**Discussion paper –**

***Is it safe to be myself?*: Responding respectfully to staff who have lived experience of trauma**

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This briefing is relevant to anyone who wishes to make a positive contribution to the wellbeing of staff with lived experience of trauma. It may be particularly relevant to Human Resources staff, trade union reps, staff with lived experience and colleagues who wish to be allies, particularly those in leadership positions.

**Overview:**

The move towards trauma informed care means not only recognising and responding to the scale of trauma in the general population, it also means recognising that many staff working in helping professions may have also been impacted by trauma, either in their personal lives or during the course of their work.

Ironically, many people who are drawn to helping professions because of their lived experiences, are actually encouraged to be silent about their experiences for fear of stigma and discrimination (Devendorf and Victor 2022). We need to change this culture and recognise the positives which those with lived experience can bring to the workforce in terms of enriched culture and innovation if it is safe to speak.

We also need to recognise that people with lived experience may have protected characteristics under The Equality Act (2010). People may need periods where they require adjustments and practical supports, in order to continue to stay healthy and at work. The value and contribution of people with lived experience is starting to be recognised (see BPS 2020), but there is still a very long way to go.

**Introduction:**

It is difficult to be entirely clear about how common trauma is in the general population, but it is thought that around one third of adults will have experienced at least one traumatic event in their lifetimes. It is likely that there are issues of under-reporting due to stigma and shame, so estimates may well be much higher.

Many staff who work in mental health may have lived experience of adversity or trauma, and this can be a powerful factor in people feeling a vocation for helping professions. Such lived experience can enhance empathy and insights for working with service users.

It is also the case that many staff, without lived histories of trauma in their personal lives, may be exposed to traumatising situations occupationally or at work. There has been greater recognition of occupational trauma in recent years, most recently recognising the traumatic experiences ICU staff were exposed to during the COVID pandemic. Staff working in mental health settings may also experience vicarious or direct trauma related to their work.

However, it is notable that, though many mental health workers may have their own experiences of personal or occupationally related trauma, there aren’t always safe spaces to speak or reflect upon this. Staff may be taught to be occupationally self-reliant, or are worried about speaking about lived experiences, in case it negatively impacts on how they are perceived or their job security and prospects (for example, see Devendorf and Victor, 2022).

So, at what point in training and work life, do staff receive messages that they must be silent about their experiences?

What happens between the calling to a vocational career and becoming silent or silenced?

These experiences seem to reflect that it is ‘not okay’ to have dual identities of both mental health professional and person with lived experiences.

Forcing people into a ‘them and us’ binary leaves many staff at risk of burnout, or vulnerable to emotional risks in the work, if they cannot be authentically themselves. It leaves little or no space to talk about the emotional impact of work, and the personal resonances it may activate. This culture permeates widely, and of course, impacts on everyone – risking burnout though unreflective practice.

It is important to open up safe discourse around these unmapped zones of experience – it is likely that people are developing thinking about these issues as they go. We need more research about this – we need to face into these zones, even though they are potentially uncomfortable, they can lead us into creative and inspiring spaces, where we can potentially connect more deeply with each other.

Colleagues with lived experience of trauma may also have protected characteristics under the provisions of The Equality Act (2010), which means that they have rights to reasonable adjustments at work. These adjustments help people to stay in employment, contributing to the service, as long as there is understanding about the potential need for flexibility and practical support.

You are invited to consider the following questions within your service:

* How does the organisation recognise that there will be many staff who have been impacted by trauma in their personal lives or during the course of their professional work?
* How do Trauma Informed values translate into the way space is created for staff working in mental health?
* Does the organisation help staff feel psychologically and physically safe to access support as needed, and value the contribution of staff with lived experience?

We hope that reflecting on some of these questions may lead to inclusive spaces for staff to be authentically themselves at work and also to access sources of support without fear, when and if needed; to be able to expect meaningful support and reasonable adjustments when needed; for there to be a culture of staff peer support for those with lived experience.

1. **Why should you consider the lived experience of staff?**

It is often surprising that staff working within mental health services do not have their job plans and work roles routinely risk assessed. It is a duty of employers under Health and Safety duties to ensure that people are safe at work, and this includes safe physical working conditions and also safety from harmful levels of stress. It is important that the risks of occupational trauma are considered and also provisions made for people with lived experience who may have ongoing periods of vulnerability or need reasonable adjustments and support.

The Long Term Plan for mental health also centralises the need for trauma informed care, and this must recognise the needs of the workforce – put simply, ‘look after them, so they can look after you’.

The NHS People Plan also recognises the need to look after the workforce, including the potential for flexible patterns of work. There has been a shift in the patterns of work during the pandemic, and it is likely that some forms of hybrid working may continue for some staff going forward – this has to be co-designed with staff, as a ‘one size fits all’ does not take account of issues of equity and the differing personal circumstances which people face.

