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Trauma-informed practice implementation pilot project in Victoria's mental health and wellbeing services

Evaluation report

November 2025



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Contents

Executive summary	iv
Introduction	1
Background and aims.....	1
Intended outcomes	1
Report purpose and audience.....	2
Participating services	2
Implementation approach	3
Project components	4
(1) Engage and Define	4
(2) Consult.....	6
(3) Analyse and prioritise	7
(4) Co-design process	9
(5) Support implementation.....	11
(6) Evaluate.....	13
Implications and recommendations	25
References	32
Glossary	34
Appendix 1 – Initial consultation questions	36
Appendix 2 – Code map from initial consultations	38
Appendix 3 – Description and list of TIP tools	39
Appendix 4 – Evaluation questions	42
Appendix 5 – Trauma-informed questions for service users	44

Executive summary

The *Trauma-informed Practice (TIP) Capability Pilot Project* was conducted across three Victorian mental health and wellbeing services (MHW services): the Brimbank Local, the Greater Geelong-Queenscliff Local, and the Women's Recovery Network's Hospital in the Home Program (Shepparton and Melbourne sites). These services are functionally distinct and came together for cross-sector partnership. The project aimed to strengthen TIP in these services through a collaborative, iterative approach to develop practical tools and resources and support the implementation of best practice. The pilot programs targeted key areas of individual practice, team culture, leadership, organisational systems and processes, with a focus on integrating clinical and lived experience approaches to care.

Project overview

Phoenix Australia- Centre for Posttraumatic Mental Health collaborated with these MHW services to co-design practical implementation resources and supports. These services have a strong foundation for trauma-informed service delivery and participated in the pilots to further embed trauma-informed practice.

The pilot programs involved extensive consultation to assess the strengths and gaps in trauma-informed service delivery with the participating services. Based on identified needs, a set of trauma-informed tools were co-designed and developed for workers, leaders, service users, their families and carers. The project provided implementation support for using the tools and making changes to organisational supports and service design. This created opportunities for ongoing feedback and future planning. The project included the following components:

- **Consultation:** In depth engagement with service users, carers, workers, and leaders to assess current strengths and gaps in trauma-informed service delivery.
- **Co-design:** Development of trauma-informed tools and resources tailored to organisational needs, involving community reference groups and working groups with diverse representation from all stakeholder groups.
- **Implementation Support:** Provision of workshops, action planning, and ongoing refinement of tools to support integration into daily practice.
- **Evaluation:** Assessment of the co-design process and perceptions of TIP implementation tools and future implementation needs.

The project employed an iterative approach, where feedback, development activities, and implementation were interconnected rather than linear. This allowed for continuous refinement and learning throughout the project.

Key findings

Overall, the process of consultation, co-design and implementation support was seen as beneficial and helped create TIP implementation tools that met the needs of participating MHW services and their workforces. The tools were seen as practical and impactful, and many workers and leaders were actively incorporating them into their practices, with the tools leading to conversations about trauma-informed care

throughout the project. This was despite communication challenges with workers not involved in the co-design process or difficulties in engaging some key staff in early stages of the project due to service-related demands. In more acute settings, there were additional challenges to implementation and participation in co-design, including engaging with staff across rotating shifts and the demands placed on small rural teams that faced difficulties in recruiting to new roles, as is often the case in rural settings.

Involving service users and community representatives was particularly valued and shaped the TIP implementation tools, ensuring that they were grounded in the experiences of people who use mental health and wellbeing services. Co-design with lived and living experience leaders and champions across many of the teams brought a strong lived experience lens to the implementation tools and supports. It also provided a truly multidisciplinary perspective on trauma-informed service delivery. In fact, collaboration across different disciplines and sharing of diverse perspectives during the project was seen as an important part of promoting a trauma-informed approach. It improved communications across teams about key aspects of care such as safe trauma disclosures, intake, and the management of risk. For one team, involving a representative from the local Aboriginal Community Controlled Health Organisation during the co-design and implementation process strengthened ongoing collaboration around trauma-informed practices and improving access to services for First Nation people.

The process offered opportunities for organisational learning beyond tool development, with value placed on reflective practice. A need for better vicarious trauma support and shared recovery approaches and a greater focus on dignity of risk approaches were of particular interest.

Implementation challenges included ongoing needs for training, leadership support, and system integration. The importance of addressing tensions between clinical and holistic care approaches during implementation of TIP was also recognised, along with the need for actively engaging service users and their family in planning and using their feedback more transparently to improve service delivery. Differences in service models, particularly between acute care service delivery and community-based MHW Locals, highlighted the importance of flexible, context-sensitive implementation strategies. The community mental health programs had more capacity to benefit from an ongoing, iterative collaborative process, mainly because the whole of the organisation was involved. Smaller, less resourced teams with a service delivery approach that includes immediate, crisis driven responses may require more contained implementation models and additional funding to engage the whole organisation and other services.

Recommendations

Table 1: Recommendations for Government

#	Recommendations for Government bodies
1	<p>Allocate dedicated funding for implementation</p> <p>Provide funding to MHW services for the implementation of trauma-informed practices, including for dedicated time to enable leaders and champions to promote TIP. Funding should also support the creation of reflective practice spaces within and across organisations. This can be supported using the tools developed during the pilots. Expert guidance for trauma-informed implementation is also important for the systematic roll out of TIP across services. This would be supported by the establishment of a state-wide trauma service with a core workforce capability support function as</p>

	recommended by the Victorian Royal Commission. Services in rural or remote locations should receive enough funding to have dedicated times or positions to support implementation, particularly if they have smaller teams as they face additional barriers with recruitment and meeting community needs.
2	<p>Work with services to ensure data and reporting requirements are aligned with trauma-informed principles</p> <p>Engage with MHW services and service user representatives to ensure data requirements and service design guidance actively promote trauma-informed principles for processes such as intake, obtaining service user feedback and service model reviews and updates.</p>
3	<p>Fund research on long-term uptake of trauma-informed practice</p> <p>Allocate funding for longitudinal studies on the impact of trauma-informed practices on both service user outcomes and worker wellbeing, using this research to continually refine and improve the approach at a state level.</p>
4	<p>Support services to establish a culturally safe and equitable service model</p> <p>Mainstream mental health services should be supported and funded to improve cross-sector collaboration to overcome barriers to engagement for people who have experienced trauma and don't access these services (e.g., area mental health services being supported to have more direct dialogue and referral processes with Aboriginal Controlled Community Health Organisations, family violence or migration services).</p> <p>TIP implementation should also involve adapting key practices to meet the needs of culturally diverse populations and be informed by culturally responsive models (e.g., the Balit Durn Durn Centre model of social and emotional wellbeing for First Nations people).</p>

Table 2: Recommendations for mental health and wellbeing services

#	Recommendations for mental health and wellbeing services
5	<p>Conduct an inclusive and systematic audit of practice</p> <p>It is recommended that services undertake a systematic audit of current practices (this can be done using the audit tool developed in this project). This process should include meaningful participation from service user representatives, frontline workers, and leaders to guide planning, support implementation, and foster shared ownership of planned improvements to support TIP. During this process identify and upskill "champions" to lead planned changes, this can include upskilling them in the use of TIP tools developed during this project.</p>
6	<p>Enable service user-centric planning</p> <p>Services should establish planning processes that put the perspectives of service user and their families at the centre of decisions. This includes adapting systems (e.g., planning forums, feedback mechanisms) to be more responsive to service-user feedback.</p>
7	<p>Ensure active leadership engagement and accountability</p> <p>Leaders should be involved from the outset of implementation planning and be provided with the necessary skills and support to champion TIP and address worker wellbeing. This includes</p>

	allocating dedicated time for TIP-related activities and having accountability measures (e.g., as part of an organisational audit of TIP or supervision).
8	Introduce TIP tools through a phased approach A clear roadmap should be developed to introduce the TIP tools into everyday practice.
9	Provide ongoing training and education Regular and potentially mandatory training should be implemented to ensure all staff have a strong understanding of key trauma-informed practices when first joining a service, when changing roles, and when being promoted. Training for workers should cover safe ways to engage with trauma narratives, manage distress and risk in a trauma-informed way, and vicarious trauma. Managers also need to be equipped to lead trauma-responsive services, provide opportunities for reflective practice, and address vicarious trauma.
10	Facilitate multidisciplinary learning Services should be resourced to create opportunities for cross-disciplinary learning and collaboration with other services. This will help promote a holistic, recovery-oriented approach to care that strengthens application of TIP across roles and services.
11	Ensure accessibility of TIP tools and integration into workflows TIP tools should be made easily accessible in both physical and digital formats and embedded within existing service workflows and models. Services are encouraged to use language and concepts in TIP tools to inform policy and service model reviews to ensure consistency and alignment.
12	Establish continuous evaluation and improvement processes Feedback mechanisms should be embedded into ongoing practice to evaluate the use and impact of TIP tools and organisational supports for trauma-informed service delivery should be reviewed on a regular basis using the audit tool to adapt support strategies as needed.

Conclusion

The pilot project demonstrated the value of collaborative, context-specific approaches to adapting trauma-informed language and principles as well as implementation support. The iterative nature of the project allowed for continuous learning and adaptation, ensuring that the resulting tools and processes were well-suited to the needs of MHW services. While the tools created offer a strong foundation, sustained implementation will require ongoing commitment, resources, and systemic support to embed trauma-informed care within MHW services. The pilot project's success in engaging a wide range of stakeholders throughout the process highlights the importance of inclusive, participatory approaches in developing effective trauma-informed practices.

Introduction

Background and aims

The Victorian Department of Health (DoH) and The Victoria Collaborative Centre for Mental Health and Wellbeing (VCCMHW) engaged Phoenix Australia – Centre for Posttraumatic Mental Health (Phoenix Australia) to facilitate an implementation pilot project aimed at strengthening trauma-informed practice (TIP) in Victorian mental health and wellbeing services (MHW services). These included two Mental Health and Wellbeing Locals (MHW Locals) and two Hospital in the Home (HiTH) programs offered through the Women’s Recovery Network (WREN) in Shepparton and Melbourne sites.

The project is aligned with recommendations of the *Royal Commission into Victoria’s Mental Health System* by supporting the mental health and wellbeing workforce to provide trauma-informed care to people who have experienced trauma. The project also aims to contribute to the implementation of *Our workforce, our future: A capability framework for Victoria’s mental health and wellbeing workforce* (Capability Framework) by providing recommendations and tools to improve workforce capability in trauma-informed care.

The services involved in the project provide an innovative service model that emphasises accessible, collaborative and trauma-informed care. During the pilot, participating services had the opportunity to operationalise TIP within their context and contribute to the development of tools and processes that support the systematic adoption of TIP.

The pilot project targeted key areas of individual practice, team culture, leadership, organisational systems and processes, with a focus on integrating clinical and lived experience approaches to care. By operationalising trauma-informed principles, the project sought to provide practical solutions for day-to-day issues faced by the service.

Intended outcomes

The intended outcomes from this project are to:

- Collaboratively operationalise TIP, ensuring the approach fits with the MHW services’ approach to service delivery, the needs of the community they serve, and aligns with Victoria’s *Capability Framework* and Royal Commission’s recommendations.
- Develop a set of co-designed practical tools and resources to support TIP in MHW services. These tools can be used to guide everyday work, reflect as a team, and provide information to leaders and service users.
- Support services to implement the tools and identify future implementation activities.
- Use findings from the pilot project to inform future implementation supports for services using the tools and wanting to improve their service delivery for communities affected by trauma.

Report purpose and audience

This report summarises the activities conducted as part of the pilot project, as well as an evaluation of the co-design, implementation, and future support needs for TIP tools. This report is intended for the VCCMHW, mental health and wellbeing services, and is also publicly available.

Participating services

Phoenix Australia collaborated with four mental health services across metropolitan and regional Victoria:

- The Mental Health and Wellbeing Local in Brimbank (Brimbank Local),
- The Mental Health and Wellbeing Local in Greater Geelong-Queenscliff (GGQ Local)
- Two Hospital in the Home (HiTH) programs delivered through WREN in Melbourne and Shepparton

Both Locals provide services to people aged 26 years or older experiencing mental health, wellbeing, and/or substance use concerns. The Locals are government funded, free to access, and do not require referrals. The Brimbank Local is delivered by cohealth in partnership with Clarity Health Care and the University of Melbourne. The GGQ Local is delivered by Barwon Health, Wellways, Erhmha365, and Wathaurong Aboriginal Co-operative. All consortium members were invited in participating in the pilot unless not directly involved in service delivery.

The WREN HiTH programs provide services to people who identify as women, aged 18 years and over who experience complex mental health issues, often related to, or exacerbated by, experiences of trauma and violence. The programs often support individuals with acute needs and work to keep them at home and out of hospital. They are government funded, free to access and require a referral. WREN services are provided by a consortium that includes Alfred Health, Goulburn Valley Health and Ramsay Health Care.

