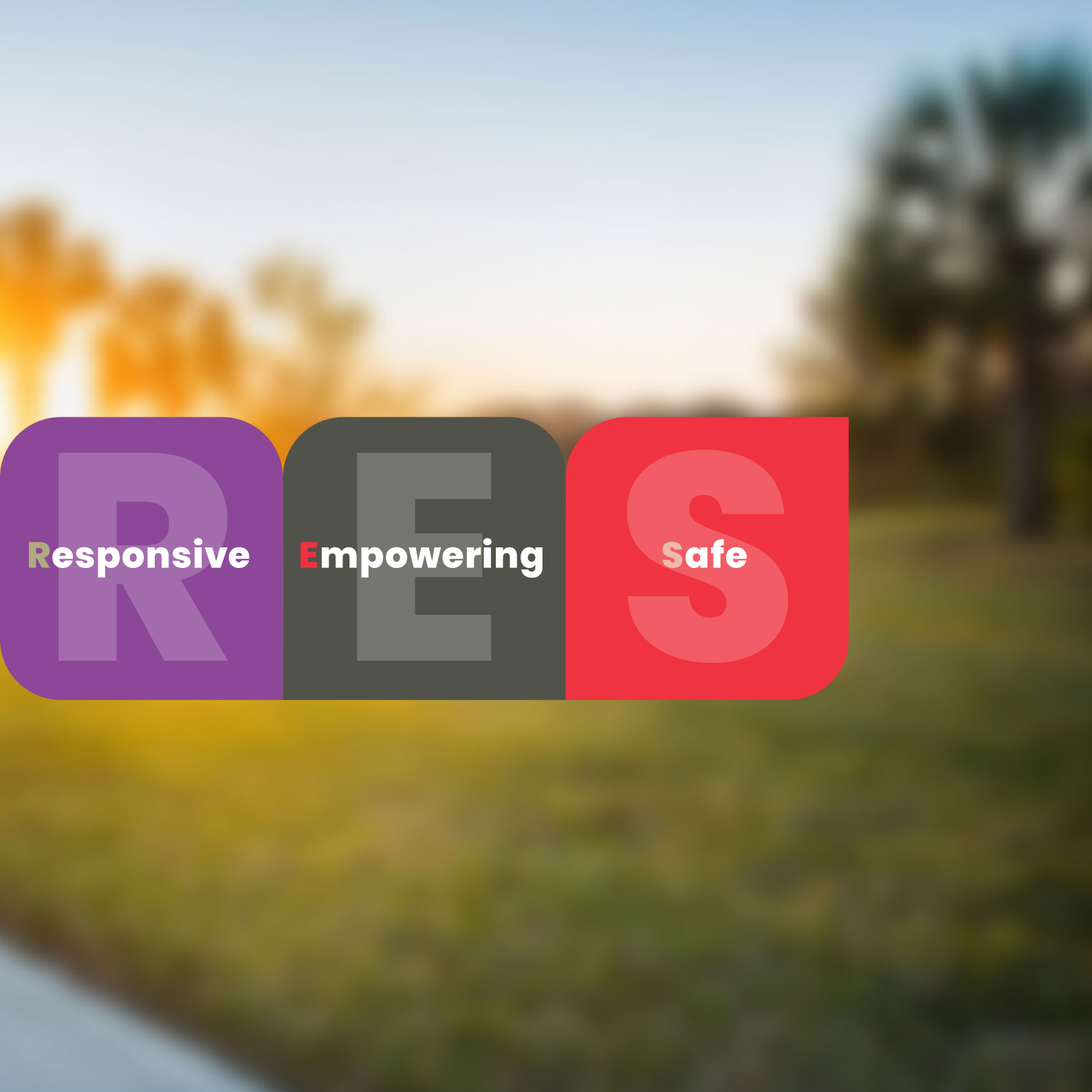
The MASP CARES

Therapeutic Model of Care

Mallee Accommodation
& Support Program Ltd

masp


masp
Connected
Accountable


Responsive
Empowering
Safe

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Acknowledgement

We acknowledge the Traditional Owners of the lands on which we work and live right across the beautiful region we are privileged to call home. We pay our respects to Elders past, present and emerging, and the ancient connection they have with their country. MASP is deeply committed to the principals of cultural safety and equality for aboriginal people, along with the many diverse ethnic, religious, and cultural groups that call the Mallee home.

Introduction

A Message From Our CEO

The MASP CARES Therapeutic Model of Care guides the way we work with our clients, our communities, and of course each other. The Model is the result of many months, indeed years, of research, collaboration, and hard work by many within our organisation. I congratulate our Director of Practice Helena Moore for her authoring of this document, it is a power of work. Helena also convened our Model of Care reference group featuring staff from across all areas of MASP, and I thank the members of this group in particular for their significant contributions to the Model development process. Our Board should be commended for their vision in introducing a Therapeutic Model, and for their commitment to providing the resourcing and ongoing belief in the project over the years.

MASP is an organisation characterised both by the people it serves and the people who serve them. We believe in early intervention and in driving generational change, but we don't shy away from doing the hard work with those most in need. The MASP CARES Model speaks directly to our Values, and is part of our commitment to live by these values with great gusto each and every day. The Model will guide us as we focus on delivering services and improving lives right across the Mallee, delivering measurable outcomes and real change for our clients and communities. Our Strategic Plan calls for MASP to spend the coming years building on strengths, addressing areas of improvement, exploring opportunities and delivering sensible and sustainable growth. The Model will be a tremendous enabler of all this work.

The success of this Model will ultimately be driven by our dedicated team here at MASP, and as always, I thank them for their incredibly hard work on behalf of our clients and communities. Finally, to you, the reader, thank you for taking the time to read this body of work, I hope you enjoy the read as much as I did, and I just know you'll get a lot out of this work. Enjoy.

Vincent Wilson
Chief Executive Officer

A Message From Our Director of Practice

The MASP CARES Therapeutic Model of Care is the culmination of almost two years of work. It began with a recommendation from our board back in 2017 and, thanks to their vision and commitment we now have a comprehensive document that contains our best ideas and MASP practice gems.

Our Model of Care documents trauma informed and therapeutic practices at MASP. It clarifies the research and practice informed evidence that we have selected to guide our work and describes our preferred ways of working. The CARES Values, "Connected, Accountable, Responsive, Empowering and Safe", are at the heart of our Model, and were derived from a service wide Model development process. Using our Model to guide us, our Values will be implemented across our organisation.

Model development is a long process involving many people. For the last two years, I have had the privilege of being project lead and 'chief Model writer', but many others have contributed along the way.

In addition to our board, I wish to extend a special mention to the Model of Care reference group membership, "the MoC", who contributed to all aspects of Model development and, to my colleagues, the MASP leadership group who read the long document prior to publication and assisted with the editing process. Our CEO, Vincent Wilson, has inspired, encouraged and contributed throughout the process.

I also wish to thank our model of care consultant, Patrick Tomlinson. Patrick has worked behind the scenes, guiding and supporting the model development process from its inception, and lending his expertise to the writing process.

To all of our staff and community members who have contributed along the way, a warm thank you, and well done!

MASP is an enthusiastic and warm-hearted organisation that is capable of achieving great things for our clients and community. I am incredibly proud to be part of the team as we deliver this, our first edition, of the MASP Therapeutic Model of Care.

Helena Moore
Director of Practice

Introduction

The MASP Story

MASP was established in 1994, following the amalgamation of the Sunraysia Youth Accommodation Project and the Sunraysia Emergency Accommodation Centre (Emmaus House).

A staffing group of eight people joined forces to support and advocate for homeless people and those at risk of homelessness in the Mallee. This included people living with disabilities, children and young people living in unsafe situations, and women and children escaping family violence.

Our main aims were to improve access to the existing housing stock, to increase appropriate housing options, and to develop social support programs that could end homelessness and disadvantage in our community.

In 1999, we began to introduce programs for children and young people entering the out of home care system, including youth residential care and foster care. We also started the important work of training and supporting foster caregivers and specialist staff.

Our youth work steadily grew to include leaving care, youth justice, and a range of innovative programs aimed at keeping families together and developing our young people.

In 2006, the newly formed youth mentoring program took a group of nine young people and their mentors to Papua New Guinea where they walked the Kokoda Track together. Since then, this innovative program has helped over 240 young people to connect with community mentors.

In 2007, we launched our Integrated Family Services program. In 2008, we were selected to be the regional provider for Child FIRST, and in 2018, our Child FIRST team relocated to the newly established Orange Door family violence response hub in Mildura. Through our continued commitment to working with vulnerable families, MASP has played an integral part in the effort to end family violence in the Mallee.

In 2011, we extended our existing housing support program and became a Registered Housing Provider. This opened the way for us to build quality social housing in the Mallee and we remain committed to providing equitable and affordable housing for all members of our community.

Alongside our growth in housing support and family services, our disability support work has grown to include supported independent living at Vidovic House, and services delivered under the NDIS.

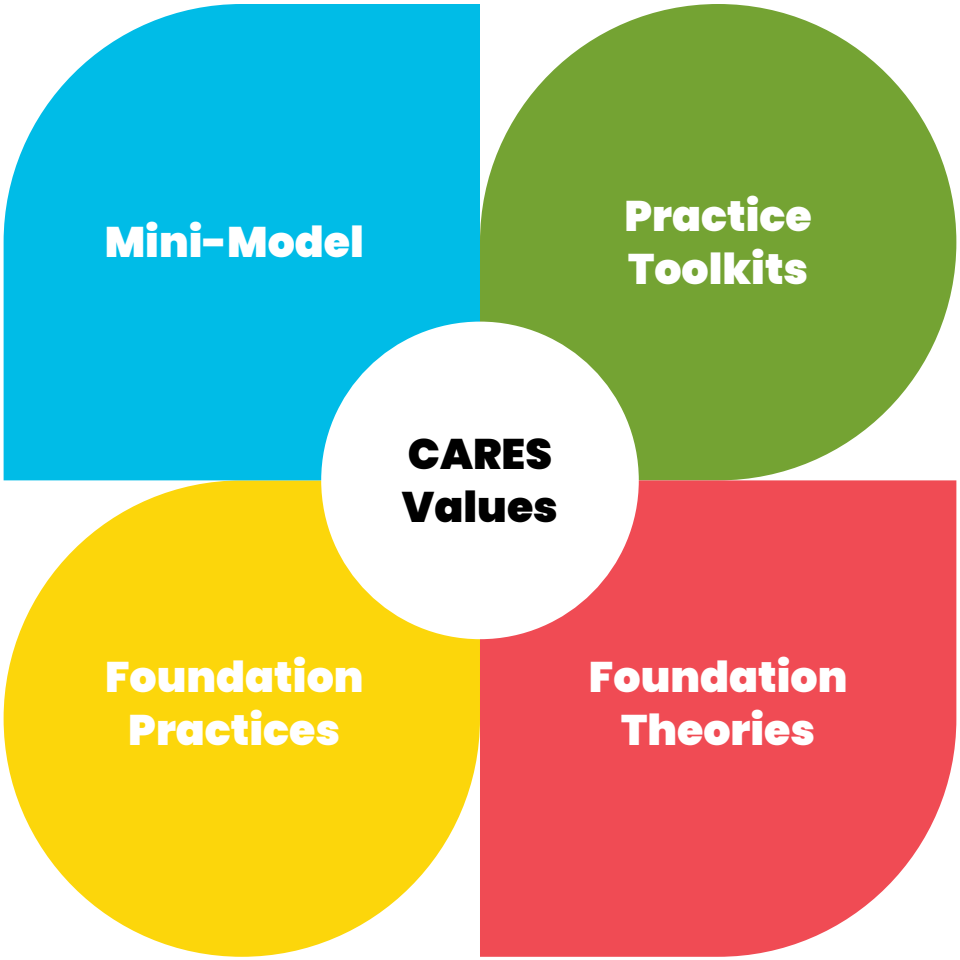
In 2019, MASP's purpose-built Service and Community Hub was opened, bringing most services under one roof and providing easier access for our clients.

In 2020, we launched the Red Earth Heart Van, a community outreach program providing social connection, meals and laundry services to those in need.

Today, MASP is a diverse community service organisation employing more than 140 staff and delivering services from multiple sites across Northern Victoria and the border regions. Guided by our purpose and our vision of a thriving Mallee, we continue, as we have from the beginning, to empower our community to be free from homelessness, abuse, poverty, and disadvantage.

Introduction

Model Development



The MASP CARES therapeutic model of care is a home-grown practice model that identifies and describes the key elements of safe, strengths-based, growth-orientated service provision at MASP from a trauma-informed and therapeutic perspective.

It describes our shared understandings derived from the evidence and practice base (theory) and how we work together (our practice) in order to achieve our organisation's purpose to empower our community to be free from homelessness, abuse, poverty, and disadvantage and our vision of thriving Mallee communities, with individuals and families equipped to lead, safe, secure, healthy, and fulfilling lives .

Introduction

Model Development

The decision to develop a therapeutic model of care was first proposed by the MASP board in 2017. MASP has a reputation as an innovative organisation that aims to empower and enable people who are discriminated against and marginalised due to their life circumstances. Many people who qualify to access funded community programs have experienced a potent mix of early childhood trauma, neglect, abuse, and the intergenerational transmission of poverty and social disadvantage, (Anooshian, 2005).

> *"With only a very limited income, the poorest of the poor are often just an illness, accident, divorce, or other personal disaster away from homelessness" (Timmer et al, 1994, p. 11 cited in Johnson & Jacobs, 2018, p. 37).*

All of us live and work in the same close-knit Mallee community. Strong community knowledge can be a valuable point of difference in the regional communities where staff will often know about or even be related to a client or community member who is "doing it tough". When something big happens in our community, there can be a ripple effect. Our staff are there to help, and, due to their community connections and relationships, they can be vulnerable to vicarious trauma, a form of workplace harm that can have serious health consequences for the person and for aspects of service delivery (Louth, Mackay, Karpetis, & Goodwin-Smith, June 2019).

MASP has consistently supported individual program responses in its work with traumatised populations and has developed key policy and practice guidelines to underpin that work. Much of this came about in response to the needs of our clients and our staff over time.

In 2020, a cultural review revealed what many of our staff already suspected, our service had, over time, arranged itself into a series of teams that were orderly and self-contained, but separate. We were operating in silos.

> *"Other than 'by accident', people do not seem to get the opportunity to see things through the eyes of other teams. Empathy is directed towards clients rather than other parts of MASP" (Pennycuick, 2020, p. 19).*

And whilst the review went to some lengths to point out that silos were not always a bad thing, for many staff, it didn't sit well. In a service that was dedicated to supporting a thriving Mallee community where everyone belonged, it didn't feel right.

Workplace silos can be defined as an arrangement of hierarchical structures or departments, "which seek to maximise vertical coordination at the expense of horizontal coordination" (Scott & Gong, 2021, p. 20). The silos are "inward-looking and self-contained with little regard for outcomes other than those which affect its own narrowly conceived goals" (p. 21). The broader human services sector has struggled with silos in general, with challenges reported in mental health (Deakin University , 2021) disability services (Hussain, et al., 2021), and family violence (Wilcox, 2010).

MASP has been proactive in relation to this feedback. Following the cultural review, work commenced to find ways to maximise opportunities for integration, and we renewed our efforts to introduce a service-wide therapeutic practice model. From the beginning, we wanted to develop a model that was relevant to the whole organisation, reflected our purpose, and could unify and guide our shared work. After careful consideration of the available options, and struggling to find the right fit, we began to discuss the possibility of writing our own model of care.

(continued overleaf)

Introduction

Model Development

In 2021, after a period of careful deliberation, our board approved the development of a home-grown model, and Patrick Tomlinson of Patrick Tomlinson Associates was engaged as our consultant in July of that year.

A group of ten people formed the model of care reference group which met fortnightly for the next year. The reference group comprised ten members of staff who worked through a curriculum of model development. The group discussed what was important for clients and staff, as well as what else was needed to support safe and effective client and team-based practices. This discussion helped to form the groundwork for the CARES values.

The development of a therapeutic model is a significant undertaking in terms of time, resources, and commitment. It is a practical process that involves following a framework, systematically working through the steps in the model-making process, reviewing existing practices, reviewing documentation, and developing new ways of doing things. It is also a creative process that needs time, trust, and good communication to happen. In many ways, the creation of a model is like good team work, it is a test of working together through the successes and the hardships of the process, in order to produce something worthwhile in the end.

At the heart of all our efforts was a firm intention to know who we were as an organisation and to harness our strengths and capacities across the silos. As Tomlinson states, it is difficult to develop a successful homegrown model of care, and doing the work is a demonstrable commitment to therapeutic principles. Model development requires time, resources, being open to self-reflection and personal growth, good teamwork, and a safe environment in which to think and share ideas.

A model clarifies the primary task and reduces confusion. It improves consistency, congruence, performance, and development.

A model creates a shared language and processes which in turn helps to integrate different professional disciplines.

It is highly beneficial for organisations to understand trauma and how to respond to it. This is becoming trauma-informed.

A complete discussion about the development of our model of care can be read in Appendix 1

Introduction

Our Choice of Language

A model will always be a work in progress. As Dr Sandra Bloom explains:

> *"...our systems of care, and all organisations that are part of the system are alive, functioning and interconnected living systems and therefore subject to the stresses, strains, and trauma of being alive" (Bloom, 2013, p. 13).*

We are particularly mindful that many of us at MASP have enjoyed the privileges of safe homes and neighbourhoods, easier access to education and learning opportunities, and regular support and income, which is often far beyond that experienced by many of our clients.

MASP prides itself on working with people from all walks of life, we value a diverse community and workforce. It is important to us that our model, and all of our associated practice materials, are written in a way that is accessible to everyone who works with us and within our organisation.

Much therapeutic model writing contains the language of therapists and health professionals. Whilst this contribution is valuable and highly regarded by us, it is not necessarily the language of MASP or its community of people. For our inspiration, we listened to our clients and staff, and we looked at the language of social workers and youth workers. Rather than health and recovery, (not so) ordinary "wellbeing" seemed a better fit for us.

Wellbeing can be described as physical health, mental health, social health, happiness, flourishing or thriving (Davis, 2022). It is a "multi-dimensional construct" that "goes beyond hedonism and the pursuit of happiness or pleasurable experience, and beyond a global evaluation (life satisfaction): it encompasses how well people are functioning (physically, emotionally, spiritually, culturally, and psychologically)", (Ruggeri, Garcia-Garzon, Maguire, Matz, & Huppert, 2020, p. 193).

There is a science of wellbeing, and we are continuing to develop better understandings and practices that can support people and communities to function in optimal and sustainable ways. Tomlinson, quoting Prilleltensky, suggests that psychological wellness might fruitfully be thought of as three related sets of conditions that nurture the personal, relational, and collective wellbeing of individuals.

> *"Based on existing research, there seems to be four main processes for the flourishing of individuals and systems: promotion of responsive conditions, prevention of threat to responsive conditions, individual pursuit and avoidance of comparisons" (Prilleltensky, 2012, p. 12).*
>
> *"Behavioural engagement, meaning making and the active pursuit of positive emotions, built on fertile soil, enhance the chances of a thriving life" (P. 14).*

Introduction

AIMS and Objectives

Primary Aims

1. To develop and document a relevant and sustainable therapeutic model of care that describes how we understand and demonstrate therapeutic and trauma-informed work at MASP.
2. To implement our model of care across the whole organisation.
3. To ensure that strategic and service documentation is fully aligned with the model care.

