PLACEMENT

Topic: Access to Trauma-Informed Services.

Aim: To Highlight the possible barriers encountered by Individuals with communication impediments in accessing trauma-informed services. To make recommendations on how to reduce such barriers.

Abstract

Trauma survivors need access to trauma care to help them deal with and heal from their trauma experiences, but this is not always easy or possible due to some barriers encountered including but not limited to language difficulties. This paper investigates the language and other barriers. The question of why anyone irrespective of their background, inabilities and or disabilities might be denied or choose to avoid access to trauma care was explored. We also examined the concept why are, and who can be retraumatised, why/how retraumatisation can easily occur without priming. We examined the concept of trauma as both individual tragedy and societal misfortune. The overarching aim of this paper was to affirm the prevalence of trauma, amongst ethnic minorities, how people who having survived varying degrees of trauma, find themselves relieving trauma all over again. Our data was derived primarily from previous research work done on the subject, and experiences of real-life survivors. The theoretical framework was rooted in the epistemic angle of cultural Sociologists and the ontological position of the constructivists. A critical look at both positions, helped us for all intent and purpose, unravel to a degree the concept of trauma, on both individual and societal levels. We took a qualitative approach using the recurring traumatic experiences of real-life victims and previous studies about trauma as reference. Our findings were consistent with previous results about the destructive nature of trauma if left untended, but also the beauty that comes out of its ashes when all parties involved do the needful to tackle the menace that is trauma. We surmised that there must be change in orientation and approach by all stakeholders if survivors are to break free. Our conclusion affirms the aim of the study. Solutions were offered based on an empirically tested model.

Keywords:

Trauma, Survivors, Trauma Informed Approach (TIA), Trauma Informed Service (TIS), Retraumatisation, Case Study, Barriers, Minority, Language, Individual, Community, FCE.

Introduction

What is Trauma?

“Trauma” is derived from the Greek language meaning a ‘‘wound’’ or ‘‘hurt’’ (Oxford Dictionaries, 2013). In Psychology, ‘‘trauma’’ suggests an emotionally painful, distressful, or shocking experience, which does often result in long-term negative mental, physical and may also include neural consequences. (Straussner & Calnan, 2014). An experience is considered to bring about a traumatic response, when the pressure or anxiety brought on by such event overpowers the individual’s psychological capability to manage his/her affairs (McGinley and Varchevker 2013). The early Greeks recognised that although trauma is often seen to be a direct result of a recognisable event, for example, if two women lose their breasts to cancer, the consequence of the trauma tends to be subjective to each woman because ‘the wound’ is unique to each woman (Miller 2004). Therefore, an event so traumatizing, and life-altering for one individual might have little or no effects on another. Such disparity in people’s reaction depends on several factors, which includes but are not limited to the person's age, gender identity, personality before the occurrence, former traumatic experiences/encounters, the intensity of the trauma, how protracted, family history of trauma, current life pressures, social supports, and one’s cultural, religious, or spiritual beliefs about adversity and perseverance. (Amir and Lev-Wiesel, 2003); (Brewin et al. 2000); (Felitti et al. 1998); (Foa et al. 2009); (Stamm and Friedman 2000); (Straussner and Phillips 2004a).

The Initiator

Fife Centre for Equalities (FCE), The initiator of this paper is an organization funded by the Fife council. It opened its doors of service to the community in 2014, with the vision to inspire and enable partners to take action that makes Fife a more equal and fairer place to live, work and study (centreforequalities.gov.uk).

FCE commissioned this work as part of their ongoing effort to live up to their mission statement. The situations which occasioned this paper may be considered a social failing by not one, but a few trauma care services set up for the purpose of helping people get through traumatic experiences but failed due to institutionalised procedural red tapism. Our task was to delve into the whys of such failures and make recommendations to prevent such going forward.

Why This Paper?

