Trauma-Informed Care:

Literature Scan

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Acknowledgements

Foreword

People can and will recover from trauma and we must honour and support their determination and resilience to do so.

A focus on what's happened as opposed to what's wrong with someone is where we believe trauma informed care should start. This will bring a positive sense of identity and wellbeing back to someone who has experienced trauma.

The three 'e's' of trauma (event, experience and effects) is a process that we've probably all experienced or are aware of. The cause and effect of trauma can be diverse and complex. We must all be aware of the impact of trauma and the benefits that a trauma-informed approach can bring to someone's recovery.

At Te Pou o te Whakaaro Nui, we believe knowing how to recognise and respond to trauma is not just the responsibility of the health sector. It needs to be a broader public health strategy.

This broader approach is a global trend and is ensuring workplace wellbeing is achieving real momentum. For example, Mersey Care's Chief Executive Joe Rafferty told us recently how Mersey Care has supported their own workforce with self-care and workplace wellness initiatives. This has resulted in a 40 per cent reduction in staff sickness – a great result.

It may take a philosophical change across a range of services to understand that trauma is an issue that needs to be addressed. Within a New Zealand context can include both individual and collective responses. Māori people continue to suffer from the trauma of colonisation for example.

The Te Pou o te Whakaaro Nui approach will be to incorporate trauma-informed practices into the current aspects of our already established programmes including reducing seclusion, *Let's get real*, Talking Therapies, CEP, Skills Matter, leadership development, resources.

Let's get real will incorporate trauma -informed practice as a core skill area.

We know this trauma-informed literature scan will help us to better understand evidence-based approaches to trauma-informed service delivery. It will also help us to ensure workforce responsiveness.

Robyn Shearer
Chief Executive, Te Pou o te Whakaaro Nui

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Executive Summary

Many people have experienced traumatic events. People who access mental health and addiction services are more likely to have experienced trauma than the general population. Trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences can also occur among workers who provide mental health and addiction services. This is especially the case if workers themselves have experienced trauma. Trauma occurs as a result of violence, neglect, abuse, loss, disaster, war, historical injustice, and other emotionally harmful experiences (Pihama et al., 2014; The Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). The adverse effects of trauma may impact people's mental, physical, social, emotional or spiritual wellbeing.

Developing a workforce that understands the impact of trauma on both people accessing services and themselves, is important for wellbeing. As is ensuring an organisation, service or team deliver services using a trauma-informed approach. There is an expectation services working across the spectrum of health care (primary, general health, and specialist mental health and addiction) ensure their staff are aware of the high incidence of past trauma among people who experience mental health and addiction issues and have the ability to provide trauma-informed services. These expectations are outlined in *Rising to the Challenge* (Ministry of Health, 2012), and the *Mental Health and Addiction Workforce Action Plan* (Ministry of Health, 2017)*.*

Trauma-informed care has been defined as:

> A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage. (Wall, Higgins, & Hunter, 2016, p. 2)

> A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (SAMHSA, 2014, p. 10)

Purpose

This review was undertaken to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness, and factors supporting implementation. This is intended to inform a national approach to trauma-informed care and help identify future intersectoral work. For New Zealand, it is important to consider the unique context of Māori people as tāngata whenua and include historical and intergenerational trauma.

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Literature scan

A broad literature search was undertaken to identify research published in the past six years about trauma and behavioural health (mental health and addiction); the implementation of a trauma-informed approach; worker wellness; and secondary, vicarious, and indirect trauma. The scan revealed literature on the concept of trauma-informed care and approaches to date has largely been based in North America. There is however some emerging literature of interest within the New Zealand context.

Key findings

Why use a trauma-informed approach?

A range of events can lead to a trauma response. When an event is experienced as traumatic by an individual, community or population, it can potentially have negative effects on behaviour, mental and physical health. While not inevitable, adverse events can negatively impact on brain development, physiology, behaviour and relationships across the lifespan and generations (Isobel & Edwards, 2017). The landmark study by Felliti and colleagues published in 1998 was among the first to describe the association between adverse childhood events (ACEs) and a person's wellbeing and has generated a plethora of ongoing studies. An individuals' response to adverse events depends in part on the balance between risk and protective factors (Carswell, Kaiwai, Hinerangi, Lennan, & Paulin, 2017).

Commonly reported events among adults include death of a loved one, and witnessing or experiencing violence. Māori people have a higher risk of experiencing traumatic events. Nearly two-thirds of Māori adults have experienced one or more traumatic events, compared to half of adults in the general population (Hirini, Flett, Long, & Millar, 2005).

A large proportion of people who experience mental health and addiction issues are likely to have experienced trauma (SAMHSA, 2014). One US study (Frueh et al. 2005) found 87 per cent of people accessing services had experienced physical or sexual assault in their lifetime. Another recent Australian study (Duhig, Patterson, & Connel, 2015) found over three-quarters of people accessing early psychosis services had experienced childhood trauma.

Any worker who supports people with experience of trauma may also experience trauma responses, such as burnout, vicarious trauma, or secondary traumatic stress. In addition, health workers may be subjected to abuse or violence from people accessing services (Spector, Zhou, & Che, 2014), as well as bullying or harassment from colleagues (McKenna, Poole, & Coverdale, 2003a; McKenna, Poole, Smith, Coverdale, & Gale, 2003b).

What is a trauma-informed approach?

A trauma-informed approach is a strengths-based model of service delivery which focuses on individuals' strengths and competencies.

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Key elements of a trauma-informed approach include recognition of the widespread impact of trauma on people; understanding the neurological, biological, psychological and social effects of trauma on individuals and populations; the ability to recognise the signs and symptoms of trauma; and the integration of this knowledge into organisational policies, procedures, programmes and practices. In New Zealand, the impact of historical traumatic events and their contribution to the resultant health disparities experienced by Māori people is also important.

Key principles underpinning trauma-informed approaches include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment and choice; and an awareness of cultural, historical and gender issues. Many of these principles are embedded into the *Six Core Strategies*© framework for reducing coercive practices within mental health services (Te Pou o te Whakaaro Nui, 2013). Principles are also embedded in *Let's get real* (Ministry of Health and Te Pou o te Whakaaro Nui, 2018), which describes the knowledge, skills, values and attitudes required of people working with people with experience of mental health issues and addiction.

A trauma-informed approach not only applies to people who access mental health and addiction services but includes the wellbeing of workers. The prevention of secondary trauma and building resiliency are essential factors needed for worker wellbeing.

The implementation of a trauma-informed approach requires an intentional process of change, using multiple-level strategies. These include identifying barriers; implementing organisation-wide systems and processes; addressing worker wellness and safety; and providing workers with the skills and confidence to support such an approach.

Future directions

There is a gap in research and resources supporting adult mental health and addiction services in New Zealand to implement a trauma-informed approach, particularly taking into consideration the long-term and complex individual and collective trauma of Māori people. Worker wellbeing is another key area of concern. Next steps should therefore include development of a unique trauma-informed approach incorporating principles and key elements for New Zealand.

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Background

The need for New Zealand mental health and addiction services to provide trauma-informed services, systems and worker knowledge and skills, is not new. Anecdotal evidence suggests the status of trauma-informed approaches here is however emergent, piecemeal and lacking an evidence-base (Peters, 2017). Generally, overseas research and resources are used, rather than those reflecting our unique cultural diversity.

The literature on the concept of trauma-informed care and approaches has largely been based in North America and described in multiple ways. One US definition of trauma-informed care is:

> A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 10)

A paper produced for the International Initiative Mental Health Leadership forum (IIMHL) provided a snapshot of work on trauma-informed care in eight countries (Peters & Silvestri, 2016). The US was the first country to have a national policy on trauma-informed care, with the Substance Abuse and Mental Health Services Administration (SAMHSA) pioneering this work. In the US, trauma-informed care is generally seen as an across-government issue. Internationally, trauma-informed approaches have been implemented across sectors including health, education, justice, social services, and community groups; city-wide; organisation-wide; and in mental health and addiction services.

In early 2017, Janet Peters conducted an environmental scan commissioned by Te Pou o te Whakaaro Nui about the application of trauma-informed approaches in New Zealand's mental health and addiction services. The workforce reported gaps in their knowledge, particularly in working alongside Māori, Pasifika and Asian peoples; refugees; disabled people; whānau and other communities (Peters, 2017). Peters suggested that:

> The emergent and enthusiastic take-up of the idea of trauma-informed care would be significantly strengthened through national leadership and collaborative initiatives to design, implement and evaluate organisational and systemic approaches. (Peters, 2017, p. 9)

Understanding the New Zealand context

Treaty of Waitangi

Any discussion of trauma in New Zealand must be underpinned by a cultural context of the Treaty of Waitangi, Te Ao Māori[1] and the realisation Māori people, as the indigenous people of this land, come from a place of individual and collective intergenerational trauma as a result of colonisation. The Treaty, in its purest context, is about - and informs - relationships. Relationships between The Crown and Iwi, the Government and citizens of New Zealand, tauiwi[2] and tangata whenua.[3] It therefore determines the obligations and responsibilities between the two parties within a framework of Partnership, Participation and Protection.[4] Te Ao Māori for many Māori people is about belonging, identity, safety and stability in a Māori cultural context, environment, and worldview and can provide healing from the intergenerational trauma of colonisation (K. Opai, personal communication, March 6, 2018).

Strategic direction

The strategic direction towards trauma-informed care is specifically set out in national policy.

Rising to the Challenge

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 (Ministry of Health, 2012) clearly outlines in terms of priority actions, taking action to assist the workforce to work effectively with people who have experienced trauma and to make better use of current resources for people with low-prevalence conditions and/or high needs. All district health boards (DHBs) and non-government organisations (NGOs) are required to ensure services are sensitive to past experiences of trauma. This plan also includes the need for continued efforts to reduce and eliminate the use of seclusion (Ministry of Health, 2012), which can be traumatic or retraumatising for people.

Mental Health and Addiction Workforce Action Plan

The *Mental Health and Addiction Workforce Action Plan 2017-2021 (*Ministry of Health, 2017; also see Appendix A) signals a need for the specialist workforce "to work differently and develop different skills so that it can provide a range of evidence-based interventions" (including trauma-informed care and talking therapies). Priority areas in the plan provide opportunities for further work on trauma-informed care approaches. Priority One includes a desire to develop an appropriate workforce that is engaged, confident and focused on people and improved outcomes. Priority Three outlines the need for a workforce that is competent and capable of providing evidence-based approaches (including trauma-informed care and talking therapies).

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[1] The Māori world/Māori worldviews

[2] Non-indigenous people

[3] People of the land – Māori people

[4] As defined by the Ministry of Health in this context https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles

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The plan takes guidance from the Triple Aim for Quality Improvement framework described by the Health Quality and Safety Commission New Zealand[5] which focuses on: improved quality, safety and experience of care; improved health and equity for all populations; and better value for public health system resources. The Ministry of Health added a fourth aim of workforce wellbeing and staff engagement, development and leadership, to support having a workforce focused on people and improved outcomes.

Workforce development

Let's get real (Ministry of Health, 2008) is a framework designed to ensure the mental health and addiction workforces have the essential knowledge skills, values and attitudes required to provide effective, consistent and supportive services to people who need them. The framework is currently being refreshed and highlights the need for workers to have knowledge and skills related to trauma-informed care. The strengthened focus on trauma in the refreshed *Let's get real* framework has been strongly endorsed by the sector.

People can be traumatised or retraumatised from adverse events when accessing inpatient services, for example by experiencing seclusion and restraint. Work by Te Pou o te Whakaaro Nui and DHBs, in supporting services to reduce and eliminate the use of seclusion and other restrictive practices, includes the need for services to be trauma-informed, see https://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102 [6] [7]

Purpose

The purpose of this review is to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness. This is intended to inform a national approach to trauma-informed care and help identify future intersectoral work. This approach will consider the unique New Zealand context of Māori people as tāngata whenua and include historical and intergenerational trauma.

The terms *trauma-informed approach* and *trauma-informed care* are used interchangeably in the literature and used in multiple ways. The terms are also used interchangeably in this review to describe a trauma-informed approach and trauma-informed care as a framework, delivery approach, or model of service delivery.

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[5] See https://www.hqsc.govt.nz/about-us/

[6] Resources to support least restrictive practice include the *Six Core Strategies© Checklist – NZ Adaption* (Te Pou o te Whakaaro Nui, 2013) and *Towards restraint-free mental health practice: Supporting the reduction and prevention of personal restraint in mental health inpatient settings* (Te Pou o te Whakaaro Nui, 2015). See http://www.tepou.co.nz

[7] Trauma-informed care is included in national 'Safe Practice Effective Communication' training for mental health clinicians in inpatient units. It is a collaboration between all DHBs, under the leadership of the National Directors of Mental Health Nursing (DOMHN), key stakeholders include service user groups and Māori, and Te Pou. See https://www.tepou.co.nz/news/safe-practice-effective-communication-launch/911

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Report structure

This review describes why using a trauma-informed approach is important, what it involves, and how organisations can implement it.