Secondary aims

The secondary aims involve identifying and resourcing the activities needed to progress toward a written model. The following table is a summary of four related aspects of the model development process.

Model Development				
Activities	Change management model	Leadership and Management	Meaningful staff engagement	Client and community collaboration
Definitions	Identify and implement a suitable research process and an agreed change management framework	Engage key leadership personnel in a shared decision-making and team development process	Involve staff in an organisation-wide change process by gaining and implementing their input, perspectives, and wishes	Survey and involve a representative group of clients, carers, and key stakeholders in a meaningful and collaborative change process.
Document the model and identify the next steps				

Objectives

The aim of the Therapeutic Model of Care is to positively contribute to excellent client outcomes through the development and practical application of the CARES therapeutic principles, and by implementing service-wide practices in trauma-informed care.

The model delivers:

1. An evidenced based and theory informed practice foundation that supports therapeutic outcomes across the continuum of care.
2. Foundation theory sets that are clearly linked to practice.
3. A basis from which to align therapeutic and trauma-informed understandings and practices across six organisational domains:
    i. Governance, management, and leadership
    ii. Policy and practice guidelines
    iii. Consumer and carer participation
    iv. Service provision including, staff supervision, education, and training
    v. Workforce health and wellbeing
    vi. Service outcomes and evaluation including, risk management
4. Guidance for our staff in their role of ensuring that trauma-informed and evidenced-based practice is resourced, implemented, and maintained at all points in the service continuum.
5. A framework for the development and support of a trauma-informed workforce.
6. A basis for the development of genuine client engagement in service design and delivery.

Introduction

Model Overview

HOW: this document articulates the over-arching ideas and practices that we have selected to guide our work at MASP.

In each section, we have summarised the theory and practice base, and included any particularly helpful frameworks and diagrams from the literature. This forms the basis for our shared understanding, the 'why' of the model.

Through a reflective process (described in Appendix 1), we have integrated theory and practice. This is our way of working, the 'how' of the model. Pop out boxes are used throughout the model highlighting key ideas, and examples of the model in action.

Our model is designed as a series of interconnected parts that can be used flexibly for different applications and can also be understood as a whole. The following is a list of the parts, what they contain and some possible applications:

Our CARES values are at the centre of our model. They are fully articulated in three key ways: as a descriptive word, as defined set of related ideas, and as a detailed set of behaviours and intentions. The CARES values are the visible face of our model and will appear on signature lines, in promotional materials, in documentation, and throughout our model-related materials.

Our "Mini-Model" articulates the next level of detail. It reflects the expectations of our clients, staff, leadership, and board. Our Mini-Model describes the behaviours and experiences that are the model in action. This is what our people, clients, and community can expect to see as they "walk around" the programs and buildings at MASP. The Mini-Model will appear in MASP promotional materials, onboarding documentation, supervision packs, and other model-related materials.

Our practice foundations are the different ways of thinking and working together that are particularly valued by our organisation, regardless of role. They are arranged as seven modules and they include established, and proven practices at MASP, as well as updated materials particularly in trauma, and trauma-informed care. The foundations can be used by all staff, supervisors, and managers to guide professional development and to serve as prompts for service delivery and planning.

The toolkits translate our practice foundations into everyday work. These are our MASP CARES 'gems'. They have been developed over time and represent the practice wisdom at MASP. It is intended that our toolkits will be the living part of the model and they will be added to, extended, and developed over time as new evidence, understandings, and practices are introduced.

Connected
We nurture trusting, collaborative, and inclusive relationships.

Accountable
We employ authentic, competent, evidence-based practice.

Responsive
We demonstrate kind, flexible, timely, and personalised care.

Empowering
We cultivate a strengths-based and enabling environment.

Safe
We embrace a culturally safe, Trauma-informed, and dependable ethos.

"Theory, practice and the relationship between them are all far too complex for there to be a clear, simple and unambiguous path to follow. Theory provides us with the cloth from which to tailor our garment, it does not provide 'off-the-shelf' solutions to practice problems"

(Thompson, 2000, p. 80)

CARES Values

Introduction

Values are a set of principles that help people to decide what is preferred, and how to act in various situations (Cambridge University Press, 2022).

Some values have no ethical or moral meaning but are helpful in certain activities. For example, empowerment can be a helpful value in some but not necessarily all fields. If accepted, values will guide and shape organisational attitudes, decisions, and actions (Gilliland, Steiner, & Skarlicki, 2003, p. 156).

Despite the proliferation of literature about values, surprisingly little academic research has occurred into the development and transmission of values within organisations (Gilliland, Steiner, & Skarlicki, 2003). We don't always know how it happens or even if it happens.

Related to this, organisational values may be imposed without reference to a considered process. They may omit important information from employees, clients, and other stakeholders. The lack of research has contributed to a lack of serious thought and a gap in our knowledge about how different kinds of organisations generate their values and the success or otherwise, of their different approaches.

> *A therapeutic model of care is built from a core set of evidenced-based and theory informed foundation principles. Ideally, an organisation with a therapeutic task will develop a set of values that are widely consulted, relevant, aspirational, and clearly linked to therapeutic principles.*


masp
aring for our community

CARES Values

Introduction

HOW: "One of the first orders of business is to assemble a working group of leaders and line staff from all parts of the organization that we call a core team to engage in frank conversations about the organizational and ethical system – what employees really believe and value in their organization – and determine if there needs to be some change in the value system based on what they now know about the impact of trauma and repetitive stress on clients, co-workers and themselves. Once they understand clearly what their value system should be, they need to assess how these beliefs and values manifest themselves in the organization's policies, practices, and programs ... the clearer the organization's values and beliefs are, the easier it becomes for all staff to do the right thing and create a morally safe environment" (Bloom, 2013, p. 263).

Our review process formally began in mid-2021 with the formation of the model of care reference group, and a series of discussions that occurred in the group about the future direction of our organisation.

We actively listened to staff, clients, and other stakeholders and we surveyed our leadership team and staff about their experiences and vision for MASP. There was an atmosphere of positive energy and renewal but also some disenchantment with the "old" ways of doing things. This was particularly so if they were perceived as standing in the way of progress toward a more inclusive, growth-orientated and egalitarian organisation. It was agreed relatively quickly that the old values no longer met the needs of the organisation.

In late 2021, we welcomed a new CEO and in early 2022, the model of care was aligned with a strategic planning process. This allowed us to revisit our vision, purpose, and values in the context of our identity as a therapeutic and trauma-informed organisation.

Throughout 2022, a great deal of work was undertaken to develop a new set of values for MASP. The Mini-Model model of care was the first detailed articulation of the new values. This, along with the values themselves was put to a whole of organisation vote in August 2022 and was overwhelmingly accepted by the staffing team, garnering a "yes" vote of almost 95%.

> *It was very important that our values should come from our community and be endorsed by our staff. An organisation that aims to be therapeutic will have a congruent set of ethical and meaningful values that is understood and embraced by the whole organisation.*

The way we developed our values can be likened, in some ways, to the helping process itself. We wanted to listen to staff, clients, volunteers, and stakeholders in order to understand and honour the MASP story.

The next sections will discuss the MASP CARES values and introduce the model of care "Mini-Model", which is our articulation of the values in action.

CARES Values

Connected

We nurture trusting, collaborative, and inclusive relationships.

The right to cultural connection is enshrined at the highest levels of government, (Commonwealth of Australia (Department of Social Services), 2021; State of Victoria, Department of Health and Humans Services, 2018; State of Victoria, Department of Health and Human Services, 2021).

Whilst this is important to all people from diverse backgrounds, the right to connection with family, community and country holds special meaning for Aboriginal and Torres Islander peoples, and is a litmus test for respect and reconciliation.

Country is the term often used by Aboriginal peoples to describe the lands, waterways and seas to which they are connected. The term contains complex ideas about law, place, custom, language, spiritual belief, cultural practice, material sustenance, family and identity.

> *"Country is everything. It's family, it's life, it's connection. — Jude Barlow, Ngunnawal Elder (Barlow, 2022)*

By focussing on connection, we recognise that social connectedness, trusting relationships, and feeling safe are key attributes of healthy, strong communities, and they are also essential to recovering and healing from the impacts of trauma (Perry, 2008).

In service systems, the value of connectedness relates to establishing and maintaining safe and strong relationships between service providers and between providers and clients. Service systems that are well connected are characterised by an enhanced capacity for thinking together, well-defined roles and boundaries, and respect for diversity (Cash, et al., 2014).

HOW: We actively support our employees, clients, and community members, to establish and sustain meaningful and enriching connections. Through our various programs and services, we support collaboration, stabilisation, resilience development, and empowerment. Our trauma-informed approach supports the development of self-worth and healing through connection to culturally safe relationships. Our partnership approach advocates for client voice and for everyone's right to be self-determining.

CARES Values

Accountable

We employ authentic, competent, evidence-based practice.

Accountability in the workplace is a disciplined way of working in which a person, team or organisation takes responsibility for following through with what they say they will do, to the best of their ability, whilst maintaining an acceptable and agreed-on professional standard. Underlying this premise, are expectations of trust, honesty, the exercise of careful judgement, and ethical decision-making.

Organisations that are tasked with supporting vulnerable children and adults are accountable for client safety. They must find ethical and effective ways to minimise risk whilst supporting the development of human potential. This can be a difficult balance to achieve.

Such environments cannot be excessively permissive, and neither can they be rigid and punitive, both positions are detrimental to client outcomes, (Menzies Lyth, 1985). Embracing a mindset that is thoughtful, responsive, and disciplined, but not too anxious and punitive, is particularly important for organisations that want to enable clients to make necessary change in their lives. A high level of accountability requires that the environment will articulate and support accountable practices.

HOW: We provide comprehensive staff Induction and training, policies and procedures, and appropriate checks and balances in the system through the use of supervision, reflective practice, teamwork and conflict resolution processes. Our clinical governance and management processes emphasise clear decision-making pathways, responsible and responsive leadership, opportunities for open communication without fear or favour, and continuous learning.

CARES Values

Responsive

We demonstrate kind, flexible, timely, and personalised care.

A responsive service can be defined as one that is flexibly and thoughtfully matched to client needs, rather than client needs matching to the service expectations (Clough, 2008; Hillan, 2006). Human service systems that are stressed will tend to respond in much the same way as the traumatised people that they work with. They may become reactive, overly controlling, fragmented, and rigid. The service gradually becomes more concerned with self-preservation than with accomplishing its purpose. The opposite of this is where an organisation has a strong and consistent culture that is aligned with its therapeutic values and purpose.

Many of our clients will struggle to ask for help, and some, particularly children and adolescents will show distress through their behaviours. Under these circumstances, the healing and recovery process begins with how the helpers respond.

At MASP, we aim to provide a consistent and congruent approach in the sense that Anglin (2002) refers to as comprising "three major properties: consistency, reciprocity, and coherence" (Anglin, 2003, p. 64). We try to focus on applying the same principles and processes over time, to engage in reciprocal and reparative "two way" relationships that are matched to client need, and to work together as a team.

Kindness is included in our definition because it can be undervalued in the workplace but it is important in a thoughtful, and reflective workplace culture (Ross, 2021). Kindness can be defined as "an action or set of actions connecting a person's internal feelings of empathy and compassion to others that is undertaken with the purpose of generating a positive effect and outcome for another" (p. 20). Actions in the workplace can include courteous behaviour, remembering names, listening attentively, taking time to welcome new staff and to farewell those who are departing, sharing time and information and responding to mistakes with care & compassion.

HOW: We have invested in a therapeutic model of care to guide trauma-specific practices and training at every level within the organisation. We are committed to a process of regular review and to continuous learning and development across all of our programs and modes of service delivery.

CARES Values

Empowering

We cultivate a strengths-based and enabling environment.

Empowering organisations create the opportunities and conditions in which self-determination can occur. This is why the term enabling is also used. We have chosen two related definitions of empowerment: the capacity to influence the forces which affect one's life space for one's own benefit (Pinderhughes, 1983, p. 332) and the capacity to produce a change (Miller & Keys, 1996). These two definitions when taken together emphasise that the focus of empowerment is not on adaptation, but on increasing the capacity of individuals, groups, and communities to solve social problems (Gutierrez, 1990).

Empowering relationships are mutual, and they recognise and build on the diverse contributions and needs of others in ways that seek to minimize inequalities over time. It is important to recognise that the reason some of us are self-determining is that we are in interpersonal and social structures that empower us (Sprague & Hayes, 2000, p. 681).

This value has important implications for cultural self-determination.

> *When viewed through the lens of empowerment, trauma-informed care requires a different question that moves beyond "what happened to you" to "what's right with you" and views those exposed to trauma as agents in the creation of their own well-being rather than victims of traumatic events (Ginwright, 2018).*

HOW: We pride ourselves on being an organisation that listens, supports, and positively contributes to the social good. By embracing our model of care, and through our commitment to a safe and responsive workplace, we wholeheartedly support capacity building, partnerships, and empowerment, as important steps toward individual and community self-determination.

CARES Values

Safe

We embrace a culturally safe, Trauma-informed, and dependable ethos.

Client-centred practice that is therapeutic and trauma-informed cannot begin until safety has been established. Safety provides the essential pre-conditions in which human beings develop and grow physically, emotionally and socially.

Brazelton and Greenspan (2000), provide a definitive list of a child's essential needs:

1. The need for ongoing nurturing relationships;
2. The need for physical protection, safety, and regulation;
3. The need for experiences tailored to individual differences;
4. The need for developmentally appropriate experiences;
5. The need for limit setting, structure, and expectations;
6. The need for stable, supportive communities and cultural continuity.

Safety comes before connection and growth is possible. When a child is able to feel cared for, supported, heard, and looked after, they internalise these feelings and experiences. They can eventually use this knowledge to help themselves to better manage their thoughts and emotions, relate to others, and to navigate tough times.

It does not matter how old a person is, returning to the six essential needs listed by Brazelton and Greenspan, will, for the majority of people, allow them to regain a sense of emotional stability and a capacity for thinking.

> *"Only when the disconnected or unconnected person begins to feel safe will they be able to take the risks involved in connection … The foundations of wellbeing can be considered as safety, connection and integration" (Tomlinson P. , 2015).*

In organisations with a therapeutic task, our job is to establish and nourish safe relationships. By doing this we enable others to thrive. The whole team from top to bottom commits to establishing and maintaining a consistent and strong culture of safety as the first and most important priority in effective service delivery.

Effective and reflective leadership rigorously models safe practices and behaviours in the form of culturally safe work practices, systems, and processes that are delivered in regulated, empathic and appropriate ways.

By doing these things, safety is internalised throughout the whole organisation where it is experienced as feelings of 'wellbeing', energy, hope, and creativity. "Relationships matter … trust comes through forming healthy working relationships. People, not programs, change people" (Perry & Szalavitz, 2008). While this is true, a well led and managed organisation is also vitally important.

HOW: We aspire to be a welcoming and safe place for everyone. Our model of care and our commitment to safety applies to everyone who comes into contact with us. This includes our clients and community members, our staff, contractors, volunteers and board members.

Our 'Mini' Model of Care

The 'Mini-Model', describes how the model of care will look and feel on the ground at MASP.

It is the key to the whole model and describes how each of the CARES values is implemented by, for, and with six key stakeholder groups: clients; volunteers, staff, leadership, executive, and board. It can be read horizontally and vertically as a description of the value, and how it is applied throughout the organisation as a way of understanding the connections between different roles and responsibilities.

Our staff will refer to the document as part of their supervision discussions. Our organisation will promote the Mini-Model in various ways throughout our building and in our documentation.

The Mini-Model model was inspired by the work of Cathy Balding (Balding, 2011) a talented Australian psychologist who specialises in quality improvement practices. Cathy impressed upon us the importance of the "I" statement, as a more powerful way of committing to change. She also reminded us of the importance of fully engaging our staff and community members who are the experts when it comes to achieving good outcomes.

Writing in this way required a high level of input from all the key stakeholders and there were several versions produced. The final version of the Mini-Model was endorsed by our board in August 2022 and is reproduced on the next page.


Caring For Our Community

MASP Mini Model of Care

masp	Clients	Volunteers	Staff
Connected	I feel heard, respected and I am part of decisions that are made about me. Staff and volunteers are supportive and trustworthy. They understand me and they are responsive to my needs.	I am valued, respected, and part of the team. I am focused on client needs and preferences, and I champion positive relationships and connections through my helping role.	I am a constructive and supportive member of the professional team. I focus on working with the client to build up their social relationships, connections and resources.
Accountable	I know what is happening for me and who is doing what. I can share feedback, and I know my wishes will be acted upon.	I make sure that I am up to date with training, that I maintain good communication with my team, and that I know who to go to for help.	I make sure I am competent and skilled in my role to deliver quality care based on the latest best practice and evidence.
Responsive	I receive the right kind of care at the right time. My care is well organised and everyone understands what is happening.	I am trustworthy, predictable and reliable. I provide support that is matched to client needs.	I deliver a service that is positive and flexible, and I work with the client to meet their goals and support needs in ways that are respectful, thoughtful and tailored to them.
Empowering	I feel accepted, and I am listened to. I am enabled to seek services and resources that are culturally safe and a good fit for me.	I focus on what is in the best interests of the client and I look for ways to support them. I value the role I play in helping others to build upon their skills and strengths.	I provide a client-centred service thatbuilds on strengths, and enables clients to engage in their own journey. I support my clients to advocate for better systems and service provision.
Safe	I feel safe and I help staff to keep me safe. My identity is respected and my family and preferred people, are part of my care.	I am a safe and reliable person. I am able to follow safety procedures and report risk. I take care of my own support needs so I can be a good role model for others.	I make sure I am a safe and supportive person for my clients. I am able to assess for client risk and I know how to respond. I contribute to an inclusive and strengths-based workplace culture.

Leaders	Executive	Board
I support staff to provide client-centred care that is well organised, culturally appropriate, and sensitive to individual differences and needs.	I foster and maintain inclusive, respectful relationships and excellent communication for the benefit of our people and our communities.	We demonstrate an unwavering commitment to the success of our clients, communities and organisation by upholding MASP's vision, purpose and values, and delivering our therapeutic model of care.
I am accountable for my own continued development and learning, and for supporting staff to maintain the highest possible standards of client care.	I proactively ensure our organisation is well managed to meet the needs of our clients, community and funding bodies.	
I tailor my support to the needs of clients and staff, and I assist staff to work with clients, families and the service system in ways that are timely and effective.	In considering the needs of our clients and community, I consult widely in order to deliver thoughtful and timely services and supports.	
I support staff to grow and develop, and to work together in ways that support good decision making for our clients and our organisation.	I empower individuals and communities to achieve their fullest potential through the promotion of a positive leadership culture.	
I understand and demonstrate excellent communication, personal boundaries and professional conduct. I strive to create a culture of safety and trust for our staff and community.	I cultivate an environment bound by safety and trust. I maintain appropriate standards and systems to ensure the safety of our volunteers, clients and staff.	

Foundations for Practice

The silo art trail of Northern Victoria and NSW is the world's largest outdoor art gallery. Each silo has been painted by a different artist to depict scenes from rural life. This beautiful image was painted by Drapl and the Zookeeper (AKA Travis Vinson and Joel Fergie), and depicts a Boorong child, looking out over Lake Tyrrell, reflecting on her indigenous heritage. In this image, the artist's imagination has worked with the silo canvass to make up one complete picture of Mallee life.

