LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY
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Submission Cover Sheet

Inquiry into Immediate Trauma Support Services in the ACT

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Inquiry into Immediate Trauma Support Services in the ACT.

My name is Amar Dhall, PhD. I am the Centre Director for the Trauma and Well-Being Centre in Phillip, ACT.

From the outset, I offer space for a conversation with the committee as this subject matter is fundamental and a subject I am passionate about. This submission was prepared while I am on holiday and away from my library. This impacts my ability to offer the committee a fully referenced submission, which I would have preferred to tender as the perspectives I share are evidence-based.

What type of immediate supports are needed by people who have experienced a sudden or traumatic incident?

To address this question, several critical aspects of trauma need to be understood, as it is through such understanding that the qualitative aspects of support are best understood, as opposed to simply listing interventions.

1. The word "trauma" is used in many different contexts and to cover an enormous range of symptoms. Peter Levine (2008), in *Healing Trauma*, listed trauma symptoms. The list ran to several pages. Divorcing trauma from its full scope does violence to many of those who suffer. A limited framing of trauma also unduly limits the conversation and results in piecemeal approaches to supporting trauma survivors.

2. Trauma is not the event (e.g. the car accident, natural disaster, etc); it is the body's response to that event.

    a. Trauma impacts both body and mind. I use the term 'psychophysiological' to describe this.

3. There are different categories of traumas, all of which imprint the affected person's psychophysiology similarly yet require different types of support to resolve.

    a. Impact traumas (i.e. traumatic events that occur in a single instant, such as car accidents, animal attacks, assault, medical trauma),

    b. Traumatic incidents: These types of traumas are the result of exposure to repeated events (i.e. coercive control, burnout, compassion fatigue, neglect, long-term survivors of abuse, veterans and first responders experiencing vicarious trauma).

c. Developmental trauma: contrary to the way many people categorise us, homo sapiens are animals. Epigenetic and intergenerational trauma and stress in utero and during the process of birth all impact developmental milestones (e.g., the stages of neurosequential development) of human animals. Like a house with poorly constructed foundations, whatever is built on top will be fraught with problems. Identifying root causes and then remedying the problem requires an understanding of this as impact trauma becomes interdigitated with developmental trauma.

4. The effect of trauma is to disintegrate the mind and body, which includes but is not limited to repatterning of the autonomic nervous system (ANS).

5. Trauma is not a death sentence. With the proper support, trauma can be healed and, in many cases, result in post-traumatic growth.

6. This submission focuses on how trauma impacts the ANS because this is my area of expertise. There is a solid and rapidly growing body of evidence supporting the ability of trauma to be resolved using several modalities; for example, Somatic Experiencing harnesses the power of the body capacity to heal the mind in the process of resolving trauma.

    a. Somatic Experiencing (SE) is a therapeutic approach developed by Peter A. Levine, a psychologist and trauma expert. It focuses on healing trauma and resolving the symptoms associated with it by addressing the physiological and physical aspects of trauma.

        SE recognises that trauma is not only a psychological experience but also a physiological one. It emphasises the importance of the body's role in processing and releasing traumatic experiences. The approach aims to help individuals regulate their nervous system and discharge the energy trapped in their bodies because of trauma.

        Through SE, individuals are guided to pay attention to their bodily sensations, movements, and physical experiences related to trauma. By gradually and safely exploring these sensations, they can release the stored energy and complete the body's natural response to the traumatic event. This process allows for the resolution of trauma symptoms and the restoration of a sense of safety and well-being.

        Somatic Experiencing can be used to address various types of trauma, including acute incidents, chronic stress, and developmental trauma. It is often utilised by therapists, counsellors, and other professionals working in the field of trauma therapy.

With this said, I submit that the immediate support needed by people who have experienced a sudden traumatic event is:

1. Trauma first aid:

    a. First responders are to be trained in psychological and as well as somatic ways to triage and offer trauma-informed care.

        i. In the initial stage, this would be to normalise, stabilise and contain the patient's psychology and physiology.

            1. Normalise: Empowering affected people to understand that trauma is the response of a healthy nervous system to experiences too large to integrate is often reparative.

            2. Stabilise: According to Dr Daniel Seigel (founder of the field of Interpersonal Neurobiology) a person triggered experiences either chaos or rigidity in the formation of self. Stabilisation refers to supporting the affected person to regain the capacity to meet their environment flexibly.