- Section one (page 16) includes definitions of trauma, the prevalence of traumatic events, and the potential impact on people and the health workforce. The role of resilience in influencing outcomes is highlighted.
- Section two (page 35) describes the benefits, key principles and elements of a trauma-informed approach. Different approaches are discussed including an ecological approach, emerging New Zealand approaches, and some specific examples used in prisons and mental health services.
- Section three (page 44) considers evidence on factors supporting the successful implementation of a trauma-informed approach, including the identification of potential barriers; supporting workplace wellness and safety; and developing workforce capability.

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Method

A broad literature search of electronic databases was conducted to identify research published between 2011-2017 related to:

- trauma and behavioural health (including both mental health and addiction)
- the implementation of a trauma-informed approach
- worker wellness
- secondary, vicarious, and indirect trauma.

Older studies considered to be seminal or landmark were included in the review. All article reference lists were scanned to identify further journal articles relating to trauma-informed approaches.

Grey literature searches were conducted for relevant documents available from government and non-governmental sources. Other sources of information resulted from recommendations of the work of Te Pou o te Whakaaro Nui, which included *Six Core Strategies© Checklist – NZ Adaption* (Te Pou o te Whakaaro Nui, 2013) and *Let's get real* (Ministry of Health, 2008).

New Zealand studies were sought from not only the sources described, but from personal knowledge of advisors in the Māori community (Milne, 2017). These contacts were particularly important in identifying emerging and unpublished New Zealand work.

Section 1: Why use a trauma-informed approach?

This section provides an overview of why it is important to use a trauma-informed care approach and includes:

- different definitions and types of trauma experienced by people, including adverse events in childhood; and acute, complex, secondary and intergenerational trauma
- the prevalence of trauma experienced by people, including Māori people, people accessing mental health services, and workers
- the impact of trauma on people and the workforce.

Consideration is given to international and national literature where relevant.

Trauma

Trauma can be defined as the lasting adverse effects on a person's functioning and mental, physical, social, emotional or spiritual wellbeing, caused by events, circumstances or intergenerational historical experiences.

SAMHSA's (2012) definition of trauma has been widely used in the literature.

> 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's functioning and mental, physical, social, emotional, or spiritual wellbeing. (SAMHSA, 2012, p. 2)

The SAMHSA definition needs further consideration within an New Zealand context as traumatic experiences may include both an individual and collective response, particularly for Māori people (Pihama et al., 2014). For indigenous people, intergenerational historical trauma is important (Wirihana & Smith, 2014).

A more inclusive definition of trauma is therefore:

> The lasting adverse effect on a person's or collective's functioning and mental, physical, social, emotional or spiritual wellbeing, caused by events, circumstances or intergenerational historical traumatic experiences.

Types of trauma

Adverse childhood events (ACEs) is the term used to describe all types of childhood abuse, neglect and other experiences that occur to people under the age of 18 years. Other types of trauma experienced by people or populations can be categorised as either acute, complex, secondary or intergenerational.

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Adverse childhood events (ACEs)

The 1998 landmark ACEs study in the US is a large epidemiological study involving more than 17,000 people.[8] The study found an association between the breadth of exposure of abuse or household dysfunction during childhood, and poor physical, mental and social wellbeing across the life-span (Felitti et al., 1998). The identified ACEs included:

- emotional, physical and sexual abuse
- emotional and physical neglect
- household dysfunction identified as mother treated violently
- household substance abuse
- household mental illness
- parental separation or divorce
- incarcerated household member.

Acute trauma

Acute trauma is a single event or circumstance that is experienced by an individual as physically and emotionally harmful or threatening.

Complex trauma

Complex trauma is the term used to describe the response from some people who have experienced repeated instances of the same type of trauma over a period of time, or multiple types of trauma.

> Complex trauma is typically interpersonal and generally involves situations in which the person who is traumatised cannot escape from the traumatic experiences because he or she is constrained physically, socially, or psychologically. (SAMHSA, 2014, p. 6)

Complex trauma can also be described as a dual experience involving the initial exposure to a traumatic event, as well as the impact of this experience on both immediate and longer-term health and wellbeing outcomes (National Center for Post-Traumatic Stress Disorder, 2002).[9]

Secondary trauma

Secondary trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, can occur among any person, including workers who provide support to people who have experienced trauma. People who, themselves have experienced childhood trauma are more susceptible to this type of trauma (Brockhouse, Msetfi, Cohen, & Joseph, 2011).

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[8] The study continues today as an ongoing collaboration between the Centre for Disease Control and Kaiser's Department of Preventative Medicine in San Diego.

[9] People who have experienced complex trauma may need an adapted or more extensive programme of varied approaches from a skilled practitioner over a period of time (Van der Kolk, 2014).

Secondary trauma experienced by the workforce can make people more susceptible to burnout, vicarious trauma, secondary traumatic stress, and compassion stress (SAMHSA, 2014). Related definitions are summarised in Table 1.

Table 1. *Definitions of Workforce Trauma*

Workforce trauma	Definition
Burnout	The cumulative psychological strain of working with many different stressors. It often manifests as a gradual wearing down over time, and of having physical and emotional exhaustion.
Vicarious trauma	The cumulative effect of working with people who have experienced trauma and includes cognitive changes resulting from empathic engagement and a change in worldview.
Secondary traumatic stress	Workers' sub-clinical or clinical signs and symptoms of post-traumatic stress disorder (PTSD) that mirror those experienced by clients, friends, or whānau. While not formally recognised as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to, or associated with, PTSD.
Compassion stress	Characterises the stress of helping or wanting to help people who have experienced trauma. Compassion stress is seen by some as a natural outcome of knowing about trauma experienced by a client, friend, or family, rather than a pathological process.

Source: Trauma Informed Oregon (n.d.).

Intergenerational historical trauma

Pihama et al. (2017) argue many researchers investigating trauma have not provided for indigenous experiences of collective trauma, such as historical and intergenerational trauma. Some historical trauma researchers (Whitbeck, Adams, Hoyt, & Chen, 2004; Yellow Horse Brave Heart, 2003) have attempted to show a cluster of symptoms particular to those who have experienced historical trauma and these symptoms together constitute a syndrome: historical trauma response. In order to understand the impact of historical trauma in New Zealand, Reid, and colleagues (2014) suggest using the multi-level model outlined by Sotero (2006), which includes three sequential stages.

- First, there is a mass trauma experience where the dominant group subjugates a population, resulting in segregation and displacement, physical and psychological violence, economic destruction, and cultural dispossession.
- Second, a trauma response is elicited in the first or primary generation that includes physical, social, and psychological responses.
- Third, the responses are transmitted to subsequent generations via various pathways across all levels of analysis from the micro to the macro.

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For Māori people the historical trauma resulting from the impacts of colonisation, have been transmitted through generations and are associated with negative health disparities experienced by many whānau (family and extended family), hapū (sub-tribes), and iwi (tribes) (Pihama et al., 2014). The intergenerational impact of the historical loss of land, decline of Māori language and cultural practices, and subsequent colonisation of indigenous values contribute to the complexities of trauma experienced by some Māori people (Smith, 2005). "The structural poverty[10] faced by many Māori families is one of the major means of transmitting the historical trauma of colonisation through the generations" (Reid et al., 2014, p. 528).

The prevalence of trauma

This discussion includes the prevalence of trauma among people in the general population, Māori people, people accessing mental health and addiction services, and in prison. Consideration is also given to specific types of trauma including whānau and intimate partner violence, and sexual assault.

General population

The types of events in childhood or adulthood leading to a potential trauma response are varied. Research across 20 countries (Stein et al., 2010) indicates common traumatic events include:

- the death of a loved one (31 per cent)
- witnessing violence to others (22 per cent)
- experiencing interpersonal violence (19 per cent).

Other traumatic events (e.g., automobile accidents and natural disasters) appear to be quite similar throughout developed countries (SAMHSA, 2014). The main difference between the US and New Zealand is in exposure to natural disasters, which were relatively rare before the 2011 Canterbury earthquake (Flett, Kazantzis, Long, MacDonald, & Millar, 2002).

A New Zealand survey of 1,500 people investigated experiences of 12 different traumatic events.[11] Results indicate over half of adults have experienced a traumatic event, with women reporting more exposure to crime and accidents than men (Flett et al., 2002).

The Dunedin Health and Development Study has examined the developmental mental health histories of adults with post-traumatic stress disorder (PTSD) and provides another perspective on experiences of trauma (Koenen et al., 2008). As shown in Figure 1, the sudden unexpected death by a traumatic event of a close family member or friend, and personal assault or victimisation were the most commonly reported 'worst' experiences before the age of 26.

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[10] Structural poverty is the marginalised position of large numbers of Māori people who face economic and social disadvantages.

[11] Including combat, child sexual assault, adult sexual assault, domestic assault, other physical assault, robbery or holdup, motor vehicle accidents, other accidents resulting in injury, disaster experiences, and being forced to leave home or take other precautions due to a natural disaster.
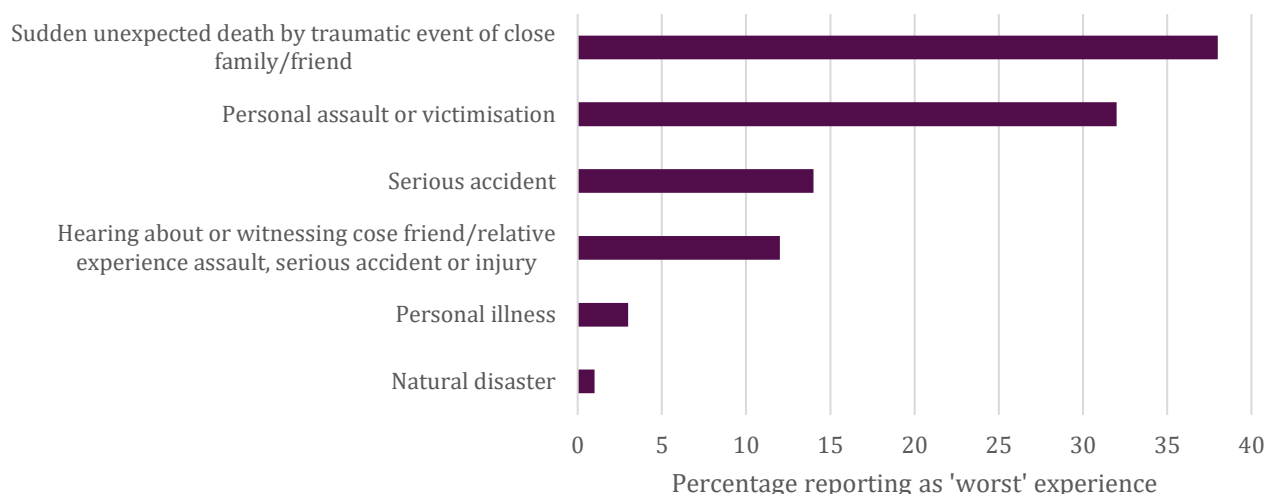
Figure 1. Worst experiences by the age of 26 years based on findings from the Dunedin Health and Development Study (Koenen et al., 2008).

For Māori people the sudden unexpected death of a close family member is similarly recognised as one of the most challenging experiences. Aupori-McLean (2013) notes in recent research on the personal journeys of whānau bereaved through suicide of loved ones, that for Māori people coping with the resultant trauma is one of the "ultimate encounters faced by survivors".[12]

Whānau and intimate partner violence, and sexual assault

New Zealand has high rates of whānau, intimate partner, and sexual violence.

Sexual assault

About 1 in 3 (35 per cent) ever-partnered women have experienced physical or sexual violence by an intimate partner in their lifetime, and over half (55 per cent) have experienced psychological or emotional abuse (Fanslow & Robinson, 2011). A nationwide face-to-face survey of 6,943 adults in New Zealand in 2014 found one-quarter (24 per cent) of women and 6 per cent of men have experienced sexual assault in their lifetime (Ministry of Justice, 2015).

Compared to other countries, New Zealand has poor rates of childhood sexual abuse (Global Health Metrics, 2017).[13] Out of 188 countries, only six countries rated as badly or worse than New Zealand. In 2016, there were 2,163 reported sexual victimisations against a child aged 16 years or younger (National Performance & Insights Centre, 2017). However, the 2014 New Zealand Crime and Safety Survey estimates less than 10 per cent of sexual offences are reported (Ministry of Justice, 2015).

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[12] Grieving family members experienced guilt, self-reproach and social isolation in response to the behaviour of others towards them, increased self-harm, an escalation in marital dysfunction, and changes in whānau interaction (either better or worse).

[13] The UN defined childhood sexual abuse as the prevalence of men and women aged 18-29 who experienced sexual violence by the age of 18 years. New Zealand's index score for childhood sexual abuse was two out of 100 The index scoring used in the study was on a range from 0 to 100, with 0 being the worst score.

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Whānau and intimate partner violence

Official statistics, data and other surveys provide further insight. Table 2 presents examples related to whānau and intimate partner violence which have been collected and reported in a variety of ways (e.g., in relation to trauma type or population group).

