Trauma-Informed Care

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1 Introduction: A Paradigm Shift Towards Trauma-Informed Thinking

Trauma was declared a global public health concern when the World Health Organisation (Kessler et al., 2017)[1] found that 70% of the world's population have experienced at least one lifetime traumatic event ranging from threatened death, serious injury or sexual violence to the unexpected death of a loved one. Of these, approximately 13% of the population report experiencing four or more traumatic events in their life. Factors at individual, relationship, community and societal levels

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[1] Based on an analysis of data captured in the WHO World Mental Health (WMH) surveys. The WMH Surveys are a series of community epidemiological surveys that used this weighting scheme to generate a representative sample of trauma occurrences in the general population of participating countries.

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have been identified as explanatory factors in both the occurrence of trauma and its sequelae. The trauma experienced in childhood (i.e. adverse childhood experiences—ACEs) has been identified as a key risk factor for poor mental and physical health in adulthood (Alvarez et al., 2011; Anderson et al., 2016; Kessler et al., 2010).

In this chapter, we refer to trauma as 'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being' (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012, p. 2). The experience of a mental health crisis in itself can have a long-term traumatic effect, with the potential for retraumatisation through the use of coercive practices (Nizum et al., 2020).

A large proportion of people with mental health problems who access services present with high rates of trauma (Anderson et al., 2016), especially complex trauma (i.e. multiple or prolonged traumatic events) (Beckett et al., 2017). Women report higher odds of lifetime trauma/post-traumatic stress disorder (PTSD) than men (Valentine et al., 2019). Black people are more likely to experience PTSD than other ethnic groups (Roberts et al., 2011). Black men in particular are more likely to be subject to detention under mental health legislation (NHS Digital, 2019), thus more likely to be involuntarily hospitalised in mental health settings (Barnett et al., 2019) and potentially retraumatised (Mohan et al., 2006; Morgan et al., 2004). Racial and socio-economic inequalities are of key concern when it comes to trauma. One would think, therefore that services are designed in a way to acknowledge these inequalities with the view to aid recovery. However, as argued in this chapter, while there are key developments in this area, mental health services have been slow in embracing and implementing approaches to care dealing directly with trauma, by recognising this important link or responding appropriately, especially with regard to socio-demographic and key cultural differences.

The trauma-informed paradigm/philosophy—also referred to as trauma-informed care (TIC), trauma-informed approach (TIA) or trauma-informed care and practice (TICP) (Muskett, 2014)—is a system development model grounded in a holistic understanding of how trauma exposure affects one's neurological, biological, psychological and social development (Paterson, 2014), using an adapted definition of TIC, from SAMHSA (2014). This means that all people at all levels within an organisation have a basic understanding that trauma affects people's experiences and behaviour in the context of coping strategies in response to childhood or past adversity and circumstances as well as current events. It represents a paradigm shift within inpatient mental health services, challenging the early twentieth century institutional practices—blaming the individual, explaining behaviour as a consequence of a mental illness rather than a response/coping mechanism to trauma—which unfortunately are still common in some services. At a fundamental level, it is a shift from a service that asks 'What is wrong with you?' to considering 'What happened to you?'; a process of organisational change supporting environments and relationships that promote recovery and reduce or prevent retraumatisation (Sweeney et al., 2018). Trauma-informed approaches encourage services to reframe behaviour

seen as challenging as a functional, innately developed survival technique for trauma developed under acute distress. It contextualises trauma based on each individual's social and political background to understand how these impact past and current presentations (Sweeney et al., 2018). Trauma-informed key principles include safety, collaboration, empowerment, trustworthiness and choice (Isobel & Edwards, 2017).

Its principles are therefore particularly pertinent to inpatient mental health services—where the biomedical model of psychiatry is still predominant. People are admitted at times of crisis, sometimes without pre-existing trauma histories but experiencing high distress, loss of autonomy, social belonging and dislocation from normal support and family/friends (Muskett, 2014), sometimes with significant trauma histories, and often subject to involuntary treatment, psychotropic medication and the use of coercive practices. If trauma goes unrecognised, there is the risk that they can be retraumatised by ward practices (Walsh & Benjamin, 2020). Thus, approaches with a trauma-informed philosophy at their core include the recognition of the high rates of trauma amongst people with mental health problems (well documented in the literature (e.g. Anderson et al., 2016)) and the need to both understand the impact of trauma and respond appropriately.

However, while there is momentum in the uptake of trauma-informed approaches, there are still many barriers to their implementation. Trauma-informed care is a widely accepted philosophical model/framework within mental health settings but it is not always clear on how to operationalise it. As highlighted further in this chapter, more needs to happen to reach a consensus and allow the articulation of this guiding philosophy/framework to inform clinical practice.

2   The Impact of Coercive Practices on Trauma and the Concept of Retraumatisation

Mental health services run the risk of retraumatising trauma survivors. The use of coercive practices within mental health settings can trigger the same physiological responses associated with the original trauma and subsequently retraumatise the individual. Retraumatisation within services affects both staff and patients. The act of regularly practising restraint can have a physical and emotional toll such as injury, chronic stress and burnout.

Since their inception, the use of coercive interventions such as seclusion and restraint and more recently broader restrictive practices have received increasing criticism. Concerns over their negative impact have continued to grow. This is especially true when one looks at the experiences of service users and how they perceive these practices and their damaging effects. Since the 1980s, the number of high-profile cases resulting in physical and psychological trauma has risen significantly and been reported widely and globally. The negative impact on those who are cared for in services is palpable. This has not only been reported upon in the media but also in day-to-day practice and the increasing research conducted in this area.

