Centre for Developmental and Complex Trauma
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Conference Posters

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Tug-of-War: A Foucauldian Discourse Analysis of care and treatment planning experiences within a Forensic Mental Health Service.

Dr Hannah Waite, Dr Julia Wane & Dr Carolien Lamers (2023) - *North Wales Clinical Psychology Programme (DClinPsy)*

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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POWER IN FORENSIC MENTAL HEALTH

With the recent drive for services who cater for people with offending backgrounds to adopt a more psychologically informed approach, it is integral to understand how being in receipt of care and treatment is talked about. When an individual is detained within a forensic mental health service, their daily life is restricted by the Mental Health Act (1983) and, within Wales, their care is managed with a Care and Treatment Plan approach (CTP) under the Mental Health Measure (MHM, 2010). The intersectionality between the medical and legal paradigms creates a complex, multi-faceted and multi-layered power structure which forms the foundation of detention and care provided within forensic mental health services. People in forensic mental health services, therefore, find themselves cared for against their will, with mental health and judicial legislation defining their care and treatment (Haines et al., 2018), and thus encountering these power structures (Johansson & Holmes, 2023).

AIM & METHODOLOGY

This research aimed to explore how people in forensic mental health services talk about being in receipt of care and cared for under the Mental Health Measure Care and Treatment Plan approach.

Qualitative semi-structured interviews were conducted which explored how people talked about being in a forensic mental health service and receiving care.

Transcripts were analysed using Foucauldian Discourse Analysis (Georgaca & Avdi, 2011) (knowledge, power, objectification, subjectification and surveillance).

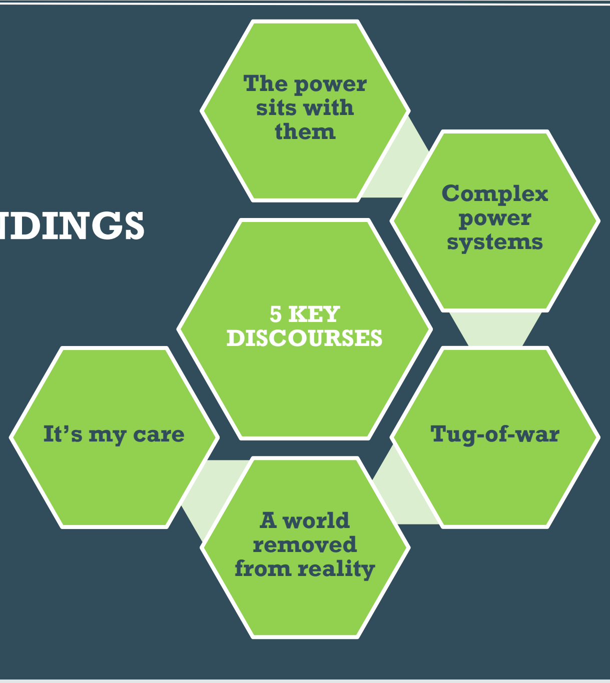
PARTICIPANTS

7 Males aged over 18 years who were residing in a forensic mental health service in Wales and detained under the Mental Health Act with or without Ministry of Justice restrictions. Participants were deemed stable in their mental health as assessed by their responsible clinician.

CLINICAL IMPLICATIONS

- Consideration to how power is utilised, enforced and received, as well as where power originates from and is held, is integral to understanding the impact of power on the recipients of care. Education and openness around the role of power, who holds it and how it is used, should be an integral component of service development. Ultimately, people should be encouraged and facilitated to hold more power over their lives, their decisions, their care and their treatment.
- An explicit acknowledgement of power differentials should be present and spoken about openly with the person in receipt of care.
- Efforts should be made to include people in their care and treatment planning at all times.
- Maintaining open and honest communication around an individual's care trajectory, regardless of the perceived level of distress is of upmost importance in maintaining their involvement with their own care.
- The people receiving care should be acknowledged as experts of their own experience, with their knowledge shared, listened to and respected.

FINDINGS



5 KEY DISCOURSES

The power sits with them

Complex power systems

Tug-of-war

A world removed from reality

It's my care

TUG-OF-WAR

Participants expressed a desire to be involved in their own care and their CTP, wanting to be heard and given more power. While participants described a level of choice and power in their engagement with the CTP, they also knew that this power and their related choices were constrained and only accepted if they were in line with the care team's knowledge, as they ultimately held the power.