Introduction

> **HOW:** *Above and beyond everything else, the MASP model of care is an attempt to involve our whole service in the delivery of Trauma-informed and therapeutic healing practices. Our board gave us the brief and resources to develop a service wide model that is useful to everyone. Our intention is for our model of care, and future versions, to provide a steady foundation that unites our workforce, clients and community.*

In human service organisations, model development will involve a comprehensive review of programs and deliverables, conversation and clarification, and other forms of research and testing in order to develop a clear understanding of the current state of practice, and what might usefully be added. In the MASP development process, most of the people developing the model were also members of staff which has its pros and cons. Time allowances, blind spots, and bias are clear "cons". These must be weighed up against inside knowledge, experience, and trust. The use of external consultancy was critical and Patrick helped us to keep the whole process balanced and honest.

The reality is, no-one understands the work on the ground as well as the people who are doing it, and the involvement of our staff at all levels was vital to the development of the model. Oreg, Vakola, & Aremankis (2011) point out in their comprehensive review of change management processes:

"Beyond the overall importance of trust and commitment, managers should invest special attention in creating a supportive and trusting organisational culture if they expect change recipients' support and cooperation in times of change. Given that creating such an atmosphere requires an ongoing process that typically takes a long time, an important first step will be the adoption of a supportive and participatory change process"
(Oreg, Vakola, & Armenakis, 2011, p. 516).

Prior to model development, MASP had already embedded and tested a number of evidence-based practices. Some programs were fortunate to have well-funded and comprehensive frameworks attached to their funding lines. The Better Futures Advantaged Thinking practice framework is a good example.

Foundations for Practice

Introduction

Better Futures is a new practice program that supports young people transitioning from care. It was developed by a consortium led by the Brotherhood of St Laurence and uses

Advantaged Thinking which came out of the UK Foyer movement (Falconer, 2014). Better Futures involves a comprehensive four-part model with guidelines, tools, phases of delivery, community of practice, research, literature, and other elements.

As good as it is, the model also highlights a dilemma for joined-up service delivery at organisations like MASP. Better Futures is one program employing less than ten staff in an organisation that employs around 140 people. The other 130 people do not use the Better Futures model, and neither is it necessarily relevant to them.

Most organisations rely on a collection of guidelines, frameworks, and models for service delivery that can be narrow in scope and focused on key deliverables for particular funding streams and program areas. Leadership, organisational culture, and staff support and development are generally not included, as they are appropriately considered to be the responsibility of the organisation.

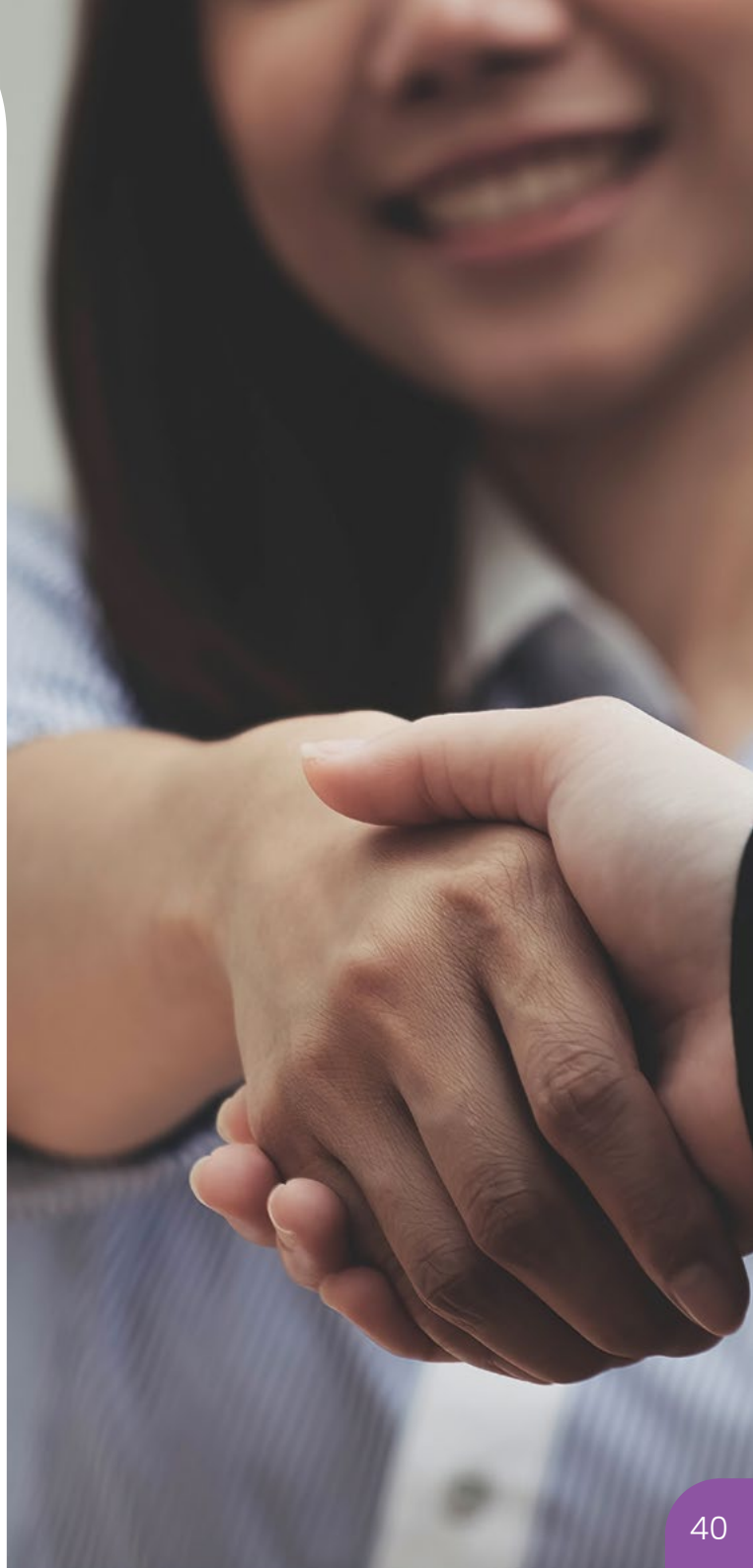
> *A model of care defines the how of service delivery, above and beyond a particular program area. This layer of thinking is usually omitted by government backed program guidelines, (or rather, it is assumed to be in place). These were some of the issues that we wanted to address in developing the MASP model.*

The practice foundations included in this model are considered by us to be the core of good human service work at MASP, and in general. They are distilled from the same therapeutic and trauma-informed principles that are common to most, if not all, human service program-specific models and frameworks.

These principles can be considered as complimentary across the whole of our service delivery, whilst at the same time adding needed context and depth for staff that are engaged in client services, such as family services and our housing team, and those that contribute behind the scenes, such as accounts and administration.

The eight practice foundations selected by us, and discussed next, are:

1. Leadership, including attributes, roles, democratic leadership, and systems work
2. Reflective Supervision
3. Learning and Development
4. Psychological Safety
5. Trauma-informed practice
6. Client Voice
7. Therapeutic Milieu
8. Cultural Competence.



Foundations for Practice

Leadership

Attributes

Friedman (1999), argues that "all leadership begins with the management of one's own health" (Friedman, 1999, p. 234), and "a leader functions as the immune system of the institution or organization he or she heads" (p. 182).

Getting the right people means developing an organisation that embraces a system of interacting elements: roles, responsibilities, and relationships are defined by the organisational structure, processes, leadership styles, people's professional and cultural backgrounds, and policy and procedures. All of these elements together drive behaviour and performance.

The Therapeutic Model of Care and the strategic plan, provide the groundwork for leadership at MASP. The two documents detail why and how the work at MASP is done. This is backed up by our policy and practice guidelines and reinforced by our governance and supervision structures.

Leaders develop over time and can work at all levels within an organisation. Training alone has proven to be relatively ineffective for developing good leaders. It seems much more important to provide the 'fertile ground' in which the "seeds" of talent can grow (Beer , Finnstrom, & Schrader, 2016).

Other research has shown that establishing "psychological safety", in which everyone feels free to speak up, is an important component of the fertile ground. Human service organisations that have an established culture of safety, led from the top and transferred through the lines of responsibility seem better able to design and implement the responsive decisions and processes needed in these dynamic environments.

Roles and Reporting Lines

In his paper on leadership, Tomlinson (2015) finds that with a few notable exceptions, remarkably little has been written about leadership in organisations that work with traumatised young people (p. 3). Similarly, little has been written about reporting lines as an organising 'internal working model' or 'schema'; we tend to overlook the importance of the connecting lines that are at the heart of the work.

Foundations for Practice

Leadership

Just as the developing human brain organises around trauma, human service organisations can organise around the fragmented lives of traumatised clients and communities.

Coupled with our tendency to remember the problems we encounter, many of our staff have an encyclopaedic knowledge of hard times. The human services story is replete with struggle. Tomlinson writes that leadership must become trauma and attachment informed if we want to stay connected and thinking together, and avoid division and defensiveness (p. 4).

Similarly, Frederick Laloux in his book "reinventing Organisations", writes about teams that seek innovation and growth through "wholeness" (integration). He writes, "striving for wholeness is no easy task. With every unsettling event, we are tempted to seek refuge in separation" (p. 173).

However, certain organisational practices can enable team integration and job satisfaction:

- Explicit ground rules
- Conflict resolution processes
- Meeting practices
- Reflective spaces
- Office buildings - location, facilities, aesthetic

(Laloux, 2014, p. 173)

During the period of model development at MASP, the organisation recruited a new CEO. Our board continued to provide unwavering, values led, leadership during the transition period. This steady approach ensured that a high standard of service delivery was maintained and important projects, such as the model of care, continued to progress. Our new CEO took a 'wholeness' approach. A new synergy between therapeutic practice, operations, and administration was made possible.

In this environment, we developed many of the innovative ideas and tools that are now in the therapeutic model.

> **HOW:** *We developed a leadership structure driven by staff consultation, a growing team and a new strategic plan. Along with suite of other changes, two new executive positions were created at MASP, Director of Client Services and Director of Practice. The deployment of the two roles occurred as the model of care reached completion. The roles were designed, from the beginning, to integrate therapeutic practice and operations from the top down.*

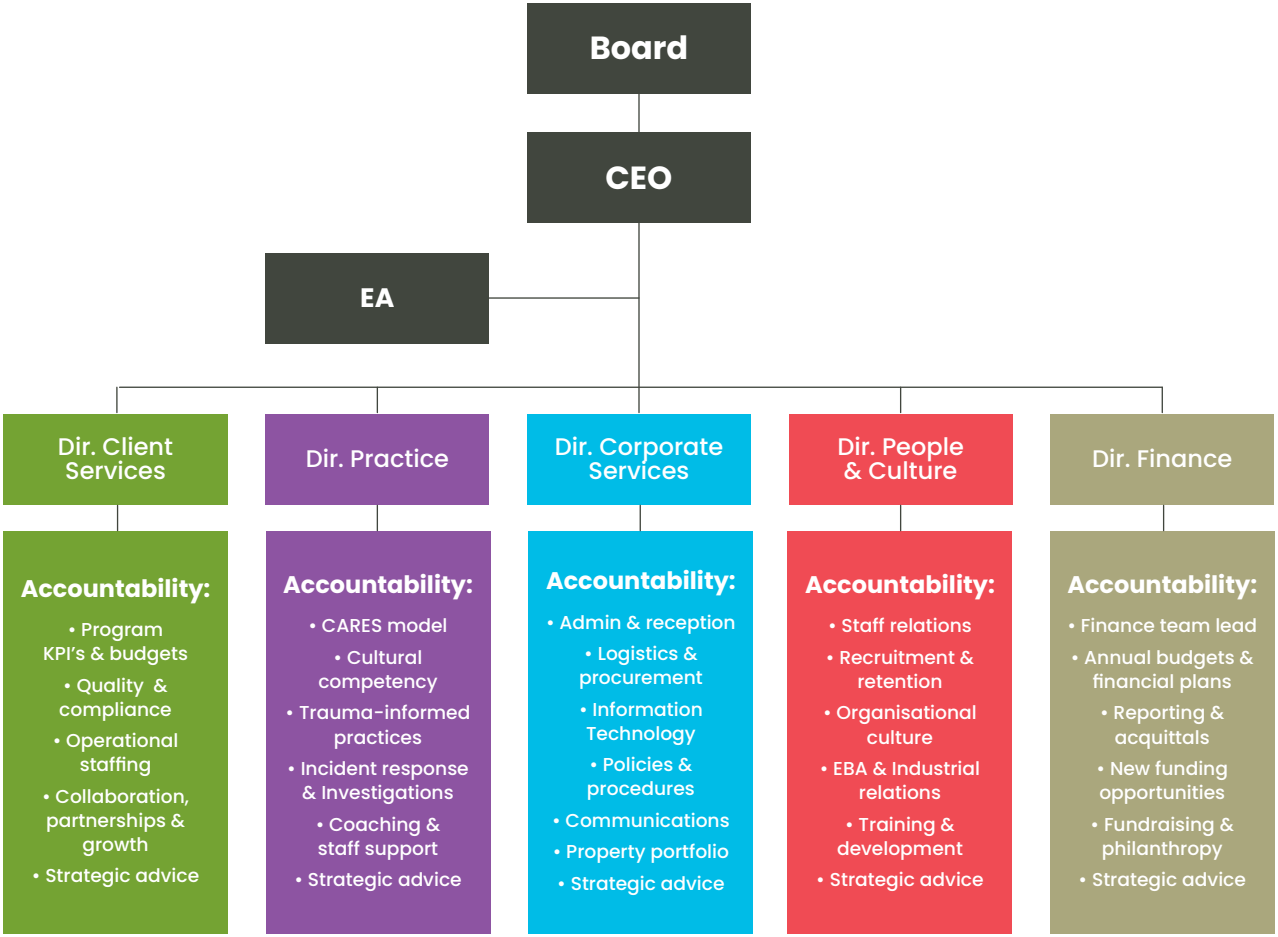
A focus on wholeness can bring clarity. The MASP organisational chart is streamlined and effective. The chart shown on the next page, depicts the main reporting lines for the executive clearly, and in such a way that the line can be understood in a practical and relational way.

"This approach to leadership means a shift from a top-down leadership-follower to a less hierarchical leader-leader model. This is also reminiscent of what has been described in the world of therapeutic communities as a 'flattened hierarchy'. This approach can greatly encourage the development of authority and responsibility throughout the organization and most importantly in the young people" (Tomlinson, 2015, p. 6).

Our organisation recognises that the work we do is dynamic, it requires good communication and a clear reporting line. Our reporting lines are designed to encourage sufficient and effective communication, and they are underpinned by working relationships that are consistent with the CARES values.

Foundations for Practice

Organisational Chart



Leadership Style

Drawing on the work of Gastil (1994), Sandra Bloom (2013), describes a preferred leadership style, democratic leadership, that is suited to health and human service settings where there is a therapeutic purpose:

> *"Democratic leadership has been described as behaviour that influences people in a manner consistent with and conducive to basic democratic principles and processes, such as self-determination, inclusiveness, equal participation, and deliberation. Democratic leadership is easily contrasted with authoritarian and laissez-faire or free-rein styles." (Bloom, 2013, p. 116).*

This should not be confused with the concept of political democracy where decisions are made by voting or on a consensus. At MASP decision-making clearly resides within the authority of different roles. There are clear boundaries around accountability, reporting structures, and the authority parameters within each role. However, MASP aspires to be inclusive and empowering in the decisions that are made.

Bloom discusses that the adoption of the democratic position is gradual and purposeful. Whilst it is the desirable core position, there is no expectation that a person or team will adopt a rigid style. Teams will ideally become knowledgeable and skilled in determining the best approach to fit the circumstances, and when to move between democratic and authoritarian, and democratic and laissez-faire styles of leadership.

Bloom describes the attributes of the three leadership styles: democratic, authoritarian, and laissez-faire, and shows how they are different. This has been reproduced on the next page:

Foundations for Practice

Leadership

Different leadership styles and their attributes:		
Democratic	**Authoritarian**	**Laissez-faire**
Share understanding of the problem with team members	Solve problems or make decisions sometimes with, sometimes without, consultation with others	Are hands-off and allow employees to make the decisions
Distribute responsibilities and empower others	Expect team members to provide information, not to generate alternative solutions.	Are good at delegation of responsibility
Facilitate a thoughtful, participatory process	May or may not tell team members what the problem is in getting information from them	Tend to avoid conflict
Aid the group in its deliberations	Work "by the book" ensuring that staff follow procedures exactly	Wait for a solution to a problem to emerge on its own
Help the group reach a consensus	Impose strict and systematic, sometimes punitive, discipline	Are flexible and can be influenced
Do not use position to influence the group	Are empowered via the office they hold	Minimise personal influence
Willing to implement the group solution	Favour individual over group decisions	Are best in situations where employees are organised, competent and need little oversight
Exercise discernment and self-awareness	May hold power through personal charisma	Expect to be liked for leaving people on their own
Determine the "how" not the "what"	Tell others what to do	Let others figure out
Are relationally transparent	Expect unquestioning obedience	Minimise relationship
Hold the mission and guiding values as the central concern	May be guided by the mission or may be dominated by self-interest	Believe in mission internally and assume same for everyone else

Reproduced from S Bloom, Restoring Sanctuary, 2013, p. 116.

Working with Systems

In their review of integrated healthcare systems in the UK, Charles et al (2018), discuss that in the modern world where healthcare is expected to be holistic and delivered over an extended life span, satisfactory care cannot be located in one part of the system. Multidisciplinary approaches and collaboration across teams and services are essential for providing good enough care.

These challenges are not confined to healthcare. Funded social services are expected to work together on issues of national concern. The Family Violence Multi-Agency Risk Assessment and Management Framework (The Victorian Government, 2022) is a good example. State legislation was changed to allow information sharing between services in order to prevent responses to family violence from being "siloed". The Victorian based Orange Door hubs (The Victorian State Government, 2018), in which family violence-related services are co-located and work together are another example.

Community based mental health services are likely to follow a similar trajectory with mental health hubs starting to become established across Victoria and NSW in 2022.

Foundations for Practice

Working with systems

Harvard Business Review conducted research across hundreds of organisations and identified that working across organisational boundaries in order to deliver more substantial projects is a key focus around the world, and difficult to do well:

"The core challenges of operating effectively at interfaces are simple: learning about people on the other side and relating to them. But simple does not mean easy; human beings have always struggled to understand and relate to those who are different" (Edmonson, Jang, & Casciaro, 2019).

They discuss that a central task of leadership in these environments is to help people overcome the challenges involved in working with others who are different from them, and who also have important contributions to make.

MASP participates in many professional networks, community groups, and client focused activities and events. It is beyond the scope of this document to describe all the many ways in which we contribute to strengthening the Mallee community.

HOW: *We acknowledge that working well with others is a two-way process. We aim to build capacity, health, and safety in our communities through conversation and learning from experience rather than assumption. We are committed to working in accordance with our model of care, and will seek to clarify our role, expertise, and contributions, and to undertake shared work with our clients, staff, and community partners in a manner that is thoughtful, respectful, and enabling.*

Collaborative work is the foundation for well-run care teams and professional meetings. Our toolkit on care teams and professional teams provides specific guidance for our staff, supervisors, and other interested parties who are working in this space.

Supervision

Supervision comes from the Latin "super" meaning over and "videre", to watch or to see. A very general definition might be "someone who watches over the work of another with responsibility for its quality" (Online Etymology Dictionary, 2013).

