



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*

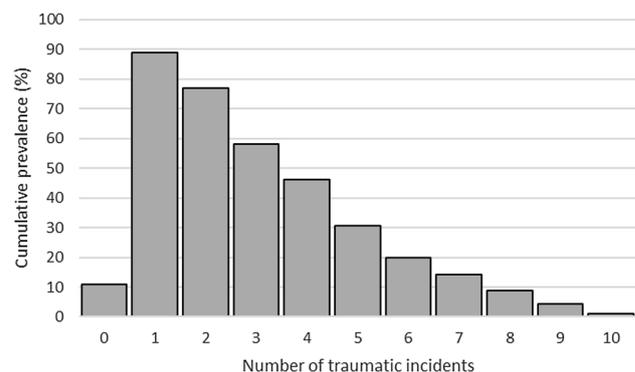


Fig. 1 Cumulative prevalence of number of traumatic events

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 |

^aFisher’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 be 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 (Kezselman 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 findings 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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