Table 2. *Summary of Official Statistics Relating to Whānau and Intimate Partner Violence*

Description	Period	Number
Family violence		
Family violence investigations by Police (National Performance & Insights Centre, 2017)	2016	118,910
Police recorded 'male assaults female' victimisations (National Performance & Insights Centre, 2017)	2016	6,377
Crisis calls to women's refuges affiliated to the National Collective of Independent Women's Refuges	2015/16	73,000
Women accessing women's refuge advocacy services in the community (National Collective of Independent Women's Refuges, 2016)	2015/16	11,062
Women and children staying in women's safe houses (National Collective of Independent Women's Refuges, 2016)	2015/16	2,446
Care and protection notifications received by Child, Youth and Family (Child Youth and Family, 2016)	2015/16	142,249
Care and protection notifications requiring further action (Child Youth and Family, 2016)	2015/16	44,689
Care and protection notifications leading to findings of abuse or neglect (Child Youth and Family, 2016)	2015/16	16,394

Furthermore, up to 2 in 5 children have witnessed violence between adults in their home, and around half of these children have lived with this for long periods (Fergusson & Horwood, 1998; Martin, Langley, & Millichamp, 2006).

Māori people

Two-thirds (65 per cent) of Māori people have experienced one or more traumatic events during their lifetime (Hirini et al., 2005).

The historical and contemporary factors contributing to whānau violence are acknowledged as complex (Dobbs & Eruera, 2014; Pihama et al., 2014; Wirihana & Smith, 2014). Māori people are overrepresented in family violence statistics as both victims and perpetrators, and have higher rates of mental health problems and incarceration than the general population (Baxter, Kingi, Tapsell, & Durie, 2006). The Public Health

Advisory Committee estimated upwards of 20,000 primarily Māori children, may be intergenerational victims of incarceration (Ministry of Health, 2010).

Statistics provided by Te Puni Kōkiri (2017) indicate Māori people are more likely to experience family violence behaviours compared to other population groups. On average, Māori people are:

- more than twice as likely to be victims of violent interpersonal offences by intimate partners (11 per cent compared with 5 per cent)
- more likely to be victims of any crime (33 per cent compared with 24 per cent)
- overrepresented among offenders who perpetrate serious crimes against family members (45 per cent of unique offenders[14] in 2016).

In addition:

- more Māori children are in care (61 per cent) and admitted to youth justice residences (71 per cent) (Te Puni Kōkiri, 2017)
- Māori students are about twice as likely (17 per cent) as pakeha students (9 per cent) to report witnessing adults hit children in their homes
- Māori people are 10 times more likely to have experienced multiple forms of racism and discrimination than other ethnic groups (Harris et al., 2006).

Mental health and addiction services

A large proportion of people who experience mental health and addiction issues are likely to have experienced trauma (SAMHSA, 2014). A 2013 trauma-informed care review in inpatient settings, concluded people needing trauma-specific services represent the greatest proportion of people accessing public mental health, forensic health, and drug and alcohol services (Muskett, 2013).

One US study (Frueh, Knapp, Cusack, Grubaugh, & Sauvageot, 2005) found 87 per cent of people accessing community mental health services had experienced trauma sometime in their life, including physical assault (47 per cent), childhood sexual abuse (30 per cent), and adult sexual assault (17 per cent). People with experiences of trauma also tended to feel more unsafe, helpless, fearful, and distressed, along with people with a probable presence of post-traumatic stress disorder (PTSD).

A more recent Australian study of 100 people attending four services for people with early psychosis found over three-quarters reported exposure to childhood trauma (Duhig et al., 2015). In line with the findings of Frueh et al. (2005), about one-third (28 per cent) had experienced sexual abuse, and half emotional abuse or neglect as shown in Figure 2.

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[14] The unique offender population is the measure that counts individual offenders once in a given 12-month reference period regardless of how many times they may have been dealt with by police.

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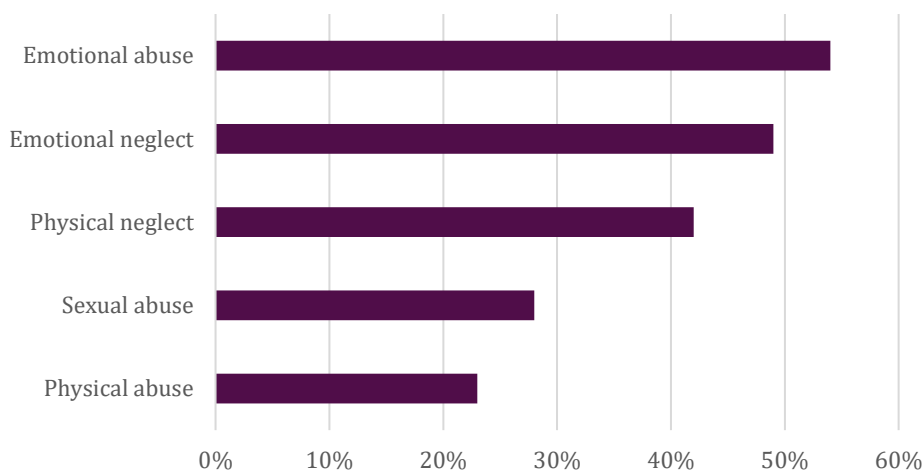
Figure 2. Exposure to childhood trauma among 100 people attending four early psychosis services in Australia. Source: Duhig et al. (2015).

Prison population

Experiences of trauma play a significant role in the lives of women who offend (McGlue, 2016). US studies show up to 90 per cent of people seeking treatment for serious and long-term mental health and addiction issues, and in contact with the criminal justice system, have experienced significant emotional, physical, and sexual abuse in childhood (Muskett, 2014).

Within the local prisoner population there are high rates of lifetime exposure to trauma (Bevan, 2017). For example, over half of prisoners have experienced sexual or family violence (75 per cent of women and 56 per cent of men); and many have PTSD (54 per cent of women and 40 per cent of men) (Indig, Gear, & Wilhelm, 2016). Indig and colleagues (2016) found 68 per cent of women in prison have been victims of family violence, and 62 per cent have experienced co-existing mental health and addiction problems sometime in their life. Moreover, the environment and culture within prison has the potential to be re-traumatising for people due to day-to-day occurrences (such as noises, shouting, confined spaces, lack of privacy and body searches which can be perceived as threatening) (Benedict, n.d.).

Mental health and addiction workforce

Health workers may experience bullying, harassment and violence from people accessing services (Baby & Carlyle, 2014; Spector et al., 2014).

Research suggests New Zealand's mental health nurses are frequently subjected to abuse and violence from people accessing services (Baby & Carlyle, 2014). Similarly, new graduate nurses working across the health sector frequently experience violence from either colleagues or people accessing services (McKenna et al., 2003ab).

Worldwide, one-third of nurses, in a range of employment settings, have experienced physical violence, bullying, or injury; one-quarter sexual harassment; and two-thirds non-physical violence (Spector et al., 2014).

Verbal abuse is most commonly experienced by the workforce. In New Zealand, McKenna and colleagues (2003ab) found the most common inappropriate behaviours towards new nurses by people accessing services involved verbal threats (35 per cent), verbal sexual harassment (30 per cent), and physical intimidation (29 per cent). Male and younger nurses were especially vulnerable to inappropriate behaviours, as well as nurses working in mental health services (McKenna et al., 2003b). Nearly half of the events described were not reported. Only 12 per cent of people who described a distressing incident received formal debriefing, and many had received no training to manage the behaviour.

Less is known about the addiction workforce. However, an Australasian survey is currently underway (National Centre for Education and Training on Addiction [NCETA], 2017) focusing on the wellbeing of the AOD (alcohol and other drugs) and addiction workforces and will be completed this year.

Bullying

Bullying can be a cause of secondary trauma in the workplace (Handran, 2013) and prevention is important to a healthy workplace. It deserves specific focus given its heavy toll on nurses and other health workers (Allen, Holland, & Reynolds, 2015), which can lead to higher levels of strain, reduced wellbeing, organisational commitment, and self-rated performance (NCETA, 2017). New nursing graduates who have experienced bullying from peers across various clinical settings, all indicate the impact of interpersonal conflict is serious (World Federation for Mental Health, 2017).

Bullying from peers in the workplace most commonly takes the form of psychological harassment, which creates hostility, as opposed to physical aggression. This harassment can involve verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunities, disinterest, discouragement and withholding of information (McKenna et al., 2003a). Recent studies indicate bullying is prevalent among workers in the medical profession. Up to half of those surveyed by the New Zealand Medical Association reported experiences of bullying (World Federation for Mental Health, 2017).

The extent of bullying within New Zealand is reinforced by a 2017 survey of senior doctors and dentists (Association of Salaried Medical Specialists, 2017). More than one-third (37 per cent) reported being bullied, and over two-thirds (68 per cent) witnessing colleagues being bullied. Much of the bullying was between medical colleagues. Other senior medical staff were frequently cited as perpetrators (53 per cent overall), followed by non-clinical managers (32 per cent), and people in clinical leadership positions (25 per cent).

Whilst the extent of workplace bullying in addiction services is unclear, one study examining the personal experiences of bullying among 1,700 workers across 36 organisations in the education, health, hospitality and travel sectors, found 18 per cent of respondents reported bullying (O'Driscoll et al., 2011).

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The impact of trauma on health and wellbeing

The impact of traumatic events on people and the health workforce is described in this sub-section. It is now well understood that while not inevitable, the effects of trauma are diverse and multifaceted. Trauma can negatively impact on the brain, behaviour and relationships across the lifespan and generations (Isobel & Edwards, 2017). Immediate and delayed reactions to events are discussed, as well as the impact of specific types of events, including adverse events in childhood, the Canterbury earthquake, and work-related trauma. The final part of this discussion includes the impact of factors that help build resilience, such as individual, interpersonal and community or social factors.

The event, experience and effects

To understand the experience and impact of trauma, SAMHSA (2015, p. 8) describes trauma as the result of a process of **three "E's"**:

1. the event that occurs to expose a person to either a single traumatic event or repeatedly over time
2. the experience of the event by an individual or a population helps determine whether it is a traumatic event. How the event is experienced may be linked to a number of risk or protective factors
3. the effects of the event, whether the effects occur immediately or have a delayed onset – in some situations, the individual may not immediately connect the event with subsequent effects.

Therefore, trauma potentially occurs following exposure to an event.

Common experiences and responses to trauma

Trauma can impact the emotional, physical, cognitive, behavioural and existential wellbeing of people. Some common reactions to trauma are described in Table 3. Immediate reactions for example may include helplessness, exhaustion, difficulties concentrating, startled reaction, **and reduced confidence in one's ability.** Reactions may also be delayed.

Table 3. *Some Common Reactions to Trauma*

Reaction	Immediate reactions	Delayed reactions
Emotional	- Numbness and detachment - Anxiety or severe fear - Guilt (including survivor guilt) - Exhilaration as a result of surviving - Anger - Sadness - Helplessness - Feeling unreal; depersonalisation (e.g., feeling as if you are watching yourself)	- Irritability and/or hostility - Depression - Mood swings, instability - Anxiety (e.g., phobia, generalized anxiety) - Fear of trauma recurrence - Grief reactions - Shame - Feelings of fragility and/or vulnerability

Reaction	Immediate reactions	Delayed reactions
	• Disorientation • Feeling out of control • Denial • Constriction of feelings • Feeling overwhelmed	• Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Physical	• Nausea and/or gastrointestinal distress • Sweating or shivering • Faintness • Muscle tremors or uncontrollable shaking • Elevated heartbeat, respiration, and blood pressure • Extreme fatigue or exhaustion • Greater startle responses • Depersonalisation	• Sleep disturbances, nightmares • Somatisation (e.g., increased focus on and worry about body aches and pains) • Appetite and digestive changes • Lowered resistance to colds and infection • Persistent fatigue • Elevated cortisol levels • Hyperarousal • Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Cognitive	• Difficulty concentrating • Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) • Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) • Memory problems (e.g., not being able to recall important aspects of the trauma) • Strong identification with victims	• Intrusive memories or flashbacks • Reactivation of previous traumatic events • Self-blame • Preoccupation with event • Difficulty making decisions • Magical thinking: belief that certain behaviours, including avoidant behaviour, will protect against future trauma • Belief that feelings or memories are dangerous • Generalisation of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) • Suicidal thinking
Behavioural	• Startled reaction • Restlessness • Sleep and appetite disturbances • Difficulty expressing oneself • Argumentative behaviour	• Avoidance of event reminders • Social relationship disturbances • Decreased activity level • Engagement in high-risk behaviours • Increased use of alcohol and drugs

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Reaction	Immediate reactions	Delayed reactions
	• Increased use of alcohol, drugs, and tobacco • Withdrawal and apathy • Avoidant behaviours	• Withdrawal
Existential	• Intense use of prayer • Restoration of faith in the goodness of others (e.g., receiving help from others) • Loss of self-efficacy • Despair about humanity, particularly if the event was intentional • Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	• Questioning (e.g., "Why me?") • Increased cynicism, disillusionment • Increased self-confidence (e.g., "If I can survive this, I can survive anything") • Loss of purpose • Renewed faith • Hopelessness • Re-establishing priorities • Redefining meaning and importance of life • Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defence class to re-establish a sense of safety)

Sources: Briere & Scott, 2015; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

Adverse childhood events (ACEs)

Experiences of adverse events in childhood[15] increase the risk of poor physical, mental and social wellbeing across the life-span (Anda et al., 2008; Felitti et al., 1998). The more ACEs experienced, the greater the likelihood of experiencing an array of health and addiction problems in adulthood, including alcohol dependency, chronic pulmonary disease, depression, illicit drug use, and liver disease (Centers for Disease Control and Prevention, 2014).