The precise origins of modern (clinical) supervision practices are not known. However, they likely began in the medical system, where supervision practices developed as a way to assess, diagnose and treat (Munson, 2001, p. 50). Differently to traditional medical fields, social work and welfare practice have a dual focus on individual care and social change. Although the structure of individual and group supervision has not changed a great deal over the years in these professions, the content and focus of supervision has evolved according to the social context, and what is deemed important (p. 51). Supervision and other forms of professional development are considered to be very important in organisations that aim to be trauma-informed where client and staff safety is considered paramount. Modern, formal supervision processes support professional development and safety, and they establish and monitor service standards. They are a continuous and meaningful part of the professional development cycle.

Foundations for Practice

Supervision

Attributes of a Good Supervisor

The following material was adapted from the Social Work Podcast (The Social Work Podcast, 2008) and the Dartington Hall Trust publication, Reflective Supervision Resource Pack, (Earle, Fox, Webb, & Bowyer, 2017).

A supervisor oversees the work of others in the day-to-day service delivery. Supervisors are part of the management team, they may have specialist knowledge, and they often share in the workload. A typical example is that of a team leader at MASP. This person may hold a 'caseload' (they may see their own allocated clients or work alongside teammates), oversee the work of other staff, monitor and report on outcomes, and contribute at management meetings.

HOW: *Our supervisors are supported to develop skills in:*

- *Communication and teamwork*
- *The ability to think and respond under pressure*
- *Forming approachable and empathic relationships*
- *Management and administrative functions*
- *Flexible and adaptable thinking*
- *Confident and positive behaviour*
- *Transparent decision making*
- *Ethical decision making and conduct.*

All of these skills and capacities provide the necessary structure and support for our professional teams, and are a focus for our emerging leaders. Our toolkit on reflective supervision provides additional support for our supervisors and teams.

Four Kinds of Supervision

There are four kinds of supervision that are supported at MASP:

1. Administrative

This is the management component of supervision and it tends to focus on paperwork; documentation and compliance. It is very important for audits and to maintain the evidence trails needed for service provision. This is a common kind of supervision that is seen in different workplace settings from factories to schools to supermarkets. It is not so concerned with the quality of the work. This is the subject of clinical/technical supervision.

2. Clinical/Technical

Clinical supervision relates to direct client work and involves aspects of the therapeutic relationship. Clinical supervision begins with rapport building, establishing a purpose for supervision, deciding what will be discussed, how the information will be recorded etc. In this kind of supervision, the supervisee might present an assessment or impression, talk about a problem they are facing or seek expert advice about an approach to try. Common questions in clinical supervision might include:

i. What is your role with the client?

ii. What goals have you and the client set?

iii. What challenges do you have right now?

iv. What is going well right now?

Technical supervision also relates to skills development and quality of work but for non-client-facing staff. Rapport building, purpose, information sharing and recording are the same. However, in a role such as IT support, questions might involve troubleshooting systems development, costing, and implementation. Many of our staff engage in different kinds of technical supervision.

Foundations for Practice

Supervision

3. Supportive

This type of supervision is not usually separate from the first two. It has the function of increasing job performance and preventing burnout. Typical questions might include:

1. What is one thing that you are most proud of since we last talked?
2. What have you found most challenging or difficult since we last talked?
3. Where do you feel confident in the role?
4. What feedback or debriefing needs to take place?
5. Are there any safety issues for you or others?
6. What contingency plans do you need?
7. Are there other tools / resources that you need?

4. Reflective

Reflective supervision is a learning process in which the supervisor engages with the supervisee to explore their practice, and factors influencing their practice responses (including emotions, assumptions, power relations, and the wider social context).

This aspect of supervision uses adult learning theory to develop a shared understanding of the knowledge base informing the problem analysis, and any limitations in the thinking, and uses this understanding to inform the next steps (Wonnacot, 2014, p. 39).

Reflective supervision adds another dimension by tapping into (often unrecognised) emotional responses, assumptions, as well as useful ideas, that can influence how we perceive a problem and its potential solutions.

At MASP, a reflective process is encouraged as part of shared decisions and problem-solving at every level. It is formally used in group supervision to widen perspectives, encourage growth, and enable better-informed solutions. For example, the Kolb Cycle of Reflection is utilised to improve team function and to support problem-solving in direct service teams and in administrative teams at MASP. Whilst most reflective practice is facilitated internally; group reflective practice is occasionally facilitated by external therapeutic consultants where there is a higher level of client complexity. The relevant Tool Kits outline this material in more depth.

In reality, supervision is a combination of all these elements. It is a process that has formal expectations, and an agreement between

the supervisor and supervisee, and it is flexibly delivered to suit the role, level of risk, experience, and needs of the supervisee. The following definition adapted from DFFH shows how the different elements might be combined:

Effective supervision supports good working relationships, helps staff address any issues and celebrate achievements, provides the opportunity to discuss learning and development areas, and promotes effective service responses.

Supervision is a collaborative process used to promote effective service provision by:

- confirming shared expectations about the staff member's and a line manager's responsibilities, and accountabilities;
- meeting organisational program objectives;
- enhancing supervisee well-being, learning and professional development;
- providing a regular opportunity for coaching and reflective practice;
- establishing and monitoring compliance with any legislative requirements.

(The Victorian Government, 2020)

How: *We have developed policy and practice guidelines that describe how professional supervision is to be delivered including frequency, content and process. Our current supervision policies are based on contemporary, best-practice, guidelines. In addition, our supervision-related policy and practice will be reviewed in 2023 to align with the MASP Therapeutic Model of Care.*

We recognise that supervision is a two-way process. We will endeavour to establish a relationship and practice that is the best fit for the supervisee (or team), and is delivered to a good standard. We will do our best to ensure that our supervisors develop their skills across all aspects of supervision, and that the learning and support needs of our staff are prioritised, particularly for those staff who are deemed to be in higher-risk roles.

Foundations for Practice

Supervision

Three Levels of Supervision

At MASP, supervision is offered across the whole organisation regardless of the role. Supervision in the workplace is an essential part of ensuring that everyone maintains a safe working environment. But the way that people are supervised will differ depending on a number of factors:

- The nature of the work being undertaken (high risk or low risk)
- The nature of the environment where the work is being undertaken (remote and isolated or well-supported) and
- The type of worker carrying out the job.

MASP has a diverse workforce, and our staff are engaged in a variety of occupations. There are different procedures required to supervise different kinds of staff. The three main groups we keep in mind are:

1. Inexperienced staff members who are building up their skills and knowledge
2. Experienced staff members who are consolidating their skills and knowledge, and perhaps overseeing or supporting the work of others
3. Workers with specialist skills, including contractors and external consultants.

(Employment Law Practical Handbook, 2021)

Inexperienced staff will require a higher level of supervision. This will involve greater frequency and oversight, more instruction, and in many of our roles, educational development is expected and/or encouraged. The frequency of supervision will be reduced over time once the supervisor and supervisee are confident that the supervisee is able to do their job safely and to the expected standard.

Experienced staff generally require less frequent supervision and the focus of supervision is likely to be on consolidating and advancing skills. However, complacency is one of the greatest risks to safety in the workplace (Employment Law Practical Handbook, 2021), and it is important that supervisors are vigilant during times of transition and change.

For example, in residential care, staff are offered group supervision and training refreshers when a new young person is introduced to a unit. In the accounts department, increased supervision is offered when a new payment system is introduced.

Contractors such as buildings and maintenance and other specialist roles, such as external consultants and therapists who are advising on client work, will have expert knowledge. Their work is monitored by our staff, but they may not be supervised by someone who has the same technical knowledge, which can present a challenge.

All incoming roles must be compliant with the same safety requirements, including client safety. For example, a building contractor who is working on the roof of our building, must not only abide by their own professional standards and regulations, but they must also conduct themselves in a safe and appropriate manner with respect to our clients, staff, and community. A consulting clinician who brings expert knowledge of child mental health must work to a professional standard, which means providing agreed notes and feedback and conducting themselves in accordance with the MASP model of care.

Foundations for Practice

Supervision

Culturally Safe Supervision

For Aboriginal Peoples, cultural safety is about providing an environment that is safe for all community members. Cultural safety involves recognising, protecting, and advancing inherent rights, cultures and traditions where there is no denial of identity and experience.

The Victorian Government references Aboriginal and Torres Strait Islander Cultural Safety Framework (see Appendix 5)defines cultural safety as:

- Shared respect, shared meaning and shared knowledge;
- The experience of learning together with dignity and truly listening;
- Strategic and institutional reform to remove barriers to optimal health, wellbeing and safety outcomes for Aboriginal people;
- This includes addressing unconscious bias, racism and discrimination, and the ability to support Aboriginal self-determination.
- Cultural safety is about Individuals, organisations and systems taking responsibility for ensuring that:
- Their own cultural values do not negatively impact Aboriginal peoples
- Supporting self-determination for Aboriginal peoples – this includes sharing power.

(The Victorian State Government, 2021)

> **HOW:** *MASP provides resources and support for supervisors who are working with Aboriginal staff and overseeing work involving Aboriginal clients. This includes the use of cultural guides; using a reflective and collaborative approach, and upskilling. Staff with specialist knowledge and/or of Aboriginal and Torres Strait Islander descent are also strongly encouraged to contribute towards building knowledge, skills, and practices at MASP. Through cultivating relationships of respect and trust we seek to make reparation, and to continuously improve our cultural knowledge and ways of working.*
>
> *For additional information see the section on Cultural Competency in this section, Appendix 1, and Appendix 5, and our toolkit on working with Aboriginal and Torres Strait Islander peoples.*

Staff are expected to engage in foundation training in working with Aboriginal and Torres Strait Islander peoples, working with LGBTQIA plus, and culturally and linguistically diverse communities, and to accept other opportunities for learning and development as they arise.

Through our model of care, and our commitment to a wider program of culturally safe practices at MASP we are focused on establishing MASP as a place of safety where dignity, respect, and empowerment are extended to all people.

Foundations for Practice

Learning and Development

The provision of evidence-based practices involves a commitment to supervised practice and continuous learning through supervision, reflective practice, and teamwork.

Formal learning and professional development are encouraged. This is accompanied by a leadership culture that supports a safe learning environment and assists staff in implementing new skills and practices.

MASP has access to a number of flexible learning options and is committed to a regular program of staff education and training. Some of the highlights include:

- Staff undertake an induction program upon commencement that includes face-to-face training, and very importantly, introduces new staff to the team and provides an opportunity for the team to establish positive relationships and to model the CARES values.
- The organisation has a program of matching new staff with someone with more experience who can provide mentoring and coaching in the first few weeks on the job. This approach is paired with formal supervision to reinforce learning and encourage the development of the supervisory relationship.
- MASP is committed to training all staff in trauma-informed practices and currently maintains trainers in Therapeutic Crisis Intervention and trauma-informed care.
- MASP utilises a number of strengths-based evaluation tools to measure client outcomes.
- The suite of MARAM tools has been implemented across the whole service and MASP is in the process of aligning assessment and intake documentation. The service has been proactive in making these changes as part of our commitment to ending family violence. Self-paced MARAM training is available to our staff online.

- We encourage staff to regularly access online and in-person professional development opportunities. Among other providers, Berry Street, the Australian Childhood Foundation, and the Centre For Excellence offer high quality specialised training in childhood trauma and other professional development that is targeted to our sector.
- Suitable strengths-based leadership training was identified in 2022 and commenced rolling out across the service. This work will continue as part of an overarching staff development framework.
- The service has access to a number of online training opportunities. Most notably: the various industry E3 learning modules; the NDIA disability support modules; and the Centre for Excellence in Child and Family Welfare modules for child and family services.
- MASP provides a number of reflective practice and team supervision opportunities aimed at enhancing collaborative decision-making and improving client outcomes.

Foundations for Practice

Psychological Safety

Amy Edmonson, Novartis Professor of Leadership and Management at the Harvard Business School, and author of 'The Fearless Organization' (2018), defines psychological safety as:

> *"a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk-taking" (Edmondson, 2018, p. xvi).*

She explains that psychological safety "is not an "anything goes" environment where people are not expected to adhere to high standards or meet deadlines" (p. 17). It is not about relaxing standards, "this conveys a misunderstanding of the nature of the phenomenon" (p. 17).

According to Edmonson, "psychological safety enables candor and openness and, as such, thrives in an environment of mutual respect. It means that people believe they can – and must – be forthcoming at work. In fact, psychological safety is conducive to setting ambitious goals and working toward them together" (p. 18).

Organisations that perform well on psychological safety for their staff, are more likely to lay the groundwork for excellence and innovation because no matter what happens "personal identity, dignity and the ability to self-protect is intact" (p. 18). However, standards and expectations are important. The goal is to achieve balance of high expectations, direction, and focus, along with the containment and support needed for active learning and collaboration.

	Low Standards	High Standards
High Psychological Safety	**Comfort Zone**	**Learning & High-Performance Zone**
Low Psychological Safety	**Apathy Zone**	**Anxiety Zone**

How Psychological Safety Relates to Performance Standards (Edmondson, 2018, p. 18)

Edmondson's simple, but effective diagram, neatly draws attention to the anxiety that can plague organisations where expectations are not supported by safe working environments. Edmondson's work suggests that psychological safety is particularly important in workplaces that support people with complex needs and trauma where staff may also have some degree of lived experience.

Bloom (2013, lists threats to psychological safety as commonplace behaviours such as "sarcasm, lecturing, putdowns, outbursts, public humiliation, negative tone of voice or body language; infantilizing treatment; blaming and shaming" (Bloom, 2013, p. 145). She states that people who have experienced this kind of behaviour in the past, particularly in childhood are more vulnerable to "profound reinjury" (p. 145).

Foundations for Practice

Psychological Safety

HOW: Supporting psychological safety in the workplace is ongoing at MASP.

- *Our leadership team leads the way in modelling self-awareness and inclusive behaviour by using Trauma-informed principles in meetings, supervision and communications. See Appendix 2, and Appendix 4.*
- *Our model of care provides information and foundation resources for our staff to learn about psychological safety. Our toolkits provide relevant ways to engage with topics such as reflective practice, conflict resolution, and wellbeing.*
- *We provide regular supportive supervision for all staff. This provides an opportunity to build a one-on-one relationship and is a safe place to explore any problems or challenges that may arise.*
- *Our team meetings include a reflective supervision component which encourages a respectful, and inclusive culture.*
- *When mistakes are made, we provide proactive support and we review any systems issues.*
- *We provide processes for conflict resolution and relationship repair.*

We celebrate our wins, and we regularly share positive experiences and service improvements

Tacking Upwind

"If you set out to build psychological safety in your organization, it's somewhat like setting sail on journey for which much is known and much is unknown. Just as skippers and crew on a sailboat must communicate and coordinate to stay the course facing shifting tides

and winds, you and your colleagues must do likewise. The sailing metaphor is apt as well because it's impossible for a sailboat to head directly to an upwind mark (almost always set as the first destination in a regatta). The boat can head at a 45-degree angle off from the target, getting closer, and then "tacking" – switching to head at a 45-degree angle on the other side. Zigzagging upwind in this manner, the boat eventually arrives at its destination, having made large (tacks) and small (sail adjustments) pivots along the way".

(Edmondson, 2018, p. 208)

Foundations for Practice

Trauma-Informed Care

"The word trauma comes from the Greek traumata, which means 'to pierce'. This is entirely apt when thinking of trauma within organisations because it can wound, pierce and permeate individual, familial, organisational and societal layers" (Treisman, 2020, p. 5).

The Diagnostic and Statistical Manual, fifth edition, DSM 5, definition of trauma is limited to an individual who has experienced "actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013) . Stressful life events not involving an immediate threat to life or physical injury such as psychosocial stressors (exposure to family violence, bullying, divorce, or job loss) are not considered in this definition of trauma.

This definition also, controversially, leaves out what many believe are the most common causes of human suffering and mental illness, namely, the environmental causes; childhood abandonment, abuse, and deprivation (Van Der Kolk, 2015, p. 165). Instead, the DSM renames this kind of trauma as oppositional defiance disorder, non-suicidal self-injury, disruptive mood regulation disorder, disruptive impulse control disorder, and many other things (p. 166).

Another way to understand trauma is that it is not usually a "single blow". It is often interpersonal, and prolonged. Sandra Bloom defines trauma as occurring "when an individual, family, organisation, system, or culture becomes fundamentally and unconsciously organized around the impact of chronic and toxic stress, even when this undermines its adaptive ability" (Bloom, 2013).

The experience of multiple types of trauma, beginning in early childhood and prolonged, has been referred to as complex or "developmental" trauma. Developmental trauma has much in common with PTSD, but it is also "uniquely associated with traumatic emotional abuse and caregiver separation from a primary caregiver" (Spinazzola, Van Der Kolk, & Ford, 2021, p. 711). The child's dependence, and forming sense of self and the world, makes them particularly vulnerable.

As suggested by Bloom, trauma might be encountered in an individual, but it extends beyond the individual to permeate the wider social group. Trauma can also be intentionally, and unintentionally, perpetuated by groups, social systems, and through systems of care.

HOW: A degree of trauma and recovery is part of ordinary human development, and as such it can also be understood as an opportunity for change, healing, and reparation.

The difficulty comes when trauma overwhelms and blocks ordinary growth and development. All human service organisations have a part to play in acknowledging and responding to trauma, and to positively and proactively aiding recovery.

How we respond can positively influence the nature of healing and recovery not only for individuals, but within our own systems of care. For additional information see Appendix 1, and Appendix 2, and our various toolkits on Trauma-informed practices.

Foundations for Practice

Trauma-informed Care (TIC) Framework

Trauma-Informed Care (TIC) is a commonly used acronym that usually describes a generalist, entry level, professional development program that is strengths-based, and aims to improve systems support for individuals and groups impacted by trauma. The material that follows next has been adapted from one such program developed by "Western Cluster" (2010), an education arm of the Victorian health sector. Although we have chosen to refer to the Western Cluster TIC program, these ideas are common to many, if not all, similar programs.

TIC emphasizes physical, psychological, and emotional safety for both providers and survivors. Its primary goal is to enhance opportunities for survivors to rebuild a sense of control and empowerment as part of receiving funded health care services and supports.

TIC provides practice guidance and support to professionals who work in environments where trauma presentations are a common occurrence. Suggestions for best practice include:

1. Being as flexible, non-threatening, & safe as possible;
2. Speaking in open ways and encouraging the yarn;
3. Respecting men's and women's business, for example, female staff not asking an Aboriginal man a sensitive question about his personal life, and vice versa;
4. Engaging an Aboriginal liaison officer or cultural guide where appropriate;
5. Explaining processes and what to expect in plain language and
6. Always keeping lived experience in mind when preparing an assessment or planning support.

MASP also trains some client facing staff in Therapeutic Crisis Intervention (TCI), (Cornell University, 2021).The program includes detailed instruction on trauma response, self -awareness, and techniques that can safely address de-escalation, co-regulation and other interventions for young people living in residential care settings.

Four Stage Model

MASP proactively works with clients in order to reduce the likelihood of causing further harm and to provide the best opportunity for recovery and growth. Becoming trauma-informed is a process and there are several different models to guide organisations in their journey. We have selected the Miesler and Myers (2013) four-stage model for our foundation, because it is theoretically robust and well-established (it is cited in Australian federal government guidelines and utilised in the NSW out of home care sector), the change continuum has a clear beginning point, and the model can be adapted to suit different organisations. The four stages of this model are:

1. trauma aware: seeking information out about trauma;
2. trauma sensitive: operationalising concepts of trauma within the organisation's work practice;
3. trauma responsive: responding differently, making changes in behaviour;
4. trauma-informed: entire culture shifts to reflect a trauma approach in all work practices & settings.