A look at FCE's mission statement and it is clear to see why. FCE runs on the wheel of a synchronous system to building a unified voice that advocates equality, diversity, inclusion, and social justice. In their daily encounters with members of the society in general, and Fife community specifically. In their capacity as an information hub, a bridge between the local authority and people of Fife or simply befrienders of isolated members of the community, there is a dossier of personal stories of deep human distress that necessitated putting together a paper that is not just about theories and concepts of trauma (a myriad of those already exists), but of examples of living, breathing people co-existing with and amongst us. They are our neighbours, friend(s), colleagues, and family members who have suffered, and continue in some cases to suffer the effects not just of past trauma, but of re-traumatization.

The Constructs

Social Theory speaks of positions, opinions, propositions, or presuppositions, about how civilizations go through the sequence from formation through various modifications, leading to the development, or eventual decline of any given society or culture (Harrington, 2011). The Social Theory paradigm posits that historically, groups within human societies are responsible for the rise and or fall of their communities. The consideration is that our interaction one with another, good or bad, is responsible for our societal outcomes, if so, we can infer that "we are our problem" and "we are our solution". Trauma is a conundrum with many moving parts in

relation to our social construct, but the barriers faced trauma survivors with communication needs, is our focus in this piece. Trauma affects us individually like in the death of a loved one, on a communal level such as the homicide of the village leader, or a missing person in our neighbourhood, causing the community to become anxious and suspicious of each other, trauma can be on a global scale like the Covid-19 pandemic or global terrorism, wars, or natural disasters leaving us feeling despondent and vulnerable. However, the exactitude of how we process the blow we are dealt by such events, and the effect of such feelings on social perceptions, continue to unravel daily in our lives and societies. The social framework views trauma as an off-shoot of society's failings. Although considered person-centred based on common sense understanding in our daily interactions, referred to as 'lay trauma theory', it is fully ramified in groups across the society. This principle of group conflict considers the object of "hurt" to include an interest refused, access denied, or capacity suppressed leading the marginalised group to either resign to fate or rebel against the perceived oppressor. It, therefore, purports that making this argument on an individualistic basis (constructivism) is both narrow and shallow, proposing instead, the idea that self-interest must embody 'collective identity'. "Trauma is not something naturally existing; it is something constructed by society" (Alexander, 2013 p 1). Furthermore, the proposition that for trauma to be considered in collective terms, the social crisis must metamorphose into cultural crises, because they claim that trauma in and of itself does not cause a group to experience pain, but that trauma is a result of the discomfort that has pervaded the centre of their identity as people.

The ontological perspective on the other hand, deals with the nature of reality, with questions including what is reality? What is our experience as we daily interact with individuals? What are people's pain and anguish? and how do they respond? They suggest that traumas are naturally occurring events that shatter an individual or a group's sense of collective well-being. The suggestion is that as humans we need direction, security, relationship, and affection among other crucial needs, therefore, whenever an unpleasant event occurs to undermine these necessities, then we can expect to be traumatized. A rational response one could agree. Both schools of thought may be rather opposed, but we aim to find a balance in this paper because balance will give us a less subjective way forward. Whether trauma is experienced at individual or communal levels, what makes it a social issue is the man-made influence on the problem. We argue that all people whoever they are and whatever their circumstance, should have access to trauma care if, and when they need it, and the evidence showing people may be denied access based on their inability to speak a language in the 21st century is somewhat worrisome.

Retraumatisation in the care system

A strong link has been established between childhood trauma and adult mental distress (Bentall et al., 2014), Also (B.Everett & R.Gallop, 2002) A lot of people looking for help within the mental health system carry with them a history of childhood trauma. We have previously underscored why trauma exacerbates mental issues. So, can a trauma survivor who has been through so much physical, mental, or emotional difficulties go through more? Yes, they can. But should they? No, they shouldn't. Retraumatising as a concept simply means to be traumatised again. An occurrence characterised by a person experiencing something in the present reminding them of a traumatic event of their past (Sweeney et al., 2016). Their present reality, therefore, elicits emotional and physical responses identical to the past event, leaving them as helpless and as vulnerable as they once were, although, people do not usually consciously connect their current condition of pain/suffering to their unpleasant past experiences, neither is it usually given a conscious thought. similarly, we do not re-experience past events rationally or intelligently (Durant, 2011).

