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Trauma-Informed Care and Practice

Practice Improvement Strategies in an Inpatient Mental Health Ward

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ABSTRACT

A growing body of evidence highlights that trauma is the single most significant predictor that an individual will need support from mental health services. Yet despite this association, mental health services have been slow to provide approaches to care and treatment that deal directly with trauma. Embedding the principles of trauma-informed care and practice (TICP) in acute inpatient ward practice can lead to practice improvement and cultural change over a number of areas. The current service evaluation highlights how these principles can inform practice and the positive affect this has on areas such as seclusion and restraint, therapeutic engagement, and ward routines. TICP complements recovery-focused models of care and promotes collaborative and empowering relationships in the inpatient setting. Embedding this approach in inpatient mental health units can lead to changes in professional practice and service provision that benefit service users. [*Journal of Psychosocial Nursing and Mental Health Services, 55*(10), 34-38.]

The current article reports a project that intended to change ward practice within an acute mental health inpatient service. The aim was to establish trauma-informed care and practice (TICP). The project developed from a growing awareness among staff of the prevalence of complex trauma in many consumers admitted to the ward. This awareness led to efforts by the multidisciplinary team to create a ward culture and develop practices that were in line with the principles of TICP.

BACKGROUND

Derived from the ancient Greek word for wound, trauma has been defined in many ways. In the most recent

iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), *trauma* has been defined as exposure to actual or threatened death, serious injury, or sexual violence in one or more of four ways: (a) directly experiencing an event; (b) witnessing, in person, an event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events (American Psychiatric Association, 2013). The concept of complex trauma has been used to describe the experience of multiple or prolonged traumatic events. Exposure to trauma has been identified as a significant public health issue (Ghafoori, Barragan, & Palinkas, 2014), with traumatic experiences in childhood found to be key risk factors for poor health in adulthood (Barrios et al., 2015).

High rates of trauma among adult mental health consumers have been well-documented (Anderson, Howard, Dean, Moran, & Khalifeh, 2016). Some studies have found exposure to traumatic events in childhood among consumers to be as high as 47.5% to 71% (Álvarez et al., 2011; Anderson et al., 2016). Epidemiological studies have provided evidence that experiences of childhood trauma are associated with dramatic increases in the risk of developing depression in later life (Heim, Newport, Mletzko, Miller, & Nemeroff, 2008). Studies have also indicated that individuals with a diagnosis of bipolar disorder report being exposed to more severe trauma in childhood than individuals without this diagnosis (Etain, Henry, Bellivier, Mathieu, & Leboyer, 2008). The intensity of these traumatic experiences has been reported to significantly influence frequency of hospitalization (Maguire, McCusker, Meenagh, Mulholland, & Shannon, 2008).

Individuals experiencing psychosis were reported to be 2.72 times more likely to have been exposed to childhood adversity and trauma than those without psychosis (Varese et al., 2012). Kelleher et al. (2013) found that exposure to childhood trauma predicted psychotic experiences as well as provided evidence that the cessation of traumatic experiences led to a reduced incidence of psychotic experiences in their study group.

This growing body of evidence highlights that a history of childhood trauma is the single most significant predictor that an individual will need support from mental health services (Kezelman & Stavropoulos, 2012). Despite this association, Australia's mental health services have been noted to have a poor record in recognizing the relationship between trauma and the development of mental health disorders and responding appropriately (Mental Health Coordinating Council, 2013). Most models in mental health services have evolved from institutional ideologies and practices from the early 20th century (Cleary & Hungerford, 2015). Therefore, TICP represents a paradigm shift for mental health services.

Inpatient mental health wards are clinical environments that have been purportedly designed to provide safe care and treatment for consumers who are experiencing mental illness and perceived to be a risk to themselves and/or others (Isobel, 2015; Muskett, 2014). The experience of nursing staff and consumers in these wards is often reported as being negative (Beckett et al., 2013). The ward culture and its associated practices can have a significant effect on consumers' experience of care and treatment. Differences can establish clinical environments where consumers feel empowered or disempowered (Isobel, 2015; Muskett, 2014).

Inpatient ward practices such as seclusion and restraint can be traumatic for consumers and cause further distress and harm. Although the reduction of seclusion and restraint is a key issue for mental health services, it is not an issue that is specific to TICP and should not be its sole focus (Muskett, 2014). Other practices such as the enforcement of ward rules, close observations, leave management, and information control must also be included as inpatient wards attempt to establish TICP (Cleary & Hungerford, 2015; Muskett, 2014).

Muskett (2014) identified the key principles of TICP as (a) consumers have a need to feel connected, valued, informed, and hopeful of recovery; (b) the connection between the experience of childhood trauma and current psychopathology is known and understood by staff; and (c) staff work with consumers, their families, friends, and supports in ways that are mindful and empowering and promote and protect autonomy. TICP can be used in mental health services to ensure every aspect of service delivery is trauma-informed and to promote a basic understanding of how trauma affects individuals who are service users (Fallot & Harris, 2009). By facilitating recovery through TICP, retraumatization from mental health service contact can be minimized and self and community wellness and connectedness can be promoted (Mental Health Coordinating Council, 2013).

In inpatient wards, TICP can be used within recovery-focused and/or person-centered models of care (Barton, Johnson, & Price, 2009). TICP complements these approaches, providing an explanation for unhealthy coping skills and how they can manifest in situations that may be frightening or stressful for individuals who have experienced trauma (Muskett, 2014). TICP acknowledges, validates, and attempts to understand and respond to trauma experiences (Barton et al., 2009). The approach promotes collaborative and empowering relationships and increases consumers' awareness about their coping skills in stressful situations (Isobel, 2015).

AIMS

The aim of the current project was to improve the quality of care provided to consumers. The approach taken to achieve this goal was based on the belief that embedding the principles of TICP in ward practices, which promoted values such as choice, collaboration, trustworthiness, safety, and empowerment, would lead to practice improvement and cultural change. Assessment data from consumers highlighted that

approximately 90% identified at least one experience of significant trauma in their lives.

METHOD

Setting

The 27-bed ward was situated in a busy public hospital in Metropolitan Sydney, Australia. The ward was divided into a six-bed high dependency unit (HDU) and 21-bed acute unit. High demands for inpatient beds and the high acuity of consumers who presented were a daily management focus. The average length of stay was 11 days and there was a separation rate of >70 consumers each month. The consumer group had high rates of comorbidity, including problematic use of alcohol and other drugs, homelessness, and physical health issues.

Admissions to the ward were almost exclusively through the hospital's emergency department (ED), although a small proportion each month were admitted for psychiatric assessment from the local magistrate courts. Many presentations in the ED involved the police and ambulance services, with the involvement of hospital security staff, physical and mechanical restraint, and intravenous sedation a regular occurrence.

