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Our thoughts are with you.

Rachael Scott
INTRODUCTION

In September 2010, February 2011, June 2011, and December 2011, four large earthquakes devastated the Canterbury area, causing widespread damage to property and person.

Straddling the boundary of two moving tectonic plates, New Zealand is shaken by frequent earthquakes. However, since Europeans settled in the area, Christchurch and the Canterbury Plains have experienced relatively few tremors compared to cities such as Wellington, Napier and Gisborne. That all changed on 4 September 2010, when a network of subsurface faults beneath the Canterbury Plains and the Port Hills were reactivated, producing a major earthquake of 7.1 Magnitude, followed by a swarm of aftershocks that are still ongoing; the most serious of which was in February 2011 (Magnitude 6.3). This earthquake caused 185 fatalities and several thousand people were injured. It was followed by two further major aftershocks, June and December 2011 (Villemure, Wilson, Bristow, & Gallagher, 2012).

The devastating magnitude 6.3 earthquake struck the Canterbury region in New Zealand's South Island at 12:51 pm on Tuesday, 22 February 2011. The earthquake was centered two kilometres west of the town of Lyttelton, and 10 kilometers southeast of the Centre of Christchurch. It followed nearly six months after the magnitude 7.1 Canterbury earthquake of 4 September 2010 (McColl, Fredrick, & Burkel, 2012).

These earthquakes have changed the fabric of Christchurch with damage exacerbated by buildings and infrastructure already weakened in the 4 September 2010 earthquake. Nearly half of the buildings in the central business district are expected to be demolished, including a significant amount of heritage buildings. Large parts of the City are cordoned off and inaccessible to the general public. Liquefaction was most extensive in February and June 2011. Properties and streets in the Northern and Eastern Coastal suburbs were buried in thick layers of silt. Over 500,000 tonnes of silt have been removed since. Water and sewage from broken pipes flooded streets. House foundations cracked and buckled, wrecking many homes (Villemure et al., 2012). The Port Hillside areas of the city experienced major rock falls, landslips and cliff collapse. Several thousand homes have to be demolished, and some sections of suburbs will never be re-occupied, displacing thousands of families.
Essential services were seriously impacted. Following the February 22\textsuperscript{nd} event, electricity was restored to 75\% of the city within three days, but water supplies and sewerage systems took a number of weeks to restore particularly in areas affected by liquefaction. Eighty percent of the city’s water and sewerage systems were severely damaged and 33,800 porta-loos and chemical toilets were distributed (McColl et al., 2012).

The government declared a State of National Emergency, which stayed in force until 30 April 2011.

There have been significant demands placed on the local infrastructure to manage in this post-disaster period. Families and businesses are dealing with displacement, financial stress and people are feeling a sense of loss, anxiety and fear with the nature of the ongoing aftershocks and unknown future. The repercussions are far reaching for all.

It is within this context that the mental health services were required to respond to the needs of individuals and families in crisis by assisting in Welfare Centres set up across the city by Civil Defence. This continued through the State of Emergency alongside usual mental health service delivery. Clinicians were expected to attend to the needs of all those affected and continue services as usual, at the very same time that their own lives had been thrown into upheaval.

This study explores the effects of all of this on the workforce of the Canterbury District Health Board Specialist Child, Adolescent and Family Mental Health Service (CAFMHS). We wished to give consideration not just to the personal impact of the Earthquakes, but also to understand how it has impacted on the work place and mental health professionals’ ability to do their job; guiding us on what might be usefully learned to inform future practice. In particular:

- Strategies regarding support for staff during future events
- Strategies for ensuring minimal disruption to service
- Strategies for utilising the resources available
- Strategies for recruitment and retention post event
- Knowledge regarding specific skill development of CAF Clinical staff in preparation for potential future events
- The review and development of planning processes to enhance future responses
CHILD ADOLESCENT & FAMILY MENTAL HEALTH SERVICE (CAFMHS) – CANTERBURY CDHB

The Canterbury CAFMHS is well resourced and made up of a number of different services to meet the needs of those children and adolescents with a diagnosed DSM IV Moderate to Severe Psychiatric Disorder, who live either centrally in Christchurch or in the wider rural Canterbury area. There are three outpatient teams, two Day Service Facilities and both a Youth Inpatient Unit and Child Inpatient Unit. The Inpatient Units are both regional services for the whole of the South Island of New Zealand.