(Miesler & Myers, 2013 cited in Wall, Higgins, &Hunter, 2016, p. 6)

Foundations for Practice

Four Stage Model: Trauma-Informed Continuum

Trauma Aware	Trauma Sensitive	Trauma Responsive	Trauma-informed
Form a change team	Be welcoming	Recognise and respond to traumatic stress	Whole system fully and meaningfully integrates knowledge about trauma into policies; procedures; language, culture, practices and settings.
Assess the organisational environment	Maximise safety	Screen for trauma history	There are systems to guide and support regular review such as supervision, team meetings, policy reviews and audit processes.
Define goals	Educate all staff on Trauma-informed care	Strengthen resilience & protective factors	Whole system pivots towards empowerment, strength and resilience.
Identify trauma champions	Work on building understanding and relationships	Address impacts of trauma	
Identify resources	Focus on enabling & empowering others	Focus on strengths rather than deficits	
Identify measures	Use first person langauge	Engage people in finding their own solutions	
	Be accountable	Assist people to make new meaning of their lives and experiences	
	Take a holistic view		
	Share vision across service systems		
	Address vicarious trauma issues		

In the four-stage model, organisations first become trauma aware. They start to plan and implement an understanding of trauma, its effects, and the importance of specialist services in their business operations. When services become trauma-sensitive, they implement strategic training and staff adapt their practice to avoid re-traumatising clients.

In the trauma-responsive service, work takes place at a broader level to reorient the organisation towards healing trauma and helping people. By the time an organisation is trauma-informed, trauma is no longer seen as something to be addressed as a separate issue, and instead, safe and empowering practices are fully integrated across the whole organisation.

Unfortunately, the term trauma-informed is now often used to mean trauma aware and Karen Treisman (2017, 2016, 2020), has emphasized the importance of trauma responsiveness. Her website offers various resources and worksheets to support implementation, such as a practical guide to having trauma-informed meetings. See Appendix 2, and Appendix 4, for further information.

Building the Evidence Base for Trauma-informed Care

The research world is continuing to define and measure best practice in trauma-informed care and recovery (see Appendix 1). In a small but important way, organisations like MASP contribute to building the evidence base by following principles and processes that include:

5. Planning for change at all levels of the organisation.
6. Providing ongoing staff and carer training to understand trauma-based behaviours.
7. Creating physically, emotionally, and culturally safe spaces for survivors.
8. Collaborating with survivors, families, and other services in the healing and recovery process.
9. Recognising and responding to long-term impacts of violence on individuals, families and communities.
10. Reaching agreement on definitions and standard measures to test practices.
11. Participating in research and evaluation to better understand effective approaches and interventions.

(The University of Sydney (Research centre for Children and Families), 2019, p. 3)

Foundations for Practice

Client Voice

Blue Knot foundation is the voice of adult survivors of sexual trauma. In their excellent foundation practice guidelines 'The Last Frontier" (2012), a contributor makes the following statement about client voice:

> *"The voice and participation of consumers, including those who identify themselves as trauma survivors, should be at the core of all systems activities- from policy and finance to training and services".*
> *(Kezelman & Stavropoulos, 2012, p. 17).*

Definitions, roles, and purposes of client voice are diverse across the sector. The role can include communication with staff and organisations during service delivery, engaging in formal and informal feedback processes, structured involvement in service planning and provision through volunteering or paid work; and systems work, including advocacy and political activism at the level of community and government.

The NSW Department of Communities and Justice has also produced useful guidelines for client involvement in commissioning services (Jakob, 2021, p. 3). See Appendix 3.

The Victorian State Government has defined client voice as:

Any and all expression of the views, opinions, needs, experiences and outcomes of individuals, families and carers who have previous or current involvement with a community service… 'Client voice' is an umbrella term that describes essential input into any activity that asks for and records the views of clients including person-centred practice, co-design, and quality governance. The client voice is also the output of these activities. The client voice is relevant at all stages of a person's involvement with the system, and at all levels.
(The Victorian State Government, 2019, p. 1).

> **HOW:** *In 2022, we spoke to several of our clients and community members about their experiences of our services and what they saw as important and valuable. The conversations were revealing and candid. Thanks to their generosity, we were able to incorporate a range of helpful and diverse views into our strategic planning process and into our model of care. For further information see Appendix 1.*

MASP is committed to involving clients in a range of planning and service delivery activities as part of continuous service improvement. We intend to expand upon this work in the coming months and years, as we seek to incorporate client voice at every stage of service delivery.

Foundations for Practice

Client Voice

Five Key Principles

The Victorian state government has identified five key principles to guide client inclusion in service provision, as well as prompts to aid thinking and discussion:

1. **The client voice is essential for quality and safety.**

   I experience safe services…

   I can speak up if something isn't right…

1. **Clients have expertise.**

   My experience and expertise are valued…

1. **The client voice is part of everyone's role.**

   I receive help and support in a coordinated way, at the right time…

1. **There are many client voices.**

   I receive help and support in a way that makes sense to me…

   I choose how much I participate in the services I receive…

1. **The client voice leads to action.**

   I can influence change…

(The Victorian State Government, 2019, p. 8)

How: In addition to listening to our adult clients, MASP is very aware that the thoughts and wishes of children and young people are easily overlooked in our systems of care. Much of our work involves advocating for children and young people who are receiving our services, as well as enabling them to have a say about what they are experiencing and what they need. For more information see our toolkits on care teams, family violence, and attachment.

Through our work with some of the most marginalised children and young people, we are also privileged to work with many proactive organisations and individuals who work hard to keep children and young people at the centre of service provision, and who willingly share their time, expertise, and resources.

Client Voice

Young Voices

As part of their commitment to client voice, the Victorian State Government (2021), recently released "Young Voices" which includes a website, written materials, and other free resources aimed at enhancing efforts to include the experiences and wishes of children and adolescents more prominently in the development of services and supports that are about them.

They have detailed a six-step plan as follows:

1. Do a readiness assessment
2. Plan the project
3. Engage the children and young people
4. Plan for participation activity
5. Set expectations during participation
6. Plan for what comes after participation

(The Victorian State Government, 2021)

Foundations for Practice

Client Voice

Co-Production

Client voice can be understood as part of a continuum of inclusive and empowering practices. To do this well requires a strong foundation and a genuine commitment to engaging and working with our community. The following guide locates where client voice fits into the overall provision of care:

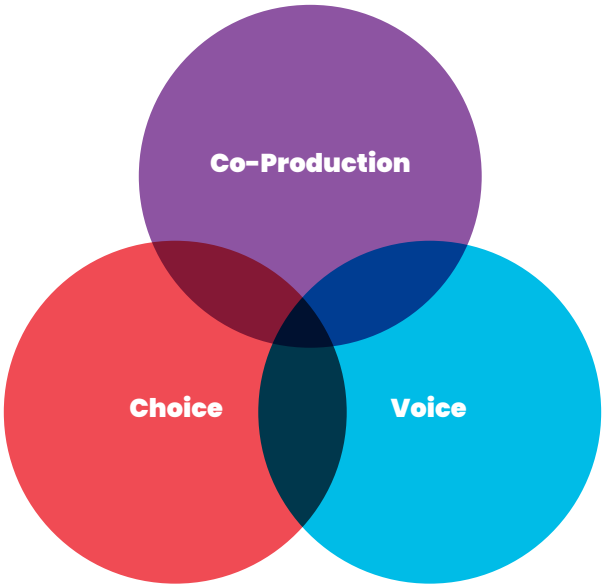
1. Choice relates to the client within the human service system.
2. Voice relates to the individual who is actively involved in decision-making.
3. Co-production is the interface between voice and choice and describes how clients engage, individually or collectively, in service delivery in partnership with providers

In much the same way as empowerment practices establish the conditions in which self-determination can occur, a commitment to co-production provides the setting conditions for choice and voice.

"There are various engagement approaches, methodologies, and tools (for example, relating to co-design, and co-evaluation) that are useful, however to co-produce means exploring and building (together) the philosophical foundations and mindsets from which other work can then be done. Co-planning, co-design, co-delivery, and co-evaluation, and other collaborative work can be undertaken without the culture shifting groundwork required for co-production. Some co-design approaches incorporate co-production activity, but many do not" (Roper, Grey, & Cadogan, 2018, p. 5).

> **HOW:** *We take the view that we are privileged to walk alongside our clients and community. We value different approaches because this can help us to find a good fit for the person, group, and community that we are working with. This work can be expressed as combination of voice, choice and co-production.*

Our toolkit on person centred care extends some of these ideas.



Foundations for Practice

Therapeutic Milieu

In contemporary understandings, a therapeutic milieu is a collective approach to providing care and a way of organising caregiving environments. Ideas about the social 'milieu' go back decades, and were first applied to children's homes in the sixties and seventies. Albert Trieschman, a Harvard psychologist who worked with children in care at that time wrote a classic book, 'The other 23 Hours', in which he talks about a framework for practice that is still in use today:

Our notion is that the actions of adults with children and the adult's control of the environment can be coordinated to improve children's lives.

Our framework is constructed for the adults who people the milieu: the child care workers, houseparents, counsellors, nurses, social workers, group workers, psychologists and psychiatrists. It is meant for all the adults who deal with the children, or plan for the children's living situations, whether they deal directly or supervise or advise those who do deal directly.

Our major concern is the 23 hours outside of the psychotherapy session – because that is when and where most of the milieu is. (Trieschman, 2017)

Trieschman describes the milieu as "like a sea chart and some word pictures" (p. 2) which he then explains in great detail. He makes the point that because of the dynamic environment, it is very important for organisations that work with children in care to work together as a team and to continually communicate what they are doing and how they are doing it.

How: The concept of a therapeutic milieu strongly resonates with the work that MASP does with children and young people living in out-of-home care. Our staff work together in close knit teams to provide safe relationships and containment for children and young people with significant developmental trauma, and unique support needs.

Our toolkits on children and family violence, attachment, and care teams, compliment and extend these ideas.

Trieschman, Bruce Perry, Dan Seigel, Dan Hughes and others who write about milieu are not just concerned with children in care. Healthy relationships are the foundation for all of our subsequent development. Rebuilding and restoring relationships is a critical part of the process toward recovery, wellness, and thriving.

To achieve this, Trieschman says, there must be a good fit between the workplace and the employee:

> *"in the ideal situation the norms and values held by the workers are highly compatible with the goals of the institution and the total (care) philosophy" (Trieschman, 2017, p. 224).*

In dynamic and emotionally demanding environments, the prevailing ethical and values-led workplace culture is critical to supporting and organising collectively held expectations, standards, and behaviours. The MASP model of care, particularly the 'Mini-Model', sets out client needs and then each person's responsibilities in unambiguous "I" statements. This document can, therefore, be understood as an articulation of the MASP therapeutic milieu.

Consider a scenario in which a child who is living in care, runs away in the night following a misunderstanding with their caregiver that happened hours earlier. A child with a trauma history, autism, or intellectual disability, will very likely struggle to engage in a conversation with their carer about what is bothering them. How are we to make sense of what might be happening and how might the child's safe adults respond?

There are many different ways to approach such a situation, all of which will involve some version of making the child safe, and then regulating, connecting, repairing, and planning together. Each person will have their part to play. The particular circumstances will vary each time. The child's individual support needs must be understood and responded to, and because human beings cannot be fully described, and each situation is different, the team must work in close communication and to some degree must "map" new terrain as it goes.

This scenario is further explored in the Toolkit on care team processes. For now, it is simply to note that the therapeutic milieu comes from ideas about the importance of the 'holding environment' in which organised, safe, predictable, resilient adults provide a nourishing place where growth can happen. Of course, this doesn't just apply to child work. Teams that work with children and adults alike can fruitfully apply these ideas in shared work that is orientated towards healing, recovery.

Foundations for Practice

Cultural Competency

Cultural competency can be defined as "culturally inclusive and responsive practice that encompasses a knowledge and awareness of other cultures as well as practice skills; but most importantly it requires workers to have an understanding of their own values and cultures as derived from family, background, and position in society" (Dewees, 2001, cited in Bender, Negi, & Fowler, 2010, p. 34).

Making the connection between our world and the worlds of others can help professionals to build on shared interests and commonalities, and to negotiate or mediate differences. Tuning in to culture develops the ability to communicate and empathise with others and to analyse intercultural experiences critically. It can also provide an opportunity to consider our beliefs and attitudes in a new light, and so gain insight into ourselves and others.

> **How:** *We provide various opportunities to improve cultural competency. Formal training and seminars are offered each year in aspects of LGBTQIA plus and Aboriginal and Torres Strait Islander cultures. Several of our programs include mandatory cultural awareness learning modules that are accessible online. MASP's Equity and Diversity Committee (EDI) organises and promotes events throughout the year and committee members can be contacted with questions or ideas.*

See Appendix 5 for more information considerations for working with Aboriginal peoples and our toolkit on working with Aboriginal and Torres Strait Islander peoples.

Foundations for Practice

Cultural Competency

Aboriginal & Torres Strait Islander Cultural Safety

MASP is serious about taking-action to address the legacy of dispossession, violence and racism that has characterised much of Aboriginal life in this country. We recognise that this is an ongoing reparative process and that there are many steps along the way. It is very important to us that we maintain positive relationships and partnerships with our local Aboriginal leaders and service providers, and that we strive to meet all of our obligations under various state & federal legislation and guidelines. In 2022, we formally commenced our first Reconciliation Action Plan, which we believe will bring a new level of awareness and energy to our organisation concerning these important issues.

Key documents for MASP include:

- Korin Korin Balit-Djak (2017), the 10-year Aboriginal health, wellbeing and safety strategic plan (The Victorian State Government (Department of Health and Human Services), 2017);
- Dhel Dja (2018) Aboriginal 10-year Family Violence Agreement (The Victorian State Government, 2018);
- The Aboriginal and Torres Strait Islander Cultural Safety Framework (The Victorian Government, Department of Health and Human Services, 2021) (See Appendix 5), and associated tools;
- Federal guidelines related to the Aboriginal and Torres Strait Islander Child Placement Principle;
- Secretariat of National Aboriginal and Islander Child Care (SNAICC) resources.

Our focus is on "working together to deliver more culturally diverse and safe environments, services and workplaces" (The Victorian Government, Department of Health and Human Services, 2021), recognising the rich cultural heritage and history of Aboriginal peoples, and honouring the right of Aboriginal peoples to dignity, respect, and self-determination.

The Victorian cultural safety framework describes four stages of learning towards cultural safety which MASP is actively working through.
They are reproduced on the next page for ease of reference:

1ST STAGE: UNAWARE 'Unconsciously Incompetent' Learning Stage	2ND STAGE: EMERGING 'Consciously Incompetent' Learning Stage	3RD STAGE: CAPABLE Consciously Competent' Learning Stage	4TH STAGE: PROFICIENT 'Unconsciously Competent' Learning Stage
Overall reflection: I am unaware of how my unconscious biases and behaviours affect the cultural safety of the workplace and services delivered	**Overall reflection:** I recognise the need to unlearn and build my skills and knowledge to improve	**Overall reflection:** I consciously apply my learnings and improve cultural safety practice	**Overall reflection:** My work practices are culturally safe and do not require a conscious correction. I am open to and enact ongoing learning and improvement

The framework describes eight guiding principles beginning with leadership, and three overarching domains for action that are highly compatible with our therapeutic model of care:

1. Creating a culturally safe workplace and organisation

This involves cultural change "by reforming strategies, policies, procedures & accountabilities"

2. Aboriginal self-determination. This domain relates to changing our workforce and to providing multiple opportunities for genuine listening, collaboration and decision-making with Aboriginal clients and the community.

3. Leadership and accountability

This domain is about establishing and maintaining quality improvement and safe practices across the organisation.

(The Victorian Government, Department of Health and Human Services, 2021, p. 10)

> **HOW:** *We have foregrounded key cultural documents in our model of care. We seek to provide multiple opportunities for conversation, questions, formal training, and cultural awareness activities. We have established clear expectations & guidelines in our policy and practice guidelines, and in our model of care documentation, and we are committed to co-developing a Reconciliation Action Plan with our Aboriginal service partners & community leaders.*

Foundations for Practice

Cultural Competency

Capacity Building

Much like the families and communities that we work with, our teams may have multiple cultures functioning within them called subcultures or nested cultures (Parker, 2000).

There may be a perceived culture and a "real culture". Writing about gender in the workplace, Ely & Meyerson (2000), say that there may be common understandings, "group norms" (p114), as well as less visible "ambiguities" (p. 124) that may be viewed as normal or abnormal within a team culture, (Ely & Meyerson, 2000).

Taking the time to reflect on family of origin, relationships, schools, language, job, values, and belief systems can assist in identifying biases and assumptions that may play out in the workplace. Similarly, group exercises such as "tree of life" or a team genogram can support colleagues to discuss and understand hidden dynamics within the team.

> **HOW:** *Understanding ourselves and how we respond to others is an important part of becoming Trauma-informed, and we encourage all of our staff to explore these issues in their teams, in supervision, and to engage in regular self-reflection.*

The following diagram provides some jumping-off points for personal reflection and discussion:


Race, Ethnicity, Tribe
Gender
Age
Satus, Class
Religion
Sexual Orientation
Language
Ability
Cultural Identity

Our Ways of Working

Introduction to the Practice Toolkits

HOW: The toolkits can be used in different ways and are designed to be adapted for a range of different purposes and settings. Materials contained in the kits can be shared, used in supervision, and form the basis for reflection and for group discussion. The PowerPoints are intended for use with care teams and in team discussions but can be used in other settings as well.

Several toolkits have been developed to support the CARES model. The kits are available online and they contain information in the form of written materials, book lists, references, PowerPoints, YouTube clips and other resources that can assist the reader to take a deeper dive into a given topic area.

The kits form the "living" part of our model. They will be regularly updated and added to over time. The only thing that is asked of staff is to seek permission from the Director of Practice if core materials are changed or updated in the toolkits. This is to preserve the integrity of the kits and to ensure that the content is as accurate as we can make it.

Finally, MASP will purchase and hold at least one copy of each of the books listed in the kits. They may not all be immediately available at all times, however, if a member of staff or a client wishes to access a book or resource they can contact the Director of Practice and arrangements will be made to obtain it.

Similarly, if staff become aware of a new book or resource that they would like to include in a kit, they can forward this information to the Director of Practice. Wherever possible, kits will be updated in a timely manner to reflect current information.

Tool Kits

1. Attachment
2. Family Violence
3. Person centred care practices
4. PACE
5. Trauma and developmental trauma
6. Working with Aboriginal and Torres Strait Islander Peoples
7. Working with children & young people
8. Conflict resolution
9. Reflective Supervision
10. Care teams and professional teams

The kits follow a similar layout which is as follows:

1. Introduction to the topic
2. PowerPoint
3. Resources
4. Booklist
5. Bibliography

> *Toolkits will be regularly updated and may change over-time. Staff can access the master list available on the MASP intranet (Sharepoint), for the most up to date information.*

Appendices

Appendix 1: Background to the MASP Therapeutic Model of Care

The Impact of Trauma

The Australian Context

There is limited data on the prevalence of trauma in the Australian population. Two studies suggest that 57–75% of Australians will experience a potentially traumatic event at some point in their lives (Mills, et al., 2011; Rosenman, 2002). International studies estimate that 62–68% of young people will have been exposed to at least one traumatic event by the age of seventeen (Copeland, Keller, Angold, & Costello, 2007; McLaughlin, et al., 2013) and we are yet to fully understand the impact of global events such as the pandemic, climate change, technology, and social media.