"Obviously it's your care, it's your treatment and your your planning for the future so it is good if you've got capacity to be involved and obviously you have your say and obviously listen to what erm the care team have to say erm … yeah so it's a good thing to be involved in if you've got capacity to"

"It's your choice to get out of bed ha, erm it's your choice to engage, erm and do things, erm but at the end of the day it all rolls down to the care team cause they have the overall end decision"

THE POWER SITS WITH THEM

The most dominant discourse centred around the care team holding the power. Participants spoke with reference to the care team as a whole and individual team members. Participants articulated a tension between the knowledge held and shared by the care team about their treatment plan and this not being relevant nor taken from the participant's perspective.

"It's like a power trip. The staff have the power"

"What they do is they strip away your ability to do things, they tell you for four or five years 'no you can't do this, you can't do that' and after four or five years you might start believing it, so then when it comes to when you you actually leaving, you can't actually do the simplest things like phone up the social security, cause you're so dependent on it cause they've told you for five years that you can't make a cup of tea for yourself"

COMPLEX POWER SYSTEMS

The powers of the care team members were limited by more powerful systems and the care team were objectified as agents of the wider power structure. Participants were aware of influences outside of their immediate care team, such as the judicial system, that exercised power over those exerting power over them.

"They [tribunal] decide if you should be detained under the Mental Health Act … … … they're scary, different, and they're sort of they're in control because like one of them speaks and then they go round everyone and all that like …"

"The impression that I got is that they were just doing it cause they had to because they made it quite clear that it's under the Welsh government that they had to do it once a year"

A WORLD REMOVED FROM REALITY

Participants referred to the 'real world' as a separate world to the one they were experiencing. As a result of the power imbalance, the participants were forced to adapt to the rules and regulations, giving up the struggle with the care team and care system and play along.

"Well it's just like, you know, … … … a pantomime isn't it … it doesn't translate to anything in the real world"

"We're products aren't we … … … well we we're the products yeah. you know, were coming into the factory one end and gonna hopefully come out the other end"

IT'S MY CARE

In conjunction with engaging in the previous discourses, two participants also positioned themselves as central in the power relationship. There was uncertainty about claiming this discourse position and a tentative desire to regain some power in relation to their position as an individual in receipt of care.

"Well it's about me init hahahaha (laughing). Erm … it's all … it's all me really, my care, my treatment … on the whole it's its about, it's about yourself, you know what I mean, where you wanna get, how do you need to get there, what you need to do, what you need to achieve"

REFERENCES

Georgaca, E., & Avdi, E. (2011). Discourse analysis. In D. Harper & A.R. Thompson Older people, euthanasia and assisted suicide 100 (Eds). Qualitative research methods in mental health andpsychotherapy (pp. 147- 161). Oxford, Wiley-Blackwel

Haines, A., Perkins, E., Evans, E. A., & McCabe, R. (2018). Multidisciplinary team functioning and decision making within forensic mental health. Mental Health Review Journal, 23(3), 185-196. https://doi.org/10.1108/MHRJ-01-2018-0001

Johansson, J. A., & Holmes, D. (2023). Poststructuralism and the construction of subjectivities in forensic mental health: Opportunities for resistance. Nursing Philosophy, e12440. https://doi.org/10.1111/nup.12440

Mental Health (Wales) Measure 2010. https://www.legislation.gov.uk/mwa/2010/7/contents.

PREPARING DOCTORS TO SECURE SERVICES THROUGH AN EMPOWERING BUDDY PROGRAMME INITIATIVE:

A QUALITY IMPROVEMENT PROJECT

Dr Ashal Uyanak, Msc in Medicine, Sec12(2), MRCPsych Paper B, DIPM

Introduction

Secure services can be challenging; staff will need to act quickly and empathetically to the complex needs of patients, often with limited specialised training.

A survey of resident doctors (pre-programme survey) identified that the current induction process does not adequately support new doctors to their role.

Three main areas of concern were identified: information about their job roles, feeling confident for on-calls, and feeling welcomed. Some doctors commented that it took up to one year for them to feel comfortable in their duties. To improve this, a Buddy system was created.

Aim

For 75% of new resident doctors to feel they have sufficient information to carry out their job duties, and feel confident in being on the on-call rota within three months of joining the charity.

