trauma impacts both the mind and body, relationships, sense of self, and systems of meaning. As outlined in the section on trauma as a process, the clinician needs to attend to be aware of physiological arousal and chronic stress processes that impact physical health, as well as emotional, cognitive, relational and existential dysregulation that impacts the whole person.[22]

Physical	Thinking	Emotional
• nausea • upset stomach • tremors (lips, hands) • feeling uncoordinated • profuse sweating • diarrhoea • dizziness • chest pain • rapid heart beat • headaches • sleep disturbances • chills • under or overweight	• slow thinking • difficulty making decisions • difficulty with problem solving • confusion • disorientation (especially to time and place) • difficulty calculating • difficulty concentrating • difficulty with remembering • difficulty naming common objects • seeing the event over and over • hyper-vigilance	• anxiety • fear • guilt • grief • depression • sadness • feeling lost • feeling abandoned • feeling isolated • worry about others • anger • irritability • feeling numb, startled, shocked

[23]

Key features of trauma-informed organisations

Trauma-informed organisations will:

- recognise that the high rates of complex mental health conditions and psychosocial disability amongst service users may be related to interpersonal trauma including exposure to trauma as a child
- be inclusive of the person's perspective, invite and value their contribution in all aspects of care and treatment
- respond empathically, be objective and use supportive language
- recognise that mental health treatment environments can be traumatising, both overtly and covertly
- provide early and thoughtful diagnostic evaluations with focused consideration of trauma in people presenting with complicated illnesses, and deemed 'treatment-resistant'
- focus on what happened to the person rather than what is 'wrong with them' (i.e. a diagnosis)
- assess a person's current safety, address the current risk issues and develop a safety plan for discharge and ongoing support
- assume trauma as the expectation, not the exception, and that every person in a treatment setting may have been exposed to abuse, violence, neglect or other traumatic experiences.[24]

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[22] A whole person approach to wellbeing – Johanna Lynch
[23] https://healthywa.wa.gov.au/Articles/S_T/Traumatic-stress
[24] http://www.mhcc.org.au/wp-content/uploads/2018/11/TICPOT-Stage-1.pdf

Relevance to primary care

Trauma-informed care aligns with generalist priorities of integrating life story, relationships and meaning into care for the whole person. It acknowledges the personal sensory, relational and environmental contributors to complex primary care presentations. It also offers new non-pharmaceutical treatment pathways grounded in the real-world context of both clinician and patient.

GPs are also uniquely placed as clinicians who routinely integrate understanding the impact of life story and events on stress physiology. Child development, attachment and psychophysiology add evidence of the biological importance of life story on health relevant to GPs.

As a clinical model of care, trauma-informed care is an approach to integrating an individual's life story and understanding of health (including multi-morbidity, somatisation, medically unexplained symptoms, chronic pain and other complex presentations). Many GPs already intuitively adopt this approach in caring for the whole person within their life story and context – evidence-based trauma-informed approaches validate that approach.

General practice provides a unique environment for the identification and provision of trauma informed care. Many trauma survivors do not seek mental health services but look for help in primary care settings. Neither patient nor providers may be aware of the link between their current physical complaints and the connection to past trauma.

Despite the increasing evidence of the lifelong health impact of ACEs, research shows that less than one-third of primary care doctors screen for ACEs on a regular basis. This was often due to a lack of knowledge of the prevalence of ACEs, discomfort with asking screening questions and perceived role. Yet, GPs are uniquely positioned to play a critical role in the identification of ACEs and facilitating referral to appropriate treatment. Interacting with adults, children and their families at regular intervals can allow patients and providers to develop a trusting relationship, which can facilitate the disclosure of ACEs. [25]

What can General Practitioners do?

GPs can provide an ideal source of support by working in a trauma informed way with all patients and assisting with referral to additional services when required.

Key goals and objectives for using this toolkit

This toolkit is to be used in general practice to:

- improve the identification and recording of patients affected by traumatic events
- ensure systems are in place at your practice to assist patients exposed to trauma to ensure care is provided in a safe and non-judgemental environment
- realise, recognise, respond to and resist re-traumatisation[26]
- review the importance of self-care for health professionals
- identify Medicare Benefit Schedule (MBS) item numbers available for patients affected by trauma.

For more support

support@bsphn.org.au

1300 467 265

[25] https://www.benchmarkpsychology.com.au/trauma-informed-care-primary-health-settings/
[26] https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf

Activity 1 – Trauma informed care

Trauma informed care (TIC) recognises that traumatic experiences terrify, overwhelm, and violate the individual.

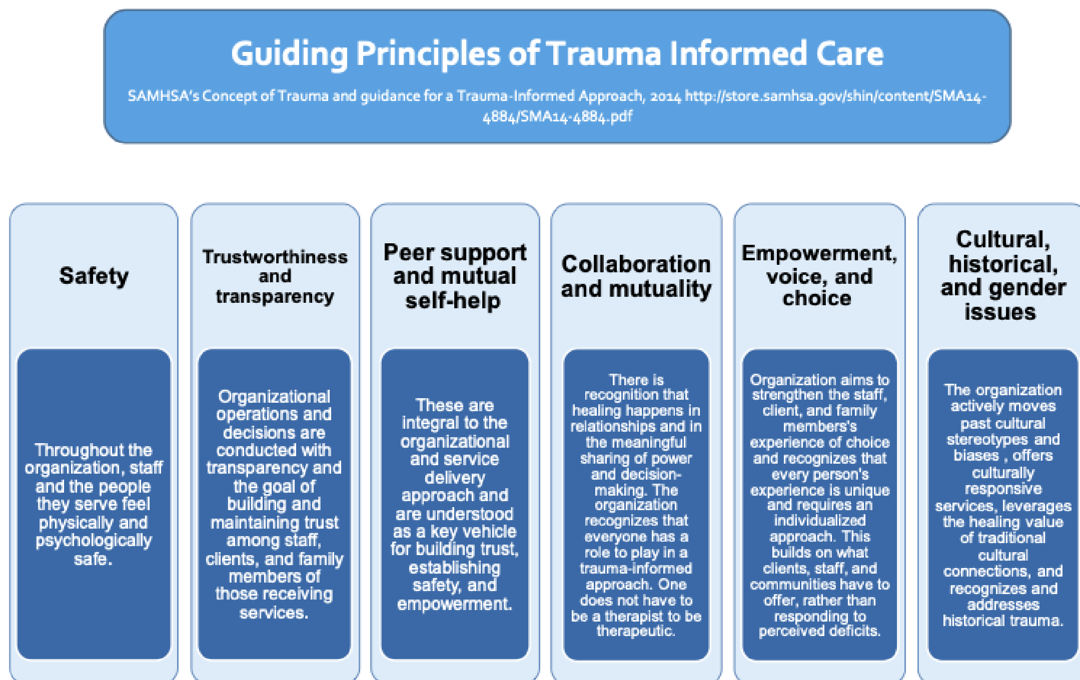
Trauma informed care is a broad whole person clinical approach that integrates understanding of life story on wellbeing (including ways people cope with distress). It is a process of care that commits to not repeat traumatising experiences and, in whatever way possible, to restore a sense of safety, power, and self-worth**.** It involves tuning in to the personal experiences that have caused physiological arousal. Trauma-informed care offers an approach to distress that is relevant across presentations and demographics – an integrative way to attend to the whole person (not divide them into body and mind).