Re-traumatisation is particularly true of minority groups for whom integration into a new environment can be difficult, as it is true of natives whose personalities are somewhat introverted and who might find approaching others for help onerous. There are thousands of immigrants in the UK, each with a unique migration story, often accompanied by a plethora of unpleasant traumatic history, but the bottom line is that they are just humans who are just trying to survive, because preserving humanity is inherent in us. Settling in is not the easiest especially if one cannot speak the language. Learning a new language or attaining proficiency is not simply a matter of desire, though important, it is as much a matter of physiology(brain), especially to do with acquiring a second language (bilingualism) studies by J. Abutalebi, & D.W. Green (2008) propositioned a neuro-cognitive standard of dual language interchange to include swapping between both languages as well as translation. Their prototype comprised of five areas of the brain deemed fundamental for interchange in bilinguals namely: left dorsolateral prefrontal cortex (DLPFC), anterior cingulate cortex (ACC), caudate nucleus, and bilateral supramarginal gyri (SMG). Their proposal was that the sub-cortical loop is responsible for the rigorous cognitive need of handling bilingualism, by enabling the selection of one language use at a time, while repressing

the language not in use and vise -versa. The point here is that learning a second language and gaining proficiency at it, is not as simple and does not come to everyone naturally, and as with somethings in life, some people find it easy and some people don't, therefore, inability should not be punished. Another consideration is education (language training is based on availability and affordability). Immigrants would need education in the local language, in the case of English language, learning it is not cheap, and if immigrants are just trying to get by, paying for expensive language classes may be last thing on their list. Minority groups face many other barriers in trying to access trauma care, but the language barrier seem to be the more common – A study by University of Oxford in 2018 revealed that 89% of those residents born outside the UK report themselves as speaking English well or very well in the 2011 census, but only around 50% of that same group spoke English well in 2018, an obvious decline. Other barriers include fear, stigma, bias, prejudice, reprisal, low self-esteem. As for natives, the language barrier is not so much about communicating in a mutual language, it is more to do with being able to speak and be understood without any ambiguity or gaps or assumed meaning, other than that which the individual is trying to communicate.

More research show that people in low-socioeconomic class and people from minority ethnic communities often experience traumatic events (e.g., Hatch and Dohrenwend, 2007). Another argument is that poverty strongly correlates with of mental illness, which further predicts many other emotional issues. (Read, 2010). In Addition, black people who are over-represented in the mental health system, are more prone to experiencing negative or judgemental pathways to care, i.e., to be diagnosed with psychotic disorders and to receive compulsory treatment (e.g., Mohan et al., 2006; Morgan et al., 2004). Nevertheless, there is little or no conversation about the part that history and culture play in trauma experience. Indeed, social trauma, like poverty, racism, and urban migration and so on, are so customarily overlooked as fundamental to poor mental health and prevalent trauma triggers by both clinicians and victims. Remarkably, people needing mental health support, with a history of childhood sexual or physical abuse, usually have a lengthier, more recurrent hospital admissions, are more medicated, are more prone to self-harm and are more likely suicidal compared to people without such past traumatic experiences (Read et al., 2007). An even stronger justification for this paper.

Real People, Real Stories, Fictitious Names

[Case study A]

'A's daughter had passed away. While dealing with his grieve and loss, he sought support for his son-in-law who required grief counselling but held back because he spoke limited English, (language barrier) they didn't know what to do. A local Councilor advised them to contact FCE to see what help they could offer. FCE on behalf of the man contacted some local bereavement service agencies. Unfortunately, the agencies were unable to help due to long waiting lists or having no interpreters. The one agency that offered to assist however, would only take the family on a self-referral basis and despite the FCE representative's best effort explaining the challenge of language barrier hence FCE acting as go-between, his case was not taken at least not by the respondent, not on that call. When FCE reached out to the enquirer on their findings to get any further information about his situation. The enquirer reiterated that his son-in-law speaks his native language fluently but inadequate English, explaining that although he has lived here for 14 years, he hasn't had the opportunity to improve his English, and as such would still need the services of an interpreter. FCE staff advised 'A' of the organisations contacted, which could assist his family and contact details were provided. The enquirer thanked the FCE staff saying he would try and follow up. We don't know if 'A' and his family ever got the help they so badly needed. Language as a barrier to any form of care but critically trauma care in this age of endless possibilities such as we are, is nothing short of objectionable.