Historically, however, there is a dearth of literature on the trauma associated with coercion and issues which do tend to be reported upon largely revolve around the use of seclusion and restraint; the 'harder end' of the spectrum of restrictions. Furthermore, there is a scarcity of literature dedicated specifically to the perspective of the patient.

Persons with mental health problems are undoubtedly vulnerable to additional traumatic or iatrogenic experiences that occur within mental health settings. It is reported that many of those diagnosed with mental disorders have been exposed to some sort of trauma historically (Mueser et al., 2004). The long-term effects of trauma can then in turn result in vulnerable hospitalised patients exhibiting distress and negative approaches to coping, often inappropriately referred to as 'challenging'.

2.1   Cycle of Trauma

It has been argued by some that a cycle of trauma for hospitalised patients can be inadvertently perpetuated by mental health professionals who respond to escalating and threatening behaviour by using coercive practices that subsequently retrauma-tise individuals (Huckshorn, 2006; National Association of State Mental Health Program Directors [NASMHPD], 2005). Admission to mental health services can then be traumatic for patients without pre-existing trauma histories as a result of loss of autonomy and dislocation from normal supports and family (Muskett, 2014). Using coercive methods exacerbates the impact of these experiences (Borckardt et al., 2007). This can result in fear, mistrust, depression and negative coping behav-iours, such as self-harm, dissociative behaviour and aggression (Saakvitne et al., 2000).

Trauma symptoms and the absence of perceived safe and supportive inpatient environments create obstacles to effective treatment and care for those in mental health services (Muskett, 2014). Providers may have no definitive way of knowing who has a history of trauma; Elliott et al. (2005) suggest accordingly that 'universal trauma precautions' should be applied to all; that is, nurses routinely using practices that are growth-promoting and recovery-focused and less likely to retraumatise those already exposed to significant interpersonal trauma.

2.2   Spectrum of Coercion

The iatrogenic harm caused by coercive practices is still poorly recognised yet the spectrum of coercion and its impact can be wide-reaching. O'Brien and Golding (2003) argue that we should understand coercion as 'any use of authority to override the choice of another' (p. 168). Szmukler and Appelbaum (2008) later conceptual-ised coercion as ranging from harder types, such as legal measures, seclusion, restraint and enforced medication, to softer types. Soft coercion is defined as a per-ceived threat of punishment or force (Gilburt et al., 2010; Lloyd-Evans et al., 2010).

The term 'softer' coercion is often used to capture the meaning of both soft and subtle coercion (Anderson et al., 2020).

When exposed to the formal harder type of coercive care, patients might be subject to forced medication, seclusion or physical restraint. During such circumstances, coercion is explicit, more likely to be documented in patients' records and is largely regulated within legal frameworks. In contrast, soft coercion could be perceived to be less obvious (O'Brien & Golding, 2003). This can include actions where health professionals use their power to put pressure on patients to behave in a certain way and comply with treatment plans. This kind of softer coercion is more implicit, is less subject to formal decisions and documentation and can also be described by some as informal coercion or more recently blanket restrictions (Anderson et al., 2020). Many examples of informal coercion exist and mental health professionals tend to underestimate the impact of their use.

Despite patients reporting harrowing experiences related to hard coercion (Hughes et al., 2009; Paksarian et al., 2014), less attention is given in the literature to softer coercion and 'the "heterogeneity of coercion" remains poorly understood' (Molodynski et al., 2016, p. 1). Szmukler (2015) calls for a more precise understanding to advance thinking and research into the broader spectrum of coercive practice (Allison & Flemming, 2019). The differences between and impact of hard and soft coercion are outlined more fully below.

2.2.1   Hard Coercion and Trauma

A plethora of studies in mental health settings over the years has cast light on the negative and complex aspects regarding, in particular, the use of seclusion with or without restraint and many patients are left with negative views of the events (Larue et al., 2013; Wilson et al., 2017). Whilst there are recommendations reporting the safe use of these practices (NICE, 2015), they remain contentious areas of mental health care. Existing literature suggests that there are serious physical and psychological implications surrounding approaches associated with 'hard coercion' for both mental health patients and nurses alike. There is growing evidence that such approaches are not compatible with the values of recovery in mental health care (Douglas et al., 2022).

Concerns associated with the use of restraint and seclusion specifically include reports of psychological trauma, physical injuries and even death (Douglas et al., 2022; Knowles et al., 2015; Wilson et al., 2017). According to the literature, the experience of restraint can have a profound physical and psychological impact on individuals, and few are likely to remain neutral about it (Bigwood & Crowe, 2008; Frueh et al., 2005). With regard to the physical impact, there is a clear evidence base that highlights issues pertaining to injuries and in some cases death (Duxbury et al., 2011; Kersting et al., 2019; Lazarus, 2001).

The psychological effects can be wide-ranging and include trauma, fear, dissatisfaction, stigma and perceptions of punishment. Some studies suggest that participants report feelings of anger (Donat, 2002; Frueh et al., 2005; Kontio et al., 2012), recall traumatic memories or experiences of trauma (Haw et al., 2011) and express feelings of abandonment and isolation (Bonner et al., 2002; Holmes et al., 2004;

Larue et al., 2013; Mayers et al., 2010). Furthermore, restraint creates the potential for corrupted cultures of care, diminishes the care experience and tends to undermine the development of a trusting relationship between staff and patients (Douglas et al., 2022).