In Shepparton, the Rumbalara Aboriginal Co-operative and local organisations supporting refugees and asylum seekers, including Foundation House and Primary Care Connect, participated in early consultations about community needs. A Rumbalara representative went on to participate in co-design and implementation support activity alongside The Shepparton HiTH team.



Implementation approach

The design of the pilot project drew from a range of implementation models. It was informed by the Consolidated Framework for Implementation Research (CFIR) which outlines the settings, behaviours, cultures, systems and interventions that need to be considered to create systemic and sustainable practice change (Damschroder et al., 2022). Specifically, our approach focussed on the use of collaborative adaptation models to support the adoption of trauma-informed practices.

High levels of collaboration have been associated with sustained adoption (Green et al., 2016; Beidas et al., 2016). Adapting best practice recommendations to meet the needs of the local context and taking a collaborative approach to designing practice change solutions has been seen as an important area of research (Geng, Mody & Powel, 2023) and shown to contribute to sustainable practice improvements (Stirman et al., 2012). There are a range of approaches that have been developed to work collaboratively with organisations and communities to adapt best practice to a particular context to ensure feasibility (Chambers, 2024) and equity (Gaias et al., 2022; Lau, Huey & Baumann, 2023). Implementation assessment frameworks have now been developed or been revised to capture adaptation and the dynamic needs of organisations and complex systems (Aschbrenner et al., 2025; Shelton, Chambers & Glasgow, 2020; Wiltsey-Stirman, Baumann & Miller 2019).

Adaptation involves collaboratively designing solutions with both staff and service users to adapt best practice and implementation activities to the needs of the organisation, its individual workers and the community it serves. Solutions designed with stakeholders are refined iteratively based on data and ongoing feedback. Critical to this is ensuring that all stakeholders' needs and views are included in the process, that adaptations are tracked and documented, and that ongoing feedback is used to monitor the effectiveness of the implementation and any adaptations made.

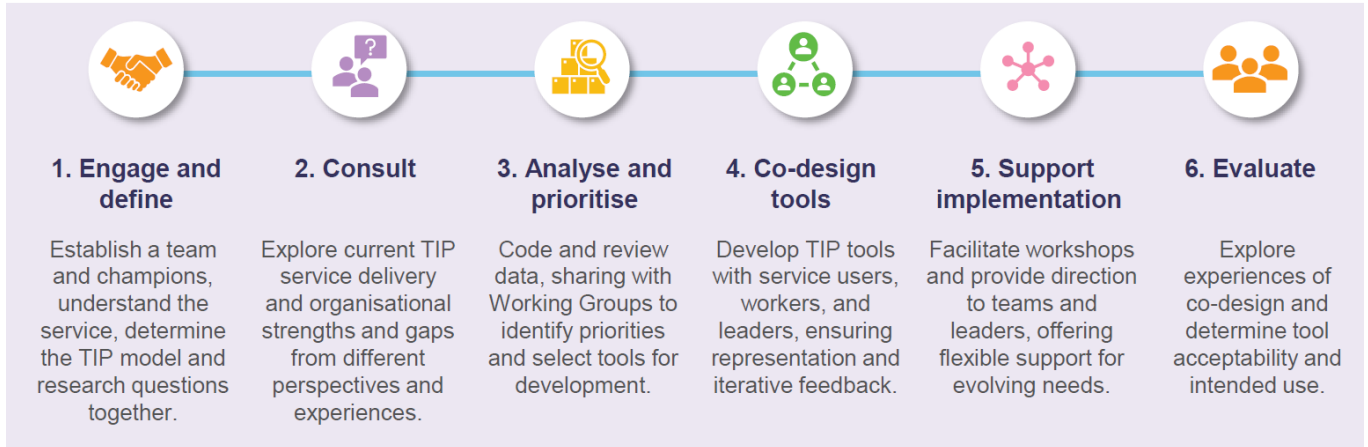
These approaches to implementation often include co-design processes to ensure equity, shared power and transparency, key values in trauma-informed practice (e.g., Stockton et al. 2024). Facilitation plays a key role in this and the project included inclusive facilitated sessions that promoted shared power and cross-disciplinary and organisational partnerships (Metz, Louison, Ward, & Burke, 2017).

The project also comes under the banner of participatory action research (PAR). PAR is carried out in the field to meet the needs of a particular community or organisation. PAR is not just about enquiry and gathering data: its purpose is to enable action and change (Baum, MacDougall & Smith, 2006). It involves testing ideas in practice as a means of increasing knowledge and creating improvements in practice. PAR proceeds in iterative steps consisting of planning, action, and evaluation. Data obtained during this process provides a basis for further planning of actions.

Project components

The project ran from March 2024 to October 2025 and included several components as outlined in Figure 1.

Figure 1: The six project components



(1) Engage and Define

Initial engagement and planning

The project commenced with a period of collaborative planning with the four MHW services. This included identifying suitable individuals responsible for the project, agreeing on project design, timelines, and developing the approach to engaging workers, leadership, service users, their families and carers in the project.

Research ethics approval was obtained for each of the MHW services through the Human Research Ethics Committees (HREC) of the University of Melbourne, the ethics advisory group (HEAG) from cohealth (Brimbank Local), the HREC from Barwon Health (GGQ Local), and the Alfred Hospital Ethics Committee (WREN, primary site) alongside research governance approval from Ramsay Health Care (WREN, Albert Road site) and Goulburn Valley Health (WREN, Shepparton site).

Working Groups

Separate Working Groups were set up for each of the MHW services to participate in the design of tools and contribute to implementation planning and rollout. The Working Groups provided guidance on practical issues, assisted with decision-making on priorities for tool development and implementation. Working Group members also had responsibility for reviewing materials and providing ongoing feedback throughout the project. Specifically, the Working Groups:

- Provided feedback in preparation for the initial consultation, including contribute to design of evaluation questions, and support the recruitment of participants.

- Contributed to operationalising TIP within the context of their service system.
- Identify and co-design tools that will support trauma-informed service delivery.
- Oversee implementation of tools through regular meetings.

The Brimbank Local Working Group included representatives from the peer and clinical workforce, executive, operational and practice excellence leadership, and Phoenix Australia. The Brimbank Local Community Reference Group (CRG) was also involved in providing feedback about service priorities and engaged in tool development. This group of service users and carers represented the wide range of communities accessing the service (e.g., diverse cultural groups, including migrants and refugees, and a range of experiences with mental health issues, trauma and adversity). The membership of the Working Group changed significantly half-way through the project with two leaders leaving the organisation and a change in executive leadership at the Brimbank Local.

The GGQ Local Working Group included service users, carers, peer and clinical workers, executive and operational managers, and Phoenix Australia. There was flexibility in members attending meetings when available and providing out-of-session input.

For HiTH programs, an executive oversight reference group brought together executive leaders across the consortium agencies delivering WREN services. A researcher specialising in participatory research methods focused on health and social care in partnership with marginalised communities and health and social care professionals also participated in the reference group. The HiTH working groups included most team members delivering HiTH programs in Shepperton and Melbourne. Consumer and carer representatives set directions for the project, identified priorities for TIP implementation and tool development and voted on tools across 3 co-design workshops that brought them together with HiTH staff. In both locations, teams were quite small and membership varied depending on staff availability, with representative from peer and clinical workforces and operational leadership invited to participate. In Shepperton, a representative of a local Aboriginal Community Controlled Health Organisation was part of the working group.

Table 3 outlines the total number of Working Group members according to role type across the MHW services, and CRG participants at the Brimbank Local.

Table 3: Number of members participating in Working Group/Community Reference Group meetings

Member group/role	Brimbank Local	GGQ Local	HiTH
Service users and carers	Up to 8 as part of the community reference group	3	5 – across three co-design workshops
Lived Experience/ Peer Support workers	3	3	2
Mental Health, allied health and Alcohol and Other Drugs workers	2	2	6 [#]
Team leads and managers*	6 (noting two left the organisation and one moved to an executive position and were replaced) [#]	6	2
External experts in TIP or collaborators	2	2	3

Note: *Leads/managers held positions in peer support, clinical, education, quality assurance, and service operations.
#Leadership changes meant that for about 6 months, the Brimbank Local Working Group operated without clinical or peer practice leads but senior workers who were seen as champions of TIP were invited to join alongside operational managers. In the Melbourne HiTH team, given shift work, while senior workers and the team leader remained constant, staff rotated through sessions leading to less consistent engagement in group, particularly during implementation support phase.

(2) Consult

Aim and research question

Initial consultations aimed to identify strengths and gaps in current service delivery at the MHW services in the context of TIP. Consultations sought to answer the following research question:

“In what ways are the experiences of service users, carers, community members, and workers consistent and inconsistent with TIP?”

Participants and data collection

Across all MHW services, workers, leaders, service users and carers were invited to participate in an initial set of consultations (interviews and focus groups). They were asked about how their service currently supports people affected by trauma and their experiences of the care being provided at their respective service. They were also asked to provide any ideas they had for improving the service for people who have experienced trauma as well as worker wellbeing. See Appendix 1 for outline of the initial consultation questions.

As shown in Table 4, focus groups and interviews were facilitated with workers ($n = 29$), leaders ($n = 14$), and service users and carers ($n = 30$) across all MHW services. For workers and leaders, there was representation from those in clinical and lived experience roles.

Table 4: Outline of consultation sessions and participation

Participant type	Brimbank Local	GGQ Local	HiTH
Service users and carers	8 individual interviews and 3 focus groups (15 participants) (total of 23 participants)	4 individual interviews	3 individual interviews
Workers	4 individual interviews and 1 focus group of 9 participants (total of 13 participants)	1 focus group (6 participants)	2 individual interviews and 1 focus group of 8 participants (total of 10 participants)
Leadership	7 individual interviews	4 individual interviews	4 individual interviews

(3) Analyse and prioritise

Collaborative approach to data analysis

A thematic analysis was performed on transcripts of focus groups and interviews to identify topics that were expressed frequently across the service user, carer, community member, worker and leadership groups. This allowed for diversity of experiences to be distilled in actionable statements about perceived strengths, gaps and priorities for improving practice.

Thematic analysis was suitable for this project, as it has a strong focus on subjective experience and individual sense-making, supporting the identification of potential needs, gaps and experiences (Guest, McQueen, & Namey, 2012).

We used a hybrid approach to analysis where we looked at emerging themes in the data (data-driven codes obtained through an inductive process) but also used coding categories (called *a priori* codes) that were derived from the trauma-informed literature, expert consensus and, importantly from the input of the working groups.

The Working Groups had input in refining the coding categories and worked with the Phoenix Australia project team to produce a coding map that captured the different elements of TIP. They did this while having discussions on how trauma-informed principles could be operationalised in the context of their service. See Appendix 2 for the coding map.

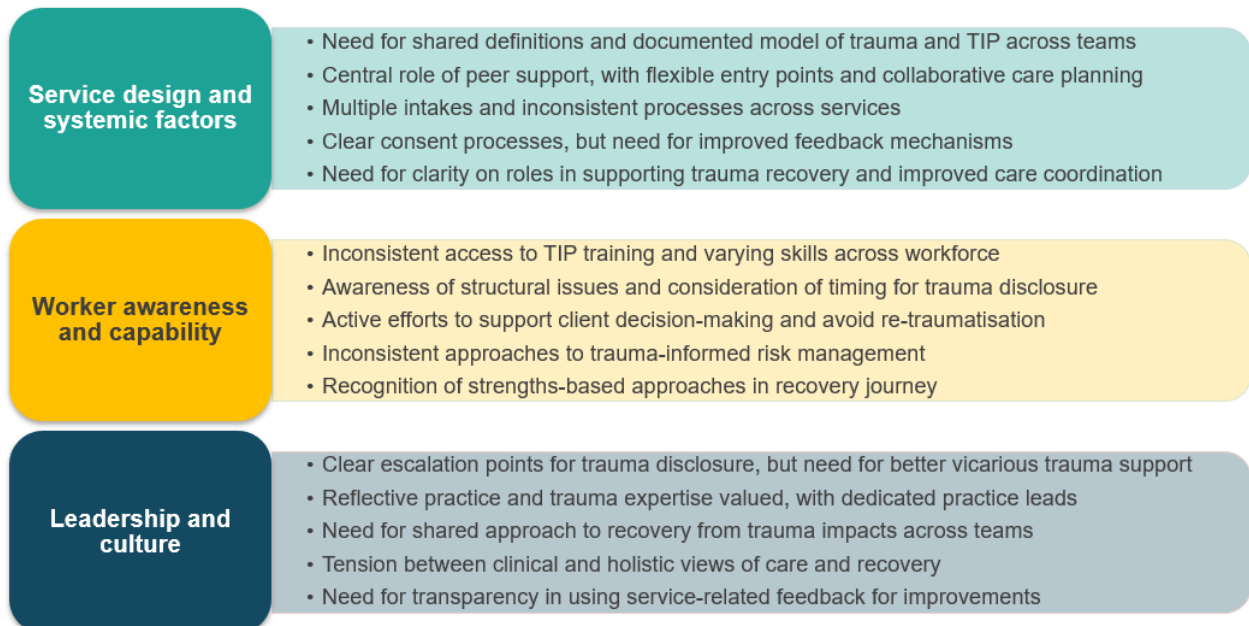
Findings

Participants reported strengths and areas for improvements across 29 trauma-informed areas of practice. Their responses fell across three broad groups of factors that are critical to service delivery:

1. **Service design and systemic factors:** This includes trauma-informed elements of the service model, including staffing, guidance and procedures put in place to promote practice that is responsive to people who are affected by trauma (e.g., trauma-informed aspects of assessment, support provision, care-coordination, and referrals). Service design can also be influenced by systemic factors such as funding models and interagency relationships. Day-to-day tools that support the application of trauma-informed aspects of the service model such as assessment or note-taking forms are also included.
2. **Worker awareness and capability:** This includes practices and systems that support worker awareness and ability to provide a trauma-informed service.
3. **Leadership and culture:** This includes leadership supports for trauma-informed practice and culture, and team and organisational practices and processes that create and maintain a culture that facilitates trauma-informed service delivery.