In general, the available evidence supports a higher prevalence rate of trauma among particular population groups such as adults living in poverty, children in out-of-home care, indigenous peoples, and people exposed to institutional and societal abuse.

Adverse Childhood Experiences (ACEs) are traumatic events that occur before a child reaches the age of 18. The USA Centres for Disease Control and Prevention (CDC) and Kaiser Permanente, a USA-based non-profit health care service, conducted the first ACE study from 1995 to 1997 (Centers for Disease Control and Prevention, 2021) . They asked more than 17,000 adults about childhood experiences including emotional, physical, and sexual abuse; neglect; and household challenges of parental separation, substance abuse, incarceration, violence and mental illness.

Nearly two-thirds of participants noted at least one ACE and more than 1 in 5 noted three or more. Researchers identified a link between ACE exposure and a higher likelihood of negative health and behavioural outcomes later in life, such as heart disease, diabetes, and premature death (Felitti, et al., 1998). This research reveals trends across thousands of people and provides important data for the development of social care services and communities more broadly. However, ACEs research cannot predict outcomes for individual people and must be considered as part of the picture, not the whole picture.

In 2017–18, adults living in the most disadvantaged areas (the first quintile) across Australia were more than twice as likely to report high or very high levels of psychological distress as compared with adults living in the least disadvantaged areas (the fifth quintile) (18% and 9% respectively). This is similar to the pattern seen in 2014–15 (18% and 7% respectively) (Australian Bureau of Statistics, 2019). 2021 research shows that disadvantage is concentrated in a small and disproportionate number of communities in each state and territory. In NSW 13% of locations accounted for 55% of the most disadvantaged positions across all indicators, and in Victoria, 5% of locations account for 29% of the most disadvantaged positions (Tanton, et al., 2021).

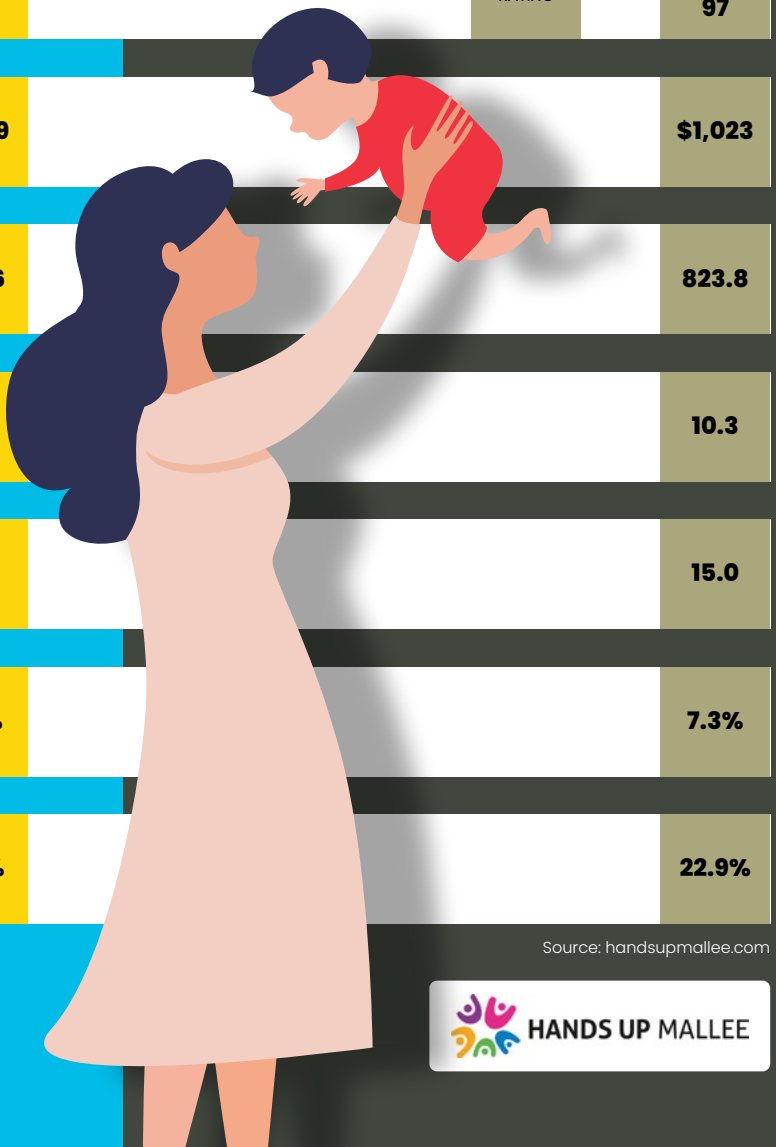
Mildura is considered to be one of the most disadvantaged communities in the state of Victoria (Tanton, et al., 2021; Hands Up Mallee, 2019). The following material was sourced from the website of "Hands Up Mallee" a not-for-profit community initiative that is driving social improvements in the Mallee:

> *"We are one of the most disadvantaged areas in Victoria; ranking 6th out of the 79 Victorian LGAs on the SEIFA index; the median wage is well below the state average; the rate of family violence incidents is the second highest in the state; we have a very high rate of children on child protection orders and children in out of home care; high numbers of our children start school vulnerable in one or more AEDC domains, and our year 12 completion rates are well below the state average"*
>
> (Hands Up Mallee, 2019)

Children in out-of-home care and in family homes where child protection services are a regular presence are particularly vulnerable to experiencing, abuse, neglect, and social deprivation. Trauma that occurs early and repeatedly in a child's life is referred to as developmental trauma (happening early in life). Whereas trauma may temporarily change the mature brain, Perry (2008) has shown that trauma in early childhood organises the brain. Not only do our children have higher rates of traumatic exposure, but these experiences can change who they are, and what their future will hold.

Beginning Life Behind

	VICTORIA	MILDURA
Index of relative socio-economic disadvantage [1]	**1000** AVERAGE RATING	**935** RATING — **6th** OF **97**
Median Income [2]	**$1,419**	**$1,023**
Domestic violence incident reports where children were present per 100,000 population [3]	**387.6**	**823.8**
Children in Out of Home Care per 1000 chidren aged 0-17 years [4]	**6.1**	**10.3**
Children on Child Protection orders per 1000 chidren aged 0-17 years [5]	**5.2**	**15.0**
Babies born with low birth weight [6]	**6.8%**	**7.3%**
Women who smoke while pregnant [7]	**10.1%**	**22.9%**



1 SEIFA
2 Australian Bureau of Statistics, 2016 Census Data
3 Victorian Police
4 Department of Health & Human Services 2015
5 Department of Health & Human Services 2010
6 Victorian Perinatal data Collection
7 Victorian Perinatal data Collection

Source: handsupmallee.com

HANDS UP MALLEE

Definitions

> *Trauma can be thought of as an experience of "extreme stress or shock" (Gomes, 2014) in the form of "a radical threat to the integrity of the subject" (Laplanche & Pontalis, 1973, p. 518).*

The fight, flight, and freeze reactions are automatic reactions that most people will experience when exposed to a significant traumatic event. They are triggered by a real or perceived threat to survival and are part of the human survival system. Fight, flight, and freeze are usually temporary experiences. Most people will effectively recover either by themselves or with a degree of support.

Post-traumatic stress disorder or PTSD, is sometimes called the 'fourth reaction to trauma'. PTSD is when a person cannot stop thinking about the traumatic event (or events) and is extremely distressed. The survival system of the brain has not recovered and fight, flight, and freeze systems are repeatedly triggered. PTSD is caused by experiences that have overwhelmed the person's natural ability to recover and is associated with prolonged and high-stress situations such as sexual assault, car accidents, traumatic childbirth, war, serious physical assault, and natural disasters. PTSD has been the subject of a large international research effort and there is ample information available online concerning symptoms, diagnosis, and treatment options for PTSD in adults.

A 'fifth reaction to trauma' that we will propose, is referred to in the clinical literature as 'developmental' or 'complex' trauma. This refers to the effects of pervasive abuse and neglect that happens early in life, in the context of primary caregiving relationships.

Modern neuroscience has shown that social/emotional trauma or neglect in infancy affect not only behaviour and psychological development, but brain growth. The dissociation that arises after trauma can interfere profoundly with growth in the feeling and relating parts of the brain (Perry, 2002; Schore, 2003 cited in Alvarez, 2012).

There is less recognition, understanding, and empirical evidence concerning the identification and effective treatment of childhood trauma. There are many reasons why. It can be more difficult to gather accurate and timely information, the skill sets needed are very specific and specialised, adults who have caused harm are usually not very forthcoming due to criminalisation and negative public opinion, and children may be very young, have limited communicated skills (they do not have a 'voice'), and they may be unable to form a relationship of trust with a safe adult. All of this adds complexity to the clinical picture for children.

MASP is part of a service system that provides care to people who have experienced trauma at different stages in life. A disproportionate number will have experienced childhood trauma. The USA-based Substances Abuse and Mental Health Services Administration (SAMHSA) is a worldwide authority on trauma, and has developed a comprehensive definition:

> *"Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual functioning and mental, physical, social, emotional or spiritual wellbeing"*
>
> (Substance Abuse and Mental Health Services Administration, 2014, p. 7)

In addition to individual treatment, 'treatment' can also be understood in the context of the systems of care. Psychological definitions do not fully capture all the different ways in which trauma can impact upon our communities and systems of care. For this we have turned to the work of Sandra Bloom (2016) who argues that "organisations, like individuals, can be traumatised" (Bloom , Destroying Sanctuary, 2016, p. 139).

> *"Just as the lives of people exposed to repetitive and chronic trauma, abuse and maltreatment become organised around the traumatic experience, so too can entire systems become organised around the recurrent and severe stress of trying to cope with a flawed mental model based on individual pathology, which is the present underpinning of our helping systems. When this happens, it sets up an interactive dynamic that creates what are sometimes uncannily parallel processes"*
>
> (p. 140)

Human service organisations are living systems; they take in the whole range of human experience and suffering, they attempt to provide meaningful connection by 'taking in' what the client brings and working with the client, and they send the client back out into the world, ideally, in better

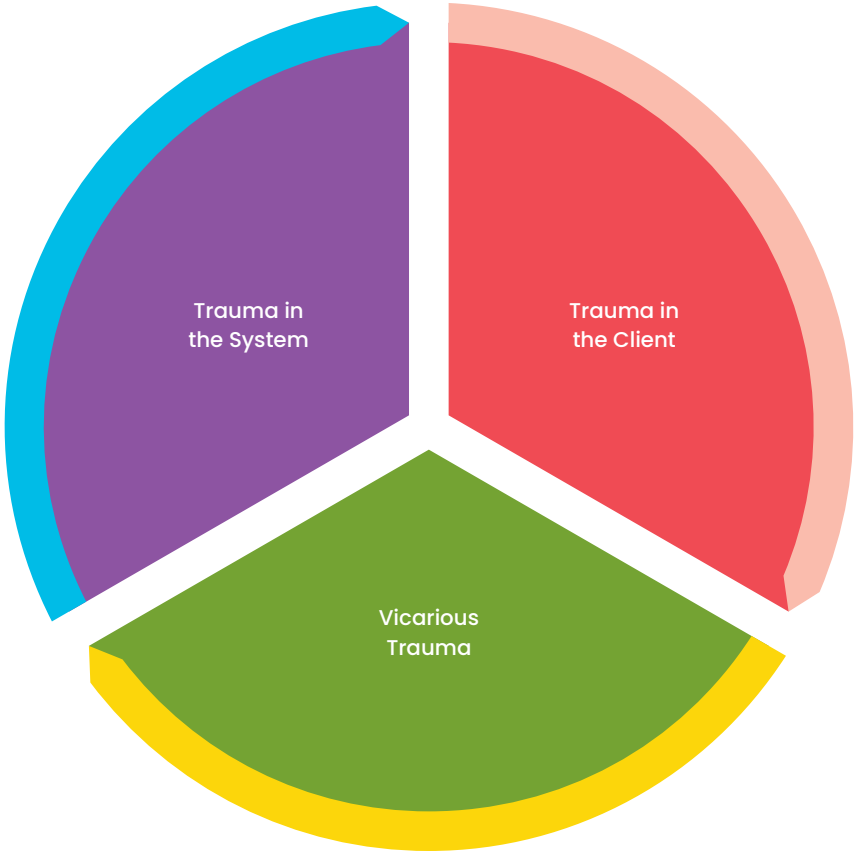
shape than they came in. This means that organisations like MASP must cultivate the right kind of practices in order for this to happen. Specifically, an organisation that seeks to be 'therapeutic' must be experienced as safe, predictable, warm, thoughtful, "good enough" places, by people that come for help.

Such an organisation, will have a shared purpose, values, ethics, boundaries, and structures in place in order to support their people to work effectively in the living system. Just as individuals can struggle to navigate trauma, without a way of deeply understanding and articulating what is "unwell" and what is "well", their how and their why, organisations will continue to take in stress, fail to metabolise it, and unintentionally replicate the same harmful patterns of behaviour that marginalise, oppress, and re-traumatise the very people that they are trying to help.

SAMHSA, makes the point that "Whilst stress is not always harmful, trauma nearly always is" (Substance Abuse and Mental Health Services Administration, 2014, p. 4), and no part of society is untouched. They suggest that the available knowledge about trauma can be seen to have a focus in the following descending order:

1. the impact of trauma on the client
2. the impact of vicarious trauma on those who work with them
3. the impact on the organisation that provides the service

HOW: We have shown the relationships between client, staff and systems as a cycle, in which each part of the trauma experience can be seen to influence and perpetuate the next. Healing can occur at any point in the cycle.



The cyclical relationship of organisational trauma
adapted from SAMHSA (2014)

Impact of Trauma on the Client

Unresolved trauma can have significant impacts not only on the person themselves but on everyone around them. Without the capacity for awareness, the cycle continues and re-traumatisation occurs.

At the individual level, trauma can become the organising principle for the developing person:

> *"Everything about us – our brains, our minds, and our bodies – is geared towards collaboration in social systems. To fully understand who we are, we must understand the process of development and how all these factors work together in an ongoing way over time"*
>
> (van der kolk, 2014, p.166)

The individual impacts are examined in more detail in Section Two of the model, where we consider experiences, perspectives, and interventions.

Vicarious Trauma

Trauma can transfer between people, and across generations, through the mechanisms of relationship, empathy, collaboration, and connection. The caring professions are particularly vulnerable. Louth et al (2019) in their excellent report state:

> *"Trauma cannot be wished away. It needs to be managed, worked through, and monitored by workers and clients alike. Moreover, trauma does not simply disappear when workers go home: It leaves a residual presence that can contribute to a cumulative reaction. Empathetic stress, burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma speak to a spectrum of dissociative or disjunctive effects"*
>
> (p. 6).
>
> *"Vicarious trauma is an unavoidable consequence of working with trauma survivors". For workers in the caring professions, this can mean actual harm over time. Indeed, there are workers who feel that their experiences are less 'vicarious' and represent direct trauma .*
>
> (Pack , 2013, p. 71)

Human service workers have been shown to rate higher on empathy scales than the standard population, regardless of gender which makes them good employees and increases their vulnerability to vicarious trauma (Williams, 1989) .

Work satisfaction, recruitment practices, onboarding, and appropriate workplace structures and supports including reflective supervision and group work, have been shown to be protective (Maslach & Leiter, 2000). In fact, and perhaps in the wake of the pandemic, there seems to be a new commitment to exploring psychological safety and emerging models for practice. This activity highlights that workplaces can make a positive difference in addressing the effects of various trauma and improving wellbeing, once the organisation commits to seeing and addressing it (Louth, Mackay, Karpetis, & Goodwin-Smith, June 2019).

In community service organisations, trauma is a central part of the work. Underestimating the challenge for organisations can lead to a failure to put in place the measures and processes necessary to support and sustain the work.

The effects of vicarious trauma extend beyond the wellbeing of the individual. Motivation, productivity and the very foundation of helping/ therapeutic relationships are impacted by vicarious traumatisation and "organizations that fail to grapple with this issue do so at their own peril" (Farragher & Yanosy, 2005, p. 94).

Trauma in the System

The Australian data on trauma in the caring professions is elusive. Louth et al (2019), remind us that organisations do not tend to measure or collect this information and academic research is still in its infancy. However, stories from victim survivors, as well as various investigations and government inquiries, paint a picture of a care system that has struggled to effectively safeguard the health and wellbeing of its own workforce (Louth, Mackay, Karpetis, & Goodwin-Smith, June 2019).

For some clients and community members, trauma has occurred in the care system itself.

> *"Indigenous people, survivors of clergy and other institutional abuse, asylum seekers and the "Forgotten Australians" are some of the diverse groups who have experienced complex trauma, which needs to be seen in these terms if it is to be adequately responded to"*
>
> (Bennett, Green, Gilbert, & Bessarab, 2013, p. 217)

> *"Social work has a 'bad name' with Aboriginal people and social workers are often feared, particularly due to their association with Aboriginal child removals"*
>
> (p. 218)

Mistrust and fear of the service system is, unfortunately, part of the legacy for MASP, as it is for all welfare services in this country. Developing trauma-informed service delivery systems is a vital part of addressing past wrongs.

Referring to the harm done by "trauma-inducing" systems of care, SAMHSA states that "it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification" (Substance Abuse and Mental Health Services Administration, 2014, p. 2). They argue that organisations have a vital role in understanding and delivering services in a genuine way, and this means examining our leadership, organisational culture, values and behaviour.

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Appendix 1: Background to the MASP Therapeutic Model of Care

Our Purpose

The MASP purpose is the task we perform over and above everything else, the reason for our existence. In 2022, following a lengthy process of consultation and staff feedback, MASP aligned its purpose, mission, and values with the therapeutic model of care. We defined our purpose as:

To empower our community to be free from homelessness, abuse, poverty, and disadvantage.

And our overarching vision as:

Thriving Mallee communities, with individuals and families, equipped to lead safe, secure, healthy, and fulfilling lives.

The following statement taken from a talk given by a MASP Kokoda Mentee articulates our purpose in action. Describing the growth that she, and others, experienced during the year-long program, she said:

> *"Though some of us share similar experiences, no two stories are the same and I would like to recognise that because even though we all took the same path to Kokoda, we did not all experience the same journey. What we did all experience, is success.*
>
> *Now, if you consider success to be finishing school, going to university, getting a well-paying job and buying a house – the success I am referring to may not impress you. But, if you can look at success as moving forward and doing the best that you can, persevering when you so wish to give up, challenging yourself and making good decisions – you can see the little victories and the great success Kokoda has been in the lives of so many youths"*
>
> (Armitage, 2021, p. 14)

The MASP purpose allows us to organise our many programs and activities whilst sustaining a sense of stability and common purpose. It is a steadying compass, and it provides us with a way to navigate complex systems whilst remaining focused on our people and our clients:

"Defining a primary task that is about empowerment in an organisation... it helps them to determine priorities among stakeholders, where they are able to identify the part they have to play in determining common interests" (Dartington, 1998, p. 1489).

Regardless of where a person is located in the organisational chart they can feel part of the MASP purpose and contribute to making it happen. This benefits the whole organisation.

Our Therapeutic Outcomes

The playful term "Maspify" is used to describe a process of good fit. We recognise that organisations learn and develop in the context of a global world. As well as learning from others, our job is to set good boundaries, and to try to bring in ideas, perspectives, and methods that are consistent with the MASP ethos. In time, we hope to contribute our own ideas and "practice gems" for the benefit of other practice communities. This practice of bringing new material in, working with it, and sending good things back out, is in itself a therapeutic practice.

