MHPN WEBINAR

Transcript

Latest innovations to embed and sustain trauma-informed care

Broadcast Date: Thursday 24 August 2023

View recording: https://mhpn.org.au/webinar-program/Webinars/One-Off/2023/August/Latest-innovations-to-embed-and-sustain-trauma-inf

Panellists:

- Nicola Palfrey (Clinical Psychologist, ACT)
- Dr. Johanna Lynch (General Practitioner, Qld)
- Beck Thompson (Teacher with a Lived Experience, Qld)

Facilitator: Professor Stephen Trumble (General Practitioner, Vic)

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Professor Steve Trumble:
Well, good evening, everybody, and welcome to the roughly at least 600 people who have joined us for tonight's webinar on exploring trauma-informed therapies and also the viewers who are watching us on recording. Further down the track, MHPN would like to acknowledge the traditional custodians that the lands, seas and waterways across Australia, upon which our webinar presenters and participants are located. We wish to pay our very sincere respects to Elders past, present, and future for the memories, the traditions, the culture, and the hopes of Aboriginal and Torres Strait Islander Australia. So, my name's Steve Trumble. I'm a general practitioner by background, but I'm also a professor of medical education at the Melbourne Medical School here in Melbourne, City of Naarm. So, I'll be your facilitator tonight, but really the focus is going to be on the panel that we have, and you can see them there on the screen. The biographies were disseminated with the webinar invitation, so hopefully you've read that, know a bit about them in the interest of ensuring we've got as much time to have a conversation about this important topic as possible. We'll skip going over the bios in detail, but you can see there that we have- we'll start with Dr. Johanna Lynch, who's a general practitioner in Queensland. Now, Johanna, as a fellow GP, I'm curious what makes a GP so interested in trauma?

Dr. Johanna Lynch:
Thank you, Steve. Well, I would say it's because I saw so much in my ordinary general practise work and it led me to go and learn more because in those days there was not access, easy access to other care for those people, and I now think it's become my passion to bring trauma-informed practise back into mainstream medicine through research, teaching and mentoring.

Professor Steve Trumble:
Right. So, hopefully the next generation of GPs will be more switched on to the importance of understanding the impact of trauma in the care they provide. Great. Well thank you very much and welcome. Looking forward to hearing what you've got to say tonight. That's great. We also are joined tonight by a colleague with lived experience who's also a teacher, which is great because this is very much a topic that's come up in the questions that have been submitted before the webinar. And that person is Beck Thompson. So, hello Beck.

Beck Thompson:
Hi Steve. Thanks for having me tonight.

Professor Steve Trumble:
It's great to have you as a teacher and because of something people having asked questions about this, what do you see as why embedding trauma-informed practise in schools is so important?

Beck Thompson:
Well, look, Steve, I think a school who works with children that looks particularly through the lens of trauma-informed practises, it actually cultivates a foundation of connection and relationships first, knowing that that's fundamental to learning and therefore increases the likelihood of a student's success.

Professor Steve Trumble:
Fabulous. Alright, well we're going to hear a lot from you tonight, so looking forward to that. Very much indeed. And then finally it's a three-person panel, Nicola Palfrey, who's a clinical psychologist based in the ACT. Hello Nicola, can you hear us?

Nicola Palfrey:
I can. Hi Steve.

Professor Steve Trumble:
Hi. Sorry, it was sort of a Canberra joke, the NBN and all that, but you're with us. That's great. Good to know. But Nicola, you've actually just recently visited several countries as part of a Churchill fellowship looking at ways to embed trauma-informed care into the broader system. Have you come across any overarching messages or approaches? There's been a lot of interest in how we drive systemic reform to make sure that trauma-informed care is part of the broader system. What have you seen around the world?

Nicola Palfrey:
Yeah, thanks Steve. A lot and hard to synthesise, but I think a couple of things spring to mind, one of which is that good practise is not new. A lot of the people listening tonight have a really good and firm understanding of what makes good care, trauma-informed care in education, health and broader systems. But implementation and sustaining that care is difficult due to a whole range of factors including funding, including workforce changes, including resistance to practise at some points. So, I think we are not alone in this challenge. I think one of the things I found was there's amazing practise happening, but no one's got it sorted and in fact Australia is in a good position, but there's always more we can learn in terms of how we can continue to fight the good fight to make this practise more commonplace and universal.

Professor Steve Trumble:
Absolutely. Well, that's part of what tonight's all about, so fantastic. Let's get into it. But before we do, those of you who have attended these webinars before will be quite familiar with the platform, but things have changed just a little bit. So, if you bear with me for a minute to interact with the webinar platform and to access resources, there's a few things you need to do. You can see the three little dots down the lower right-hand corner of your screen. You use those to access information and under the information tab you'll find there are links to the slides that our presenters are showing tonight as well as resources that they've chosen that they feel might help you in your practise. There's a survey that we really need you to fill out to make sure that we get feedback on how this evening's gone, whether it's

been effective and useful for you, and also you can click on those three little dots to access technical support.
We have a team standing by ready to help out if you run into any problems. There is also a chat room, which is usually very popular given that most people in the audience are good discussants. So, you'll see the speech bubbles top right of your screen. You click on that, and you should be connected to the chat room where you can converse with other people watching the webinar tonight. That's not where you ask questions though to ask a question of the panel. Then you click on the speech button, speech bubble icon, which is at the lower right of your screen. You submit a question there and we'll be monitoring the questions and trying to find common themes that we can present or stand out questions that we can present that the presenters will respond to. Now if you do need any technical support, you can click live webcast support as I've mentioned under the three dots, the info tab down there.
If the webcast does freeze up on your screen at any time, please just try refreshing your browser. You'll be re-entered to the webcast, but if you can't get back in then it is being recorded so you can watch it at a time that suits. Now a few ground rules about the chat box in particular. Please keep your comments on topic in the chat box rather than going off on threads and distracting people and be respectful of other participants and the panellists and the ideas that are being presented. The keyboard warriors can sometimes derail things a little bit, so please do try and maintain your professional standards in that chat. I'm sure you will. Now, uniquely or not uniquely, we do this quite often, but there's no case presentation tonight because we thought it was more important to discuss this area in a bit more detail without necessarily following a case. You can see there that there is the aim of the webinar, I think, as slide five and the learning outcomes. Our aim is to discuss latest innovation in trauma-informed practises and ensure sustainability in practise. The learning outcomes are all about that, discussing those innovations, outlining these practises from around the globe. And then most importantly, it may be describing how these trauma-informed care practises can be integrated into the daily practise that you have in a sustainable way. I'll have a little lie down and hand over now to Nicola. Thank you.