Strengths-based trauma-informed care prioritises building a "sense of safety" for each person and considering their context and relationships.[27]

Given the high prevalence of trauma exposure among primary care patients, GPs are well placed to support and monitor the wellbeing of individuals, and to deliver simple interventions to those experiencing acute distress and support an individual's engagement in effective therapies and longer term treatment. In doing so, GPs can initiate a team approach to help patients to develop positive coping skills that will support a return to healthy functioning. This type of support can also prevent the development of more enduring and long-term mental illness.[28]

GPs can be guided by and promote the six principals of trauma informed care.

Six Principles of Trauma Informed Care



[27] A whole person approach to wellbeing – Johanna Lynch

[28] https://www.racgp.org.au/afp/2013/september/psychological-trauma/

Sense of safety

Promotion of a sense of safety is particularly relevant to GPs. When promoting a sense of safety with a patient, it is important to:

- ensure physical and emotional safety
- ensure common areas in the practice are welcoming and privacy is respected
- be realistic and specific, rather than provide vague and potentially inaccurate reassurances
- provide simple and accurate information on how to meet the person's basic needs
- repeat information as often as needed.

Calming

Contact with patients following disclosure of trauma provides an opportunity for GPs to promote calming and address heightened arousal, anxiety or other emotions that can undermine confidence and active coping. There are a number of helpful calming strategies that GPs can provide, such as:

- attuned co-regulation using tone of voice, mirrored slow breathing and grounding
- teaching patients to use controlled breathing when anxious
- 'normalising' psychological reactions to such events
- encouraging sufficient rest, exercise and a healthy diet
- assisting patients to schedule enjoyable and relaxing activities.

It is also important to encourage the patient to avoid unhelpful coping strategies such as substance use and social withdrawal.

Self-efficacy

After experiencing a traumatic event, patients may present to their GP feeling overwhelmed and unable to prioritise or cope with a range of practical and emotional concerns. For example, following a natural disaster, patients are frequently concerned about lost possessions, organising childcare and schooling, completing insurance forms and lack of employment. When promoting a sense of self efficacy with a patient, GPs can:

- highlight those aspects of the situation that the person has some control over
- remind the person about past experiences of successfully coping with stressful situations
- encourage the person to actively address problems and solve one problem at a time
- assist the person to 'recalibrate' their expectations of themselves
- ask 'how do you usually cope with stressful events?' to find resources from the past.

Connectedness

Support from family, friends and community services is a strong protective factor and enhances recovery following trauma. There are many different forms of social support (e.g. emotional support, material and physical assistance, a sense of belonging), and people can derive benefit from receiving support and from helping and connecting with others. GPs can help to promote a patient's connectedness by:

- explaining the known benefits of social support
- encouraging the person to identify opportunities to spend time with family and friends
- telling the person that they may find talking to others helpful, but should do so when they feel ready
- directing and referring the person to appropriate community support services
- anticipating that some people will not feel deserving of assistance.

Promoting hope

Many patients seen by their GP in the days and weeks following disaster or trauma will feel pessimistic and defeated by their recent experiences, and may have difficulties envisaging a future for themselves or their family. A GP has an early opportunity to promote hope about the patient making a successful recovery, by conveying that:

- most people recover with time by using helpful coping strategies and with the support of family and others
- the patient has strengths, such as their ability to cope under stress or their available social supports[29]
- post traumatic growth is a research area that confirms the way that traumatic events can teach people they are stronger than they thought they were, which relationships are trustworthy, and how to face difficulty as part of life. [30]

Prescription of medications for PTSD

- In rare instances cautious and time-limited use of prescribed medications (e.g. benzodiazepines) may be required to reduce severe arousal, insomnia and distress. However, if benzodiazepines are prescribed, the course of treatment should be kept as brief as possible due to the risk of tolerance and dependency.

Activity 1.1 – Reviewing your practice’s systems for providing trauma informed care

From booking systems that allow choice and having a range of chairs that allow the patient to determine how close they sit to reception, nursing staff tone of voice and a collaborative approach to patient interaction, most practices can improve systems so that they increase the sense of safety for patients in distress.

Complete the checklist below to review your practice’s systems for providing trauma informed care.

Description	Status	Action to be taken
Do the practice’s services and settings maximise patient experiences of choice and control?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Consider how can services be modified to ensure that patient experiences of choice and control are maximised?
Have relevant practice team members participated in training related to trauma informed care?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to training options.

[29] https://www.racgp.org.au/afp/2013/september/psychological-trauma/
[30] https://www.apa.org/monitor/2016/11/growth-trauma

Description	Status	Action to be taken
Do the practice's services and settings ensure the physical and emotional safety of patients?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Consider how services can be modified to ensure safety is effective and consistent? (*E.g. physical safety of practice setting etc*). Review how you would describe the reception and waiting areas? Are they comfortable and inviting? ☐ Yes ☐ No Are the first contacts with patients welcoming, respectful and engaging? ☐ Yes ☐ No
Does the practice seek input from patients on the types and availability of services provided by the practice?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Review options for obtaining patient input into practice services. This may include: • Formal survey as required for accreditation purposes. • Using a happy or not terminal in the waiting room. • Providing feedback portal on the practice website. • Creating an online survey (e.g. using survey monkey), and email to patients for completion.
After reviewing your practice's systems for providing trauma informed care, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 2 – Identify individuals who have been exposed to trauma