[Case study B]

'B' from East Asia is married to a Scottish man. They had met several years earlier outside the UK, in and out of a relationship until they finally decided to get married when 'B' was facing deportation on an Island they both lived at the time. While out there, her husband's health began to fail and due to lack of a good health infrastructure on the island, they both agreed to move back to Scotland. But some illnesses are debilitating, and such was her husband's. His general and mental health had steadily declined, making 'B' become both his carer and his victim. With no one to talk to due to language barrier, being a long way from home and no knowledge of how the system works to help her out of her predicament, 'B' suffers daily abuse at the hands of her sick husband. Then because of one of the FCE community initiatives, 'B' came to be befriended by a worker who could speak her language and give her valuable support

and advice on what help the system had to offer herself and her husband through their daily struggles.

[Case study C]
C didn't want to trust the staff from FCE when she was first approached. A widow, she had come to depend solely on her son upon her husband's demise, she felt like a burden to her son who also had a family of his own to cater for, she desperately needed some independence. Not knowing whether she could trust her befriender from FCE with confidential information and afraid of community backlash if word got out, she asked her worker, "you will keep what I tell you between us, the same way a doctor keep any patient's information right"? And only began to speak up after she got that assurance from her worker. They began to talk about her concerns which she couldn't share with her closest family members and her worker filed on her behalf for some much-needed benefits helping to give her some measure of financial freedom and semblance of human dignity.

[Case study D]
When a child finds himself in the role of a father overnight following his father's passing, and a mother who has no income and no education with several siblings to cater for, it is not surprising that he steals. When a person steals and is caught, penalties abound. Unable to communicate well in English, 'D' originally from a country whose parents had fled the war and were seeking asylum in the UK, suddenly found the status of the father, head of the family, protector and provider thrust on him at the age of twelve after the sudden death of his father. In his bid to fill the role as the first son, he resorted to petty thieving from his mates in school but was soon caught. Facing expulsion from school without the opportunity to properly explain why he had chosen to go down that path (no attempt to excuse the act) and indeed would have been expelled but for the timely intervention of an equality organisation called upon as a mediator, who through an interpreter was able to get to the bottom of D's ordeal. A child so hung down with the weight of family commitments thrust on him by cultural/traditional beliefs and practices led him to commit a crime that was set to truncate his education, with the potential to turn his world upside down thereby relieving the life they left behind anew. Because of the effort of staff and an interpreter, bad as it was, D's reason for stealing was understood but not condoned and empathised with rather than judged. He was given a lighter punishment of suspension and his family's plight was directed to the right department, where they received financial help and much-needed benefits for the family to live on.

[Case study E]

Arranged marriage has been the norm in some cultures for centuries and still is quite popular today. 'E' was educated in her native country; she would be working in the computer or related field had she remained and married in her own country she admits. Her marriage to her husband 'F' was arranged and certified by her family members based on their knowledge and relationship with F's family. After the marriage rights were concluded, she moved to the UK to join her husband and started a family. 'E' discovered too late that she had been duped. Her husband belonged to a long line of criminal families, and the community from her own country here didn't want to be identified with such a family. Isolated and a long way from home and now with a young child, E was in dire straits, if that wasn't bad enough, it didn't take long for her husband's crimes to catch up with him, and he was sent to jail. With no job, no money and ostracised from the community, she was living a nightmare. While her husband was in prison, the house needing repairs here and there, started to fall apart, the ceiling collapsed on her and her child with no help in sight. When the equality organisation got information about E's plight, they stepped in as a befriender who she came to trust and was able to unburden to. They listened without judgement, pointing her to the right local authority where she received the much-needed relief package. More stories abound too numerous for this paper. Time will fail me to talk about husbands simply absconding leaving terrified and vulnerable wives all alone who for fear of being seen as abandoned and taken advantage of by opportunistic men who would take advantage of their vulnerability, chose to suffer in silence, or people with refugee status who have to send their stipend back home to their families and cannot work legitimately to improve their living standard, have had to resort to shady means of earning money to keep life going….. Or the young native lady 'G' who has struggled with identity crisis all her life battled through substance abuse and didn't get help because she considered herself a burden to the society and unworthy of their help. "I am a burden to society," she said, "no one will listen to me".