            3. Contain: This is performed in tandem with stabilisation. Returning people to a sense of 'being in their body' and being able to engage their capacity for cognition rather than being reactive is the goal here.

        ii. Some currently standard medical practices, such as administering anti-convulsants after an accident, can 'lock' trauma into the body as it frustrates the completion of natural physiological responses to trauma.

    b. Police face specific hurdles to supporting clients after traumatic incidents, which are unpacked below in the submission relating to challenges.

2. Access to medium-term trauma resolution work that works on reintegrating body and mind (something in the order of 6-12 months) would be appropriate.

3. Better integration and more straightforward compliance procedures with Workcover and Insurance companies.

What challenges/role do ACT Police and Emergency Service members face at the scene of an accident or a traumatic event to support affected community members or, family members, or witnesses?

Role:

1. Ensuring as much as possible that the traumatising stimuli or circumstance is ended or at least contained.

2. Assessing the affected person's state vis-à-vis the event's impact on the physiology and nervous system.

    a. Minimise the impact of trauma by supporting affected community members to restore (as much as possible) their sense of safety and security.

        i. Several techniques can be used; for example, supporting the affected community member to become aware that the T_0-traumatic event is over makes a significant difference to long-term trauma resolution.

            1. T_0-traumatic event: the moment trauma is created, e.g. the instant of a car accident or attack, etc.

    b. Ensure that the affected community member is put onto a track that creates a framework of support, including access to more refined trauma resolution work consisting of both psychological and somatic approaches.

        i. Trauma takes time to resolve; months or years is the timescale. Failure to integrate this understanding into the strategy for trauma resolution means compromised outcomes.

Challenges:

1. Having the necessary level of training to identify and appropriately the psychophysiological state of the affected person and offer appropriate interventions.

2. Psychophysiological effects of trauma are mistaken for a chosen attitude or expressions of personality, such as disassociation or aggression.

    a. Disassociation and aggression are two types of instinctive responses driven by changes in the autonomic nervous system. There are others; however, these are offered to illustrate the point with brevity.

    b. One related mistaken assumption is that such behaviours can be changed with effort. The process of being triggered is not a choice but a physiological process. As such, the process for the restoration of a sense of goodness needs finesse to implement. This is within the scope of possibility for first responders with appropriate training.

3. ACT Police occupies a position different from that of other first responders. Police are vested with the power to use force as they deem fit and are also responsible for detaining and arresting members of the public. Public members have varied perceptions of the police, some of which will be antithetical to feeling safe around

them. The result is that, for some members of the public, police will heighten the impact of trauma rather than support its minimisation or resolution.

a. Making judgements about the trauma patterning of the affected community is juxtaposed with the needs of police to perform situational analysis, which is often complex and carries a high emotional charge for the officers themselves.

    i. De-escalation tactics and other training (such as triaging, detention and handling of people subject to strip searches) all need to have trauma-informed principles integrated into them. Often, the approach advocated exacerbating or re-traumatising affected community members.

    ii. Such training needs to be aligned with the reality and 'on the ground' experience of police and first responders. This requires input from first responders in formulating such training to be efficacious.

b. The culture around trauma within first responder workplaces may mean that members attempting to offer trauma-informed care themselves carry unprocessed trauma (e.g. vicarious trauma, implicit trauma, etc.). Regardless of their intention, such people will elicit unpredictable responses from the interventions they attempt.

What is best-practice, evidence-based, 'trauma-informed' immediate trauma support service response to community members, witnesses, family members, etc, who may be involved in a traumatic incident?

Best practice, evidenced-based, trauma-informed immediate trauma support must include somatic as well as psychological support.

The critical insight presented here is the imperative for somatic trauma triage and care approaches. There is a growing body of robust evidence that demonstrates the criticality of somatic (e.g. body-centred) approaches to resolving trauma.

Additionally, as implied by the question, a systemic approach to trauma resolution is necessary to ensure the metabolisation of the traumatic event. This means understanding that a traumatised individual will be changed by their experience, shifting their relational dynamics, capacity, and personality presentation. For this reason, offering support to everyone in an affected system (e.g. family unit or workplace) would be ideal. Often, some basic psychoeducation and support for people connected with impacted individuals can make a tremendous difference. This psychoeducation and support need to be appropriate

for the unique position in which the people in the unit find themselves and not generic psychoeducation and support.

Basic training for first responders need not be overly complex and lengthy; the basics of somatic trauma techniques could be taught in several days (at a minimum) and expanded from there to meet the community's needs and the government's capacity to support such training.

Any other relevant information:

Trauma is part of the human experience. It is not a death sentence; trauma can be resolved. One of this submission's most critical dimensions is advocating for the implementation of somatic approaches to stabilise and resolve trauma.

I thank the committee for their attention and reiterate my openness to present this information in person.