Tomlinson (2019), discusses that the core principles of a therapeutic model tend to be transferable from one setting to another and can be defined as:

- The centrality of relationships
- A phased approach beginning with safety
- The need to regulate emotion
- The importance of the whole system.

(Tomlinson P. , What a Therapeutic Model is and Why it is Important , 2020, p. 3)

The core principles are informed by decades of research and they are the solid ground for therapeutic outcomes. Exactly how these principles are implemented in practice needs to be worked out, and this is an important part of the process. To be effective, therapeutic models must be shaped to fit the unique cultural values, language, and belief systems of the people involved (p. 4). Two examples highlight this "same but different" quality of tailored models.

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Brendtro, Brokenleg, and Van Bockern (2019), describe a model that merges therapeutic principles and tribal customs and teachings as a way to reclaim traumatised Indigenous youth:

> *"The Circle of Courage model of resilience and positive youth development (is) based on Native American values of Belonging, Mastery, Independence, and Generosity. When the circle is complete, humans live in harmony and balance. When the circle is broken, discouragement ensues, with youth being particularly at risk of becoming lost. But they can be reclaimed" (Brendtro, Brokenleg, & Van Bockern, 2019, p. 2).*

Dadirri is a unique conception of healing that originates from the Ngan'gikurunggurr and Ngen'giwumirri Aboriginal people of the Daly River region in the Northern Territory. "It involves listening to the inner self (feelings, thoughts, reactions) and taking responsibility for for internal responses. It is the "self" that yearns for connection with all others and its environment, and that strives for spiritual reconnection with the cosmos" (Morris, et al., 2022, p. 2). Dadirri is described as a phased approach beginning with a meditative state, this progresses to new awareness and insights, followed by new knowledge, and action (p.3). Dadirri shows great promise as a way to develop an evidence base freed from oppression. It has been used to transform organisations through building "healing networks" and safe spaces where recovery, empowerment, and new knowledge can happen (p. 5).

In an organisation that strives to be therapeutic, a shared language of healing and empowerment serves to calm and focus the system. Reflective conversations are made more possible, and the organisation is able to pivot towards the primary therapeutic task. Models that are successfully written from the foundation principles will have some similar ideas, but will also evolve over time, and reflect the particular organisation or community of people involved in the development.

Tomlinson points out that having a coherent model is, in itself, a core principle.

Our Approach

Model Development

Three main approaches were considered for model development:

1. The Sanctuary Model, developed by Sandra Bloom, offers a fully developed and resourced "operating system for trauma-informed systems of care". Organisations enter into a phased three-year change process guided by Sanctuary consultants with the goal to become Sanctuary Certified. Ongoing quality assurance is embedded through a service-wide fidelity program.
2. The home-grown approach requires a whole of organisation development process, with the leadership team refining, writing, and implementing a model of care in collaboration with staff and key stakeholders. In late 2020, MASP consulted Patrick Tomlinson, a social care consultant and model development expert, about a possible collaboration.
3. A third option involved sourcing a "good enough" model imported from a similar-sized organisation and adapted to suit our needs. This was considered to be the least likely to succeed due to the lack of a structured and articulated process, and a lack of "buy in" from our staff.

MASP decided against Sanctuary for reasons to do with timing, our particular needs, and cultural fit. It was felt that implementing Sanctuary could substantially change our organisation, possibly in ways that we were unprepared for, and that we would lose the benefits of developing our own unique approach.

A home-grown model was selected for several reasons:

4. Therapeutic model writing provides an integrated and relational process that involves the whole organisation.
5. A successful change maturational process takes time and we believe it is better to "modify anxious emotional processes" (Friedman, 1999, p. 66), rather than seek quick fix, technical solutions.
6. Writing a model provides opportunities to build relationships across the silos and to bring in outside expertise.
7. Model writing is a process of creativity, perseverance, self-discovery and empowerment, it is, in itself, a beneficial process.

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Appendix 1: Background to the MASP Therapeutic Model of Care

Tomlinson (2020) states, the development process is fundamentally one of significant organisational change. It will be greatly valuable, but also challenging and difficult. There will need to be processes such as supervision, training and consultation to work through the issues involved. Some of this work will take place before the model development begins and it can continue alongside. Without this work, there is a greater risk that the development project will be undermined (Tomlinson P. , What a Therapeutic Model is and Why it is Important , 2020).

Foundation theories for a model must be robust, based on evidence, and open to testing and critique. Barton et al (2011), include an excellent section in their book on the importance of a theoretical base in the helping professions.

> *"People often use the phrase 'it's common sense'. This phrase immediately suggests that everyone, regardless of their own experiences and cultural background would have the same view. Therefore, it tends to be culturally engrained and to reflect the dominant culture. Closed forms of knowledge like 'common sense' are not easily open to critique and challenge in the same way that theory is"*
>
> *(Barton, Gonzalez, Tomlinson, & Burdekin, 2011, p. 32)*

An extensive review of relevant books, papers, practice guides, and websites was conducted by MASP. Our own program documents and guidelines were gathered together, and reviewed over the next twelve months in order to develop a "good fit" between the model of care and existing practices. We identified key documents to form the basis of the model listed in the "literature" section of this appendix (a complete list can be located in the bibliography).

Lee & Hunsley (2015) state in their paper on evidence-based practice that "although the process of becoming evidence-based is generally transparent, programs may be unable to allocate the time and talent required to complete it" (Lee & Hunsley, 2015, p. 22). They discuss that partnerships are often required to bring in the necessary skills and expertise that organisations may lack.

External Consultancy

Patrick Tomlinson was contacted during the decision-making process and he later agreed to support MASP with the model development. Patrick's vast knowledge of organisational theory and practice, model development, and the writing process was invaluable. He provided weekly consultations via zoom and made himself available for questions and contact in between. We followed his twenty-two step curriculum throughout the development period and were given access to a curated library of resources, books, PowerPoints, and papers that provided inspiration and direction.

Model development of this kind takes many months. It is a combination of technical work, creative thinking, and persistence. Edwin Friedman (1999), captures something of the style that Patrick adopted when consulting to MASP:

> *"Instead of anxiously providing data or offering advice and new techniques, a consultant can provide the kind of inquisitive, non-anxious climate that helps clients view the effects of their own thinking, those clients, whether parents or presidents, can often begin to develop more objectivity and self-regulation with regard to that relationship system"*
> *(Friedman, 1999, p. 127)*

Independent consultation is, in our view, essential to good model writing. Patrick, provided generous support, invited new questions, and contributed new knowledge. The work with him felt like a protected space and was a place where learning and creativity could flourish.

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Information Gathering

In addition to conducting an extensive literature review, we also gathered information from within our own organisation. The MASP cultural review; our model of care reference group; the staff survey; leadership interviews, and the client voice survey are discussed next.

MASP Organisational Culture Review

In 2020, the MASP board commissioned an external consultant, Leigh Pennycuick, to conduct a service-wide culture review for the purposes of service planning.

> *The review defined culture as "a collection of behaviour patterns and beliefs built through the perceptions people have about how they are expected to behave in relation to their jobs, the people they work with, and their external stakeholders" or "the way we do things around here", and it sought to examine and document the prevailing patterns and beliefs at MASP (Pennycuick, 2020, p. 4).*

Reference group

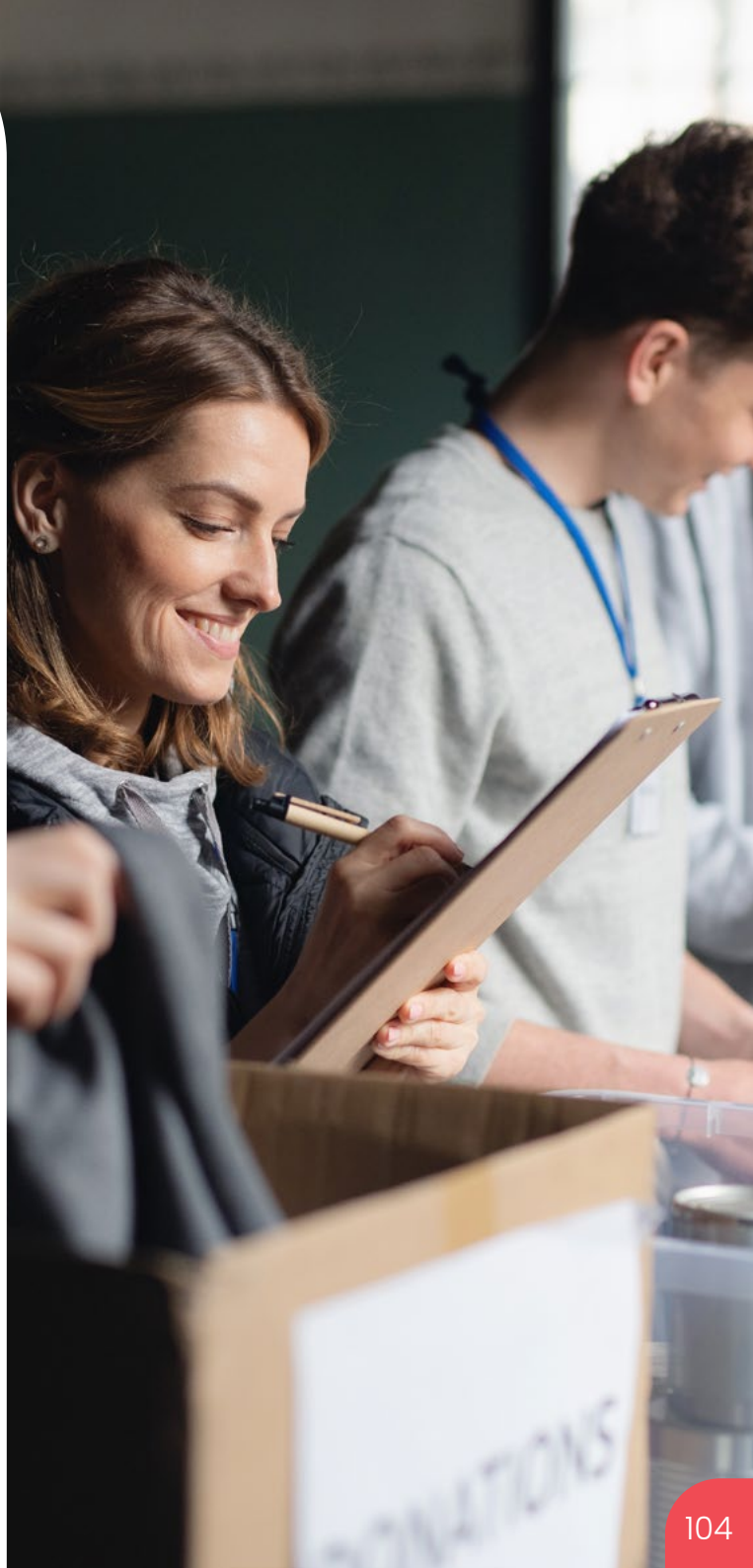
In June 2021, we established a model of care reference group, comprising the Practice Leader, the CEO, and nine staff identified as leaders in their teams. We tried to include at least one member of staff from every part of the organisation, including, practice, operations, administration, finance, and management. Some participants were in formal positions of leadership and all were talented and influential members of staff who wanted to contribute. The practice leader met with Patrick each week and used these discussions and other materials that Patrick provided, to prepare, facilitate and document the "MoC" meetings.

The reference group worked through a twenty-two-step curriculum set by Patrick. We met for ninety minutes each fortnight and spent up to four months discussing each of three related aspects of model development: leadership; culture and practice - twelve months total. Patrick made it clear that we could work through the material in our own way. However, much of the content was new to us and we implemented the curriculum more or less as written.

Each time the group met we discussed a key topic, worked through a related exercise and we wrote down anything that we thought was relevant to the model. Whiteboard notes were photographed and transcribed into minutes. Group participants were also encouraged to send any written reflections or comments to the practice leader in between meetings.

The communication strategy involved regular agenda items at management and leadership team meetings, email updates to staff, a poster campaign, and word-of-mouth discussions initiated by the reference group participants.

In addition to the MoC meetings, three questionnaires were conducted. Staff were encouraged to complete a self-report survey on Google forms, and two sets of semi-structured interviews were completed, one with the leadership team, and one with clients. These are described next.



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Staff Survey

In August 2020, a survey was conducted to measure staff awareness of therapeutic principles, and their application of trauma-informed practices, and to invite comments and questions relevant to the model. The intention was to measure change pre-and-post implementation and to begin to identify practice examples and the 'language of MASP' that we could use in the model.

We achieved a forty percent return rate (N = 54), and were able to gather data on two demographic questions, six multiple choice questions, and three longer questions covering perceptions of client satisfaction, responsiveness, evidence base, consistency, and excellence.

Staff provided long answers to three questions:

1. In your opinion, what is the one thing that MASP does that makes the most difference for our service users?
2. Please comment on the resources and support that you have available.
3. Are there any other comments that you would like to make about MASP's activities & services?

Analysis of the raw data revealed several themes:

At the time of the survey, fully one-third (33.5%) of staff had worked at MASP for a year or less. Another third (31.5%) had been employed for two to five years, ten percent for one to two years, and the rest between five and ten years. The relatively low number of staff in year two was a notable observation.

Despite relative inexperience, (three-quarters had less than five years' experience on the job), the workforce was optimistic and hopeful, with many reporting that MASP is doing good work with clients:

- Ninety percent agreed or strongly agreed that MASP understands the needs of its service users and that MASP knew how to respond to the needs of service users.
- Over sixty percent of staff agreed or strongly agreed that MASP has a clear evidence base and consistent way of working.

This result was consistent with other human services workforce surveys that show genuine satisfaction derived from client outcomes paired with a reluctance to identify workplace behaviours that might be perceived in a negative light (Day & Leiter, 2014).

The staff were asked to rate themselves on eight client-based activities that represented a combination of trauma-informed and traditional practice as defined by the Victorian government guidelines on trauma-informed care. The results were mixed and suggested that staff could not easily differentiate.

The inclusion of three open questions was intended to give staff an opportunity to expand upon their answers. Much of the commentary about best practice was descriptive and related directly to client outcomes. This was typical:

> *"Tailored service to meet the needs of the client, advocating strongly for clients and sitting alongside clients through risk. Supporting clients to overcome barriers and achieve."*

A few staff took the opportunity to share constructive feedback:

> *"We seem to have lost our identity and purpose. Vision and mission statements do not reflect our work. There is very little collaboration between various programs."*

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Leadership Interviews

In 2020, seven members of the MASP leadership team agreed to participate in a series of semi-structured interviews. Each participant was interviewed for sixty to ninety minutes on topics related to management practices, ideas about leadership, personal and organisational values, challenges, and proudest moments. Our interests were driven by the idea that the overarching organisational culture is determined by the leadership team and that what they model, how they interact with their staff, and aspects of their beliefs and values, are reflected in the work within teams and ultimately, with our clients.

Friedman (1999), states that "all leadership begins with the management of one's own health" (Friedman, 1999, p. 234), and "...a leader functions as the immune system of the institution or organization he or she 'heads' (p.182)". The interviews were a litmus test for the health of our leadership team.

Our leadership interviews were recorded, transcribed, and sorted into key phrases and themes. This material directly influenced model development, implementation, and the material contained in the toolkits.

Client Voice Project

In 2022, we designed a client voice questionnaire to gather information for the MASP strategic plan and the model of care. The project was developed in accordance with the four sets of Victorian Government Human Service Standards for service delivery (1) empowerment (2) access and engagement (3) wellbeing and (4) participation.

Clients were randomly selected, with some finessing provided by management to ensure that project aims could be met. Each client was interviewed personally by the MASP practice leader. Interviews covered a series of demographic questions and four qualitative questions seeking thoughts and feedback. Ten clients provided their input. We protected their privacy to the best of our ability given the small group size.

We asked two specific model of care questions:

1. In your opinion what are the most important things we can do for our clients?

All of the clients discussed a combination of practical and emotional support. Clients with

dependents and those with a disability rated their relationship with the staff more highly.

> *"I needed more compassion"*
>
> *"I needed someone to listen"*
>
> *"My worker is real, down to earth and she understands me"*
>
> *"The worker gave me an opportunity and accepted me. Then I opened up."*

2. If you were the boss and you could do anything you wanted to help people in our community, what would you choose to do?

Housing featured strongly in the responses to this question, and two responses are offered here verbatim:

> *"There should be more funding for housing. Maybe residential but also units (one bedroom). It needs to be like public housing but better. Clients need to go through a real estate agent so they can get a rental history. The housing should be modern. (There should be) a MASP person to contact if you need one. Real estate agents can be difficult to deal with. This service should extend to twenty-five years for young people leaving care".*

And

> *"I would look into fundraising so you can get emergency accommodation like on a property. You need temporary houses (tiny houses) or something. Offer short-term housing and get staff to visit weekly so that they can check-in. Some people need help and some people aren't good tenants (and need moving on). I would want that (emergency housing) to continue, that's why you need the fundraising".*

Matching staff to clients was the next most common response:

> *"My first worker (didn't work out). The staff was focused on case management and I needed more compassion."*
>
> *"(MASP should) try to match staff with clients so they can "get along". This is about forming a relationship where they get to know each other and (where they) look at personal values together."*

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Staff suitability was a related theme:

"Workplaces need to employ the right people and supervise them. It can just be one or two people that aren't any good. They shouldn't go through that journey or get to the end point where they treat clients or other staff badly. Staff need to maintain empathy otherwise how can they help when clients have questions?"

One client discussed the importance of programs providing a gateway to the service system:

"My aunties talked me into it but the program sounded interesting...it seemed like something I'd like to do"

The client voice project has contributed to high-level service planning at MASP, and prompted a bigger conversation about how we can develop a more formal framework. We were impressed by the genuine interest and helpful feedback, and some clients agreed to help in the future. Clients "help us to make services better; help us to make services safer; help us to understand unforeseen risks and understand what is working well" (Vic.gov. au, 2019, a guide to the client voice framework for community services). Further information about client voice at MASP is provided in the model.