Figure 2 provides a summary of key themes that emerged from the consultations.

Figure 2: Sample of key themes from pre-implementation consultations with MHW services



(4) Co-design process

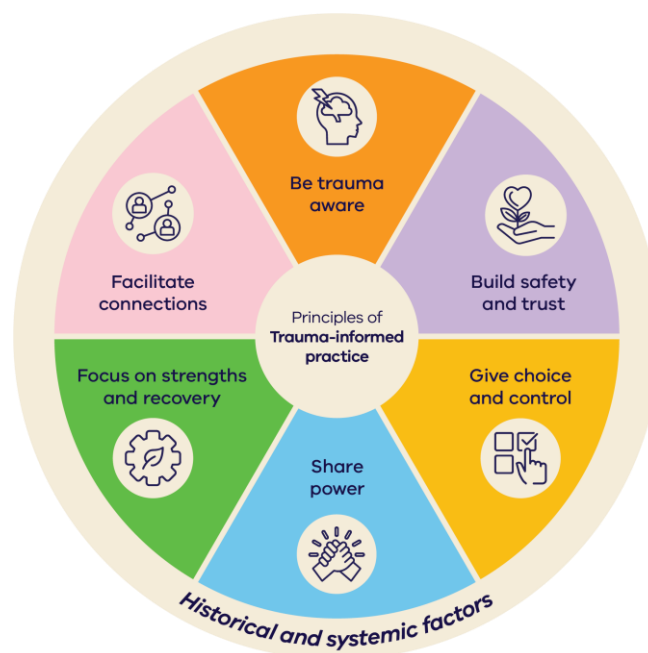
Agreeing on a trauma-informed model of practice

The co-design process started with the Working Group discussing the principles of TIP and agreeing on how they would operationalise each principle (see previous section on collaborative approach to analysis of consultation findings). This led to an agreed model to trauma-informed service delivery. The concepts that were presented to the Working Groups to stimulate discussion and arrive at a consensus were based on a range of sources including:

- The principles of trauma-informed practice in the *Victorian Mental Health and Wellbeing Workforce Capability Framework*. This was the most critical to guiding discussions as the operationalised model in this project needed to support the implementation of these principles
- The Phoenix Australia framework which is largely based on Harris and Fallof's (2001) original trauma-informed principles but with a greater focus on recovery
- The Substance Abuse and Mental Health Services Administration's (SAMSHA; 2013) model of trauma-informed care which highlights the importance of peer work and sharing power
- The trauma and violence informed approach (Varcoe et al. 2016) which highlights the role of gender, disadvantage and discrimination in maintaining trauma in society and service systems.

Figure 3 provides an illustration of the model adopted across the four pilot program sites.

Figure 3: Trauma-informed practice model based on consultation and co-design process



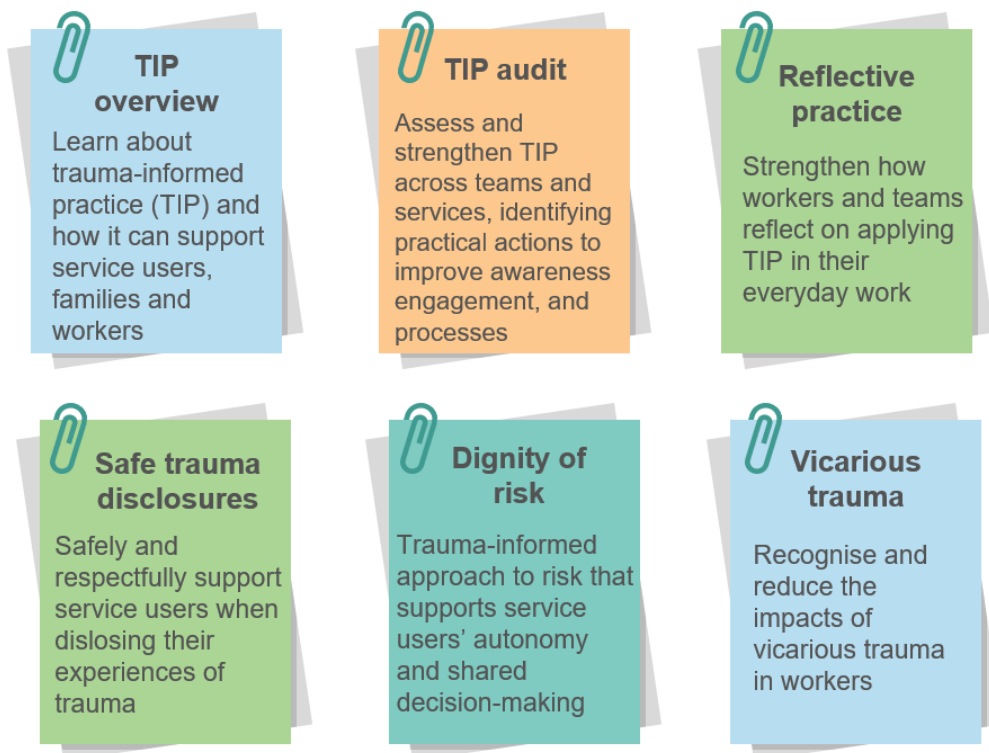
Prioritising needs and selecting tools

The selection and development of resources and tools to help embed trauma-informed practices was based on the feedback obtained during the initial consultation process. Key themes and gaps were presented to the Working Groups, with discussion and activities to identify priority areas of need. Working Group members across all MWH services then voted on a list of tools to select the top six most important ones and had the opportunity to add additional suggestions. During the prioritisation and tool selection process, Padlet boards (online virtual bulletin boards) were used as a communication tool to summarise consultation findings, Working Group decisions, share relevant information, and allow members to vote and add comments anonymously.

Once the tools were selected, Phoenix Australia prepared a proposed overview of each tool and a number of questions for co-design input and direction. Through Working Groups discussions and Padlet feedback, the aims, audience, format, proposed content and best way to use in practice was agreed to. There were several rounds of review, input and revisions to ensure the agreed tools were fit for purpose at each MHW service.

It was agreed to focus on toolkits for six priority topics that include a set of resources that can be used flexibly by individual workers, teams or operational leaders or practice leads. See Figure 4 and Appendix 3 for a list of the six priority topics. The tools aimed at providing guidance, promoting shared language but also offer practical ways to make decisions, reflect on practice or have planned discussions with service users, their families or carers.

Figure 4: Overview of sets of tools to promote trauma-informed practice



The idea of a manual or having complex online forms or tools were discarded as they would diminish accessibility and likelihood that resources would be used. Consideration was given to what supports a range of learning styles and needs, with tools encouraging:

1. **Knowledge acquisition:** Provide educational information (e.g., handouts with definitions, examples of best practice and tips to enhance day-to-day practice)
2. **Application of practice:** Offer resources that encourage integration of TIP approaches into daily practice (e.g., worksheets, checklists, forms to fill out together with service users)
3. **Focus on lived experience:** Include examples of service users and carers' experience of service delivery as well as conveying what practice feels and looks like from a worker's perspective (e.g., quotes, case examples).

Across all phases, lived experience experts, service users and carers were involved in the co-design process, and there was agreement that the voice of service users remain central throughout all tools. At the Brimbank Local, the Community reference Group (CRG) provided guidance on the tools, developing personas and case examples used across resources to represent the experience of service users, their families and carers. The CRG also reviewed a set of tools created for service users, their families and carers. For the WREN services, three co-design workshops conducted with members of their lived experience advisory group and HiTH workers set priorities for the tools from a service user and carer perspective.

Feedback obtained from Working Group members and workers during the development and implementation support phases of the project was incorporated in the tools. A graphic designer was engaged for professional design of the tools, maintaining the agreed style chosen by the Working Groups whilst also incorporating colours and branding from the DoH and the VCCMHW. During this stage of development, accessibility was a key consideration with a design that had free white spaces and was not text heavy. The language used was free of jargon or statements that would be difficult to translate in another language.

(5) Support implementation

Workshops and support activities

A set of introductory and follow-up workshops were provided at each MWH service to support implementation. The introductory workshops were delivered to workers and leaders and provided an overview of the TIP tools and how to use them. Ahead of the workshops, PDF copies of the tools were shared with attendees, as well as printed copies during the session. Additional implementation sessions were facilitated as requested and delivered in a flexible manner depending on the organisational need. The follow-up workshops provided a chance to talk through any questions workers and leaders had with understanding of using the tools and provided opportunities to plan next steps in implementation supports. Some sessions provided an opportunity to talk through specific trauma-informed practices and supporting tools while others focussed on actions that executive managers, team leaders or quality assurance managers could take to support TIP.



Tables 5a and 5b outlines the workshops and activities facilitated across all MHW services. There was representation from workers and leaders in clinical, operational and lived experience roles.

Table 5a: Implementation workshops and participation for MHW Locals

Workshop	Brimbank Local	GGQ Local
Introduction workshops	1 workshop with 6 leaders 1 workshop with around 30 workers	1 workshop with 9 leaders 2 workshops with 23 workers
Follow-up sessions	1 workshop with 8 leaders 1 workshop with 10 workers	1 workshop with 19 workers 1 workshop with 9 leaders
Follow-up targeted workshops	1 workshop with 3 leaders (orientation for new practice leads) 1 workshop with 5 leaders (managers & practice leads) 1 session with executive lead	1 workshop with 5 team leaders and coordinators 1 session with QA leader regarding audit tool

Table 5b: Implementation workshops and participation for WREN HiTH programs

Activity type	Detail and participant numbers
Workshops to support HiTH Shepparton (leaders, senior worker and workers all invited to participate together as small team working together).	1 introductory workshop with 5 workers. 1 follow-up workshop with 1 leader and 4 workers.
Workshops for HiTH Melbourne (leaders, senior worker and workers all invited to participate together as small team working together).	3 consecutive workshops focussing on 2 or 3 tools at a time with follow-up action to support implementation. Workshops had 6 (including 1 leader), 7 (including 2 leaders) and 5 (including 1 leader) participants, respectively.
Additional leadership engagement across both sites.	Multiple 1:1 discussions held as required to plan engagement, provide reminders, and discuss implementation priorities and actions.
Skills for Life Adjustment and Resilience (SOLAR) training and supervision across both sites.	Training delivered across 2 half-day workshops for up to 19 participants (mixture of workers and leaders) each. 8 supervision sessions offered with low and irregular attendance, with between 3 and 6 attendees per session, over time. The Melbourne team disengaged after 2 sessions due to lack of service users identified as suitable for SOLAR.

HiTH = Hospital in the Home; SOLAR = Skills for Life Adjustment and Resilience

Phoenix Australia developed a tailored manual for an evidence-based low-intensity, skills-based brief intervention called Skills for Life Adjustment and Resilience (SOLAR; Cowlshaw et al., 2023; Gibson et al., 2021; O'Donnell et al., 2020), and provided training and supervision to HiTH workers to support their adoption and roll-out of this intervention. SOLAR can be used with service users, their carers and family members as an additional support to address trauma-related mental health concerns and recovery needs in a structured way. The implementation of SOLAR was intended to support team-based delivery wherever possible. Team members could deliver modules separately when providing home-based support. An advantage of the use of SOLAR is that it can be delivered by any profession without requiring clinical expertise. As outlined in Table 5b, Phoenix Australia delivered training that provided a comprehensive overview of the SOLAR modules, with follow-up supervision sessions offered to discuss practical implementation strategies within day-to-day service delivery.