Methodology

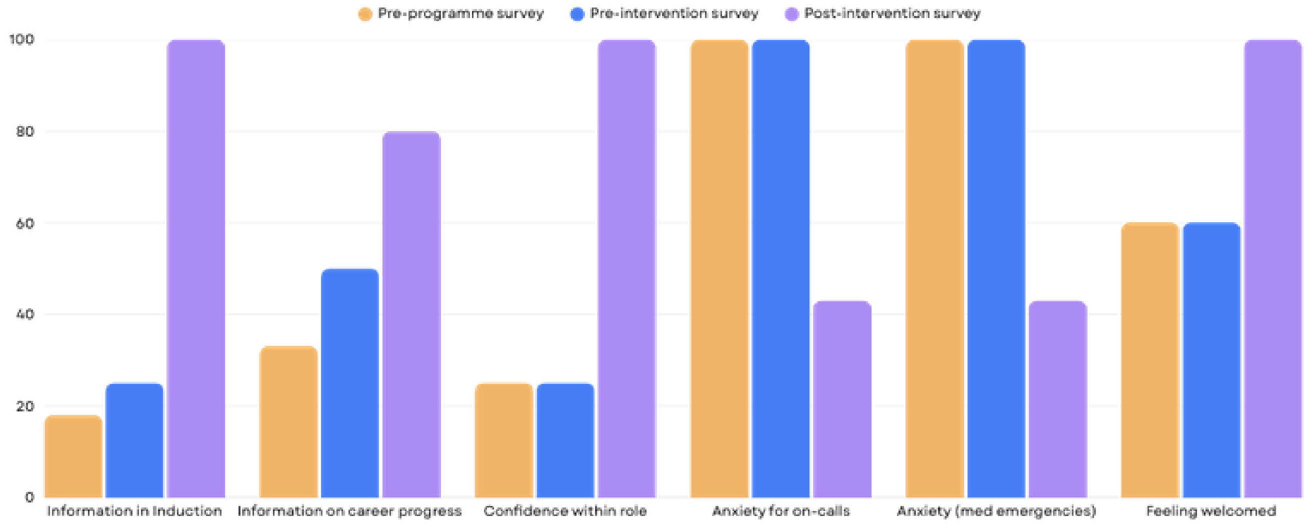
Buddy system matched doctors in the same division. Eligibility: Clinical Teaching Fellows, Specialty Doctors and Associate Specialists newly joining the hospital

Doctors met everyday on the first week, then weekly, to fortnightly with an increased frequency for 3 months. They went through an information booklet together, which included information on how to support an IMG colleague having their first job in the UK to experienced doctors. Buddy provided support as "first-point-of-contact" for non-patient related queries; such as "where to request bloods" .

- 7 eligible participants.
- Commenced in Medium secure for 6 months, then all wards, for a total of 18 months.

- Pre and post Buddy programme survey with binary answers and additional comments received via e-mail
- Surveys had 3 main topics: **Information, On-calls and feeling welcomed**
- Brief questions that focused on the emotional experience with key words such as "**confidence, anxiety, skills, feeling responsibility**"

Results



- The Buddy programme included all eligible doctors, with one leaving during the programme. Available data from that doctor, both quantitative and qualitative, was still included in this analysis.
- The pre-programme survey noted only 18% of Resident Drs having enough information during their induction. Post-intervention survey increased this to 100%.
- Confidence within the job role has increased from 25% to 100%.
- Most doctors were not aware of opportunities to progress their careers within St Andrews' when they joined (33% & 50%). The programme increased this to 80%.
- Despite the increase of confidence for starting on-calls, there was still remaining anxiety noted about the complexity of cases.
- All doctors scored for anxiety about the on-calls in the pre-questionnaire. The questions that still scored for anxiety on the post-intervention survey were the ones about the size of the site, the complexity of cases during on-calls, and medical emergencies. It is therefore considered that the programme enhanced the preparedness for on-calls by 57%.
- Additional comment from the doctor who resigned also included further context into worries around the size of the site and complexity of cases.
- Feeling welcomed had increased from 60% to 100%
- An incidental finding was that 75% of doctors who were part of this programme have moved onto higher grade roles by the end of the QIP. This included both internal and external roles.

Additional feedback from doctors via e-mails

- *"I wanted to write and thank you for being such a welcoming mentor over the past three months. I have **felt very lucky** that you have been so helpful at the start of this job and **supported my progress** and **confidence** as I have become more used to this new role"*
- *"Thank you for being there during incidents and risky situations. I **felt** much **safer**, and it helped me learn how to manage these circumstances **safely for everyone involved**."*
- *"Having dedicated space to discuss emergencies **without judgment** helped me soo much! I would have been **so afraid to be in charge**, but now I know what to do and the procedures."*
- *"I don't know what I would do (referring to med emergency - death) if you (Buddy) were not there. Thank you for guiding me and for the debrief. **I can't imagine doing this alone**."*
- *"I know I am leaving, but thanks to your guidance and support, **I felt really safe even in risk incidents**. I remembered what we discussed and followed, and it was a great experience. Thank you!"*
- *"I was **apprehensive** to working in forensic, and a bit unsure, but thanks to you (Buddy), I **felt really safe**. Thank you for being there when I needed"*

Discussion

In general, it is considered that the Buddy programme had an overwhelmingly positive effect for new Resident doctors.
This was a feasible programme that did not require additional funds.