Immediately following the February 2011 earthquake, services were disrupted with units being displaced. The Child Outpatient Service (CFSS) had to move as their building was assessed as too dangerous to enter. It was ‘red stickered’ by the Christchurch City Council and placed in the city cordon (large areas of the city were restricted in access to anyone but official personnel). This team was immediately moved into site sharing with the Youth Outpatient Service (YSS). This site sharing is ongoing and more recently porta-cabins have been added.

The Child Inpatient Unit (CFIU) was merged into the Youth Inpatient Unit (YIU) space due to staff shortages and to free up hospital beds. This continued for approximately six weeks during the state of emergency.

The Child and Family Rural Service (CAF Rural) ended up sharing space with some Adult Services (due to the Adult Services city offices being ‘red-stickered’ and placed in the city cordon). This space and resource sharing is also ongoing.

The site sharing means that clinical space, computer and telephone access and even desk space are at a premium across all of the CAFMH Service. Staff have to ‘hot desk’ carrying with them all of their ‘tools of the trade’. Rooms and resources have to now be booked in advance.

The Child, Adolescent and Family services are staffed by a multi-disciplinary group of health professionals made up of Consultant Psychiatrists, Psychologists, Nurses, Social Workers, Occupational Therapists and Pukenga Atawhai (Māori Health Workers). All staff were invited to participate in this study.
METHOD OF RESEARCH

A qualitative methodology was chosen as the preferred research method. The goal of qualitative methodology is described as the development of concepts which help us to understand social phenomena in natural settings, giving due emphasis to the meanings, experiences and views of all the participants (Pope & Mays, 1995). It was decided that a semi structured Interview would give participants the opportunity to tell their story of their unique experience and give consideration as to how this related to their workplace experience.

Permission was sought from the CDHB Research Committee and granted. The Research Committee did not consider ethics approval as necessary, so this was not applied for. An email was circulated amongst all of the staff of the CAFMHS inviting participation. Clinicians could respond confidentially to the researcher. This was then followed up with the arrangement of an interview time, at a location of the participants’ choice. Altogether there were 12 clinicians who responded from the following disciplines: Consultant Psychiatry, Clinical Psychology, Social Work and Nursing. For the purpose of this research, all participants will be referred to as Mental Health Clinicians to preserve anonymity. Also for this reason, whilst there was a mix of genders who participated in the study, the gender descriptor of ‘she’ will only be used throughout this narrative.

Prior to the face to face interview being started a consent form was completed. Interviews were approximately one hour long and recorded for the researcher to reflect on when collating the data. Notes were also taken during the interviews.

As the researcher, I had the benefit of having worked within this workforce for 10 years and knowing all the participants collegially. At the time of research, I was on long term leave, but was still a full time staff member within CAFMHS when the September earthquake happened. This clearly will have provided some advantages in that rapport was easy to establish with respondents, and perhaps this influenced the high response rate. Also it must be recognised that this may bring with it some bias in my interpretation of the data. Certainly my own experiences during the earthquake will also have influenced the data.

One overarching question was asked at the beginning of the interview:

“Tell me what the Canterbury Earthquakes have meant to you?”
The participants were guided through four areas of conversation: Personal Impact, Workforce Environment, Workforce Factors and Supports and Networks. Challenges and opportunities were explored across these four areas. It was important to understand personal context as well as the impact on the service within which participants worked. As the researcher, I explored what had changed since the earthquakes. Questions were asked such as: “Tell me about how you felt coming to work after the earthquakes?”; “Tell me about any changes to the service since the earthquakes?”; “Tell me about what support was around for you during the earthquakes?”

