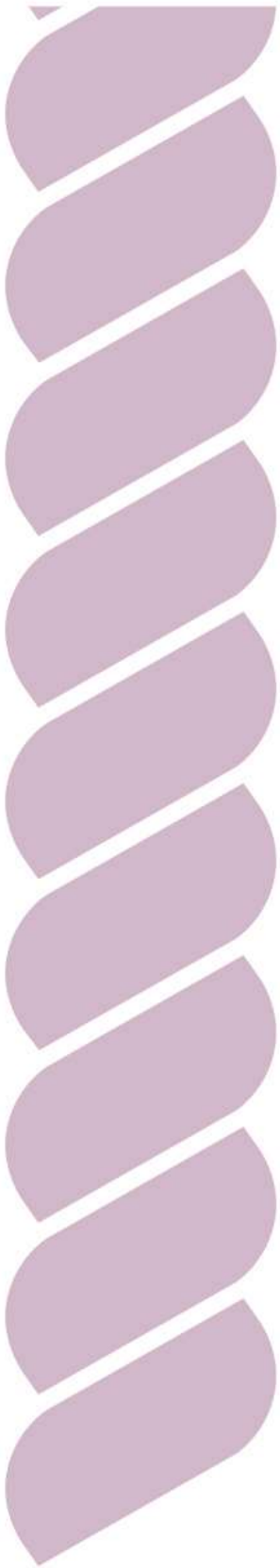
Trauma-Informed Care:

Literature Scan Summary Report



Te Pou o te Whakaaro Nui

Published in May 2018 by Te Pou o te Whakaaro Nui

Te Pou o te Whakaaro Nui is a national centre of evidence-based workforce development for the mental health, addiction and disability sectors in New Zealand.

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ISBN 978-1-98-855101-2

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Introduction

This report is a summary of the findings from a literature scan undertaken to better understand evidence-based approaches to trauma-informed service delivery and workforce responsiveness, and factors that can support implementation. This is intended to inform a national approach to trauma-informed care, which also reflects the experience of Māori as tāngata whenua and includes the historical and intergenerational aspects of trauma.

Many people have had past experiences of traumatic events. People who access mental health and addiction services are estimated to have experienced more trauma than the rest of the population. Trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences can also occur among workers who support people who have experienced trauma. 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; SAMHSA, 2015). The adverse effects of trauma may impact people's mental, physical, social, emotional and spiritual wellbeing.

Developing a workforce that understands the impact of trauma on a person's wellbeing, including for themselves, is important in gaining the best possible wellbeing. As is ensuring that an organisation, service or team deliver services using a trauma-informed approach. There is an expectation that 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 service delivery. These expectations are outlined in *Rising to the Challenge*, and the *Mental Health and Addiction Workforce Action Plan,* and are linked to supporting least restrictive practices (including reducing and eliminating restraint and seclusion) (Te Pou o Te Whakaaro Nui, 2017b).

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)

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

Any discussion of trauma in Aotearoa New Zealand must be underpinned by a cultural context of the Treaty of Waitangi, Te Ao Māori[1] and the realisation that Māori people, as the indigenous people of this land, come from a place of individual and collective intergenerational trauma as a result of colonisation must inform all trauma approaches. The Treaty, in its purest context, is about - and informs - relationships. Relationships between The Crown and Iwi, the Government and citizens of Aotearoa 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 worldveiw and can provide healing from the intergenerational trauma of colonisation (Opai, 2018).

Literature scan

A broad literature search of electronic databases was undertaken to find research from the past six years involving trauma and behavioural health (including both mental health and addiction); the implementation of a trauma-informed approach; as well as worker wellness, secondary trauma, vicarious trauma and indirect trauma. The scan revealed the literature on the concept of trauma-informed care and trauma-informed approaches has to date been based mostly 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 have been shown to 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. 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. Trauma experienced as a result of ACEs increase the likelihood as an adult of experiencing an array of health problems such as long-term pulmonary disease and liver disease; and other problems including addiction to alcohol and other substances (Centers for Disease Control and Prevention, 2014). Adults who have experienced sexual abuse, intimate partner violence, violence by non-partners, a serious crime, active hostilities during war, workplace physical violence and bullying are also at risk of developing mental health issues (Volpicelli, Balaraman, Wallace, & Bux, 1999). These experiences may add to the effects of ACEs or be associated with ACEs (VicHealth, 2004).