There are identified areas for future improvement.
The organizational changes on the size of the site are likely to resolve one of these.

- There needs to be further call-log analysis on the complexity of cases that requires reviewing and resolving by the on-call doctors, as there is remaining anxiety around them. This was particularly mentioned by the doctor leaving the hospital, but not solely.
- Further analysis is needed on the turnover rate of resident doctors. Current finding could be incidental or related to other factors such as increased confidence and experience. There was no trend noted apart from moving to a higher-grade post.

  Limitation of this programme relate to the small number of participants and roll out at a singular site.

Restorative Just Culture Project- Victoria Gardens

"There remains a fear of blame in mental health settings when safety events happen. This contributes to a more defensive culture despite staff actively wanting to learn." **(HSSIB, 2025)**

Louise Kennedy - Lead Psychologist
and Joe Allen - QI Practitioner
Elysium Healthcare

Scan the QR code to watch Mersey Care's powerful Just Culture summary

The aim is to understand **why** something happened, not **who** is at fault.
Why did it make **sense** to them at the time?

Why do we want to change culture?

Our journey into trauma-informed care began in 2021, when we started to explore psychological safety within the workforce. This work led us to exploring the Restorative Just Culture evidence base, which closely aligns with trauma-informed care principles, the Duty of Candour, and the Freedom to Speak Up work already underway at Victoria Gardens.

The landscape within healthcare is shifting and we need to move away from a system where we sometimes inadvertently look to blame individuals, towards one which considers the wider system issues, human factors and the need to learn and improve. The Patient Safety Incident Response Framework (PSIRF) implementation emphasises the need for compassionate engagement with those affected by incidents, including patients their families and carers and staff who were involved. The focus is now on learning rather apportioning blame. PSIRF supports this cultural shift when it comes to patient safety incidents, but we know that learning will only occur in a culture where learning from **ALL** incidents is encouraged and supported. Our focus is on understanding what happened and why, supporting those involved, and learning at a system level, engaging staff openly, with dignity and ensuring they are supported throughout post-incident processes.

What is the evidence base?

Several NHS trusts have already made significant changes to the way they respond to unexpected events and incidents, acknowledging: the potential for **avoidable employee harm**; the cost and impact of employee investigations; and the impact on those who investigators who lead them.

What is our aim?

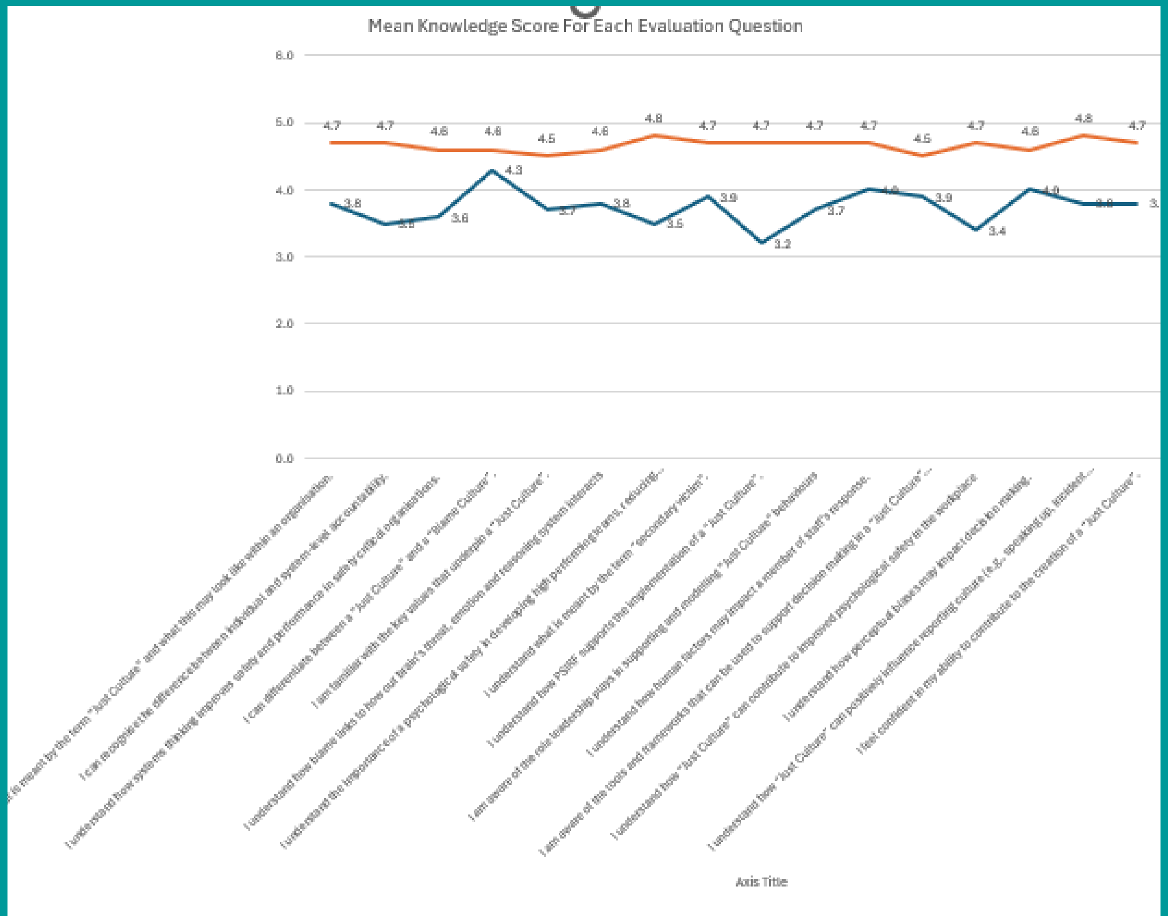
To increase **psychological safety** by 10% through the implementation of a Just Culture by December 2026 at Victoria Gardens.