Mental health nursing staff were responsible for the day-to-day management of the ward environment, ensuring safety and care for all. High acuity, turnover of consumers through the ward, consumer aggression and hostility, and frustrations with the largely medical focus of treatment had left many nurses feeling negative about their role, resulting in cynicism and emotional fatigue. Aggressive and challenging behaviors were often interpreted negatively with consumers being labeled as antisocial, borderline, or forensic. A perceived lack of safety was a common theme among nursing staff, particularly in the HDU, and there was clear evidence of some staff avoiding and/or minimizing face-to-face contact with consumers in this part of the ward. The rates of seclusion were among the highest in the State, and uniformed, male hospital security staff were routinely used to restrain consumers due to the low rates of appropriately trained staff on the nursing team. Audits revealed an over-reliance on pharmacological interventions to manage aggression and disruptive behavior.

Trauma-Informed Care and Practice Workshops

The ward Clinical Nurse Consultant (P.B.) and Senior Clinical Psychologist (M.P.) devised a series of workshop sessions to raise awareness of trauma and trauma-informed care and stimulate discussions on how they might be useful in improving practice. Through these workshops, six key practice development areas were identified by staff and working teams were formed to explore these areas further. The six practice areas included: (a) reducing seclusion and restraint, (b) increasing staff confidence by improving skills in de-escalation and physical safety, (c) ensuring best practice for pharmacological interventions, (d) introducing strengths-based philosophy and practices, (e) providing sexual safety training and awareness, and (f) improving access to therapeutic activities on the ward.

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RESULTS

During the next 3 years after conclusion of the workshops, seclusion rates were reduced by 80%, with the majority of seclusion incidents <60 minutes in duration. Training in de-escalation and physical safety combined with trauma-informed perspectives on behavior resulted in nursing staff feeling more confident and motivated to stay engaged therapeutically with consumers who were exhibiting high levels of emotional distress and behavioral disturbance. The use of security staff on the ward was also minimized. The changes to the ward environment enabled staff to use the seclusion suite as a voluntary, de-escalation area for consumers rather than a place of enforced detention.

A working party comprising staff from nursing, medicine, pharmacy, and consumer backgrounds was established to investigate the use of medication in the unit. A literature review to identify best practice in the use of pharmacological interventions resulted in the revision of rapid sedation protocols on the ward, emphasizing lower doses of sedating medication and more specific protocols for different groups of consumers, such as those who were neuroleptic naive, frail, or elderly.

The integration of strengths-based philosophies and practice was reflected in a reduction in the use of clinical jargon and pejorative descriptions of consumers (e.g., chronic schizophrenic) and efforts to focus on consumer strengths and resources during clinical discussions and handover. Greater awareness of childhood and adult adversity encouraged greater understanding, compassion, and respect for consumers.

Ensuring sexual safety in inpatient settings is an area of vital importance, and this was reflected in the staff workshops and practice development groups. One of the nursing staff devel-

oped a sexual safety training module, which all staff attended, and revised the ward policy and procedures to ensure best practice. A section of bedrooms, in clear view of the ward office, were designated as female-only, providing further security to female consumers. Avoiding the use of male staff in the restraint of female consumers was also a key focus of care.

Nursing and allied health staff worked together to improve the range and number of therapeutic activities on the ward. Many groups focused on relaxation, self-care, and positive relationships, including art, yoga, meditation, and strengths- and recovery-focused conversations.

The Consumer Participation Officer (D.H.) redeveloped the ward information booklet to improve the quantity and quality of information provided to consumers about the admission process. The Officer also ensured that there were regular opportunities on the ward for informal groups in which staff and consumers could meet to talk about concerns, experiences, and ideas for improvement.

DISCUSSION

Exposure to trauma results in wide ranging and long-term consequences for consumers, as well as resulting implications for those working in mental health care and mental health services in general. It has been widely recognized that trauma symptoms arising from consumers' pasts can create a significant barrier for partnering with health professionals in effective care and treatment (Walsh & Boyle, 2009).

The examples from the inpatient ward demonstrate how the concept of TICP can be developed in the culture and practices in this context. Strong leadership, opportunities for staff and consumer empowerment, and sustainability strategies are vital to the ongoing success of these efforts. In addition, access to reflective clinical supervision, debriefing, and support for staff are vital, particularly for nursing staff, as they are expected to work therapeutically for long periods with individuals with high levels of emotional and behavioral disturbance. Mental health nurses need to comprehend how the history of the consumer is re-enacted through his/her interactions (Cleary & Hungerford, 2015), meaning that mental health nurses are responsible for navigating interactions with consumers regardless of the situation or consumer's predicament.

Developing and maintaining a culture and associated practices of TICP is only possible when health professionals know about trauma and its effects on the individual and are competent in practicing within this context (Gatz, Brounstein, & Noether, 2007). Central to this approach is that nurses provide recovery-focused and growth-enhancing practices and interventions to those at risk of retraumatization (Cleary & Hungerford, 2015). In addition, it has been suggested that inpatient units in particular could do more to ensure that the physical environment is one that supports caregivers in the provision of trauma-informed care rather than emphasizing security (Walsh & Boyle, 2009).

CONCLUSION AND IMPLICATIONS FOR PRACTICE

Given the significance between childhood trauma and the need for mental health services in adulthood, the current authors believe it is imperative that a trauma-informed approach to care and treatment be adopted by mental health professionals. The outcomes reported in the current project demonstrate the benefits to professional practice and ward culture through facilitating culture change and promoting TICP in an inpatient mental health ward. The collaborative and participatory methodology used to promote improvement to patient care was underpinned by the principles of TICP. This is not a completed project, but part of a continuing process of change.

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Why you should read this article:

- To enhance your awareness of the link between trauma and mental health conditions
- To understand how you could implement the principles of trauma-informed care in your practice
- To count towards revalidation as part of your 35 hours of CPD, or you may wish to write a reflective account (UK readers)
- To contribute towards your professional development and local registration renewal requirements (non-UK readers)

Implementing trauma-informed care in mental health services

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Abstract

It has been recognised that trauma underpins several mental health conditions, and that retraumatisation, in which a person re-experiences a traumatic event, is common in mental health services.

This article explores the effects of childhood trauma on adult mental distress, and describes the symptoms and behaviours associated with trauma. Mental health practitioners, services and organisations need to ensure trauma-informed care is standard practice to enable service users to move beyond the traumatic events they have experienced. Trauma-informed care should be viewed as a concept rather than an intervention to promote a cultural shift from what is 'wrong' with a person to what has happened to them.

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Keywords

management, mental health, mental health therapies, post-traumatic stress disorder, service development, therapeutic relationships

Aims and intended learning outcomes

The aim of this article is to enhance nurses' understanding of the concept of trauma-informed care and to encourage them to consider the potential benefits of implementing it in their area of practice. After reading this article and completing the time out activities you should be able to:

- Define trauma and describe its effects.
- Understand the link between trauma and mental health conditions.
- Explain the symptoms and behaviours that may be associated with trauma.
- Outline the main principles of trauma-informed care.
- Identify the implications of trauma-informed care for mental health practitioners and organisations.