Nicola Palfrey:
Thanks Steve. Okay, so my presentation is trying to synthesise some of the things that I saw and discussed and learned about in conversations across seven countries in seven weeks. So, forgive me if I talk quite quickly and please reach out for any further information, but I think when we were talking about pulling this webinar together and thinking about it from a perspective of embedding trauma-informed practises and sustaining them, these are some of the things that came to mind. So, the first of which is policy. So, starting at the macro level and the best example of policy that I saw in my travels is The Promise, which is a policy document that was developed by Scotland. It's a few years old now. It was developed in February, 2020 and it's not been without its challenges in implementing the policy and its implementation terms of practical advancements in service delivery, but the commitment of the Scottish government to speak to over five and a half thousand people, children, young people and adults who'd been and had experiences of the out-of-home care system or living away from their birth family as well as practitioners led to this document that really outlined the aspiration of Scotland for it to be a great place for children and young people to grow up is quite astounding I think.
And the implementations of that, I've just got to call out The Pinky Promise- it's like the cutest thing I've ever seen. Which is the policy written for children and young people in language for children and young people who contributed to the policy in terms of best practise, quality of engaging youth, voice, child voice participation, and hearing from those people who are most impacted by what happens in our services and systems. It is outstanding and one of the things I'll call out is that their work and their advice around the workforce and the support the workforce need to do this work is quite exceptional. And one of the things they talk a lot about is the relational approach and we'll all be a familiar with that term, but actually unpacking that and how difficult that is to actually do in practise and the support our workforces need to be able to understand the balance between being relational with children and young people, maintaining boundaries, but also caring for people and how professional boundaries and

systems and processes can work actively against us in what we know is really good practise in terms of caring for children and young people who have had adverse life experiences. So, if you haven't seen it or looked at it, it's in the resources. There's a call out to Australia. I think we need a policy. We need not just different strategies and so forth, but actually a really strong statement about what we think our children and young people deserve in terms of the quality of life that they can expect. Next slide please.

Legislation and advocacy. Again, these two pitches are pitches from Massachusetts in Boston where Boston, Massachusetts or Massachusetts as a state are the only state/country that I've come across that actually have legislation in place, which actively says that every school in Massachusetts needs to provide a safe and supportive schools environment. I.e., a trauma-informed approach to schooling. Now that is the work of people within the Harvard Medical School. I'll say that again, the medical school, not the psychology school, not the social work school, but the, sorry, the legal school, not the medical school.
The legal office of Harvard Law School worked with their powers around legislation to talk to legislators in Massachusetts to say this is essential. This needs to happen in order to ensure the wellbeing of our young people. And so, they managed to get it into law and now schools are required to show what they're doing to provide this safe and supportive environment. The other arm of many arms that they're doing on the right is youth voice and advocacy. So, actually crazy as it may seem, it shouldn't be, is talking to young people about what makes them feel safe and supported in school. So, actually talking to young people about what they need in their school environment to make them feel safe to thrive. Certainly, police officers with guns is not that, but actually supporting the children, young people of their state to come and talk to legislators, to government about what needs to happen in their school settings to make them feel safe. Next slide.

The other thing which I think we'd all agree on is the sharing of practise wisdom. I saw this across many different places I went to, and we all strive to do this. Competitive funding models work against us in this space, and I think we would all agree with that. Short funding models, competitive funding models mean we don't necessarily progress at the rate we could if we were all funded for a long period of time to do the good work that we do in philanthropy and so forth in other countries is much more well established. But a lot of you, particularly from the education sector, will be very aware of these. They're called the purple and teal books in generic terms, but they are resources that were produced by the Trauma and Learning Policy Initiative at Harvard Law School about how to embed trauma-informed practises in schools, how to make it work. This was the foundation of work that I was working and lucky to be involved in the ACT around trauma-sensitive schools programming, but this generous sharing of wisdom of what works, how do you do it, what have we learned, 160,000 downloads of these books across the world in terms of taking what we know works and what they've seen has worked and doesn't work, and sharing that with others.

The Paces Connection is another example that's out of California was called ACEs Connection Adverse Childhood Experiences. They added the P around protective that has over 57,000 followers, which is sharing small communities, broader communities, journey of implementing trauma-informed care and practises across health, education, justice, other systems so people can learn from and get a leg up in boosting what they're trying to do. So, everyone's not starting from scratch.

The next lever universal practises, which is universal screening. Now, this is controversial and I'm happy to have conversations around this and I know Johanna will talk about this in general practise, but the notion of making it normal to talk to and work with children, young people, parents, adults, about their experiences, their early adversities as a way of tailoring their care and helping them to do the best they can. I saw this poster many years ago. We ask everyone, this is in California, this is up in all health clinics, which basically normalises when you come in and chat with me as a GP, as a health nurse practitioner, I

may ask you about your experiences as a child, your experiences of adversity as a parent, as a carer, because it will help me understand and work out how to help you. And I think it takes the stigma out of it. And in California the use of the adverse childhood experiences screen or similar tools are used universally as part of a whole child check, a whole person check and used as a way of formulating and discussing with people and giving respect to the experiences they've had and what they may want to do differently as a parent, what they might want to understand as a young person, what's going on for them and taking that stigma that we only ask certain people that look a certain way or behave a certain way. We know that trauma and adversity is really common. And so, I think thinking about how we can do that in the context, there's a lot of controversy about the use of adverse childhood experiences when it's not used in context, when it's just used as a tick and flick, but how you can do it well and do it as part of a whole person conversation. I think we've got a lot to learn and that's obviously starting to happen here. Next slide please.