Most people will have been exposed to at least one traumatic event in their lifetime. Multiple and prolonged exposure to complex trauma and traumatic processes (such as neglect) is also common. When a person presents at the practice with symptoms of trauma, or with very challenging behaviours and a difficult communication style, the way that others around them respond can significantly affect the person's ability to understand and cope with their experience. Some aspects of trauma remain largely misunderstood, especially when it comes to its relationship with mental health.[31]

Screening for trauma

Although trauma screening is recognised as the most fundamental aspect of a clinical trauma-informed approach, experts often differ on *when* and *how* to screen patients for trauma. Upfront and universal screening involves screening every patient for trauma history as early as possible. Proponents of this approach assert that it allows providers a better understanding of a patient's potential trauma history, helps target interventions, provides aggregate data, and quantifies the risk of chronic disease later in life. Universal screening can also reduce the risk of racial/ethnic bias by screening all patients. Furthermore, a patient can be asked to share a cumulative ACE or other trauma screening score after completing a questionnaire rather than identifying specific traumatic experiences, which allows patients to decide how much detail to provide.
High functioning patients can still have significant lifelong health impacts from traumatic experiences.

Acknowledging and witnessing life story can be therapeutic.

Opponents of upfront screening feel that patients should have the opportunity to build trust in providers before being asked about their trauma history. Those who favour later screening for trauma contend that upfront screening removes the patient's choice of sharing sensitive information, can re-traumatise a patient, and may hinder progress made if there are not appropriate interventions or referrals in place.

Clinical priorities regarding screening differ from research and public health data collection priorities. In every care, the patient's present and future safety is paramount. The clinical question to ask is: Will **not screening** deprive this person of relevant trauma-specific treatment options?

Despite differing viewpoints, consensus is building in the field around several aspects of screening:

- Treatment setting should guide screening practices. Upfront, universal screening may be more effective in primary care settings and later screening may be more appropriate in mental health settings.
- Screening should benefit the patient. Providers who screen for trauma must ensure that, once any health risks are reported, they can offer appropriate care options and referral resources.
- Re-screening should be avoided. Frequently re-screening patients may increase the potential for re-traumatisation because it requires patients to revisit their traumatic experiences. Minimising screening frequency and sharing results across treatment settings with appropriate privacy protections may help reduce re-screening/traumatisation.
- Ample training should precede screening. All health care professionals should be proficient in trauma screening and conducting appropriate follow-up discussions with patients that are sensitive to their cultural and ethnic characteristics (e.g., language, cultural concepts of traumatic events).[32]

Our interactions with one another are always important, especially for people living with the impacts of trauma. Trauma interrupts the connections between different systems of functioning in the brain. People

[31] https://www.orygen.org.au/Training/Resources/Trauma/Mythbusters/Trauma-mh-yp/Trauma_and_MH_in_YP_Mythbuster?ext=.
[32] https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

recover from trauma when disruptions between different levels of functioning – physical, emotional and cognitive (thinking) – become connected or 'integrated' again.

It is important to understand that:

- positive experiences in our relationships can help us heal
- negative experiences make our emotional and psychological problems worse.

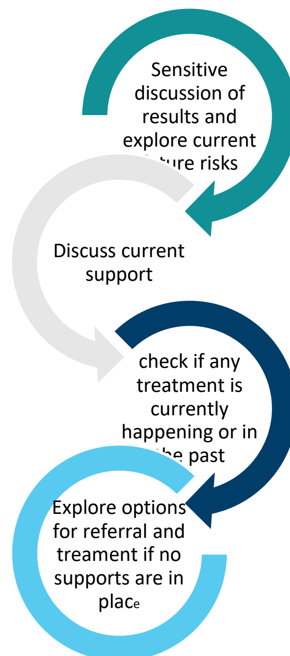
We should not underestimate the capacity of positive empowering interactions, even in routine interactions, to be soothing and validating. This applies to all of us, and especially to people with trauma histories. Support is crucial to the process of recovery.[33]

Trauma identification tools

There are a number of tools available to assist with identifying trauma.

Assessment name	Description
Adverse Childhood Experiences (ACE) questionnaire	The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest prospective population investigations of childhood abuse and neglect and household challenges and later-life health and well-being.
Primary Care PTSD Screen (PC-PTSD)	The PC-PTSD is a brief 4 item screen.

Next steps if trauma is identified



[33] https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care-and-practice

Activity 2.1 – Review your practices systems for identifying people who have been exposed to trauma

Complete the checklist below to review your practice's systems for identifying individuals who have been exposed to trauma

Description	Status	Action to be taken
Do relevant team members have access to appropriate trauma identification tools?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Refer to more information on identification tools. How will this information be communicated to the practice team?
Are longer appointments booked for patients when a mental health treatment plan or screening assessment is required?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Discuss at next team meeting how to ensure longer appointments are booked for patients, so they don't feel rushed.
Are there minimal questions addressing neglect, physical and sexual abuse included in trauma screening in an appropriate way?	☐ Yes: continue with activity. ☐ No: **see action to be taken**.	Review screening tools to ensure questions addressing physical and sexual abuse are included. How will this information be communicated to the practice team?
Is screening done in a way that avoids over complication and unnecessary detail so as to minimise stress for patients?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the six principles of trauma informed care.
Does the practice have access to trauma related resources to provide to patients if required?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to resources.
After reviewing your practice's systems for identifying individuals who have been exposed to trauma, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 3 – Building your practice register

Advantages and disadvantages of labelling patients with conditions

If someone has a history of trauma, it is important it is recorded correctly so that the treating team are aware for safety and to allow correct treatment. Any diagnosis should be discussed with the person and consent obtained to record any sensitive information. Just as we would record a physical health diagnosis, trauma should be recorded if it has been identified. If preferred, it **may be marked as confidential, or inactive** if it is no longer of concern, and the patient may choose not to upload it to My Health Record if desired.

Unfortunately, current coding options are limited to those within practice software. The capacity to clarify the duration and intensity of traumatic experiences is limited, complete this information in the additional information box.

Activity 3.1 – Marking condition as active/inactive

It is important when completing each patient's progress notes, to mark the consult with an appropriate condition. PLEASE NOTE: if condition/diagnosis is marked as 'active' the patient will be included in any appropriate reports produced on CAT4. If the condition is marked 'inactive', they may not be included in CAT4 reports. The clinical team should understand the importance of marking conditions as active or inactive.