Introduction

Experiencing childhood trauma can have long-term consequences and a significant link between early trauma and adult mental distress has been identified (Mock and Arai 2011). There is growing evidence that childhood trauma affects neurological development (Sweeney et al 2018) and that trauma is linked to negative health outcomes in various physical and mental health conditions, including depression, anxiety, diabetes mellitus, heart disease and cancer, and to substance misuse (Felitti et al 1998, D'Andrea et al 2011). Sweeney et al (2018) also noted that people who have experienced physical or sexual abuse in childhood and are using mental health services are prescribed more medicines, have longer and more frequent hospital

admissions, and are more likely to engage in self-harm and suicide attempts than people who have not experienced childhood abuse.

A large percentage of people using mental health services have experienced trauma, with many experiencing particularly high rates of complex, repeated traumatic events (Sweeney et al 2018). One study found that almost one third of young people in the UK experience trauma during childhood or adolescence that doubles their risk of experiencing a range of mental health disorders (Lewis et al 2019, Torjesen 2019). Sara and Lappin (2017) suggested that childhood trauma may be 'psychiatry's greatest public health challenge'.

The author believes that the evidence of a link between trauma and mental health conditions is sufficient to warrant a significant change in the approach currently taken to care in mental health services. This article provides an overview of trauma-informed care and its implementation in mental health services, primarily based on the author's experiences and observations in clinical practice, since further research is required in this area.

TIME OUT 1

Consider your understanding of the term 'trauma'. What does this term mean to you and how does it inform your practice?

Definition of trauma

The fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association (APA) 2013) broadened its definition of trauma to include direct, or repeated or extreme indirect, exposure to or witnessing of 'actual or threatened death, serious injury, or sexual violence'. Compared with previous versions, this definition is more encompassing of human experience and the types of trauma that mental health service users may have experienced.

The DSM-5 (APA 2013) states that the effects of exposure to trauma can include:

- Intrusion symptoms, such as recurrent distressing memories and dissociative reactions.
- Persistent avoidance of stimuli associated with the trauma.
- Negative alterations in cognitions and mood associated with the traumatic event.
- Alterations in arousal and reactivity associated with the traumatic event.

It states that these symptoms must persist for more than one month, result in significant symptom-related distress or functional impairment, and not be caused by medicines, substance misuse or other illness (APA 2013).

Trauma can be experienced as a single event or multiple events over time. Complex trauma involves a traumatic event and additional factors, such as poverty and deprivation, suboptimal relationships, lack of support, racism, bullying, domestic instability and parental separation. Furthermore, complex trauma often indicates multiple traumatic events throughout childhood, adolescence and into adulthood.

Symptoms and behaviours associated with trauma

Herman (1992) stated that, after a traumatic experience, the human system of self-preservation seems to go into permanent alert, as if the danger might return at any moment. This is a state known as hyperarousal.

In practice, mental health practitioners, including nurses, may encounter service users who are hyperaroused, agitated, hypervigilant and/or exhibiting fear responses such as anxiety, anger, dissociation or numbing. In addition, service users frequently experience high levels of distress and, as a result, behavioural responses are triggered to manage, avoid or eliminate these symptoms and emotions. Box 1 provides examples of symptoms and behaviours associated with trauma, based on the author's experience and observations from clinical practice.

In the author's experience, many mental health service users will present with these symptoms and behaviours, supporting the view that trauma often underpins mental health conditions. Mental health practitioners may observe that service users who have experienced multiple and/or complex trauma find it challenging to establish healthy relationships with staff and their peers. For example, a person may: be seen as being needy, clingy or demanding; attempt to extend boundaries to seek personal relationships, special care or special privileges; keep their

Box 1. Examples of symptoms and behaviours associated with trauma

- Agitation
- Attempting to leave
- Difficulty establishing relationships
- Disengagement
- Hostility or violence
- Pacing
- Refusal to engage with particular activities, people or places
- Self-harm or suicide attempts

Key points

- The definition of trauma includes direct, or repeated or extreme indirect, exposure to or witnessing of actual or threatened death, serious injury or sexual violence
- A large percentage of people using mental health services have experienced trauma, with many experiencing particularly high rates of complex, repeated traumatic events
- Trauma-informed care should be viewed as a concept rather than an intervention to promote a cultural shift from what is 'wrong' with a person to what has happened to them

distance or oscillate between being demanding and distant; misinterpret social cues, leading to arguments; or find empathising with others and mentalisation (the ability to understand the mental state of oneself or others) challenging. These symptoms and behaviours are examples of the person trying to manage the internal experiences of trauma that affect everyday life.

The reason that mental health practitioners may encounter services users exhibiting such symptoms and behaviours in practice is that the experience of trauma activates a biological stress response. When a person experiences an event they perceive to be threatening to their physical or emotional health, physical safety or personal integrity, the amygdala, the area of the brain responsible for assessing risk, becomes overactive as the person attempts to make sense of what is happening.

Typically, a traumatic event is so far outside social norms or expected outcomes that the brain cannot make sense of what is happening and is unable to provide a narrative for the event. This means that the event is stored in the person's emotional memory and, without a narrative, the stress response continues to be activated whenever they are reminded of the event. These reminders are known as matching triggers, and can be smells, colours, a tone of voice, a sensory perception or an external trigger such as a news story or television programme. When the person encounters these triggers, they are likely to experience an immediate stress response; in practice, this is when mental health practitioners are likely to encounter service users who are presenting with symptoms and behaviours associated with trauma (Box 1).

Understanding the reasons for a person's symptoms and behaviours is a fundamental principle of trauma-informed care, because it shifts the focus of care from what is 'wrong' with a person to what has happened to them.

Risk of retraumatisation in mental health services

Retraumatisation occurs when a person in care is exposed to an experience that activates their memory of a past traumatic event, and common occurs in mental health services. The exposure activates the same emotional, physical or cognitive responses as the initial traumatic event. This can be disorientating because the person may find it challenging to separate time, place or person in that moment, and they may feel that they are back in the original event. Based on patient reports and the author's observations in clinical practice, experiences that could lead to retraumatisation include:

- Restraint, restrictions or other deprivations of liberty.
- Disorientation, resulting for example from ward transfer, sedating medicines or being placed out of area.
- An interpersonal experience, for example meeting unfamiliar staff on ward rounds or in outpatient clinics.
- A sense of powerlessness, for example as a result of being subjected to mental health service routines such as medicines administration times, smoking times or waiting for appointments.

Retraumatisation is frequently unintentional and can occur as mental health practitioners undertake routine care activities. However, the potential for retraumatisation is significant and it can perpetuate trauma. Therefore, trauma-informed care that is aimed at to reducing the risk of retraumatisation should underpin all mental health services.

TIME OUT 2

Can you think of any service users you have encountered who presented with any of the symptoms or behaviours described in Box 1? What was their diagnosis and their understanding of their difficulties? Reflect on the team supporting the service user and their understanding of the person they were treating. Was there any risk of retraumatisation in the care the person received?

