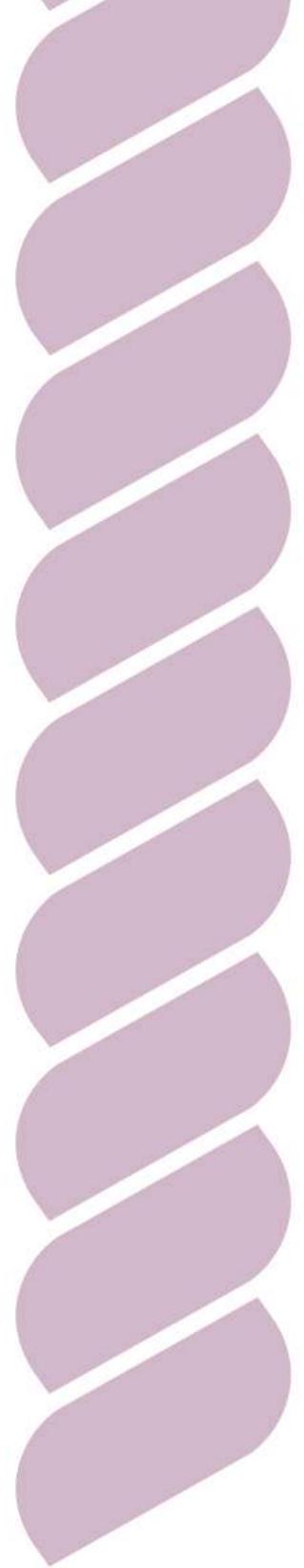


Trauma-informed care

Literature scan
Section three

May 2018



**Te Pou o te
Whakaaro Nui**

About this document

This publication is extrapolated from the *Trauma-Informed Care: Literature Scan* (Te Pou o te Whakaaro Nui, 2018) [ADD LINK](#)

In 2018, Te Pou o te Whakaaro Nui conducted a literature scan to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness, and factors supporting implementation. This scan was intended to inform a national approach to trauma-informed care and help identify future **intersectoral work**. **In New Zealand, it is important to consider the unique context of Māori 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.

The literature scan described why using a trauma-informed approach is important, what it involves, and how organisations can implement it. The report has three sections.

- Section one: includes definitions of trauma, the prevalence of traumatic events, and the potential impact on people and the health workforce.
- Section two: describes the benefits, key principles and elements of a trauma-informed approach.
- Section three: considers evidence on factors supporting the successful implementation of a trauma-informed approach.

This publication is section three of the literature scan. The reference list can also be accessed in the full publication.

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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 1 summarises some common themes in the implementation process.

Table 1. *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).
Identify implementation barriers	Identification of local barriers to be addressed to support implementation (see page 7 for some examples).

Implementation area	Common features
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 assist practitioners in engaging with Māori people and their whānau (Child Youth and Family, 2016).

Implementation area	Common features
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.

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 2 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 2. *Workplace Factors to Promote Workers’ Wellbeing*

Organisational culture	Involvement and influence
<ul style="list-style-type: none"> • Psychological and social support • Clear leadership and expectations • Civility and respect • Psychological demands • Growth and development • Recognition and reward 	<ul style="list-style-type: none"> • 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.

Work and health have a two-way relationship as illustrated Figure 1 (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.¹

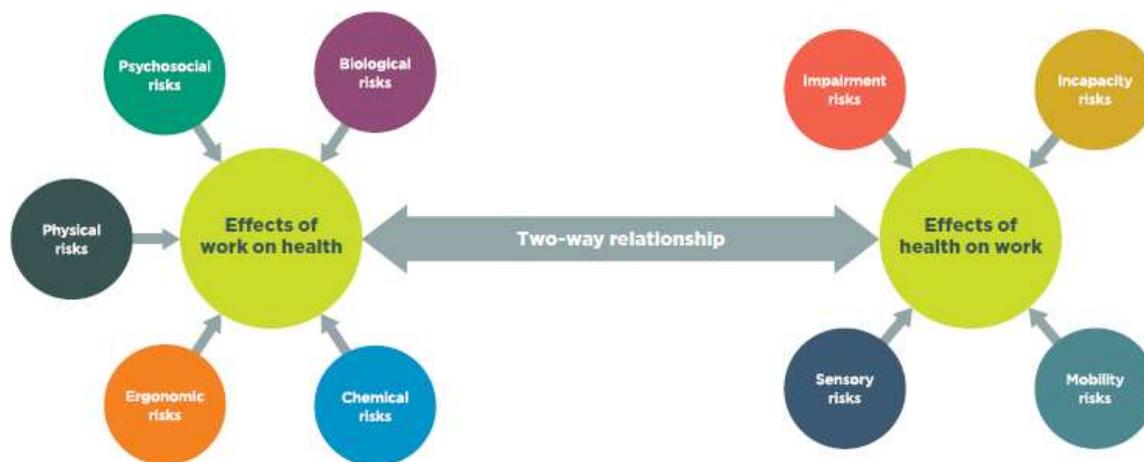


Figure 1. Two-way relationship between health and work (WorkSafe NZ, 2017).

Bullying

In protecting the health and wellbeing of workers, organisations need 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 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

¹ 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>

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 3. 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 3. *Recommended Strategies Promoting Mental Health Workers' Wellbeing*

Recommended strategies
<ul style="list-style-type: none">• 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

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 (in the full document), 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.

Summary

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.