Consequences of ACEs reported from a 2013 English national study of 4,000 adults[16] included health-harming behaviours in early adulthood such as substance use, physical inactivity, eating disorders, and conduct disorder (Bellis, Hughes, Leckenby, & Jones, 2014). Other key findings are summarised in Table 4. For example, people who have experienced four or more ACEs are seven times more likely to have been involved in violent incidents in the past year. Recent research also suggests people exposed to six or more ACEs have a risk of suicide 35 times higher than others (Larkin, 2016).

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[15] The identified ACEs included emotional, physical and sexual abuse; emotional and physical neglect; household dysfunction identified as mother treated violently; household substance abuse; household mental illness; parental separation or divorce; and incarcerated household member.
[16] Which compared people with no ACEs to those with four or more.

Table 4. *Summary of the Occurrence of Health Harming Behaviours for People with Four or More ACEs*

Behaviour	Compared to others*
• Currently binge drink and have a poor diet	2 times (x) more likely
• Current smoker	3x
• Sex under the age of 16 years	5x
• Had or caused an unplanned teenage pregnancy	6x
• Involved in violence in the last year	7x
• Used heroin or been incarcerated	11x

Note. * Compared to people with less than four ACEs. Source: Bellis et al., (2014).

An analysis of the World Mental Health Survey Initiative of 51,945 adults across 21 countries, found adversities experienced in childhood are usually inter-related and occur in clusters (Kessler et al., 2010). Kessler and colleagues found childhood adversities associated with maladaptive family functioning (such as parental mental health issues, child abuse and neglect), were the strongest predictors of issues with mental health in adulthood.

The relationship between ACEs and trauma is captured in Figure 3. However, it is important to note this UK model does not include indigenous historical and intergenerational trauma.
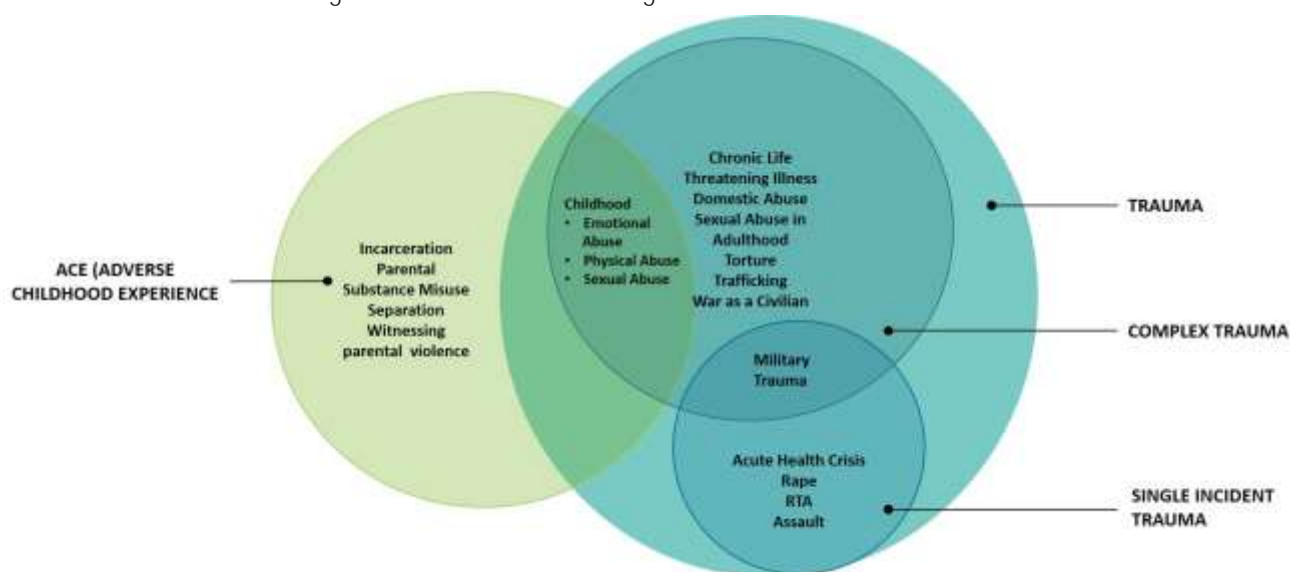
Figure 3. Relationship between ACEs and trauma (NHS Education for Scotland, 2017, p. 20).

New Zealand findings on adverse childhood events
New Zealand studies have found similar effects of adverse events in childhood. The Christchurch Health and Development Study (Fergusson & Horwood, 2001) concluded sexual abuse in childhood increases the risk of depression, anxiety disorders, substance use disorders, and suicidal behaviours. This longitudinal study also

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found five per cent of children with the greatest disadvantage and family dysfunction had risks of multiple problem behaviours over 100 times those of children in the advantaged 50 per cent of the cohort.

Exposure to childhood trauma is common among people who experience early psychosis and is associated with increased symptomology (Duhig et al., 2015). Another study found an association between childhood trauma, particularly emotional trauma, and an increased likelihood of experiencing bipolar disorder (Watson, Gallagher, & Dougall, 2014).

The effect of early childhood disadvantage[17] on adult behaviour was reported in the Dunedin Multidisciplinary Health and Development study (Dunedin Multidisciplinary Health & Development Research Unit, 2016). Twenty per cent of the study cohort as adults, accounted for over 80 per cent of service use in health care, criminal-justice, and social welfare systems.

In a report to the New Zealand Mental Health Commission, Debra Wells (2004) emphasised how people abused as children are more likely to enter mental health services at a younger age (Read, 1998) and have longer and more frequent hospitalisations; spend more time in seclusion; receive psychotropic medication more often; relapse more frequently (Read, 1998); attempt suicide (Lothian & Read, 2002); and engage in deliberate self-harm (Read, Hammersley, & Rudegeair, 2007).

Neuroscience of adverse childhood events (ACEs)

Neuroscience research is helping to understand the pathway or mechanism by which childhood trauma impacts on health and wellbeing. The earlier the onset of trauma and the longer its duration, the greater the adverse effect, as the structure and functioning of the developing mind and brain are shaped by experiences (Cozolino, 2002).

Lupien and associates explain that excessive stress activation during early childhood shifts mental and physiological resources from long-term development to immediate survival (Lupien, McEwen, Gunnar, & Heim, 2009). Effects include increased vigilance at the cost of focused attention; impulsivity stimulated at the cost of behavioural regulation; and limits on long-term biological investment in the brain and other organ systems to the detriment of later health and capacity. Over time, long-term stress can alter biological functions associated with immunity, growth, cardiovascular function, metabolism, and sleep (Lupien et al., 2009).

The neurobiological consequences of trauma include impaired brain development, reduced cognitive (learning ability) and socio-emotional (social and emotional) skills, and lower language development (Leitch, 2017). Different types of abuse and neglect appear to target the sensory systems and pathways involved with processing the abuse and are associated with risks for different forms of neurobiological alterations (Teicher & Samson, 2016). For example, young adults exposed to emotionally abusive language in childhood, showed changes in brain regions involved in processing language and speech (Tomoda et al., 2011). Young adults who

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[17] Members of this group grew up in socioeconomically deprived environments, experienced child maltreatment and exhibited low childhood self-control.

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experienced ongoing, harsh physical punishment in childhood showed alterations to the cortical pathways involved with pain (Tomoda et al., 2009). Teicher and Samson (2016) therefore concluded it may not just be the total number of adverse events that matter, but also the type of maltreatment, given the different types of neurobiological changes.

There are gender differences in how the brain responds to early trauma. Reduced corpus callosum size (the area that connects the two hemispheres of the brain) in victims of child abuse and neglect is one of the most significant anatomical changes in the brain (Teicher et al., 2004). Males are affected more than females, particularly males who have experienced neglect (De Bellis & Keshavan, 2003). The corpus callosum of females is more vulnerable to the effects of sexual abuse (Teicher et al., 2004). The hippocampus, the area of the brain involved with the formation and retrieval of memories, is highly susceptible to the effects of early abuse and neglect (Twardosz & Lutzker, 2010) with greater effects (reduced volume) found in the male brain (Teicher & Samson, 2016).

It is important to note while trauma can negatively affect the brain, the brain has a lifelong ability to change and adapt. This is known as neuroplasticity (Cirti & Malenka, 2008), and can contribute to the development of resiliency through learning to focus cognitive attention on strengths and positive experiences (Muskett, 2013; Leitch, 2017). Due to its role in facilitating recovery, neuroplasticity has been described as "the 'hope' of the nervous system" (Miller-Karas, 2015 p. 8).

Adults and older adults

Adults who have experienced sexual abuse, intimate partner violence, violence by non-partners, serious crime, active hostilities during war, workplace physical violence and bullying are at risk of developing mental health issues (Volpicelli, Balaraman, Wallace, & Bux, 1999; Baxter et al., 2006). These experiences may add to the effects of ACEs or be associated with them (VicHealth, 2004).

Older adults may have somewhat different responses to adverse events than those who are younger. Traumatic experiences (whether experienced in childhood or adulthood) may affect levels of both depression and anxiety in older adults, according to a large New Zealand study of 1,216 older adults (Dulin & Passmore, 2010). The study found avoidance of prior traumatic memories and situations played a large role in late-life anxiety and depression. Results indicate trauma experienced during young adulthood or middle age is a stronger predictor of anxiety and depression among older adults than trauma experienced in childhood or adolescence.

Historical and Intergenerational trauma

Yellow Horse Brave Heart (2003) in the American Indian context was one of the first people to provide researchers with a framework to identify the collective impact on indigenous peoples, of historical or intergenerational trauma. This framework offered a process for researchers to understand the long-term, complex individual and collective trauma of Māori people (Wirihana & Smith, 2014). Yellow Horse Brave Heart (2007) describes the response and impact of historical trauma:

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Cumulative emotional and psychological wounding, over the life span and across generations, emanating from massive group trauma experiences. The reaction to this intergenerational trauma (which reads almost like a menu of self-hatred) is the historical trauma response, which may include self-destructive behaviour, substance abuse, suicidal thoughts and gestures, depression, anxiety, low self-esteem, anger, intrusive trauma imagery, identification with ancestral pain, fixation to trauma, somatic symptoms, and elevated mortality rates. Associated bereavement accompanies historical trauma grief, known as historical unresolved grief. This grief may be considered impaired, delayed, fixated, and/or disenfranchised. (p.177)

For Māori people and communities the impact of historical trauma transmitted through generations has been associated with high suicide rates; a heightened risk of exposure to violence, physical, sexual and psychological abuse; and poverty (Reid et al., 2014; Smith, 2005). The impact of trauma on Māori people includes experiences linked to racism and discrimination, negative stereotyping, and inequalities in health (Pihama et al., 2017). Health and social policies themselves may be sources of historical and intergenerational trauma, and can continue to impact on individual and community health for marginalised groups (Bowen & Murshid, 2016).

Natural disasters

Research following the 2011 Canterbury earthquakes suggests the capacity to function effectively in life (e.g., work, parental roles) and in relationships may be severely affected by natural disasters, such as an earthquake (Dorahy et al., 2016). Dorahy and associates concluded aftershocks make a significant contribution to mental health outcomes. Aftershock anxiety and controllability of response were stronger predictors of psychological symptoms than other factors, including the extent of neighbourhood damage, loss, and disruptions.

Blake and Lyons (2016) demonstrated the importance of mitigating vulnerability and risks for people accessing opioid substitution treatment (OST) after a disaster. After the Canterbury earthquake health workers and emergency planners identified the importance of OST preparedness planning to ensure service continuity, to reduce physical and psychological distress for people accessing services, their whānau, and wider community.

Work-related trauma

Secondary traumatic stress, vicarious stress, or occupational burnout experienced by mental health and addiction workers have been shown to adversely impact on their wellbeing and interpersonal relationships, along with service delivery, treatment outcomes, and satisfaction amongst people accessing services (Byron et al., 2015; Bateman, Henderson, & Kezelman, 2013; Evans & Coccoma, 2014).

To help identify responses to trauma exposure, Laura van Dernoot Lipsky (2009) identified 16 warning signs as outlined in Table 5.

Table 5. *16 Warning Signs of Trauma Exposure Responses (van Dernoot Lipsky, 2009)*

Warning signs	
1. Feeling helpless and hopeless	9. Dissociative moments
2. A sense that one can never do enough	10. Sense of persecution
3. Hyperviligence	11. Guilt
4. Diminished creativity	12. Fear
5. Inability to embrace complexity	13. Anger and cynicism
6. Minimising	14. Inability to empathise/numbing
7. Chronic exhaustion/physical ailments	15. Addictions
8. Inability to listen/deliberate avoidance	16. Grandiosity - an inflated sense of importance related to one's work.