And lastly, I'll finish up, it's hard to know how long I'm going because it's been flicking back and forth, but I'll be quick, which is training. One of the things I came out from is we have good trauma-informed care training in Australia. I think it needs to be evolved and it needs to go to the next level in terms of skills development. There's a lot of research out from workforce surveys that people are super keen to learn about trauma-informed practise. They understand the importance of it, but the skills in terms of doing it, we really need to support our workforces to do it needs to be provided in pre-service, in training, in early career and in ongoing career. And it also needs to look at not just noticing, but how to respond to effectively and provide support around people's experiences of trauma and adversity. And I'll leave it there, Steve.

Professor Steve Trumble:
Thanks Nicola. Thank you so much for persevering and also to all our participants. Hopefully the technical issues will be sorted out soon if people are still having trouble, but what you said was very, very valuable. This is probably a bit of a flippant comment, but it does seem extraordinary that the US appears to be leading the way in this area when there are such issues with trauma in school. But I guess that's the very pointy end of school shootings and things like that.

Nicola Palfrey:
Yeah, I think they've got absolutely the broadest spectrum, Steve. Absolutely.

Professor Steve Trumble:
Yeah. Well, we'll come to further discussion about that. So, again, Nicola, so we'll move on now to our next presentation, which is Johanna giving us the GPs perspective.

Dr. Johanna Lynch:
Thanks so much Steve. And as I mentioned at the beginning, I've become really passionate about bringing trauma-informed practise into mainstream medicine, mostly through new ways of thinking about our work and new ways of seeing the person and pattern recognition that goes across a life story, not just about the symptoms that are in front of us at the time and also integrating the latest in the science around how our bodies respond to our lived experiences. I have here an image that I got to present an Australian association for academic primary care on a dangerous idea. And that idea was, is multi-morbidity iatrogenic, which means is when someone has multiple diseases, is it because the doctor has only seen them in fragments and has named all the fragments without actually seeing what's going on underneath? And this image was used to say, what about if we as people are like trees in a forest with the other trees nearby, connecting under the ground and through the air, through pheromones.

And the bits of the tree that are easy to see are the leaves and they're easy to measure and name and they can be signs, symptoms, behaviours, and test results that become the focus. Other parts of our community in the social sector are really good at seeing what's underneath the ground, the connections to our community, to our history, to our environment, to our culture. And that's a different kind of knowing that those communities do really well. But somewhere in the middle is a connection between the roots and the leaves. And it's this connection that when I teach GPs and medical students and other mental health professionals, I say this is sometimes the neglected piece of what's going on that's connecting what we see on the surface in the leaves and what was happening down in the roots. And things like our immune system and our stress response system are in there from a bodily point of view, but there's also things like feelings of belonging and our spirit.
And for my work, it's come to mean the sense of safety. How safe is this tree feeling in the forest? So, I think we need new shared language and Nicholas said that good care is not new, but sometimes we've gone down alleyways and I think sometimes the chase for precision and confidence and certainty to predict means that we've got less good at noticing things that are happening to the whole tree that are more uncertain and more in flux and happen over time. And so, I hope that what a speak today will be of encouragement to those of you in the audience. Ready for the next slide?

So, I would see that trauma-informed practise is a new way of seeing the whole, it's actually a code word for a new paradigm of care. It's saying that those original ways of seeing people that have become encoded in sort of biotechnical ways of seeing the person and in the fragmented ways we see people in community and the different ways sort of vulnerabilities. We identify and say that that's what's wrong. We've started to forget to see what's happening in the whole. And I would see that if we start out on the left of the slide there, trauma-informed practise brings in social determinants of health, the climate because that can cause threat to people, housing and finances. And if we go round to the right, it also includes our understanding of culture and community. It's violence and neglect informed, it's child aware. And then if we look at relationships, it's about respectful relationships, attunement, attachment, making sure that people experience trust, choice, consent, and that we focus on the quality of our therapeutic relationships. And then if we look at the body, it's actually really helps us to encode and bring in the latest science around our senses and our neurophysiology and immunology and toxic stress, which I'll mention in the next slide.

And of course, it brings in the inner experience of the person, their lived experience, only they can tell us whether or not something was traumatic to them. And the loss of sense of safety is the sort of way that I would frame that. And it includes not just thoughts, but perceptions and attention and memories and images and nightmares and visions and all the good things that can be in there as well. And sense of self is central in trauma-informed practise and often missing in other forms of mental health care. And it includes how people are traumatised on the inside reflecting on their external experiences of relationships that they might ignore or attack themselves and lose the capacity to reflect on their own self. And lastly, it integrates people, how people make sense of the world as a way of recovery from trauma or coping with trauma. So, it includes culture, it includes inherently a recovery orientation because people can recover from trauma when once we thought they couldn't. And it includes things that help us to recover like hope and existential beliefs around spirit and transcendence. And it addresses shame in a really intentional way. So, these are the things I think trauma-informed practise can bring to help see the whole person ready for the next slide.

And we have the sense of patterns in trauma-informed practise that help us to notice what our senses are there to protect. They're there to protect our sense of integrity and our bodies, but also our identity. They're there to protect our sense of coherence. How do we make sense of the world? How do we fit into the world? How do we organise ourselves and understand our own emotions and the people around us and how do we stay safe in connection with other people? And as mammals, all three of

those matter. It's not just the violations of our integrity that matter, it's the things where we become disconnected from other people or confused and can't make sense of our world that also cause us trauma. And so, each of those attacks on our sense of integrity, coherence or connection can be noticed whether it's in the school playground, in the doctor's office, in the dentist's office, in the veterinarian's office.