Trauma-informed care

Trauma-informed care is a fundamental shift towards acknowledging the long-term effects of trauma, and is an extension of existing mental health practice. It is consistent with the broader developments of psychologically led, formulation-driven approaches that have become increasingly prevalent in mental health services over recent decades. This includes the shift towards multidisciplinary working that takes a holistic and individualised approach to care.

There is no single accepted definition of trauma-informed care, but it can be explained as 'understanding that most people in contact with human services have experienced trauma, and this understanding needs to permeate service relationships and delivery' (Sweeney et al 2016). Viewing trauma-informed care as a concept rather than an intervention enables the approach to be widely implemented, thus supporting a cultural shift from what is 'wrong' with a person to what has happened to them. According to Lawlor (2019) 'trauma-informed care is the biggest thing for mental health services this century'.

Sweeney et al (2016) set out principles to support the development of trauma-informed care in UK mental health services (Box 2).

The author has observed that, in clinical practice, trauma-informed care may: improve patient outcomes; reduce the use of restraint, restrictions and detention; and increase staff satisfaction, which in turn can increase staff retention and engagement. However, further research is required to support these findings. Hales et al (2017) undertook a review of staff satisfaction surveys examining the effect on staff of implementing trauma-informed care in practice. They found that staff satisfaction improved across a range of areas, including collaboration, empowerment and self-care, connection and relationships, and control and autonomy, which reflects the benefits cited by service users.

While there are many examples of innovative practice across services worldwide, Gilliver (2018) asserted that healthcare settings are falling behind in implementing trauma-informed care. The author has identified several barriers to implementing trauma-informed care, including: resistance to acknowledging the link between trauma and childhood abuse as a factor in the development of mental distress; lack of acknowledgement of historical and cultural trauma legacies; mental health practitioners finding it challenging to manage the trauma that service users have experienced; and a lack of effective supervision.

Much progress has been made but trauma-informed care is still a relatively new concept in practice and is not yet embedded in the organisational culture of mental health services.

TIME OUT 3

Consider your area of practice and note any examples of the principles of trauma-informed care in your service and the care you provide. How would you describe trauma-informed care to a person who visits your service?

Implementing trauma-informed care

Since it has been identified that trauma may underlie several symptoms and behaviours with which service users present (Box 1), trauma-informed care should underpin all assessments, care and interventions provided by mental health services. Trauma-informed care should be integrated in all mental health organisations so that an understanding of the effects of trauma can inform care delivery. This may also reduce the risk of retraumatisation in mental health services.

Mental health services, care and interventions should provide individualised, formulation-driven care that focuses on a person's experiences. It is important that mental health practitioners are supported to move away from symptom-focused models of illness that lead to prescriptive care, towards strengths-based care that develops resilience and empowers service users to move beyond the traumatic events that have affected their lived experiences.

Identifying traumatic experiences

It is important that mental health practitioners ask about service users' experiences, not only their signs and symptoms of illness, to identify any traumatic events they may have experienced. While there are a range of trauma assessment tools available, for example the Clinician Administered Post-Traumatic Stress Disorder Scale for DSM-5 (Weathers et al 2013), these are often time consuming and costly and require specific training. Trauma-specific services will undertake such formal assessments, but in general practice asking

Box 2. Principles of trauma-informed care

- Recognition. Recognise the prevalence, signs and effects of trauma. This is often referred to as 'having a trauma lens'. Recognition should involve routine enquiry about trauma that is sensitively asked and appropriately timed. For service users who have experienced trauma, recognition can result in feelings of validation, safety and hope
- Resist retraumatisation. Understand that operational practices, power differentials between staff and service users, and many other features of mental health care can retraumatise service users. Take steps to eliminate retraumatisation
- Cultural, historical and gender contexts. Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender appropriate. Recognise the effects of intersectionalities, and the healing potential of communities and relationships
- Trustworthiness and transparency. Services should ensure organisational and individual decisions are open and transparent, with the aim of building trust. This is essential to building relationships with trauma survivors, who may have experienced secrecy and betrayal
- Collaboration and mutuality. Understand the inherent power imbalance between staff and service users, as mentioned earlier, and ensure that relationships are based on mutuality, respect, trust, connection and hope. This is crucial because abuse of power is typically at the centre of trauma experiences, often leading to feelings of disconnection and hopelessness, and because it is through relationships that healing can occur
- Empowerment, choice and control. Adopt strengths-based approaches, with service users supported to take control of their lives and develop self-advocacy. This is essential because trauma experiences are often characterised by a lack of control, with long-term feelings of disempowerment
- Safety. Trauma engenders feelings of danger. Give priority to ensuring that everyone within a service feels, and is, emotionally and physically safe. This includes the feelings of safety engendered through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, socially, morally and culturally safe
- Service user partnerships. Understand that peer support and the co-production of services are integral to trauma-informed organisations. This is because the relationships involved in peer support and co-production are based on mutuality and collaboration
- Pathways to trauma-specific care. Service users should be supported to access appropriate trauma-specific care, where this is desired. This care should be provided by mental health services and be well resourced

(Adapted from Sweeney et al 2016)

a person if they have encountered anything that they have experienced as traumatic is sufficient. Being alert to a person's story and noting single and multiple traumatic events they have experienced during assessment will enable the development of a narrative in which their experiences and symptoms can be further understood to guide their care.

A quick and useful way of assessing the effects of any traumatic experiences reported is to use the Impact of Event Scale-Revised (IES-R) (Weiss 2004). This is a 22-item self-report assessment tool in which a person is asked to rate the distress-associated symptoms they have experienced over the past seven days in relation to a stated traumatic event. The score indicates the person's level of distress and dysfunction associated with the event. It is important to note that a low score does not negate a person's experiences and does not mean their story should be discounted. The IES-R is not a diagnostic tool, but rather it guides understanding of a person's experience and is a method for opening a dialogue with them.

It is important for mental health practitioners to enquire openly about a person's traumatic experiences and to employ curiosity in attempting to understand the context and effects of these experiences through assessment. The author suggests that this can begin a process of attachment and human connection, a therapeutic relationship, that provides a platform for all other interventions.

Reducing the risk of retraumatisation

Trauma-informed care seeks to reduce the risk of retraumatisation by acknowledging the effects of traumatic events and how these are linked to a person's current presentation. It is important that mental health practitioners aim to reduce the risk of retraumatisation in their interactions with service users and in mental health settings, and that they are aware of each person's triggers and risks. This will enable them to understand an individual's current emotions or behaviours; for example, understanding that an inpatient placed on 'observation' levels may present as anxious or defensive because it reminds them of intrusions from a traumatic event.

Interventions, such as grounding techniques, that are aimed at reducing arousal can be used to support the person to regulate their distress and to manage triggers, risk and interpersonal challenges. Individual trauma-focused therapies, such as trauma-focused cognitive behaviour therapy (TF-CBT) or imagery rescripting, may be beneficial for service users who need additional support to process specific traumatic memories and consequences. However, trauma-informed care can significantly contribute towards reducing the effects of trauma in an individual's day-to-day life and can promote the hope that is necessary to guide their recovery.