[1] The Māori World/Māori Worldveiws

[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

A large proportion of people who experience mental health and addiction issues are likely to have experienced trauma (SAMHSA, 2014). In a review of the literature about trauma-informed care in inpatient settings, Muskett (2013) concluded that people needing trauma-specific services represent the greatest proportion of people accessing public mental health, forensic health, and drug and alcohol services. A recent Australian study of people with early psychosis for example found over three-quarters reported exposure to childhood trauma (Duhig, Patterson, & Connel, 2015). Aotearoa New Zealand has high rates of childhood sexual abuse compared to other countries (Global Health Metrics, 2017). 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. Aotearoa New Zealand's index score for childhood sexual abuse was two out of 100[5], with only six countries doing as badly or worse.

Within the Aotearoa New Zealand prisoner population there are high rates of lifetime exposure to potentially traumatising events (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 a large proportion have PTSD (54 per cent of women and 40 per cent of men) (Indig, Gear, & Wilhelm, 2016). Indig and colleagues (2016) also report that among women in prison 68 per cent have been victims of family violence, and 62 per cent have experienced coexisting mental health and substance problems sometime in their lifetime.

Experiencing psychiatric symptoms resulting in functional impairment could be considered the *norm*, not the exception (Schaefer et al., 2017). Informed by data from the Dunedin longitudinal study, these authors found only 17 per cent of repeatedly assessed study members managed to reach midlife (age 38) without experiencing such symptoms at some point in their life. For many this effect is transient so the response to trauma is the emotional and behavioural functioning at the present time.

Commonly reported traumatic events among adults include death of a loved one; witnessing or experiencing violence; serious injury to self, friends or family; and natural disasters. 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).

The historical and contemporary factors contributing to whānau violence are acknowledged as complex (Dobbs & Eruera, 2014; Pihama et al., 2014; Wirihana & Smith, 2014). Research indicates 65 per cent of Māori people in Aotearoa New Zealand have experienced one or more traumatic events during their lifetime (Hirini et al., 2005). Māori people are also 10 times more likely to have experienced multiple forms of racism and discrimination than other ethnic groups (Harris et al., 2006). Some historical trauma researchers (Whitbeck, Adams, Hoyt, & Chen, 2004; Yellow Horse Brave Heart, 2003) have attempted to show that there is a cluster of symptoms particular to those who have experienced historical trauma and that these symptoms together constitute a syndrome: historical trauma response.

A person's response to trauma events throughout the course of their lifetime depends in part on the balance between risk and protective factors (Carswell, Kaiwai, Hinerangi, Lennan, & Paulin, 2017). Carswell and colleagues suggest the complex interaction between risk and protective factors leads to a person's resilience, which evolves

[5] The index scoring used in the study was on a range from 0 to 100, with 0 being the worst score.

over time, and leads to responses to further outcomes. Resilience was described in this Aotearoa New Zealand study as the capacity to achieve developmental milestones, such as education and employment, in spite of adversity in childhood (Carswell et al., 2017). Resilience strategies can be divided into individual, interpersonal and community/societal factors. 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 overall wellbeing (Carswell et al., 2017). Examples of ways that whānau in particular contribute to the wellbeing of whānau members include (Waiti & Kingi, 2014):

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

Trauma-related stress reactions and symptoms resulting from exposure to another person's traumatic experiences can occur among any worker that provides services to people who have experienced trauma. In the process of forming ongoing empathetic therapeutic relationships with people to support their recovery, workers are vulnerable to experiencing vicarious traumatisation (Davies, 2009). Workers who themselves have experienced childhood trauma are more susceptible to indirect trauma (Brockhouse et al., 2011). This indirect trauma can lead to secondary traumatic stress, vicarious stress, or occupational burnout experienced by mental health and addiction workers (Cieslak, Shoji, & Douglas, 2014) and has been shown to adversely impact on their wellbeing along with service delivery, treatment outcomes, and satisfaction amongst people accessing services (Byron et al., 2015). Difficulties in interpersonal relationships as a result of experiencing trauma, including indirect trauma, is often reported in studies by both the people accessing services, and the workers (Bateman, Henderson, & Kezelman, 2013; Evans & Coccoma, 2014). People who feel less supported by their organisations are at a higher risk of developing secondary trauma and job burnout. If, however, the wellbeing of staff is a primary consideration, these risks may be reduced. Organisational support enables staff to feel confident that the trauma services they are providing improves resiliency (Laschinger, 2001) and may help diminish the negative effects of compassion stress (Conrad & Kellar-Guenther, 2006).