Action Logs were developed for each MHW service to support the implementation and rollout of the TIP tools. Ideas and suggestions raised throughout implementation workshops were recorded as key actions and organised according to topic areas. The Action Log was provided in an online Padlet board, so it could be accessible for all leaders and workers. It also enabled them to provide comments, make suggestions or vote on top priorities. The Action Logs were updated after each workshop and then handed over to the MHW service's leadership team to continue working on. One service elected to use emails rather than Padlet for this process. Planning workshops were provided for groups as needed. For example, two planning workshops expanding on Padlet action logs and previous workshops were provided to the new leadership team at the Brimbank Local.

(6) Evaluate

Aims and research questions

A brief evaluation sought to examine MHW services' workers and leaders' experience of being involved in the development of the tools, and their views about the way in which the tools fit within current service delivery. The evaluation also examined what factors influenced the adoption of the tools and recommended trauma-informed practices in day-to-day service delivery, and what future supports the MHW services needed to continue to implement TIP.

The evaluation aimed to answer the following research questions:

1. How did the co-design process help develop tools that were useful?
2. In what ways did the co-design process help or hinder implementation of the tools?
3. How did the process lead to a set of tools that were perceived as usable and relevant?
4. How did the project lead to an intent to use the tools?
5. What future supports are still required to implement the tools?

Participants and data collection

Workers and leaders from each of the MHW services were invited to participate in focus groups and interviews to evaluate the pilot. As shown in Table 6, 18 workers and 12 leaders provided their views about the co-design process, implementation support and tools. See Appendix 4 for outline of evaluation questions.

Table 6: Outline of participation in evaluation focus groups and interviews

Participant type	Brimbank Local	GGQ Local	HiTH
Workers	Individual interviews (3 participants)	1 focus group (7 participants)	4 individual interviews 1 combined worker/leader focus group (4 worker participants)
Leadership	Individual interviews (2 participants)	1 focus group (8 participants)	1 individual interview 1 combined worker/leader focus group (1 leader participant)

Analytic approach

Data were themed using a deductive orientation. This means that broad themes were pre-determined to answer the research questions. We remained open to inductive analysis, which allowed for identification of novel ideas.

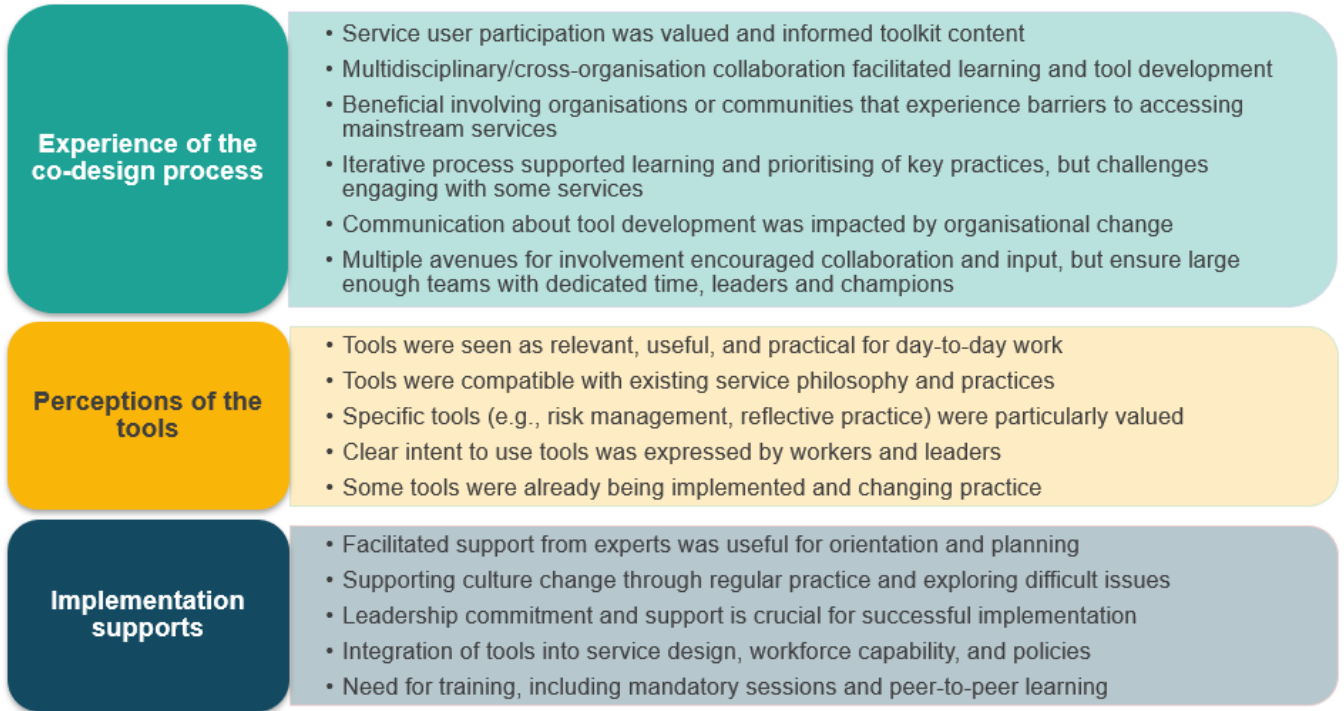
Results

Overview

The evaluation aimed primarily to understand how the co-design process and engagement in implementation supports contributed to (1) developing tools that workers and leaders saw as useful, relevant, and compatible with their service philosophy, and (2) generating intent to use the tools. It also aimed to identify future implementation supports, that is, supports required for people to use the tools in an ongoing, sustainable way.

In order to achieve the aims, evaluation consultations involved exploration of participants' experiences of the co-design process (reported in Part I), perceptions of the co-designed tools (reported in Part II), and support needs for implementation (reported in Part III). Figure 5 provides a brief summary of key themes that emerged from the evaluation consultations.

Figure 5: Key themes from the evaluation consultations with MHW services



Part I: Experience of the co-design process

Participants were asked about their experience of co-design and they described a range of factors that facilitated the development of tools that met their needs and were tailored to their organisational context. Key enabling aspects of the process included involving service users and community representatives, providing multiple avenues for worker involvement, and a focus on identifying practical needs and systems issues. The main themes included:

1. The participation of services users was valued and informed toolkit content

Participants recognised the value of involving service users and community representatives in identifying gaps in practice and shaping their understanding of what was needed for trauma-informed service delivery. This was despite some challenges in initial recruitment of service user representatives for one of the organisations involved. Engagement with service users led to practical outcomes such as co-designing personas (or case studies) with service user representatives to ensure the experience of people affected by trauma was central in the tools aimed at worker and leadership. Another practical outcome was having service user and carer resources in the toolkits that promoted a shared definition of trauma and trauma-informed care with service providers.

“I think for me, a real highlight was having it presented at the Community Reference Group. Because at the end of the day, their voice is really important, and we want them to see the things that we often forget to share. So having them be able to see the tools and look at the tools and share their thoughts on that was really great” (Leader)

2. Opportunities for multidisciplinary and cross-organisation collaboration facilitated learning and tool development

Participants also noted that having a range of opportunities for involvement in the consultation and co-design process encouraged multidisciplinary input and collaboration. This led to sharing knowledge and values across disciplines and developing practical solutions to promote TIP. For one team, there were some challenges noted in collaborating with lived experience colleagues to set priorities and develop tools. This was due to their service model including lived experience workers as advisers rather than being fully integrated in day-to-day service delivery and separating lived experience interventions from clinical interventions. It meant that they did not participate in meetings and had a strong focus on intentional peer support models and therefore saw some components of the project such as the SOLAR program or safe disclosure tools as separate from their role.

“It’s good to get people from different backgrounds because, for me, I remember sitting in that room thinking, you know, I’ve never been exposed to this school of thinking before, and that kind of practice experience.” (Worker)

“Looking at these models or these tools from a lived experience framework perspective. Other teams with lived experience...they’re like, no, you can’t because that’s not in their job role, 100% that’s not their job role, but you can provide this care and these tools from a lived experience perspective based on your own skills. ... Like yes, I understand it might be completely outside of scope of practice, providing interventions but it doesn’t stop you from partaking in those interventions from a lived experience perspective.” (Worker)

“I personally feel like it was a very collaborative experience. ... I felt like we sometimes had many people online at once and I was amazed at the ability that we were able to hear each other at those different points in time from such different perspectives and locations” (Worker)

For two of the sites, participants noted that the pilot encouraged communication and collaboration across organisations. These organisations were either part of their consortium but had a different culture and approach to trauma-informed service delivery, or delivered services to communities that experienced barriers to engagement. For example, as part of the pilot, one of the participating services included a representative of the local Aboriginal Community Controlled Health Organisation on their working group and this collaboration not only informed the design of the trauma-informed implementation tools, but also led to a more direct intake route for First Nations people seeking help.

“Because [in] area mental health, triage is like their gatekeeper. So you know, as a clinician, if you think: ‘Oh, this person really suit [this program] ... So ... they were like, ‘Oh no, we can’t change it’. I was like, ‘no, maybe.. we can see how it will evolve’. And it has evolved because now [they] said I can direct refer to them...So, yeah that’s great. It’s helped to strengthen those relationships ... the project definitely helped build those bridges and allow for direct referrals...” (Worker from partner organisation in community)

3. Iterative process supported learning and prioritising of key practices

Participants noted that the iterative and collaborative nature of the process led to learning and refining their approach to TIP and implementation. The timing of the co-design process meant that it could influence wider organisational planning such as the review of their service model or documenting their approach to staff training and supervision.

“It was a really collaborative process, incredibly collaborative. I really liked that it was a phased approach, so that we kept building on information that had been consulted on or collaborated on, if you like, from previous sessions that we had and there was a real kind of testing and feedback, sort of refinement process happening as well” (Leader)

While participants in more acute service delivery settings described learning from the co-design process and appreciated how it encouraged them to go from high level principles to practical applications, they found engaging in an iterative process more challenging.

“It started to kind of make more sense and then you just had a really nice process to figure out how to select tools. Like it was really cool that you gave us lots of different ideas and then we got to, you know, vote or nominate which ones we thought might be helpful. It started to become more tangible... I think that, often, the trickiness is between [being] caught up in the really tangible day-to-day, but being able to help us kind of step by step go from the really theoretical ... to a really practical outcome.” (Worker)

The ability to engage in iterative co-design and implementation was more challenging because of limited resourcing or a culture that prioritised service delivery and responsiveness, with participants noting that the process would have benefitted more from leadership support and dedicated time for leaders and workers to come together as a team and reflect. One rural service found the iterative process lost momentum due to the difficulties in replacing lost positions, roles on rotation (like psychiatry registrars) or having a small team where team members could not be replaced if someone went on leave or was ill.

“... I think by the nature of our work, it's very dynamic. We're rushing here, rushing there and then when we sit down it's really hard to bring us all together...” (Leader)

“There should have been more planning on our part.....I think it's getting the buy-in from leadership and then having that sort of reflected in the in the rosters and the shifts that it's not just about who's on the day and just carving out X amount of hours for someone to participate..” (Worker)

4. Communication and awareness of tool-development among workers impacted by organisational change

While the co-design process created strong buy-in and awareness for leaders and champions, this was more variable for workers not directly involved in the co-design process. This was mainly due to internal communications being impacted by extensive change across organisations that were new and still building their service. For example, new team leaders in one MHW Local were unable to fully participate in the co-design due to the demands of establishing a new role and were, as a result, not as confident to use the tools developed. In another MHW Local, a new leadership team had to be oriented to the project to be able to support effective communication and use of the tools.

Some newer staff also reported being less aware of the co-design process and the organisation's plans to use the tools. In addition, the project required time for leaders and champions to support and promote the project. While these champions actively supported all aspects of the project because they saw the benefit, they also sometimes struggled with the amount of time required when no dedicated funding or time was allocated for them to take on this responsibility. Despite these challenges, many described early engagement with draft tools and conversations about TIP held among staff due to the co-design process.

Part II: Perceptions of the tools

Participants were asked about their perception of the tools, including their relevance and their intent to use them. Overall, they were satisfied with the tools, finding them practical and relevant to their day-to-day work. They provided many examples how the tools impacted on their practice and were starting to be used.

5. Tools are relevant, useful, and practical

The tools were generally positively received and perceived to be aligned with the values of their service, with many participants talking about the relevance of the tools in their day-to-day work and their practicality. Trauma-informed approaches to risk, reflective practice, and vicarious trauma tools were seen as particularly relevant to improving practice.

“I did find the scripts, like the tools that provided some prompting of scripts was helpful...when you're ending a session and how that can really have a lasting impact on people...” (Worker)

“The dignity of risk tool has been used individually and with the team... when exploring suicide risk and safety planning and how to go about that in a trauma informed way. It's been really beneficial for a couple of staff who are working with people with long standing, chronic suicidality and how they felt around supporting people around that” (Leader)

“The vicarious trauma was really impactful for me and I'm sure for other people as well. I hadn't really considered all the multitude of factors that kind of contribute towards burnout” (Worker)

Participants also noted that tools were flexible, being useful in various contexts, including team meetings and individual or group reflection, for example,

“I want [the reflective practice tool] to be an option in supervision...to go into supervision and they know how to use the tool and I don't need to explain where it came from...To have it as part of a debrief process would be cool...sometimes we'll do the initial debrief and then I can imagine having the space to then reflect, and then coming back with using the personal reflection could be really fruitful learning...having the choice to be able to use them like this...we can use it when we want to” (Worker).