These stories only scratch the surface of what is fast becoming a monumental retraumatising crises in our backyards and on a global scale. A situation where individuals feel so isolated and traumatised that they cannot reach out and touch or ask for help. Encumbered by their past experiences and the reality of their present situation mirroring their past, it proves to be more than they can handle on their own, so they stay quiet and choose to suffer in silence.

As earlier established, we discuss some of the barriers faced as follows:

Language barrier specifically, appears to be a recurring theme amongst ethnic minority groups when it comes to the issue of access to trauma care. However, the following emerging themes came through the case studies. The researcher fully accepts that they are by no means exhaustive:

- **Ignorance:** For context in this study, by ignorance we mean *"lacking awareness"* it may be a combination on seeing oneself as an outsider in a new environment and wanting to just remain in the shadows, simply grateful to be alive and be shown sympathy to stay in this new environment but having a sense of not really being welcomed or accepted, to outright hostility and rejection echoed in some of the stories. Knowledge and awareness of what to do and how to get help is difficult with such outlook. some are not aware that help is available to them as they go through trauma.
- **Poor Self Rating** (PSR)**:** Derived from a personal progress inventory based on one's ability to self-appraise. The interactions with the people who told their stories revealed that they seem to lack the ability to self-evaluate their own deficiencies, hence everything hung on 'what was done to them, a victim mentality which keeps them from crying out. In nearly all the cases, when unsolicited help came along, it was met with suspicion.
- **Fear:** Another obvious index, the fear ranges from other people finding out their innermost struggles, to the fear of being identified then named and shamed, then there's fear of being a burden or even being repatriated. And so on. There are many definitions of fear, but my favourite is the bible definition 'Fear has torment' (1john 4:18). Tormented by their past experiences and comparing with their present nightmare means they choose to suffer alone.
- **Trust:** Lastly, but certainly not least, is the issue of trust. Who to trust? Can I trust? People have seen betrayal on such scale that they have only come to trust themselves, which on the surface may not be such a bad idea but for the fact that 'Two are better than one' it has always been proven. The researcher's viewpoint has always been that while as humans we tend to be each other's problem at the best of times, we are by the same token each other's solution providers. As observed in nearly all the stories, it was initially difficult for the individuals to trust their workers, but as they got familiar, they trusted more and got helped.

Discussion

While we have some knowledge of the devastating effect of trauma, it only but scratches the surface, but we need to ask a pertinent question, with what we have learnt so far, what manner of approach ought we to have, As survivors, friends, family, and especially, the trained professionals? (Whom we are looking to help remove the barriers). Everyone has a role to play. The fundamental principle upon which any trauma care must be built, is "Trauma Patient Centred" (Peitzman et al., 2012) anything less is unacceptable. Hence, no stone should be left unturned in making sure that people who suffer trauma are identified and helped. Trauma can be treated in a variety of ways by trained professionals out there. It is well agreed across the health platforms that we are better equipped to treat health issues generally including emotional well-being than was possible some half century ago. Before now, treatment for patients was all about doing 'to' or 'for' them as opposed to doing with them. Any progressive treatment for trauma patients must be built around the patients themselves.