The aim of this activity is to ensure all the clinical team within the practice understand the importance of marking conditions as active or inactive.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of marking conditions or reason for visits as active or inactive?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s the importance of marking patient's history and/or reason for visit as active or inactive.
Are relevant practice team members aware that they can mark sensitive information as confidential?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s some information on marking patient's history and/or reason for visit as confidential. This is generally only done for very sensitive information.
Does your practice policy and procedure manual include a section on marking patient past history and/or conditions as active or inactive?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Update policy and procedure manual.
Are practice team members aware of how to enter active/inactive in your practice's clinical software?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	See instructions for Best Practice or MedicalDirector users.

Description	Status	Action to be taken
Are practice team members aware of what conditions, if marked inactive, are not included in CAT4 searches?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Refer to information from CAT4.
After reviewing your practice's active/inactive conditions processes, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 3.2 – Data collection from clinical software program

The aim of this activity is to collect data to identify the number of patients with a history of post-traumatic stress disorder from your practice software.

You will need to search for patients from your clinical software package. Instructions are available from Best Practice **or** MedicalDirector.

	Description	Number
3.2a	Number of active patients with a past history of post-traumatic stress disorder	
3.2b	Number of active patients with a past history of trauma – childhood (MD users only)	

Please note: if a patient has not had the above items marked in their past history, they will not display in the results. More information on coding is available in activity 3.

Activity 3.3 – Reviewing your practice's PTSD profile

Complete the checklist below to review your practice's post-traumatic stress disorder patient profiles.

Description	Status	Action to be taken
After completing **activity 3.2**, are there any unexpected results with your practice's PTSD profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with PTSD than expected.)* How will this information be communicated to the practice team?

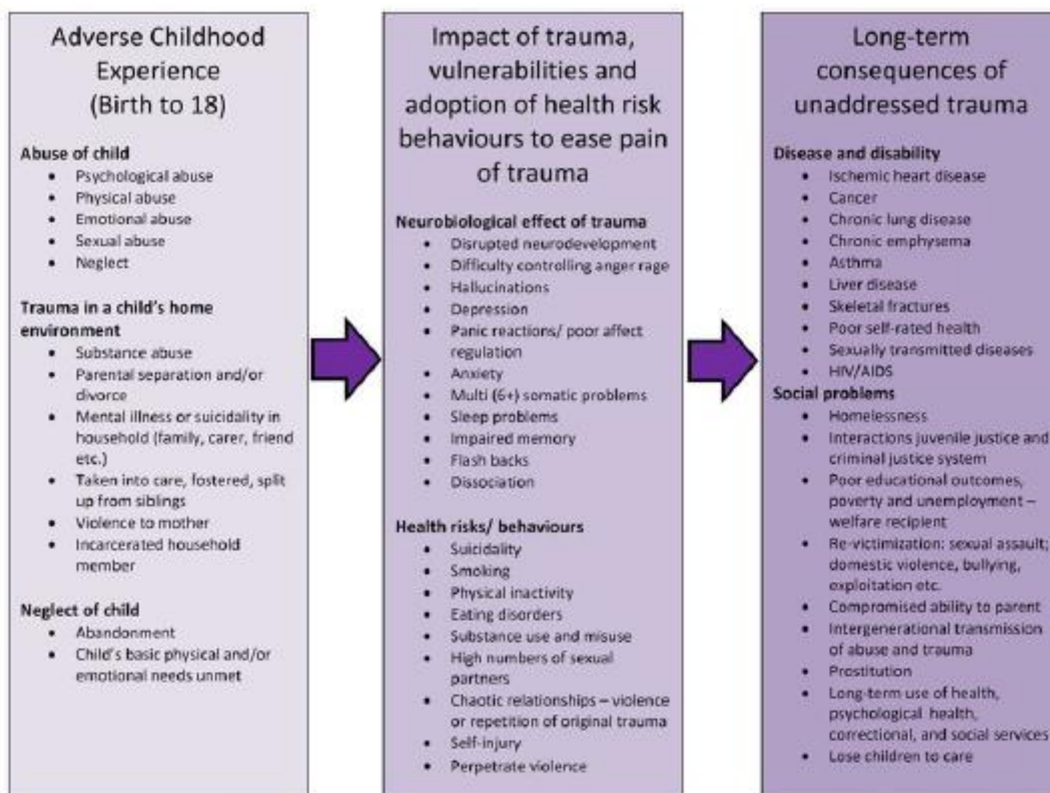
Description	Status	Action to be taken
After reviewing your practice's PTSD profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken to help set your goals.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 4 – Trauma & co-morbidities

Any form of abuse and violence has implications for the health of patients, both physically and emotionally. Health outcomes may also be affected by the quality of care received, which in turn will affect the health of the entire family. Recent research shows that children who live in abusive families experience negative effects on their health, wellbeing and ongoing relationships.

Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in their adult lives, is one of the most significant clinical and moral deficits of current mental health approaches. As previously discussed, trauma in the pregnancy, infancy and early years shapes brain and psychological development, sets up vulnerability to stress and vulnerability to a range of mental health problems. [34]

A high exposure to adverse childhood experiences can increase the chances of adult morbidity and early death by a ratio as high as 30:1.[35]



[36]

[34] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book
[35] https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/dream-big/Dream-Big-Act-Big-for-Kids-Issue-1-ACEs-Toxic-Stress.pdf
[36] https://www.mhcc.org.au/wp-content/uploads/2018/05/ticp_awg_position_paper__v_44_final___07_11_13-1.pdf

Activity 4.1 – Data collection from clinical software program

The aim of this activity is to collect data to identify the number of patients with a history of PTSD who may also have other health risks.

You will need to search for patients from your clinical software package. Instructions are available from Best Practice **or** MedicalDirector. *(Please note: you will need to select both conditions before selecting search).*

	Description	Number
4.1a	Number of active patients with a past history of PTSD and anxiety	
4.1b	Number of active patients with a past history of PTSD and asthma	
4.1c	Number of active patients with a past history of PTSD and cancer	
4.1d	Number of active patients with a past history of PTSD and cardiovascular disease	
4.1e	Number of active patients with a past history of PTSD and diabetes	
4.1f	Number of active patients with a past history of PTSD and obesity	
4.1g	Number of active patients with a past history of PTSD and drug dependence	
4.1h	Number of active patients with a past history of PTSD and alcohol addiction	

Please note: if a patient has not had the above items marked in their past history, they will not display in the results. More information on coding is available in activity 3.

Activity 4.2 – Reviewing your practice's PTSD and other health risks profile

Complete the checklist below to review your practice's PTSD patient and other health risks profiles.