TIME OUT 4

Consider the service user you reflected on in time out 2. How might they have experienced your service differently if their care had been guided by the principles of trauma-informed care (Box 2)?

Implications for mental health practitioners

To provide effective trauma-informed care, mental health practitioners need to be able to provide empathy, consistency and stability in therapeutic relationships and clinical environments, enabling them to establish compassionate boundaries that promote service user engagement.

Nurses are well placed to lead this approach to care: long before the concept of trauma-informed care was discussed, prominent nursing theorists were writing about the importance of the therapeutic relationship as a central aspect of nursing, which is now considered essential in trauma-informed care. Peplau (1991) wrote that the 'common goal of nursing is safety and security for the patient in the therapeutic relationship; by attending to the patient's needs and not simply to their behaviours and actions'. Being attuned to each person's needs, rather than only observing their symptoms or behaviours, can enable a nurse to develop the empathy and compassion that is required to provide trauma-informed care in practice.

In Neuman and Young's (1972) systems model, the therapeutic relationship is central to informing how a person's experiences, strengths and skills influence how they cope with and react to stressors. Therefore, the validation of their experiences, collaborative working and co-production are essential to trauma-informed care, which reduces the risk of retraumatisation and promotes resilience.

While trauma-informed care has been emerging for some time, most mental health practitioners have not yet received formal training in this approach. Furthermore, although nurses are well placed to have an integral role in the advancement of trauma-informed care, some literature suggests that they are often confused by vague definitions

of this concept and find it challenging to know how to translate the concept of trauma-informed care into day-to-day practice (Muskett 2014, Hall et at 2016).

Stokes et al (2017) undertook a small-scale study that explored nurses' knowledge and experience of trauma-informed care. They found that, although few nurses reported that trauma-informed care was included in their education, and that many were unfamiliar with the concept of trauma-informed care, the care they were delivering was 'trauma sensitive'. For example, the nurses described how they 'meet the patient where he or she is at', the consequences of trauma and the effects of trauma, such as anxiety, emotional dysregulation, dissociation, personality disorders and psychosis.

Stokes et al (2017) also found that nurses were mindful of individual experiences and 'acknowledged their patients as people', with particular emphasis on strengths-based approaches to care, all of which are in accordance with the principles of trauma-informed care.

Compassionate workforce

A compassionate workforce is essential, since various members of staff will interact and undertake interventions with service users. All members of staff, including doctors, nurses, healthcare assistants, receptionists and domestic support staff, as well as visiting staff such as pharmacists and phlebotomists, should aim to provide a warm, compassionate and nurturing experience for service users, which will form the foundation of a trauma-informed environment.

To provide an effective trauma-informed service, it is essential that that all staff involved in the delivery of care understand the effects of trauma, the symptoms and behaviours associated with trauma with which a person may present, and the risk of retraumatisation in mental health services. Reflective practice groups and supervision should be provided to support the development and maintenance of compassionate workforces.

It is also important to acknowledge the effects of caring for people who have experienced multiple and/or complex trauma and to consider the risk of vicarious or secondary trauma for staff members. Service users' experiences are often distressing, so an organisational culture that promotes openness, sharing and sense-making through supervision, reflective practice groups and peer support is necessary to ensure staff are resilient and practise effectively.

Risk reduction

Physical safety is essential in environments that can be unpredictable or high risk. It is important to be aware that some mental health practices may perpetuate trauma. For example, a person with a trauma history presenting with a risk of self-harm may be placed on 'observations', which may increase their distress and cause them to feel powerless. Subsequently, the person's urge to self-harm may increase, so restrictions may be increased to ensure their safety. However, these restrictions may place greater intrusions on the person, so the risk is perpetuated. Therefore, mental health service staff need to be mindful and proactive, offer early intervention to manage service users' distress and/or disengagement and be flexible and creative in responding to risk, so that harm, retraumatisation and staff burnout are reduced.

Co-production is an important aspect of risk reduction, and involves working collaboratively to consider staff and service user needs and what is required to ensure they feel safe and supported. This is integral to trauma-informed care and requires support from the wider healthcare team and organisation.

Implications for mental health organisations

Senior managers and directors in mental health organisations can significantly influence ways of working to support the implementation of trauma-informed care. At ward and team levels, leaders and managers can consider how trauma may affect the experiences of service users and how it can lead to disengagement or non-engagement with services. Thinking about why a person may be disengaging or unable to engage with traditional mental health services is the first step towards developing trauma-informed services. Healthcare teams could consider revising their policies for non-attendance or non-engagement, and review appointment or discharge letters to ensure they promote engagement with service users as much as possible.

Developing mental health services that take into account the childhood trauma that service users may have experienced is a priority in trauma-informed care. All mental health services should consider whether their policies, procedures and protocols are trauma informed. Shifting from models of containment and disempowerment to co-production and empowerment will support trauma-informed policy development.

Rethinking restraint procedures, observations and responses to self-harm protocols, as well as embedding the standardisation of positive behaviour support plans and peer support strategies in policy, can all inform a shift towards trauma-informed care in mental health organisations.

These developments will not occur quickly or in isolation and a change in the organisational culture is required to ensure trauma-informed care underpins mental health services. Directors, senior leaders and managers of mental health services also need to feel safe, supported and well informed to move from traditional ways of working towards trauma-informed care. Consultation, training, working groups and service user involvement are also necessary to support this shift.

TIME OUT 5

Write a paragraph detailing some ideas for implementing trauma-informed care in mental health services. Discuss these with your manager and consider what service developments may be possible

Conclusion

It has been identified that childhood trauma is linked to adult mental distress, and that a large percentage of people using mental health services have experienced traumatic events. Therefore, it is essential that mental health practitioners and other staff in their organisations ensure trauma-informed care underpins the services they provide. The implementation of trauma-informed care in mental health services can be achieved with the appropriate support, policies and systems in place.

Mental health practitioners can support service users to move beyond the traumatic events that they have experienced by shifting from focusing on patients, symptoms and illness towards providing holistic, individualised care that considers the whole person. Mental health practitioners also need to be mindful of the risk of retraumatisation in mental health services and understand how to provide trauma-informed care that reduces this risk.