We even see it and there's growing awareness of it being seen in those spaces, right all the way through to our law courts. The next slide just summarises the concept of toxic stress and Nicola referenced how much is being done in California. It's a fantastic story of one woman's amazing changes in one state, and that's through a paediatrician called Nadine Burke Harris. Her Ted talk should be in your resources sheet and her website number story.org outlines the latest in the area of toxic stress. This is my image to remind us that toxic stress happens when people don't have safe relationships around them and they have a lot of stressors from outside them attacking them, and that we have positive stress as well when we are well supported, and life happens, and we learn how to grow. And there's such a thing as post-traumatic growth. In the middle is tolerable stress where we have so many stressors, but the presence of another human being makes it tolerable for us.

And so again, highlighting the importance of relationship in trauma-informed practise. And lastly, I just remind you of the sense of noticing the whole person through the image on the next slide of us as a whole person, where we feel threatened and where we feel safe and who we feel safe with really matter for our whole sense of self, from our meaning, our sense of self, right the way through our body, our relationships, and where we're living all matter. And I really commend all of you who do this work for the deep noticing that you do to in your care. And over to you, Steve.

Professor Steve Trumble:
Thanks very much indeed. Johanna, I must say I'm struck by those images, how much they resonate with some of the work being done in First Nations communities about broader holistic understanding of public health. It's a very thorough and thoughtful approach to considering this matter. So, congratulations on your work. That's great.

Dr. Johanna Lynch:
Yeah, thank you. Sometimes give the story that Humpty Dumpty was pushed off the wall by western science to study him and nobody put him back up together, but thankfully First nations communities have held him together and never kicked him off the wall.

Professor Steve Trumble:
Exactly. That's the whole point. Well done. Thank you. And now we'll finish the presentations with Beck, and we'll move to a conversation after that. But Beck, you're going to tell us a bit about the lived experience and also what happens in the classroom.

Beck Thompson:
Thanks, Steve. Yes. So, my slides will focus largely on how trauma is impacted in the classroom. And as we know, we've been so much research and evidence now that we know, particularly with all the neuroscience coming out, that stress and distress and trauma actually interferes with the process of learning something that was never considered 30 years ago when I was at school for sure. But those with students with a history of trauma have an abnormally activated stress response, which actually as we're learning, shuts down the cortex, the upper region of the brain, which consequently limits the child's capacity to learn. And so, in the classroom that would look like their inability to concentrate, pay attention, particularly retain and recall new information. So, it might look like they're listening, and they are attuned to what's going on, but not actually take anything on because that toxic stress actually

interrupts their focus and ability to actually retain anything of what's being said. And of course, it impairs their emotional regulation so they're not able to deal with what's going on inside. So, the question I guess for a lot of educators is what can we do to minimise or work with these stress responses so that we can maximise students' learning potential? Next slide please.

So, one of the ways that I have found it's simplified because neuroscience is a huge topic. There's a lot to understand in the brain, and I know educators can feel overwhelmed with so much information. There's not only the pedagogy and the student's emotional needs, but now we've got to understand how the brain works and how that really affects the child's ability to learn. And then on top of that, the trauma affecting the brain. One of the things that I think is really simplified version is Dr. Perry's neuros sequential model, which is also known as the sequence of engagement. And the neuros sequential model in education is based on an understanding of the structure and the sequential nature of the brain. You can see with the arrows pointing up way the brain is organised in a hierarchical way so that when we process information in that sequential manner from the bottom to the top. So, it means that when the lower part of the brain around the brainstem is not regulated or when a child is dysregulated, the higher brain regions such as the cortex cannot function optimally. So, I think it is just such a great, you don't need to know a whole lot, but you just need to know the process and those three main parts of the brain. Next slide please.

So, one of the things that I love, Bruce Perry says this a lot for educators, and it's something that I remember when I'm teaching with students is to get to the cortex. That's our job is we want students to be engaged, we want them to learn, we want them to retain, we want them to recall, and obviously we want them to do that in an environment that is relaxed and safe and trusting. So, using the Bruce Perry's neuros sequential model, we start in that hierarchical position at the bottom. And our first job is to help a student create calm and be regulated and calming that flight or fight response first. Because it's sequential, we have to have some sort of degree of regulation before we can even try and connect with the student. So, once we have that minimal degree of regulation, we can then move on to the mid part of the brain and use our skills to connect with the student so that they feel relationally connected to and they need to feel like they are, that we can relate and that we are connected before we can even begin to access the cortex.

And so, the idea is that once they're connected and calm or regulated, they can then have be in that space to then be able to engage and do all the things that the cortex does, which is part of it is thinking, planning, focus, focusing. So, next slide please. So, in the classroom, these are the practical things that you can do when using the neuros sequential model. Again, I'll keep saying it, it's bottom to top. So, the first thing we need to do is to help the students regulate and calm their fight or flight response. So, as a whole class, this might look like the first five minutes of the day just to engage in a rhythmic pattern movement, whether that's song or dance or both, just a couple of games that I can mention, follow the leader or just dance. YouTube has some wonderful kid, child friendly YouTube videos like just dance. And it's just that first five minutes of the day. I used to take my kids out for the first 10 minutes outside for a game, whether it was fruit salad or just some game that they loved to play. And it was just that active rhythmic movement for the first 10 minutes. Now, you can also do it throughout the day or after each break, and it really is dependent on your class and dependent on your students. And you will know that as a teacher in the classroom, what's going to work for you. It doesn't have to be so structured. And it's about, I guess observing the classroom and noticing, okay, is the energy being depleted? Do they need a break? So, you can use your knowledge of your classroom to be able to decide, but there should be some breaks through the day that can just give them a chance to regulate.