Description	Status	Action to be taken
After completing **activity 4.1**, are there any unexpected results with your practice's trauma and other health risks profile?	☐ Yes: **see action to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with PTSD and obesity than expected).* How will this information be communicated to the practice team?

Description	Status	Action to be taken
After reviewing your practice's trauma and other health risks profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Link to other QI toolkits from Brisbane South PHN

Brisbane South PHN have a suite of QI toolkits available for general practice. The toolkits are designed to:

- improve patient care and outcomes
- generate increased revenue for GPs
- help practices fulfil their quality improvement requirements under the Practice Incentive Program Quality Improvement Incentive (PIP QI)
- be complete at your own pace
- be available so that you choose your own adventure – you choose which topic/toolkit you would like to work on.

After completing this toolkit, you may benefit from choosing one of the following:

- Mental health overview
- Alcohol and other drugs
- Eating disorders
- Anxiety & depression
- Asthma
- COPD
- Diabetes
- Cardiovascular disease
- Children and young people in care.

The full suite of toolkits are available on Brisbane South PHN's website.

Activity 5 –Self-care for the practice team

Working with those who are experiencing or have experienced trauma can be emotionally challenging and result in the experience of vicarious trauma.

- It is important to maintain an environment, both individually and in practice, where there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence.
- Health practitioners cannot give to others if they are experiencing compassion fatigue, so it is advised that self-care and a whole of practice approach be addressed so that patients receive the best care. Refer to and encourage all health practitioners to complete the sense of safety self-care audit.
- Working as a team within the practice by using a system that provides peer support and the ability to discuss distressing cases may help protect against stress. [37]

Example of awareness, balance and connection strategies		
	Personal	**Organisational**
Awareness	• Proactively instigate self-care strategies. • Understand and improve your awareness of when you are stressed, tired, overwhelmed.	• Ensure your practice has a mentor or supervisor to support your professional development. • Consider using debriefing strategies (formal or informal) in your practice working with those who are experiencing or have experienced trauma can be emotionally challenging and result in the experience of vicarious trauma. • It is important to maintain an environment, both individually and in practice, where there is adequate protection from burnout or the vicarious trauma that may come from hearing the stories of patients involved in abuse and violence. • Health practitioners cannot give to others if they are experiencing compassion fatigue, so it is advised that self-care and a whole of practice approach be addressed so that patients receive the best care. Refer to and encourage all health practitioners to complete the sense of safety self-care audit. • Working as a team within the practice by using a system that provides peer support and the ability to discuss distressing cases may help protect against stress.

[37] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/white-book

Example of awareness, balance and connection strategies		
	Personal	**Organisational**
		• Cultivate open and supportive dialogue with your practice team. • Ensure organisational boundaries are known and understood by patients (e.g. home visits, consultation length).
Balance	• Review your lifestyle and consider healthy options. • Seek balance in all spheres of your life: physical, psychological and social.	• Review workload regularly to ensure that all members of the practice team are adequately supported. • Take care in scheduling complex care needs patients.
Connection	• Consider joining a social action group where you have a passion for change. • Talk to others about work, debrief safely. • Nurture positive relationships with family and friends.	• Join a peer support or Balint group or informal network. • Undertake regular continuing professional development with your colleagues.

Sense of safety self-care audit

SENSE OF SAFETY SELF CARE AUDIT Adapted from Transforming the Pain: A Workbook on Vicarious Traumatisation. Saakvitne, Pearlman and Staff of TSI/CAAP (Norton, 1996) Integrating insights from Lynch (2021) *A Whole Person Approach to Wellbeing: Building Sense of Safety* Routledge.					
Sense of safety - Dynamic	It never occurred to me	Never	Rarely	Occasionally	Frequently
BROAD AWARENESS					
Be curious					
Spend time outdoors					
Notice your inner experience – your dreams, thoughts, imagery, feelings, sensations					
Read literature unrelated to work					
Be open to inspiration					
Cherish your optimism and hope					
Be aware of non-tangible (non-material) aspects of life					
Have awe-filled experiences					
Listen to inspiring music					
Identify projects or tasks that are exciting, growth promoting, and rewarding for you					
CALM SENSE MAKING					
Make time to complete tasks					
Get regular supervision or consultation					
Spend time in nature					
Express gratitude					

Celebrate milestones with rituals that are meaningful to you					
Make time for prayer, meditation, reflection					
Remember and memorialise loved ones who have died					
Get away from stressful technology such as papers, faxes, telephones, email					
Make time for self-reflection					
Go and see a psychotherapist or counsellor for yourself					
Write in a journal					
Let others know different aspects of you					
Re read favourite books, re-view favourite movies					
Take a day trip or mini holiday					
RESPECTFUL CONNECTION					
Take a step to decrease stress in your life					
Practice receiving from others					
Get regular medical care or prevention					
Get medical care when needed					
Take time off when you are sick					
Get massages or other body work					
Get enough sleep					
Spend time with others whose company you enjoy					
Stay in contact with important people in your life					
Identify and seek out comforting activities, objects, people, relationships, places					
Play with children					
Plant a tree or weed a garden					
Participate in a spiritual gathering, community or group					
Nurture others					
Take time to chat to co-workers					
Have a peer support group					
Set limits with clients and colleagues					
Balance your case load so no one day is “too much”					
OWN YOURSELF					
Arrange your workspace so it is comfortable and comforting					
Negotiate for your needs					
Take time to eat lunch					
Treat yourself kindly (supportive inner dialogue)					
Feel proud of yourself					
Allow yourself to cry					
Find things to make you laugh					
Eat healthfully					
Take time to be sexual					

Wear clothes you like					
Say no to extra responsibilities sometimes					
CAPABLE ENGAGEMENT					
Exercise					
Lift weights					
Practice martial arts					
Do physical activity that is fun for you					
Do something at which you are a beginner					
Engage your intelligence in a new area – go to an art gallery, museum, sports event, exhibit or cultural event					
Speak up for yourself					
Express your outrage in constructive ways					
Contribute to or participate in causes you believe in					
Take on a challenge you have previously avoided					

Activity 5.1 – Reviewing your practice's strategies for self-care for your practice team

Complete the checklist below to review your practice's strategies for self-care for your practice team.