In a concerning number of studies, patients have reported that they felt restraint had been employed abusively and that staff had applied undue force. In a study by Haw et al. (2011), for example, 84% of forensic inpatients experienced the use of seclusion and restraint negatively, saying it reminded them of a 'prison cell', and believed it was a consequence of disobedience to staff. Keski-Valkama et al. (2010) found that 66.3% of patients perceived seclusion as a punitive measure; this proportion was significantly higher in the forensic group (73.1%) than in the general psychiatric group (54.1%). Patients also reported that the imposition of seclusion and/or restraint was the consequence of 'bad behaviour'.

In contrast, research on practitioners' views tends to focus on the management of safety and less so on the impact on the patient. For example, various studies focus on an increase in violent acts and risk of injury for both patients and staff during SR episodes (Paterson & Duxbury, 2007). Furthermore, whilst there are some reports of restraint being experienced in a positive light providing patients with a sense of security when they have lost control of their actions (Iversen et al., 2011; Wynn, 2004), evidence suggests that the practice is largely experienced by those receiving it as negative.

2.2.2 Soft Coercion and Trauma

There is increasing evidence today of the negative impact of practices referred to as soft, subtle or informal coercion, blanket restrictions and/or broader restrictive practices as described above. Allison and Flemming (2019) conducted a qualitative evidence synthesis to obtain an overview regarding experiences related to softer coercion. They concluded that it is important for practitioners to have a greater understanding of how the clinical environment has an impact on their role and the power of coercion within 'caring relationships'.

The impact of the environment and ward culture has been reported upon for some time (Duxbury, 2002). Studies, for example, have provided important insights into patients' perceptions of a range of contributory factors including the physical and atmospheric milieu of an environment, the culture of wards and levels of aggression and acuity in psychiatric settings. Yet their impact with regard to trauma is often overlooked. Many practices and procedures, such as ward rounds, ward rules, search procedures, locked doors and mixed-sex patient populations are retraumatising, as they are experienced by patients as emotionally unsafe and disempowering practices (Borge & Fagermoen, 2008; Clark et al., 2008; Cleary, 2003).

The potential negative impact of restrictions such as unit rules is also evident. The Mental Health Act Code of Practice (Code) defines blanket restrictions as rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or classes of patients, or within a service, without individual risk assessments to justify their application. Studies suggest that the overarching experience of psychiatric hospitalisation may be distressing, harmful, or traumatic

to many patients, and patients report that coercion is incompatible with expectations of care and that it is 'anti-recovery' (Frueh et al., 2005). Consequently, patients may express feelings of animosity towards staff due to the diminishment of trust.

The impact of soft coercion in the form of blanket restrictions is gaining growing attention and their role in exacerbating trauma outcomes cannot be underestimated. Deveau and McDonnell (2009) argued some time back that the practice of blanket restrictions has the potential to cause immediate and lasting harm whilst breaching people's human rights. They further suggested that the misapplication of BR can disrupt the delivery of care that is respectful and responsive to people's preferences, needs and values, and therefore needs to be addressed.

3   Trauma-Informed Care Approaches and Interventions

Trauma-informed care (TIC) approaches and care systems are seen as an essential component in reducing the use of seclusion and restraint, and other types of coercive measures in mental health settings (Huckshorn, 2004). This approach assists professionals in gaining insight into the causes of violence and aggression and understanding factors that may trigger violent episodes. On an organisational level, this approach requires being conscious that their services can retraumatise admitted patients by the use of coercive measures (Aremu et al., 2018). In this section, we provide an overview of existing TIC-based approaches and interventions to reduce coercive measures and their impact on health outcomes and practice.

Trauma-informed interventions have been explored in different mental health settings, including acute inpatient units for adults (Aremu et al., 2018; Blair et al., 2017; Blair & Moulton-Adelman, 2015; Duxbury et al., 2019), forensic inpatient mental health care for adults (Maguire et al., 2012; Putkonen et al., 2013 [men only]), children and adolescent units (Azeem et al., 2011), substance abuse units (Borckardt et al., 2011), geriatric units (Borckardt et al., 2011) and community-based services (Craig & Sanders, 2018). To establish the impact or effectiveness of using trauma-informed approaches, various study designs have been adopted including quality improvement (e.g. Aremu et al., 2018; Blair et al., 2017; Blair & Moulton-Adelman, 2015), quasi-experimental (e.g. Azeem et al., 2011; Borckardt et al., 2011; Duxbury et al., 2019), experimental (Putkonen et al., 2013) and retrospective evaluation (Guzman-Parra et al., 2016).

TIC approaches related to the aim of decreasing the use of coercive measures in inpatient settings have been most widely studied about the Six Core Strategies, originating from TIC (e.g. Azeem et al., 2011; Craig & Sanders, 2018; Guzman-Parra et al., 2016). These six strategies include the use of restraint and seclusion reduction tools, consumer roles in inpatient settings, debriefing techniques, leadership towards organisational change, use of data to inform practice and workforce development. The strategy related to the leadership is seen as a mandatory core intervention, including defining and articulating a vision, values and philosophy that expects the reduction of coercive measures, creating an action plan to implement that vision and holding staff accountable to that plan. TIC is an essential part

of the strategies, such as workforce development on service and staff education levels. The use of tools includes measurement of trauma, and debriefing techniques take into account the potentially traumatising effects of coercive measures (Huckshorn, 2008).