And so you can start again on any other task, but as an individual, sometimes I've found that you can do the first five, 10 minutes and most children are fine, but you will get some students that need that little

bit of extra time, they won't necessarily be engaged and ready to go with the rest of the class. So, that again, is to use to your discretion as far as what you know about the student, what their needs are. But I would always offer more to that individual student. Do they need extra time? Do they want to walk with a safe person? I always offer a safe person for them. If you have a sensory corner or a regulation sort corner in your classroom, you can give them an opportunity just to go to that space and do some sensory quiet activities just until they feel ready.
And most of the time, I have found doing these kinds of things, students will naturally come to you, and you do that connection. Are you okay now? And they're usually okay. So, that again is individual to the student's needs. Next slide please. So, the next step obviously is to connect. That is to relate and connect with them. Now, this is, again, it's individual and it's always going to be dependent on some kids come to school with some heavy staff first thing in the morning and quick five-minute chat might do it, and other times it might be a bit longer, but they absolutely need to feel relationally connected before they can access the cortex. So, it is about being present and just listening. It's not rushing or being dismissive and quickening their pace to get to the task because we know they need to feel seen and heard and supported first.
There needs to be a strong message that says, I actually care about what's going on for you. And I know that at the end of the day you are not going to be able to concentrate or do anything unless there's someone here that is attuned and relating to you in a way that says that I actually care about what's going on for you. So, that, as I said, it might look like a five-minute conversation and listening to the student and speaking with compassion, and I put in humour there. But obviously if it relates, some kids just like that little bit of humour to break it up a little bit, they'd obviously use that to your discretion. But it absolutely is about stepping back, giving them some space and just being present with some. And those connections really do matter. And generally, for me, I would absolutely check in on with those students specifically, if a student has come to me in the morning with something, it's not just about connecting. And I'll mention it again at the end, but it's not just about connecting once. It's about checking in on them, how they are going throughout the day and what supports do they need as we go along. Next slide, please.

So, hopefully once we've done that regulation and connected relational kind of work, they should be at a point, should be at a point where they are, the cortex is open for business. And I just love hearing it like that because it makes it easier for me to understand as a teacher. Like I said, we're teachers, we're not trained in neuroscience, but I think having these terms makes it easier and more applicable for us to understand and to be able to apply it in a practical setting. But once we've done those things, they should then have access to that sinking part of the brain, which obviously will help them to be able to relate, learn, and focus, which does actually set them up for greater success because you've done, you've gone through that model from the bottom up in that sequential manner. But I will say that because of the way that the trauma does affect the brain with that abnormal stress response, often quite hyperactive or hypervigilant I should say, to a real or perceived threat, it just needs to be revisited because obviously a lot happens throughout that day, whether it's in class with another student or whether it's outside with a situation on the playground.

So, it's not sort of restricted to doing it in the morning and right. We've got them for the morning. You might have to revisit that every session. And for some students it will be multiple times throughout the session. And I've had kids that I've worked with more recently where it is, it's every session and it's multiple times. So, you just keep going back and just keep going back because they're often so hypervigilant to threat around them. As I said, perceived threat. You've got to just keep going back to regulation and connection and building up that for them to be okay. So, it is about gauging them throughout the day as you know your students. So, next slide. Sorry, next slide, please.

Yeah, just one more. Okay. So, yes. So, by understanding how trauma affects the brain alerting and engagement, I should say, what I love about the sequential model is that it actually gives educators a really clear pathway to working with students in particular those with a history of trauma, which I believe sets both the teacher and student up for greater success to be able to teach and learn.

Professor Steve Trumble:
Great. So, thank you. And the neurosequential pathway sounds fabulous. Obviously, the sense organs are a big part of that pathway. And we've had a comment from a colleague in the chat box about occupational therapists and thinking about extending the professional network. Have you ever used or worked with an occupational therapist in the classroom to try to look into the sensory inputs that a student's receiving?

Beck Thompson:
No, not me specifically, but I know that we have them on the grounds where I work. It's often a part of our team, but not specifically, no.

Professor Steve Trumble:
And somebody's also said that this model would seem to be applicable to adults as well with some appropriate modifications. I don't know whether you or Nicola or Joanna have any thoughts about that.

Dr. Johanna Lynch:
Yes, yes. I would say that we teach GPs this model, not in as beautiful detail, As Beck just did, but we teach that when we say give someone bad news in the GPs practise, there's no point in just going straight for reason. We must do the steps before that which to help them to regulate enough so they can take the information in and to build the connection so they feel safe enough before that news is given. That's a blunt example of how we would use it in general practice.

Professor Steve Trumble:
So, trying to deal with that cerebral fibrillation that hits you, I guess when the neurons all just fire off and you're not hearing anything, that sounds like a wonderful approach. Well, thank you all for your presentations. I was very excited when I saw the number of questions that had come in. Unfortunately, 98% of them were asking where the sound had gone. So, we have found some good questions as well about the presentations and really good feedback to each of you about your presentations. But I'm curious, I'm just having Nicola in Canberra. I'm just going to give you a nightmare scenario, Nicola, where you're stuck in a lift briefly with the Minister for Health, the education minister, the Prime Minister. It could be all one person under the last one, of course. But anyway, your challenge is within what's a short elevator ride. How would you explain this topic? Trauma-informed care, and so that they understand why it's important that it's embedded and sustained within the system.

Nicola Palfrey:
I might press stop at first; emergency stop to give you a little more time! But no, I think that there is a succinct notion of what trauma-informed care and practise is, is it's the best evidence-based practise for engaging and supporting children, young people and adults in learning and succeeding in life. And that we know that trauma and adversity is common, but all of us have been doing this work for a while. I think in 2023, having lived through the past few years of pandemic bushfires and climate crisis, economic crisis, I would like to think the argument is over that every person in the globe has experienced significant adversity and disconnection. So, it's there, it's real, it's happening. People keep questioning why people are distressed. It's not a question for a lot of us is because people have been denied opportunities to connect, to relate as everybody's spoken about tonight. They've been presented with greater levels of stress and distress and frightening experiences, and they previously have. And

trauma-informed care is a way that we can have a lens, a curiosity about what people have gone through. There's a catchphrase. Trauma-informed care is not what's wrong with you? What's happened to you? I can see the screens come up again.

Professor Steve Trumble:
I think we can still hear you. I hope we can still. Okay.