Data was analysed to identify the common themes. Whilst the interviews were recorded, they were not transcribed (due to time constraints). Instead, written notes were used to identify emergent themes. The interviewer then used the recordings to reflect on, clarifying points and ensuring accuracy.
FINDINGS

Some major themes emerged in the experience of the workforce of the CAF service immediately following the September, February and June Canterbury earthquakes. These themes were relevant to both the personal impact and the workforce impact and are described below.

• PERSONAL IMPACT

Eight of the 12 participants considered the earthquakes to have had a huge personal impact, both in the immediacy following the February earthquake and in the subsequent months that have followed.

One clinician describes:

“I was emotionally wasted by it; 8 months of nightmares about earthquakes have followed.”

Clinicians reported a heightened startle reflex in response to the ongoing aftershocks and some reported clear distress and grief in relation to dealing with fear, damaged belongings, damaged housing, community disruption, the major damage of the city and overall a significant sense of loss. This sense of loss appeared to be not only in relation to all that had physically changed but also in the sense of loss of what one knew about oneself.

One clinician describes:

“I won’t park in multi-storey carparks, I accelerate under flyovers and past rocky outcrops (even outside of Canterbury). I understand theoretically but cannot manage my physiological response.”

Of the eight clinicians who felt significant impacted, three considered themselves to be seriously traumatised and felt that they had to manage some considerable psychological and physiological distress responses:

“We were emotionally wasted by it. I was surprised I was utterly traumatised by the first one. I was stuffed. It was such a shock.”

These clinicians reported significant fear at times of the aftershocks, sleep issues, nightmares, increased forgetfulness, overwhelming exhaustion, inability to concentrate, irritability and a heightened startle reflex to loud noises (such as a truck going by on a road). Certainly this personal
trauma response was not what any of these individuals expected of themselves. Whilst they all reported slow improvement as time went on, the nature of the ongoing aftershocks meant that these clinicians were finding it hard to move on from these feelings. Subsequently it was also inducing feelings of frustration and irritability as they felt it impacting on their work.

Even those who did not feel overly traumatised recognised that they were perhaps struggling to achieve a standard of work they normally felt easily able to. One clinician reflected:

“One of the biggest challenges is simply trying to remember everything at work with everything going on at home also, particularly trying to remember what was going on for different staff members at home and work… I then feel frustrated and annoyed with myself that I am not doing as good a job as I would like.”

Even managing insurance processes felt overwhelming for some due to the lack of adequate response from insurance agencies and the feelings of enormous frustration that this provoked. One Clinician described:

“At times I feel very on edge. I consider myself significantly traumatised, mostly by bureaucracy. I feel anger whenever I talk about EQC [Earthquake Commission].”

There has also been an acknowledgment from some of the Clinicians that because of the aftershocks and ongoing stress, their alcohol consumption has increased. One Clinician talked of a ‘wee drop of whisky every night’ helping to induce sleep in the few weeks that followed the February event.

As one participant commented nearly 11 months past the main February event:

“The weekend glass of wine has become the every evening glass of wine. I must try and cut back again.”

• **COMMUNITY IMPACT**

Those Clinicians living in the Centre and the Eastern suburbs of the city certainly had immediate safety issues to consider for themselves and their families following the February earthquake and felt their communities were hugely impacted.

One participant described seeing a building topple in front of her onto parked cars as she raced across the city to get to her children’s school. She then had to break a window to get into her house
and fetch essentials to camp out in her office next door with no power or water. The evening of February 22nd 2011 was spent with her children watching black smoke and billowing dust, hearing helicopters flying over with monsoon buckets, watching tanks and army trucks driving down the street, listening to sirens of fire trucks wailing and experiencing the earth rumbling as frequent Magnitude 4 and 5 aftershocks continued:

“It was like pretty much a war zone. It was surreal.”

Another participant describes her partner having to run for an hour and half over the Port Hills to get home to the family due to all road access being closed to their community because of rock fall. They were then stuck there, with no power or water for two days and with limited supplies until Navy ships docked in the harbour and came to help out the township.