The representative of the Aboriginal Community Controlled Health Organisation partnering with one of the pilot sites in this project stated that both the process of developing the TIP implementation tools and the tools themselves were culturally responsive, as they had the potential to empower their own workers to deliver trauma-informed services with practical resources.

“I think mostly throughout the start I've felt that it's been culturally safe and you know, that makes a big difference in building trust ... [we are] an Aboriginal Community Controlled Health Organisation ... instead of going, oh, we're chucking money at [services] that a majority of the consumers I talk to, they won't call these mobs. They won't. ... So something practical that builds up workers' strengths and gives them the education and knowledge which they can pass like that is so important...” (Worker from partner organisation in community)

6. Workers and leaders intend to use the tools and are trialling ways to use them

Participating leaders and workers consistently stated that they intended to use the tools. In fact, many described how the tools were already being implemented and were starting to change practice at the time of the evaluation:

“I think it's definitely being implemented. I can hear it in the way we speak to consumers, in the messaging that we have in regards to sharing power.” (Worker)

In fact, organisations spoke about sharing tools and lessons learned with their networks and other organisations. The ACCO who partnered with one of the pilot sites during the project also discussed developing their own internal working group to roll out the TIP tools and SOLAR program in their service, and further adapt them to their cultural context. They also mentioned how senior clinicians from the pilot site were providing support and advice to do this.

Many described how the iterative and collaborative approach to the project led to buy in from workers, particularly those with a lived and living experience or peer support role.

“I think being involved in this project in itself has spawned a lot of conversations to start talking more or even deepen the knowledge of what trauma-informed care is. I think people know what the word is, but do... they know why each principle matters and what it is?” (Leader)

“I'm encouraged by the fact that we had some lived experience and wellbeing workers from our team go from the very beginning right to the very end of the programme. So there feels like there's some good sustainable buy-in” (Leader)

Some participants in more acute delivery settings noted that a more contained approach to co-design (e.g. two days of planning) might have been more beneficial given their team's tendency to prioritise service delivery and the challenges associated with shift work in bringing a team together along a longer-term journey and getting buy-in for the tools.

In general, participants described how they valued seeing priorities that they identified during the co-design process coming to life as practical tools and how this led to using the tools.

“I remember bringing something to the fore. ... I asked about dignity of risk and how to grapple with it. And I have really liked how I've been able to go back to those tools and even just in the last week, I've really enjoyed having the colour manual in front of me ...and I think it helped me to take a few steps back from my own agenda and just look at the risk in a way where I could... have a bit of a richer conversation about that ... So, I really love those petals [referring to conversation guide about risk] and I will use it many, many times over. (Worker)

A number of participants described how engaging in the process of operationalising TIP or using the tools has led to changes in their attitudes and perception of TIP and their own practice.

“So, there's some of the things that I've been using. There was one around: ‘How I am I creating a sense of safety for the people I support?’ I did one with a colleague of mine. So they come across a few people who've experienced trauma. So, having those prompts and working through that with them in a reflective practice session was helpful. So you know, this is practice that I wouldn't usually do.” (Worker)

7. Implementation of the SOLAR program

The SOLAR program was only introduced to the WREN sites. Although SOLAR was seen as potentially useful, and fostered communication and collaboration across teams and organisations, it was not trialled systematically by the teams resulting in low engagement in supervision sessions. Some of the key barriers to engagement were the requirement to adhere to a strict protocol rather than using the SOLAR modules in a flexible manner (this was required during the training as there is currently no clear evidence about a flexible approach to delivering SOLAR). The training's focus on content rather than application was also seen as a barrier to adoption by some as it was seen as duplicating existing knowledge.

"I'm like, it's such good stuff [referring to SOLAR manual] and it's absolutely still in our mind as a possible thing we could use...., but I think we just probably spent too much time on the content of it and that maybe added to some fatigue... So, I just think we should have maybe just kept that a bit shorter and just focus on how we use it." (Worker)

"So it was good to see the feedback of what consumers wanted and what everyone else in the team thought would go well as well because I think often we might have had similar views.... about the way we were implementing that SOLAR program ... and how it worked with the consumers." (Worker from partner organisation in community)

SOLAR was seen as particularly useful by the ACCO involved as a partner in co-design and implementation, as they were considering ways to roll it out and ensure it is culturally safe for their community.

"I would be like, OK, how I know we need to adapt it so it's got that cultural lens on it. ... So, a couple of those chats with the senior clinician in WREN was about how to adapt it with that cultural lens. So you know, around the language, which I think we brought up in [implementation] meetings anyway. And then she's made some suggestions, like "let's get a more senior person in your organisation that are from the area because I'm from up Queensland way". (Worker from partner organisation in community)

Part III: Implementation supports

Participants discussed what facilitated a sustainable implementation of TIP and use of the tools overtime. This included stressing the usefulness of expert facilitated support, the challenges involved in transforming culture and the need for leadership commitment and support. The importance of training and need for integration of key TIP concepts and practices in the service model and other key policies and procedures was discussed at length. The need for continuous evaluation was also noted.

8. Facilitated support for implementation

Participants described the usefulness of having facilitated support by the Phoenix Australia project team to help orient workers to the trauma-informed model and the trauma-informed toolkits. The facilitated support was also key to assist leadership in planning for implementation.

"[The project team] have been very generous along the way as well with offering opportunities to discuss different things and offer more insights. So, I think that's worked really well." (Worker)

"... we're going to have a launch of the service model which will be a real opportunity for us to ensure we've got our implementation plan, which I think was really great when you worked

with us around the implementation plan to ensure that we actually do follow through, that we do integrate all of this great work into our model...” (Leader)

9. Supporting culture change

Participants noted that culture change was required and that regular practice and having opportunities to explore difficult issues such as dignity of risk, cultural safety and power imbalances were important to TIP gaining momentum in their day-to-day practice. Reflective practice tools were of particular importance in that context and were seen as a central mechanism to support good practice.

“There are things that are challenging. Like, if we look at the risk side that we're looking at the moment and looking at the times where we could have done better and how could we do better? Yeah, so I think for me that's really important. Like, how can we support the staff to sit in an uncomfortable conversation as opposed to escalate to somebody else?” (Worker)

“I think the practice excellence lead... who has just started, he's very excited ... he'll be running co-reflection sessions ... for staff ... those tools [TIP reflective practice tools] will be really important around reflective practice because I think that's where the learning will really occur when it's not just the doing, it's the reflecting on the doing.” (Leader)

Some noted the usefulness of having tools (e.g., planners, prompt cards) that could be used by teams or individuals and encouraged a flexible approach to introducing reflective practice in day-to-day work. Other participants stressed the need for a planned approach to reflective practice sessions.

“It [reflective practice] needs to be planned ... It needs to be in your calendar... and you have to attend. Otherwise, we'll just book another appointment over it, because the consumer wants this appointment. ... We prioritise the consumer sometimes.” (Worker)

Many participants discussed the importance of taking a more systematic approach to creating reflective spaces for teams to come together to discuss TIP. This was a particular challenge for teams in acute settings due to a number of factors including a culture of prioritising responsiveness to emerging demand, having small teams with roles that were difficult to replace, including when leaders were required to act up or were on leave.

“But I think in the last few weeks as the team, we've gotten better at huddling together and reflecting on what's happening ... it's been great for our team and well, I personally think some of these tools, it'd be great if we had little study groups or something where we could kind of meet at different points and just discuss something of it so that we can apply it I think. Something to support the busy nature of our work, to make us stop and reflect, basically.” (Worker)

“But are there some things we could make more systematized. Like I think there are some things around reflective practice, for example, that we probably haven't yet done... we did discuss how [the Phoenix team] did a really good job of actually providing space and support for us to think about how we're going to use that in practice. And I think that's been one of ... of the big differences that it has been focused on the more practical implementation side ... without being too prescriptive.” (Worker)

Some participants questioned if the tools developed in the project would be sufficient to shift practice in people coming from a purely medical model (e.g., a registrar) with no previous training in TIP and entrenched views about service delivery. They were worried that the language and concepts used to support practice change may be too foreign and that additional training may be required.

10. Leadership support

Participants suggested that workers' use of the TIP tools should be supported by leadership commitment to implementation (e.g., by allowing dedicated time, having a planned approach and leading by example). Ongoing encouragement to use the tools in supervision and team meetings, and support for worker wellbeing was also mentioned. Some noted that this was already starting to happen while others stated that leadership required additional training, particularly around vicarious trauma support.

"...management have been really effective on trying to find spaces ...for us as workers to have reflective practice or to talk more about it ..." (Worker)

"Having our leadership actually be able to sit down with us and say, yes, 'we're going to support you through this. ... knowing how to speak with us really openly and give us the tools that we need to reflect. We might be struggling more than what's actually understood" (Worker)

Some participants noted the importance of having leadership buy-in for pilot projects, to ensure the process runs smoothly for workers in service delivery roles and that they have dedicated time set aside.

"... if we're going to allocate a team to take on a significant pilot, I think they need to have protected time and leadership needs to ensure that the people involved in these projects get that protected time so that they can do the work and wholeheartedly be involved in it without the stress and worry of having to juggle other things. I know that it's really hard in the public health system, but it makes it even harder for people to learn and to take things on without having that, support from higher up." (Worker)

11. Integration in service design, approach to workforce capability and policies

Many participants discussed the integration of the trauma-informed model and key practices into the service model and current systems, and ensuring current policies and procedures are consistent with recommended approaches. As previously mentioned, (see theme 3) participants in both services stated that there were plans to integrate what was learnt during the project in their service model. Some noted that their supervision model and approach to workforce capability would make use of the tools.

"We're looking at redeveloping what supervision looks like within the Local and within our services. And I I'm thinking how we can embed some of the learnings and resources from this project. I love reflective practice, we kind of do that as. clinicians." (Leader)

12. Need for training and orientation to tools

Participants discussed the role of training to support the implementation of TIP, including the need for a planned approach, dedicated time to help workers prioritise learning about TIP and the tools, and for some, even mandating training. Some discussed the need to review existing mandatory training to ensure they align with the concepts and language used in the TIP tools developed during the project, particularly in area of managing risk and escalation in distress. The importance of orienting new staff was also mentioned by both workers and managers.

"You know, it's really just about building up the team, like looking at what training do we give to new staff. ... they come with their experience, and obviously they're interviewed and reference checked and all the rest of it, but ...we will try to get them into certain training"

straight away. Are there other trainings that we could implement around trauma-informed practice as well? Or can we challenge some of the trainings that are mandatory” (Leader)

“...it needs to be scheduled, it needs to be, like, normalised. And mandatory. ...it should be, like, there on the calendar, without any excuses” (Worker)

Some participants discussed their preferred approach to training, stressing the need for demonstrations or opportunities to rehearse skills. Having opportunities to do so with peers in team meetings or supervision was seen as important in community settings. In more acute settings, some noted that videos or brief online overviews would help hold on to new information and skills, and address access issues related to shift work. Others in these settings stressed the need to step out of their environment to be less reactive to presenting needs of service users and more focussed on learning and rehearsing new skills. This would require off-site face to face learning rather than online learning.

“... make the information [provided in implementation workshops during project] accessible for staff that are on in the afternoons and may have time to review the information in the on their own terms. ... I want to be able to remember and hold on to some of that earlier information, and I'd love to be able to access it and go back and reflect ...” (Worker)

“... perhaps a full day training., I think role plays would be helpful, especially in going through some of these skills from the toolkit. ... I like to see things practically and try them out” (Worker)

Some noted that a phased, sequential approach to implementing the tools where tools could be trialled in a stepped manner would support learning. Participants in acute settings, highlighted the need for leadership support to systematically introduced team members to the tools and the need to formally nominate champions in the team and provide dedicated time to support learning and gradual adoption.

“For me how we implement the tools, I think slowly because we need to get this right.. We need to do it slowly and involve the people that are going to bring it in, such as team leaders.” (Leader)

13. Accessibility of TIP toolkits

Participants noted the fact that the TIP tools were easy to read and stressed the importance of making them available through different distribution channels including print and online. Some mentioned that they liked that the tools will be in the public domain and can be accessed by service users as well as workers, promoting transparency and shared understanding.

“Accessibility is a really big thing and this isn't text heavy... It's very easy to read. You can read in a couple of minutes if you have a few spare minutes around here and ... having spaces like reflective practice.” (Leader)

14. Continuous evaluation and reflection

Some participants discussed the importance of continuous evaluation for sustained implementation of TIP. They discussed using the organisational audit process to guide improvements as well as the use of continuous reflection on practice at a team level to promote change.