In the UK, an adapted version of the Six Core Strategies, 'REsTRAIN YOURSELF', was developed and implemented (Duxbury et al., 2019). This version also includes six main strategies: Setting team goals for the reduction of restraint, reflecting upon the use of restraint and personal communication styles, using approaches to help patients and staff ascertain needs and challenges with regard to aggression on the ward, employing partnership working strategies to reduce restraint such as 'advance directives' (my safety plan), and positive communication, exploring environmental challenges to make appropriate changes, and debriefing following incidents or near misses of restraint. These six are further divided into smaller interventions (Table 1). It is mentioned that 'REsTRAIN YOURSELF' notices the impact of trauma for both staff and service users, and by clinical supervision seeks solutions to reduce it (Duxbury et al., 2019).

Another multicomponent model based on TIC is the engagement model (Blair & Moulton-Adelman, 2015; Borckardt et al., 2011; Hardesty et al., 2007), with its origins in the Sanctuary approach (Bloom, 1997; Sanctuary Institute, 2022). The model aims to provide a safe and healing environment founded on trauma-informed care. It has two main components, key clinical interventions and leadership approach, which are divided into smaller interventions (Table 1). In the engagement model, trauma history is screened during admission, to better understand individual

Table 1 Components of different TIC-based interventions

Six Core Strategies[a]	REsTRAIN YOURSELF[a]	Engagement model
Use of restraint and seclusion reduction tools	My safety plan sensory/comfort/low-stimulus rooms	*Key clinical interventions* admission process Minimising the power differential: a culture shift physical environment
	Visible nurse	
Consumer roles in inpatient settings	Community meetings advocacy and peer support	
Debriefing techniques	Debriefing tool	*Leadership approaches*
Leadership towards organisational change	Identified and agreed on targets and philosophy	Shared decision-making: Empowering staff to own their practice staff education and quality review rewards and recognition
	Use of ward champions	
	Executive walk rounds	
Use of data to inform practice	Visual display data including safety crosses and mood boards	
Workforce development	Trauma- and prevention-orientated training	

[a]*REsTRAIN Yourself* has its origins in Six Core Strategies and their similar components are in the same row

triggers and to provide helpful strategies to cope. A trauma-informed approach is present also, for example, in staff education (Blair & Moulton-Adelman, 2015).

The components of these TIC-based interventions are described in Table 1. While these interventions share similar components, albeit with various names, they are also unique in what they comprise. For example, the Six Core Strategies include a component called 'Use of Restraint and Seclusion Reduction Tools'. In 'REsTRAIN Yourself', this component has been divided into three smaller interventions: My Safety Plan, Sensory/Comfort/low stimulus rooms and Visible Nurse (Duxbury et al., 2019). They all include clinical interventions to reduce the use of coercive measures, leadership activities and organisational-level changes.

The TIC approach has also been used together with other interventions to reduce coercive measures. These interventions have included brief solution-focused therapy (Aremu et al., 2018) and different intervention packages. For example, Blair et al. (2017) combined TIC-based training for staff with the use of the Brøset Violence Checklist (BVC), crisis intervention course, changes in hospital policy and procedures, and environmental enhancements. Aremu et al. (2018) focused on increasing staff's engagement with service users, and Blair et al. (2017) on staff behaviour (Risking Connections® training).

3.1 Outcomes of Trauma-Informed Care (TIC) Approaches and Interventions Related to Coercive Measures

Multiple intervention studies have been conducted worldwide on TIC approaches and the reduction of coercive measures. TIC interventions have had a positive impact on the reduction of coercion.

The use of the TIC approach to reduce the use of coercive measures has been studied in the USA (e.g. Aremu et al., 2018; Blair & Moulton-Adelman, 2015; Borckardt et al., 2011), Australia (Maguire et al., 2012) and Europe (Finland, Putkonen et al., 2013; Spain, Guzman-Parra et al., 2016; UK, Duxbury et al., 2019). The Six Core Strategies, a trauma-informed intervention, have spread in clinical practice in many countries, including Canada, Australia, New Zealand, Germany, Turkey, Sweden, Finland, the United Kingdom and the Czech Republic (LeBel et al., 2014).

Studies evaluating the impact of TIC approaches have reported results related to the use of physical restraint (Duxbury et al., 2019), mechanical restraint (Guzman-Parra et al., 2016; Guzmán-Parra et al., 2022; Putkonen et al., 2013), seclusion rooms (Putkonen et al., 2013), involuntary medication (Aremu et al., 2018) and observation (Putkonen et al., 2013). Other outcomes measured have included physical violence towards others or self (Putkonen et al., 2013), injuries of staff and patients (Putkonen et al., 2013), attitudes towards patient aggression and engagement with patients (Aremu et al., 2018).

Results related to the reduction of mechanical restraint events by implementing TIC have been mixed. In the USA, when using Six Core Strategies, the length, events and percentage of patients experiencing mechanical restraint declined

(Conley, 2004). In Spain, in a small-scale study conducted in one unit using four of the Six Core Strategies, a significant reduction was seen in mechanical restraint events (Guzman-Parra et al., 2016), while on a larger scale, with 20 units, implementation did not have an impact; however, the length of the events decreased (Guzmán-Parra et al., 2022). In Finland, the length of mechanical restraint events decreased significantly after implementing the Six Core Strategies (Putkonen et al., 2013).