For those that lived outside of the city, there was the fear of having to drive across life line bridges into the city and negotiate building debris, road closures and changed landscapes to get to work. One clinician reported “I was terrified to come into the city, I did not know which road to come.” Another described it taking a week to pluck up the courage to come over the Waimakariri bridge and having to use positive self-talk to try and not retreat to home and stay away from work.

Many experienced seriously damaged houses with walls having fallen down for one person, a house coming off its piles for another and others describing serious cracking and possible future demolition being required. Belongings were also wrecked and one Clinician described rather sheepishly, that for her, this was the biggest impact of the earthquakes; when all of her material possessions were broken in the June event she felt a huge sense of loss.

Of the four participants who felt less impacted by the earthquake, three were living outside of the most damaged areas of Christchurch, such as on the West side of the city or further away in North Canterbury. The other who lived in an area very impacted; particularly by liquefaction, seemed to approach the situation very pragmatically. This clinician stated that she “just got on with it and focussed on what we could do to assist others.” She described delivering water to council flats despite buses not running, power being out, water being limited in supply, food supply running low and not being able to use the car locally due to silt and mud.

Those who lived outside of the city also became involved in assisting others and two of the clinicians described friends, whose houses had been badly damaged, living with them for up to four months.
Overall there appeared to be a definite correlation as to where someone lived and how damaged their home and community was as to how negatively impacted they felt. Also it would seem that those living alone or with younger dependents felt more vulnerable.

There was an overwhelming positive reflection by all the participants on increased neighbourly relations and positive community feeling immediately following the earthquake in February 2011.

One Clinician described that her community was a very big part of helping her family cope. There were ‘street meals’ at the local community centre, shared social evenings by torch-light and activities organised in the day, particularly for the children.

Participants talked of getting to know their neighbours better, helping one another out, sharing emergency supplies, shoveling liquefaction alongside of a neighbour they had not previously met, sharing BBQ’s for cooking and even in one instance offering a bed to a volunteer who had travelled from the North Island to help out.

Social boundaries were described as being crossed. There was an example described even amongst service-users and staff who lived in the same community, when a long term service-user of the adult mental health services ended up sitting alongside a Clinician on a roof together securing roofing iron when a chimney had toppled from their mutual neighbour’s house. There was a real sense of connectedness reported amongst people within their communities, knowing that everyone had experienced the same trauma.

- **RECREATIONAL IMPACT**

Six out of 12 interviewed commented also on the loss of recreational options and how this was hard. Reflections were made as to how valuable this was for outside work occupation, managing stress levels, creating ‘down’ time and helping sleep. In particular not being able to do physical activity with the loss of local swimming pools, recreational gyms, and even outside areas such as the beaches, which were off limits due to sewage outfall and the Port Hills biking and walking tracks that were closed due to rock-fall. Many of the cinemas remained closed due to building damage and ongoing risk, as were the libraries. Additionally, shopping was not possible initially due to Mall closures and the loss of the city centre. Simple tasks such as getting groceries became hugely time consuming as people were required to travel three times the distance they had previously to find an intact supermarket.
• **TRAVEL IMPACT**

Travelling across the city did present its frustrations for a few and was reported by four of the participants as one of the biggest challenges to manage since the earthquake. For some clinicians a journey to get to work that had previously taken 40 minutes was now taking two hours due to much of the city being cordoned and route options being greatly reduced. This challenge even led one clinician to consider whether it is viable to remain a CDHB employee in the city as it had such an impact on quality of life. Fortunately this issue has slowly improved as time has gone on and no-one interviewed has since changed jobs.

**RETURNING TO WORK:**

• **IMPACT OF COMMUNICATION**

For some team members when they returned to work things looked very different from their pre-earthquake experience, due to units being merged, buildings being ‘red stickered’ and work belongings and files initially being inaccessible.