Key Literature

Many international books, models, frameworks and academic papers were reviewed during the development of our model of care. For readers who would like to know more about the Australian context, the following is a selection of documents that we found helpful:

Victoria

- Aboriginal and Torres Strait Islander Cultural Safety Framework (2019)
- Aboriginal Child Care Placement Principle Guide (2002)
- Berry Street Take Two Healing Childhood Trauma (2018)
- Best Interests Case Practice Model (2022)
- Better Futures Advantaged Thinking Framework (2020)
- Dhelk Dja: Safe our Way - Strong Culture, strong peoples, strong families (2018)
- Family Violence Multi Agency Risk Assessment and Management Framework (MARAM)
- In our own words: systematic inquiry into the lived experience of children and young people in the Victorian out-of-home care system (2019)

- Program Requirements for Residential Care in Victoria (2016)
- The Circle Program: an evaluation of a therapeutic approach to Foster Care (2012)
- Trauma-informed care in child/family services (Australian Institute of Family Studies 2016)
- Understanding vicarious trauma: Exploring cumulative stress, fatigue and trauma in a frontline community services setting (Centacare & University of South Australia, 2019)
- Victoria's new child safe standards (2022)

NSW

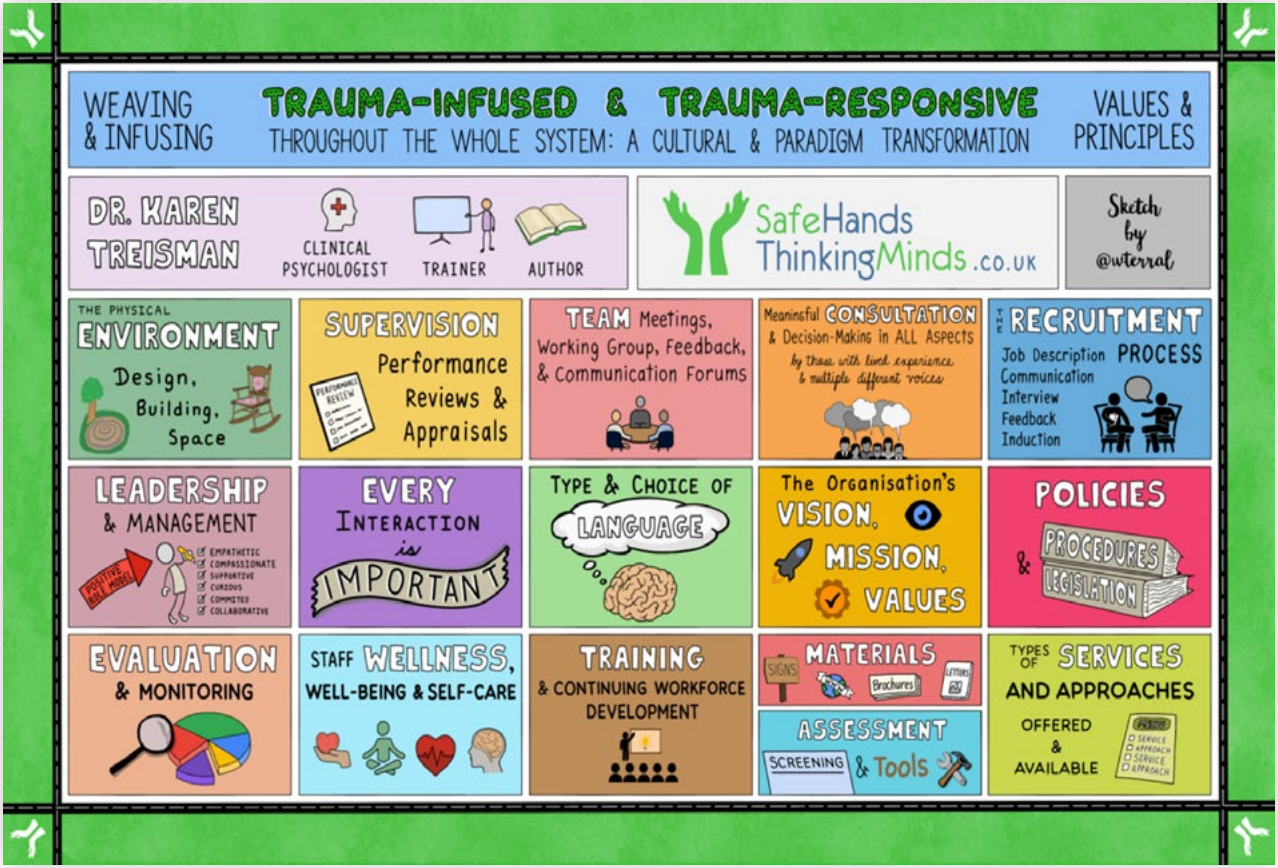
- The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support and Implementation (2019)
- Therapeutic Care Framework (2017)
- Trauma-informed Care and Practice Organisational Toolkit (TICPOT) series (2018)

National

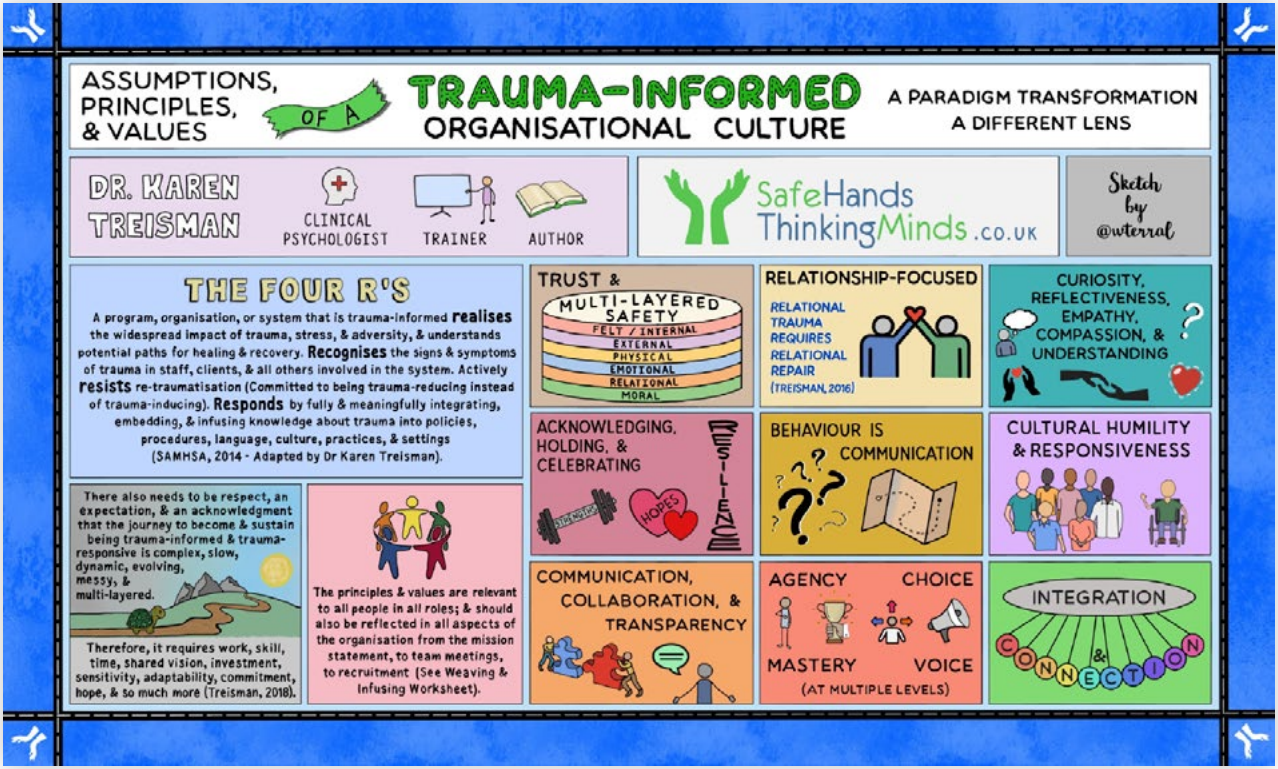
- Blue Knot Foundation: Organisational Guideline for Trauma-Informed Service-Delivery (2020)
- Child and Family Services Workforce Capability Framework (2019)
- Dropping off the edge 2021: Persistent and multilayered disadvantage in Australia (Jesuit social services & Centre for Just Places, 2021)
- National Disability Insurance Scheme Psychosocial Disability Recovery Orientated Framework
- The Trauma and Homelessness Initiative: Trauma and homelessness service framework (2014)

Appendices

Appendix 2: Karen Treisman Model The Different Organisational Elements and Areas that Trauma-Informed Principles and Values should be Infused and Woven into.

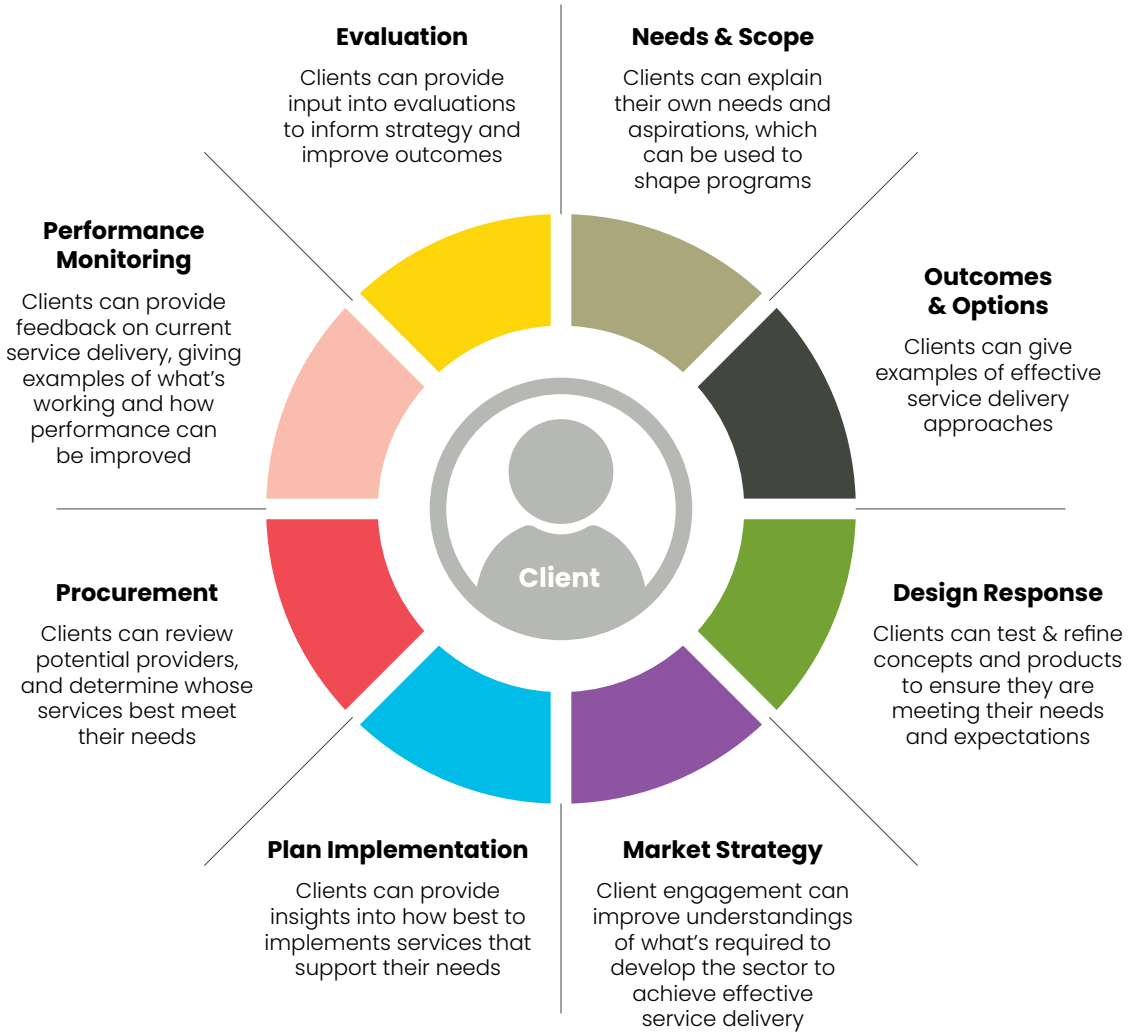


Karen Treisman Model: Trauma-Informed Values, Principles and Assumptions.


ASSUMPTIONS, PRINCIPLES, & VALUES OF A TRAUMA-INFORMED ORGANISATIONAL CULTURE
A PARADIGM TRANSFORMATION
A DIFFERENT LENS
DR. KAREN TREISMAN
CLINICAL PSYCHOLOGIST
TRAINER
AUTHOR
SafeHands ThinkingMinds .co.uk
Sketch by @wterral
THE FOUR R'S
A program, organisation, or system that is trauma-informed realises the widespread impact of trauma, stress, & adversity, & understands potential paths for healing & recovery. Recognises the signs & symptoms of trauma in staff, clients, & all others involved in the system. Actively resists re-traumatisation (Committed to being trauma-reducing instead of trauma-inducing). Responds by fully & meaningfully integrating, embedding, & infusing knowledge about trauma into policies, procedures, language, culture, practices, & settings (SAMHSA, 2014 - Adapted by Dr Karen Treisman).
There also needs to be respect, an expectation, & an acknowledgment that the journey to become & sustain being trauma-informed & trauma-responsive is complex, slow, dynamic, evolving, messy, & multi-layered.
Therefore, it requires work, skill, time, shared vision, investment, sensitivity, adaptability, commitment, hope, & so much more (Treisman, 2018).
The principles & values are relevant to all people in all roles; & should also be reflected in all aspects of the organisation from the mission statement, to team meetings, to recruitment (See Weaving & Infusing Worksheet).
TRUST &
MULTI-LAYERED SAFETY
FELT / INTERNAL
EXTERNAL
PHYSICAL
EMOTIONAL
RELATIONAL
MORAL
RELATIONSHIP-FOCUSED
RELATIONAL TRAUMA REQUIRES RELATIONAL REPAIR (TREISMAN, 2016)
CURIOSITY, REFLECTIVENESS, EMPATHY, COMPASSION, & UNDERSTANDING
ACKNOWLEDGING, HOLDING, & CELEBRATING
HOPES
RESILIENCE
BEHAVIOUR IS COMMUNICATION
CULTURAL HUMILITY & RESPONSIVENESS
COMMUNICATION, COLLABORATION, & TRANSPARENCY
AGENCY
CHOICE
MASTERY
VOICE
(AT MULTIPLE LEVELS)
INTEGRATION
CONNECTION

Appendices

Appendix 3: NSW State Government (DCJ): Client Engagement tool



(Jakob, 2021)

Appendix 4: Karen Treisman

Trauma-informed/ Healthier Team Meetings (Therapeutic/Frontline Context)

By Dr Karen Treisman

This crib sheet contains some questions & reflection points to consider & to hold in mind when planning/reviewing/improving team meetings within a trauma-informed lens.

These are not exhaustive or prescriptive, & there is an acknowledgement that each team meeting will significantly differ & will be unique; & that they will be influenced by an array of factors, such as, the aim/task/relationship/ people/ context/ system they are positioned within/ location/timing etc.

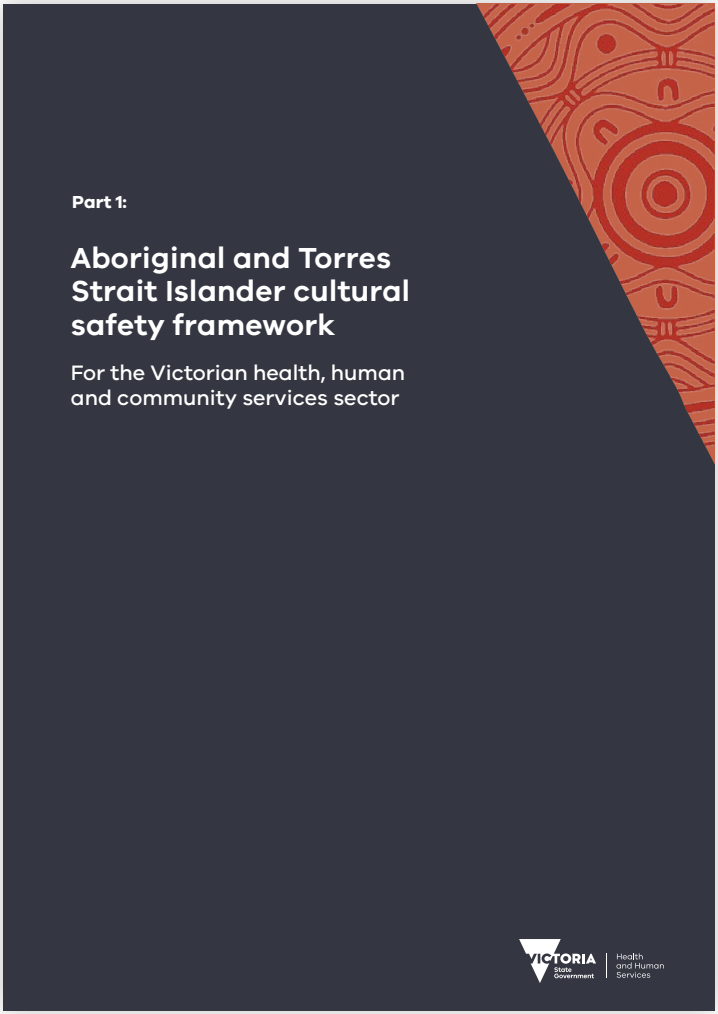
Team meetings, also like people, & like organisations. will change, evolve, go through different stages/ emotions etc; & therefore, they need to be reviewed, monitored, nurtured, & developed. It is also acknowledged that many of these ingredients & principles are not exclusive to "trauma-informed" practice.

It is also important to remember that trauma-informed meetings are just one aspect of trauma-informed practice, & therefore should be integrated & supported by other trauma-informed organisational & practice aspects (See Worksheet on Weaving & Infusing Trauma-Informed & Trauma-Responsive Values & Principles Throughout the Whole System).

- It is also worth considering & reflecting on which ones of the below are possible/relevant/ realistic to your specific team meeting. And if they are not (e.g. Having a positive physical environment when you work within a restricted building setting etc.)- then that this is at least named, validated, & acknowledged. It might also be that there could be some collaborative problem-solving around this (e.g. Are there ways to optimize the space? Are there alternative options? etc.).
- There also needs to be an acknowledgement & a shared understanding of both the value & importance of team meetings; including this being a space to connect, develop, & support.
- Trauma-informed team meetings should respect & respond to the prevalence of trauma; as well as to the multi-layered impact that trauma, adversity, & stress can have on individuals, on the work, & on the organization, & vice averse. This includes an awareness around the parallel processes & the mirroring which can occur within teams/ groups/ organizations.

Appendices

Appendix 5: Aboriginal and Torres Strait Islander Cultural Safety Framework



(Source: Aboriginal and Torres Strait Islander Cultural Safety Framework p.9)

Principles

The cultural safety framework is supported by an agreed set of guiding principles.
Table 1 (below) outlines the principles to be applied across the three domains of the framework.

Principle	Explanation
Leadership	Organisations provide meaningful leadership opportunities to design, deliver and evaluate culturally safe policies, programs, initiatives and services. Organisations have leadership at all levels that understand and champion the organisation's role in cultural safety.
Self-Determination	Aboriginal staff, people and communities have meaningful leadership and decision-making roles, and are involved in designing, delivering and evaluating Aboriginal health, wellbeing and safety policies, programs and initiatives.
Human Rights Approach	The rights-based approach that drives this framework is an essential part of Victorian Aboriginal service delivery and sector development. The United Nations Declaration on the Rights of Indigenous Peoples recognises both the principle of self-determination (Article 3) and the right to culture (Articles 11 and 31). The Victorian Charter of Human Rights and Responsibilities Act 2006 also recognises culture as a right.
Support & Sustainability	Staff at all organisational levels are supported to undertake ongoing cultural safety professional and personal development. Workplaces have processes to build individual and organisational capacity, provide mentoring opportunities and establish culturally safe spaces for Aboriginal staff and clients.
Culturally Safe Systems	Embed culturally safe practice into recruitment and retention processes, as well as into existing policies, programs, procedures, procurement and services.
Ongoing learning	A continuous process of reflection and quality improvement to identify and reflect on individual and organisational practice, and implement the actions required for ongoing learning and self-reflection at all levels of the organisation
Accountability & Transparency	Individuals reflect on their own level of competency in cultural safety and identify required improvements. Organisations reflect on their current policies, practices and procedures and reflect on their organisational competency. Organisations demonstrate accountability by implementing key performance indicators.
Respect & Trust	Individuals and organisations establish a relationship of trust and respect with Aboriginal staff, clients and local Aboriginal communities.

Table 1: Cultural safety framework principles

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