For seclusion and observation events, the effect of Six Core Strategies in Finland in units with men with schizophrenia was a significant decrease in the length of mechanical restraint (Putkonen et al., 2013). In Australia, a project following Six Core Strategies resulted in a significant decrease in seclusion events and hours (Maguire et al., 2012). A quality improvement project conducted in the USA found a decrease in the use of involuntary medication after implementing the TIC approach together with brief solution-focused therapy (Aremu et al., 2018).

A declining trend in the use of seclusion and restraint after the introduction of TIC approaches has been established in both adult (Borckardt et al., 2011) and children and adolescent psychiatric care settings (Azeem et al., 2011). Beyond the impact on the level of coercive measures, evidence suggests that implementing TIC approaches, for example, the Six Core Strategies did not affect physical violence (Putkonen et al., 2013), nor attitudes towards patient aggression or engagement with patients from the staff perspectives (Aremu et al., 2018).

Existing evidence about impact points to the fact that, as with other types of complex interventions aiming to reduce the use of coercive measures, implementation and achieving sustainability can be an issue (Wieman et al., 2014). Currently, there is a lack of studies showing the long-term impact or effectiveness of TIC-based interventions. However, there are some results showing reduction of the use of coercive measures could be sustained over time, possibly benefiting from the use of a structured implementation model, such as the Iowa Model for Evidence-Based Practice–Revised (Hale & Wendler, 2023). Such a model could give a structure for translating research evidence to clinical practice in a way that an intervention would be permanently integrated into care. In addition, current research on the TIC approach in reducing the use of coercive measures does not give clear answers on whether this approach works for all genders equally or for people with different ethnic backgrounds. One of the few randomised-controlled trials in this area, for example, conducted within forensic mental health wards for men, indicated an over-representation of white Finnish Caucasians (Putkonen et al., 2013), limiting the generalisability with regard to other genders, nations and ethnicities. As the TIC approach has been, in general, tested in organisational and ward contexts without individual randomisation (e.g. Duxbury et al., 2019; Maguire et al., 2012), there is a lack of information about whom this intervention might work best.

In studies aiming to reduce the use of coercive measures, the main outcomes have self-evidently focused on seclusion, restraint and involuntary medication. So far, there is a lack of knowledge about patient experience, namely if the intervention has an impact at an individual level on post-traumatic symptoms, retraumatisation or psychological symptoms. We propose that future research should focus on the

perspective of people with lived experiences, patients and family members. To help us contextualise and better understand trauma histories/journeys, the next section incorporates the accounts, views and reflections of one of the authors with lived experience of psychosis.

4 Emerging from the Depths of Trauma: A Lived Experience Account

4.1 The Circle of Trauma: Between a Rock and a Hard Place

I was travelling in Thailand on my own and feeling free with independence. I'd stopped taking my psychiatric medication as no one was monitoring me on it anymore. I had trouble sleeping, I wasn't eating or drinking properly and I began to feel unsafe travelling on my own. This was the perfect storm that meant I became consumed by my psychosis. I was uncovering the mysteries of the universe laying in a hammock on the beach, realising the moon in the night sky was responsible for the formation of waves I saw lapping the sea. Everything was mesmerising until my thoughts became terrifying and instead of seeing a beautiful reality, my world was consumed by terror and delusion. Slowly over time, I thought people were trying to poison me, there were conspiracies going on through the news I saw on TV, and I thought I was the only one who knew the truth.

I was swimming and the sea was so grand and overwhelming. I was hurt and felt stuck between the crashing waves pushing me against the rocks. My experiences of delusion led me to feel unsafe, feel out of control and think that bad things were happening to me. These were manifestations of a previous trauma I suffered in my childhood where I experienced bullying. This circle of trauma was repeating itself and what I was experiencing in Thailand was me reliving that trauma in a different way. Maybe it was bubbling to the surface as I had not dealt with my childhood trauma. I couldn't recognise that these experiences were replications of my past and so I became consumed by my psychosis.

I had overstayed my visa and needed to return home to the UK, but I had to navigate Thai Airways. I thought the people in the airport were sending dangerous people to different countries via their different airlines. It was my duty to alert people of this risk to the world. I found it difficult to get home, I was taken off an aeroplane as I was considered a risk and driven in the back of a car outside the airport with a bag over my head. On reflection, I don't understand the need for this; the only sense I can make now is they did this to calm me down. I needed a medical check that was communicated to me by the British Embassy. Eventually, I returned home after a long flight during which I remained hypervigilant and terrified throughout the whole journey. I thought that as soon as we landed, I would be killed. As the plane landed, nothing happened, and I didn't need to stay longer on the plane or be handcuffed by anyone. At the airport gate, I fell into my mother's arms and cried and cried.

We eventually reached home, but my psychosis followed me. Over the next few days, I thought my mother and family were imposters taken over by Thai people

who were out to get me and poison me. I couldn't eat or drink anything or leave home as I thought everyone wanted to harm me. My family realised I was unwell and called the GP. Two GPs came and went, and then some others arrived to assess me, but I didn't trust them. They said they were social workers that were there to help. But were they going to harm me? Why was my mum listening to everything they said? Did she not believe me that they were sent here by someone to kill me? Or were they the ones that were going to help me alert the world to danger? They told my mum to pack a bag for me. My mum told me to go with them. I did what my mum said, even though I believed they were going to kill me, but I walked to my death.