What is a trauma-informed approach?

A trauma-informed approach is strengths-based model which includes a focus on individuals' strengths and competencies. This approach is based on a set of principles (SAMHSA, 2014; Trauma Informed Oregon, 2017) and key elements (Cieslak et al., 2014; Isobel & Edwards, 2017).

The principles most identified in the literature include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and an awareness of cultural, historical and gender issues. Trauma-informed care is about creating an organisational culture which embodies these principles or core values.

The literature identifies four key elements for a trauma-informed approach.

1. A realisation that trauma has a widespread impact on people, families, groups, organisations, and communities; and an understanding of pathways to wellbeing.
2. A thorough understanding of 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. The integration of trauma knowledge into policies, procedures, programmes, and practice.
4. Avoid re-traumatisation of people accessing services, and the workforce. A trauma-informed model acknowledges the need for services to address the safety and wellbeing of staff who may experience indirect trauma or organisational or hierarchical disempowerment.

Aotearoa New Zealand research demonstrates that a trauma-informed approach needs to include additional elements.

- In order to engage fully 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 an inclusive factor in care (Pihama et al., 2014; Te Atawhai o Te Ao - He Kokonga Whare, 2016).
- As a trauma-informed approach is a strengths-based model (Leitch, 2017) key elements need to include a resiliency and positive or protective resilience focus.

A trauma-informed approach includes 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 Aotearoa New Zealand we need to include the impact of historical traumatic events and their contribution to the resultant health disparities experienced by Māori people.

Many of the principles that underpin a trauma-informed approach are embedded into the *Six Core Strategies*© an evidence-based framework for services to use in reducing coercive practices within *Let's get real*, an Aotearoa New Zealand-based framework of skills, values and attitudes. The recently refreshed *Let's get real* has trauma-informed approaches embedded in the new framework.

A trauma-informed approach doesn't only affect people who access mental health and addiction services but includes the wellbeing of workers. Again, the prevention of secondary trauma and building resiliency are essential factors needed for worker wellbeing.

How can organisations implement a trauma-informed care approach?

To support the implementation of a trauma-informed approach, a number of system level elements need to be in place along with multiple-level strategies (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), which requires planning and support (Isobel & Edwards, 2017). Successful implementation needs to; identify and address barriers to implementation; have leadership commitment and

participation (including that of consumer advisors) to realign organisational systems and processes; address worker wellness and safety; and develop the skills and confidence of staff to support people accessing services with experiences of trauma. An awareness by leaders and managers of Māori frameworks and models to help develop or maintain cultural connections and understanding frameworks towards healing and recovery is also necessary.

Other key learnings from the literature for developing a trauma-informed approach are outlined below.

- 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 acknowledged. This includes having predictable organisational practices which are transparent and in discussion with people accessing services (Isobel & Edwards, 2017).
- Establishing an accurate picture of the trauma needs of people accessing services by using processes such as automatic screening for all (Muskett, 2014).
- 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).

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

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

Future directions

The development of a unique trauma-informed approach for Aotearoa New Zealand, particularly one that works for Māori people is essential. An Aotearoa New Zealand trauma-informed care approach needs to address individual, collective and historical trauma. It also needs to consider the wellbeing of workers. The collaborative development of Aotearoa New Zealand principles and key elements to inform a national approach for trauma-informed care is needed.

Emerging research in Aotearoa New Zealand is contributing to our knowledge of effective practice and will help shape a unique trauma-informed approach for this country. For example, *He Oranga Ngākau: Māori approaches to trauma-informed care* is exploring the notion of trauma-informed care with the intention of developing a framework for working with whānau Māori.

Conclusion

In conclusion, this literature scan provides evidence about why a trauma-informed approach is important for mental health and addiction service delivery; what a trauma-informed approach looks like; and suggests how it can be implemented in practice. This body of knowledge enables understanding of the prevalence of potentially traumatic events in people's lives; the individual and collective responses to traumatic events; the importance of resilience factors in allowing people to overcome adversity; and the need to consider the health and wellbeing of the workforce to achieve better outcomes for people with experience of trauma.

It is important that mental health and addiction organisations, services and workers use the knowledge gained worldwide alongside the context of Aotearoa New Zealand to develop a unique responsive trauma-informed culture and way of working.

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