TIME OUT 6

Consider how providing trauma-informed care relates to The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council 2018) or, for non-UK readers, the requirements of your regulatory body

TIME OUT 7

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: **rcni.com/reflective-account**

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Trauma-informed care

TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Which statement is false?

a) There is growing evidence that childhood trauma affects neurological development ☐
b) There no link between early trauma and adult mental distress ☐
c) Trauma can be experienced as a single event or multiple events over time ☐
d) The definition of trauma includes direct and indirect exposure to actual or threatened death, serious injury, or sexual violence ☐

2. One of the potential effects of exposure to trauma is:

a) Intrusion symptoms, such as recurrent distressing memories and dissociative reactions ☐
b) Persistent avoidance of stimuli associated with the trauma ☐
c) Negative alterations in cognitions and mood associated with the traumatic event ☐
d) All of the above ☐

3. Which of the following is not considered a symptom of trauma or behavioural response?

a) Agitation ☐
b) Self-harm ☐
c) Difficulty establishing relationships ☐
d) Hypoarousal ☐

4. Complex trauma is defined as:

a) Experiencing a traumatic event and additional factors, such as poverty and deprivation, suboptimal relationships and lack of support ☐
b) Witnessing a traumatic event as a bystander ☐
c) Watching a traumatic event on the news ☐
d) Caring for a family member or friend who has experienced a traumatic event ☐

5. Which of these is not a potential matching trigger for people who have experienced trauma?

a) Smells or colours ☐
b) A news story or television programme ☐
c) Validation of experiences ☐
d) A sensory perception ☐

6. What is retraumatisation?

a) When a person in care is exposed to an experience that activates their memory of a past traumatic event ☐
b) When healthcare practitioners experience secondary trauma as a result of caring for people who have experienced trauma ☐
c) When additional support is provided to enable an individual to process specific traumatic memories and consequences ☐
d) When healthcare practitioners cause intentional harm to service users ☐

7. Trauma-informed care aims to:

a) Optimise an individual's physical health ☐
b) Promote a cultural shift from what has happened to a person to what is wrong with them ☐
c) Provide care that is consistent with the medical model ☐
d) Acknowledge the long-term effects of trauma ☐

8. Which of the following is not one of the principles of trauma-informed care?

a) Trustworthiness and transparency ☐
b) Collaboration and mutuality ☐
c) Medicines administration ☐
d) Empowerment, choice and control ☐

9. One barrier to implementing trauma-informed care in mental health services is:

a) Resistance to acknowledging the link between trauma and childhood abuse as a causal factor in the development of mental distress ☐
b) Lack of acknowledgement of historical and cultural trauma legacies ☐
c) Healthcare practitioners finding it challenging to manage the trauma that their patients have encountered ☐
d) All of the above ☐

10. Which of these nursing concepts is considered essential in trauma-informed care?

a) Task-based care ☐
b) The therapeutic relationship ☐
c) Activities of daily living ☐
d) Setting SMART goals ☐

How to complete this assessment

This multiple-choice quiz will help you test your knowledge. It comprises ten multiple choice questions broadly linked to the previous article. There is one correct answer to each question.

You can read the article before answering the questions or attempt the questions first, then read the article and see if you would answer them differently.

You may want to write a reflective account. Visit rcni.com/reflective-account

Go online to complete this multiple-choice quiz and you can save it to your RCNi portfolio to help meet your revalidation requirements. Go to **rcni.com/cpd/test-your-knowledge**

This multiple-choice quiz was compiled by **Alex Bainbridge**

The answers to this quiz are:

1.b 2.d 3.d 4.a 5.c 6.a
7.d 8.c 9.d 10.b

This activity has taken me ___ minutes/hours to complete. Now that I have read this article and completed this assessment, I think my knowledge is:

Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor ☐

As a result of this I intend to: _____

_____

_____

_____

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ORIGINAL PAPER

Prevalence of Trauma in an Australian Inner City Mental Health Service Consumer Population

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Abstract
This study examined the rates and types of trauma reported by consumers utilising an inner city mental health service in Sydney, Australia. The study also explored whether consumers felt that it had been helpful to be asked about their experience of trauma, whether they thought that these questions should be asked routinely and if they wanted to talk about these experiences. Ninety-one consumers from an inner city mental health service were assessed. Eighty-eight percent of the consumers assessed reported that they had experienced at least one traumatic event, while 79% reported having experienced two or more events. A majority of consumers identified that they thought it was helpful to be asked about trauma and that it should be part of an assessment. However, less than one-third of these consumers surveyed wanted to talk about the trauma at the time of assessment. Concerns that clinicians may have in regards to addressing trauma in mental health assessment are not matched by consumers' expressed beliefs on the issue.

Keywords Assessment · Mental health · Psychiatric seclusion · Trauma-informed care · Trauma

Introduction

Derived from the ancient Greek word for wound, trauma has been defined in many ways. In the most recent iteration of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), trauma has been defined as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing an event; (b) witnessing, in person, an event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing repeated or extreme exposure to aversive details of such events (American Psychiatric Association 2013). Studies examining the incidence of trauma among mental health service consumers have found lifetime exposure to traumatic events to be as high as 73–98% (Mueser et al. 1998; Cusack et al. 2004, 2006; Bendall et al. 2008). Trauma among this population is associated with more severe outcomes including increased substance abuse, higher rates of relapse, more frequent hospitalisations and poorer psychosocial functioning (Cusack et al. 2006; Lommen and Restivo 2009).

Epidemiological studies have provided evidence that experiences of childhood trauma are associated with dramatic increases in the risk of developing depression in later life (Heim et al. 2008). Studies also indicate that people with a diagnosis of bipolar disorder report being exposed to more severe trauma in childhood than people without this diagnosis (Etain et al. 2008). The intensity of these traumatic experiences have been reported to significantly influence factors such frequency of hospitalization (Maguire et al. 2008).

Research has found that people with a diagnosis of schizophrenia report high rates of childhood physical or sexual abuse; Read et al. (2008) concluded that 21–65% of individuals with a diagnosis of schizophrenia had such experiences. It was also been observed that people experiencing psychosis were 2.72 times more likely to have been exposed to childhood adversity and trauma than those who were not (Varese et al. 2012).

The prevalence of exposure to trauma and long-term adverse mental health outcomes provides compelling evidence for mental health services to become trauma-informed

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in their approaches to treatment and care. Muskett (2014) has identified the key principles of trauma-informed care as (i) consumers have a need to feel connected, valued, informed, and hopeful of recovery; (ii) the connection between the experience of childhood trauma and current psychopathology is known and understood by staff; and (iii) staff work with consumers, their families, friends and their supports in ways that are mindful and empowering, and promote and protect the autonomy. Despite the relationship between trauma and mental health, Australia's mental health services have been criticised about their poor record in recognising the relationship between trauma and mental health, and responding appropriately in this area (Mental Health Coordinating Council 2013). In addition, many consumers have reported experiencing re-traumatisation through being exposed to trauma-associated events such as physical restraint and seclusion within mental health services (Watson et al. 2014, NSW Mental Health Commission 2014).

Despite the high rates of trauma reported by consumers and the potential for services to re-traumatise consumers, clinicians can be reluctant to ask about trauma (Mental Health Coordinating Council 2013; Briere and Scott 2014). The reasons for this reluctance may include clinicians not feeling sufficiently skilled to ask about and respond to trauma, and concerns that asking about trauma may exacerbate distress being experienced by consumers (Frueh et al. 2006; van den Berg and van der Gaag 2012). The authors note however that clinicians do regularly ask consumers about historical incidents of self-harm or suicide attempts which sit in clearer boundaries of clinical frameworks such as risk assessments.