Description	Status	Action to be taken
Are GPs and medical students aware of the DRS4DRS support line?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to the DRS4DRS website for more information.
Do relevant team members have mentors or supervisors who they can talk to about stressful situations?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Consider developing a buddy system in the practice. Assist GPs to identify supervisors/mentors.
Do practice team members take adequate leave during the year?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Create leave calendar and ensure all team members are given adequate leave each year. Ensure all team members are taking leave on a regular basis.

Description	Status	Action to be taken
Does the practice ensure practice team members are provided with physical security and a safe, confidential workplace?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to tips and tools from the RACGP general practice – a safe place guidelines.
Are relevant team members supported to complete continuing education?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to RACGP QI&CPD planning learning and need information.
Are you aware of the availability of professional counselling services for your entire team made available by Brisbane South PHN via an employee assistance program?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Refer to support information.
After reviewing your practice's strategies for self-care for your practice team, are there any changes you would like to implement in the practice to help manage staff over the next 12 months?	☐ Yes: **see action to be taken to help set your goals.** ☐ No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 6 – Medicare item numbers

The aim of this activity is to outline some of the Medicare item numbers that you may use in general practice for eligible patients.

Patients experiencing trauma ***may be eligible*** to access item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number; please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive toolkit looking at MBS items.

MBS items

- Mental health consultations (item 2713)
- Mental health treatment plan & review
- GPMP & TCA
- Aboriginal and Torres Strait Islander health assessment
- MBS telehealth fact sheet

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Can you claim a mental health plan and a chronic disease plan on the same patient?

The CDM Medicare items continue to be available for patients with chronic medical conditions, including patients needing multidisciplinary care.

Patients with a mental illness only, who require a treatment plan to be prepared, should be managed under the GP mental health treatment items (MBS items 2700, 2701, 2712, 2713, 2715 and 2717).

Where a patient has a mental illness as well as significant co-morbidities and complex needs requiring team-based care, the GP is able use both the CDM items (for team-based care) and the GP mental health treatment items. [38]

Please note: GPs should always ensure they fully understand the criteria from Medicare before claiming the item number.

[38] https://www1.health.gov.au/internet/main/publishing.nsf/Content/pacd-gp-mental-health-care-pdf-qa#7_1

Activity 6.1 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with exposure to trauma.

Description	Status	Action to be taken
Are there any patients with PTSD who would benefit from a mental health treatment plan? *(Note: not all patients are eligible for a mental health plan).*	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain: What action will you take? How will you use this information to increase the number of mental health treatment plans completed?
Have you created a Topbar prompt on all patients who may be eligible for a mental health plan?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Follow the instructions to complete this.
Do relevant staff know what the criteria is for completing Mental Health treatment plans and GP management plans through Medicare?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	Refer to MBS criteria at: • Mental Health treatment plans. • GP management plan.
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	Email: askMBS@health.gov.au Provider enquiry line - 13 21 50
Do relevant staff know that Medicare provides online training modules?	☐ Yes, continue with the activity. ☐ No, **see action to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the MBS claiming for patients exposed to trauma, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see action to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 7. Referral pathways

A range of psychological interventions are currently used in the treatment of people who have experienced trauma. In routine clinical practice, of course, these interventions do not occur in isolation, but in the context of a trusting therapeutic relationship and, in many cases, broader mental health care for a range of associated post-traumatic mental health issues. They are not mutually exclusive, and overall treatment may involve several interventions at various stages of the treatment process. Identifying a service that specialises in therapy related to the source of the trauma is important e.g. sexual abuse, domestic violence, Aboriginal and Torres Strait Islander healing.

Interventions include the following:

- Trauma Focussed Cognitive Behavioural Therapy is designed to assist in the recovery from the symptoms of PTSD. It involves an exploration of the components of traumatic memories in a safe and supportive environment and techniques designed to reduce the discomfort associated with them. The therapy also involves the use of homework tasks to confront these memories outside of sessions.
- Dialectical Behaviour Therapy (DBT) is a modified version of cognitive-behavioural therapy designed to treat borderline personality disorder. It can also be used to treat other conditions, like suicidal behaviour, self-harm, substance use, PTSD, depression and eating disorders.
- Eye Movement and Desensitisation and Reprocessing (EMDR) is a psychotherapy treatment that is designed to alleviate the distress associated with traumatic memories.
- Parent-Child Interaction Therapy is a dyadic behavioural intervention for children (ages 2 – 7 years) and their parents or caregivers that focuses on decreasing externalising child behaviour problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship.

National Services and Organisations

Blue Knot Foundation is the National Centre of Excellence for Complex Trauma. They operate a phone and email counselling service for adult survivors of childhood trauma and abuse. Blue Knot also provide workforce education for health professionals to build a workforce that understands trauma and works in a trauma-informed way.

Australian Childhood Foundation are dedicated to helping children heal from the devastating impact of trauma, abuse, neglect and family violence. They provide services for children and families across Australia and, information and professional development/ education for a wide range of health professionals, to provide trauma informed care for infants, children and adolescents.

Services available from Queensland government

- The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) aims to support parents, caregivers and communities to have the confidence, knowledge, skills and resources to support their own wellbeing and raise emotionally healthy and resilient children. QCPIMH provides clinical assessment and therapy services to infants, young children and their families 0 – 4 years of age presenting with severe and complex mental health difficulties, in the metropolitan Brisbane region. They also offer a state wide perinatal and infant mental health telepsychiatry consultation service, and support the development of other perinatal and infant mental health services across Queensland.

- The Queensland Transcultural Mental Health Centre offers information, advice and trauma informed clinical consultation services for culturally and linguistically diverse communities in Queensland. Phone (07) 3167 8333.

- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)offers free help to people who have been tortured or suffered refugee related trauma before migrating to Australia. Phone (07) 3391 6677.
- Harmony Place offers mental health services for culturally and linguistically diverse people and communities. Phone (07) 3848 1600.
- Culture in Mind is a community-based service that supports the social, emotional and mental wellbeing of migrants, refugees and people seeking asylum in the greater Brisbane area. Phone (07) 3333 2100.
- Find out more about help lines, counselling and support groups in Queensland.

Brisbane South PHN commissioned specialist trauma specialists

Brisbane South PHN have commissioned a number of specialist trauma services who deliver groups and programs which can assist people. Information is available on the mental health, suicide prevention, alcohol and other drugs page. There is also information available if someone is effected by domestic violence and also patients from multicultural communities.

Trauma Support Providers

Trauma Support Providers assists to identify psychologists and specialist in the area of trauma in the local area specialising in children/adolescents and trauma therapy. You can apply filters for child, adolescent, ethnicity, type of practitioner etc.