We want to bridge clinical and operational policies, combining **systems thinking** and **safety science expertise.**

Our Managerial Training

Victoria Gardens is progressing toward a Just and Learning Culture, with this poster focusing on one testable change within the wider programme: a bespoke managerial training package exploring accountability, systems thinking, and human factors to support constructive, learning-oriented responses to unexpected events. Early process outcomes are encouraging despite wider organisational barriers, with positive qualitative feedback such as: "I thought it was excellent; it helped me make sense of PSIRF, Just Culture, previous investigations, empathy for staff involved, and my own experiences within current systems" (P5).A quality improvement approach using PDSA cycles informed the design, testing, and refinement of the training, with participant feedback shaping ongoing adaptations

Positive Outcomes



Pre- and post-training evaluation demonstrated a 14.3-point improvement in knowledge, indicating the positive impact of this initial change initiative. Increased leadership confidence in fair and transparent responses to incidents is expected to strengthen psychological safety for staff and, in turn, improve the quality of care for individuals with trauma-informed needs in mental health settings.

Monthly measures of staff psychological safety have also been collected as part of the wider project. While results have been variable due to wider organisational change, this process has prompted meaningful conversations about psychological safety and reinforced its importance.

Listen to Silence: Trauma Disclosure in Men With Learning Disabilities or Autism

Dr Elanor Webb,[1,2] Emily Brewin[1] & Dr Deborah Morris[1,2]

[1]Centre for Developmental and Complex Trauma | [2]Faculty of Medicine and Health Sciences, University of Buckingham

Introduction

Exposure to early adversity is pervasive in the lives of men detained in forensic services, with prevalence estimates of 75% and 84% reported in secure care[1] and prison[2] populations, with poly-victimisation also being commonplace. Risk appears to be further inflated for people with a learning disability and Autistic people[3,4], and current estimates may be somewhat under-inflated, due to poor recording[5], lack of recognition (individual and system), and an absence of tailored assessment tools. Yet, despite high levels of exposure to adverse and traumatic events, men are less likely to disclose such experiences and seek support from health professions. Accordingly, supporting disclosure is a priority for services and clinicians supporting men with a learning disability or Autism and criminogenic needs.

Disclosure is a prerequisite for accessing appropriate support and treatment, though reluctance to disclose trauma, and negative disclosure experiences, are somewhat common in male populations[6]. Accordingly, identifying factors that facilitate and act as a barrier to disclosure is a key avenue for research to address. Thus, the current study sought to pilot the Disclosure of Trauma Questionnaire (DTQ), to explore attitudes towards and experiences of trauma disclosure in men with a learning disability and Autistic men detained to a secure mental health service.