Nicola Palfrey:
So, my paraphrase of what trauma-informed care is it's a lens through which you have curiosity about what a person may be experienced or have experienced, and you approach that with care, compassion and interest and behaviour is communication, whether it's an adult or child or anything in between. When a child is distressed in the classroom, no child wants to be that child. They don't want to be excluded from the classroom. Something's going on for them that makes them feel unsafe or disconnected as has been so beautifully spoken about tonight. And trauma-informed carers about educating yourself about how to be curious about those things. How to engage with people in a way that feels safe and secure, builds connection and relationships and does not seek to retraumatize.

Professor Steve Trumble:
Great, thank you. And Natasha has asked a question about what about in general practise with, as you've talked about being interested in the whole person, but Natasha has asked, what happens within the famous 15-minute slot? How can you actually introduce the person to the concept of trauma informed care and actually practise it? So, how do you talk to people about trauma informed care in your practise, Joanna?

Dr. Johanna Lynch:
Well, I would say that it's not about opening the Pandora's box in that 15 minutes. As one of my GP colleagues has said, I don't want to open that box. And instead, I would say that this is about sensitivity to the possibility that the other person may have been harmed by people. And in the intimacy of the general practise clinic conversation, we need to be very aware that just our presence, our very presence might be making them feel alarmed because of how close we are to them or what we're talking about. So, it's an attitude towards the person that can be there from a five-minute consultation to a much longer one. And I would add to that, GPs, we talk about having one long conversation that happens in multiple episodes of care so that the 15 minute consult, if it's done by someone who seeks to see the whole person, they will be using that 15 minute consult to build relationship for the next time the person needs them and for the time after that and for the time their child needs it or their grandparent needs it.
And so that's how we build a picture of the whole person through shorter consultations. The other thing I would say in general practise when I teach GPs is that this is up-to-date science about how disease forms in a person that enables us to do better prevention and early intervention. So, if we understand that somebody's life experience is encoded into their body right the way down through to their cells and DNA changes their stress response, it changes their heart rate, their blood pressure, it impacts their cholesterol levels, it impacts so many things about how illness forms. And so, this is the most up-to-date way to understand how illness forms in humans that it's superseding a disease categorisations way of seeing. And lastly, I would add, if those of you are new to this, the Blue Knot Foundation has some fantastic guidelines that give a really good overview of what trauma-informed practise looks like and what the key elements of it are. And I would add that I think the traumatised in my community have taught me so that I could see the whole community better. They show us big deep patterns through what happens to them and their bodies and through their bravery and talking about suffering, that enables us to see other people more clearly who can't explain it as well as they do. So, that would be my summary about the 15 minutes to you, Natasha.

Professor Steve Trumble:
Thanks, Johanna. That's very, very helpful. And Beck, I'm wondering what your thoughts are, having listened to that. One of the questions that was asked before the webinar was about what a person, what really matters most to a person with respect to their therapist in this area? What qualities and attributes, the things that Nicola and Johanna have been talking about, showing interest in the whole person and those sorts of factors? Is that what you believe people are looking for when they're seeking out trauma informed care? Somebody is genuinely interested in the whole person.

Beck Thompson:
From my lived experience. Is that what-

Professor Steve Trumble:
If you're happy to share that?

Beck Thompson:
Yeah, look, I do get it is really challenging because often, as you say, GPs usually have such a limited time and they're supposed to get a whole scope of a person in such a short amount of time. Obviously if it's a GP that you see consistently. And I've been quite lucky with my own history that I have had the same GP for about 10 years each go. So, they've been able to develop a history just from my visits and then look at patterns to what's going on with my visits. Sometimes I think with the interesting part, Johanna was talking about the cultivation of diseases with trauma is that I actually did actually have a huge amount of health issues that I didn't realise was related to my own trauma. And it is, I think as someone who's gone through it, you don't always present. You certainly don't show up and say, oh look, I think my trauma's giving me heartburn, or I think it's giving me palpitations or the chronic stress that affects digestion and all sorts.
Gosh, I had a long list of issues. But you don't know that. You honestly don't know that you really think that there's something going on you if you're not informed, you don't understand that the stress from your own trauma can impact your health like that. So, I do think it's challenging for GPs to kind of get that, because I assume their primary care is to make sure you are physically okay and then maybe look at the history behind that. But yeah, it definitely takes consistency. I think the GP has to have that relationship with the patient to be able to see that, I think, and look beyond what they're coming and presenting with physically.

Professor Steve Trumble:
Well great. That's actually a really good opportunity to mention an upcoming webinar that Johanna has been involved in setting up where we'll focus particularly on the physical issues related to trauma and the interface with the psycho or the physical and the psyche aspect of the general practitioner's work. So, thanks for mentioning that. That works out really well. I should also just mention, if anybody is concerned, the recording of this webinar will be edited to remove any gaps in the sound. So, feel free to recommend it to people to listen to the edited version. They'll probably wonder why we all look so stressed, but it'll be seamless in the edit as they say. Okay. So, thank you very much for your comments so far. There've been some great questions coming in as well. One question that I think was asked possibly the most frequently, was about particular populations of people and their experience of trauma. And the group that came up most commonly was people with an intellectual disability. I was wondering if anybody on the panel has any thoughts about the particular approach to addressing trauma in the lives of people with a disability when we're counselling them?
It's a question without notice. It's a difficult area, but Johanna, it looked like you were going to have a go.

Dr. Johanna Lynch:
I was just thinking back to one of my patients who was in that situation, and there are some blocks to some of the ways we use that are top down where you're using cognition to help explain something or make sense of something that helps 'em to calm from that direction. But we've still got openings for using ways that soothe the body and finding out what ways soothe that particular person's body from the bottom up, as Beck has so beautifully explained to us today. So, things like movement and moving our right and left sides of our bodies, music and addressing what the body needs to feel calm is a way in with this group of people. I guess I would also bring into our attention today, the recent study called the Australian Childhood Maltreatment Study, which took eight and a half thousand telephone calls to a representative sample of Australians and has got a fantastic website if you'd like to check that out about what populations have and what the incidence is and how much this is a problem in our wider community for us all to be aware.