New Zealand perspective on work-related trauma

As in any trauma response, the severity or degree of impact trauma has on the workforce can vary from worker to worker, based on factors such as past experiences of sexual violence and traumatic events; training and education; personality styles; and existing self-care strategies (Pack, 2013).

Puckey (2001) explored the nature of vicarious traumatisation, and its contemporary conceptualisation of helping-induced trauma, and concluded vicarious trauma among mental health nurses is a safety risk. Puckey advocated for taking measures to engage in a process of personal safety risk management for both nurses and people accessing services.

Vicarious trauma not only affects health workers personally but can impact on relationships with other professionals, and significant others (Baby & Carlyle, 2014; Pack, 2013). The negative impact of vicarious trauma can include overextending, overindulging, avoiding situations, absenteeism, substance use, self-criticism, and experiencing intrusive thoughts (Rakei, 2016).

A New Zealand study revealed mental health nurses felt unprepared for the possible negative impacts of trauma on themselves, such as vicarious traumatisation (Davies, 2009). Davies found caring-induced trauma often led to mental health nurses leaving the profession altogether, especially when they did not understand what was happening to them.

Pack (2013) asserts that organisational systems can increase the risk of vicarious trauma among counsellors. When workers' personal philosophies differ from the values and attitudes dominant within the organisation and its practices, there is conflict (Pack, 2013). Social workers have reported oppressive systems of management, intimidation and direct violence by co-workers as traumatising (van Heugten, 2007).

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Resilience

Individual responses to adverse events vary. For example, some children exposed to adverse events, especially isolated events, do not necessarily require services if other resilience-enhancing factors are present in the child's immediate environment (Boyce & Harris, 2011).

A person's response to trauma events throughout the course of their lifetime is dependent on the balance between risk and protective factors (Carswell et al., 2017). Carswell and colleagues suggest the complex interaction between risk and protective factors leads to a person's resilience, which evolves over time. Resilience is described as the capacity to achieve developmental milestones, such as education and employment, in spite of childhood adversity (Carswell et al., 2017). The authors of this New Zealand study interviewed 49 people face-to-face, from a range of backgrounds[18] and identified resilience factors, including individual, interpersonal and community/societal factors, as summarised in Table 6.

Table 6. *Summary of Individual, Interpersonal and Community/Societal Resilience Factors*

Level	Factors
Individual	• Hope and desire for a better life expressed as hope for the future, for a better life, to be loved and appreciated, and their children's future. • Self-determination, for example regaining a sense of control over their lives and bodies. • Spiritual, religious and knowledge frameworks expressed as a quest to better understand what had happened and to identify positive coping strategies. • Building self-esteem and confidence. • Accessing supportive relationships and services such as counselling, community groups, and courses. • Ability to reflect and make choices, being self-aware, able to assess consequences and make good choices for themselves and their children. • Using good self-management and self-care strategies.
Interpersonal	• People who believe in and encourage them to achieve more. For example, being acknowledged for being good at something and valued; and not feeling judged. • Supportive relationships in childhood with significant people such as family members, carers and friends who provided love, stability and encouragement. • The development of trusting relationships during childhood tended to provide a foundation for good relationships later in life. • Breaking the intergenerational cycle of violence and addiction, and helping people understand violent relationships are not the norm.
Community and societal	• Early intervention for children and responsive service provision. Experiences of no action from authorities for help sought for childhood abuse, led many participants to distrust authorities and the non-disclosure of future abuse.

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[18] Participants included 26 Māori people, 18 Pākehā and five Pacific people, of whom two-thirds of were female and were aged 36 years on average (range 16-56 years).

	• Healing and rehabilitation for children, adults and whānau, such as accessing family violence and counselling services. This was beneficial in helping to understand the abuse experienced and developing coping strategies. • Services that are accessible and skilled at engaging with whānau. • Education services supporting children living in adverse environments. • Building skills and capability – education services supporting young people and adults back into education. • Support to get into employment, including initial involvement in some type of training and skills development as part of the motivation to journey towards long-term, positive and sustainable change. The accessibility of night schools, short courses and introductory courses were invaluable for building confidence and as first steps back into education.

Source: Carswell et al. (2017).

Māori people and resiliency

Studies demonstrate the notion of whānau resilience has a unique interpretation for Māori people (Carswell et al., 2017; Waiti & Kingi, 2014). While Māori people share similar resilience strategies to those found in western literature, there are cultural differences aligned with a Māori worldview and whānau dynamics. Māori culture and identity in general are factors which significantly contribute to wellbeing (Carswell et al., 2017). Whānau contribute to the wellbeing of whānau members through (Waiti & Kingi, 2014):

- whanaungatanga (networks and relationships)
- pūkenga (abilities and skills)
- tikanga (meanings, values and beliefs)
- tuakiri-ā-iwi (secure cultural identity).

For Māori people, supporting a whānau ora approach and intensive strengthening of capability and capacity of whānau through the strengthening of cultural practices, will allow growth in all areas of resiliency (Carswell et al., 2017).

Worker wellbeing and resiliency

Worker wellbeing refers to the extent to which workers perceive their lives as going well. It incorporates the degree to which they enjoy good physical and mental health and are resilient (Handran, 2013). Handran indicates worker wellbeing and resiliency are crucial and enhanced by an organisation creating a strengths-based trauma-informed culture. A strengths-based approach can be based on the compassion and satisfaction workers gain from working with people who have experienced trauma. Organisational support enables staff to feel confident the trauma services they are providing improves resiliency (Laschinger, 2001), and may help diminish the negative effects of compassion stress (Conrad & Kellar-Guenther, 2006).

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Section 2: What is a trauma-informed approach?

A trauma-informed approach recognises and understands trauma can negatively affect whānau, groups, organisations and communities, as well as individuals. People's experience and behaviour in response to traumatic events (their own or others) can be improved if systematically addressed through prevention, treatment, and achieving wellbeing.

The benefits, key principles and elements of a trauma-informed approach are discussed in this section. Different approaches are presented including an ecological approach and emerging approaches in New Zealand. Some specific examples used in prisons and mental health services are provided.

Principles of a trauma-informed approach

A trauma-informed approach is based on a set of principles, rather than a prescribed set of practices or procedures. It is about creating an organisational culture that embodies general principles or core values (SAMHSA, 2014; Trauma Informed Oregon, 2017). The six principles used by SAMHSA (2015) outlined in Table 7 are representative of principles evident in the literature. These principles include safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and understanding cultural, historical and gender issues.

Table 7. *Principles of a Trauma-Informed Approach (SAMHSA, 2015)*

	Principle	Description
1.	Safety	Looking after the physical and psychological safety of the organisation, workers, and people accessing services.
2.	Trustworthiness and transparency	Organisational operations and decisions are transparent and have the goal of building and maintaining the trust of workers and people accessing services.
3.	Peer support	People who have experienced trauma and healing are key people in establishing safety and hope, building trust, and enhancing collaboration to promote achieving wellbeing.
4.	Collaboration and mutuality	The organisation acknowledges everyone has a role to play in a trauma-informed approach by levelling power differences among all staff, and between workers and people accessing services. This recognises that healing happens in the context of relationships and the meaningful sharing of knowledge, power, and decision-making.
5.	Empowerment, voice and choice	Throughout the organisation and among workers and people accessing services, people's strengths and experiences are recognised, built on, validated, and new skills developed as necessary. The organisation aims to strengthen the experience of choice and recognise every person's experience is unique and requires an individualised approach.

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Principle	Description
6. Cultural, historical, and gender issues	The organisation actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age and geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognises and addresses historical trauma.

The draft refreshed *Let's get real* framework[19] (Ministry of Health and Te Pou o te Whakaaro Nui, 2018) includes several principles outlined in Table 7 (see Appendix B), and the need for workers to demonstrate an **understanding of the impact of trauma and loss on people's wellbeing**. Changes related to trauma-informed care in the current draft refreshed *Let's get real* framework include:

- the provision of a definition of trauma-informed care
- many of the principles and elements of trauma-informed care are reflected in the values and attitudes, such as trustworthiness, choice, collaboration, empowerment and safety
- recognition of individual, collective and historical intergenerational trauma for Māori people, and worker wellbeing
- the addition of indicators related to trauma-informed care to some Real Skills, such as those focused on working with people with experience mental health problems and addiction, Māori people, whānau; and maintaining professional and personal development.

Working in a trauma-informed way means taking a multi-level approach that considers processes and systems, the organisation, and individuals. Incorporating a trauma-informed approach into services shapes the whole environment and creates relationships that build trust and a sense of empowerment (Leitch, 2017).

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[19] Currently being finalised and will be published mid-2018.

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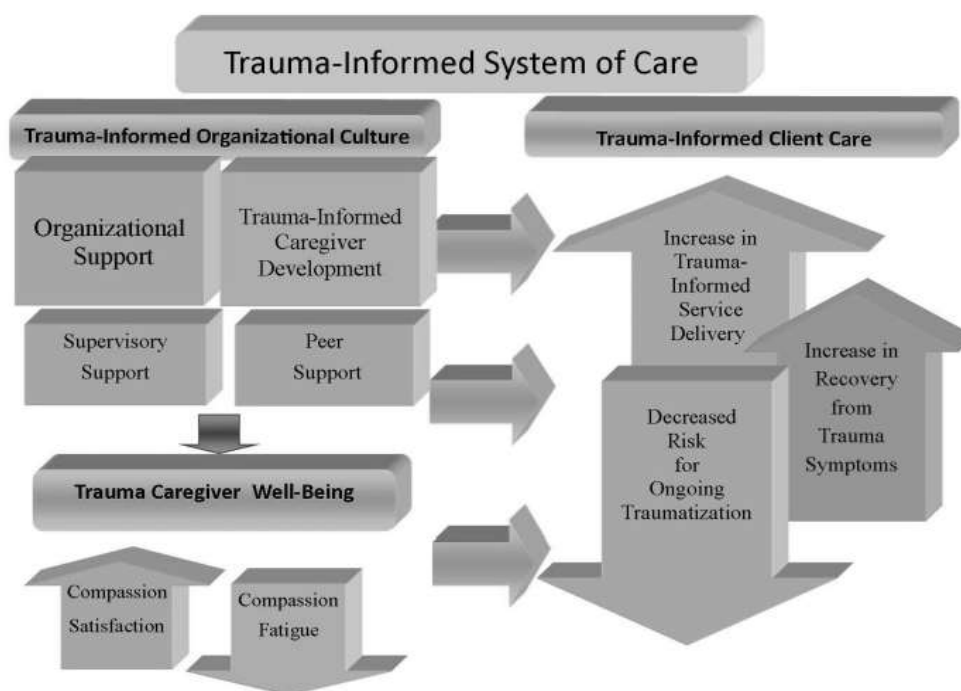
Figure 4. Trauma-informed system of care (Handran, 2013, p. 111).

Figure 4 is a representation of the various components of a trauma-informed system of care, demonstrating how the organisational culture and worker wellbeing aspects need to be in in place in the provision of support.

Key elements of a trauma-informed approach

Along with a set of principles, four key elements for a trauma-informed approach are outlined below (Cieslak et al., 2014; Isobel & Edwards, 2017).

1. Realisation of the widespread impact of trauma on people, families, groups, organisations, and communities; and an understanding of pathways to wellbeing.
2. Recognition of the signs and symptoms of trauma through understanding the profound neurological, biological, psychological, and social effects of trauma and violence on people; coupled with an ability to recognise the signs and symptoms of trauma in people accessing services, staff, and others.
3. Responding by integrating trauma knowledge into policies, procedures, programmes, and practice.
4. Avoiding the re-traumatisation of people accessing services, and the workforce. Trauma-informed care acknowledges the need for services to address the safety and wellbeing of staff who may experience indirect trauma or organisational or hierarchical disempowerment.

New Zealand research indicates trauma-informed care needs to include an additional element. In order to fully engage with the impacts of colonisation on the wellbeing of Māori people, the impact of historical trauma events and their contribution to negative health disparities experienced by many whānau (extended family), hapū (sub-tribes), and iwi (tribes), needs to be included (Pihama et al., 2014; Te Atawhai o Te Ao - He Kokonga Whare, 2016). Traditional narratives to support cultural healing influence Māori hauora (wellbeing) (Wirihana & Smith, 2014).

> At the heart of hauora are cultural protocols of whānau, whānaungatanga (familial relations and relations of care) and kanohi kitea (being present and with family), which are key social relationships within Māoridom. These form intergenerational safety nets. (Reid et al., 2014, p. 60)

Generational wellbeing and acknowledging the importance of ancestry through knowledge and discussion of whakapapa, can be valuable practices in relation to healing from trauma for Māori people (Wirihana & Smith, 2014).

Resilience

Trauma-informed care is a strengths-based model of care (Leitch, 2017). How a traumatic event is experienced, and the impact of the response, is linked to risk and protective factors (SAMHSA, 2015). There is a danger in over-focussing on negative risk factors and neglecting resilience and protective factors (Leitch, 2017). Any approach used needs to enhance the resiliency of people accessing services, to help reduce stress and the possibility of re-traumatisation (Leitch, 2017). The building of resiliency involves the complex interplay between various factors that allow people and populations to overcome, to some degree, the adversity they have experienced (Carswell et al., 2017).