The introduction of Staff Support Hubs during the pandemic has opened up a long overdue conversation about mental health impacts of NHS working. These Hubs are valuable, but it is also important to recognise that such Hubs are not a substitute for decent working conditions, reasonable staffing and a living wage. Moral injury, where personal and moral values are violated because of workplace demands or changes in work ethos (such as an excessive focus on targets and productivity) can lead to a dehumanising and reductive workplace culture.

Of course, there is also an interface with staff wellbeing, and also staff who may have lived experience of personal or occupational trauma as well.

Staff working in trauma settings can face a high degree of emotional pressure, and so attention needs to be paid to supervision, compassionate and relational culture and the physical working environment. Traumatisation may be an occupational hazard for some colleagues. This would include morally injurious situations, where colleagues are not able to respond to the demands of the job due to issues such as under-resourcing, compromised core personal and professional values, and contextual factors which lead to command and control culture

1. **Challenges facing staff who have lived experience of trauma**

As already outlined, those who have felt called to a vocational helping role may actually find themselves silenced during training (see Rouf for a personal reflection, 2020).

This can lead to mental health staff not feeling safe to speak up; there can be genuinely founded worries about being picked on, marginalised or having their professional capabilities called into question. Viewing lived experience in this way is associated with a deficit model of experience, and not seeing lived experience as something which can be an asset and enriching to both clinical work, co-production and service innovation. Making these links can foster a culture of imagination, creativity and innovation.

For those who have previously undisclosed or ongoing trauma, it can be very frightening to disclose into a culture that does not speak about or recognise that staff may be struggling with their own issues. It prevents people accessing adequate practical and emotional support to access help which allows people to function healthily. It may be difficult to know how to access adequately resourced clinical support (if needed) without stigma. This clinical support needs to be potentially more than very short term intervention, or help that is outsourced and temporary, as this may be inadequate in terms of what is needed and (at worst) can be actively unhelpful.

Within this area, it is also important to consider the intersecting experiences that people can face because of other minoritized experiences associated with identity, such as those based on gender, ethnicity, sexuality and class. There is a growing awareness of the impacts of minority stress, associated with experiences such as homophobia and racism, and how this can impact on mental and physical health (for example, see Professor David Williams 2017 on the impact of everyday racism and biological weathering).

It is in everyone’s interests for work culture to be inclusive and anti-discriminatory.

Inequality diminishes everyone.

1. **Trauma Informed Principles and the workforce**

One of the fundamental pillars of a truly trauma informed work culture, is for the organisation to look after its staff. Trauma informed principles include safety, trust, empowerment, choice and collaboration (Sweeney et al, 2016).

Underlying this are fundamental underpinnings which seem so obvious that they are often not explicitly drawn out – they include compassion, empathy, respectful communication, ethics and values and the ability to perspective take.

These are part of the umbrella of trauma informed care. They also align with the principles of safety culture – which include organisational justice, being safe to speak up and a learning culture (Reason, 2000).

If we are to think about what this could mean at an applied level, some scenarios to consider are as follows:

* Staff are experiencing current trauma and harms outside or within work, such as Intimate Partner Violence, racial abuse or sexual harassment
* Staff disclose non recent abuse – the abuse has ended but colleagues may make first time or early disclosures about what has happened to them
* Staff have experienced past trauma for which they are getting help but they are reactivated and need reasonable adjustments
* Staff are traumatised in the course of their job, either due to clinical work, minoritisation in the workplace, or systems level stressors which may lead to moral injury

In each of these potential scenarios, some reflection points may be:

* Is the organisation building in stress risk assessments under Health and Safety responsibilities as part of their duty of care to employees?
* Are there adequate policies in place to ensure that employers are looking after their staff?
* Do these policies translate into meaningful organisational justice and practical support for employees who are potentially vulnerable because of their lived experience or intersecting minoritised status?
* Has the organisation got the skills and policies in place to ensure that staff are responded to with dignity, compassion and proportionate confidentiality and privacy?
* Do managers feel trained and skilled in responding?
* Is it safe to speak in supervision sensitively about what a person’s needs may be?
* Is there thought on how to manage boundaries when discussing the impact of work or lived experience – this can be very difficult when the usual position is silence.
* Is there a culture of trust, safety, connection, kindness?
* Are all staff heard and included?

The ROOTS framework is a useful tool to develop some of these reflections (see Thirkle et al, 2021) in its recognition and focus on people in the workforce with lived experience. The particular items of relevance concern the areas which acknowledge that staff may have their own personal/professional trauma journeys that influence their motivation (domain 2 language); focussing on staff experience (domain 3 social); people with lived experience of trauma are encouraged to be in positions of leadership and influence (domain 5 empowerment) and that there is a culture where people can talk safely about lived experiences of adversity (domain 7 compassionate leadership).