Trauma care professionals are lauded for their everyday good work, as they should, and we laud them again especially during these unprecedented times when the pandemic has exacerbated the pressures on the health care system. However, the presence of barriers undeniably remains, a veil between trauma service providers and trauma survivors. The barriers need to be removed so that needless suffering can end individually and communally.

Recommendations - Trauma-Informed Approach (TIA).

Jennings proposes that whilst retraumatisation may not be pre-meditated by staff and unexpected by survivors, it will persist so long mental health systems deny its existence, and the negative role it plays in the lives of already traumatised persons, followed by their need for safety, mutuality, collaboration, and empowerment (www. theannainstitute.com). Existing trauma care centres and support organisations that do not acknowledge these issues, may unintentionally retraumatise survivors seeking help, thus strengthening their need for ways to

cope including, unlawful use of drugs, self-harm, denial, silence and keeping up appearances, etc, further exacerbating their ordeal. This also has a negative import for staff members making a wreckage of policies, procedures, and practices which they may be required to perform (Bloom and Farragher, 2010), a conflict of interest between their personal and ethical codes of conduct. As an example, the practice of seclusion and restraint does invalidate the (PAGE 176 j MENTAL HEALTH REVIEW-JOURNAL j VOL. 21 NO. 3 2016). The very meaning of compassion and care, which is the primary reasons most health care and allied professionals enter their chosen field. Staff whose principles contradicts their job description, are themselves under chronic stress and must learn how to cope and adapt, which they tend to do by "shutting off" their ability to sympathise, they view persons receiving services as 'other', essentially a 'we' vs 'them' approach, thereby erasing their human nature and fundamental human rights in the process. Staff may also suffer from the feeling of pessimism, as opposed to being enthusiastic and hopeful, which insulates them from their own vulnerabilities (Chambers et al., 2014). Occasionally organisations place more importance on risk management over investment in human capital. For example, A nurse who is required to perform a personal search may become frustrated by a service user's resistance, failing to recognise the patient as a stranger who may very well be a rape survivor, which explains the patient being uncomfortable to a stranger's touch. Another problematic issue occurs when organisational cultures become corrupted, giving rise to undue control by staff, which reinforces people's vulnerability and desperation – In this scenario, the roles are reversed, making the needs of staff superior to the needs patients as a result of the erosion of core values, thus paving way for practices such as restraint and intimidation being widely used when in fact things could be done differently, impracticable hierarchical structures, with no supervision and so on. All such practices lead to dehumanising of both staff and service users, followed by human rights violations (for an account of corrupted cultures and the impact on coercion see, Paterson et al., 2013; Wardhaugh

and Wilding, 1993). The National Institute for Clinical Excellence (NICE) have expressed their displeasure at the first resort to the strong-arm practices, instead of more responsible approaches as documented (NICE, 2005). The influence of trauma-organised services on their workforce, directly impacts on trauma care of the survivors – it reshapes and re-constructs self-identity and can shatter individual meaning and purpose (Knight, 2015).

(Fig 1)* *A Sample Study.

Many studies on traumatic events have focused on either children or younger adults, while traumatic events in older adults have not been sufficiently investigated. Older immigrants encountered a wide range of traumatic events across their life span, before and after migrating, either in their home or host countries. This study provided a descriptive epidemiology of lifetime traumatic events in older Chinese Americans. The data were drawn from the Population Study of Chinese Elderly in Chicago (PINE) in 2017-2019, with a sample size of 3,126. Traumatic events were evaluated by natural disasters, personal and historical events. After examining the lifetime prevalence of natural disasters, they found typhoon (64.46%) has the highest prevalence, followed by earthquake (39.81%) and tornado (7.25%). In terms of personal events, death of a loved one (69.78%) was the most prevalent, followed by robbery (12.57%), physical assault (5.36%), fire (5.29%), divorce (5.16%), cancer (5.10%), falsely accused (2.15%), homeless (1.57%), sexual assault (0.99%), and imprisonment (0.74%). In addition, 18.91% of women experienced abortion and 11.25% of women experienced miscarriage. With respect to historical events, most participants

experienced the Cultural Revolution (73.27%), the Great Leap Forward (62.71%), and famine (60.01%). A small proportion experienced the Japanese invasion of China (27.14%), Tiananmen Square protests (7.86%), and the Vietnam war (4.78%). In our sample, women were more likely than men to encounter traumatic life events. (Dong & Bergren, 2019).