Trauma-informed approach continuum

Different approaches have been used internationally by organisations and services to implement trauma-informed care. These approaches create a continuum of worker and organisational care, covering four stages of complexity (Mieseler & Myers, 2013; Wall et al., 2016).

1. Trauma aware: where staff understand trauma and how individuals may have behavioural presentations in response to traumatic experiences.
2. Trauma sensitive: where an organisation's work practice can operationalise some concepts of a trauma-informed approach.
3. Trauma responsive: where the individual and organisational response enables changes in behaviour and strengthens resilience and protective factors.
4. Trauma-informed: where the culture of the whole system reflects a trauma-informed approach in all work practices and settings.

Working within a trauma-informed model of care has been described as supporting services to move from a 'caretaker to a collaborator role' (Fallot & Harris, 2009). This means designing services to accommodate the unique vulnerabilities of people who have experienced trauma, and allowing for their wider participation in care planning (Butler, Critelli, & Rinfrette, 2011).

Benefits of a trauma-informed approach

The benefits of using a trauma-informed approach, based on a review of US studies (Sweeney, Clement, Filson, & Kennedy, 2016), include:

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- reduced seclusion use
- reduced post-traumatic stress symptoms and mental health issues
- increased coping skills
- improved physical health
- shorter inpatient stays.

Other benefits (Mental Health Coordinating Council, 2017) include:
- better outcomes than 'treatment as usual' for many symptoms, including a decrease in psychiatric symptoms and substance use (Cocozza, Jackson, & Hennigan, 2005; Kammerer, n.d.)
- improved daily functioning and decreased trauma symptoms (Morrissey, Jackson, & Ellis, 2005)
- decreased use of intensive services, such as hospitalisation and crisis intervention (Community Connections, 2002)
- improved staff morale, fewer negative events, and more effective services (Community Connections, 2002).

Ecological approach to traumatic experiences

The importance of taking an ecological approach to trauma in New Zealand has been highlighted (Adamson, 2005). An ecological approach considers an individual's cultural context and other factors that may directly or indirectly shape trauma responses (Hoshmand, 2007). Ecological approaches are already well utilised locally. For example, in social work practice an ecological approach is used as a theoretical framework. Figure 5 represents the cross-cutting factors that could influence cultural attitudes, behaviours, resources, and opportunities for a trauma-informed approach.
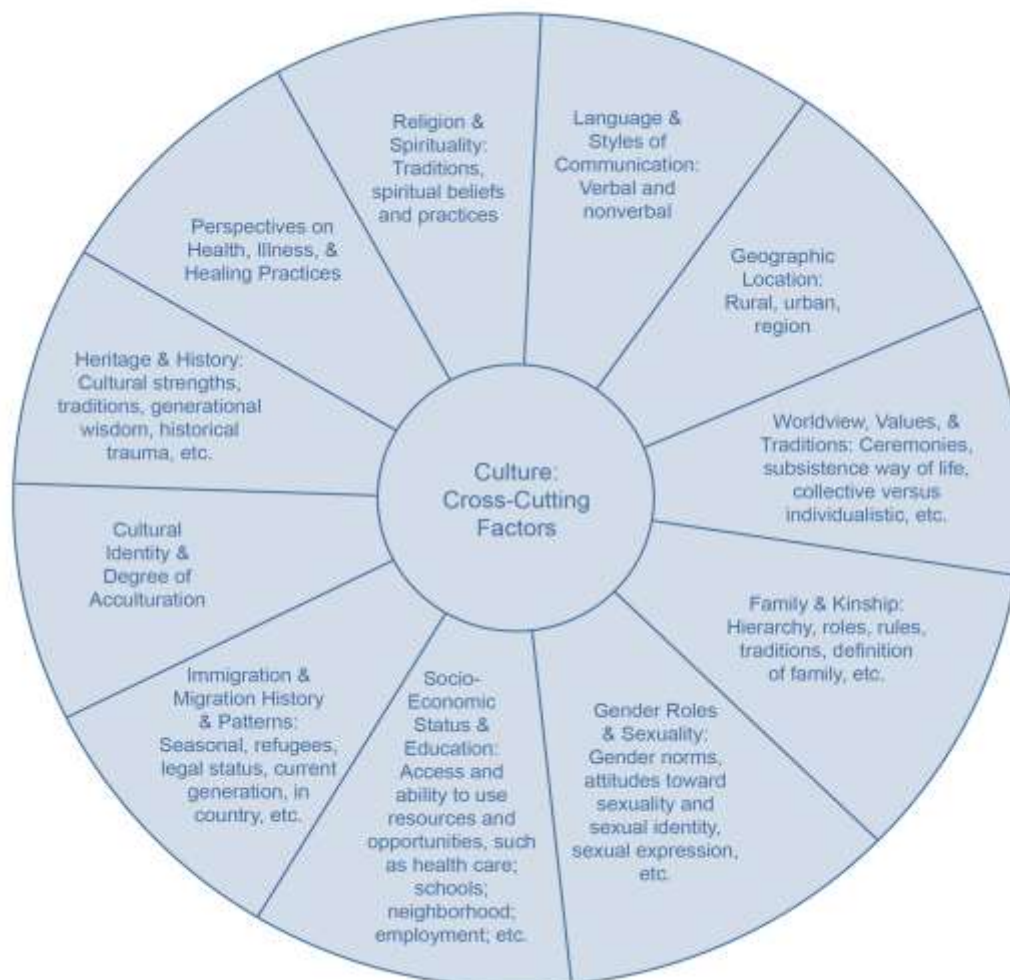

Figure 5. Ecological approach to traumatic experiences (SAMHSA, 2014, p. 26).

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New Zealand trauma-informed approaches

While not consistently applied, a trauma-informed approach is not new to most organisations providing mental health and addiction services in New Zealand. Trauma-informed approaches are beginning to be implemented.

Principles included within local approaches to trauma-informed care need to be contextualised and culturally safe (Pihama et al., 2017). Pihama and colleagues discuss factors important to cultural safety, including the principle of indigeneity and recognition of Māori worldviews. Indigeneity is a key principle in quality service provision for Māori people (Durie, 2003).

Recent work includes the Oranga Tamariki Ministry for Vulnerable Children (2017) evidence-based, theoretical perspectives for the development of systems, policies and practices to support children and whānau. This paper informs a New Zealand context with some key messages for a Te Ao Māori perspective when working with Māori children and whānau, see Table 8.

Table 8. *Key Messages for a Te Ao Māori Perspective when Working with Māori Children and Whānau*

Key factor	Key message
Te Tiriti o Waitangi	• Trauma and resilience occur within a cultural framework, and it is paramount Te Tiriti o Waitangi[20] relationships are clearly understood by those working across the cultural border. • Te Tiriti o Waitangi obligations to work in a bi-culturally informed way with mokopuna and whānau Māori.
Responsive cultural frameworks and models	• The experiences of Māori people, and their perspectives, are diverse, and therefore require responsive cultural frameworks and models of practice. • Understanding trauma and healing from tāngata whenua and tauiwi diverse cultural perspectives is pivotal in supporting the wellbeing of all children.
Trauma experiences	• As evidenced by Māori concepts such as tapu and mana, there are different cultural interpretations of, and influences on, how a child experiences trauma.
Historical trauma	• For tāngata whenua[21] who have experienced the trauma of colonisation, both collective and individual resilience is affected across generations, resulting in further vulnerability for mokopuna and influences the resilience of the collective: whānau, hapū and iwi.

Source: Adapted from Oranga Tamariki Ministry for Vulnerable Children (2017).

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[20] Treaty of Waitangi.

[21] Indigenous people.

These approaches are working to uphold Te Tiriti o Waitangi principles, obligations and relationships when working with Māori children and whānau. However, there appear to be gaps in the New Zealand context for a similar approach for adult mental health and addiction services. A recently published framework developed by the Ministry of Social Development, *Family Violence, Sexual Violence and Violence within Whānau: workforce capability framework* (2017), is specific to that sector, but may inform a wider trauma-informed approach. The purpose of this framework is to provide the workforce with a common understanding of family and sexual violence and is underpinned by universal principles for prevention, restoration, and transformation as illustrated in Figure 6.

Underpinning the principles of aroha, whanaungatanga, rangatiratanga, ūkaipō, manakitanga and kaitiakitanga, are six domains around which the framework is organised.

1. Understanding people's experiences of family violence, sexual violence and violence within whānau.
2. Upholding the dignity, values and beliefs of people and their diverse cultural identities.
3. Enabling disclosures and response to help seeking.
4. Using collective action to create safety for victims.
5. Using collective action to sustain safe behaviours of perpetrators.
6. Working as part of an integrated team.

The Whare Tapa Whā model also remains a relevant concept, representing four interconnected aspects of spiritual, social, physical and whānau wellbeing (Durie, 1995). This framework for understanding wellbeing is relevant for all people, but particularly so for Māori people (Mark, 2012), and may help put a trauma-informed approach into a meaningful context.

Further work on trauma-informed care is progressing. He Oranga Ngākau, based at Waikato University, aims to contribute to Māori models of health by exploring kaupapa Māori trauma-informed care practice principles. This research will inform the development of a framework to support both Māori and non-Māori practitioners working with whānau who have experienced trauma (Te Kotahi Research Institute, 2017). In the context of developing a unique local approach to trauma-informed care, the results of this study due to be released this year, will be important.

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Figure 6. Principles underpinning workforce capability framework for family violence, sexual violence and violence within whānau (Ministry of Social Development, 2017, p. 5).

Prison

A new programme for women managed by the New Zealand Department of Corrections, based on the work of **Professor Tracey McIntosh (Ngāi Tūhoe)**, is an example of an implemented trauma-informed approach. The programme is focused on stopping the intergenerational transfer of social inequality. The department manages around 750 women in prison and 6,000 in the community (over half are **Māori**), and have recognised the effect of trauma on women in prison (Department of Corrections, 2017a). Corrections has a new evidence-based programme *Wahine – E rere ana ki te pae hou: Women's Strategy* which aims to make treatment and management more specific to women to help address issues such as trauma and victimisation, mental health issues, unhealthy relationships, parenting difficulties, stress, and financial pressures. The focus is on giving

women the treatment, encouragement, counselling, skills and support they need to shape better futures for themselves, their children, and whānau (Department of Corrections, 2017b).

Mental health services

Within New Zealand's mental health inpatient services, work has been undertaken to support least restrictive practices and the elimination of seclusion, restraint and other restrictive practices. This work has been supported by the *Six Core Strategies©*, which include:

- leadership towards organisational change
- using data to inform practice
- workforce development
- use of seclusion and restraint reduction tools
- service user or consumer roles in inpatient units
- debriefing techniques.

A strong component of the *Six Core Strategies©* is ensuring services provide trauma-informed care, and the workforce uses strategies to support this approach. To support quality improvement within services, the *Six Core Strategies© Checklist – NZ Adaption* was created (Te Pou o te Whakaaro Nui, 2013). Research examining implementation of the *Six Core Strategies©* within services found clinical leaders introduced practical policy changes to reduce seclusion, which in turn allowed staff to interpret and respond to changes in ways meaningful to them (Webster, 2013). Ultimately these dual processes influenced the daily interactions of staff with people accessing services and led to reduced seclusion and restraint.

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Section 3: How can organisations implement a trauma-informed approach?

This section provides an overview on how organisations can implement a trauma-informed approach. Multiple strategies are needed for successful implementation to ensure trauma-informed care is embedded into systems, policies and practices within organisations (Oranga Tamariki Ministry for Vulnerable Children, 2017). Specific strategies are common in the literature (Ashmore, 2013; Muskett, 2014; Quadara, 2015; SAMHSA, 2014; Trauma Informed Oregon, 2017) and can be grouped into four broad areas.

1. Transferring knowledge to practice by realigning organisation processes and systems needed for the workforce and people accessing services.
2. Identifying barriers to implementation.
3. Addressing workforce wellness and safety.
4. Developing workforce skills and confidence needed to support people with experience of trauma.

These strategies are discussed further in this section.

Organisational culture, systems and processes

In order to support a trauma-informed model of care, a number of system level elements need to be in place (Ashmore, 2013; Quadara, 2015). Systems change can be described as the intentional process of changing the current state in order to translate the key principles of a trauma-informed approach into practice (Quadara, 2015). This requires planning and support (Isobel & Edwards, 2017). Sweeney (2016) emphasises the role of implementation science in supporting individuals and organisations to enact change faster than the present 10–15 year translational gap between research and implementation into practice. While not intended to be an implementation checklist, Table 9 summarises some common themes in the implementation process.

Table 9. *Some Common Themes for Supporting Effective Implementation*

Implementation area	Common features
Planned process of change	Creating awareness of gaps and needs based on evidence; gaining management commitment and priority for the organisation; and developing a planned and supported implementation strategy (Schaffer, Sandau & Diedrick, 2013).
Leadership	Clinical leaders and managers are highly visible and involved in planning for change. Implementation of a trauma-informed organisational culture needs to be an organisation-wide endeavour that starts at the top (Handran, 2013). This includes the allocation and support of a project planning role with access to monitoring, communication, and evaluation resources (Muskett, 2013).
Collaborative design and implementation	Leadership commitment and intent to support and work collaboratively with all staff and people accessing services (Quadara, 2015; Sweeney et al., 2016).