Professor Steve Trumble:
Okay. Well thanks for that insight. There's always been a big focus in general practise, though, I guess when mental health became more recognised by government within general practise of CBT contact therapy, obviously Barry's asked a question about thoughts on the insistence reliance of so many clinicians working with stress, anxiety, and trauma on a top-down CBT approach rather than bottom-up body-based modalities. I was wondering, Nicola, would you have a thought about that to begin with?

Nicola Palfrey:
So many. Anyone working with clients needs to work from the evidence base, and there is evidence for modalities such as trauma-focused CBT or EMDR or other trauma specific therapies in terms of dealing with the specific characteristics of some outcomes of trauma such as post-traumatic stress disorder and intrusive thoughts or nightmares and so forth. I think CBT has its place, but it requires exactly what we have discussed is often not easily accessible for people who have experienced trauma and adversity, particularly if you put them in a therapy context, which is potentially stressful, potentially re-triggering, which is access to the prefrontal cortex in order to think rationally about things which are incredibly distressing for them. So, my response to that is that CBT has a great evidence base for certain mental distress, anxiety, depression, those sorts of things.
However, any of us that have worked in any way, whether it be as an educator, a human, a clinician with people who have experienced significant trauma, would recognise that there's a lot of other modalities that work much better and are much safer and more secure for people to feel a sense of efficacy and safety in their own experience. And they are things around, how are you in the world? How do I help you? The sorts of information that's been shared tonight is the sort of information that I share with clients when you have experienced really frightening, overwhelming events as a young person, these are the ways your body responds, and your brain takes over. So, it makes complete sense that you dissociate, or you are hypervigilant. We know that kids that have experienced family violence are super attuned to changes in tone of volume. That's why you freak out when your teacher just change their tone of voice and you think they're shouting.
There's so much more that we can do when we understand this work, which makes people feel, excuse my language, but less crazy because they feel crazy and they're not. They actually are having a really sensible, safe response to what they're being exposed to. And that is not CBT. It is understanding, questioning, curiosity, empathy, and working with them to understand all the mechanisms they have in place have been protective, but maybe you don't need them anymore. And there's a lot of evidence around those different modalities. So, sorry, I could talk about that for a long time, but that would be my response is that it's meeting people where they're at and not just following a step-by-step path is really, really important in trauma-informed practise.

Dr. Johanna Lynch:

Nicola, I jump in there more and say, actually I would see that CBT is often contraindicated in this population because it doesn't acknowledge dissociation and it often will train one part of the person to dominate the other parts of the person that are terrified and make them be quiet and ignore them even more than they were before, without caring for them as embodied beings. And I think the dominance of CBT has become partly because it's easy to measure and easy to give in modules that make it evidence more easy to do a randomised controlled trial with doesn't actually mean it's the best treatment modality for our community as a whole. And I think it's a side effect of a community that highly values rational disembodied thinking and doesn't tune into our senses and our bodies in a way that is helpful for healing.

Professor Steve Trumble:
Beck, I don't think the audience can see your face. I can see your face. And you've been a cascade of facial emotions as people have been talking. Lots of nodding, but also some raised eyebrows. What are you thinking about what we've been talking about?

Beck Thompson:
Well, I mean obviously I've had a lot of therapy and back in the nineties, I think when I started therapy there was no such thing as thematic experiencing, and it was very much talk therapy. But I mean, listening to Johanna and Nicola just nailed so many things for me personally, the thing that CBT and I ended up abandoning it in the later stages of my recovery because it didn't fundamentally address my immense unsafety. I just didn't feel safe. And I remember going to a therapist at the time and I just said, I can't do this because it's too rational and it's not rational in my body. So, I had to kind of learn myself to just pay attention to the fear. And it's just this, you can't be told not to be afraid. And that was what I think I really just really struggled with is that, well, let's reframe your thinking.
Well, no, I needed to reframe my body. I absolutely needed to feel safe because as soon as you feel any threat, whether it's perceived or not, and we are very hypervigilant to any kind of threat because that's what we've learned to do to keep ourselves safe. You're not thinking, oh yes, I must stop and reframe my thinking. You've got to go inside and address the body, the sensations of the body. So, I think it has its place, but I think it's got to be that felt sense of safety first and that trust in the body to be able to then go to cognition. Yeah, that's what worked for me anyway.
Professor Steve Trumble:
So, you mentioned safety and others have mentioned safety as well. So, many questions we had from people who were worried about causing harm, particularly from a couple of students who said that they are terrified of making things worse by delving into an area that they don't feel able to manage. Had we done harm? Do people have thoughts about that?

Dr. Johanna Lynch:
Yes. Happy to go there. I really think it's important for us to have a strength-based approach to trauma, which is knowing where we want to help someone get to. And so that's part of why my work has been centering around the sense of safety that someone has. It's their own personal experience of feeling safe in the world, and that our encounters with someone is always trying to build that sense of safety. And Christine C, who's a key thinker in this space, says that safety always takes precedence over story. And I would say that when I was a young therapist, I used to feel I needed to hear the story that someone had experienced and witnessed with them and grieve with them for what they'd experienced. But now I would say that I focus more on knowing the patterns of what I see and of what an injury might've caused in someone.
And that their time for talking about what has happened to them happens long after they've developed their own sense of safety. And in fact, Judith Herman would say, our first job is to help someone stabilise or feel safe in the world. Only then do they go to what she calls grief and remembrance or mourning and remembrance. And then finally to reintegrating with life. And I would say therefore, if we just got really

good at helping our community feel safer through the things in their environment, their housing, their jobs, their workplaces, their schooling, their capacity to relate to other people safely and be treated respectfully and their inner world of how they treat themselves. We don't need to actually talk about what harmed them until many, some of my patients, it would take years till they're at the place where they can, what we would normally do in grieving, which is to have a little dose of something that reminds us of something sad and to metabolise that and understand it and then recover from that and move on to the next part of the memory. So, I hope that's of some help into that answer.