Seven out of the 12 Clinicians interviewed found returning to work a positive experience:

> “Coming to work provided a focus – a reprieve.”
> “Quite like the stimulation and focusing on what I can do.”

However there were those who felt they required more time to adjust:

> “Hard going back to work, I did not feel like I had the energy for the kids.”
> “Surreal coming back to work, people from the other side of town had no idea what it was like.”

One participant commented that it would have helped if:

> ‘Management would acknowledge that all employees were affected differently and acknowledge people’s different situations and different feelings about these.”

She went on to suggest that then perhaps those that felt they could get really involved in helping could be coordinated into extra tasks and those that couldn’t, would have been able to perhaps take more time out and be involved in lighter duties.
Certainly there was some feeling from participants that at times management lacked transparency and empathy during their communication with their staff and failed to acknowledge individuals own trauma and crisis around their personal families and housing situations. This led to some feeling very unsupported and mistrusting of the information that was being relayed. An example included the process of change amongst the units as spaces had to be shared and resource consolidated. One clinician reported in relation to management, that they had ‘lost faith in what anyone tells me’ and two participants reported that they no longer felt positive about work as a result of these feelings.

Generally however the majority of participants felt that expectations and requirements for work in the immediate aftermath of the earthquakes were communicated well, either by telephone, text or email.

Some reflected on their appreciation of telephone calls of support from immediate management and ongoing understanding as some of the participants tried to sort out child care and school issues. Some commented that they would have appreciated this approach but did not feel they received it, rather they were reliant on ‘the rumour mill’ amongst colleagues to hear messages about options such as Earthquake-leave.

One Clinician suggested that perhaps professionally specific leaders could have taken some responsibility for compassionate communication amongst their professional groups.

• IMPACT ON TIME MANAGEMENT

Practical solutions were offered by management to manage time and resources such as the introduction of glide time which some found useful in managing office and computer space. Clinicians described becoming more efficient in their communication with their clients. For example sending an email summarizing a therapy session when previously they may have done this with a phone call that would take twice as long.

There was some sense from a couple of the Clinicians that due to lack of coordination during the state of emergency that there was a lack of efficient use of ‘people’ resource and time. One clinician commented some colleagues were ‘spreading themselves too thin’ in respect of trying to work in the Welfare Centres and also trying to manage their usual day to day job. Managing this in addition to personal impacts, some people described feeling ‘over wrought and burnt out.’
Meanwhile other clinicians were left wondering how to productively use their work time, when files were stuck in ‘red stickered’ buildings and clients were trying to manage ‘day to day’ and not feeling the need to connect to mental health services.

**IMPACT OF SHARED SPACES**

This down time however was useful in allowing Clinicians to connect with one another. There appeared to have been a real sense of camaraderie amongst teams and a pulling together of resources. Participants talked of the usefulness of shared lunches, social fun activities being organized such as a friendly game of touch rugby, and informal debriefs in the staff room allowing time to talk to one another about their personal experience of the earthquakes and their effects on family, homes and communities. As one participant describes: “Informal permission/acceptance was given for us to hang out in the tea room. We had regular morning teas during that period.” Another stated that she had “never eaten so much at work(!).”

In respect to being ‘flung’ into space sharing, Clinicians felt very welcomed by their colleagues whose offices and spaces were now shared. There was a real sense of flexibility amongst teams to accommodate those who had been displaced. As one participant described when talking about moving into the Youth Services building: “staff at YSS have been fantastic, really brilliant.”

This in itself, some reported, catalysed the development of more efficient systems to accommodate room bookings, computer use and clinical space. Home visits were increased which most saw as a positive thing.

All participants considered the space sharing as necessary and that it initiated more of a sharing culture of resources, ideas, understanding of others roles, cross-pollination of ideas and understanding of each others’ team cultures. Two participants even suggested that it changed cultures that needed to be changed. Four out of the twelve participants talked of about how the earthquake had resulted in the creation of more openness between services and between colleagues.