I got to the hospital and was there for 4 weeks. I was detained under the Mental Health Act[2] against my will. The Mental Health Act (1983) in the UK is where a patient is identified as suffering from a mental health disorder and can be detained against their will by mental health professionals if the patient is considered to be a risk to themselves and/or others. This detention is for the purpose of assessment and/or treatment. Multiple independent mental health professionals must be in agreement about the decision to detain. This meant I had to be there, I didn't have a choice, and again I felt as though I was not in control or safe. The first week I refused all treatment as I didn't trust their intentions, and I became angry as I felt unsafe and didn't know why I was there; they were delaying my mission. I became angry and the rapid response team started running towards me, there were a dozen or so of them, against only me. I was forcibly restrained and injected with an intramuscular injection. I went into a deep sleep. Over the next few days, I slowly returned to reality, and I didn't feel as scared, and the delusions were slowly dissipating. Despite the benefits of this forced treatment, at the time I still experienced terror, violence and coercion.

My family were also traumatised by my experiences. They didn't know what was happening in Thailand, just through snapshots of phone calls with them at different times and stages in my trauma. They had no control over my situation while I was abroad. Then my mum was having to navigate visiting me in hospital whilst looking after my younger sister and my dad who was ill with cancer at the time. My family and I went through a shared trauma, but I was the only one who got help with this at the time. It felt like everything around me was consumed in trauma, I was between a rock and a hard place. I needed support and cushioning from the constant blows happening both in reality and what I thought was reality.

4.2   Recycling Trauma

There is much talk on trauma-informed care, but how can forcible treatment ever be considered trauma-informed? For it to be trauma-informed, it requires learning

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[2] Add brief info about the MHA for non-UK readers.

from accounts and experiences of trauma that may run the risk of retraumatising individuals through reliving that experience and asking them to reflect on it. There are ways to make the process much less harmful, through drawing on effective communication strategies, understanding the history and triggers of the patient, ensuring they have as much choice and control over the situation, and kind and compassionate care. This all seems incompatible with forced treatment and detention under the Mental Health Act. Although, in order to prevent those who have experienced trauma from additionally experiencing iatrogenic harm at the hands of service providers, listening and learning from patient experience are essential. Although reflections of those with lived experiences of trauma are beneficial and can better inform clinical practice. It may however run the risk of retraumatising patients. Therefore, there is an opportunity to inform clinical practice by those who work as experts by experience, who are more likely to be in recovery and be more distanced from their traumatic experiences. Often contexts in which the medical model is re-enacted can be triggering for those who have experienced coercion or trauma. This might also occur for those who work in expert-by-experience roles. For example, displays of power imbalances, and lack of choice and control in everyday life, may be especially triggering for those who have experienced trauma. It is essential to find ways to process trauma and make sense of our experiences, but it is not to justify or make sense of why others were violent towards us as we may never understand this and it feels wrong to justify or humanise any kind of violence.

4.3   Trauma-Informed Care: The Calm After the Storm and the Warmth of the Sun

Following my 4 weeks under detention of the Mental Health Act, I was discharged to the early intervention in psychosis team (EIP). This team lay in contrast to the risk and medically informed approach of inpatient treatment. The EIP team felt like it was enveloping me in safety and support across all areas of my life. I was emotionally validated, and I had continuous consistent compassionate support for 3 years. My needs were met across those years in a number of areas such as psychological, psychiatric, social, employment, family and physical health support. I was able to understand my experiences, the trauma I went through and how to manage my health needs going forward. The support was also extended to my family, so they could understand my experiences. The treatment felt like the calm after the storm, I was at peace, and I could feel the warmth of the sun, trust my experiences and understand my reality as it was. I was able to understand my experiences through the narrative I constructed. I started writing a blog called 'The Teal Tiger' (Gupta, 2022), which embodied my experiences of psychosis, in which I share my experiences, with creative license, which gives me control over the meanings I want those experiences to have. The trauma remains in that body of work, and so I can leave it there, and be free of it in my own world.

4.4   Post-Traumatic Growth and Emerging Identity: Weathering the Storm

To help me understand my own experiences and learn ways to move forward, I completed a BSc in Psychology, a PGDip in Mental Health Nursing and an MSc in Psychological Research Methods. I have now currently completed my PhD in psychology and am working as a Research Associate on the EXTEND EIP study to understand how to personalise the duration of EIP care for people with psychosis. It feels as though I have moved forward from my own lived experiences to conduct research that can support others with similar experiences. I have been able to make sense of my experiences through psychological and conceptual models of mental health and disability that I identify with and I have created my own ways to understand my experiences.

Having worked as an expert by experience, where I use my experiences to help inform the training of clinical psychologists, I became interested in understanding how my identity was affected by my experiences of working in roles that related to my lived experiences. I developed the EMERGES framework (Gupta et al., 2023) through a systematic narrative review. The framework has helped me understand the trajectory of my own experiences and it is a framework that embodies my lived experience. It explains the identity of lived experience researchers and providers, which identifies influencing factors through the acronym of EMERGES: of Empowerment, Motivation to integrate our lived experiences, Empathy of the self and others that occurs through sharing and constructing narratives that we understand our own experiences through learning through the experiences of others, Recovery model and medical model, Growth and Transformation, discussing experiences of Exclusion and our historical experiences of Survivor roots. This conceptual model helps me understand my experiences of trauma and who I am now, having moved through the stages of the framework.