Implementation area	Common features
Identify implementation barriers	Identification of local barriers to be addressed to support implementation (see page 47 for some examples).
Co-design	Involve people accessing services and consumer advisors in planning and implementation (Sweeney et al., 2016). Co-design is based on mutuality and collaboration and builds trust with people accessing services.
Workforce wellbeing	Organisational systems and culture actively support the wellbeing of the workforce and avoid re-traumatisation. This includes identifying and acting on barriers to wellbeing in the workplace and creating effective systems to support a positive culture (Isobel & Edwards, 2017).
Staff commitment	The assessment and development of a culture and belief in the value of a trauma-informed approach, including an assessment of organisational readiness and all staff identifying what it means for their roles and support required (Muskett, 2014; Trauma Informed Oregon, 2017).
Build staff capability	Develop staff who are confident and competent in the knowledge of the prevalence and impact of trauma on people and understand their role in achieving wellbeing (Muskett, 2013). The most effective transfer of knowledge is when workers are engaged in the learning process; and active learning is delivered in a range of ways by providers, and is part of ongoing systematic processes (DeCanandia, Guarino & Clervil, 2014).
Supportive environments	Creating emotionally and physically safe environments which are welcoming for both staff and people accessing services (Muskett, 2014; Quadara, 2015), in which trauma is framed around 'what happened to you' as opposed to 'what is wrong with you' and responses are acknowledged. This includes having predictable organisational practices which are transparent and in discussion with people accessing services (Isobel & Edwards, 2017).
Understand population needs	Establishing an accurate picture of the trauma needs of people accessing services by using processes such as automatic screening for all (Muskett, 2014). For people accessing mental health inpatient services, who have not experienced trauma, a universal precautions trauma-informed approach is beneficial. Taking this approach assumes all people experience some degree of difficulty or trauma. This contributes to a responsive and supportive milieu and therapeutic engagement (Spector et al., 2014).
Understand Māori frameworks and models	An understanding of Māori frameworks and models to develop or maintain cultural connections and understanding frameworks towards healing and recovery (Oranga Tamariki Ministry for Vulnerable Children, 2017). Using the guiding principles of tikanga, te reo Māori, whakamanawa, wairuatanga, kaitiakitanga, whakapapa, manaakitanga and rangatiratanga, to

Implementation area	Common features
	assist practitioners in engaging with Māori people and their whānau (Child Youth and Family, 2016).
Evaluate outcomes	Use of written plans and procedures to develop methods to identify and evaluate improvements and outcomes (Trauma Informed Oregon, 2017). Development of processes for long-term sustainability and reinforcement, for example ensuring people have enough time to implement practice changes and receive evaluative feedback (Schaffer et al, 2013).

Bryson and colleagues (2017) sum up effective strategies for the implementation of trauma-informed care in mental health inpatient settings as including senior leadership commitment; sufficient staff support; amplifying the voices of people accessing services and families; aligning policy and programming with trauma-informed principles; and using data to help motivate change.

In New Zealand, Ashmore (2013) reiterated the importance of using best practice change management principles in implementing a trauma-informed approach, including a facilitative organisational culture, use of champions, organisation-wide support, resources and training. At a national level other factors were identified as important, including:

- a national agenda to pursue changes to mental health systems
- less siloed funding arrangements that actively facilitate partnerships
- access to resources and training, supported by adequate funding, to guide implementation.

Potential barriers to implementation

Many evidence-based practices and interventions fail to translate into health care practices and improved outcomes for people (Damschroder et al., 2009). International research and development over the last 20 years has provided a raft of literature on the implementation of evidence-based practices in health service. The identification of barriers is seen as a key initial step in implementation (Johnson, 2015).

Some barriers to implementing a trauma-informed approach identified are listed below.

- A strong resistance by many to the acceptance of trauma and adverse events in childhood as having a causal role in psychosis and mental distress (Sweeney et al., 2016).
- Widespread resistance to change due to a lack of knowledge and confidence in the ability to work in a trauma-informed way (Isobel & Edwards, 2017; Quadara, 2015).
- Introducing new models of care or concepts of care can be seen as time-consuming and viewed as 'another change' imposed on staff (Muskett, 2014; Sweeney et al., 2016).
- Stand-alone training and education programmes continue to be the primary approach to developing skills, knowledge, and practices within health workplaces, including mental health (Wensing & Grol, 2005). However, evidence indicates the provision of training and education alone has limited uptake and maintenance of new, evidence-based methods into practice (Torrey, Bond, McHugo, & Swain, 2012).

- The use of the word 'trauma' is seen by many nurses as emotive and open to misinterpretation (Isobel & Edwards, 2017).

New Zealand context

Within the New Zealand context, some barriers to implementing trauma-informed care have been identified. Some are like those identified internationally, others are particular to the New Zealand context.

One barrier to the effective implementation of trauma-informed services, not only in New Zealand but within indigenous populations globally, includes a lack of knowledge and acceptance in western societies to the effects of historical and cultural trauma (Pihama et al., 2014; Pihama et al., 2017). For Māori people, further exploration and identification of practice principles is needed to understand how to implement culturally specific interventions within a trauma-informed approach (Pihama et al., 2017). Pihama and colleagues (2017) also claim one of the limitations for an effective trauma-informed care approach for Māori people is the dominant position psychiatric definitions and associated service structures have within health services.

As identified internationally, resistance to change due to a lack of knowledge and confidence in the ability to work in a trauma-informed way has been identified as a barrier (Ashmore, 2013; Sampson & Read, 2017). Sampson and Read (2017) found mental health staff did not know how to ask about sexual abuse or neglect, or respond to disclosures. These authors examined the extent to which abuse and neglect were identified and recorded by mental health services in 2017 compared with 10 years earlier. Significant increases were found in the asking rates of childhood sexual and physical abuse, and adulthood sexual assault. Despite improvements, it was concluded mental health services are still missing significant amounts of childhood and adulthood adversities, especially neglect (Sampson & Read, 2017).

Some services in New Zealand have a policy of screening for trauma. However, Ashmore (2013) found there was little evidence of implementation of a trauma-informed approach when it was not well resourced. Further barriers to implementation within mental health services identified by Ashmore (2013) are described below.

- The use of a traditional model of care underpinned by the medical model that creates two sources of power imbalance. The first is between clinicians and people accessing services; the other between staff themselves.
- Lack of clear policies and guidelines.
- Lack of a clear definition of what trauma-informed care is and how to translate principles into practice.
- Lack of management capacity to introduce philosophical changes in services.
- Fragmentation of funding as a barrier to implementing integrated care.
- Limited knowledge of best practice change management principles.

These findings are consistent with those reported by Peters (2017) in preliminary discussions with people actively working in health, mental health, and addiction services, where barriers to implementation identified included organisational culture, staff attitudes, and knowledge gaps.

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Workforce wellness and safety

Supporting the workforce is a critical first step to implementing a trauma-informed approach. Many workers may have their own lived experience of trauma, and workplace factors are critical for the wellbeing of workers (Brockhouse et al., 2011; Handran, 2013; Paller & Perkins, 2004; SAMHSA, 2014). People who feel supported by their organisation are at a lower risk of developing vicarious trauma, secondary traumatic stress, and job burnout (Handran, 2013). Staff wellbeing refers to the extent to which workers perceive their lives as going well. It incorporates the degree to which they enjoy good physical and mental health and are resilient.

The Mental Health Commission of Canada (Canadian Standards Association, 2013) has proposed a number of workplace factors that need addressing to promote the wellbeing of staff, and to prevent harm to people's mental health in negligent, reckless, or intentional ways. The factors outlined in Table 10 are consistent with Pack's (2013) comprehensive framework for wellbeing in the workplace, with the inclusion of factors such as meaning and purpose; choice and autonomy; camaraderie and teamwork; daily improvement; wellness and resilience; and real-time measurement.

Table 10. *Workplace Factors to Promote Workers' Wellbeing*

Organisational culture	Involvement and influence
• Psychological and social support • Clear leadership and expectations • Civility and respect • Psychological demands • Growth and development • Recognition and reward	• Workload and management • Engagement • Balance • Psychological protection • Protection of physical safety

Source: Canadian Standards Association (2013).

Organisation strategies to support worker wellbeing

Supporting worker wellbeing means using a combination of both organisational and individual measures (Bährer-Kohler, 2012; McGilton, Hall, Wodchis, & Petroz, 2007). Organisational strategies that protect workers' wellbeing have more impact than reactive measures to staff stress and burnout (McGilton et al., 2007). Evidence points to several protective factors from secondary traumatic stress and vicarious trauma such as:

- organisation culture
- supervisors and managers who are themselves trauma-informed
- an individually determined self-care regime.

Developing and maintaining a culture in the workplace, that reflects the values and beliefs needed to support the workforce, is the ultimate responsibility of senior leaders (Bährer-Kohler, 2012; McGilton et al., 2007; Pack, 2012). Safety, support, and trauma awareness are the specific components crucial for an organisation to

promote the wellbeing of staff who provide services to people who have experienced trauma (Handran, 2013). Trauma awareness and timely education about vicarious trauma are protective factors for staff (Pack, 2013). Webster (2013) suggests a reduction in symptoms of secondary traumatisation may be gained by the education of all staff on how working with people who have experienced trauma may affect their own wellbeing. In addition, Rakei (2016, p. 91) indicates spirituality is an important protective factor in the New Zealand context:

> Spirituality for Māori is an important component for mental health and wellbeing. These cultural and spiritual practices aid in buffering and ameliorating some of the effects of vicarious trauma.

There is a relationship between the amount of time spent providing direct services to people who have experienced trauma, and secondary traumatic stress (Handran, 2013). This finding suggests a reduction in caseloads and balancing the nature of trauma workers are hearing about from people accessing services, may be important considerations in the prevention of secondary trauma. The redesign of work flow and capacity have been shown to support staff wellbeing by reducing stress (Linzer et al., 2015), for example:

- changing call schedules
- reassigning clinic staff work
- including meaningful meetings for clinicians, such as discussions about clinical cases and work life
- listening and acting on clinician's concerns around automated prescription and routine screening processes.

NCETA (2017) discusses a range of organisation programmes and interventions aimed at enhancing worker wellbeing, including:

- broad based health promotion
- workplace wellness programmes
- effective supervision (line management, peer, clinical, cultural and/or group as appropriate)
- performance appraisals
- effective leadership
- addressing organisational structures and practice
- encouraging help seeking behaviours in the workplace
- enhancing worker resilience.

All New Zealand workplaces must comply with the *Health and Safety at Work Act* (April 2016). Employers need to ensure initiatives are in place to reduce workplace stress, including:

- having health and safety policies and procedures
- ensuring workplace stress is on a hazard register
- monitoring stress indicators
- providing training on stress and techniques for dealing with it for staff and managers
- implementing a culture where staff are encouraged to report workplace stress without fear of retribution or inadequacy.

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Work and health have a two-way relationship as illustrated Figure 7 (WorkSafe NZ, 2017). Workers can become unwell or develop poor health from their work and work environment. Similarly, poor mental or physical health may reduce a worker's ability to work safely and productively. WorkSafe highlights the important role organisations have in protecting workers' health and promoting mental and physical wellbeing.[22]
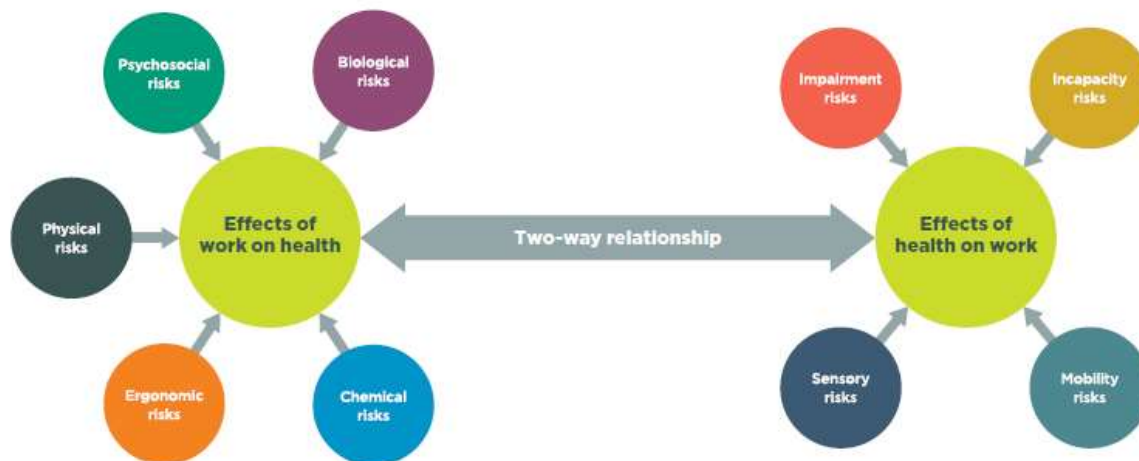

Figure 7. Two-way relationship between health and work (WorkSafe NZ, 2017).