As one Clinician described:

“**There used to be a divide in Child and Young Persons’ services. It now feels like we are together more.**”
However some felt it also created more stress, less efficiency, poorer service to clients and low morale in the workforce, particularly as time has gone on and work load expectations returned to normal levels while space and resources are still limited.

Being squashed into one building and lacking resources has taken its toll on some Clinicians who report that it is much harder to do their job well and efficiently due to this lack of space. Once participant reported:

“People are complaining about memory, concentration, poor motivation... no matter what everyone is traumatised and part of that is that our work space is now so scattered.”

Throughout this study, low morale was definitely apparent however with this was also a considerable acknowledgement collegially about how supported staff felt amongst one another.

The sharing of work space and resources appears to have developed a better understanding of roles between child and youth services. A number of the participants made comments about there being more openness across services and a process of getting to know staff better across service interfaces. Some staff have developed this to the point that they have been able to negotiate the use of space in other units, while they remain displaced from their own office.

There was an overwhelming appreciation of one another’s ability to be flexible in relation to work requirements. The space sharing, managers offering glide time to assist with travel, clinicians sharing resources that previously had been unit specific, and the role understanding had resulted in as one participant commented, a real “generosity of spirit” and far greater awareness and sensitivity towards others emotional well-being. Compassion was talked about many times by participants as a positive attribute thatClinicians noticed amongst themselves, but not always attributed to Managers.

As one participant describes that “there are overall good intentions in relation to support from CDHB Management but perhaps a little more compassion would be helpful.”
• IMPACT ON WORK PRACTICE

Most of the Clinicians reported the usefulness of training delivered by the University of Queensland on Trauma Focused CBT, and have found ways of integrating ‘Earthquake thinking’ into their practice.

The CAFMH Service also set up a specific Earthquake Response Team to meet the needs of Children, Young People and their Families impacted emotionally by the Earthquakes. Using the Choice and Partnership Approach (CAPA) model for ‘Earthquake’ referrals has been very useful in this context. Referral criteria for acceptance of CAFMHS service has been relaxed a little and all persons referred for Earthquake issues are being seen. Often brief intervention is offered in 1-3 sessions or a referral into an Earthquake Anxiety specific group.

Clinicians have described innovative ways in which they are now practicing. For example using email and electronic resources more, seeing clients in outside spaces and generally providing a more efficient and accessible service than perhaps we did previously. One participant describes is as if “everything has become more flexible.”
DISCUSSION

Although there are exceptions, most disaster studies examine the effects of a particular event that occurred at a particular time to a particular population in a particular place. Thus the literature might at best be described as a series of case studies (Norris et al., 2002). This particular study fits that description. A moment (or moments) caught in time of each participant’s experience of the Canterbury earthquakes and the subsequent impact it has had on their lives and work experience.

What is apparent from those that we interviewed is that the biggest impact of all has been the ongoing nature of the events and the endurance that is required to continue to ‘bounce back’ and remain positive in the context of an uncertain future in respect to living, community and work environments.

Also what was evident was that those who experienced serious house and community damage on the whole appeared more negatively impacted than others. This is also reflected in Hideki Kuwabara and colleagues study (2008) on factors impacting on psychological distress and recovery after the 2004 Niigata-Chuetsu earthquake in Japan. Kuwabara et al., (2008) suggest that some factors such as female gender, serious house damage and injury or physical illness after the earthquake were indicated to affect psychological distress and that this is consistent with previous reports.

A significant focus of Clinician’s descriptions involved their low morale; not feeling as positive about work as they had previously. They also talked of experiencing an unexpected level of trauma, having less energy for clients and feeling much more aware of others emotional states. It is for this reason that it is relevant to explore what is meant by vicarious trauma and compassion fatigue. Both these terms are often used interchangeably to describe the therapist’s personal experience when working with traumatised populations.

Vicarious trauma is defined as “a transformation of the helper’s inner experience, resulting from empathic engagement with clients’ trauma material” (Saakvitne & Pearlman cited in Figley, 2002, p. 3). When therapists experience vicarious traumas, their inner experiences and their views of the world are affected. Though one client story can elicit traumatic responses in a therapist, repeated exposure to traumatic material across time and across clients can lead to vicarious traumatization.