E-Mental Health

There are a number of therapist guided online programs for trauma and PTSD. See Head to Health and eMRPrac for more information.

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane South catchment with web-based information outlining the assessment, management and referral to other clinicians for more than 550 conditions. It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

GP Smart Referral

Smart Referrals are digital referrals integrated with Best Practice and MedicalDirector software to enable faster, streamlined management of referrals to Queensland public hospitals. Register here for smart referrals. A number of templates are available on the Brisbane South PHN website.

Refer your patient

Metro South Health is the major provider of public health services, and health education and research, in the Brisbane south side, Logan, Redlands and Scenic Rim regions. The refer your patient website assists health professionals with accessing public health services for patients. It provides a single point of entry for all new referrals.

The website outlines available health professionals, criteria to access appointments with the health professionals and expected wait times as well as all the information required in the referral.

Health Services Directory

Health Services Directory is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to provide health professionals and consumers with access to reliable and consistent information about health services.

My Community Directory

My Community Directory lists organisations that provide services that are free or subsidised to the public in thousands of locations across Australia. These services are organised into various Community Directories.

Activity 7.1 – Referral Pathways

Complete the checklist below in relation to referral pathways.

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Description	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes: continue with the activity. ☐ No: see **action to be taken.**	Obtain access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes: continue with the activity. ☐ No: see **action to be taken.**	See instructions**.** Or contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.
Do all GPs and nurses know how to refer to Brisbane South PHN commissioned trauma health services?	☐ Yes, continue with the activity. ☐ No, see **action to be taken.**	Refer to Brisbane South PHN website. Refer to the FAQs page.
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your practice referral system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see action to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Activity 8 – Resources

The following are credible sources for resources, webinars, and practice guides related to trauma and trauma informed care. These are aimed at health professionals and do not have any cost.

Frameworks and Guidelines

- Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery
- Mental Health Coordinating Council toolkit and policy and procedure templates
- Recovery oriented language guide (MHCC)
- Beyond Blue - Building resilience in children aged 0–12: A practice guide
- Blue Knot - Organisational Guidelines for Trauma-Informed Service Delivery
- A whole person approach to wellbeing – Johanna Lynch (fees associated)
- The deepest well (fees associated)

Online Professional Development in Trauma-informed Care and Trauma-Specific Care

- Emerging Minds – National Workforce Centre for Child Mental Health has webinars such as *The Impact of Trauma on the Child*. Many are RACGP accredited, therefore aimed at health professionals, and are between 1-3 hours.
- RACGP and Emerging Minds Child Mental Health Series covering adverse childhood experiences (ACEs), trauma-informed care, social and emotional development, and relationships and attachment. This is not yet available on demand.
- Evolve Therapeutic Services self-paced course on Attachment is approximately 30-90 minutes to complete. Available on the QH ilearn platform via log in. A course on the Foundations of Trauma will be available late 2020.
- Blue Knot Foundation
- Australian Society for Psychological Medicine
- MSAMHS: Introduction to Trauma. Becoming Trauma Informed. - Overview | Rise 360 (articulate.com)
- Children's Health Qld Project ECHO Kids Behaviour & Mental Health series
- Mental Health Professionals Network webinars and podcast on trauma
- TED talk by paediatrician Nadine Burke Harris
- Emerging Minds – Supporting children who have experienced trauma e-learning course.

Local Professional Development in Trauma-informed Care

- Local Evolve Therapeutic Services within Health and Hospital Services may be able to arrange face-to-face training in trauma-informed care as part of their professional development role
- Mental Health Professionals Network
- A number of high quality fee for service options are also available through Act for Kids, BlueKnot Foundation and others

Resources

- Blue Knot Foundation – Factsheet – Talking about trauma for General Practitioners and Primary Health providers
- CHQ Dream Big, Act Big for Kids: Tools and Resources to educate frontline workers on the social determinants of health to improve children's health and wellbeing. The highly recommended first edition is on Adverse Childhood Experiences and Toxic Stress and has self-reflection tools, action plans, TED talks, and research.
- Emerging Minds Trauma topic page with factsheets on trauma responses by age
- Emerging Minds Toolkit for working with Aboriginal and Torres Strait Islander children and families
- Child Family Community Australia – Australian Institute of Family Studies
- Qld Centre of Perinatal and Infant Mental Health resources, services and programs
- Healing Foundation Aboriginal and Torres Strait Islander healing
- Head to Health – digital mental health services
- 1800RESPECT is a phone line and website providing information, advice and connection to resources in the area
- Blueknot helpline and email counselling
- MindSpot PTSD course – therapist guided online course
- PTSD coach app
- PTSD online program

E-Newsletters

- Emerging Minds
- Dream Big, Act Big for Kids
- Child Family Community Australia – Australian Institute of Family Studies

QI activities using the MFI and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of patients exposed to trauma. Follow these steps to conduct a QI activity using The MFI and PDSA. The model consists of two parts that are of equal importance.