Method

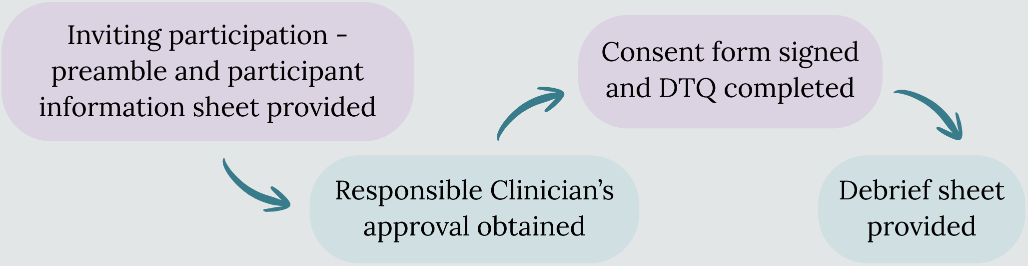
Participants

Eligibility criteria: i) Male, ii) aged 18+, iii) proficient in English, iv) has capacity to consent, v) previously disclosed childhood trauma to a professional

Measure

Disclosure of Trauma Questionnaire (DTQ) - 34 items rated for agreement from 0 (not to all) to 3 (completely) relating to three subscales: 'reluctance to talk', 'urge to talk' and 'emotional reactions'.

Procedure



Inviting participation - preamble and participant information sheet provided

Responsible Clinician's approval obtained

Consent form signed and DTQ completed

Debrief sheet provided

Results

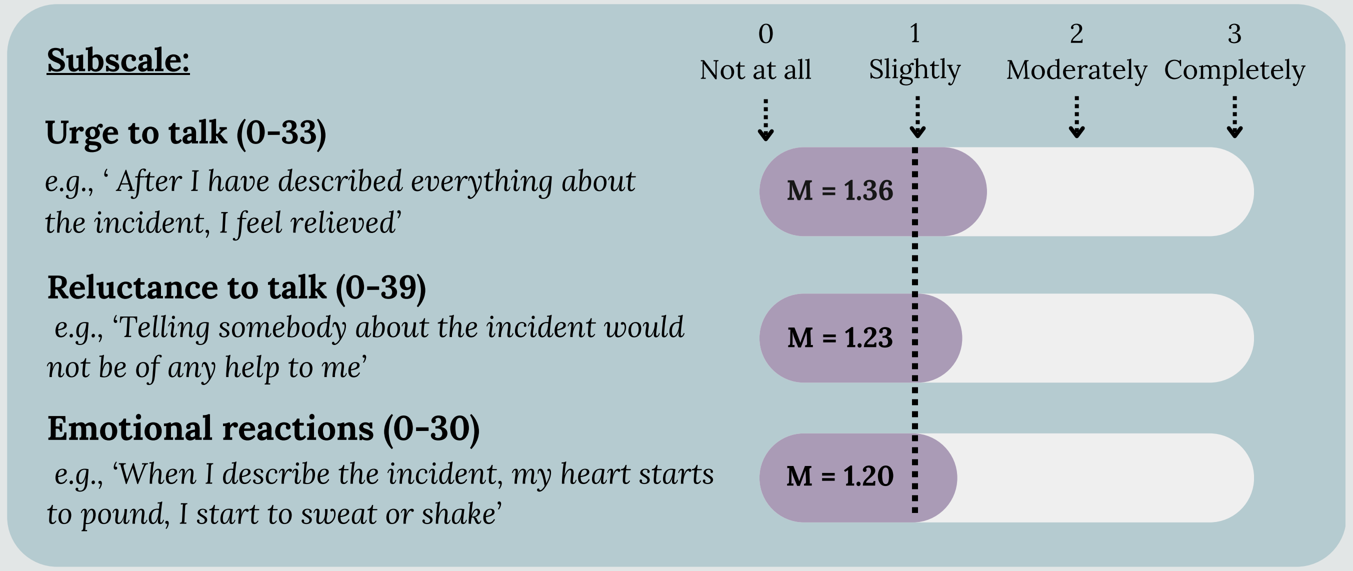
Sample demographics

15 service users from low (33.3%) & medium secure (66.7%) wards

- Aged 21-47 (M=28.00).
- From White British (80.0%), White Other (13.3%) and Mixed ethnic groups (6.7%)
- Mild/moderate LD (46.7%) and ASD (53.3%)

Profiles of scores on the DTQ

Participants endorsed a 'slight' urge to talk, in the context of a 'slight' reluctance, suggesting a degree of internal conflict. Participants also 'slightly' agreed that talking evoked certain inner emotional reactions. When compared to forensic service users without LD/ASD, surge to talk ($p=.43$), reluctance to talk ($p=.43$), and emotional reactions ($p=.78$) scores were comparable.