Compassion fatigue is defined as the formal caregiver’s reduced capacity or interest in being empathetic or “bearing the suffering of clients” and is the “natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by the person”
(Figley cited in Adams, Figley, & Boscarino, 2008, p. 3) and can lead to job ‘burn-out’.

The relevance of both is apparent in that Clinicians have had to continue to work with traumatized clients whilst managing their own trauma experience. Saakvitne (2002, p. 443) comments that ‘in addition to clinical challenges, shared trauma increases a therapist’s vulnerability to vicarious traumatization’. Adams, Figley and Boscarino (2008) also conclude from their study: The Compassion Fatigue Scale: It’s Use with Social Workers following Urban Disaster, that compassion fatigue and its association with psychological problems should be considered as a risk factor for social workers counseling traumatised clients.

It is for these reasons that reflecting on what might help reduce the psychosocial impact for clinicians in disaster situations is necessary, and consideration given as to whether what was offered by CAFMHS following the Canterbury Earthquakes was actually helpful in reducing potential stress responses in staff.

Certainly the literature would suggest that in mitigating stress and reducing risk for psychosocial issues, enabling staff the time to create a community of support is probably critical in the over well-being of teams (Eidelson, D’Alessio, & Eidelson, 2003).

Batten and Orsillo (cited in Eidelson et al., 2003) have also reported on findings showing that therapists who received empathic support from others during their work following the Oklahoma City bombing had lower levels of secondary traumatisation and psychological distress.

Participant reports in this study would suggest that mostly, the CAFMHS managers did well in allowing Clinicians the space and time required to connect to one another and create an environment of support. It maybe that in part this happened accidently due to the fact that CAFMHS clients in the early period post-earthquakes did not connect with services, so space and time was created for collegial connection. Nevertheless the fact that clinicians felt that there was permission for these informal catch-ups probably went a long way in mitigating potential stress responses in some.

Another factor that appears to mitigate the secondary stress experienced by trauma workers is the presence of a supportive organizational environment.

Sarb Johal (2009) who prepared documentation for the New Zealand Ministry of Health Emergency Management team, reflects on staff and self-care and suggests that three factors seem to predict impact on workers. These are the level of exposure to the trauma, environmental factors such as
working conditions and management practices and individual factors such as worker perceptions, personal coping and stress reduction practices, personality and applicable training and expertise.

Johal (2009) suggests some solutions would be a clear organisational structure with defined roles and responsibilities, the education of workers on normal stress reactions, consistent adherence to occupational safety (i.e. workers not working for longer than 12 hours and be rotated through high, mid and low stress tasks) and finally that those in Leadership roles use this information and ‘do as you preach’.

Reflecting on participants responses in this study, some of the adherence to Johal’s (2009) suggestions by the CAFMHS was perhaps variable. It would seem to have been dependent on the Manager’s response from the particular team that each staff member worked in and also individual factors of each staff member such as personal experience of the disaster and worker personality and perception. The interplay between these will also have an impact. Johal (2009) certainly talks of the ‘fit’ between your (managers) understanding and others in an organisation causing challenges and this was certainly evidenced in this study.

Overall however given the magnitude and extent of the Canterbury earthquakes it would seem that the CAFMHS managers in fact did very well in providing a safe and supportive work environment to the best of their ability at the time of the events. The general sense from participants was that the CAFMHS managers has done a positive job in communicating and providing support structures for staff during a very challenging period. However it is the ongoing needs of Clinicians that will need to be considered during these uncertain times.
CONCLUSION

It is at this point that it would be useful to remind ourselves of what we hoped to achieve in conducting this research and consider what we might have usefully learned to inform future practice. In particular in respect of:

- Strategies regarding support for staff during future events
- Strategies for ensuring minimal disruption to service
- Strategies for utilising the resources available
- Strategies for recruitment and retention post event
- Knowledge regarding specific skill development of CAF Clinical staff in preparation for potential future events
- The review and development of planning processes to enhance future responses.