"I'd be really interested too, just from our team's perspective to have a space ... or ... some kind of mechanism to ... think about what's working and what's not as we implement it..."
(Worker)

"So I think the service model framework will be really key in ensuring that it's integrated into our service model because that alongside that, ... we're developing up our monitoring and evaluation framework as well and I guess a lot of that work around our organisational audit and how we're going with that will be embedded into that." (Leader)

Observed differences between MHW Locals and HiTH programs

The evaluation highlighted both similarities and differences between services that provide services to address acute presentations (i.e., HiTH) and community-based models (i.e., the MHW Locals) in their engagement with the co-design process, perceptions of the TIP tool suitability, and implementation support needs.

Experiences of the co-design process

Participants across both the MHW Locals and HiTH services valued the co-design process, particularly the opportunity to contribute to tools that reflected their service priorities. However, differences in service models and structural constraints affected the ability for some teams to engage consistently in co-design and implementation activities. Whilst all services involved in the pilot program experienced resourcing challenges (e.g., due to shift work, service demands or change processes), the impacts on project participation over time was more pronounced for HiTH services due to their care model focussing more on acute and complex presentations. The fact that they were small teams also was a challenge, particularly when in a rural location where it is difficult to replace or recruit to roles. The MHW Locals had the whole organisation involved and had a larger pool of workers and leaders to draw from and were more able to engage a whole of organisation process. The MHW Locals were also generally more able to integrate lived experience workers' perspectives, given their use of large peer teams, which created greater opportunity to ensure different trauma-informed skills and tools were suited to lived experience roles and leadership. Although observed across all services, HiTH participants made mention of the value of including partner organisations, which strengthened relationships and improved access to trauma-informed care for under-served communities.

Perceptions of the TIP tools

Both the MHW Locals and HiTH participants found the TIP tools practical, relevant, and aligned with the priorities identified during co-design. There was shared appreciation for tools addressing risk management, recovery, and vicarious trauma, with HiTH teams placing particular emphasis on these areas due to their acute service model. All participants valued seeing their contributions reflected in the tools, which fostered a sense of ownership and buy-in.

Support needs for implementation

Implementation support needs were broadly similar across the MHW Locals and HiTH services, with participants highlighting the importance of leadership buy-in, tailored training, and dedicated time for reflective practice. Teams from MHW Locals strongly highlighted the need for integrating implementation supports in service design and frameworks for training and supervision, while HiTH teams noted more challenges in bringing their teams together to reflect on TIP and introduce the tools gradually. They described how staffing constraints and the demands and culture around acute service delivery limited opportunities for team-based reflection and opportunities to discuss TIP as a team on a regular basis. In rural

settings, there was more team cohesion and reflective spaces due to the small team size, but this also led to challenges with roles not easily replaced to engage in long-term projects. The tools were seen as particularly useful to orient workers in rotating positions like registrars, but some noted these workers may require tailored support to engage with TIP concepts, which were sometimes perceived as too far removed from medical frameworks.

Implications and recommendations

Overall, the process of consultation, co-design and implementation support was seen as beneficial and helped create TIP implementation tools that met the needs of the MHW services and their workforces. The tools were seen as practical and impactful, and both workers and leaders were actively incorporating them into their practices, with the tools leading to conversations about trauma-informed care throughout the project. This was despite communication challenges with workers not involved in the co-design process or difficulties in engaging some key workers in early stages of the project because of service-related demands.

Involving service users and community representatives was particularly valued and shaped the tools, ensuring that they were grounded in the experiences of people who use mental health and wellbeing services. The involvement of lived experience leaders and champions from the beginning also led to the voices of consumers, families and carers being central to the project and provided a truly multidisciplinary lens to trauma-informed service delivery. In fact, collaboration across different disciplines and sharing of diverse perspectives during the project was seen as an important part of promoting a trauma-informed approach. It improved communications across teams about key aspects of care such as safe trauma disclosures, intake, and the management of risk.

There were four broad areas of learning during the pilot:

1. **Adapt TIP framework to context:** A key to effective implementation was the process of adapting the TIP model to the context of community mental health service delivery and prioritising areas of practice that are not addressed by more generic trauma-informed training and advice.
2. **Adapt implementation supports and tools:** The set of tools developed to support implementation of TIP were based on best practice in educational and implementation support but was also guided by workplace needs and culture. The implementation support provided also needed to be consistent with trauma-informed values and include the voice of service users.
3. **Co-design and consultation are key to implementation:** The iterative and collaborative approach to consultation and tool development created buy-in and led to promoting conversations and on-going learning about TIP, providing a strong underpinning for adoption of trauma-informed practices and commitment from leadership. A flexible, briefer approach to co-design with dedicated time and funding may need to be considered in more acute settings.
4. **Focus on ongoing implementation support needs:** While pilot project activities and tools offered a sound basis for TIP implementation, there were processes that needed to be supported in an on-going manner for the sustained use of the TIP tools and adoption of trauma-informed practice.

Further detail about each of the four broad areas of learning are provided below.

1. Adapt TIP framework to context

In early consultations, workers and leaders across all participating services stated that having a shared definition of TIP was important to improving their practice. While staff had access to trauma-informed training from a range of external organisations and understood how key aspects of their service delivery was aligned with TIP (e.g., having a peer-led welcoming entry point to promote safety and trust or a collaborative care meeting prior to providing care in a person's own home), workers in different role or working in different parts of the services did not always share an understanding of key elements of TIP. It was therefore important to operationalise the principles of TIP within their service context to create shared practices, values and culture. It was particularly important to go beyond the more generic models of trauma-informed practice for models of care that addressed more acute and complex presentation. To do this the Phoenix Australia facilitators worked with the Working Groups to articulate a TIP model that:

- aligned with both clinical, casework and peer support values and language. For example, this led to the model emphasising sharing of power with service users, families and carers and holistic approaches to understanding trauma and care. The Working Groups discussed what this looked like in practice and these discussions influenced the concepts and language used in the TIP tools and code during qualitative analysis of initial findings.
- captured critical aspects of mental health service delivery. This led to an increased focus on defining recovery and healing from the impacts of trauma, and the inclusion of dignity of risk to support the trauma-informed principles of choice and control.
- stressed the importance of examining power and its role in planning and service delivery, and the central role of lived experience in service review and improvement cycles. For example, this led to discussions about how service users and their families were engaged in ongoing planning and how feedback was obtained and transparently used to address service delivery gaps. In particular, the tension between having to meet government data requirements, which necessitated the use of long surveys and getting regular, actionable feedback was noted and simpler surveys examining key aspects of trauma-informed delivery developed (see Appendix 5).

2. Adapt implementation supports and tools

Tailoring implementation supports and tools led to buy-in and a deeper understanding of TIP amongst participating staff, particularly leaders and internal champions. The implementation supports were based on best practice educational principles and factors that are important to sustained implementation such as leadership support and use of continuous feedback for improvement (e.g., Beidas et al., 2016; Damschroder et al., 2022; Stirman et al., 2012; Aarons et al., 2016). Most importantly, they were informed by the needs of the teams participating in the project and helped address the cultural differences across teams and organisations working together to deliver MHW services.

Organisational readiness also influenced the way in which supports were delivered. All organisations had strong cultures and practices around elements of trauma-informed care such as fostering trustworthy and safe interactions, valuing lived experience and working to be strength-based. At the same time, as newly established organisations, they experienced a lot of change and were either establishing new roles or

experiencing turn-over in staff. Additionally, implementation can be particularly challenging for services that have rotating shifts to meet out-of-hour demands, and for smaller teams in rural services that often face recruitment challenges and have limited capacity for activities outside service delivery.

Implementation supports provided were therefore flexible to avoid change fatigue and to address the evolving needs of different teams. To do this, we worked closely with leaders and champions to help identify and prioritise actions to support TIP and provided a range of avenues to participate in discussions and decision-making. Having dedicated internal champions was critical in supporting this process and designing tools that could easily fit in to changing environments and culture. Despite this, resource demands, acute models of care and culture meant that some teams found ongoing engagement in implementation difficult.

To support differing needs, tools to support TIP implementation were designed to be used flexibly and to require limited time and investments (e.g., prompts to reflect about practice with peers or for a few minutes at the start of a meeting, or planners to help use supervision effectively). Participants also noted that the tools followed trauma-informed principles emphasising the voice of service users, and using practical and transparent language that could be used across disciplines and with service users, their carers and families.

3. Co-design and consultation are key to implementation

The project participants appreciated the opportunities for iterative learning and testing through the facilitated sessions. Rather than adopting a top-down consultation and education approach, a two-way process was employed. The Phoenix Australia facilitators gained insight into organisational needs and trauma-informed care delivery from the practice and lived experience perspective of service users, workers and leadership. In turn, project participants learned about TIP concepts and principles and had the opportunity to explore their application in their day-to-day context. The collaborative and phased nature of the process allowed participants to refine the tools being developed but also the actions they wanted to undertake to support trauma-informed service delivery. The iterative nature of co-design also helped align practices with broader organisational goals such as service model reviews.

The co-design process ensured that implementation was in line with trauma-informed principles. The collaborative nature of the session promoted transparency and safety – many participants noted the trauma-informed and culturally safe nature of the process because of the involvement of service users, and the fact that there were safe spaces to have conversations about their experience of care delivery. The inclusion of lived experiences perspectives both from workers and service users and their families was central to being trauma informed.

Involving representatives from partner organisations in the community that address the needs of groups that don't access mainstream mental health services or have experienced harm during their interaction with them was also beneficial. One of the teams involved a representative from the local Aboriginal Community Controlled Health Organisation during the co-design and implementation process strengthening ongoing collaboration around trauma-informed practices and improving access to services for First Nations people.

4. Focus on ongoing implementation support needs

Differences in service models, particularly between acute care service delivery and community-based MHW Locals, highlighted the importance of flexible, context-sensitive implementation strategies. The community mental health programs had more capacity to benefit from an ongoing, iterative collaborative process, mainly

because the whole of the organisation was involved. Smaller, less resourced teams with a service delivery approach that includes immediate, crisis driven responses may require more contained implementation models and additional funding to engage the whole organisation and other services.

Overall, the pilot highlighted ongoing implementation support needs for organisations wanting to be more responsive to trauma-related needs and planning to use the tools and resources developed during this project. These include:

- **Inclusive and systematic audit of practice:** An audit of current practices would not only help with planning and focusing implementation efforts, but also provide an opportunity to include key service user representatives, workers and leaders so that they can influence decisions and champion change. The audit tool developed in this project can provide a structure to this process.
- **Processes that support service user-centric planning:** Many requirements for service provision and reporting were not fully trauma informed (e.g., requirement for intake form or service user feedback) which meant it was difficult for organisations to make changes to their services or to make use of service user feedback in a trauma-informed manner.
- **Leadership engagement:** Leaders need to be actively involved in the implementation process and it is critical that leaders responsible for teams to be involved in planning from the start and supported to have the required skills to support workers' wellbeing and engagement in TIP. Supporting leaders and champions with dedicated time would also be important. It may also be helpful to provide accountability measures for leaders to actively promote TIP and use the tools (e.g., as part of organisational audit process described in previous dot point or by adding it as a regular discussion item in supervision).
- **Cultural safety and equity:** Cultural safety and minimising systemic barriers to accessing safe and responsive support are critical to trauma-informed service delivery, and integrating these as part of day-to-day trauma-informed practice requires that implementation support includes collaboration with community representative groups and expert services.
- **Phased introduction to TIP tools:** The findings suggest a need for a well-structured, phased introduction to each set of tools. MHW services could develop a clear roadmap for introducing and integrating the tools into daily practice.
- **Reflective practice to embed TIP:** Creating ongoing flexible and easily accessible spaces for teams to come together to reflect on their practice and what it means to be trauma-informed from a service user's perspective was valued and seen as critical to sustained practice change. Some services, particularly those in acute settings, those that rely on shift work or have a dominant clinical or medical approach to discussing practice would need additional support to address practical and cultural barriers to regular reflective team-based discussions.
- **Ongoing training and education:** The project highlighted the importance of regular, potentially mandated training. It also highlighted areas where this training is critical. For workers this included supporting people to share their experience of trauma safely and gaining clarity about how to do this within the confines of one's role, as well as understanding trauma responses and having trauma-informed approaches to managing distress and risk. For managers, having training in how to support

a trauma-informed culture and trauma-responsive services, particularly through reflective practice, and having the skills to address vicarious trauma were important.