1. **Planning ways to develop and evolve**

We are starting to talk – we need to move these conversations into practical and applied change to improve the experiences of people who are trauma survivors. We cannot expect people to speak about lived experiences if it isn’t safe to do so, or the organisation makes well-intentioned but harmfully clumsy efforts to respond in trauma informed ways.

We also need to recognise that the journey (or process) matters as much as the destination (or outcome). How we do things matters, and it is important to understand that the work is continuous and non-linear – understanding this can facilitate a learning mindset, reflection and help to sustain motivation.

*Lived experience leadership-*

Developing a culture which is inclusive of those with lived experience as staff, involves practical change at all levels of the organisation, including valuing lived experience in leadership roles, the courage to be open about lived experience. It also vitally includes a moral imperative on employers to foster a culture where colleagues can speak about their experience without fear of intrusion, scrutiny and pathologisation. An example of valuing lived experience at a very senior leadership level can be seen in the creation of Lived Experience Director posts in NHS Trusts (see Tees, Esk and Wear Valleys NHS Foundation Trust).

There are also examples of innovation around the creation of Staff Lived Experience Networks (Barnes and colleagues) which can provide a safe space to gain peer support, away from hierarchical systems which can sometimes ‘other’ staff who do not fit the historical ‘norm’. People can have well founded fears about speaking out or being authentic, if it leads to negative perceptions of them from colleagues and it is common to worry that this could have a detrimental impact on job prospects.

*Thinking about models of care and allyship-*

Moving to models of allyship, where we locate ourselves in spaces where we are ‘closer’ to service users and the community is vital to changing organisational culture. Sustained community development is vital here, as there are many people who are under-served in the wide population but do not become ‘service users’ for a whole variety of reasons, including stigma, embedded racism within institutions and the cultural specificity of models of intervention, which do not apply to many global majority cultures.

A very clear place in which to show allyship are Recovery Colleges, and other clear third sector organisations working with survivors, such as Rape Crisis England and Wales. Partnerships with Recovery Colleges allow a greater reach in terms of health messaging, culture change and key ingredients of a recovery focus. In Recovery Colleges, staff/clinicians can be students and service users can become staff, which leads to a culture of being led and informed by each other.

Recovery Colleges allow a plurality of approach – one size does not fit all; students and tutors are able to say what topics for courses matter to them; there is more opportunity for the use of creativity in healing.

This point about plurality of approach is key. Creativity is increasingly recognised as important to recovery. Before COVID, an All-Party Parliamentary report (2017) highlighted the importance of arts in recovery. The Welsh NHS confederation (2018) developed a strategy around arts and wellbeing, as has Manchester. Some NHS Trusts have artists and poets in residence, and forward thinking Trusts such as Leicestershire Partnership NHS Trust, have a role for an Arts in Mental Health Co-ordinator.

Not everything that helps people recover from trauma is documented within NICE guidelines, and more attention needs to be paid to other forms of therapeutic activity. Again, this reduces the barriers of a ‘them and us’ culture between service users and staff, and can have universal benefit for all of us.

*Developing a pluralistic evidence base-*

There is an opportunity to develop the evidence base, researching and evaluating as ideas develop. There needs to be a culture where innovations are possible. For instance, many Recovery Colleges are adult focussed. There are examples of innovations for young people in the transitional phases from CAMHS, an acknowledged time of life transition, and one which can be very difficult to navigate. The Oxfordshire Discovery College for young people, which includes experts by experience in working with children, families and young people (Corbally), and again, has the opportunity to destigmatise mental health at a crucially important time in a person’s development.

The ethos is about taking control of one’s own recovery and learning about the impacts which life events have had, offering potential tools for recovery, helping to create connection between young people – if young people do not feel alone in their trauma experiences, then this can be hugely powerful.

*Reflecting on organisational culture at all levels -*

As well as developing relationships with key stakeholders in mental health, it is important to also reflect routinely on our own organisational cultures. This is in order to develop compassionate care but also to enable staff to recognise unhealthy aspects of institutional dynamics and human factors within decision making. This can include noticing where organisational windows of tolerance and how the institution may exert forms of ‘power over’ people and aim to reduce coercive and controlling practices. Organisations should aim to reduce hierarchy (note this does not mean reducing accountability and responsibility), to reduce self-reliance and improve team cohesion; and increase a sense of safety to talk about lived experience.

*Trauma informed Human Resources policies –*

If we recognise that staff are also people with potentially lived experiences of complex / complicated trauma, then it is vital that we recognise the need for co-designed, trauma informed HR policies to help people faced with domestic violence/ intimate partner violence, non recent abuse, PTSD or other impacts of trauma and develop smoother pathways to get help and more victim/survivor centred ways of responding.