Reflecting on these areas of investigation, it would seem that Johal’s (2009) recommendations should be at the forefront of future process for disaster management within the CAFMHS. What we have learned is that creating a supportive culture amongst staff and between staff and management is critical for staff wellbeing and resilience.

Allowing time and giving permission for the informal catch-ups amongst staff in the early days following the major earthquakes was highly valued. It is also perhaps something, alongside regular ‘support sessions’ from managers that should be considered on an ongoing basis whilst the city, communities and services are still in such a state of flux. In particular as time goes on, and Clinicians feel the increasing pressure of normal work-loads in space-compromised environment, maintaining a positive culture within teams will be a challenge.

Also providing a clear structure and expectation around process for teams is critical. Certainly an empathetic, transparent and clear communication process from management that is consistent across services is invaluable for staff to feel safe, supported and committed to their role.

It would perhaps be useful to consider more team specific disaster management plans that are localised and relevant to each service that all staff can have input into. Such things as a telephone tree for communication, clinicians knowing in advance who is prepared and able to step into ‘extra’ roles such as staffing welfare centres (for example those without dependents). With this level of preparation in advance ‘back ups’ and contingencies can be agreed upon to manage usual caseloads.
The use of glide time also was clearly highly valued as a supportive process and certainly when we consider the fact that travel pressure was almost a catalyst for some to consider changing jobs it is a staff retention issue to consider. Perhaps it might also be considered that some Clinicians can work from home and be on call, particularly during a State of Emergency, and whilst they are trying to resume some normality in their personal environment.

Staff recruitment and retention post event however is not something that was considered in great detail in this study as time constraints meant that further exploration into this was not achievable. What we can conclude in this respect however is that in addressing staff morale, communicating with compassion and providing a transparent process, staff will feel more supported and are perhaps less likely to consider options such as moving jobs.

Another consideration when reflecting on personal impact is consideration to be given to recreation. Participants talked of the importance of down time and exercise as a means of ‘de-stressing’ yet across the city found it hard to know where to find this because of the level of devastation. Would it be possible to provide some ‘gym’ classes whilst at work? Certainly Clinicians talked with enthusiasm about the informal touch games that were organised between services and it is known that the wider CDHB were offering massage sessions and ‘time out’ spaces however perhaps a more formal exercise focus to some of this might have been useful.

In respect of knowledge for skill development, participant reports suggest that the training provided post event was useful and enhanced practice. There were no indicators to suggest that staff felt anything else was required.

When considering service disruption it would seem from this study that CAFMHS did an excellent job in providing business as usual in a highly challenging environment. Clinicians must be congratulated on the supportive environment that they created for one another, their innovative and creative ways of working, the cross pollination of knowledge and skills, and their flexibility in respect of shared space and generally thinking outside the square. What appears to be evidenced clearly is that in many ways a more flexible and responsive service is now being offered post-earthquake and this is likely to support positive outcomes for the clients whom we serve.
LIMITATIONS

The writer must acknowledge the lack of cultural reflections in this study and recognise its limitations and relevance to the Māori population. It would have been very insightful to have the opportunity to reflect on a Māori perspective however unfortunately none of the Pukenga Atawhai came forward to volunteer participation. If more time had been available, following this up personally by seeking participation in a face-to-face way might have engaged some Māori representation. Perhaps a future area of research is to consider the impact of the Canterbury Earthquakes on the Māori workforce.

A final reflection is described succinctly by Eidelson, D’Alessio and Eidelson (2003, p. 149) when commenting on the impact of September 11 on psychologists: “One noteworthy aspect of the aftermath of 9/11 was the way in which citizens across the country ‘pulled together’ in a united display of resilience and resolve.” This also appears to be an accurate summary of where we are all at here in Canterbury 18 months on. As one Clinician in this study describes:

“It feels like everyone is nicer to each other... Kinder.”
REFERENCES