- **Promoting multidisciplinary learning:** TIP is underpinned by a recovery oriented, holistic view of people seeking support, continuity of care and by honouring lived experience perspectives. Creating opportunities for cross-disciplinary learning and application of the tools can provide a powerful way support this.
- **Accessibility of TIP tools and Integration into workflow and service model:** The TIP tools need to be easily accessible and integrated into existing workflows. Having access to both physical and digital strategies to make the tools readily available in day-to-day practice is important. In addition, the concepts and language used in the tools can be used to during the review of service models and to inform policies and procedures.
- **Continuous Evaluation and Improvement:** Implementing regular feedback mechanisms and being open to adapting practice and use the TIP tools over time is critical.

Recommendations

Recommendations for Government and mental health and wellbeing services are summarised in Tables 7 and 8 on the next page.

Table 7: Recommendations for Government

#	Recommendations for Government bodies
1	<p>Allocate dedicated funding for implementation</p> <p>Provide funding to MHW services for the implementation of trauma-informed practices, including for dedicated time to enable leaders and champions to promote TIP. Funding should also support the creation of reflective practice spaces within and across organisations. This can be supported using the tools developed during the pilots. Expert guidance for trauma-informed implementation is also important for the systematic roll out of TIP across services. This would be supported by the establishment of a state-wide trauma service with a core workforce capability support function as recommended by the Victorian Royal Commission. Services in rural or remote locations should receive enough funding to have dedicated times or positions to support implementation, particularly if they have smaller teams as they face additional barriers with recruitment and meeting community needs.</p>
2	<p>Work with services to ensure data and reporting requirements are aligned with trauma-informed principles</p> <p>Engage with MHW services and service user representatives to ensure data requirements and service design guidance actively promote trauma-informed principles for processes such as intake, obtaining service user feedback and service model reviews and updates.</p>

3	<p>Fund research on long-term uptake of trauma-informed practice</p> <p>Allocate funding for longitudinal studies on the impact of trauma-informed practices on both service user outcomes and worker wellbeing, using this research to continually refine and improve the approach at a state level.</p>
4	<p>Support services to establish a culturally safe and equitable service model</p> <p>Mainstream mental health services should be supported and funded to improve cross-sector collaboration to overcome barriers to engagement for people who have experienced trauma and don't access these services (e.g., area mental health services being supported to have more direct dialogue and referral processes with Aboriginal Controlled Community Health Organisations, family violence or migration services).</p> <p>TIP implementation should also involve adapting key practices to meet the needs of culturally diverse populations and be informed by culturally responsive models (e.g., the Balit Durn Durn Centre model of social and emotional wellbeing for First Nations people).</p>

Table 8: Recommendations for mental health and wellbeing services

#	Recommendations for mental health and wellbeing services
5	<p>Conduct an inclusive and systematic audit of practice</p> <p>It is recommended that services undertake a systematic audit of current practices (this can be done using the audit tool developed in this project). This process should include meaningful participation from service user representatives, frontline workers, and leaders to guide planning, support implementation, and foster shared ownership of planned improvements to support TIP. During this process identify and upskill "champions" to lead planned changes, this can include upskilling them in the use of TIP tools developed during this project.</p>
6	<p>Enable service user-centric planning</p> <p>Services should establish planning processes that put the perspectives of service user and their families at the centre of decisions. This includes adapting systems (e.g., planning forums, feedback mechanisms) to be more responsive to service-user feedback.</p>
7	<p>Ensure active leadership engagement and accountability</p> <p>Leaders should be involved from the outset of implementation planning and be provided with the necessary skills and support to champion TIP and address worker wellbeing. This includes allocating dedicated time for TIP-related activities and having accountability measures (e.g., as part of an organisational audit of TIP or supervision).</p>
8	<p>Introduce TIP tools through a phased approach</p> <p>A clear roadmap should be developed to introduce the TIP tools into everyday practice.</p>
9	<p>Provide ongoing training and education</p> <p>Regular and potentially mandatory training should be implemented to ensure all staff have a strong understanding of key trauma-informed practices when first joining a service, when changing roles, and when being promoted. Training for workers should cover safe ways to engage with trauma</p>

	narratives, manage distress and risk in a trauma-informed way, and vicarious trauma. Managers also need to be equipped to lead trauma-responsive services, provide opportunities for reflective practice, and address vicarious trauma.
10	Facilitate multidisciplinary learning Services should be resourced to create opportunities for cross-disciplinary learning and collaboration with other services. This will help promote a holistic, recovery-oriented approach to care that strengthens application of TIP across roles and services.
11	Ensure accessibility of TIP tools and integration into workflows TIP tools should be made easily accessible in both physical and digital formats and embedded within existing service workflows and models. Services are encouraged to use language and concepts in TIP tools to inform policy and service model reviews to ensure consistency and alignment.
12	Establish continuous evaluation and improvement processes Feedback mechanisms should be embedded into ongoing practice to evaluate the use and impact of TIP tools and organisational supports for trauma-informed service delivery should be reviewed on a regular basis using the audit tool to adapt support strategies as needed.

Conclusion

The pilot project demonstrated the value of collaborative, context-specific approaches to adapting trauma-informed language and principles as well as implementation support. The iterative nature of the project allowed for continuous learning and adaptation, ensuring that the resulting tools and processes were well-suited to the needs of each MHW service. While the tools created offer a strong foundation, sustained implementation will require ongoing commitment, resources, and systemic support to embed trauma-informed care within MHW services. The pilot project's success in engaging a wide range of stakeholders throughout the process highlights the importance of inclusive, participatory approaches in developing effective trauma-informed practices.



References

- Aarons, G., Green, A., Trott, E., Willging, C., Torres, E., Ehrhart, M., & Roesch, S. (2016). The roles of system and organizational leadership in system-wide evidence-based intervention sustainment: A mixed-method study. *Administration & Policy in Mental Health & Mental Health Services Research*, 43(6): 991-1008. <https://doi.org/10.1007/s10488-016-0751-4>
- Aschbrenner, K., Rabin, B., Bartels, S., & Glasgow, R. (2025). Methodological recommendations for assessing the impact of adaptations on outcomes in implementation research. *Implementation Science*, 20:30 <https://doi.org/10.1186/s13012-025-01441-8>
- Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, 60(10):854-7. <https://doi.org/10.1136/jech.2004.028662>
- Beidas, R., Adams, D., Kratz, H., Jackson, K., Berkowitz, S., Zinny, A., . . . Evans Jr, A. (2016). Lessons learned while building a trauma-informed public behavioral health system in the City of Philadelphia. *Evaluation and Program Planning*, 59, 21-32. <https://doi.org/10.1016/j.evalprogplan.2016.07.004>
- Chambers, D. (2023). Advancing adaptation of evidence-based interventions through implementation science: Progress and opportunities. *Frontier in Health Services*, 3. <https://doi.org/10.3389/frhs.2023.1204138>
- Cowlshaw, S., Gibson, K., Alexander, S., Howard, A., Agathos, J., Strauven, S., Chisholm, K., Fredrickson, J., Pham, L., Lau, W., O'Donnell, ML. (2023). Improving mental health following compound disasters in Australia: A randomised controlled trial of the Skills for Life Adjustment and Resilience (SOLAR) program. *European Journal of Psychotraumatology*, 14(2), p 2284032 <https://doi.org/10.1080/20008066.2023.2284032>
- Damschroder, L., Reardon, C., Widerquist, M., & Lowery, J. (2022). The updated consolidated framework for implementation research based on user feedback. *Implementation Science*, 17:75. <https://doi.org/10.1186/s13012-022-01245-0>
- Gaias, L., Arnold, K., Liu, F., Pullmann, M., Duong, M., & Lyon, A. (2021). Adapting strategies to promote implementation reach and equity (ASPIRE) in school mental health services. *Psychology in the Schools*. 59. 2471-2485. <https://doi.org/10.1002/pits.22515>.
- Geng, E., Mody, A., & Powell, B. (2023) On-the-go adaptation of implementation approaches and strategies in health: Emerging perspectives and research opportunities. *Annual Review of Public Health*, 3 (44):21-36. <https://doi.org/10.1146/annurev-publhealth-051920-124515>
- Gibson, K., Little, J., Cowlshaw, S., Toromon, T., Forbes, D., & O'Donnell, ML. (2021). Piloting a scalable, posttrauma, psychosocial intervention in Tuvalu: The Skills for Life Adjustment and Resilience (SOLAR) Program. *European Journal of Psychotraumatology*, 12 (1). <https://doi.org/10.1080/20008198.2021.1948253>
- Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. SAGE Publications, Inc., <https://doi.org/10.4135/9781483384436>

- Harris, M., & Fallot, R. D. (Eds.). (2001). *Using trauma theory to design service systems*. Jossey-Bass/Wiley.
- Lau, A., Huey, S. Jr, & Baumann, A. (2023). Advances in the adaptation and implementation of evidence-based interventions for historically marginalized groups. *Behaviour Research and Therapy*, 168:104377. <https://doi.org/10.1016/j.brat.2023.104377>
- Metz, A., Louison, L., Ward, C., & Burke, K. (2017). Implementation support practitioner profile: Guiding principles and core competencies for implementation practice. National Implementation Research Network, University of North Carolina at Chapel Hill.
- O'Donnell, M. L., Lau, W., Fredrickson, J., Bryant, R. A., Bisson, J., Burke, S., Busuttill, W., Coghlan, A., Creamer, M., Gray, D., Greenberg, N., McDermott, B., McFarlane, A. C., Monson, C., Phelps, A., Ruzek, J. I., Schnurr, P. P., Ugsang, J., Watson, P., Whitton, S., Williams, R., Cowlshaw, S., & Forbes, D. (2020). An open label pilot study of a brief psychosocial intervention for disaster and trauma survivors. *Frontiers in Psychiatry*, 11, 483. <https://doi.org/10.3389/fpsy.2020.00483>
- Shelton, R., Chambers, D., & Glasgow, R. (2021). An extension of RE-AIM to enhance sustainability: Addressing dynamic context and promoting health equity over time. *Frontiers in Public Health*, 8:134. <https://doi.org/10.3389/fpubh.2020.00134>
- State of Victoria. (2021). *Royal Commission into Victoria's Mental Health System Full Final Report*. State of Victoria. Available at www.health.vic.gov.au/mental-health-wellbeing-reform/recommendations
- State of Victoria. (2023). *Our workforce, our future. A capability framework for the mental health and wellbeing workforce*. Department of Health. Available at <https://www.health.vic.gov.au/our-workforce-our-future>
- Stirman, S., Kimberly, J., Cook, N., Calloway, A., Castro, F., & Charns, M. (2012). The sustainability of new programs and innovations: A review of the empirical literature and recommendations for future research. *Implementation Science*, 7(1), 17-17. <https://doi.org/10.1186/1748-5908-7-17>
- Stockton, D., Fowler, C., Debono, D., & Travaglia, J. (2024). Development of a framework for the collaborative adaptation of service models for child and family health in diverse settings (CASCADES). *Journal of Child Health Care*, 28(2): 329-347. <https://doi.org/10.1177/13674935221129003>
- Substance Abuse and Mental Health Services Administration's (SAMHSA). (2014). Concept of trauma and guidance for a trauma-informed approach. Available at <http://store.samhsa.gov/shin/content/SMA144884/SMA14-4884.pdf>
- Varcoe, C., Wathen, C., Ford-Gilboe, M., Smye, V., & Browne, A. (2016). VEGA Briefing Note on Trauma- and Violence-Informed Care. VEGA Project and PreVAiL Research Network.
- Wiltsey Stirman, S., Baumann, A., & Miller, C. (2019) The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implementation Science*, 14(1): 58. <https://doi.org/10.1186/s13012-019-0898-y>

Glossary

Acronym	Description
ACCO	Aboriginal Community Controlled Health Organisation
Brimbank Local	Brimbank Mental Health and Wellbeing Local
Capability Framework	Victorian Mental Health and Wellbeing Workforce Capability Framework
CFIR	Consolidated Framework for Implementation Research
CRG	Community Reference Group
DoH	Department of Health
GGQ Local	Greater Geelong-Queenscliffe Mental Health and Wellbeing Local
HiTH	Hospital in the Home program
HREC	Human Research Ethics Committee
MHW Locals	Victoria's Mental Health and Wellbeing Locals
MHW services	Victoria's mental health and wellbeing services
PAR	Participatory action research
SOLAR	Skills for Life Adjustment and Resilience program
TIP	Trauma-informed practice
VCCMHW	The Victoria Collaborative Centre for Mental Health and Wellbeing
WREN	The Women's Recovery Network

Term	Definition
Carer	Any person, including people under the age of 18, often a family member or friend, who provides support, assistance, or personal care to a person with a mental health condition.
Co-design	An approach of design that allows workers and service users of a healthcare service to be equal partners in the improvement of service delivery. This means that organisations, workers, service users, and carers work together to design solutions to improve care.
Leadership	Team leads and managers of a service, holding senior positions in lived experience/peer support, clinical, education, quality assurance, and service operations
Lived experience	A person with lived and living experience of trauma and mental ill health and recovery whose trauma may include a diverse range of life experience.
Service	An organisation/program providing mental health and wellbeing programs to people experience mental health and wellbeing concerns (inclusive of trauma).
Service user	Any person who has used or is using a healthcare service. A person's support system including their family or carer can also be service users. Also referred to a consumer, client, patient, or participant.
Tool	A resource that provides guidance, a process, or practical assistance for use by a worker, leaders, or service users, families and carers.
Trauma	Trauma is when a person experiences very stressful, frightening, or distressing events that are difficult to cope with or out of our control.
Trauma-informed practice	A framework that outlines the best way to provide care to individuals who have been exposed to trauma.
Worker	A staff member or volunteer of a service. Inclusive of lived experience/peer workers, clinicians (e.g., psychologists, social workers, nurses), mental health alcohol and other drugs (AOD) and other allied health workers.