Professor Steve Trumble:
Alright, thank you for that. And actually, we might just have a quick word from Nicola. I think you've come up.

Nicola Palfrey:
Yeah, I think it's a really good point to raise when you work with particularly people wanting to work therapeutically with people, it's the biggest barrier to working in a trauma-informed way is wanting to do harm. And it's a good question to have. My framing would be a decade or two decades ago, we used to think asking people about whether or not they had thoughts of suicide would cause them to act on thoughts of suicide. And we know that not to be true. And the same is with regards to trauma and adversity. Johanna's absolutely right. You don't need to ask people to unpack or give detail of what they may have experienced. But if you have an understanding of trauma-informed care and you communicate to people why you may be asking the question, you won't do harm. And if you respond to it with care and compassion and do no harm philosophy, which is I seek to understand this in order to help deliver the best care to you, you'll not do harm but not asking about it.
There's been a lot of research around not asking. And if you think about a biopsychosocial assessment, we ask a whole lot of awkward questions of people. We ask them about their behaviour, their drug taking, their sexual activity, their suicidal ideation, and people talk about the fact you never ask what happened to me. So, I may engage in all of these other behaviours, risk-taking behaviours or self-harming behaviours or other behaviours, but you'd never ask me did I have anything unpleasant or distressing or frightening happened to me as a child or young person or adult. And so, I think if you frame it in that way as a part of, as we said, a whole person assessment and conversation, we can step away from our discomfort. And that's another big finding for my Churchill is adult discomfort, adult discomfort of hearing stories gets in the way of good practise a lot of the time. So, equip yourself, train yourself. There's hundreds of good resources out there because it's evidence-based to do this stuff.

Professor Steve Trumble:
Thanks Nicola. We could spend all night talking about this. There are many, many more questions to cover, but I do think there's an opportunity just to run around the panel and ask each person, just 'em, just to sum up their feelings about what they've spoken about tonight. It was interesting. One of the questions we got was whether people were able to give a message of hope about moving ahead with trauma-informed care and what might be able to be done in the future. But just to hear from each person about what the final remarks you wanted to make. And I think we should start with you, Nicola, to keep in that order.

Nicola Palfrey:
I'm going to be brief. I've had a lot of airspace. I feel like it is hopeful there is, anytime there is this sort of information or any other information about this practise, there is massive support and interest across the community. We need to band together, share, practise, do the good work, and please if anyone's interested, reach out and learn from each other. And recovery is not just possible. It is likely that the world wouldn't turn if people who had experienced trauma and adversity didn't thrive.

Professor Steve Trumble:
Alright, well I'm going to take that as hopeful. Thanks very much, Johanna, your final thoughts?

Dr. Johanna Lynch:
Well, I was going to say that 15 years ago when I set up my practise trauma informed practise called Integrate Place, I would never have believed we'd be having this discussion today with so much moving around the world and so much understanding. And I really see trauma-informed practise as the bringing in of a new paradigm of care. That means that we're training healers so that they can see and notice suffering more easily. And so, I guess I wanted to honour the people listening tonight for giving up their evenings, for taking the time to try and see and hear their patients more carefully and understand the impact of someone's childhood on their present life as an adult. And so, I wanted to encourage them in their work and in their journey to become better healers.

Professor Steve Trumble:
Right. Alright, well we'll take that encouragement. Thank you so much. And Beth, the final word's going to be with you.

Beck Thompson:
I am going to say something a little bit different, but I love the idea of the very possibility of hope because there is hope with trauma-informed practises. And in fact, I think it gives so many people within the community, certainly in education, the sequential model gives educators not only the framework, but it helps students to relate and connect more and develop those relationships, which I think are really critical. And I just think the emergence of trauma-informed practises in schools is an incredible step forward in really helping us understand how many people we need. We need people, students, children need relationships to grow and thrive and of course learn and then engage in communities outside of school. So, I think it's such a wonderful, it's just amazing. I mean, I'm thinking when I went to school many, many years ago, decades ago, what an opportunity we would have to change the landscape for so many students had we had that practise embedded 30 odd years ago. So, I think it's always an opportunity to do better and I think trauma-informed practises certainly does that. It gives students an opportunity to thrive.

Professor Steve Trumble:
Fantastic. It's all about thriving. Thank you so much for your thoughts tonight. It's been incredibly valuable having you on the panel and certainly the chat room has been buzzing with accolades for what you've said. So, that's fantastic. Thank you all very much for your presentations. You've all been very well received tonight. There's just a few things and I'll ask people to please not drop the connection yet. We've got a few things to ask of you. The main thing is to get you to fill out the exit survey to provide us with feedback, the technical issues we know about, but obviously you can comment on those. But we'd also love to hear from you what you think about the content and where we can improve the webinars in the future. I have mentioned that the recording will be available. You'll be sent a link to access the recording if you want to.

And as I say, it will be edited down to just the important bits where things were working well for us. There are some really important webinars coming up that I'd ask you to take note of, particularly the webinar on Trauma-informed Care part two, which look at therapies and approaches to improving your practise, which is on the 20th of September. And that will cover a lot of the things, well, it'll build on the things that have been discussed tonight obviously. And then as I've already mentioned, the webinar coming up in the 19th of October, which looks at the impact of trauma physically and what that can do to mental health. So, broadening the perspective there. So, please join us for those ones. There will be

further notifications about other webinars coming up. The podcast, the MHPN podcast programme releases episodes on a fortnightly basis, and this is a really important one.

The latest one is In the First Person, a peer worker talking about being an expert by experience, which I know our audience always finds really, really valuable. So, thank you to Beck and Johanna and Nicola and to all the team running the webcast tonight who have managed to keep us on the air despite the difficulties. But before I close, I would like to acknowledge the lived experience of people and carers who have lived with mental illness in the past and those who continue to live with mental illness in the present. So, thank you everybody on the panel and participants for being with us this evening, and I wish you a very good night. Thank you.