For example, having been a survivor, this is the root of all my experiences and the foundation on which my interests and professional experience are based. Through exclusion from social networks and society due to the stigma of my diagnosis, I have been supported to get through these experiences with support from Early Intervention in Psychosis care. Through engaging in expert-by-experience work, I have been able to grow and transform into someone who is much more than someone who has been a service user, and I have much more to offer, and my experiences can be learned from, supporting service providers and services to also grow. The different models in psychology such as the recovery model, medical model and the EMERGES framework help me to understand my own experiences and the power imbalances in my trauma, and experiences of healthcare. It also makes me realise the complexity of recovery, which does not just limit someone to being symptom-free but being able to live alongside difficulties and traumatic experiences, that are so prominent. It seems unfair and invalidates the severity of the trauma experienced if we are expected to overcome these experiences completely. I have gained empathy and a shared understanding of others with similar experiences. This extends to survivors of different types of traumas, but the violence and

boundaries crossed in personal relationships and experiences with the mental health system are something each of us can understand, relate to and which connect us as survivors. These experiences motivate me to want to integrate my own lived experiences into the work I do and ensure that the training of healthcare professionals is informed by lived experience and trauma-informed approaches. These experiences of survivorship inform the perspectives I bring to my expert-by-experience role and the things I advocate for to make services safer spaces for people with mental health experiences. Although, those in expert-by-experience roles also require support due to their increased risk of being triggered when drawing on and reliving their lived experiences.

My professional experiences in mental health have been empowering, and I feel I have come a long way from what I consider my survivor roots and the raw and emotional experiences I have gone through. I have weathered the storm and emerged whole. I previously lost myself in my psychosis and experiences of trauma, but through trauma-informed care, and seeking to understand my experiences through more compassionate psychological models and trauma-informed models, I have built myself up through a better understanding of my own experiences, building resilience and fostering aspects of myself such as my professional skills that move me further away from my survivor roots.

It is difficult to not be self-defined by trauma, but it is empowering knowing I have emerged on the other side and can help inform trauma-informed services from a more distanced position as a professional with expertise in the area. This perspective from which I approach trauma-informed work helps me maintain a distance from the raw and emotional burden of these experiences that I might experience writing this from a survivor's point of view. Instead, the expert-by-experience role helps me articulate these experiences from a distance and in ways that can be tolerated by myself and others. I encourage other survivors to understand their own traumas in ways they find helpful to process what has happened to them.

That trauma I experienced is submerged, and whilst there may be triggers that raise it to the surface, I know I can remain afloat. I have emerged from the depths of trauma despite aspects of myself that have eroded away but with the remnants of the strongest, and most resilient aspects of myself that have weathered the storms, as my basic needs of warmth and compassionate care have been met.

5   What Next?

This chapter has brought together evidence, reflection and lived experience to raise awareness about the importance and impact of trauma and retraumatisation for people accessing mental health services internationally, the range and effectiveness of trauma-informed interventions used to reduce coercive measures, and key shortfalls within both research and practice in this area.

The evidence suggests that traumatic and harmful experiences within mental health settings are wide-ranging and warrant greater attention. Whether coercion is deemed to be hard or soft, formal or informal, it is a complex phenomenon with

harmful repercussions and outcomes. It has been described as a necessary evil by some (Wilson et al., 2017) and without doubt remains challenging for nurses who struggle between a wish to do good and a desire to stay within the norms of existing nontherapeutic cultures of 'care'. According to Iversen et al. (2011), maintaining the therapeutic alliance and being mindful of the objectives of person-centredness, safety and comfort during, prior to and following incidents including the use of restrictive practices can positively influence perceptions of the experience of coercion (Larue et al., 2013). Nonetheless, Hodas (2006) states that trauma-informed organisations, programmes and services are those that are cognisant that their services can retraumatise those with significant trauma histories through the indiscriminate application of any coercive practice. A trauma-informed approach to inpatient care provides an alternate lens by understanding the negative effects of trauma history on patients so that staff can develop a milieu that anticipates and responds to those who feel distressed and out of control. To develop a culture of safety, staff perceptions, approaches and policies need to change in a myriad of ways.

Firstly, the importance of collaboration between staff and patients needs to be recognised and the issue of trauma placed at centre stage and at the heart of all aspects of policy, procedures and workforce development (Douglas et al., 2022). To influence the clinical practice that governs the use of coercion and to address resulting trauma, it is essential to explore and listen to patients' experiences, and concerns of, and about the use of coercive practices. The call for meaningful involvement of people with lived experience, patients and family members/carers resonates in all sections of this chapter. Veenu's story takes us to experiences of a multiplicity of traumas and retraumatisation but highlights that, when services are trauma-informed, compassionate and person-centred, they can aid recovery. It also alludes to the idea that survivors need to understand their traumas in their own ways, in contrast to forced formulations from service providers, to enable them to make sense of their own experiences of trauma and survivorship in ways they personally identify with, consequently giving them more control over their experiences. Much anecdotal evidence on service user involvement identifies that experts-by-experience have emphasised the importance of introducing trauma-informed models of care in service provision, but that service providers are slow to implement changes in service provision. Veenu's account identifies how learning from lived experiences can help inform trauma-informed services and justifies and provides a rationale to introduce trauma-informed services as a matter of urgency. It also identifies that learning from lived experience may be a process that is retraumatising, and so the emphasis is placed on learning from service users who work in expert-by-experience roles, where they may be more distanced from their survivorship. This can support services to become trauma-informed, without inflicting more harm on survivors to re-live their experiences. Although, increasing support for those in these roles is important through, for example, supervision, reflective or trauma-informed practices that may be important for them in their roles.