Appendix 1 – Initial consultation questions

Questions for service users and carers (in interviews and focus groups)

1. How do you or your loved ones (or members of your community) access programs at the Local/service?
2. Are there things that could make you [or people from your community] feel less safe or comfortable when first coming to the Local/service?
3. How did you [or people from your community] decide what kind of help you [or they] needed?
4. Are there things that make it easier or harder to get the help that you need?
5. What was involved in you agreeing to (or providing consent for) the care and services you received?
6. Are people supported in sharing stressful or traumatic life experiences in this service?
7. Are people using the service, their carers and/or community members involved in planning and reviewing programs?
9. Overall is there anything that we haven't covered that could be improved in your program area? That is, is there anything else that you think works well and what needs to improve at the Local/service?

Questions for workers and leaders (in interviews and focus groups)

Section 1: About client experience

1. How do clients access your program?
2. How are you made aware of individuals' experiences of trauma in your program?
3. How are clients supported to make choices about their care?
4. How is healing or recovering from impacts of trauma considered in your program?
5. When managing escalation in distress or risk, how are clients' potential trauma histories taken into consideration?

Section 2: About staff support and training

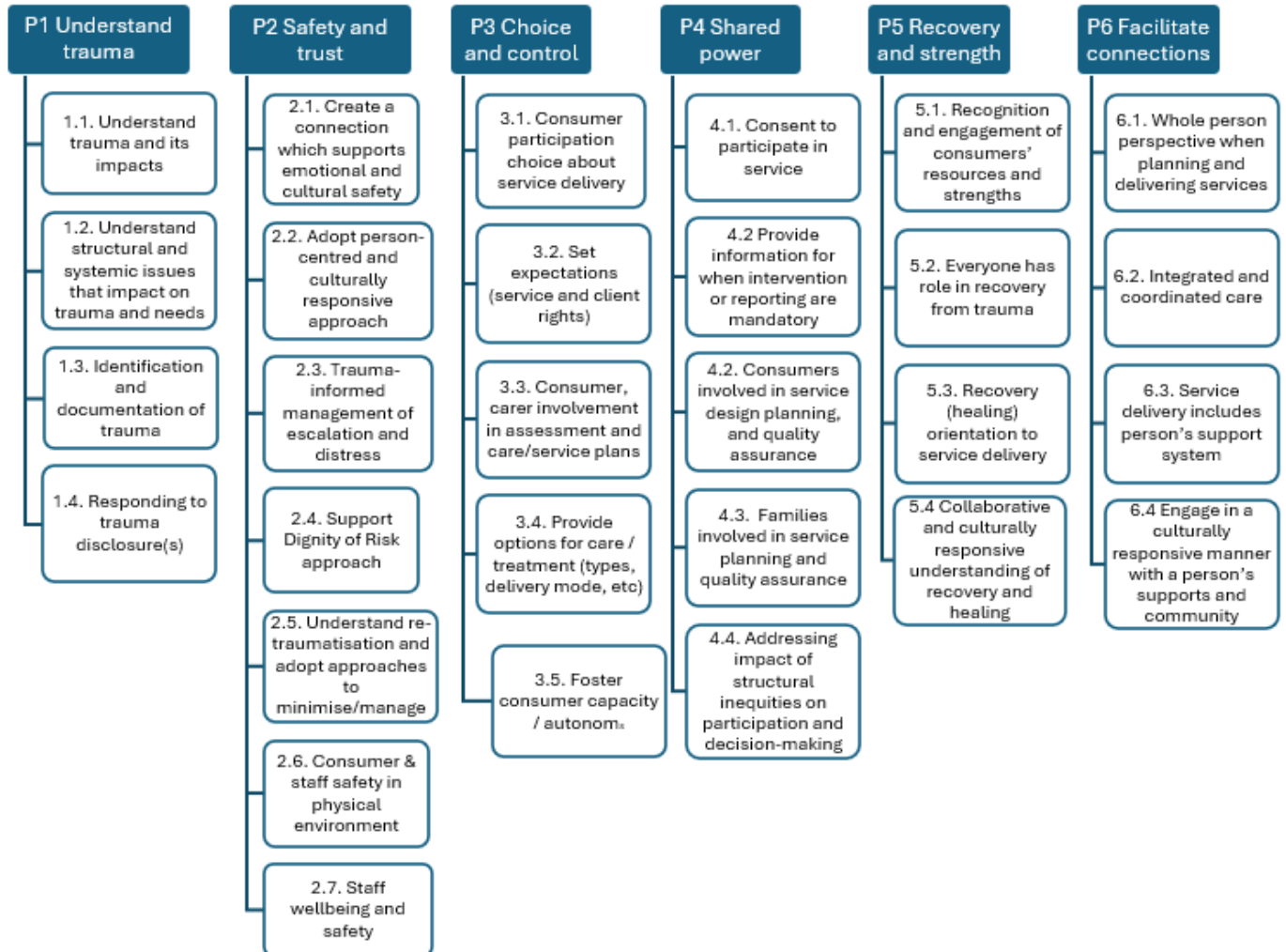
6. How are staff members' sense of safety and wellbeing supported when they interact with people affected by trauma?
7. How are staff supported to manage disclosures of traumatic experiences?
8. What support and training have you received in trauma-informed practice?

Section 3: About organisational processes

9. Is there guidance provided about how to make the organisation trauma-informed?
10. Are clients and carers and/or community members involved in planning and review of programs?
11. How do leaders in your organisation support trauma-informed service delivery?
13. Overall is there anything that we haven't covered that could be improved in your program area to ensure that services are more responsive to the needs of people and communities affected by trauma?

Note: Each question included several prompts.

Appendix 2 – Code map from initial consultations



Appendix 3 – Description and list of TIP tools

Trauma-informed practice (TIP) tool sets

Understanding trauma-informed practice

Learn about what trauma-informed practice (TIP) involves and how it can support both service users, families and workers. These tools strengthen knowledge of TIP principles, language, and approaches — and support service users, families, and teams in a more trauma-aware way.

Practical tools for workers

- Understanding and applying TIP
- Applying the six principles of TIP
- Talking about TIP with service users
- Using trauma-informed language
- How to support recovery from trauma
- What supports recovery when addressing the impacts of trauma?

Tools for leaders and organisations

- Six principles of TIP (poster)
- Leadership and organisation quick checklist of TIP
- Shared responsibilities for TIP

Handouts for service users

- Understanding and talking about trauma
- What to expect from TIP services (poster)
- What to ask workers when getting help for trauma

Organisational audit of TIP

Assess and strengthen TIP across the service. Identify practical actions to improve awareness, engagement, processes, and procedures.

Organisation/leadership tools

- Online survey platform (REDCap)
- Information about using the TIP Audit tool

Supporting safe disclosures of trauma

Practical tools to support safe, respectful trauma disclosures with service users. Explore strategies for responding to service users sharing their experiences of trauma in ways that ensure they feel heard, supported, and empowered working together. Includes guidance for leaders to foster a supportive culture and processes where workers feel safe after these experience.

Practical tools for workers

- All workers can support safe trauma disclosures
- Talking about trauma is an opportunity to help
- Understanding and addressing service user barriers to disclosing trauma
- Making decisions about trauma disclosures
- Supporting service users with disclosing trauma experiences
- Containing disclosures

Tools for leaders and organisations

- Creating a supportive culture around trauma disclosures

Trauma-informed approach to risk

Tools that support autonomy and shared decision-making with a trauma-informed lens approach risk. These resources promote equal partnership with service users, balancing dignity of risk and duty of care, and include guidance for workers, leaders, and service users.

Practical tools for workers

- TIP risk management: Dignity of Risk and Duty of Care
- Steps to promote a trauma-informed approach to risk management
- How trauma-informed is my approach to managing risk? Post-session checklist
- Talking about risk: Making a decision together
- Service user example of TIP approaches to risk (Jordan)

Tools for leaders and organisations

- Workers' needs to support dignity and choice when addressing risk

Handouts for service users

- Talking about risk: Making decisions together

Strengthening trauma-informed reflective practice

Strengthen how workers and teams reflect on applying TIP in their everyday work. Resources for workers and leaders to plan, run, and review reflective practice sessions that support wellbeing, shared learning, and improved TIP with service users. Can be used for individual or group reflective sessions.

Practical tools for workers

- Aims and benefits of trauma-informed reflective practice
- Reflective practice: Post-session check-in
- Service user example of TIP principles (Emily)
- Service user example of TIP principles (Daren)
- Service user example of TIP principles (Fatima)

Tools for leaders and organisations

- Planning tool for trauma-informed reflective practice
- Planning reflective practice: Tips for managers and workers
- Worksheet planner for running a reflective practice session: A TIP approach for managers
- Reflective practice questions (flip cards)

Minimising impacts of vicarious trauma

Support teams to recognise and reduce the impacts of vicarious trauma. These tools help monitor wellbeing, strengthen healthy boundaries, and guide team conversations about the emotional impact of trauma-related work.

Practical tools for workers

- What is vicarious trauma?
- Self-monitoring tool – Recognising the signs of Vicarious Trauma and track wellbeing
- Setting healthy boundaries within your team and with service users

Tools for leaders and organisations

- Tips for managers: Having conversations about vicarious trauma
- Thinking ahead as a team: Preventing the impact of indirect trauma

Appendix 4 – Evaluation questions

Questions for workers and leaders (in focus groups)

“This discussion has three sections. We will look first at the process of developing and designing the trauma-informed practice (TIP) tools, then we’ll ask you about the relevance and usefulness of the tools, and finally at the likelihood that the tools will be used and what may support or hinder you in the use of the tools.

Section 1: Your experience of the development and design process

(A) Communication - *First, we would like to hear your views about communication in the codesign process.*

1. What was communicated about the project to the staff group?

(B) Engagement - *Next, we are interested in finding out about your experience of the development of the tools. For some of you it would be through consultation (that is, the focus groups and interviews we held in July last year and any discussions you’ve had with members of the working group), and for others it would be through the Working Group. Or perhaps you were involved in both.*

2. Please describe your experience of the development process.

Section 2: Usability/relevance of the tools

“In this section, we would like to understand how useful the developed tools are in your day-to-day practice, and how compatible they are with your current service design and processes.”

3. In what ways are the tools compatible with the service model and processes already in place at the Local/service?
4. In what ways will the tools be useful in your day-to-day practice?

The last two questions have asked you about the tools themselves. Now, we would like you to think about how the tools can help improve practice at the Local/service.

5. How can the tools help increase awareness and support change in practice?

Section 3: Intent to use the tools

For the final section, we will ask you about whether you think you, your teams, and your leader will use the tools.

6. How likely is it that you/your team/your leadership will use the tools?
7. What will make it easier or harder for you/you team/your leadership to use the tools?
8. Have you noticed any actions from the Action Log that were implemented? Can you give me one or two examples?
9. What future supports are still required to implement the tools?

10. Overall is there anything that we haven't covered that you think we should know about how the co-design process, and the tools may impact (positively or negatively) on the needs of people and communities affected by trauma?

Note: Each question included several prompts.

Appendix 5 – Trauma-informed questions for service users

Proposed service user questions for obtaining feedback and assisting with assessing trauma-informed practice (TIP) service delivery at organisational level.

#	Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	I was treated with respect					
2	My choices and preferences about my care were respected					
3	I felt like people in the service believed in me and prioritised my goals					
4	I was encouraged to express my opinions about my care, including when I disagreed or was dissatisfied					
5	I felt comfortable in the building and environment					
6	I felt comfortable sharing stressful experiences with at least one person in this service					

Note:

- For Question 4, can replace “*about my care*” with “*about the service*” if more appropriate.
- Questions 5 and 6 are bonus questions if wish to use
- Usually a 5-point Likert is recommended, and can include three alternatives:

Strongly agree (5)	Agree (4)	Neutral (3)	Disagree (2)	Strongly Disagree (1)	
Strongly agree (5)	(4)	(3)	(2)	Strongly Disagree (1)	Prefer not to say (0)
Strongly agree (5)	Agree (4)	Disagree (2)	Strongly Disagree (1)	Prefer not to say (0)	