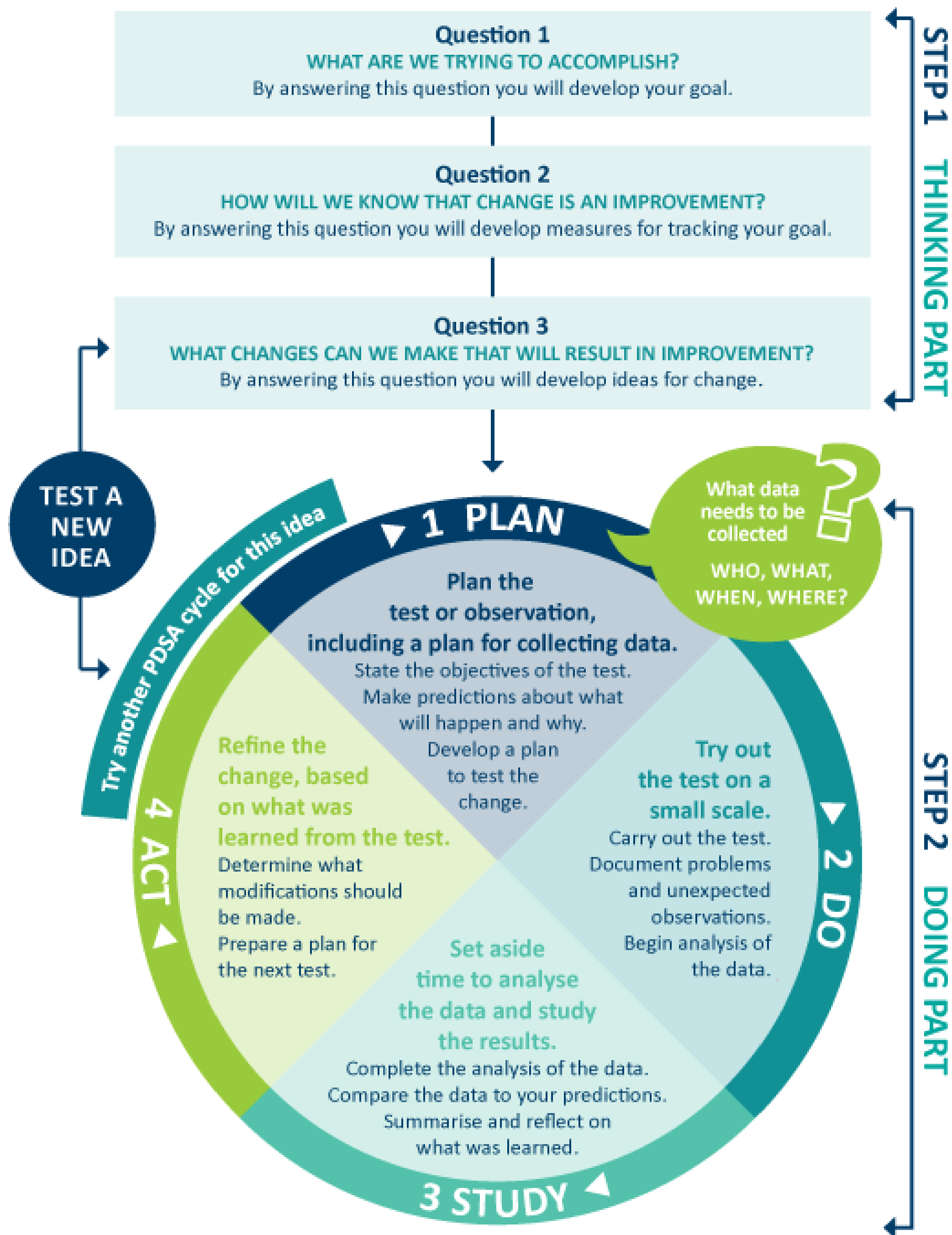
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **'doing'** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. These include:

- Helping you test the ideas
- Helping you assess whether you are achieving your desired objectives
- Enabling you to confirm which changes you want to adopt permanently.

Model for Improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

MFI and PDSA worksheet EXAMPLE

Step 1: The thinking part - The 3 fundamental questions

Practice name:	Date:
Team member:	
Q1. What are we trying to accomplish? (Goal)	
By answering this question, you will develop your GOAL for improvement.	
Our goal is to: • Improve training on trauma informed care within the practice. ***This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.*** ***So, for this example, a better goal statement would be:*** **Our S.M.A.R.T. (Specific. Measurable. Achievable. Realistic.Timely) goal is to:** • Have 50% of the clinical practice team complete training on trauma informed care by 30th June.	
Q2. How will you know that a change is an improvement? (Measure)	
By answering this question, you will develop MEASURES to track the achievement of your goal. ***E.g. Track baseline measurement and compare results at the end of the improvement.***	
We will measure the percentage of practice team members who have completed training on trauma informed care. To do this we will: A) Identify the number of practice team members. B) Identify the number of practice team members who have completed training on trauma informed care. B divided by A x 100 produces the percentage of practice team members who have completed training on trauma informed care.	
Q3. What changes could we make that will lead to an improvement? (List your IDEAS)	
By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal. ***You may wish to BRAINSTORM ideas with members of our Practice Team.***	
Our ideas for change: 1. Identify practice team members who have not completed any training in relation to trauma informed care. 2. Identify where practice team members can complete training in relation to trauma informed care. 3. Source and provide endorsed education resources (in lunch rooms, etc). The team selects one idea to begin testing with a PDSA cycle.	

Note: Each new GOAL (1st Fundamental Question) will require a new MFI Guide

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA worksheet EXAMPLE

Step 2: The doing part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	**Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
Idea: Identify practice team members who have not completed any training in relation to trauma informed care. What: Mary will conduct a search on practice team members education records. Who: Practice Manager (Mary) When: Begin 20 May Where: at the practice. Prediction: 20% of the practice team members will have completed training in relation to trauma informed care. Data to be collected: Number of practice team members and the number of practice team members who have completed training in relation to trauma informed care.	
DO	**Who is going to do what? (Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*
To measure the outcome of the change, we will compare the percentage increase of the number of practice team members who have completed training in relation to trauma informed care.	
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
Completed 20 May – the receptionist contacted Brisbane South PHN to identify reputable organisations who provide training in relation to trauma informed care for practice team members. A total of 4 practice team members (15%) had completed trauma informed care training prior to the QI activity = 5% lower than predicted.	

ACT	Do you need to make changes to your original plan? (What next) OR Did everything go well?
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

1. Create a calendar prompt to check the number of team members with trauma informed care training on a six monthly basis.
2. Include in the new staff orientation checklist that new team members access trauma informed care training on commencement at the practice.
3. Ensure the clinical team know where to access trauma informed care training.
4. Remind the whole team that this is an area of focus for the practice.

Repeat Step 2 for other ideas – What idea will you test next?

MFI and PDSA worksheet template

Step 1: The thinking part - The 3 fundamental questions

Practice name:	Date:
Team member:	
Q1. What are we trying to accomplish?	**(Goal)**
By answering this question, you will develop your GOAL for improvement.	
Q2. How will you know that a change is an improvement?	**(Measure)**
By answering this question, you will develop MEASURES to track the achievement of your goal. ***E.g. Track baseline measurement and compare results at the end of the improvement.***	
3. What changes could we make that will lead to an improvement?	**(List your IDEAS)**
By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal. ***You may wish to BRAINSTORM ideas with members of our Practice Team.***	
Idea: Idea: Idea: Idea:	

Note: Each new GOAL (1st Fundamental Question) will require a new MFI plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

MFI and PDSA worksheet template

Step 2: The doing part - Plan, Do, Study, Act cycle

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data.	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
DO	**Who is going to do what? (Action)**
Run the test on a small scale.	*How will you measure the outcome of your change?*
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions.	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step.	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

Repeat Step 2 for other ideas - What idea will you test next?

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