Secondly, there is a need to foster and implement data-informed practice, exploring the extent and nature of disproportionality with regard to trauma to better

understand the intersectionality between socio-cultural historically embedded traumas such as racism, poverty, colonialism, disability, sexism and gender-based abuse (Sweeney et al., 2018). We stress the importance of hearing from minorities who are trauma survivors yet who are under-represented in coercive practice-related data. While future research should aim to un-silence these communities to address significant gaps, using innovative inclusive methodologies and approaches, services should strive to address disproportionality through a wide range of strategies beyond data-informed practice, including the involvement of people with lived experience in staff training.

Evidence presented in this chapter suggests that, while a number of trauma-informed interventions have been found to be effective in different mental health settings, leading to substantial reductions in the use of coercive measures, more research is still warranted to understand if these interventions work in different populations (taking into account gender, ethnicity, sexuality, religion, etc.,) and whether they create positive and sustainable change, beyond the reduction of coercion, to individual outcomes, such as post-traumatic symptoms. In some studies, there has not been any significant effect on the use of coercion by TIC-based interventions. These contradictory findings suggest that there is room to explore for whom and in which circumstances these interventions actually work.

The literature exploring trauma in relation to coercion is not comprehensive and to a certain extent dated. More importantly, it lacks diversity, especially with regard to ethnicity and other key protected characteristics. This is probably due to the legacy of longstanding 'whiteness' in academia (and implicitly the people who undertake the research in this field) and in psychiatry in general. These implicit biases and gaps in evidence need to be addressed to adequately explore the relationship between trauma and coercion in mental health settings and the response to this, especially given the drive to use evidence-based practice.

Thirdly, we argue that there are limitations and gaps in knowledge regarding the implementation of trauma-informed interventions in mental health settings and the sustainability of their impact in the long term. When aiming to transform research findings into practice, a more detailed description of intervention fidelity, feasibility, sustainability and the implementation process is warranted. As previous research has been conducted in high-income countries, it would be invaluable to also understand the costs of implementation. Low- and middle-income countries may not have, for example, the same resources as high-income countries in their mental facilities to support clinical leadership to implement and sustain complex TIC-based interventions. Knowing the costs of implementation could help these countries to plan if the implementation is feasible or not.

The final argument, however, reiterates the principle of 'universal precautions,' whereby all inpatients are treated as if they have been traumatised (Walsh & Benjamin, 2020). This would mean that trauma does not necessarily need to be diagnosed, as the principles of collaboration, engagement, compassion, etc., are implemented for all individuals, given the distress during the admission process, in addition to their own suffering from mental health problems (Sweeney et al., 2018). While trauma-informed care is highly pertinent to mental health inpatient settings

where there are high levels of trauma amongst patients, its principles are relevant to all inpatients, regardless of their experience of trauma, providing a theoretical framework for understanding and implementing many approaches to care. For mental health nurses, for example, it is not necessarily about identifying or treating complex trauma, but acknowledging and being mindful of its presence, neurobiological and psychological effects on people, and the relevance of past trauma on current presentation and interactions, including the potential for retraumatisation (Isobel & Edwards, 2017). While it might not be possible to eradicate all coercive practices (and implicit traumatisation), given the paradox of custodial care, there is a need for all services to use a model of care that is transparent and that places the patient at the centre of care, enabling individual care plans, choice and flexibility (Muskett, 2014). This might be a useful approach going forward, where all people accessing inpatient mental health services are treated as if they have already been traumatised (Walsh & Benjamin, 2020), thus diminishing the importance of diagnosing trauma in the first place.

These arguments are closely linked to those for and against using solely the DSM-5 or ICD-11 frameworks to define and recognise or diagnose trauma (Sweeney et al., 2018); especially the arguments against the over-medicalisation of human experience (Frances, 2013) and the conceptualisation of responses to trauma as symptoms specific disorders rather than natural human reactions to extreme adversity (McHugh & Treisman, 2007). Alternative conceptualisations of trauma acknowledging the role of social traumas overlooked by DSM-5 or ICD-11 might be better placed, given that a higher likelihood of trauma experience is linked to social inequalities such as poverty and racial discrimination—especially for Black people. These include the psycho-social narrative-based 'Power Threat Meaning Framework' alternative to the psychiatric diagnostic approach (Johnstone et al., 2018) and SAMHSA's (2014) conceptualisation of trauma response, acknowledging the life-threatening trauma event, as well as the way one experiences that event (i.e. intra- and interpersonal context) and its effects (SAMHSA, 2014).

Research exploring in-depth trauma survivors' cases and experiences advocates for these alternative approaches (Sweeney et al., 2018). They argue that trauma-informed care should not need validation or diagnosis, but the principle of same engagement for all at its core; a process of organisational change that creates recovery and compassionate-based environments for all, acknowledging that experiences of trauma go beyond the patient, and are common to staff, family members, friends and others (Sweeney et al., 2018, p. 321). Trauma-informed care should not be an afterthought, an add-on to existing mental health services, services should be developed following a trauma-informed approach from the start.

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