Subscale:

Urge to talk (0-33)
e.g., ' After I have described everything about the incident, I feel relieved'

Reluctance to talk (0-39)
e.g., 'Telling somebody about the incident would not be of any help to me'

Emotional reactions (0-30)
e.g., 'When I describe the incident, my heart starts to pound, I start to sweat or shake'

Items most strongly endorsed were:

Internal processing

"I think considerably more about the incident than I talk about it."

"I must get the experience clear in my mind."

Emotional responses

"It is difficult for me to speak about the incident in detail."

"Describing the event makes me feel very sad."

"When I describe the incident in detail, I feel like I am back in the event."

Discussion

Overall, the findings indicate a tendency for internal processing of the trauma event(s), over external communication. Whilst participants did endorse items reflecting a reluctance to talk, ratings on items reflecting their urge to talk about their trauma(s) was typically higher. Additionally, participants typically reported that talking about trauma experiences evoked negative emotions and a sense of re-living.

Research and Clinical Implications

- Primarily, the current pilot study warrants replication in larger samples of men detained to both prison and secure care services.
- Additionally, research that seeks to explore whether the tendency for internal processing of the trauma event(s) is due to preference, the potential for negative emotions to be triggered, external constraints (e.g., lack of safe opportunities), or factors instrinsic to learning disabilities or Autism would be of value.
- Such research may then identify whether alternative, non-verbal methods of communication may be beneficial for facilitating future trauma disclosure.
- Additionally, findings highlight the importance of establishing psychological safety, and preparing service users for and normalising their emotional responses to the disclosure of trauma(s).

References

1. McKenna, G., Jackson, N., & Browne, C. (2019). Trauma history in a high secure male forensic inpatient population. *International Journal of Law and Psychiatry*, 66.
2. Ford, K., Bellia, M. A., Hughes, K., Barton, E. R., & Newbury, A. (2020). Adverse childhood experiences: A retrospective study to understand their associations with lifetime mental health diagnosis, self-harm or suicide attempt, and current low mental wellbeing in a male Welsh prison population. *Health and Justice*, 8(1).
3. Collins, J., Horton, K., Gale-St. Ives, E., Murphy, G., & Barnoux, M. (2023). A systematic review of autistic people and the criminal justice system: An update of King and Murphy (2014). *Journal of Autism and Developmental Disorders*, 53(8), 3151-3179.
4. Ierna, A., Tolland, H., McGinley, A., & Mathieson, L. (2024). Trauma and adversity in forensic patients with an intellectual disability: a review of risk assessment reports. *Journal of Intellectual Disabilities and Offending Behaviour*, 15(3-4), 17-30.
5. Brackenridge, I., & Morrissey, C. (2010). Trauma and post-traumatic stress disorder (PTSD) in a high secure forensic learning disability population: Future directions for practice. *Advances in Mental Health and Intellectual Disabilities*, 4(3), 49-56.
6. Weare, S., Hulley, J., & Craig, D. (2024). *'Nobody believes you if you're a bloke': Barriers to disclosure and help-seeking for male forced-to-penetrate victims/survivors. International Review of Victimology*, 30(3).

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THE RELATIONSHIP BETWEEN NON-OCCUPATIONAL SOURCES OF STRESS ON WORKPLACE WELLBEING IN A SECURE MENTAL HEALTHCARE SETTING

Authors Tompkins. K., Webb, E.L., & Morris, D.J.

Introduction

Occupational sources of stress in healthcare workers who are experiencing burnout, secondary traumatic stress and compassion satisfaction have been the focus of a growing body of literature and research. However, non-occupational sources of stress has been largely unexplored, including in relation to gendered ethnic groups.

This is despite the argument that stress is experienced in a cumulative fashion and is experienced differently based on gender and ethnicity. As well as the reported impact of healthcare worker wellbeing, the quality of patient care and the healthcare provider.

Study Aims

To consider the (i) presence and (ii) relationship of non-occupational stress on workplace wellbeing in healthcare workers in a secure mental health setting, to inform service design and policy in the support of healthcare workers well-being.