This study aimed to examine reported rates of trauma using a brief self-report measure with the view to establishing the role trauma has played in the lives of this consumer population. Additionally, the participants were surveyed on whether they felt that it had been helpful to be asked about their experience of traumatic events; whether they thought that these questions should be asked about routinely and if they wanted to talk about these experiences. With ongoing concerns raised by clinicians about addressing trauma in assessment identified in literature and experienced by the authors in practice, it was hoped that study's findings could guide practice away from assumptions about talking about trauma and be useful in decision-making about the future directions for assessment, treatment and care.

Method

Participants

This study was conducted in St Vincent's Hospital in Sydney, Australia across five clinical areas within its mental health service. These were the acute inpatient unit, the psychiatric emergency care centre (PECC), rehabilitation service, early intervention service and case management service. The service's catchment area includes a density of homeless shelters and crisis accommodation services, as well as a large population of rough sleepers. It has also been one of the epicentres of the sex and illicit drug industries in Australia for over three decades (Petersen and Janssen 2007).

Ethical clearance for the study was granted by the St Vincent's Hospital Sydney Human Research Ethics Committee (HREC ref: LNR/13/SVH/44). The authors report no conflict of interests in the study. Participant recruitment was undertaken amongst all consumers admitted to the mental health service inpatient units over a 1-month period and from current consumers within the community based services. There were no exclusion criteria amongst this group. Potential participants were provided with an information sheet about the study by clinical staff (clinical psychologist and nurses). Counselling support was identified as being available to any potential participants if they became distressed by undertaking the TAA. The information provided by participants was de-identified so as to ensure confidentiality.

Ninety-one consumers across the five different areas of the mental health service participated, with non-English speakers excluded. A clinical staff member remained with the participant when they completed the questionnaire. The mean age of participants was 40.92 (SD = 10.81) with ages ranging from 16 to 79 years of age, and only two participants under 18 years of age. There were 58 males and 33 females. Data on race and ethnicity was not collected in accordance with mental health assessment policy of the facility. All participants were able to speak English at a level that they were judged to be able to adequately understand the questions by clinical staff. 30 participants were recruited from the acute inpatient unit, 28 from the psychiatric emergency care centre, and 22 from the community rehabilitation service, six from the early intervention service and five from case management.

Measure

Participants were screened using the Trauma Assessment for Adults (TAA) (Resnick et al. 1996). This assessment tool has shown consistency with other measures used in trauma assessment (Resnick et al. 1996). A brief revised version of this assessment tool used in this study has been used to measure lifetime history of traumatic events (Bendall et al. 2008, Cusack et al. 2004) and has been shown to be valid and reliable for trauma measurement in adults (Gray et al. 2009). The brief revised version of the TAA consists of 12 domains that ask respondents to respond "yes" or "no" in response to whether they have or have not experienced a specific traumatic event. The domains include war, accidents,

illness and natural disaster, sexual and physical assault, witnessing traumatic events and also allows for respondents to specify other stressful events not specifically asked about. This assessment tool was chosen specifically because of its short length and ease of answering without requiring respondents to add any details of the events that they had experienced. As this was a study focused on the prevalence of trauma, it was felt that requiring participants to provide too many details about their experiences was unnecessary and may have reduced response rates.

Three additional questions were asked to support the research aims. These were: "Do you think this was helpful to be asked?", "Would it be useful to have these questions asked as part of a routine assessment?" and "Would you like the opportunity to talk about this?" The first two questions had options for either yes or no answers and the third questions gave options of yes, no or maybe in the future.

Procedure

In the acute inpatient unit, the clinical psychologist and three interested registered nurses were provided with an explanation of the study and about the TAA and survey questions. They were instructed to approach all consumers over the 1-month period, at a time during their admission when their mental state made assessment possible. They were asked to explain the research and ask if consumers would agree to participate in the study. Additionally, the lead researcher attended many of the morning meetings held for consumers and explained the research and asked whether consumers would agree to complete the assessments at the end of the meeting. Attached to the research document containing the TAA and survey, were information about ethics and a consent form that participants were asked to sign. A sticker was placed on each patient's file when they had completed the research, or if they declined to participate, to avoid them being assessed on multiple occasions. In the PECC, the forms were included in the admission packs and the lead researcher attended the unit regularly to ask consumers if they wished to participate. Clinicians were present when consumers were completing the questionnaires.

For all three community-based teams, the lead researcher attended team meetings to provide an explanation for the research and the assessment tool. Clinicians were asked to offer the study to all of the consumers on their caseloads; however, it was not a mandatory task for clinicians, as well as consumers.

Across all five settings, consumers were given the choice of whether or not they wished to participate and were not approached again if they declined. Consumers were given the choice of completing the research forms independently or having the clinician read it to them and record their responses. This also allowed for screening of consumers who had poor literacy skills, were from a non-English speaking background or whose mental state made reading difficult.

Analysis

Analysis was undertaken using SPSS software (Version 16.0, Chicago, IL, USA). As the number of males and females were unequal, results are presented as percentages as well as counts for the male and female subgroups and for all respondents. The questions contained on the research form were of the form yes/no, hence only the numbers responding yes are reported, with the percentage representing the prevalence of this traumatic event. Pearson's Chi square test with one degree of freedom was conducted to examine differences in prevalence between male and female subgroups for each traumatic event, except for where subgroup response rates were <5, where Pearson's exact test was used. For the additional questions, only the final question allowed three responses (yes/no/maybe later) and hence the Chi square tests performed had one degree of freedom for the first two questions and two degrees of freedom for the last question to evaluate the difference between male and female subgroups for this measure. All analyses met the minimum participant requirements for the tests. Statistically significant results are reported with decision level $p < .05$.

Results

The study identified high rates of trauma reported by consumers utilising the service. Eighty-nine percent of the consumers assessed identified that they had experienced at least one event from the TAA domains. Seventy-nine percent had experienced two or more events (Fig. 1). The types of events that consumers acknowledged experiencing highlighted that consumers had experienced a wide range of trauma in their lives (see Table 1). The highest overall prevalence was for *bad accident* (49.5%), *physical attack with a weapon*

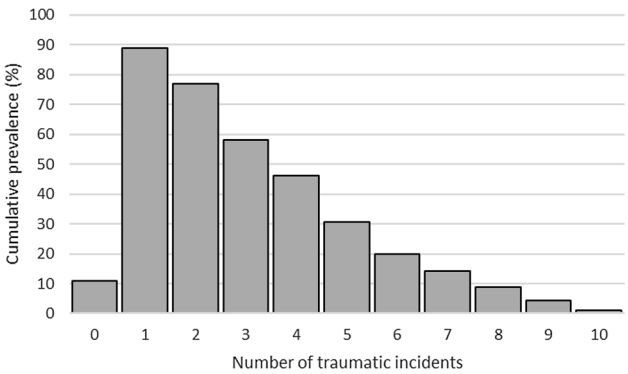

Fig. 1 Cumulative prevalence of number of traumatic events

Table 1 Prevalence of traumatic events among 91 mental health consumers screened with the Trauma Assessment for adult—brief revised version