Bullying
In protecting the health and wellbeing of workers, organisations needs to manage bullying as a workplace hazard and prevent the physical and psychological harm (including stress) which may result.

Progress on protecting the wellbeing of the workforce is underway. In October 2017, the World Medical Association adopted the New Zealand Medical Association's (NZMA) policy condemning bullying and harassment in the medical profession (World Federation for Mental Health, 2017). Workplace policies and practices need to be in place to reduce instances of bullying and proactively address it when it does occur (Maslach & Leiter, 2008). These policies and practices also include support for worker self-care as a mitigating factor in lowering the risk of developing trauma in the workplace (Handran, 2013).

Worker self-care
While organisations need to be accountable for supporting worker wellbeing, there are individual strategies of self-care that are universally recognised as a key aspect of worker wellness and resiliency.

> Self-care for individual professionals and teams, who are regularly exposed to distress and tension in their workplace, is a vitally important component of best practice. Attention paid to self-care supports

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[22] WorkSafe NZ is the government body enforcing workplace health and safety legislation, which provide a range of information and guidance about health and safety in the workplace. See WorkSafe NZ http://www.worksafe.govt.nz/worksafe/information-guidance/work-related-health

a professional approach in the workplace and the personal health and wellbeing of the professional. Communication in tense and distressing situations is more likely to be positive, confident and collaborative if the professional's own health and wellbeing is optimal. Communication under pressure and in difficult circumstances is a skill that requires development and reflection over time. Some people find this easier than others and, for some staff, such communication can trigger their own personal issues and circumstances. (Te Pou o te Whakaaro Nui, 2015, p. 45)

Self-care has been highlighted as important for doctors. A New Zealand doctor's amendment to the modern Hippocratic Oath sworn by all doctors, was ratified unanimously by the World Medical Association in October 2017. The Physician's Oath, first adopted in 1948, is a modern version of the ancient Hippocratic Oath and is the vow read out by doctors when they qualify. The Hippocratic Oath was amended to include the clause "I will attend to my own health, well-being, and abilities in order to provide care of the highest standard". Until now, the declaration had no provision relating to self-care (Radio New Zealand, 2017).

Recommendations for mental health workers to promote and plan for wellbeing are summarised in Table 11. Rakei (2016) also recommended strategies for mental health workers to manage the effects of vicarious trauma, including supervision, professional support, trust, being real, good organisational resources, having fun, not taking work home, and having a positive interest in helping others. Pack (2013, p. 74) commented:

> A formal individualised plan to prevent vicarious trauma is needed to be developed with the worker, the clinical supervisor and organisational support to encourage a range of self-care.

Pack recommended self-care plans consider not only individual level strategies, but also relationships with significant others, and the workforce as a whole. Positive relationships within the workplace provide professional, emotional and social support and can help provide safe and supportive working environments (Handran, 2013).

Table 11. *Recommended Strategies Promoting Mental Health Workers' Wellbeing*

Recommended strategies
• Mindfulness
• Trauma-informed clinical supervision
• Debriefing
• Employee Assistance Programme (EAP)
• Written self-care plan
• Peer networks or groups

Source: Byron et al., 2015; Handran, 2013; Knight, 2013; Pack, 2012, 2013; Te Pou o te Whakaaro Nui, 2015.

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Developing workforce capability

A commitment is needed from organisations to supporting the ongoing training of employees' awareness, knowledge and skills, so they are confident and capable of providing safe and effective trauma-informed care (DeCanandia et al., 2014; Mental Health Coordinating Council, 2017). Training in trauma-informed care benefits staff, and all levels of the organisation (Morrissey et al., 2005).

The specific skills recommended differ in the literature, with more recent research emphasising safety and harm reduction within a cultural context, more so than earlier recommendations. For example, earlier recommendations by an international expert consensus panel convened in the US (Weine et al., 2002) described core components of trauma-informed training as including:

- listening and counselling skills
- recognising problems, and knowing how to assess appropriately
- familiarity with established interventions and understanding the local context
- using problem-solving strategies to work with the individual, family, community, and local resources and agencies
- knowing appropriate treatment approaches for medically unexplained somatic pain (SAMHSA, 2014, p. 105).

The Australian Mental Health Coordinating Council's paper, the *National Strategy on Trauma-Informed Care and Practice* (2017, p. 38), concludes:

> In order to ensure safety and reduction of harm, curriculums used for orientation and basic training should cover dynamics of re-traumatisation and how insensitive practice can mimic original abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability and socio-economic status on individuals' experiences and perceptions of trauma and their unique ways of coping or healing.

The NHS Education for Scotland (2017), recognises the need for staff to understand the knowledge, skills and competencies required to successfully deliver quality, evidence-based trauma-informed services. The framework *Transforming Psychological Trauma*, outlines capabilities in relation to four-tiers of workforce development which reflect the range of staff member roles. The framework supports a phased approach to understanding recovery from trauma. Within each workforce tier there are four specific focus areas which include:

- being safe and protected from harm
- coping well
- processing and making sense of trauma
- living the life you choose.

As shown in Figure 6 (page 42), the Ministry of Social Development recently developed the *Family Violence, Sexual Violence and Violence within Whānau: workforce capability framework* (2017), which is specific to that

sector, but may be applicable to others. The framework categorises the workforces' response into three levels: primary, specialist, and leadership. The required knowledge, benchmarks, and actions expected of the workforce at each level are described under each of the six domains (see Figure 6 page 429).

In summary, some national and international capability frameworks help describe the knowledge and skills required to deliver safe and effective trauma-informed services, which may be relevant for mental health and addiction services in New Zealand.

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Conclusion

This literature scan was undertaken to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness. The scan provides evidence about why a trauma-informed approach is important for service delivery; what a trauma-informed approach looks like; and how this can be implemented in practice. The review supports greater understanding of the prevalence of potentially traumatic events in people's lives; the impact these have on the wellbeing of individuals, groups and communities; the importance of resiliency in overcoming adversity; and the need to consider the health and wellbeing of the workforce to achieve better outcomes for people with experience of trauma.

Many people in New Zealand experience trauma. Over half of adults in the general population, and two-thirds of Māori people have experienced trauma in their lifetime. Death of a loved one, witnessing violence to others, and experiencing interpersonal violence are among the most common and negative events experienced.

New Zealand has high rates of family, intimate partner, and sexual violence. Compared to other countries, New Zealand has one of the poorest rates of childhood sexual abuse. However, many sexual offences are not reported. Within mental health services, a large proportion of people may have experienced trauma, including physical or sexual assault.

The effects of trauma are multifaceted and diverse. Common immediate and delayed reactions to trauma can affect the emotional, physical, cognitive, behavioural and existential wellbeing of people. Trauma also increases the risk of mental and physical health problems across the lifespan and generations. A person's response to trauma events throughout their lifetime is however dependent on the balance between risk and protective factors.

A trauma-informed approach means working in a compassionate, knowledgeable and responsive way with people who have experienced trauma, and colleagues. Principles and key elements describe a way of working to ensure the safety, integrity, support and empowerment of people accessing mental health and addiction services, and workers. A focus on individual strengths and competencies is essential. From the perspective of people accessing services this means being part of a transparent and collaborative care approach, based on a holistic understanding of the neurological, biological, psychological, social and spiritual effects of trauma and violence, on individuals and whānau.

The implementation of a trauma-informed approach requires an intentional organisational change process that identifies and addresses barriers; ensures leadership support and resourcing; supports collaborative co-design and planning processes; builds staff commitment; and provides evaluation and sustainability support.

For worker wellbeing, organisations need to ensure there is a positive, supportive, no-blame culture in the workplace; and workers are supported to put in place individually determined self-care regimes.

Developing workforce knowledge, skills and confidence is required to successfully deliver quality, evidence-based trauma-informed services. Some knowledge and skills frameworks are available overseas, and some New Zealand frameworks are emerging. However, there is generally gaps in research and resources supporting adult mental health and addiction services in New Zealand to use a trauma-informed approach. This includes a knowledge and skills framework specifically for this workforce.

Other gaps are specific to a New Zealand way of working and culture. These include the use of co-design principles when planning for service change. Co-design meaning not only the involvement of people with lived experience in the process, but also other groups who are particularly impacted by traumatic experiences and tāngata whenua. An awareness by leaders and managers of Māori frameworks and models to develop or maintain cultural connections and understanding frameworks towards healing, is identified as necessary within a process of implementation, but a gap in research to date. This includes having an understanding that trauma within a New Zealand context means traumatic experiences may include both individual and collective responses, particularly for Māori people.

A trauma-informed approach includes building on resilience and focusing on strengths. There are however gaps in how this is included within principles and elements in overseas models. Work in New Zealand is needed to build on resiliency for the general population, people with experience of mental health and addiction, and the workforce. This includes work on asking people about traumatic events as an integral aspect of care, as well as strengths and resilience factors.

Looking to the future, policies at both national and organisational levels need to make provision for mental health and addiction services to be trauma-informed and culturally safe. The development of a unique trauma-informed approach for New Zealand, particularly one that works for Māori people is essential. This approach needs to address individual, collective, and historical trauma, as well as the wellbeing of workers. The collaborative development of principles and key elements to inform a national approach for trauma-informed care is needed.

In conclusion, all people need to be aware of the prevalence and impact of trauma and how a trauma-informed approach applies to their work. Organisations need to enable systems and processes to support a trauma-informed approach and provide leadership for implementation. Consideration of the wellbeing of workers is also paramount. Implementation of a trauma-informed approach across the continuum of health services will not only benefit workers and organisations, but also people accessing services – whether these are in the community or specialist mental health and addiction services.

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Appendix A: Mental Health and Addiction Workforce Action Plan intervention logic

New Zealand Health Strategy: All New Zealanders live well, stay well, get well in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in smart system.			

People are thriving and experience wellbeing

Outcomes: What are our goals for New Zealanders?

New Zealanders experience joined-up care delivered by an integrated, competent, capable, high-quality and motivated health workforce focused on improving health and wellbeing

Pae ora – healthy futures

Mauri ora (healthy individuals)   Whānau ora (healthy families)   Wai ora (healthy environments)

Impacts: What difference will it make?

1 A workforce that is focused on people and improved outcomes	2 A workforce that is integrated and connected across the continuum	3 A workforce that is competent and capable	4 A workforce that is the right size and skill mix

Outputs: What actions are we taking?

1.1 Implement an outcomes approach by commissioning workforce development in line with the New Zealand Health Strategy and national frameworks. 1.2 Develop strong leadership programmes and pathways at all levels to support the changing environment. 1.3 Use data gathered to revise and adapt the workforce development infrastructure (national, regional and local) to ensure expected outcomes are being met.	2.1 Enable a more mobile, responsive workforce that can adapt to new models of care. 2.2 Strengthen collaborative ways of working to deliver coordinated and integrated responses. 2.3 Facilitate health and other agencies to share information, knowledge and resources they can use to address the social determinants of health.	3.1 Build capability across the health workforce to respond to mental health, addiction and physical health issues. 3.2 Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses. 3.3 Strengthen and sustain the capability and competence of the mental health and addiction workforce. 3.4 Strengthen the workforce's capability to work in multidisciplinary ways.	4.1 Use workforce data to understand the current and future size and skill mix of the workforce. 4.2 Grow and develop the Māori workforce. 4.3 Develop recruitment and retention strategies to address shortages and grow the Pacific, peer and consumer workforces. 4.4 Develop mental health and addiction career pathways both for those already working in health and social services and for new recruits.

Glossary

Māori word/phrase	Meaning
Aroha	Love, sympathy, empathy, compassion
Hapū	Subtribe, a grouping of kin whānau
Hauora	Health, well-being
Iwi	Tribe, a larger grouping of kin hapū
Kaitiakitanga	Guardianship, the right to be guardians
Kanohi kitea	To be seen, to be present, to be relevant
Kaupapa Māori	Organisations, schools or anything where the foundation is based on an ethos of Māori worldviews
Mana	Prestige, authority, control, power, influence, status, charisma
Māoridom	Colloquialism for te ao Māori – the Māori world and inherent Māori worldviews
Manaaki	To look after, care for, tend, foster, extend hospitality
Manaakitanga	The process of extending hospitality
Mokopuna	Grandchildren, coming generations
Pūkenga factors	Skill factors
Rangatiratanga	Self-determination, right of decision making
Tāngata whenua	Plural form of indigenous people, people of the land
Tapu	Sacred, prohibited, restricted
Tauiwi	Non-indigenous people
Te Ao Māori perspective	A perspective from a Māori world view
Te Reo Māori	The Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
Tikanga	Appropriate action, custom, protocol, etiquette
Tuakiri-ā-iwi factors	Factors of identifying oneself via iwi (tribe)
Ūkaipō	Origin, original home, mother, source of sustenance
Wairuatanga	Spirituality
Whakamanawa	To urge, excite, encourage
Whakapapa	Genealogy, descent, ancestry
Whānau	Family, can include nuclear and extended family
Whanaungatanga	Relationships, kindred spirit

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