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A Case for TIC:
A Complex Adaptive Systems Enquiry for Trauma Informed Care

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ABSTRACT

Trauma Informed Care (TIC) is an approach to human services based on the understanding that most people in contact with services are more likely to have experienced some level of trauma, adversity and loss and this understanding needs to be held by those involved so that it is may permeate service relationships and delivery. This article reviews TIC literature and introduces a case example outlining the successes and challenges of TIC implementation in practice, i.e. staff awareness, knowledge and skills, communication and quality of human interaction, wellbeing and resilience, organisational structures and artefact, measurement and monitoring for success. Insights from complexity and interpersonal neurobiology are interpreted in the context of facilitating TIC implementation, i.e. parallel safe-to-fail interventions, managing constraints and boundary conditions, monitoring change through trusted sensor networks, maintaining awareness development practices.

KEYWORDS

Complex Adaptive Systems, Complex Responsive Processes, Interpersonal Neurobiology, Trauma Informed Care

1. INTRODUCTION

The purpose of this paper is threefold: - review the concept of Trauma Informed Care (TIC) and identify challenges of implementation, as presented in the literature; - introduce experiences and learning from practice through a case example; - outline ontological and epistemological perspectives from complexity science and interpersonal neurobiology towards relevant action in facilitating TIC implementation.

2. TRAUMA INFORMED CARE – A VIEW FROM THE LITERATURE

The Trauma Informed Care (TIC) approach is based on the understanding that most people in contact with human services are more likely to have experienced some level of trauma, adversity and loss (Anda et al., 2006), and this understanding needs to be held by those involved so that it is may permeate service relationships and delivery (Fallot & Harris, 2001). It requires sustained system leadership

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and governance to address toxic stress in such organisations and a culture of open learning (Sandra L Bloom & Sreedhar, 2008). Paterson (2014) defines TIC as "a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development" (Paterson, 2014).

There are several published sets of trauma-informed principles to guide implementation efforts (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Jennings, 2004). Quadara and Hunter (2016) define the principles of TIC as:

- Having a sound argument of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and functioning;
- Ensuring that organisational, operational and direct service provision practices and procedures do not undermine and indeed promote the physical, psychological and emotional safety of consumers and survivors;
- Adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches;
- Recognising and being responsive to the lived, social and cultural contexts of consumers, which shape both their needs as well as recovery and healing pathways;
- Recognising the relational nature of both trauma and healing.

Yatchmenoff, Sundborg, and Davis (2017) argue that TIC principles fall into three domains: safety, empowerment and self-worth. TIC is a systems-wide endeavour, to change the organisation and all of its aspects to be oriented with trauma. This does not require the organisation or the people within it to provide the treatment or interventions that work on the symptoms of trauma (Quadara & Hunter, 2016).

Efforts to define TIC, outline its principles and generate buy-in require a focus on implementation (Miller & Najavits, 2012). Service providers are requesting concrete examples of what it means in practice, and are seeking the most effective strategies to make the changes required for implementation. However, as expressed by Yatchmenoff et al. (2017), despite an abundance of national centres, web-based resources, conferences, training opportunities and experts offering technical assistance or consultation, much of the dialogue regarding implementation remains academic, resting on principles and general guidelines.

3. TRAUMA INFORMED CARE IN MENTAL HEALTH SERVICES

It is known that people in contact with mental health services who have experienced sexual or physical abuse in childhood typically undergo longer psychiatric treatment and are admitted more frequently into hospitals, are prescribed more medication, more likely to self-harm and are more likely to die from suicide than those who have not experienced variations of childhood abuse (Read, Bentall, & Fosse, 2009). Survivors are often re-traumatised when in contact with mental health systems; this is due to the operating principles of coercion and control (S.L. Bloom & Farragher, 2011). Current services and supports that do not acknowledge the role of trauma in people's lives and fail to realise the need for safety, mutuality, collaboration, and empowerment will expect to see re-traumatisation, enforcing the need for survivors to seek other means to cope (Sweeney, Clement, Filson, & Kennedy, 2016).

Staff can encounter conflicts between their own personal and ethical codes of conduct whilst working in mental health systems, due to the policies, procedures and practices they may be required to perform (Sweeney et al., 2016). An example is given by Sweeney et al. (2016): 'The use of seclusion and restraint as an institutional practice erodes the very meaning of compassion and care, the primary reasons why most staff enter their chosen field.' The conflictions between job duties and personal moral code warrant chronic stress for staff, and they must learn and adapt. Coping strategies can