Traumatic event	Males		Females		Total		χ^2	p
	n	%	n	%	n	%		
Military experience	8	13.8	3	9.1	11	12.1	.438	.508
Bad accident	34	59.6	11	33.3	45	49.5	5.79	.016
Natural disaster	9	15.8	6	18.2	15	16.1	.860	.769
Serious illness	7	12.1	2	6.1	9	9.9	.852[a]	.479
Sexual contact under age 13 (with person 5 years older)	11	19.3	8	24.2	19	21.1	.307	.580
Pressured to have sexual contact under age 18	14	24.6	14	42.4	28	31.1	3.11	.078
Physical force or threat to have sexual contact at any age	12	21.4	18	54.5	30	33.7	1.1	.001
Physical attack with weapon	27	46.6	12	36.4	39	42.9	.891	.345
Physical attack without weapon	23	39.7	13	40.6	36	40	.008	.928
Witness someone killed or seriously injured	25	43.1	11	34.4	36	40	.655	.418
Other stressful situation	32	55.2	14	43.8	46	51.1	1.08	.299
Close friend or family member murdered/killed	2	3.5	6	18.8	8	9	5.82[a]	.023
Close friend or family member killed by drunk driver	5	8.8	2	6.2	7	7.9	.180	.671

[a]Fisher's exact test

(42.9%), *physical attack without a weapon* (40.0%), *witness someone killed or seriously injured* (40.0%), *physical force or threat to have sexual contact* (33.7%). There was a greater than 50% prevalence for the reporting of *other stressful situation* (51.1%) perhaps indicating that the questions in the survey did not fully elucidate all the different life events considered traumatic by the consumers. The only traumatic events which had < 30% prevalence for this cohort were *natural disaster* (16.1%), *serious illness* (9.9%) and *close friend or family member murdered/killed* (9.0%).

The breakdown by gender highlighted that both gender groups had experienced one or more traumatic events in their lifetime, although there was variance in the gender groups between the types of trauma experienced (see Table 2). Eighty-eight percent of females and 89% of males reported experiencing one traumatic event, while 79% of females and 81% males reported experiencing two or more traumatic events.

There were some gender differences identified in this study, Females reported a significantly higher prevalence for *physical force or threat to have sexual contact* (males = 24.6%, females = 54.5%, p = .01) and *close friend or family member murdered/killed* (males = 3.5%, females = 18.8%, p = .02) and also reported higher prevalence for *pressured to have sexual contact under 18* (males = 24.6%, females = 42.4%, p = .078) which shows a trend towards significance. Most other traumatic events had similar reported rates for males and females, except for *bad accident* (males = 59.6%, females = 33.3%, p = .16), *physical attack with a weapon* (males = 46.6%, females = 36.4%, p = .35) and *witness someone killed or seriously injured* (males = 43.1%, females = 34.4%, p = .35), however the increased prevalence for males were not found to be statistically significant.

The responses to the survey questions examining consumer views on being asked about trauma highlighted that 70% of consumers believed it was helpful to asked about trauma; 65% of the group believed that trauma assessment should be part of routine assessment and 26% of the consumers would like the opportunity to talk about this trauma, while 36% did not want to talk about it at the time of assessment (see Table 2). This corresponds to a lower agreement that they willing to talk about trauma at all (61.2%), either now or in the future, compared to agreeing that being asked was helpful, or that it should be part of routine assessment. There were no significant differences between males and females on these measures, although females were more likely to agree that it was helpful to talk about trauma (males = 70.4%, females = 77.4%) yet were less likely want to talk about

Table 2 Extra questions: did consumers find these questions helpful, should they be part of a routine assessment and did they want to talk about it

Question	Male		Female		Total		χ^2	p
	n	%	n	%	n	%		
Helpful to be asked	38	70.4	24	77.4	62	72.9	2.68	.262
Should be part of routine assessment	38	66.7	20	69.0	58	67.4	.526	.769
Talk about this now	17	29.8	6	21.4	23	27.1	2.209	.331
Maybe talk about it in the future	21	36.8	8	28.6	29	34.1		

it both now (males = 29.8%, females = 21.4%) or in the future (males = 36.8%, females = 28.6%).

Discussion

This study aimed to examine reported rates of trauma using a brief self-report measure with the view to establishing how much of a role trauma has played in the lives of this mental health service consumer population across five clinical areas within an inner city mental health service. In addition, consumers were questioned to ascertain whether they felt that it had been helpful to be asked about their experience of traumatic events; whether they thought that these questions should be asked about routinely and if they wanted to talk about these experiences. The study found the reported incidence of trauma amongst the consumers was in line with the high rates found in international studies (Mueser et al. 1998; Cusack et al. 2004, 2006; Bendall et al. 2008). The rates of trauma identified by the population highlight that the great majority had experienced one or more significant traumatic events in their lifetime and that a majority of the consumers who completed the self-report measure believed it was helpful to be asked about trauma.

A growing body of evidence highlights that the single most significant predictor that an individual will need support from mental health services is a history of trauma (Kezelman and Stavropoulos 2012). Yet despite this link, Australia's mental health services have been noted to have a poor record in recognising the relationship between trauma and the development of mental health disorders and responding appropriately (Mental Health Coordinating Council 2013). The responses by mental health service consumers indicate that one of the ways mental health services can respond appropriately is by addressing trauma within assessment throughout their clinical areas, including inpatient and community services. Such changes are needed as part of much broader evolution in service delivery to ensure mental health services provide approaches to care and treatment that are "trauma-informed" and deal directly with trauma and its effects on the mental health of consumers. These services are underpinned by knowledge of trauma and the impact it has on the lives of consumers (Harris 2004). The wide range of trauma that consumers acknowledged experiencing also highlights the importance for clinicians to be aware of a wide range of possible traumatic events and the potential impact of these on consumers, including but not limited to childhood sexual and physical abuse.

This study only focused a relatively small group of mental health consumers utilising an inner city mental health service in Australia and this is a key limitation in regards generalising its finding. Further research is required to see if these findings are relevant with populations outside of this setting. Despite the limitations in the study, it has brought new insights on consumer's perspective on trauma assessment to this area in mental health service provision. These finding show most consumers think it is helpful to be asked about trauma and that it should be part of a mental health assessment. Our experience throughout the research process was that asking consumers about trauma did not further exacerbate distress being experienced by them or was in any way counter-therapeutic.

Conclusion

A growing body of evidence suggests that the single most significant predictor that an individual will need support from mental health services is a history of trauma (Mental Health Coordinating Council, 2014). Despite this link, Australia's mental health services have been noted to have a poor record in recognising the relationship between trauma and the development of mental health disorders and responding appropriately. Given the level of trauma that exists in this consumer population of mental health services, it is imperative that mental health services adopt a trauma-informed approach to care and treatment. Concerns that clinicians' may have in regards addressing trauma in mental health assessment are not matched by consumers' expressed beliefs on the issue. Clinicians need to be aware that consumers may have been exposed to a wide range of traumatic events and consider the possible impact of any of these events when working with consumers in both assessment, problem formulation and treatment phases.

Compliance with Ethical Standards

Conflict of interest The authors report no conflict of interest.

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