Recommendations:

For this research, recommendations are made based on the Trauma Informed Approaches (TIA), perspective and their framework referenced, because we are proposing 'Trauma patient centred' solutions, and the TIA offers a good solution that addresses the problems that survivors have encountered trying to access care. For example, looking at our above sample study, (for the purpose of example only), the data gives us facts and figures into a minority community in the US (Chinese American), where different past traumatic events were identified and measured.

Specific to communication barrier therefore, we propose that:

- detailed research such as sampled above, be conducted, on this question of "barrier to accessing trauma care", within local communities, to give empirical authenticity to the exact nature of the trauma barriers that victims are dealing with. Only then can we appropriately design a patient centred services that well addresses their peculiarity.
- Investment in interpreter services based on the knowledge of the ethnic backgrounds of the local community in which they are set up to serve.
- Advancement in technology means that more can now be done with the introduction of translation apps (Google translate, Microsoft translator, and so many more)

which was previously unavailable. Government and all stakeholders will do well to consider investing in such technology to make trauma care services more efficient and effective patient centred service. these apps can serve as complimentary tools to professional interpreters, and cut back the long waiting times due to the rota nature of staffing and attendant human experiences including but not limited to absence from work due to illness, holidays, and off-duty, emergencies, etc. Trauma patients should not have to wait endlessly due to long waiting system to get help, certainly not in this age of possibilities.

- Awareness – For the plight of trauma survivors cannot be overemphasised. If trauma services are to be about helping trauma patients, being proactive by creating awareness for example in form of posters and advertisements (in English and other languages representative of each community) in public spaces such as the local GP practices, libraries, bus stations, post offices, bus stops etc, should be considered to make sure that victims needing help, know where to go, to get the help.
- Flexibility – [As reflected in our first case study, when the FCE worker contacted the trauma agency on behalf of 'A' and his family, but the agency insisted on talking directly with the victim.] This paper advocates for a more flexible approach by trauma centres in booking patients. It shouldn't matter who contacts the services on behalf of the victims, it is in fact the responsibility of everyone concerned with the victim (family, friends, care givers, social service, other agencies etc) all have a duty of care to the victims getting help instead of turning a blind eye.

Further inclusive recommendations based on the TIA approach are enumerated below:

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

Table 1 (Fig 2) – courtesy: PAGE 178 | MENTAL HEALTH REVIEW JOURNAL | VOL. 21 NO. 3 2016

1. Recognition – this is no doubt the first step in fixing any problems, especially one with a negative social implication as trauma. To recognise according to TIA, is to have what is referred to as *'trauma lens'* as emphasised in our earlier discussion, that *trauma care must be trauma patient centred*. Recognising therefore involves methodically detecting the pervasiveness, nuances, and effects of trauma such as
    - Regular investigations of trauma survivors
    - Approaching questions in a sensitive and timely manner.

    Recognition is argued to build feelings of support, security, and hope.

2. Resist Retraumatisation – Understanding that some of the principles and practices of the psychiatric care employed in trauma units, can lead to retraumatisation of the victims as well as staff, by skewing the balance of power. Deliberate efforts must be made to eliminate such.
3. Cultural, Historical and Gender Considerations – In this age of cultural, historical and gender diversity any successful trauma service must:

- Identify and acknowledge ‘community specific’ trauma.
- Recognise individual needs and ensure tailor made service to meet those targeted needs.
- Awareness of the interconnected nature of the social categories within their community of care.