Selected References

Erbe, A. M. (2022). Compassion fatigue and mental health in health care professionals. Workplace Health & Safety, 70(6), 303. https://doi.org/10.1177/21650799221081237

Gui, J., Liang, K., Yang, Y., & Du, L. (2025). Protective and risk factors of social support for healthcare workers in high-pressure occupational settings. Frontiers in Psychology, 16. https://doi.org/10.3389/fpsyg.2025.1547777

Hudnall Stamm, B. (2009). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). Retrieved from https://proqol.org/proqol-measure

BM Corporation. (2020). IBM SPSS Statistics for Windows. Version 27. [Software], IBM Corporation, Armonk.

Jannini, T. B., Rossi, R., Socci, V., Reda, F., Pacitti, F., & Di Lorenzo, G. (2023). Psychometric and factorial validity of the International Adjustment Disorder Questionnaire (IADQ) in an Italian sample: A validation and prevalence estimate study. Clinical psychology & psychotherapy, 30(2), 436–445. https://doi.org/10.1002/cpp.2813

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress process. Journal of Health and Social Behavior, 22(4), 337. https://doi.org/10.2307/2136676

Rehder, K., Adair, K. C., & Sexton, J. B. (2021). The Science of Health Care Worker Burnout: Assessing and Improving Health Care Worker Well-Being. Archives of Pathology & Laboratory Medicine, 145(9), 1095–1109. https://doi.org/10.5858/arpa.2020-0557-ra

Methodology

- A survey design was used to collect quantitative, cross-sectional data.

- A voluntary sample of 323 participants, both clinical and non-clinical, registered and non-registered healthcare workers, from a charity, in-patient mental health setting. The majority of participants were White British (74.3%) and female (70.9%) and held clinical roles (67.2%). The age of participants ranged from 20 years old to 67 years old.

- Demographic data pertaining to participant age, ethnicity, role and length of experience was collected via the survey questions.
- The PRoQOL was used to measure the well-being of healthcare workers, specifically in relation to burnout, compassion satisfaction and secondary traumatic stress.
- The IADQ was used in the study to identify non-occupational sources of stress for participants.

- The host organisation Research and Innovation Team approved the study.

Results

- Healthcare workers experience a range of non-occupational sources of stress and that these differ based on gender and ethnicity, most specifically in relation to black ethnic males.
- High burnout and secondary traumatic stress scores and low compassion satisfaction scores were found where high total number of non-occupational stress has also been scored.
- Five of the eight non-occupational sources of stress categories showed significant relationships with all three categories of occupational distress.

Correlation Matrix number of IADQ non-work problems and occupational distress outcomes overview

		CS Total	STS Total	BO Total	IADQ Total
Spearman's rho	CS Total Correlation Coefficient	1			
	STS Total Correlation Coefficient	-.174**	1		
	BO Total Correlation Coefficient	**-.581****	**0.612**	1	
	IADQ Total Correlation Coefficient	**-.222****	**0.314**	**0.372**	1

IADQ Percentage Score by Gender & Ethnicity and Total Participants

	Black & Ethnic Minority Male	Black & Ethnic Minority Female	White Male	White Female	Total Across All Participant Groups
IADQ1- Financial Problems	48.1%	32.4%	28.8%	41.1%	38.24%
IADQ3- Educational Problems	18.5%	20.6%	24.2%	13.5%	16.92%
IADQ4- Housing Problems	37%	17.6%	9.1%	13%al	14.73%
IADQ5- Relationship Problems	33.3%	23.5%	27.3%	28.6%	28.21%
IADQ6- My Own Health Problems	29.6%	38.2%	39.4%	51%	45.45%
IADQ7- A Loved Ones Health Problems	25.9%	38.2%	33.3%	42.2%	38.55%
IADQ8- Care Giving Problems	29.6%	47.1%	36.4%	41.7%	40.12%
IADQ9- Some Other Problem Not Mentioned Above	29.6%	41.2%	43.9%	27.6%	32.60%

Conclusion & Implications

- Interventions focused solely on occupational sources of stress for healthcare workers will not be effective in addressing the range of sources of stress that impact their occupational performance and wellbeing.
- Healthcare providers require a more holistic approach to supporting healthcare worker well-being, and an awareness that the sources of non-occupational stress that impact on occupational stress may differ based on gender and ethnicity.
- Changes to the approach of Healthcare providers might include supportive interventions that consider practical advice and support in terms of non-occupational sources of stress such as problems with housing, finances and physical health.
- Healthcare providers may also need to factor in the impact of these on the interventions being considered. For example, problems with care giving responsibilities, problems with own and a loved ones health and financial problems featured highly for healthcare workers in a secure mental healthcare setting, such problems could impact a healthcare workers resources to engage with certain interventions or services aimed at improving well-being and mental health outcomes.

Centre for Developmental and Complex Trauma