*Training for managers and colleagues –*

It is really important to train our workforce about ‘happening now’ and ‘future focussed’ issues which intersect with trauma and its impacts, so that everyone is prepared and can respond to trauma – or its impacts - at least at a basic level. It is important to skill the workforce so they feel confident and are confident about at least basic ways to respond. It is suggested that this becomes mandatory, and is a natural expansion of safeguarding training.

This would include areas such as

* Sensitively scaffolded but routine enquiry about trauma and abuse;
* Recognition of the intersections between trauma and suicide, which would also mean mandating suicide prevention training. It is striking that we mandate life saving issues such as resus; safeguarding; handwashing, but we do not teach people how recognise the signs of and respond to suicide.
* Responding to the increasing challenges of a fragile climate, which will leave many vulnerable to trauma

That these areas are built into job plans and regular supervision, so that the conversation is foregrounded

The challenges of scaling up these messages, mean that responding in trauma informed ways must be ‘everybody’s business’. Such challenges mean that we must look at community resilience models, and again, task share and co-design helpful ways to respond with the communities we work in.

*Trauma informed environments-*

Another important area is to think about the physical context we offer services and workspaces in - It is important that those commissioning buildings and estates adopt the creation of trauma informed workspaces. As well as communicating a sense of worth to staff and service users, well planned and designed spaces can create a sense of community that can counteract the isolation that can be a consequence of significant trauma (Sweeney et al, 2021). This includes the digital spaces which have evolved, partly as a result of the pandemic, and which can increase access for people in remote communities or individuals who are unable to access usual physical spaces.

Changing the culture in this way is not an easy task, but it can be a hugely fulfilling one, which allows team development, improvements in the offer for service users and organisational development.

We must task share in order for this to meaningfully happen. This is a shared endeavour.

It can mean ‘Big Change’ in terms of structures, but also ‘small change’ in our language, how we interact with each other and our attitudes – sometimes it is this everyday small change which will have the biggest impacts.

*Questions to ask:*

In moving towards trauma-informed responses to staff, consider these questions.

* Does the organisation have a Trauma Informed Strategy which includes not only clinical services, but also Estates, corporate functions such as HR, and look towards incorporating a pluralistic approach to healing and sustained wellbeing, including the provision of reflective practice as routine in all areas of the organisation, the provision of green spaces and creative and therapeutic spaces for staff and service users?
* Can colleagues with lived experience be involved in the evaluation and redesign of existing bases and therapy spaces?
* Is there a consistent Quality Improvement and narrative approach to service development?
* Is there ongoing and honest reflection on how projects have progressed – whether they have achieved their intended aims? Are these experiences remembered by the organisation, thereby providing a learning mindset for the organisation? Can the project be evaluated – and we measuring what matters for trauma survivors in their recovery?

1. **A culture of safe inclusion, equity and equal rights:**

A trauma informed culture is one that is inclusive, safe for all to be themselves and one which meaningfully addresses its duties concerning human rights, equity of opportunities and outcomes.

We cannot talk about trauma without talking about power; and we cannot talk about power without talking about social justice.

We need to create environments so staff with lived experience can thrive. We need to change so organisations live the values of trauma informed care. This means not simply adjusting the culture but making the whole environment one which people can flourish within.

During the ongoing Covid pandemic, there has been increased recognition of the impacts of trauma on mental health, and that many of us have faced challenges and trauma, to varying degrees. This potentially levelling experience has allowed us to glimpse different ways of working together- many people have spoken about a ‘de-role’ from their professional exterior and being ‘more human’ at work. This has been an unexpected and welcome aspect of what has been a dreadful time.

It is important to try to sustain this authenticity, as it enriches our work together.

As Sweeney et al (2016) point out,

‘The policies, procedures and practices that staff may be required to perform in “trauma organised

systems” (Bloom and Farragher, 2010) can conflict with personal and ethical codes of

conduct. For example, the use of seclusion and restraint as an institutional practice erodes the

very meaning of compassion and care, the primary reasons most staff enter their chosen field.

Staff who experience conflicts between job duties and their moral code are under chronic stress

for which they must learn to cope and adapt. Those coping strategies may include “shutting off”

the ability to empathise, and viewing people receiving services as “other” thereby disqualifying

their humanity and basic human rights. Pessimism – rather than enthusiasm and hope – may

buffer staff from their own feelings of helplessness’ (p.176).

We invite you to reflect together with your colleagues on some of these questions posed in this article. And we return to the original question, ‘Are you safe to be yourself at work?’

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Further information about the charity, Oxfordshire Discovery College can be found here

<https://www.oxfordshirediscovery.co.uk/>

This briefing is based on experience and the following resources:

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