4. Trust & Transparency – Having identified trust as an overriding reason why trauma victims avoid seeking help, trauma led services must ensure that all decisions taken at individual and organisational levels, are open and transparent to engender trust.
5. Collaboration and Support – Relationship built on mutual respect and trust, empathy and openness will no doubt help the healing process in the care of trauma victims. Therefore, understanding the existence of imbalance of power between victims and staff (with staff having more power and control), it is vital to ensure that relationship between them is based on mutual respect, transparency and trust and hope.
6. Empowerment choice and control – Trauma victims will be more comfortable and open to get help knowing that trauma services have power of control in the hands of patients practices in place that place.
7. Safety – Trauma stimulates danger; therefore, every effort must be made at prioritising the safety of service users. Specifically, their physical and emotional safety, considering their choices, control, their culture, and gender awareness. For trauma victims to feel safe, it is important that the service be physically, psychologically, socially, culturally, and morally safe.
8. Survivor partnerships – Central to a TIA service, must be programmes that foster partnerships and collaborations amongst survivors. Programmes such as.
9. Pathways to Trauma specific-care – It is important that victims of trauma can access trauma-specific care. E.g., someone might just be needing bereavement counselling as opposed to mental health counselling. Hence services should be structured specifically and widely resourced.

Conclusion.

The problems faced by survivors of trauma are multi-faceted, damaging, and sad and, they are not well documented especially among ethnic minorities/immigrant communities. Sadly, the cost though primarily to the victims, has a collateral damage on the society. This therefore puts a collective demand on us all as communities to be our brothers' keeper, and to lay aside our prejudices, assumptions, and fear, so our help can be genuine and impactful.

To answer our earlier question, knowing what we do now, what trauma does to its people individually and collectively, what manner of people ought we to be? What support should we lend?

As friends and family, we need to be loving and empathetic, sensitive, and vigilant, patient and kind, persevering when our help is rebuffed, we must continue to stand with people we know, are suffering from trauma, and not abandon them.

To the trauma service(s), they need to be accessible, and create an environment that is warm and welcoming, free of judgementalism. A system that treats anyone walking through its door with respect and dignity, a system that creates awareness of "*we are here if you you need us"*, flexible to reach and easy to access. Not only should they treat the patients with utmost respect, allowing them be part of their own care, deliberate attempts must be made to tear down any structure which dehumanises them, and ultimately the question should be what we can do with you – A healthy partnership where the victim brings openness and honesty and the trauma professional brings his expertise, and understanding.

The FCE is already doing such fantastic work putting a spotlight on these problems, and so will do well to continue. Improving on the work to make their community a more equitable place for everyone. Future considerations may include organising English classes, (physical or online), in an informal and social space, where anyone needing to learn or improve their proficiency can learn through interaction. Professional in-house counselling may also be helpful to bridge the gap, finally, to consider investing in further research into other areas of social phenomenon which the community is experiencing.

The government and health agencies will do well to consider major investment into trauma services in the form of funds for equipment's, training and retraining of staff, science, and technology, for the overall improvement of the services. Also to revisit and revise policies that have engendered retraumatisation.

Finally, to the survivors of trauma / minority group, they have a key role to play in their own recovery, a duty to protect their mental health and dignity. Language is central to integration, hence learning the language must be a priority at least to the degree of basic communication, confidence builds on this. The responsibility of a non–native(s), is to familiarize oneself with the culture of the place one has come to settle, study or work. Language is an integral part of any culture and people, it is our identity as a people, learning it helps us to blend in and make friends and forge partnerships and alliances, which is essential for support, cooperation, and coexistence. Overcoming language barrier must be seen as a survival skill because surviving is what humans do.

These solutions have huge financial implications, and human capital development to change the status quo. Money can only go so far, hence, these recommendations are only as good as the willingness of trauma care professionals and all concerned policy makers to work consciously and conscientiously to making the necessary change/s that puts trauma victims at the centre of trauma care service, based on the TIA approach.

The limitation of this study is its online nature, it would have been interesting for the researcher to talk to a wider group of trauma victims within one or two local councils for a richer data and for comparison. However, that was not possible due to the ongoing government measures aimed at curbing the corona virus which is still ongoing at the time of the report.

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